



NSW LAW REFORM COMMISSION

Consultation Paper 6

**People with cognitive and mental  
health impairments in the criminal  
justice system: criminal responsibility  
and consequences**

January 2010

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## Terms of Reference

Pursuant to s 10 of the *Law Reform Commission Act 1967*, the Law Reform Commission is to undertake a general review of the criminal law and procedure applying to people with cognitive and mental health impairments, with particular regard to:

1. s 32 and s 33 of the *Mental Health (Criminal Procedure) Act 1990*;
2. fitness to be tried;
3. the defence of "mental illness";
4. the consequences of being dealt with via the above mechanisms on the operation of Part 10 of the *Crimes (Forensic Procedures) Act 2000*; and
5. sentencing.

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The Commission invites submissions on the issues relevant to this review, including but not limited to the proposals and issues raised in this Consultation Paper.

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**The closing date for submissions is 28 May 2010**

### **Confidentiality and use of submissions**

In preparing further papers on this reference, the Commission will refer to submissions made in response to this Consultation Paper. If you would like all or part of your submission to be treated as confidential, please indicate this in your submission. The Commission will respect requests for confidentiality when using submissions in later publications.

Copies of submissions made to the Commission will also normally be made available on request to other people or organisations. Any request for a copy of a submission marked “confidential” will be determined in accordance with *the Freedom of Information Act 1989* (NSW).



## ABBREVIATIONS

<b>COAG:</b>	Council of Australian Governments.
<b>CP 5:</b>	Consultation Paper 5.
<b>CP 6:</b>	Consultation Paper 6.
<b>CP 7:</b>	Consultation Paper 7.
<b>CP 8:</b>	Consultation Paper 8.
<b>CP 9:</b>	Consultation Paper 9.
<b>CROC:</b>	Convention on the Rights of the Child.
<b>CTO:</b>	Community Treatment Order.
<b>DSM-IV:</b>	American Psychiatric Association, <i>Diagnostic and Statistical Manual of Mental Disorders</i> (4th edition, 2000).
<b>HREOC:</b>	Human Rights and Equal Opportunity Commission.
<b>ICCPR:</b>	International Covenant on Civil and Political Rights.
<b>MHA:</b>	<i>Mental Health Act 2007</i> (NSW).
<b>MHCPA:</b>	<i>Mental Health (Criminal Procedure) Act 1990</i> (NSW).
<b>MHFPA:</b>	<i>Mental Health (Forensic Provisions) Act 1990</i> (NSW).
<b>MHRT:</b>	Mental Health Review Tribunal.
<b>MOU:</b>	Memorandum of Understanding.
<b>NSWLRC:</b>	New South Wales Law Reform Commission.

## ISSUES

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### Issue 6.1 - see page 5

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Should the MHFPA expressly require the court to consider the issue of fitness whenever it appears that the accused person may be unfit to be tried?

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### Issue 6.2 - see page 11

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Do the *Presser* standards remain relevant and sufficient criteria for determining a defendant's fitness for trial?

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### Issue 6.3 - see page 12

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Should the test for fitness to stand trial be amended by legislation to incorporate an assessment of the ability of the accused to make rational decisions concerning the proceedings?

If so, should this be achieved by:

- (a) the addition of a new standard to the *Presser* formulation, or
- (b) by amendment of relevant standards in the existing formulation?

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### Issue 6.4 - see page 12

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As an alternative to the proposal in Issue 6.3, should legislation identify the ability of the accused to participate effectively in the trial as the general principle underlying fitness determinations, with the *Presser* standards being listed as the minimum standards that the accused must meet?

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### Issue 6.5 - see page 12

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Should the minimum standards identified in *Presser* be expanded to include deterioration under the stress of trial?

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### Issue 6.6 - see page 12

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Should the minimum standards identified in *Presser* be altered in some other way?

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### Issue 6.7 - see page 19

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Should the procedure for determining fitness be changed and, if so, in what way?

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**Issue 6.8 - see page 19**

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What should be the role of:  
(a) the court; and  
(b) the MHRT  
in determining a defendant's fitness to be tried?

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**Issue 6.9 - see page 20**

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Should provision be made for the defence and prosecution to consent to a finding of unfitness?

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**Issue 6.10 - see page 21**

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Should the *Criminal Appeal Act 1912* (NSW) be amended to provide for the Court of Criminal Appeal to substitute a "qualified finding of guilt" in cases where a conviction is quashed due to the possible unfitness of the accused person at the time of trial?

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**Issue 6.11 - see page 22**

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Should fitness procedures apply in Local Courts? If so, how should they be framed?

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**Issue 6.12 - see page 25**

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Should legislation provide for the situation where a committal hearing is to be held in respect of an accused person who is or appears to be unfit to be tried? If so, what should be provided?

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**Issue 6.13 - see page 35**

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Should the special hearing procedure continue at all, or in its present form? If not, how should an unfit offender be given an opportunity to be acquitted?

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**Issue 6.14 - see page 37**

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Should a procedure be introduced whereby the court, if not satisfied that the prosecution has established a prima facie case against the unfit accused, can acquit the accused at an early stage?

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**Issue 6.15 - see page 39**

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Should deferral of the determination of fitness be available as an expeditious means of providing the accused with an opportunity of acquittal?

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**Issue 6.16** - *see page 40*

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Should the special hearing be made more flexible? If so, how?

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**Issue 6.17** - *see page 42*

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Should the MHFPA provide for the defendant to be excused from a special hearing?

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**Issue 6.18** - *see page 43*

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Should the finding that “on the limited evidence available, the accused person committed the offence charged [or an offence available as an alternative]” be replaced with a finding that “the accused person was unfit to be tried and was not acquitted of the offence charged [or an offence available as an alternative]”?

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**Issue 6.19** - *see page 44*

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Should a verdict of “not guilty by reason of mental illness” continue to be available at special hearings? Are any additional safeguards necessary?

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**Issue 6.20** - *see page 51*

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Should the defence of mental illness be replaced with an alternative way of excusing defendants from criminal responsibility and directing them into compulsory treatment for mental health problems (where necessary)? For example, should it be replaced with a power to divert a defendant out of criminal proceedings and into treatment?

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**Issue 6.21** - *see page 57*

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Should legislation expressly recognise cognitive impairment as a basis for acquitting a defendant in criminal proceedings?

If yes, should the legislation expressly include cognitive impairment as a condition coming within the scope of the defence of mental illness, or is it preferable that a separate defence of cognitive impairment be formulated as a ground for acquittal?

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**Issue 6.22** - *see page 61*

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Should the defence of mental illness be available to defendants with a personality disorder, in particular those demonstrating an inability to feel empathy for others?

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**Issue 6.23 - see page 63**

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Should the defence of mental illness be available to defendants who lack the capacity to control their actions?

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**Issue 6.24 - see page 64**

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Should the test for the defence of mental illness expressly refer to delusional belief as a condition that can be brought within the scope of the defence? If yes, should the criminal responsibility of a defendant who acts under a delusional belief be measured as if the facts were really as the defendant believed them to be?

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**Issue 6.25 - see page 65**

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Should the current test for determining the application of the defence of mental illness be retained without change?

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**Issue 6.26 - see page 67**

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If the *M'Naghten* rules were reformulated in legislation, should the legislation define the concept of a disease of the mind? If so, how should it be defined? Should the common law requirement for a "defect of reason" be omitted from the statutory formulation?

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**Issue 6.27 - see page 68**

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If the *M'Naghten* rules were reformulated in legislation, should the legislation recognise, as one way of satisfying the defence, a lack of knowledge of the nature and quality of the act? If so, should the legislation provide for a lack of actual knowledge, or a lack of capacity to know?

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**Issue 6.28 - see page 69**

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If the *M'Naghten* rules were reformulated in legislation, should the legislation recognise, as one way of satisfying the defence, a lack of knowledge that the criminal conduct was wrong? If so, should the legislation provide any guidance about the meaning of this alternative? For example, should it require that the defendant could not have reasoned with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong? Should the legislation require a lack of capacity to know, rather than a lack of actual knowledge?

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**Issue 6.29** - *see page 78*

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Should the approach for determining the application of the defence of mental illness under the *M'Naghten* rules be replaced with a different formulation? If so, how should the law determine the circumstances in which a defendant should not be held criminally responsible for his or her actions due to mental illness or other impairment of mental function?

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**Issue 6.30** - *see page 83*

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Should a defendant's self-induced intoxication or withdrawal from an intoxicant be able to form a basis for claiming that the defendant is not guilty of a charge by reason of mental illness and, if so, in what circumstances?

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**Issue 6.31** - *see page 85*

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Should the defence of mental illness apply to a defendant's involuntary act if that involuntary act was caused by a disease of the mind? If yes, should legislation provide a test for determining involuntary acts that result from a disease of the mind as opposed to involuntary acts that come within the scope of the defence of automatism, and if so, how should that test be formulated?

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**Issue 6.32** - *see page 87*

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Should the MHFPA be amended to allow the prosecution, or the court, to raise the defence of mental illness, with or without the defendant's consent?

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**Issue 6.33** - *see page 87*

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Should the MHFPA be amended to allow for a finding of "not guilty by reason of mental illness" to be entered by consent of both parties?

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**Issue 6.34** - *see page 87*

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Should the court have the power to order an assessment of the defendant for the purpose of determining whether he or she is entitled to a defence of mental illness?

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**Issue 6.35** - *see page 89*

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Should a process other than an ordinary trial be used to determine whether a defendant is not guilty by reason of mental illness?

**Issue 6.36** - *see page 90*

Should the defence of mental illness be available generally in the Local Court and, if so, should it be available in all cases?

**Issue 6.37** - *see page 105*

If the umbrella definition of cognitive and mental impairment suggested in Consultation Paper 5, Issue 5.2 were to be adopted, should it also apply to the partial defence of substantial impairment?

**Issue 6.38** - *see page 106*

As an alternative to an umbrella definition of cognitive and mental impairment, should the mental state required by s 23A be revised? If so, how?

**Issue 6.39** - *see page 107*

Is the requirement in s 23A of the Crimes Act that the impairment be “so substantial as to warrant liability for murder being reduced to manslaughter” sufficiently clear? If not, how should it be modified?

**Issue 6.40** - *see page 117*

Should the defence of substantial impairment be retained or abolished? Why or why not?

**Issue 6.41** - *see page 133*

Is there a continuing need for infanticide to operate, either as an offence in itself, or as a partial defence to murder?

**Issue 6.42** - *see page 133*

Should the continued operation of the infanticide provisions be conditional on the retention of the partial defence of substantial impairment?

**Issue 6.43** - *see page 133*

If infanticide is to be retained, should it be recast? If so, how?

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**Issue 6.44** - *see page 144*

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Should the MHFPA be amended to provide a mechanism and/or requirement for the court to notify the MHRT of the terms of its order under s 27 of the MHFPA?

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**Issue 6.45** - *see page 148*

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To what extent (if any) should sentencing principles continue to apply to the court's decision whether to detain or release a person who is UNA?

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**Issue 6.46** - *see page 150*

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Should the MHFPA be amended to provide additional guidance to the court in deciding whether to order detention or release of persons found NGMI?

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**Issue 6.47** - *see page 151*

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Should the MHFPA be amended to provide guidance to the court in relation to the conditions that may be attached to an order for conditional release?

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**Issue 6.48** - *see page 153*

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Is there any reason to retain a distinction between the orders available to the court in cases where the person is UNA or NGMI?

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**Issue 6.49** - *see page 155*

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If the present frameworks are to be retained:

- (a) should the definition of "forensic patient" be amended to include a person who is UNA and in respect of whom a non-custodial order is made?
- (b) should the MHFPA be amended to provide a power for the court to order conditional release if it does not make an order for detention under s 27?

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**Issue 6.50** - *see page 157*

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What orders should be available to the court?

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**Issue 6.51** - *see page 157*

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Should the same orders be available both for persons who are UNA and for those who are found NGMI?



**Issue 6.52 - see page 157**

What orders should result in a person becomes a “forensic patient”?

**Issue 6.53 - see page 159**

To what extent (if any) should the court take into account a risk of harm to the person him- or herself, as distinct from the risk (if any) to other members of the community?

**Issue 6.54 - see page 159**

Should the court be provided with a power to refer a person to the civil jurisdiction of the MHRT, or to another appropriate agency, if the person poses a risk of harm to no-one but him or herself?

**Issue 6.55 - see page 161**

What kind of possible “harm” should be relevant to decisions by the court to detain or release persons who are UNA or NGMI?

**Issue 6.56 - see page 161**

Should “harm” be defined in the MHFPA?

**Issue 6.57 - see page 163**

How should the relevant degree of risk of harm be expressed in the MHFPA? Should it be defined?

**Issue 6.58 - see page 164**

Should a presumption in favour of detention continue to apply when courts are making decisions about persons who are UNA or NGMI?

**Issue 6.59 - see page 164**

When deciding what order to make in respect of a person who is UNA or NGMI, should the court be required to apply a principle of least restriction consistent with:

- (a) the safety of the community?
- (b) the safety of the person concerned? and/or
- (c) some other object(s)?

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**Issue 6.60** - *see page 166*

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In relation to court proceedings involving people who are UNA or NGMI, are the current provisions concerning notification to, and participation by:

- (a) victims; and
  - (b) carers
- adequate and appropriate?

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**Issue 6.61** - *see page 168*

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What principles should apply when courts are making decisions about persons who are UNA or NGMI?

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**Issue 6.62** - *see page 168*

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What factors should courts be allowed and/or required to take into account when making decisions about persons who are UNA or NGMI?

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**Issue 6.63** - *see page 169*

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In cases where the person is UNA, should the possibility that the person will become fit to be tried be a sufficient basis for the court to make an order of some kind?

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**Issue 6.64** - *see page 170*

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Should legislation specify what standard of proof applies to facts which form the basis of the court's decision as to what order to make in respect of a person who is UNA or who has been found NGMI? If so, what standard of proof should be specified?

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**Issue 6.65** - *see page 173*

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What powers or procedures (if any) should be provided to assist the court in determining the appropriate order in cases where the person is UNA or NGMI?

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**Issue 6.66** - *see page 173*

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Should legislation provide a mechanism for the court to notify the MHRT of its final order in cases where the person is UNA or NGMI?

**Issue 6.67 - see page 177**

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In what circumstances (if any) should the *Criminal Appeal Act* provide for the person the subject of the proceedings to appeal against:

- (a) a verdict of NGMI;
- (b) orders by the court in cases where the person is NGMI;
- (c) non-acquittal at a special hearing?
- (d) orders by the court in cases where the person is UNA?

**Issue 6.68 - see page 178**

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In what circumstances (if any) should the *Criminal Appeal Act* allow the prosecution to appeal against:

- (a) a verdict of NGMI?
- (b) orders by the court in cases where the person is NGMI?
- (c) orders by the court in cases where the person is UNA?

**Issue 6.69 - see page 178**

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Should the *Criminal Appeal Act* be amended to require the Court of Criminal Appeal to consider the safety of the person and/or the community prior to making an order for release?

**Issue 6.70 - see page 178**

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What manner of appeal is most appropriate for reviewing:

- (a) findings; and
- (b) consequent orders in cases where the person is UNA or NGMI?

**Issue 6.71 - see page 178**

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Should any ancillary powers be provided to assist the Court of Criminal Appeal in deciding such cases?

**Issue 6.72 - see page 180**

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Is there any reason why Local Court magistrates should not have power to make orders in respect of persons who are UNA or NGMI?

**Issue 6.73 - see page 180**

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If the Local Court should have powers for cases involving persons who are UNA or NGMI, should they be the same as the powers of the District and Supreme Courts? If not, what should be provided?

**Issue 6.74** - *see page 186*

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Should the MHFPA provide for a forensic patient to apply for a review of his or her case?

**Issue 6.75** - *see page 187*

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Are the provisions regarding the conditions that may attach to leave or release adequate and appropriate? If not, what changes should be made?

**Issue 6.76** - *see page 188*

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Should the MHFPA be amended to abolish the requirement for the MHRT to notify

- the Minister for Police;
- the Minister for Health; and/or
- the Attorney General

of an order for release?

**Issue 6.77** - *see page 189*

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Should legislation provide specific roles for an agency or agencies in relation to supporting and supervising forensic patients in the community?

**Issue 6.78** - *see page 190*

---

Are there any legislative changes that should be made in relation to the making and implementation of orders for:

- leave; and/or
- conditional release

of forensic patients?

**Issue 6.79** - *see page 190*

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Are the procedures relating to breaches of orders adequate and appropriate? If not, what else should be provided?

**Issue 6.80** - *see page 192*

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Are the current provisions concerning notification to, and participation by victims in proceedings of the MHRT adequate and appropriate? If not, what else should be provided?

**Issue 6.81** - *see page 192*

Are the current provisions concerning notification to, and participation by carers in proceedings of the MHRT adequate and appropriate? If not, what else should be provided?

**Issue 6.82** - *see page 194*

Are the current provisions relating to people who are UNA who become fit to be tried adequate and appropriate?

**Issue 6.83** - *see page 194*

Should a person cease to be a forensic patient if he or she becomes fit to be tried and the Director of Public Prosecutions decides that no further proceedings are to be taken?

**Issue 6.84** - *see page 194*

Should legislation specify circumstances in which, or a period after which, fitness ceases to be an issue?

**Issue 6.85** - *see page 195*

Should the requirement that the MHRT have regard to whether a forensic patient who was UNA has spent "sufficient" time in custody be abrogated?

**Issue 6.86** - *see page 196*

Are the provisions of the MHFPA which define the circumstances in which a person ceases to be a forensic patient sufficient and appropriate? If not, are there any additional circumstances in which a person should cease to be a forensic patient?

**Issue 6.87** - *see page 196*

Should there be provisions for referring a person who is UNA into other care, support and/or supervision arrangements at the expiry of the limiting term? If so, what should they be?

**Issue 6.88** - *see page 198*

Are the provisions regarding the entitlement to be released from detention upon ceasing to be a forensic patient adequate and appropriate? If not, what else should be provided?

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**Issue 6.89** - *see page 199*

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Are the provisions for appeals against decisions by the MHRT adequate and appropriate? If not, how should they be modified?

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**Issue 6.90** - *see page 203*

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Should the MHFPA be amended to exclude the detention of forensic patients in correctional centres?

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**Issue 6.91** - *see page 203*

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If detaining forensic patients in correctional centres is to continue, are legislative measures needed to improve the way in which forensic patients are managed within the correctional system?

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**Issue 6.92** - *see page 209*

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Under what circumstances, if any, should forensic patients be subject to compulsory treatment?

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**Issue 6.93** - *see page 209*

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Should different criteria apply to:

- (a) different types of treatment; and/or
- (b) forensic patients with different types of impairment?

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**Issue 6.94** - *see page 209*

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Is the range of interventions for which the MHA and the MHFPA provide adequate and appropriate for all forensic patients? In particular, are different or additional provisions needed for forensic patients who have cognitive impairments?

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**Issue 6.95** - *see page 210*

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Are the present safeguards regarding compulsory treatment of forensic patients adequate? If not, what other safeguards are needed?

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**Issue 6.96** - *see page 212*

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Should the MHFPA provide any additional factors to which the MHRT must have regard when making decisions about forensic patients?

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**Issue 6.97 - see page 213**

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Should the relevant risk of harm be expressed and defined in the same way for the purposes of decisions by the Forensic Division of the MHRT as it is for the court? If not, how should the provisions relating to the MHRT be different?

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**Issue 6.98 - see page 213**

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In what circumstances, and to what extent should the Forensic Division of the MHRT be required to have regard to a risk of harm only to the person concerned, in the absence of any risk to others?

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**Issue 6.99 - see page 215**

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Should a requirement to impose only the “least restriction” apply to all decisions regarding forensic patients?

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**Issue 6.100 - see page 215**

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How should any such principle of “least restriction” be expressed in the MHFPA? Should it be expressed differently for the purposes of different types of decisions?

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**Issue 6.101 - see page 220**

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Should a limit apply to the length of time for which people who are UNA and/or people who are NGMI remain subject to the forensic mental health system?

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**Issue 6.102 - see page 224**

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If there is a time limit, on what basis should it be determined?

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**Issue 6.103 - see page 224**

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Should the same approach be used both for persons who are UNA and for those who have been found NGMI?

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**Issue 6.104 - see page 241**

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Should s 21A of the CSPA be amended to include “cognitive and mental health impairment” as a factor in sentencing?

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**Issue 6.105** - *see page 241*

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Further, should the CSPA contain a more general statement directing the court's attention to the special considerations that arise when sentencing an offender with cognitive or mental impairments? If so, how should that statement be framed?

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**Issue 6.106** - *see page 242*

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Should the purposes of sentencing as set out in s 3(1)(a) of the CSPA be modified in terms of their relevance to offenders with cognitive and mental health impairments? If so, how?

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**Issue 6.107** - *see page 248*

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Should the CSPA be amended to make it mandatory for a court to order a pre-sentence report when considering sentencing offenders with cognitive or mental health impairments to prison?

If so:

- (a) what should the report contain?
- (b) should the contents be prescribed in the relevant legislation?

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**Issue 6.108** - *see page 250*

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Should the CSPA be amended to give courts the power to order that offenders with cognitive or mental health impairments be detained in facilities other than prison?

If so, how should such a power be framed?

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**Issue 6.109** - *see page 252*

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Should the CSPA provide a mechanism for courts to notify other agencies and tribunals of the needs of offenders with cognitive and mental health impairments who are sentenced to imprisonment?

If so, should the legislation state that the sentencing court:

- (a) may make recommendations on the warrant of commitment concerning the need for psychiatric evaluation, or other assessment of an offender's mental condition as soon as practicable after reception into a correctional centre; and/or
- (b) may forward copies of any reports concerning an offender's impairment-related needs to the correctional centre, Justice Health, the MHRT, or the Disability Services Unit within DCS, if appropriate?



**Issue 6.110 - see page 253**

Should the CSPA be amended to empower the court, when considering imposing a sentence of imprisonment on an offender with a mental illness, to request that the MHRT assess the offender with a view to making a community treatment order pursuant to s 67(1)(d) of the MFPA?

**Issue 6.111 - see page 253**

What similar powers, if any, should the court have with regard to offenders with other mental conditions or cognitive impairments?

**Issue 6.112 - see page 257**

Should provisions regarding parole be amended to refer specifically to offenders with cognitive and mental health impairments? In particular, should the relevant legislation require specific consideration of an offender's cognitive or mental impairment:

- (a) by the Probation and Parole Service when preparing reports for the Parole Authority;
- (b) by the court when setting parole conditions; or
- (c) by the Parole Authority when determining whether to grant or revoke parole, and when determining parole conditions.

**Issue 6.113 - see page 266**

Should the relevant legislation dealing with periodic detention, home detention, community service orders and good behaviour bonds be amended to increase the relevance and appropriateness of these sentencing options for offenders with cognitive or mental impairments?

**Issue 6.114 - see page 267**

In particular, how could:

- (a) the eligibility and suitability requirements applicable to each type of order; and
- (b) the conditions that may attach to each semi or non-custodial option be adapted to meet the requirements of offenders with cognitive or mental impairments.

**Issue 6.115 - see page 268**

Should s 11 of the CSPA concerning deferral of sentencing be amended to refer expressly to rehabilitation or intervention programs for offenders with cognitive or mental health impairments?



## PREFACE

0.1 The purpose of this review is to examine the law and practice regulating what happens to people with a mental illness or a cognitive impairment, or both, who commit crimes. The law recognises that a defendant's mental state may affect the nature of the criminal justice response that would ordinarily attach to his or her actions. For example, a Local Court magistrate may, in certain circumstances, consider it more appropriate that a defendant be treated in a mental health facility rather than receive a criminal sanction, and order that the defendant be diverted away from the criminal justice system. Offenders appearing before the District or Supreme Courts may be deemed to be unfit to stand trial, or may be tried before a court or a special hearing and receive a qualified acquittal on the ground of mental illness. Alternatively, an offender may be found guilty following an ordinary trial, but have a mental impairment that may lessen the degree of criminal liability, or be relevant to the sentencing process.

0.2 In this review, we assess the effectiveness of the current operation of the criminal justice system in its dealings with offenders who have cognitive or mental health impairments. We do so against the background of the current legislative and administrative regime and a comparison with other jurisdictions, together with Australia's obligations under relevant human rights instruments.

### A series of consultation papers

0.3 This Paper is the second in a series of five consultation papers on this reference, dealing with the following subjects:

1. **Consultation Paper 5** – presents a background and overview of the laws affecting people with a mental impairment or a cognitive impairment when they become involved as defendants in the criminal justice system. It sets the context for whole inquiry examining the current civil and forensic system in practice. It also questions the appropriateness of the legislative terminology describing cognitive or mental impairments, and the effectiveness of measures within the criminal justice system to identify such impairments.
2. **Consultation Paper 6** – considers the laws determining the nature and extent of criminal responsibility in relation to

offenders with cognitive or mental health impairments, primarily in relation to Supreme and District Court proceedings, and the consequences that may follow. In particular, Consultation Paper 6 deals with:

- fitness for trial and the options for dealing with offenders found unfit but not acquitted;
  - the elements of the defence of mental illness and how the criminal justice system should respond to offenders found not guilty on the ground of mental illness;
  - the partial defence of substantial impairment;
  - infanticide; and
  - sentencing principles and options.
3. **Consultation Paper 7** – examines the laws relating to the diversion of offenders with a mental illness or cognitive impairment away from the criminal justice system, focusing on the diversionary mechanisms available to the Local Court.
  4. **Consultation Paper 8** – looks at the use of forensic samples taken from a defendant who has been diverted from the criminal justice system, or found unfit to be tried or not guilty by reason of mental illness;
  5. **Consultation Paper 9** – considers issues specific to young offenders with a mental illness or cognitive impairment.

The first four papers (Consultation Papers 5-8) have been released concurrently. Consultation Paper 9 will be released early 2010.

0.4 We have chosen to publish separate consultation papers rather than one longer paper given the breadth of the subject matter. Also, although the issues raised in this inquiry are interrelated to an extent, they deal with separate and discrete questions. People with an interest and expertise in a specific area can then focus their attention on the paper dealing with that topic.

### Structure of this paper

0.5 Chapters 1 to 5 examine the impact of an offender's cognitive and mental health impairment on the establishment of criminal responsibility.

In Chapter 1, we discuss the procedures for determining a defendant's fitness to stand trial in the District or Supreme courts, including the meaning of fitness, when and how the question arises, the most suitable forum for establishing fitness, and whether a similar procedure should apply in the Local Court. Once a finding of unfitness has been made, the court conducts a special hearing to provide the defendant with an opportunity for acquittal. The adequacy of the special hearing procedure is discussed in Chapter 2.

0.6 Chapter 3 analyses the defence of mental illness, questioning whether it remains relevant or should be reformulated in some way. The related partial defence of substantial impairment is examined in Chapter 4, while Chapter 5 deals with infanticide.

0.7 The remainder of the paper looks at the consequences of an offender's contact with the criminal justice system. Chapters 6 and 7 discuss the powers of the Court and the Mental Health Review Tribunal respectively to make orders concerning people found unfit but not acquitted at a special hearing, or who have successfully pleaded the defence of mental illness and been found not guilty as a result. Finally, chapter 8 reviews sentencing principles and options applicable to offenders who have been convicted of criminal offences, with a particular focus their appropriateness, or otherwise, people with cognitive and mental health impairments.

### Preliminary consultations

0.8 To assist in isolating relevant issues and concerns, the Commission invited preliminary submissions from medical practitioners, judges and magistrates, and agencies such as the Office of the Director of Public Prosecutions, the Legal Aid Commission, the Law Society of NSW, the Public Defenders Office, the Intellectual Disability Rights Service, the NSW Council for Intellectual Disability, and community legal centres. Meetings were also held with the Mental Health Review Tribunal, NSW Police, the Intellectual Disability Rights Service, the Public Interest Advocacy Centre, and Professor Susan Hayes. The Commission is very grateful for this input.

## Submissions and further consultation

0.9 A number of issues are raised in this series of consultation papers, designed to stimulate consultation on a much broader level. Submissions in oral, written or electronic form are invited from any interested person or agency, and will assist the Commission in developing its final recommendations.

# 1. **Fitness for trial**

- Introduction
- When and how the question of fitness arises
- The meaning of fitness to be tried
- The role of the Mental Health Review Tribunal
- Procedures ancillary to the determination of fitness
- Fitness in local courts

## INTRODUCTION

1.1 The origin of the modern requirement that a person must be fit to stand trial is found in the old common law rule that a criminal trial could not take place unless, among other matters, the accused pleaded to the charge.<sup>1</sup> If the accused would not plead, he or she could, until 1772, be put to death by crushing. This penalty would not follow if the accused's failure to plead resulted from his or her incapacity to do so. Incapacity tended to be articulated in terms of "insanity", although that expression was never given a narrow meaning in this context. It is now clear that, while questions of fitness do commonly arise from a person's cognitive or mental health impairment,<sup>2</sup> they may also arise from other incapacities, such as physical illness<sup>3</sup> or disability.<sup>4</sup> The requirement that the accused be fit to stand trial is now seen to rest on broad considerations such as "trial fairness, humanity and the need for the public appreciation of and respect for the dignity of the criminal process".<sup>5</sup>

1.2 The common law continues to govern the test of fitness to stand trial in NSW. However, Part 2 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) ("the MHFPA") contains provisions applying to fitness determinations and the consequences of such determinations in criminal proceedings in the Supreme and District courts. Part 3 of the MHFPA makes separate provision in relation to Local Court proceedings for diverting defendants who appear to have a mental illness, developmental disability or other mental condition away from the criminal justice system

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1. The historical development of fitness is traced in *R v Mailes* (2001) 53 NSWLR 251, [112]-[215].
  2. Eg, *R v Mailes* (2001) 53 NSWLR 251.
  3. Eg, *R v Sexton* (2000) 116 A Crim R 173 (inoperable heart disease, risk of stress-induced heart attack if required to stand trial), cited in *R v Mailes* (2001) 53 NSWLR 251, [170] as an example of "the ambit of conditions which may warrant a finding of unfitness to stand trial".
  4. See, eg, *Ebatarinja v Deland & Ors* (1998) 157 ALR 385 (deaf mute Aboriginal youth unable to communicate except by hand gestures for simple needs held unfit to stand trial). See also *R v Willie* (1885) 7 QLJ (NC) 108 (four Aboriginal defendants discharged because no interpreter available to communicate the charge to them).
  5. *R v Cummings* [2006] 2 NZLR 597, [37].



in appropriate circumstances.<sup>6</sup> Consequently, this chapter applies only to proceedings in the Supreme and District courts.<sup>7</sup>

1.3 This chapter examines five principal issues:

- when and how the question of fitness arises during a trial;
- the meaning of fitness to be tried;
- the forum for determining fitness;
- the procedures for determining fitness; and
- whether or not fitness procedures should be adopted in the Local Courts.

## WHEN AND HOW THE QUESTION OF FITNESS ARISES

1.4 A defendant is presumed to be fit to be tried unless and until a question as to his or her fitness is raised.<sup>8</sup> That question may be raised by any party to the proceedings, or by the court.<sup>9</sup> At common law, the court has a duty to consider the question of the defendant's fitness if there is material before it that raises the issue, even if neither the defence nor the prosecution asserts that the defendant is unfit.<sup>10</sup> Additionally, a legal practitioner may have an ethical obligation to raise the issue of fitness, even contrary to the client's instructions, as part of the overriding duty to the court.<sup>11</sup>

1.5 While it is preferable to raise the question before arraignment, it may be raised at any time during the proceedings,<sup>12</sup> including at

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6. See Consultation Paper 7 ("CP 7).

7. This chapter also applies only to the procedures for determining fitness to stand trial, and not to fitness at earlier stages of the criminal justice process, eg, fitness for interview during police investigations.

8. *Eastman v The Queen* (2000) 203 CLR 1, [86].

9. *Mental Health (Forensic Provisions) Act 1990* (NSW) ("MHFPA") s 5.

10. *Eastman v The Queen* (2000) 203 CLR 1, [84]-[87] (Gaudron J), [172], [177]-[179] (Gummow J), [282] (Kirby J), [294]-[296], [300]-[301] (Hayne J), [333] (Callinan J). Gleeson CJ and McHugh JJ dissented on this point: [41], [46]-[48], [102], [166]-[167]. See also *Kesavarajah v The Queen* (1994) 181 CLR 230. But contrast *R v Riley* (Unreported, NSW Supreme Court, Mathews AJ, 2 May 2008).

11. *Eastman v The Queen* (2000) 203 CLR 1, [297] (Hayne J), but contrast [373] -[374] (Callinan J); see, eg, *R v Zhang* [2000] NSWCCA 344 (question of fitness raised by prosecution).

12. MHFPA s 7(1).

sentencing,<sup>13</sup> or retrospectively on appeal.<sup>14</sup> If a question of fitness is raised, the court must hold an inquiry into the defendant’s fitness,<sup>15</sup> unless the question is not raised in good faith,<sup>16</sup> or the court discharges the defendant.<sup>17</sup> A question is raised in good faith unless “no reasonable jury, properly instructed, could find that the accused was not fit to be tried”.<sup>18</sup> The court may decide not to conduct a fitness inquiry and instead discharge the defendant if the trivial nature of the charge or offence, the “nature of the person’s disability” or any other matter render it inappropriate to inflict any punishment.<sup>19</sup>

1.6 A judge sitting alone<sup>20</sup> determines the question of the defendant’s fitness on the balance of probabilities<sup>21</sup>. The judge must give reasons for his or her decision.<sup>22</sup> While the defendant must be represented by a legal practitioner unless the court otherwise allows, the inquiry is not conducted in an adversarial manner and no party bears the burden of proof.<sup>23</sup>

1.7 The question of fitness is not determined once and for all: the fact that a question of fitness has been raised in the proceedings does not

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13. *Wills v The Queen* (2007) 173 A Crim R 208, [51]-[81].

14. The appellate court must quash the conviction unless it is satisfied that, had the question been raised at trial, the trial court would have found that the accused was fit to stand trial: see *Eastman v The Queen* (2000) 203 CLR 1; *R v RTI* (2003) 58 NSWLR 438; *R v Rivkin* (2004) 59 NSWLR 284, [297]-[301]; *R v Henley* [2005] NSWCCA 126, [4], [13]-[15]; *R v Kirkwood* [2006] NSWCCA 181, [7]-[15]; *Wills v The Queen* (2007) 173 A Crim R 208; *Robinson v The Queen* [2008] NSWCCA 64; *R v Zhang* [2000] NSWCCA 344.

15. MHFPA s 10(1).

16. MHFPA s 10(2). The threshold is also referred to as a “real”, “genuine” or “real and substantial” question as to fitness: see *Ngatayi v The Queen* (1980) 147 CLR 1, 9; *Eastman v The Queen* (2000) 203 CLR 1, [296], [319]; *R v Tier* [2001] NSWCCA 53, [1]-[6], [69]-[72]; *R v Mailes* (2001) 53 NSWLR 251, [173]-[181], [224].

17. MHFPA s 10(4).

18. *Kesavarajah v The Queen* (1994) 181 CLR 230, 245.

19. MHFPA s 10(4).

20. MHFPA s 11(1). At common law, a jury had to be empanelled for the purpose of determining whether or not the defendant was fit to plead or fit to be tried: see discussion in *R v Mailes* (2001) 53 NSWLR 251, [112]-[132].

21. MHFPA s 6.

22. MHFPA s 11(2).

23. See MHFPA s 12; *Eastman v The Queen* (2000) 203 CLR 1, [294].

preclude the question of the defendant's fitness being raised again later in the same proceedings.<sup>24</sup>

## Issue 6.1

Should the MHFPA expressly require the court to consider the issue of fitness whenever it appears that the accused person may be unfit to be tried?

## THE MEANING OF FITNESS TO BE TRIED

### The *Presser* standards

1.8 The MHFPA does not define fitness to be tried. At common law, a person is fit to plead if he or she is sufficiently able to comprehend the nature of the trial so as to make a proper defence to the charge.<sup>25</sup> In *R v Presser*, Justice Smith developed the common law test by identifying “minimum standards” that the accused must meet before he or she was considered to be mentally fit to stand trial within the meaning of the then *Crimes Act 1926* (Vic).<sup>26</sup> The *Presser* “standards” are now applied throughout Australia to determine whether the accused person's cognitive or mental health impairment renders him or her unfit for trial, including for the purposes of the MHFPA.<sup>27</sup>

1.9 The *Presser* standards require that the accused be able to:

- understand the offence with which he or she is charged;
- plead to the charge;
- exercise the right to challenge jurors;

24. MHFPA s 7(2).

25. See *R v Pritchard* (1836) 7 C & P 303, 173 ER 135; *Ngatayi v The Queen* (1980) 147 CLR 1, 6-7; *Kesavarajah v The Queen* (1994) 181 CLR 230, 245.

26. *R v Presser* [1958] VR 45, 48, now reduced to statutory form in *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 6. See also *R v Robertson* (1968) 52 Cr App R 690.

27. See especially *R v Mailes* (2001) 53 NSWLR 251, [144]-[151]; *R v Sexton* (2000) 116 A Crim R 173, [50]-[58]. And consider *Crimes Act 1900* (ACT) s 311; *Criminal Code Act 1983* (NT) s 43J; *Criminal Law Consolidation Act 1935* (SA) s 269H; *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 9; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 8.

- understand generally the nature of the proceeding as an inquiry into whether he or she committed the offences charged;
- follow the course of proceedings so as to understand what is going on in a general sense;
- understand the substantial effect of any evidence that may be given against him or her;
- make a defence or answer to the charge;
- where the accused is represented, give necessary instructions to counsel regarding the defence, and provide his or her version of the facts to counsel and, if necessary, the court; and
- have sufficient mental capacity to decide what defence he or she will rely on and to make that known to counsel and the court.<sup>28</sup>

1.10 Failure to meet any of these standards renders the accused unfit to stand trial. The determination is made by reference to expert psychiatric evidence which addresses the standards and may also express an opinion about the overall ability of the accused to stand trial.<sup>29</sup>

1.11 The minimum standards set out in *Presser* do not require that the accused be conversant with court procedure or understand the law governing the case.<sup>30</sup> Nor do they require that the accused have sufficient capacity to make an able defence or to act wisely in his or her best interests.<sup>31</sup> As the Court of Criminal Appeal has pointed out, to set the test at some such level would be inappropriate.<sup>32</sup>

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28. See *R v Presser* [1958] VR 45, 48.

29. Research in England has revealed that, in practice, psychiatric reports most commonly focus on the ability of the accused to understand the course of the proceedings and to instruct a lawyer: R Mackay, B Mitchell and L Howe, “A Continued Upturn in Unfitness to Plead – More Disability in Relation to the Trial under the 1991 Act” [2007] *Criminal Law Review* 530, 536.

30. *Ngatayi v The Queen* (1980) 147 CLR 1, 8-9; *R v Mailes* (2001) 53 NSWLR 251, [148].

31. *Ngatayi v The Queen* (1980) 147 CLR 1, 8-9; *R v Presser* [1958] VR 45, 48.

32. In *R v Rivkin* (2004) 59 NSWLR 284, the Court of Criminal Appeal noted that interpreting the *Presser* standards to require the accused to act in his or her best interests “might invite invidious comparisons between accused of different intellectual backgrounds or personalities. It could also invite a fruitless search for a hypothetical accused with the capacity, intellectual or otherwise, which might equip him or her with the ability to conduct a defence at a predetermined level of skill”: [299].

## Are the *Presser* standards sufficient?

1.12 In other jurisdictions, considerations distinct from, or additional to, the *Presser* standards are relevant to determining a defendant’s fitness for trial. We seek views as to whether the following issues should supplement the *Presser* standards:

- the ability to make rational decisions;
- the ability to participate effectively in proceedings; and/or
- deterioration under the stress of trial.

### *The ability to make rational decisions*

1.13 The standards articulated in *Presser* look to the defendant’s understanding of various matters relating to the proceedings and to some associated functional skills, such as the ability to instruct advisers. They do not expressly refer to the capacity of accused persons to make rational decisions in the light of the understanding that they do have. In contrast, the legislative definition of unfitness in South Australia does incorporate such references. It provides:

A person is mentally unfit to stand trial on a charge of an offence if the person’s mental processes are so disordered or impaired that the person is –

- (a) unable to understand, or to respond rationally to, the charge or allegations on which the charge is based; or
- (b) unable to exercise (or to give rational instructions about the exercise of) procedural rights (such as, for example, the right to challenge jurors); or
- (c) unable to understand the nature of the proceedings, or to follow the evidence or the course of the proceedings.<sup>33</sup>

1.14 Case law in the United States and some European jurisdictions also requires that, to be fit, a defendant must, to some degree, be able to function rationally. For example, in *Dusky v United States*, the Supreme Court formulated the test as a question of “whether [the defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and whether he has a rational as well as

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33. *Criminal Law Consolidation Act 1935* (SA) s 269H (emphasis added). The legislative restatements of the *Presser* standards in other Australian jurisdictions do not attempt to rewrite those standards in any significant respect.

factual understanding of the proceedings against him.”<sup>34</sup> This requires that the defendant should be able to interpret facts, at least at a simple level.<sup>35</sup> Thus, the ability to assist in one’s own defence requires, among other matters, the capacity to recall and relate facts, assess the testimony of witnesses, make simple decisions between alternatives and, if necessary, to testify in one’s own defence. The defendant must also be oriented to time and place, have an understanding of the trial process and of the roles of the judge, jury, prosecutor and defence counsel, and have “sufficient intelligence and judgment to listen to [the] advice of counsel and, based on that advice, appreciate [the] fact that one course of conduct may be more beneficial to him than another”.<sup>36</sup>

1.15 A focus on the accused person’s rationality is also apparent in the fitness tests adopted in some European jurisdictions. For example, courts in Jersey determine fitness by reference to factors that equate to the *Presser* standards, and to “the ability of the [defendant] to ... make rational decisions in relation to his participation in the proceedings (including whether or not to plead guilty), which reflect true and informed choices on his part”.<sup>37</sup> That approach is intended to ensure that the defendant is able to participate effectively in the proceedings, as required by the guarantee of a fair trial in the European Convention on Human Rights.<sup>38</sup>

1.16 Justice Smith intended that the *Presser* standards should be applied in “a reasonable and commonsense fashion”, not in “any over-literal sense”.<sup>39</sup> The standards are articulated in terms that are capable of allowing courts to take into account, in determining the defendant’s

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34. *Dusky v United States*, 362 US 402 (1960).

35. See generally discussion and references cited in AP Wilkinson and AC Roberts, “Defendant’s Competency to Stand Trial” 40 *American Jurisprudence Proof of Facts* 2d 171 (online edition, 25 September 2007), §4.

36. Wilkinson and Roberts, §4.

37. *Attorney-General v O’Driscoll* [2003] JLR 390, 402-03, discussed in R D Mackay, “On Being Insane in Jersey Part Three – the Case of *Attorney-General v O’Driscoll*” [2004] *Criminal Law Review* 291, 294-96.

38. *Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, 213 UNTS 222, art 6(1) (entered into force 3 September 1953). In the United States the unfitness test relates to a person’s due process right to a fair trial: see *Pate v Robinson* 383 US 375 (1965); *Drope v Missouri* 420 US 162 (1975).

39. See *R v Presser* [1958] VR 45, 48.

understanding or capacity, his or her ability to make rational decisions in relation to participation in the trial proceedings.<sup>40</sup> However, this is not explicit. A defendant who cannot make rational decisions in relation to participation in the proceedings may nevertheless be able to satisfy the minimum standards set in *Presser*; for example, where he or she understands the indictment but insists on making an irrational answer to it.<sup>41</sup> Our preliminary view is that this is unsatisfactory because it sets the requirements for a fair trial too low.

1.17 We would, therefore, propose two alternative legislative reformulations of the *Presser* standards. One is to add a general requirement that the accused should be able to make rational decisions in relation to his or her participation in the trial before being considered fit for trial. The other is to amend relevant individual standards to indicate the need for rational decision-making in respect of those standards, along the lines of the South Australian legislation set out above.<sup>42</sup> It is important to note that, since a “rational” decision does not have to reach any predetermined standard, the addition of this requirement would not affect the present law that the accused need not act in his or her best interests or with an understanding of the law applicable to the case.<sup>43</sup>

#### *Effective participation in proceedings*

1.18 An alternative approach may be to subsume the *Presser* standards into a general principle that the accused should be able to “participate effectively” in the trial before being considered fit. The Scottish Law Commission has pointed out that the “idea of effective participation captures the notion of full or rational appreciation by the accused of the proceedings”.<sup>44</sup> The Law Commission argues that this justifies recasting the fitness test in terms of a general principle that the accused should be able to participate effectively in the proceedings, followed by a non-

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40. See discussion in *R v Minani* (2005) 63 NSWLR 490 (accused must be able to understand what election of trial by judge-alone involved). See also *Re CER* [2004] QMHC 27, [27] (defendant found unfit to be tried due to incapacity to provide counsel with rational instructions). And consider *R v Friend* [1997] 2 All ER 1011 (whether the defendant “can understand and reply rationally to the indictment is obviously a relevant factor”).

41. See, eg, *R v Cumming* [2006] 2 NZLR 597; *Eastman v The Queen* (2000) 203 CLR 1.

42. See [1.13].

43. See [1.11].

44. Scottish Law Commission, *Report on Insanity and Diminished Responsibility*, Scot Law Com No 195 (2004) [4.14].

exhaustive list of standards (resembling those set out in *Presser*) that would have to be met for the defendant to be considered competent.

1.19 While the concept of a general principle supported by non-exhaustive standards is attractive, this proposal is not without some disadvantages. First, the “effective participation test” runs the risk of over-inclusiveness. For example, the European Court of Human Rights has held that a young person, so intimidated by the experience of a public trial that he was unable to consult or cooperate with his lawyers for the purpose of giving them information about his defence, was unable to participate effectively in the criminal proceedings and thus was denied a fair trial.<sup>45</sup> It might also be arguable that an accused person lacks the capacity to participate effectively in the trial by reason of poor educational attainment or a disadvantaged social background.

1.20 Secondly, even if the effective participation test were restricted to contexts where the accused person’s cognitive or mental health impairment is in issue, its application would be uncertain. In particular, effective participation may require a level of knowledge or competence on the part of the accused that goes beyond rational participation.

*Deterioration under the stress of trial*

1.21 In the United States, courts must consider whether the defendant “is sufficiently stable to enable him [or her] to withstand the stresses of the trial without suffering a serious prolonged or permanent breakdown”,<sup>46</sup> as well as the defendant’s capacity to refrain from irrational behaviour during trial. Clinical factors that are relevant in this regard include “the defendant’s tendency towards violence, the presence and extent of acute psychosis, suicidal depression, regressive withdrawal, and organic deterioration”.<sup>47</sup>

1.22 In a similar vein, the *Mental Health Act 2000* (Qld) provides that fitness for trial means that a person is fit to plead, to instruct counsel and

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45. *T v United Kingdom* and *V v United Kingdom* (2000) 30 EHRR 121, developing *Stanford v United Kingdom* (Series A282-A) (1994). See also *SC v United Kingdom* (2005) 40 EHRR 10.

46. *People v Picozzi*, 106 AD2d 413, 414; *People (of the State of New York) v Morton*, 173 AD2d 1081, 1083 (1991, 3d Dept).

47. See generally Wilkinson and Roberts, §5.



to “endure” the trial, “with serious adverse consequences to the person’s mental condition unlikely”.<sup>48</sup>

1.23 Arguably, the *Presser* standards can currently accommodate deterioration under the stress of the trial. In *Kesavarajah*, the High Court made it clear that the standards are applied having regard to the length of the trial.<sup>49</sup> This means that the court does not judge the accused person’s fitness solely by reference to his or her condition immediately before the commencement of the trial, but, where relevant, takes into account the condition in which the accused will be, or is likely to be, during the course of the trial. The rationale is that “[t]here is simply no point in embarking on a lengthy trial with all the expense and inconvenience to jurors that it may entail if it is to be interrupted by reason of some manifestation or exacerbation of a debilitating condition which can affect the accused’s fitness to be tried”.<sup>50</sup> Further, if the defendant’s condition does deteriorate during the trial, the question of fitness can always be raised again at that stage.<sup>51</sup>

1.24 We raise for consideration the issue as to whether deterioration during the course of a trial should be specifically articulated as a criterion for determining fitness for trial.

## Issue 6.2

Do the *Presser* standards remain relevant and sufficient criteria for determining a defendant’s fitness for trial?

48. *Mental Health Act 2000* (Qld) s 10, sch 2. In *R v House* [1986] 2 Qd R 415, 422, Connolly J said: “Just what is meant by ‘serious adverse consequences to his mental condition’ is far from clear. No doubt anyone’s mental condition is likely to be adversely affected by the ordeal of a criminal trial. Whether an adverse consequence can be serious without being permanent is something which remains to be determined”. See also *R v Sarracino* [1988] 2 Qd R 707, 710.

49. *Kesavarajah v The Queen* (1994) 181 CLR 230, 246-47 (Mason CJ, Toohey and Gaudron JJ). Compare at 249 (Deane and Dawson JJ dissenting).

50. *Kesavarajah v The Queen* (1994) 181 CLR 230, 246.

51. See [1.7].

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### Issue 6.3

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Should the test for fitness to stand trial be amended by legislation to incorporate an assessment of the ability of the accused to make rational decisions concerning the proceedings?

If so, should this be achieved by:

- (a) the addition of a new standard to the *Presser* formulation, or
- (b) by amendment of relevant standards in the existing formulation?

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### Issue 6.4

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As an alternative to the proposal in Issue 6.3, should legislation identify the ability of the accused to participate effectively in the trial as the general principle underlying fitness determinations, with the *Presser* standards being listed as the minimum standards that the accused must meet?

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### Issue 6.5

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Should the minimum standards identified in *Presser* be expanded to include deterioration under the stress of trial?

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### Issue 6.6

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Should the minimum standards identified in *Presser* be altered in some other way?

## THE ROLE OF THE MENTAL HEALTH REVIEW TRIBUNAL

1.25 If the court finds the defendant fit to be tried, the criminal proceedings against him or her commence or continue in the ordinary way.<sup>52</sup> However, if the defendant is found unfit, the court must refer the defendant to the Mental Health Review Tribunal (“MHRT”).<sup>53</sup> The defendant then becomes a “forensic patient”.<sup>54</sup> Pending a decision of the MHRT, the court may adjourn proceedings, grant the defendant bail, remand the defendant in custody or may make any other order that the court considers appropriate. Except for the purpose of taking those actions, proceedings against the defendant must not be recommenced or continued.<sup>55</sup>

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52. See MHFPA s 13.

53. The subsequent process is summarised in a flowchart in Appendix X.

54. MHFPA s 42.

55. See generally MHFPA s 14.

1.26 On receipt of the reference from the court, the function of the MHRT is to determine, as soon as practicable, whether the person will, during the period of 12 months after the finding of unfitness, become fit to be tried for the offence. The determination is made on the balance of probabilities.<sup>56</sup>

1.27 If the MHRT finds that the person *will not* become fit to be tried within 12 months, it must notify the court and the Director of Public Prosecutions (“the DPP”) of its determination.<sup>57</sup> The court must, as soon as practicable, conduct a special hearing<sup>58</sup> unless the DPP advises that no further proceedings will be taken against the defendant.<sup>59</sup> If the DPP so advises, the court must order that the defendant be released.<sup>60</sup>

1.28 Alternatively, if the MHRT finds that the person *will* become fit to be tried within 12 months from the date of the court’s finding of unfitness, it must also determine whether or not the defendant has a mental illness or a “mental condition for which treatment is available in a mental health facility” and whether the defendant objects to being detained in a mental health facility.<sup>61</sup> The MHRT must notify the court of its determination.<sup>62</sup> The court may then grant the defendant bail or, if the MHRT has determined that the defendant has a mental illness or mental condition, may order that the person be detained in a mental health facility or other place for a period not exceeding 12 months.<sup>63</sup> The defendant continues to be a forensic patient.<sup>64</sup>

1.29 As soon as practicable after the court order for bail or detention is made, the MHRT must again review the defendant’s case and determine

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56. MHFPA s 16(1).

57. MHFPA s 16(3)-(4).

58. See ch 2 for a discussion of the special hearing procedure.

59. See MHFPA s 19(3). The DPP must notify the Minister of Police of its decision not to proceed with the matter: s 19(3).

60. MHFPA s 20.

61. MHFPA s 16(2). “Mental condition” is defined: MHFPA s 3. See also discussion in Consultation Paper 5 (“CP 5”), [4.17]-[4.18].

62. MHFPA s 16(3).

63. MHFPA s 17. The court may order that the person be detained in a hospital only if the MHRT has determined that the person does not object to being so detained: s 17(3). The court’s registrar must notify the MHRT of the terms of the court order: s 17(4).

64. MHFPA s 42.

whether the person has become fit to be tried; and whether the safety of the defendant or of any member of the public would be seriously endangered by the defendant's release.<sup>65</sup> If the MHRT is of the opinion that the person has become fit to be tried, it must notify the court and the DPP.<sup>66</sup> If the MHRT is of the opinion that the defendant remains unfit, but that his or her release would not seriously endanger the safety of the defendant or any member of the public, it must order the defendant's release.<sup>67</sup>

1.30 The MHRT must conduct a similar review of the defendant's case at least once every six months.<sup>68</sup> The MHRT must notify the court and the DPP if it finds either that the defendant has become fit, or that the defendant has not and *will not* become fit within the relevant 12 month period.<sup>69</sup>

1.31 If the court is notified that the defendant has become fit, the court must hold a further inquiry into the defendant's fitness unless it is advised by the DPP that no further proceedings will be taken against the person, in which case the Minister for Health must release the person.<sup>70</sup> If the court finds the defendant fit, criminal proceedings may be commenced or continued in the ordinary way.<sup>71</sup> If the court finds the defendant unfit, and he or she has been an inmate in a correctional facility or a forensic patient in a mental health facility for a period in excess of 12 months, the court must conduct a special hearing. For defendants who have been detained for less than 12 months, the court may conduct a special hearing, or order that the defendant be returned to custody.<sup>72</sup>

1.32 If the court receives notification from the MHRT that the defendant will not become fit within the relevant 12 month period, the court must, as soon as practicable, hold a special hearing unless the DPP advises that

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65. MHFPA s 43, 45(2).

66. MHFPA s 45(3).

67. MHFPA s 43, 47(1).

68. MHFPA s 46(1).

69. MHFPA s 45(3).

70. See MHFPA s29.

71. MHFPA s 30(1).

72. MHFPA s 30(2).

no further proceedings will be taken against the defendant in respect of the offence charged (in which case the defendant is released).<sup>73</sup>

### A simplified procedure?

1.33 The above discussion highlights the complexity associated with determining a defendant's fitness. Referring an unfit defendant back and forth between the court and the MHRT involves duplication resulting in delay and expense. It also increases stress for defendants, victims and other people connected with the case.<sup>74</sup> We suggest that duplication could be minimised by assigning certain functions exclusively to either the court or to the MHRT.

1.34 In most other Australian jurisdictions, the question of fitness is determined exclusively by the court.<sup>75</sup> In Western Australia, the question of fitness is determined by the presiding judicial officer.<sup>76</sup> If the defendant is found, on the balance of probabilities, to be unfit, the presiding judicial officer must determine whether the defendant is likely to become fit within six months.<sup>77</sup> If so, proceedings may be adjourned for up to six months,<sup>78</sup> after which the defendant is presumed to remain unfit.<sup>79</sup> If the defendant is unlikely to, or has not, become fit within six months, the court, "without deciding the guilt or otherwise of the accused", must quash the indictment or committal and must either release the person, or

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73. See MHFPA s 19(1), 19(3), 20.

74. The Hon Greg James QC, *Review of the New South Wales Forensic Health Legislation*, Report (August 2007), [6.9] ("the James Report").

75. *Crimes Act 1900* (ACT) pt 13; *Criminal Code Act 1983* (NT) pt IIA; *Criminal Law Consolidation Act 1935* (SA) pt 8A; *Criminal Justice (Mental Impairment) Act 1999* (Tas) pt 2; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic); *Criminal Law (Mentally Impaired Accused) Act 1996* (WA). The *Crimes Act 1914* (Cth) does not provide a procedure for determining fitness, which follows the procedure of the State or Territory where the matter is being tried: *Kesavarajah v The Queen* (1994) 181 CLR 230.

76. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 12.

77. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 19(1).

78. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 19(1)(b), (2). Successive adjournments may be ordered but the total adjournment period cannot exceed six months: s 19(2).

79. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 10(2).

make a custody order.<sup>80</sup> In cases before the District and Supreme Courts, the making of those orders does not preclude the accused being indicted or tried at a later date.<sup>81</sup> In courts of summary jurisdiction, the orders are a bar to further prosecution.<sup>82</sup>

1.35 In Queensland, a specialist Mental Health Court investigates issues concerning fitness to be tried, as well as the defences of “unsoundness of mind” and diminished responsibility.<sup>83</sup> If the Mental Health Court finds a person unfit to be tried, it must make a determination as to whether that unfitness is temporary or permanent.<sup>84</sup> The court then decides what order(s) to make in respect of the person.<sup>85</sup> Criminal proceedings are discontinued in respect of people found permanently unfit for trial, or who remain unfit for trial up to the statutory time limit.<sup>86</sup> The Mental Health Court does not displace the ordinary criminal process, but dovetails with it.

1.36 There are advantages to the court being the final arbiter of fitness to be tried. Fitness is a legal concept, not a medical diagnosis, and has legal, not clinical, implications. A finding of unfitness has the effect of removing the defendant from the ordinary criminal justice process. Taking this view, it would appear that a finding of unfitness should be made exclusively by a court, with input from expert witnesses as appropriate, rather than by the MHRT. Moreover, since a question of fitness may arise in the course of a trial, it would be more convenient for the question to be resolved in the forum in which it arises. Submissions to a recent review asserted that current court-based procedures work well in

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80. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 16(5), 19(4). A custody order is an indefinite order that the person be detained in an “authorised hospital”, a “declared place”, a detention centre, or a prison, as determined by the Mentally Impaired Accused Review Board, until released by the Governor: *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 38(1). See ch 7 and 8 for a discussion of the orders that may be made following a finding of unfitness.

81. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 19(7).

82. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 16(1), (8).

83. *Mental Health Act 2000* (Qld) ch 7, s 383. The Mental Health Court is constituted by a Supreme Court judge and two assisting psychiatrists: *Mental Health Act 2000* (Qld) s 382, ch 11 pt 1-3.

84. *Mental Health Act 2000* (Qld) s 271.

85. *Mental Health Act 2000* (Qld) s 288.

86. *Mental Health Act 2000* (Qld) s 215, 283.

practice, especially since fitness has come to be determined by a judge alone.<sup>87</sup>

1.37 On the other hand, decisions about the subsequent management of the person involve considerations about the person's clinical needs, possible recovery, risk management and placement in an appropriate community setting or facility. These decisions relate to the particular expertise of the MHRT in the area of mental health and in the protection of the community.<sup>88</sup> Accordingly, it may be more appropriate that such decisions be made by the MHRT than by a court.<sup>89</sup>

1.38 On that basis, we propose that the current procedure for determining fitness should be streamlined as follows:

- (1) A defendant should be presumed to be fit to be tried, unless and until a question of fitness is raised in good faith, by the defence, prosecution or the court.
- (2) If a question of fitness is raised, the court should hold a fitness inquiry. Unfitness must be established on the balance of probabilities, but no party bears the onus of proving it and the fitness hearing should be conducted in a non-adversarial way.
- (3) If the person is found to be fit, the trial continues in the ordinary way.
- (4) If the person is found to be unfit, then:
  - (a) the court may adjourn the proceedings for a specified period of time<sup>90</sup> if the court considers that the person is likely to become fit during that period, and it would be in the interests of justice to delay resolution pending that possibility; or
  - (b) the court may hold a special hearing.
  - (c) In either case, the person would be referred to the MHRT as a forensic patient. The MHRT would periodically review the

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87. See James Report, [6.11].

88. James Report, [6.12].

89. See James Report, [6.12].

90. Currently 12 months: MHFPA s 16-17. However, a different time-frame could be adopted.

person's case, including a determination as to whether or not the person has become fit to be tried. The MHRT would make orders as to whether the person should be detained or released into the community, with or without conditions. Any court order for bail or remand would have effect only until the MHRT considered the person's case and made its determination.

- (5) If the MHRT finds that the person has become fit to be tried, the MHRT would notify the court and the DPP of its finding. The MHRT's finding would operate to restore the presumption that the person is fit to be tried.<sup>91</sup> The ordinary trial process would commence or continue, unless and until a further question of fitness is raised.
- (6) If the person is still unfit to be tried at the end of the adjournment period, or if, on a review, the MHRT finds that the person will not become fit to be tried during the adjournment period, the MHRT would notify the court and the DPP of its finding. The matter would return to court and the special hearing procedure would be followed.<sup>92</sup>

1.39 The Commission's proposal would draw upon the expertise of both the court and the MHRT, and eliminate the duplication that arises when both the court and the MHRT are each required to determine the same issue on the basis of similar evidence. It would also avoid determinations with a foregone conclusion, for example, the current requirement that the MHRT must determine whether or not a person who has a relatively permanent impairment (such as an intellectual disability) will become fit within 12 months before a special hearing can take place.<sup>93</sup> Further, an unfit defendant could be removed more swiftly from the criminal justice system and into the forensic mental health system where

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91. Currently, if the MHRT finds that the defendant has become fit, the court has to hold a fitness inquiry before the trial can commence or continue: MHFPA s 29. As to the presumption, see MHFPA s 15.

92. The procedure governing the special hearing is discussed in ch 2. The orders that may be made by the court and the MHRT concerning unfit offenders are discussed in ch 6 and 7.

93. See MHFPA s 14, 16, 19.



he or she could be appropriately managed according to clinical and risk management (rather than punitive) principles.<sup>94</sup>

1.40 We seek views as to whether this proposal improves upon the current procedure, or if another method of determining fitness should be adopted.

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#### Issue 6.7

Should the procedure for determining fitness be changed and, if so, in what way?

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#### Issue 6.8

What should be the role of:

- (a) the court; and
- (b) the MHRT

in determining a defendant's fitness to be tried?

## PROCEDURES ANCILLARY TO THE DETERMINATION OF FITNESS

1.41 We seek views as to whether the existing or proposed procedures could be enhanced by giving courts the additional powers to:

- order assessment reports in relation to a defendant before conducting a fitness inquiry; and
- enter a finding of unfitness by consent; and
- substitute a verdict where unfitness is successfully raised on appeal.

### Assessment reports

1.42 In Consultation Paper 5 (“CP 5”), Chapter 5, we discuss whether or not the court should have a general power to order reports and assessments on a defendant’s mental state at any time during the proceedings, including the determination of fitness.<sup>95</sup>

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94. See MHFPA s 40, 43, 74, 76B; MHA s 68.

95. See CP 5, ch 5.

## Consent orders

1.43 In South Australia, the Northern Territory and Tasmania, legislation provides that if the defence and prosecution agree that the defendant is unfit, the court may enter a finding to that effect.<sup>96</sup> In cases where the defendant's unfitness is not in dispute, those jurisdictions are thereby able to avoid the delays and expense of conducting a fitness inquiry that would be, effectively, a foregone conclusion.<sup>97</sup>

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### Issue 6.9

Should provision be made for the defence and prosecution to consent to a finding of unfitness?

## Appeals in relation to fitness at the time of trial

1.44 If a person is convicted of an offence and appeals on the ground that he or she was, or may have been unfit at the time of the trial, the conviction must be quashed and a new trial ordered. In some such cases, the person is still unfit at the time of the appeal and is likely to remain so. The quashing of the person's conviction and the subsequent retrial in such cases consists of a special hearing which almost invariably reaches the same conclusion as the trial – the person is not acquitted of the offence.<sup>98</sup> Given that the purpose of the special hearing is to provide the unfit accused with the chance of being acquitted, in a manner as similar as possible to an ordinary trial, it may seem superfluous to require a special hearing in cases where the ordinary trial process has resulted in a conviction.

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96. *Criminal Code Act 1983* (NT) s 43T(1); *Criminal Law Consolidation Act 1935* (SA) s 269M(A)(5), 269N(B)(5); *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 19.

97. Compare *R v Wilson* [2000] NSWSC 1104 where, notwithstanding a joint submission of unfitness by the Crown and defence, Bell J nevertheless had to make an independent finding of unfitness before referring the defendant to the MHRT.

98. See, eg, *Tuigamala* [2004] NSWSC 1254 (convicted of murder); [2006] NSWCCA 380 (conviction quashed, new trial ordered, because of possible unfitness at time of trial); [2007] NSWSC 493 (found unfit to be tried at subsequent retrial); [2008] NSWSC 706 (qualified finding of guilt and imposition of limiting terms). See also *R v Mailes* [1999] NSWSC 942 (convicted of murder); (2001) 53 NSWLR 251 (conviction quashed, new trial ordered, due to possible unfitness at trial); (2003) 142 NSWLR 353 (qualified finding of guilt and imposition of limiting term).

1.45 The *Criminal Appeal Act 1912* (NSW) could be amended to provide that the Court of Criminal Appeal may quash the conviction and substitute a finding that “on the limited evidence available”, the accused person “committed the offence charged” or “committed an offence available as an alternative”.<sup>99</sup> The provision could require the Court to be satisfied that there is no reasonable possibility of any other finding if a special hearing were to be held, and/or that the parties consent to the order. The Court of Criminal Appeal might also require ancillary powers, for example, a power to ascertain whether or not the defendant is presently fit.<sup>100</sup>

#### Issue 6.10

Should the *Criminal Appeal Act 1912* (NSW) be amended to provide for the Court of Criminal Appeal to substitute a “qualified finding of guilt” in cases where a conviction is quashed due to the possible unfitness of the accused person at the time of trial?

## FITNESS IN LOCAL COURTS

### Summary proceedings

1.46 In Consultation Paper 7 (“CP 7”), we discuss the procedures that apply in the Local Court in circumstances where a magistrate determines that it would be more appropriate to discharge a defendant, or divert him or her into a treatment facility rather than proceed with a criminal justice response. These diversionary provisions, contained in part 3 of the MHFPA, apply to the Local Court in lieu of fitness proceedings, which are confined to the District and Supreme courts.

1.47 The inapplicability to the Local Court of the fitness procedures that currently apply in the Supreme and District Courts may be justified because the cost and other burdensome aspects of those procedures, which may be appropriate for serious offences, would be disproportionate in relation to minor offences. However, while expediency in summary matters is beneficial, it may be that provisions additional to the current diversionary procedures are required to deal

99. MHFPA s 22(1)(c)-(d).

100. See, eg, *Criminal Appeal Act 1912* (NSW) s 6A, 12; see also *Mental Health Act 2007* (NSW) s 164; MHFPA s 77A(8)-(13).

with unfit defendants in the Local Court. This may be particularly the case given the fact that the jurisdiction and caseload of the Local Court has been expanded in the past decade, with the result that it now regularly determines relatively serious cases, and deals with the vast majority of criminal matters in NSW.<sup>101</sup>

1.48 The Commission proposes that, in addition to the changes to the existing diversionary procedures recommended in CP 7, a simplified fitness procedure should be introduced in the Local Court. Such a procedure could, at the least, empower the magistrate to:

- order a psychological or psychiatric assessment of the defendant;
- determine the question of fitness;
- determine whether the defendant should be acquitted, or discharged pursuant to the existing diversionary measures, which would operate in parallel; and
- order that the defendant become a forensic patient, that is, subject to the supervision of the MHRT.<sup>102</sup>

#### Issue 6.11

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Should fitness procedures apply in Local Courts? If so, how should they be framed?

### Committal proceedings

1.49 It would seem that a magistrate has no authority to commit an unfit accused for trial,<sup>103</sup> since it is an essential principle of criminal law

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101. Her Honour Helen Syme, Deputy Chief Magistrate of the Local Court of New South Wales, “Local Court procedure and sentencing of offenders with mental illness” (paper presented at The Mental Health Act – Issues and Consequences seminar, University of Technology Sydney, 28 March 2008). In 2006, the Local Court dealt with 91.7% of cases, in comparison with the District and Supreme Courts which finalised only 2% of cases: Calculated from data in Bureau of Crime Statistics and Research (NSW), *Criminal Courts Statistics 2006* (2007), 3, 9, 11.

102. Consider, eg, *Crimes Act 1900* (ACT) pt 13 div 13.1, 13.2, 13.6; *Criminal Law Consolidation Act 1935* (SA) pt 8A; *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) pt 2-3; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 4(1), pt 2; *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 4(1), 9-14, 23-25, 38-40.

that the accused is physically present, and able to comprehend the facts and circumstances being alleged against him or her, at a committal hearing.<sup>104</sup> Further, the diversionary mechanisms in MHFPA do not apply to committal proceedings.<sup>105</sup> Technically this means that, in the case of an unfit accused, the Crown ought to proceed by way of *ex officio* indictment.<sup>106</sup>

1.50 In practice, the fitness issue is not raised at committal hearings. It will generally be in the interests of the accused to allow the hearing to proceed so as to provide an opportunity not only for early discharge,<sup>107</sup> but also to screen and test the evidence. The issue of fitness can subsequently be raised at trial. Although the committal of an unfit accused is a nullity, this does not – once the indictment has been presented or filed – affect the validity of the trial itself.<sup>108</sup>

1.51 The recently enacted *Criminal Case Conferencing Trial Act 2008* (NSW) (“the *Criminal Case Conferencing Trial Act*”) applies to specified indictable offences in respect of which a committal proceeding is to be held at either the Downing Centre or the Central Local Court.<sup>109</sup> The Act, subject to certain exceptions,<sup>110</sup> requires the magistrate to order a pre-trial case conference between the prosecutor and the accused person’s legal representative for the purpose of determining whether the accused is willing to plead guilty to the offence(s) charged and for certain other procedural purposes.<sup>111</sup> The Act provides incentives, in the form of

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103. *Ebatarinja v Deland and Others* (1998) 194 CLR 444, [33].

104. *Ebatarinja v Deland and Others* (1998) 194 CLR 444, [25]-[28]. And consider *Criminal Procedure Act 1987* (NSW) s 71. See also *R v Mailes* (2001) 53 NSWLR 251, [159]-[162].

105. MHFPA s 31.

106. Consider *Ebatarinja v Deland and Others* (1998) 194 CLR 444.

107. See *Criminal Procedure Act 1986* (NSW) s 66.

108. *Ebatarinja v Deland and Others* (1998) 194 CLR 444. Consider also *Criminal Procedure Act 1987* (NSW) s 8(2), 67(1). For a case where a committal hearing was declared a nullity, see *McKay v Cook* (Unreported, Enderby J, NSW Supreme Court, 19 February 1988).

109. *Criminal Case Conferencing Trial Act 2008* (NSW) s 4, 5, 18. See also generally NSW, *Parliamentary Debates*, Legislative Council, 2 April 2008, 6243-6246 (the Hon John Hatzistergos, MLC).

110. *Criminal Case Conferencing Trial Act 2008* (NSW) s 6(1).

111. *Criminal Case Conferencing Trial Act 2008* (NSW) s 6, 11, 12(3).

sentencing discounts, to plead guilty at an early stage.<sup>112</sup> The accused person's legal representative must obtain instructions from his or her client before participating in the conference.<sup>113</sup>

1.52 The magistrate, on the application of either party, may order that no conference be held if satisfied that "exceptional circumstances exist that would make it impossible or impracticable to hold the conference or that it would be highly unlikely that the holding of the conference would achieve the purpose [of the conference]".<sup>114</sup> If an accused person is unfit to be tried and unable to give instructions,<sup>115</sup> that might amount to "exceptional circumstances" such that a conference would not be required and, indeed, could not be held.<sup>116</sup> However, if the accused person's legal representative raised the issue of the accused person's fitness in respect of the case conference, the magistrate would have no jurisdiction to hold a committal hearing.

1.53 Preliminary submissions received by the Commission indicated that there may be a need for a magistrate, on a committal hearing, to have a power to order an assessment of the accused person.<sup>117</sup> The DPP expressed the view that, in cases where the fitness of the accused person to be tried is an issue, "it would be advantageous to all parties to have the matter raised as early in the proceedings as possible".<sup>118</sup>

1.54 Legislation could provide for powers to be conferred on a magistrate so that, if there is sufficient evidence to put the accused person on trial for the offence, fitness procedures could be set in motion at that stage. In CP 5, we discuss whether there should be a general power in all courts to order a psychiatric, psychological or other expert assessment of an accused person.<sup>119</sup> That power could be exercised by the magistrate during or after the committal hearing. Additionally, if the responsibility

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112. *Criminal Case Conferencing Trial Act 2008* (NSW) pt 4.

113. *Criminal Case Conferencing Trial Act 2008* (NSW) s 11(3).

114. *Criminal Case Conferencing Trial Act 2008* (NSW) s 6(5).

115. See *Presser* criteria at [1.8]-[1.11].

116. *Criminal Case Conferencing Trial Act 2008* (NSW) s 6(5), 11(3).

117. Intellectual Disability Rights Service, *Preliminary Submission*, 6; Law Society of New South Wales, *Preliminary Submission*, 2; The Shopfront Youth Legal Centre, *Preliminary Submission*, 2-3.

118. Director of Public Prosecutions, *Preliminary Submission*, 2; see also Intellectual Disability Rights Service, *Preliminary Submission*, 2.

119. See CP 5, ch 5.

for determining a question of fitness is to be conferred solely on the MHRT,<sup>120</sup> the magistrate, if satisfied that there is a real and substantial question as to the accused person's fitness to be tried, could refer the person directly to the MHRT for a determination of fitness.

1.55 Alternatively, if the power to determine the question of fitness is to remain with the court,<sup>121</sup> and if a power is conferred on the Local Court to deal with questions of fitness,<sup>122</sup> the magistrate could determine the question of fitness at the committal hearing. If fit, the accused person would be committed to stand trial or be sentenced. If unfit, the accused person could be committed to a special hearing, or interim orders could be made to allow time for the accused person to become fit if that is a possibility.

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#### Issue 6.12

Should legislation provide for the situation where a committal hearing is to be held in respect of an accused person who is or appears to be unfit to be tried? If so, what should be provided?

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120. See Issue 6.8.

121. See [1.33]-[1.40], and Issue 6.7 and 6.8.

122. See [1.46]-[1.48], and Issue 6.11.





## 2. **Procedure following a finding of unfitness**

- Introduction
- The special hearing
- Abolishing or modifying the special hearing

## INTRODUCTION

2.1 In the previous chapter, we discuss the meaning of fitness for trial, and the procedures involved in determining a defendant's fitness. This chapter builds on that discussion, examining the procedure following a finding of unfitness. In NSW, a special hearing is held to assess whether or not, on the limited evidence available, the accused committed the offence with which he or she has been charged. The special hearing is significant in that it provides the accused with an opportunity to be acquitted.

## THE SPECIAL HEARING

2.2 Where a defendant is found to be unfit to stand trial, and likely to remain so for a period of 12 months or more,<sup>1</sup> the court must conduct a special hearing to determine whether or not, on the limited evidence available, the defendant committed the offence charged.<sup>2</sup> The prosecution must prove the accused person's guilt beyond reasonable doubt,<sup>3</sup> and the hearing must be conducted as nearly as possible as if it were a trial of criminal proceedings.<sup>4</sup> The defendant must be represented by a legal practitioner unless the court otherwise allows.<sup>5</sup>

2.3 At the special hearing, the defendant is presumed to have pleaded not guilty.<sup>6</sup> He or she is entitled to give evidence<sup>7</sup> and "may raise any defence that could be properly raised if the special hearing were an ordinary trial of criminal proceedings".<sup>8</sup>

2.4 A special hearing is held before a judge sitting alone, unless the defendant (having sought, received and understood advice from a legal practitioner), the defendant's legal representative or the prosecutor elects

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1. See ch 1 for an account of the procedure for establishing fitness for trial.
  2. *Mental Health (Forensic Provisions) Act 1990* (NSW) ("MHFPA") s 19(2).
  3. MHFPA s 19(2).
  4. MHFPA s 21(1).
  5. MHFPA s 21(2).
  6. MHFPA s 21(3).
  7. MHFPA s 21(3)(d).
  8. MHFPA s 21(3)(c).

for determination by a jury.<sup>9</sup> If there is a jury, the judge must explain to them:

- the fact that the accused person is unfit to be tried in accordance with the normal procedures;
- the meaning of unfitness to be tried;
- the purpose of the special hearing;
- the verdicts which are available; and
- the legal and practical consequences of those verdicts.<sup>10</sup>

### Verdicts available at a special hearing

2.5 Section 22 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) (“the MHFPA”) provides:

- (1) The verdicts available to the jury or the Court at a special hearing include the following:
  - (a) not guilty of the offence charged,
  - (b) not guilty on the ground of mental illness,
  - (c) that on the limited evidence available, the accused person committed the offence charged,
  - (d) that on the limited evidence available, the accused person committed an offence available as an alternative to the offence charged.<sup>11</sup>

2.6 The effect of a finding under paragraph (1)(a) or (1)(b) that the defendant is not guilty, or not guilty by reason of mental illness, is the same as if it had been made at an ordinary trial.<sup>12</sup> A finding under paragraph (1)(c) or (1)(d) that, on the limited evidence available, the defendant committed the offence or an alternative offence, constitutes a

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9. MHFPA s 21A(1). As to the validity of a defendant’s election, see *R v Minani* (2005) 63 NSWLR 390, [11]-[23]; *R v Lincoln (Kesteven) Justices ex parte O’Connor* [1983] 1 WLR 335; *R v Wilson* [2000] NSWSC 1104, [2]-[4].

10. MHFPA s 21(4).

11. MHFPA s 22(1)(d).

12. MHFPA s 22(2), 26. See ch 6 for a discussion of the special verdict of not guilty due to mental illness.

“qualified finding of guilt”.<sup>13</sup> Such a finding requires the court to indicate whether, had the special hearing been a normal criminal trial, it would have imposed a sentence of imprisonment or not.<sup>14</sup> If not, “the Court may impose any other penalty or make any other order it might have made” if the person had been convicted of the offence at an ordinary trial.<sup>15</sup>

2.7 If the court would have imposed a sentence of imprisonment, it must indicate a “limiting term”, which is the best estimate of the sentence, based on the application of general sentencing principles, that the court would have considered appropriate if the special hearing had been a normal trial at which the defendant had been found guilty.<sup>16</sup> If the Mental Health Review Tribunal (“the MHRT”) considers that the defendant has a mental illness or other mental condition,<sup>17</sup> the court may order that the person be detained in a mental health facility or other place, which, in NSW, is generally a prison.<sup>18</sup> The offender will generally be released at the end of the limiting term,<sup>19</sup> unless released earlier by order of the MHRT.<sup>20</sup>

2.8 The orders that the court may make in respect of an unfit accused who is not acquitted, the question of whether a limiting term should apply to such orders or whether they should be indeterminate, and the

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13. Although not a basis for conviction, such a finding “is subject to appeal in the same manner as a verdict in an ordinary trial of criminal proceedings”; constitutes “a bar to further prosecution in respect of the same circumstances” except if the person becomes fit to be tried while detained under a limiting term; and is treated as a conviction for the purposes of victims’ compensation: see MHFPA s 22(3), 28.

14. MHFPA s 23(1).

15. MHFPA s 23(2).

16. MHFPA s 23.

17. For which treatment is available in a mental health facility: see MHFPA s 24.

18. New South Wales Legislative Council Select Committee on Mental Health, *Mental Health Services in New South Wales*, Final Report (2002), [14.65]-[14.88], recommendations 109-112; G James QC, *Review of the Forensic Provisions of the Mental Health Act 1990 and the Mental Health (Criminal Procedure) Act 1990*, Consultation Paper (2006), 14, 42.

19. MHFPA s 52(2)(a).

20. MHFPA s 47(1). In certain circumstances, the person may be detained as a civil patient pursuant to the *Mental Health Act 2007* (NSW) (“the MHA”): see Consultation Paper 5 (“CP 5”), [2.5]-[2.19] for an account of the MHA procedures.

mechanisms for release of forensic patients are reviewed in Chapters 6 and 7.

### The rationale of the special hearing

2.9 The special hearing has its origin in New South Wales in the 1974 report of the Edwards Committee.<sup>21</sup> Prior to the introduction of the special hearing, defendants found unfit to plead were detained indefinitely at the Governor's pleasure without consideration as to whether they had in fact committed the offence with which they were charged. The Committee identified key reasons why a procedure to test the prosecution case was required where the accused was found unfit to plead:

[The present rules involve] two quite significant injustices for the mentally defective:

- (1) When found unfit to plead (or to be tried) it is virtually impossible for such a person to be released from confinement ever ...
- (2) This condition of virtually permanent incarceration, in some cases, is brought upon the mentally defective person by a legal process which in fact gives him no opportunity to contest the charges against him and be acquitted.

...[I]n the case of the mentally well, we do not assume guilt. We assume innocence and allow the accused a reasonable chance for it to be demonstrated that the charges brought against him are without foundation. But in the case of the mentally defective, we in effect assume guilt. On the basis of protecting the mentally defective against unfair trial, we lock him up perhaps forever.<sup>22</sup>

2.10 Accordingly, a fundamental purpose of the special hearing is to provide an opportunity for the unfit defendant to be acquitted outright.<sup>23</sup> Even now that indefinite detention is no longer the automatic consequence of a finding of unfitness, affording a defendant the

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21. Dr G Edwards, Chair, New South Wales Health Commission Mental Health Act Review Committee, *Report* (1974), 66-85 ("the Edwards Report").

22. Edwards Report, 77-79.

23. MHFPA s 19(2). See further New South Wales, *Parliamentary Debates*, Legislative Assembly, 22 November 1983, 3090 (the Hon Laurie Brereton, MP).

opportunity for acquittal prior to possible detention for a limited term remains important.

## ABOLISHING OR MODIFYING THE SPECIAL HEARING

2.11 Although the rationale of the special hearing remains sound, it is problematic in other respects. Arguably, it is contrary to basic principles of justice and logic that a person who is unfit to be tried should be subject to a procedure that aims, as far as possible, to imitate a trial and to achieve a result that approximates that of a trial.<sup>24</sup>

### Abolishing or limiting the special hearing

2.12 Two Australian jurisdictions, Western Australia and Queensland, have not adopted the special hearing model. In Western Australia, a judicial officer determines whether or not a defendant is fit to stand trial without reference to his or her guilt or otherwise. If the defendant is unlikely to, or has not, become fit within six months, the court, irrespective of likely culpability of the defendant, must quash the indictment or committal and must either release the person, or make a custody order.<sup>25</sup> The decision as to whether to order release or to make a custody order is governed by the following provision:

A custody order must not be made in respect of an accused unless the statutory penalty for the alleged offence is or includes imprisonment and the court is satisfied that a custody order is appropriate having regard to—

- (a) the strength of the evidence against the accused;
- (b) the nature of the alleged offence and the alleged circumstances of its commission;

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24. See Public Interest Advocacy Centre, *Time for Change: Response to the Consultation Paper: Review of the forensic provisions of the Mental Health Act 1990 and the Mental Health (Criminal Procedure) Act 1990*, 9.

25. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 16(5), 19(4). A custody order is an indefinite order that the person be detained in an “authorised hospital”, a “declared place”, a detention centre, or a prison, as determined by the Mentally Impaired Accused Review Board, until released by the Governor: *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 38(1). See ch 7 and 8 for a discussion of the orders that may be made following a finding of unfitness.

- (c) the accused's character, antecedents, age, health and mental condition; and
- (d) the public interest.<sup>26</sup>

2.13 The Western Australian court process offers a number of advantages. For example, there is no special hearing, so lengthy court processes are avoided and the stress for defendants, victims and others may be reduced. There is a formal judicial review of the strength of the evidence against the accused, and the court has the power to order unconditional release if there are serious doubts as to the accused person's involvement in the alleged offences.

2.14 However, it is arguable that the legislative criteria create a discretion so broad that there is insufficient guidance for decision-makers. The content of the "public interest" criterion is unclear and it has not been consistently applied.<sup>27</sup> Further, with regard to the requirement to assess the strength of the evidence, there is no guidance provided to the court as to factors which may be of particular significance in the context of an unfit accused, such as the reliability of confessions.<sup>28</sup>

2.15 Also, the requirements to have regard to the nature and circumstances of the alleged offences, and to the person's "character, antecedents, age, health and mental condition", respectively, are akin to sentencing considerations.<sup>29</sup> There is a risk that the decision-making process could become, in effect, a quasi-sentencing exercise in respect of a

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26. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 16(6).

27. See, eg, *R v Gardiner* [1999] WADC 23, *R v Gardiner (No 3)* (2000) 24 SR (WA) 136, *GFS v The Queen* [2001] WASCA 219, [24]-[26], [51]-[60]; *R v Garlett* (2002) 29 SR (WA) 1, [25]-[26].

28. See, eg, *R v Dunne* [2002] WASC 196, [31]-[32]; compare *Chang v Turner* [2005] WASC 246, [6]. As to reliability of admissions made by persons with cognitive and mental health impairments, see M Ierace, *Intellectual Disability – A Manual for Criminal Lawyers* (1989), ch 9; NSWLRC, *People with an Intellectual Disability and the Criminal Justice System*, Report No 96 (1996), [4.15]-[4.19], [4.34]-[4.39], [4.54]-[4.113], Recommendation 6-8; New South Wales Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System: Policing Issues*, Discussion Paper No 29 (1993), ch 6; and see for example *R v McLaughlan* [2008] ACTSC 49, [49]-[73]; *Murphy v The Queen* (1989) 86 ALR 35, 44-49 (Mason CJ and Toohey J), 58-60 (Deane J), cf 53-56 (Brennan J, dissenting on this point), 60-63 (Dawson J, also dissenting on this point).

29. See ch 8 for the principles that guide sentencing decisions.

person who has not been tried for the offence.<sup>30</sup> In some circumstances, it may be appropriate that the nature and circumstances of the alleged offences be examined in light of, not separately from the accused person's impairment, but this is not required by the legislation and does not always occur in practice.<sup>31</sup>

2.16 In Queensland, a specialist Mental Health Court determines the question of a defendant's fitness, in conjunction with issues concerning the defences of unsoundness of mind and diminished responsibility, and the consequences that follow that determination.<sup>32</sup> The Mental Health Court is constituted by a Supreme Court judge and two assisting psychiatrists.<sup>33</sup> The Court is not bound by the rules of evidence,<sup>34</sup> and may excuse an offender from appearing if it is "expedient and it is in the person's best interests" to proceed in his or her absence,<sup>35</sup> and appoint a person to assist a defendant at a hearing.<sup>36</sup>

2.17 Other jurisdictions adopt procedures similar to the special hearing, but with modifications.<sup>37</sup> In South Australia, the ACT and New Zealand, the special hearing is limited to trying only the physical elements of the offence, with no requirement to establish the mental elements of the offence.<sup>38</sup> Defences such as self-defence, mistake, duress and the defence of mental impairment are excluded.<sup>39</sup> The result is that the unfit accused

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30. See, eg, *GFS v The Queen* [2001] WASCA 219, [60].

31. *Chang v Turner* [2005] WASC 246, [15], [21]-[24]; compare *R v McKitterick* (2001) 26 SR (WA) 206, [8]-[9], [14]-[15], [17]

32. See *Mental Health Act 2000* (Qld). As the consequences that follow a determination of unfitness, see ch 6 and 7.

33. *Mental Health Act 2000* (Qld) s 382, ch 11 pt 1-3.

34. *Mental Health Act 2000* (Qld) s 404.

35. *Mental Health Act 2000* (Qld) s 409.

36. *Mental Health Act 2000* (Qld) s 410.

37. See *Crimes Act 1900* (ACT) s 316; *Criminal Code Act 1983* (NT) s 43W; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 15-17; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1977* (Vic) s 15-17.

38. See *Crimes Act 1900* (ACT) s 316(9)(c), 300 ("conduct"), as defined in *Criminal Code 2002* (ACT) s 13; *Criminal Law Consolidation Act 1935* (SA) pt 8A Div 3; *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 9.

39. See *Criminal Law Consolidation Act 1935* (SA) s 269M(B)(3), 269N(A)(3); *Question of Law Reserved (No 1 of 1997)* (1997) 70 SASR 251; *R v T* [1999] SASC 429; *Crimes Act 1900* (ACT) s 316(9)(c); *R v Ardler* [2004] ACTCA 4; *Criminal Procedure*



is effectively subjected to a stricter standard of criminal responsibility than if he or she were facing an ordinary trial. Additionally, excluding those defences could lead to a waste of resources if the accused later becomes fit and is tried for an offence in respect of which he or she was entitled to an outright acquittal at the special hearing.<sup>40</sup>

2.18 However, the special hearing procedure could be modified in other ways, drawing on the different procedures adopted in other jurisdictions. The following aspects are of particular note:

- the provisions of the *Crimes Act 1914* (Cth) that provide the unfit accused with the opportunity of acquittal where the prosecution cannot establish a prima facie case against him or her;
- trial procedures that permit postponement of the determination of fitness;
- flexibility in the procedure that is adopted for the special hearing itself;
- a discretion to excuse the defendant from appearing; and
- amendment of the findings that are available at a special hearing, to reflect the fact that the accused person has not been convicted of an offence.

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#### Issue 6.13

Should the special hearing procedure continue at all, or in its present form?  
If not, how should an unfit offender be given an opportunity to be acquitted?

#### Requiring a prima facie case

2.19 In cases involving federal offences, if a court finds an accused unfit to stand trial, it must then determine whether the evidence establishes a prima facie case that the accused committed the offence charged.<sup>41</sup> A “prima facie case” is one in which “there is evidence that would (except for the circumstances by reason of which the person is unfit to be tried)

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(*Mentally Impaired Persons*) Act 2003 (NZ) s 9-14, 23-25; *R v Codd* [2006] 3 NZLR 562.

40. See, eg, *R v McLaughlan* [2008] ACTSC 49.

41. *Crimes Act 1914* (Cth) s 20B(3). In unfitness cases, a prima facie will not have been established at committal proceedings: *Crimes Act 1914* (Cth) s 20B(1).

provide sufficient grounds” to put the accused on trial for the offence.<sup>42</sup> In determining whether a prima facie case has been established, the legislation provides that:

- the accused may give evidence or make an unsworn statement;
- the accused may raise any defence that properly could be raised if the proceedings were a trial for the offence; and
- the court may seek such other evidence, whether oral or in writing, as it considers likely to assist in determining the matter.<sup>43</sup>

2.20 If a prima facie case is not established, the court must dismiss the charge and order that the accused be released.<sup>44</sup> If a prima facie case is established, the court may nevertheless decide to dismiss the charge and discharge the defendant on discretionary grounds.<sup>45</sup>

2.21 The requirement to establish a prima facie case provides a less cumbersome means of providing the accused with an opportunity of acquittal than proceeding to a full special hearing. However, excluding from evidence the “circumstances by reason of which the person is unfit to be tried” could, in some instances, too easily facilitate the finding of a prima facie case. For example, in *Minani*, the circumstance that the defendant had a mental illness (the circumstance that rendered him unfit to be tried) was relevant to the establishment of an ingredient of the offence in question, namely, an intention to cause grievous bodily harm.<sup>46</sup> Notwithstanding the difficulties of proving the circumstances contributing to the defendant’s unfitness, we are of the view that excluding their consideration in determining the existence of a prima facie case could potentially impact unfairly on the accused.<sup>47</sup>

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42. *Crimes Act 1914* (Cth) s 20B(6).

43. *Crimes Act 1914* (Cth) s 20B(7).

44. *Crimes Act 1914* (Cth) s 20BA(1).

45. *Crimes Act 1914* (Cth) s 20BA(2). See also Consultation Paper 7 (“CP 7”).

46. *R v Minani* (2005) 63 NSWLR 490, [31].

47. The issue resembles that which arises where legislation excludes, from the inquiry giving the unfit accused the opportunity of acquittal, evidence of the “subjective” ingredients of the crime or defences: see *Crimes Act 1900* (ACT) s 316(9)(c), 300 (“conduct”), as defined in *Criminal Code 2002* (ACT) s 13; *Criminal Law Consolidation Act 1935* (SA) pt 8A Div 3; *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 9. See above.

2.22 A second point is that many defendants who appear for trial on indictment have been committed for trial by a court of summary jurisdiction. Therefore, a court of summary jurisdiction must have been satisfied that “there is evidence that would ... provide sufficient grounds to put the person on trial in relation to the offence.”<sup>48</sup> To apply the same threshold in determining whether or not the same charge against the unfit defendant should be dismissed is therefore, in some cases, effectively to apply no threshold at all.<sup>49</sup> For that reason, if the charge is not dismissed, the accused should retain the right to be acquitted if the prosecution case is not sufficient to eliminate reasonable doubt.

2.23 Subject to these reservations, we see merit in the Commonwealth legislation as a means of providing the unfit accused with an early opportunity of acquittal, and seek views on this matter.

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#### Issue 6.14

Should a procedure be introduced whereby the court, if not satisfied that the prosecution has established a prima facie case against the unfit accused, can acquit the accused at an early stage?

### Postponing the determination of fitness

2.24 In England and Wales, legislation provides for two alternative procedures if a question of fitness arises in the Crown Court.<sup>50</sup> Under the first procedure, which is presumptively followed, the court determines the question of fitness as soon as it arises.<sup>51</sup> If the person is found to be fit, the trial proceeds in the ordinary way.<sup>52</sup> If the person is found to be unfit, a jury must consider whether the defendant “did the act or made the

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48. *Crimes Act 1914* (Cth) s 20B(6).

49. If a question as to fitness is raised at committal proceedings, “the magistrate must refer the proceedings to the court to which the proceedings would have been referred had the person been committed for trial”: s 20B(1). In such cases the magistrate is not necessarily required to be satisfied of the evidential basis of the prosecution case. However, the assumption is valid in cases where a question as to fitness is raised for the first time during trial for which the defendant was committed by a court of summary jurisdiction.

50. An alternative procedure also exists in Canada: see *Criminal Code*, RSC 1985, C-46, pt XVIII.

51. *Criminal Procedure (Insanity) Act 1964* (UK) s 4(4), (5).

52. *Criminal Procedure (Insanity) Act 1964* (UK) s 4(5).

omission charged against him as an offence”.<sup>53</sup> The finding is to be based on evidence already given (if any) and on any additional evidence adduced by the prosecution or by a person appointed by the court to put the case for the defence.<sup>54</sup> If the jury is not satisfied that the defendant committed the relevant act or omission, the defendant is acquitted.<sup>55</sup>

2.25 Under the alternative procedure, the court “may postpone consideration of the question of fitness to be tried until any time up to the opening of the case for the defence”.<sup>56</sup> The court may elect to adopt this procedure “[i]f, having regard to the nature of the supposed disability, the court is of the opinion that it is expedient ... and in the interests of the accused”.<sup>57</sup> If the accused is acquitted, the question of fitness does not fall to be considered.<sup>58</sup> If the accused is not acquitted, the court (without a jury) must determine the question of fitness.<sup>59</sup> If the defendant is found to be unfit, the trial jury must consider whether the defendant did the act or omission charged as an offence.<sup>60</sup> If the jury is not satisfied that the defendant committed the relevant act or omission, the defendant is acquitted.<sup>61</sup>

2.26 Postponing the determination of fitness provides a less cumbersome procedure for providing the accused with the opportunity of acquittal than does a special hearing, but is subject to two reservations. First, as noted above, there are drawbacks to excluding consideration of the mental elements of the offence. Arguably, the question for the jury should not be limited to whether or not the accused did the act or omission charged.

2.27 Secondly, the defence case should not necessarily be excluded. There may be evidence that does not form part of the prosecution case but which is capable of exonerating the accused. Examples might include

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53. *Criminal Procedure (Insanity) Act 1964* (UK) s 4A(2).

54. *Criminal Procedure (Insanity) Act 1964* (UK) s 4A(2).

55. *Criminal Procedure (Insanity) Act 1964* (UK) s 4A(4).

56. *Criminal Procedure (Insanity) Act 1964* (UK) s 4(2).

57. *Criminal Procedure (Insanity) Act 1964* (UK) s 4(2).

58. *Criminal Procedure (Insanity) Act 1964* (UK) s 4(3).

59. *Criminal Procedure (Insanity) Act 1964* (UK) s 4(5).

60. *Criminal Procedure (Insanity) Act 1964* (UK) s 4A(1)-(2), (5) (trial jury to determine).

61. *Criminal Procedure (Insanity) Act 1964* (UK) s 4A(4). A similar procedure also exists in Canada: see *Criminal Code*, RSC 1985 (Canada) s 672.25-672.31.

a witness who is able to provide the accused with an alibi, or expert evidence regarding the physical ability of the accused to carry out the acts alleged. If the accused is not acquitted at the end of the prosecution case, there should remain an opportunity for the defence case to be put. This possibility exists in Canada, where determination of the issue of fitness may be deferred “until a time not later than the opening of the case for the defence or, on motion of the accused, any later time that the court may direct.”<sup>62</sup>

#### Issue 6.15

Should deferral of the determination of fitness be available as an expeditious means of providing the accused with an opportunity of acquittal?

### Flexibility in the way the special hearing is conducted

2.28 Another possibility is that the court could have a broad discretion to modify the manner in which proceedings are conducted, provided that the rules of evidence apply and the evidence is subject to the ordinary level of scrutiny. This would enable the court to adopt a more informal procedure so that the procedure would be less intimidating and distressing for the accused. For example, it may be unnecessary to require the accused to sit in the dock. A support person could accompany the accused and assist him or her to understand, to the greatest extent possible, what is going on.<sup>63</sup> If the hearing is before a judge alone, it might not be essential that it be held in a courtroom. Insofar as it would promote the participation of the unfit accused in the proceedings,<sup>64</sup> such an approach has the advantage of consistency with the principles of

62. *Criminal Code*, RSC 1985 (Canada) s 672.25(2)(b) (emphasis added).

63. See, eg, the special measures adopted in the trial of a young person in *V v United Kingdom* (2000) 30 EHRR 121, [81]-[91]. Similarly, in Queensland, the Mental Health Court may appoint a person to assist at a hearing, “including, for example, a person with appropriate communication skills or appropriate cultural or social knowledge or experience”: see *Mental Health Act 2000* (Qld) s 410.

64. Intellectual Disability Rights Service, *Enabling Justice: A Report on Problems and Solutions in relation to Diversion of Alleged Offenders with Intellectual Disability from the New South Wales Local Courts System* (2008), 38-44.

inclusiveness and non-discrimination in respect of persons with disabilities.<sup>65</sup>

2.29 In *Re IMM*, the Queensland Mental Health Court found that an accused person with an intellectual disability was nevertheless fit to be tried, because the trial court could adapt its procedures sufficiently to accommodate his impairment.<sup>66</sup> The decision was upheld by the Court of Appeal. Chief Justice de Jersey observed:

...[T]he public interest warrants the trial of persons accused of criminal offences whether their level of intellectual capacity be normal or otherwise. In this case, the appellant's intellectual capacity means that the process of trial will be longer and somewhat disjointed... The court will bear with him to ensure his trial is fair.

To deny a person like this appellant a trial would, having regard to both his interest in responding to the charge and possibly having his name cleared (while acknowledging of course that he bears no onus), and the interest of the community in ensuring that criminal charges are properly pursued, be frankly inconsistent with the rule of law, essentially because it would be discriminatory. Contemporary courts are sensitive to the varying needs of those who come before them.<sup>67</sup>

2.30 The decision in *Re IMM* has, however, been distinguished in two subsequent cases. In both cases, the Mental Health Court was particularly concerned that the defendants, in light of their respective impairments, could not fairly be subjected to cross-examination.<sup>68</sup>

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#### Issue 6.16

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Should the special hearing be made more flexible? If so, how?

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65. *Convention on the Rights of Persons with Disabilities*, art 3(c); see for example *Disability Services Act 1993* (NSW) s 3.

66. *Re IMM* [2002] QMHC 12.

67. *R v M* [2002] QCA 464, [14]-[15]. See also *R v Langley* (2008) 19 VR 90, [26]; *R (on the application of P) v West London Youth Court* [2005] EWHC (admin) 2583, [18].

68. *Re WLW* [2004] QMHC 6, [10]-[11]; *Re M* [2006] QMHC 19, [24]-[26], [30]. In *Re IMM* [2002] QMHC 12 (above), the issue of cross-examination was raised, but was not decisive: [12]. See also *Mantell v Molyneux* (2006) 165 A Crim R 83, [25], [28]-[36].

## The requirement for the defendant to be present

2.31 Attendance at the special hearing is, for some unfit accused, a source of distress.<sup>69</sup> Ordinarily, a criminal trial must be conducted in the presence of the accused.<sup>70</sup> The basis of the rule is “that the accused, by reason of his presence, should be able to understand the proceedings and decide what witnesses he wishes to call, whether or not to give evidence and, if so, upon what matters relevant to the case against him”.<sup>71</sup> The only exceptions to the rule are where the accused consents to absent him- or herself,<sup>72</sup> or where the conduct of the accused is so violent or deliberately disruptive as to make it lawful to continue in his or her absence.<sup>73</sup>

2.32 However, a special hearing is not a criminal trial. It is a proceeding intended to afford an opportunity of acquittal to an accused who, by definition, cannot understand criminal proceedings.<sup>74</sup> The usual rationale for requiring the presence of the accused is therefore inapplicable, at least in some cases.<sup>75</sup>

2.33 In some cases it might be of no disadvantage to the unfit accused to conduct the special hearing in his or her absence.<sup>76</sup> However, there is currently no express power in the MHFPA for the presiding judge to excuse the accused from appearing at the special hearing. Such a power exists in Queensland, where the Mental Health Court may proceed in the

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69. Public Interest Advocacy Centre, *Time for Change: Response to the Consultation Paper: Review of the forensic provisions of the Mental Health Act 1990 and the Mental Health (Criminal Procedure) Act 1990*, 9. See also *R v Mailes* (2001) 53 NSWLR 251.

70. *Lawrence v The King* [1933] AC 699, 708; *Kunnath v The State* [1993] 4 All ER 30, 35-36; *Ebatarinja v Deland and Others* (1998) 194 CLR 444, [26] and see *Criminal Procedure Act 1986* (NSW) s 71-73.

71. *Kunnath v The State* [1993] 4 All ER 30, 35-36; cited with approval in *Ebatarinja v Deland and Others* (1998) 194 CLR 444, [26].

72. *Kunnath v The State* [1993] 4 All ER 30, 36.

73. *Lawrence v The King* [1933] AC 699, 708.

74. *R v Presser* [1958] VR 45, 48.

75. Contrast *R v Sexton* (2000) 116 A Crim R 173 (inoperable heart disease, risk of stress-induced heart attack if required to stand trial).

76. See, eg, *R v McLaughlan* [2008] ACTSC 49, [81] (where the evidence was adduced by the consensual tender of the statements by the prosecution witnesses, who were not cross-examined).

absence of the accused person if the Court “is satisfied [that] it is expedient and in the person’s best interests to do so”.<sup>77</sup>

2.34 The Commission invites submissions on the question of whether the court should have a power to excuse the accused from attending all or part of the special hearing.

### Issue 6.17

Should the MHFPA provide for the defendant to be excused from a special hearing?

### Findings at a special hearing

#### *The “qualified finding of guilt”*

2.35 Currently, if the accused person at a special hearing is not acquitted, the court enters a finding that, “on the limited evidence available”, “the accused person committed the offence charged” or “committed an offence available as an alternative”.<sup>78</sup> Either finding “constitutes a qualified finding of guilt”.<sup>79</sup> This wording creates an erroneous perception that the accused person has been found guilty of an offence, despite the fact that there has not been a full and fair trial of the facts.<sup>80</sup> In contrast, legislation in Tasmania provides for the court to enter a “finding” that “a finding of not guilty cannot be made”, in relation to the offence charged or an alternative offence.<sup>81</sup> Alternatively, a finding could be entered that “the accused person was unfit to be tried and was not acquitted” of the offence charged or an alternative offence.

77. *Mental Health Act 2000* (Qld) s 409. See for example *Re SAB* [2003] QMHC 14, [24]-[27].

78. MHFPA s s 22(1)(c)-(d).

79. MHFPA s 22(3)(a).

80. See for example *R v AN (No 2)* (2006) 66 NSWLR 523, [66], [77]. This is reinforced by legislative references to the subsequent imposition of a limiting term or other “penalty”: see MHFPA s 23, 74(e); *Criminal Appeal Act 1912* (NSW) s 6A(c); *Smith v The Queen* [2007] NSWCCA 39, [45]-[47], [63]; *Director of Public Prosecutions v Mills* [2000] NSWCA 36, [38]-[39]; but compare *R v Mailes* (2004) 62 NSWLR 181, [32] and *R v AN (No 2)* (2006) 66 NSWLR 523, [32]. And see *Kable v Director of Public Prosecutions (NSW)* (1995-96) 189 CLR 51, 97 (Toohey J), 106-107 (Gaudron J), 131-132 (Gummow J); *Fardon v Attorney General (Qld)* [2004] 78 ALJR 1519, [153]-[156]; *Chu Kheng Lim v Commonwealth* (1992) 176 CLR 1, 27.

81. *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 17.



Appropriate legislative provision could be made for such a finding, and consequential orders, to be subject to appeal in the same way as a conviction and sentence, as currently occurs in relation to the “qualified finding of guilt”.<sup>82</sup>

#### Issue 6.18

Should the finding that “on the limited evidence available, the accused person committed the offence charged [or an offence available as an alternative]” be replaced with a finding that “the accused person was unfit to be tried and was not acquitted of the offence charged [or an offence available as an alternative]”?

#### *Verdict of “not guilty by reason of mental illness”*

2.36 The MHFPA also provides that an accused person at a special hearing may be found “not guilty on the ground of mental illness”.<sup>83</sup> There is no provision for such a finding to be reopened in the event that the person becomes fit for trial.<sup>84</sup> This is important for two reasons. First, the defence of mental illness requires not only that the person have a qualifying mental condition at the time of the offence, but also that it was related in a particular way to the conduct with which the person is charged.<sup>85</sup> If a person is unfit to be tried and therefore unable to give an account of the reasons for his or her behaviour at the time of the alleged offence, it may be unsafe to return a verdict of “not guilty by reason of mental illness”.

2.37 Secondly, and in a similar vein, the consequences of a verdict of “not guilty by reason of mental illness” are different from the consequences of a finding that “on the limited evidence available, the accused person committed the offence charged”. In particular, although in both instances the person may become a forensic patient,<sup>86</sup> those found not guilty on the ground of mental illness do not receive a “limiting

82. See MHFPA s 22(3); *Criminal Appeal Act 1912* (NSW) pt 3 especially s 6A; and see *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 36.

83. MHFPA s 22(1)(b).

84. Compare MHFPA s 28, 45(2), 47(4)-(5), 52(3).

85. See ch 3.

86. See MHFPA s 23-24, 39, 42.

term”.<sup>87</sup> Instead, the person remains a forensic patient indefinitely, until such time as the MHRT orders that he or she be unconditionally released.<sup>88</sup> If an accused person is wrongly found not guilty by reason of mental illness at a special hearing, he or she is thereby deprived of the opportunity to have a “limiting term”.<sup>89</sup>

2.38 If, however, the defence of mental illness were not available at a special hearing, that may lead to an outright acquittal in cases where the accused person’s cognitive or mental health impairment makes it difficult for the prosecution to establish mental elements of the offence. This is particularly so where the person’s impairment calls into question matters such as voluntariness of conduct, and the intent which actually accompanied the accused person’s actions;<sup>90</sup> and where the “actus reus” of the offence has a mental element, such as knowledge of lack of consent in a sexual assault case.<sup>91</sup>

2.39 Moreover, an accused person who is unfit to be tried nevertheless has an interest in the matter being finally resolved if possible, whether by outright acquittal or a qualified acquittal on the grounds of mental illness.<sup>92</sup>

#### Issue 6.19

Should a verdict of “not guilty by reason of mental illness” continue to be available at special hearings? Are any additional safeguards necessary?

87. See MHFPA s 23-24, 52(2)(a) and see ch 7.

88. See ch 7.

89. This point would not arise if indefinite detention were not the consequence of a finding of not guilty on the ground of mental illness in NSW: see discussion in ch 7 concerning the possibility of introducing a limiting term following such a finding.

90. See, eg, *Bratty v Attorney General (Northern Ireland)* [1963] AC 386 (“insane automatism”); *R v Sullivan* [1984] AC 156 (“insane automatism”); *R v McLaughlan* [2008] ACTSC 49 (voluntariness); *R v Minani* (2005) 63 NSWLR 490, [29]-[32] (specific intention).

91. See especially *R v Ardler* [2004] ACTCA 4; *R v Ardler* [2003] ACTSC 24. The verdict of “not guilty by reason of mental impairment” is not available at special hearings in the ACT.

92. See *R v Langley* (2008) 19 VR 90, [32]-[40] (limited finding of guilt at special hearing quashed because defence of mental impairment was not left to the jury).

### 3.

## **The defence of mental illness**

- Overview of the defence
- A continuing need for the defence?
- The current test for mental illness
- Reforming the test for the defence of mental illness
- Intoxication and the defence of mental illness
- Distinguishing the defence of mental illness from the defence of automatism
- Procedural aspects of the defence of mental illness
- Application of the defence to the Local Court

## OVERVIEW OF THE DEFENCE

3.1 A person can be found not guilty of a crime if he or she was mentally ill at the time of committing it.<sup>1</sup> This principle is commonly known as the defence of mental illness.

3.2 Along with the rules relating to fitness to be tried and the defence of substantial impairment,<sup>2</sup> the defence of mental illness is one way in which our criminal justice system makes concessions for those who commit crimes while suffering from some form of mental impairment. Although related, these three sets of rules are conceptually distinct. They have evolved for different reasons and are justified on different grounds.

### Why do we have a defence of mental illness?

3.3 As early as the thirteenth century, the common law (on which our criminal justice system is based) showed an inclination to treat mentally ill offenders leniently.<sup>3</sup> From that inclination developed the idea that, in some instances, mental illness may actually negate a person's responsibility for a criminal act. This principle developed over centuries in consort with the notion of intention as an all-important mark of criminal responsibility, a notion that was originally influenced by the Church and its focus on bad intention as an indication of moral wickedness. Offenders with impaired mental functioning were not capable of forming bad intentions and were therefore not blameworthy. The defence of insanity (as it was then called) provided the mechanism by which to excuse these offenders from blame, initially by providing a basis for granting them a royal pardon after they were convicted, but by the 16<sup>th</sup> century, by providing a means for acquitting them at trial.<sup>4</sup>

3.4 The original basis for the evolution of the defence was therefore a principled one, sprung from the premise that impaired mental

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1. For the application of the defence to defendants with a cognitive impairment, see the discussion at [3.32]-[3.34].
  2. See ch 1 and 4.
  3. At that time, criminal wrongdoing was usually dealt with by demanding compensation from the perpetrator. In cases where the perpetrator was known to be "insane", compensation might be demanded of his or her family, rather than from the perpetrator himself or herself: see N Walker, *Crime and Insanity in England* (1968) vol 1 ch 1.
  4. See Walker vol 1 ch 2; *R v S* [1979] 2 NSWLR 1, 24-26.

functioning negated criminal responsibility. A second basis for its continued operation was much more practical and had developed by the turn of the 18<sup>th</sup> century, when the defence of insanity became a means of empowering the courts to order a person's indefinite detention in a gaol or asylum.<sup>5</sup> Protection of the community by incapacitation of the mentally ill offender therefore developed as a second focus of the defence of mental illness.

3.5 The modern defence of mental illness remains grounded in these two principles: that is, recognition of impaired mental functioning as an excuse from criminal responsibility, and protection of the community through detention of those who, because of their mental illness, pose a threat to themselves or others. Arguably, a shift in social attitudes over the last half a century in favour of a more humanitarian approach to those suffering from mental illness has widened the focus of the modern defence of mental illness. Now, at least in theory, the defence can be considered as a means of providing treatment to offenders with a mental illness or cognitive impairment, in recognition of the limitations of criminal sanctions in having any deterrent or retributive effect in this context.

### Which crimes does the defence cover?

3.6 The defence of mental illness can be raised at an ordinary criminal trial or in a special hearing after a person has been found unfit to be tried.<sup>6</sup> The defence can be used to acquit a person accused of any type of crime. In practice, it is usually raised for the most serious crimes, such as

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5. See the case of *R v Hadfield* (1800) 27 St Tr 1281, which gave rise to the introduction of legislation expressly directing the court to order the detention of a defendant found not guilty by reason of insanity.
  6. And the defendant is not expected to become fit to be tried within 12 months. See *Mental Health (Forensic Provisions) Act 1990* (NSW) ("the MHFPA") s 22, 25 and ch 1.

murder.<sup>7</sup> Figures suggest that the defence is raised, or at least successful, in a relatively small number of cases.<sup>8</sup>

### What are the consequences of being found not guilty by reason of mental illness?

3.7 Explanations for why the defence of mental illness is used so infrequently and for only the most serious crimes (carrying the most serious penalties) may be partly found by looking at the consequences of being judged not guilty by reason of mental illness. There is perhaps a perception in the community that an insanity plea is a legal loophole that allows criminals to escape punishment.<sup>9</sup> If so, then that perception does not reflect reality. It is true that a person who is found not guilty of a crime by reason of mental illness is theoretically acquitted. Being exonerated of all wrongdoing, he or she is not subject to punishment. But in practice, unlike an ordinary acquittal, a person acquitted on the grounds of mental illness is not usually released but faces the prospect of indeterminate detention.

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7. Although it seems that the defence can apply to defendants in the Local Court (who are charged with less serious crimes), there is uncertainty about its operation there. The application of the defence to the Local Court is discussed in greater detail at [3.114]-[3.116].
  8. Statistical data is not readily available to provide a clear indication of the frequency with which the defence is sought to be relied on in the superior courts. Figures from the Mental Health Review Tribunal (“MHRT”) indicate that a total of 48 cases coming before the Tribunal for the two and a half year period from the beginning of 2006 to 30 June 2008, involved the review of forensic patients following court orders for their detention upon a finding of not guilty by reason of mental illness (whether following a trial or at a special hearing). This figure would not cover any cases where a person was found not guilty by reason of mental illness and immediately discharged from custody. See NSW, MHRT, *Annual Report 2007-2008*. The MHRT reported that, as at 30 June 2007, 208 out of a total of 309 forensic patients in NSW had been found not guilty by reason of mental illness: see G James QC, *Review of the New South Wales Forensic Mental Health Legislation (2007)* (“the James Report”) [5.9]. Of course, these figures give no indication of whether or not there are many more cases where the defence is raised but rejected.
  9. See K Freeman, “Mental Health and the Criminal Justice System” *Crime and Justice Bulletin* (October 1998) no 38, 1.

3.8 In the Supreme and District Courts (being the courts where the defence of mental illness is almost exclusively used), a defendant acquitted on the grounds of mental illness:<sup>10</sup>

- may be ordered to be detained in such place and in such manner as the Court thinks fit;
- may be discharged from custody, either conditionally or unconditionally, but only if the Court is satisfied that the safety of the defendant or of the public is not seriously endangered; or
- may face any other order that the Court considers appropriate.

3.9 If a defendant is detained or released subject to conditions, the Mental Health Review Tribunal (“MHRT”) must conduct an initial review of his or her case and must then conduct regular, subsequent reviews if he or she continues to be detained.

3.10 Although there are a variety of orders that can be made, in most cases the effect of an acquittal on the grounds of mental illness is that the person is detained for an indeterminate time. Detention is not necessarily in a mental health facility, but may be in a prison.<sup>11</sup>

3.11 The consequences of a finding of not guilty by reason of mental illness are discussed fully in Chapters 6 and 7. They are outlined briefly here to put the operation of the defence in its proper context. Clearly, however the defence of mental illness is formulated, and whoever is brought within its scope, it is not an easy alternative to a criminal sanction. To the contrary, it may often be just as harsh or an even harsher option for the individual to face.

### What are the issues for discussion in this chapter?

3.12 The focus of this chapter is on the test that the law applies to decide whether or not a defendant is mentally ill so as to be not guilty by reason of mental illness. There is a considerable body of literature criticising this test, and a number of proposals have been put forward in Australia and overseas for reformulating it.<sup>12</sup>

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10. The same orders are available for a defendant who is acquitted in a special hearing following a finding of unfitness as are available in the course of ordinary criminal proceedings. See MHFPA s 25, 39.

11. See [7.48]-[7.55].

12. See [3.49]-[3.88].

3.13 Among these criticisms, there seems to be general agreement that the current formulation of what constitutes mental illness for the purposes of the defence is based on outmoded ideas and does not sit easily with modern medical knowledge. These criticisms beg the question, first of all, whether there remain valid grounds for maintaining a defence of mental illness as a means of acquitting people who commit crimes while suffering from mental impairment. This chapter deals first with that question. It moves on to discuss the details of the test itself, that is, the separate elements that comprise it and the problems that have arisen in their interpretation and application. This discussion aims to discover whether, while perhaps based on outmoded concepts, the current formulation of the defence nevertheless works well in practice, or whether a different formulation would be easier to understand and apply and would delineate more appropriately the scope of the application of the defence to particular groups of defendants.

### A CONTINUING NEED FOR THE DEFENCE?

3.14 Given the level of criticism that surrounds its formulation, the question arises whether the defence of mental illness is so outdated and fundamentally flawed that it should be rejected altogether as forming part of a modern criminal justice system.<sup>13</sup> That question requires consideration, first of all, as to whether the underlying rationale for the defence remains valid. Is there still a need to provide a legal mechanism for excusing from criminal responsibility those offenders whose mental capacity is significantly impaired, for protecting them from themselves or the community where their impaired mental capacity makes them susceptible to dangerous behaviour, and for providing them with the opportunity for treatment, rather than punishment? In the Commission's view, the answer to that question is uncontroversial, and the underlying rationale for the defence of mental illness remains as valid today as it did when it first evolved. There are a variety of ways in which our criminal justice system continues to acknowledge that mental impairment can reduce or negate criminal culpability. The defence of mental illness is one way in which it does so.

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13. See Tasmania, Law Reform Commission, *Insanity, Intoxication and Automatism*, Report 61 (1988) 9-11; Victoria, Law Reform Commission, *Mental Malfunction and Criminal Responsibility*, Report 34 (1990) [19]-[28]; Western Australia, Law Reform Commission, *The Criminal Process and Persons Suffering from Mental Disorder*, Report, Project 69 (1991) [2.2]-[2.4].



3.15 But the question then remains whether there is an alternative and more effective means of excusing mentally impaired offenders and redirecting them into treatment other than by way of a defence of mental illness. One alternative would be to replace the defence of mental illness with a diversionary power that would obviate the need for a defendant to stand trial and allow the court to divert him or her out of criminal proceedings. The same consequences could follow that now apply, in particular, the potential for detention for an indeterminate period subject to regular reviews. This diversionary power could be framed in a way that would require the court to apply a specific test to determine whether a defendant were mentally impaired and so eligible for diversion, in a way similar to the current approach under the defence of mental illness. Alternatively, the power could be framed in a way that would give the court a greater discretion than it currently has under the defence to determine that a defendant should not be held responsible for his or her criminal actions because of mental impairment.

3.16 It is difficult at this stage of our consultation process to know whether there would be any significant advantage or disadvantage in replacing a well-established defence with a power of this kind, and in particular whether there are advantages and disadvantages in providing for a power which would mean that a defendant would not have to stand trial, or have a jury decide the question of his or her criminal culpability (although at the moment, there is opportunity for a defendant to be tried by judge alone, without a jury). We would be interested to know people's opinions on this alternative.

#### Issue 6.20

Should the defence of mental illness be replaced with an alternative way of excusing defendants from criminal responsibility and directing them into compulsory treatment for mental health problems (where necessary)? For example, should it be replaced with a power to divert a defendant out of criminal proceedings and into treatment?

### THE CURRENT TEST FOR MENTAL ILLNESS

3.17 In the absence of a more radical move to replace the defence of mental illness altogether with a new approach, such as the exercise of a diversionary power, there are changes that could be made to the existing criteria required to satisfy the defence. The following discussion examines this possibility.

3.18 At the moment, the test for deciding whether a defendant is not guilty by reason of mental illness is regulated according to a mixture of legislation and common law.

### The legislative framework

3.19 The *Mental Health (Forensic Provisions) Act 1990* (NSW) (“the MHFPA”) sets out a framework for the operation of the defence of mental illness in the Supreme and District Courts.<sup>14</sup> Part 4 of the Act provides for a special verdict of not guilty by reason of mental illness. It then maps out the procedures that follow such a verdict as referred to in paragraphs [3.8]-[3.10].

3.20 Section 38(1) of the Act provides for the defence in the following terms:

If, in an indictment or information, an act or omission is charged against a person as an offence and it is given in evidence on the trial of the person for the offence that the person was mentally ill, so as not to be responsible, according to law, for his or her action at the time when the act was done or omission made, then, if it appears to the jury before which the person is tried that the person did the act or made the omission charged, but was mentally ill at the time when the person did or made the same, the jury must return a special verdict that the accused person is not guilty by reason of mental illness.<sup>15</sup>

3.21 The legislation does not define the phrase, “mentally ill” or the required nexus between the defendant’s mental illness and his or her act or omission. Responsibility “according to law” picks up the criteria for mental illness at common law, articulated in what is commonly known as the *M’Naghten* test or the *M’Naghten* rules, in reference to the case of *M’Naghten* in 1843 in which they were first definitively set down.<sup>16</sup>

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14. It is unlikely that this legislation regulates the operation of the defence of mental illness in the Local Court, where instead the common law governs its application. See [3.114]-[3.116] for discussion of the defence of mental illness as it applies to Local Court proceedings.

15. See too the MHFPA s 22, which provides for a special verdict of not guilty by reason of mental illness to be returned at a special hearing following a finding of unfitness to be tried.

16. See *R v S* [1979] 2 NSWLR 1, 38 (O’Brien J), 6 (Street CJ agreeing), 67 (Slattery J agreeing). While the court was considering the now repealed s 23(2) of the

## The *M'Naghten* rules

3.22 The common law test for the defence of mental illness (and consequently, the defence as provided by s 38(1) of the MHFPA requires that, at the time of committing the offence:

- the defendant was labouring under a defect of reason caused by a disease of the mind; and
- because of that disease, the defendant either
  - (i) did not know the nature and quality of the act, or
  - (ii) did not know that the act was wrong.

3.23 The courts have developed a significant body of case law concerning the *M'Naghten* rules. The case law has focused on interpreting what the rules mean in their application to particular cases, rather than in developing them further or modifying them in any way. In fact, the formulation of the test remains the same as when it was first articulated in the *M'Naghten* case. The discussion below considers each element that makes up the *M'Naghten* rules and the ways in which the courts have interpreted it.

### *“Defect of reason caused by disease of the mind”*

3.24 To establish the defence of mental illness, the defendant must first be shown to have suffered from a defect of reason. The courts have found this requirement uncontroversial, demanding a diminution or malfunction of the normal capacity for rational thought, that is, a defect in the capacity of the defendant to reason. Its focus is said to be on the cognitive capacities of the defendant.<sup>17</sup>

3.25 The meaning of the term, “disease of the mind” has proved more controversial. The requirement that the defect of reason be caused by a disease of the mind has been said to link the defect of reason to an internal cause, some “underlying pathological infirmity of the mind ... which can be properly termed mental illness, as distinct from the reaction

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*Mental Health Act 1958* (NSW), a predecessor to the current provision, the reasoning remains valid.

17. See *R v Porter* (1936) 55 CLR 182; *R v S* [1979] 2 NSWLR 1, 42; N Walker, *Crime and Insanity in England* (1968) vol 1, 115; D Howard and B Westmore, *Crime and Mental Health Law in New South Wales: A Practical Guide for Lawyers and Health Care Professionals* (2005) [5.23].

of a healthy mind to extraordinary external stimuli”.<sup>18</sup> It is not enough to satisfy the defence that a person’s capacity for rational thought is diminished by external factors such as poverty, limited education, intoxication, or drug use. Although factors such as these may impact significantly on a person’s thought processes, the law adheres to what has been described as a medical model of mental illness. It exonerates only those whose capacity for rational thought has been overcome by illness or internal infirmity. That position has been described as reflecting what is essentially a value judgment about the factors that should negate criminal responsibility: a person’s environment is seen to be more subject to individual choice and control and therefore less deserving of exculpation from criminal responsibility.<sup>19</sup>

3.26 A disease of the mind does not necessarily mean that a person’s brain must be affected in any way, for example, through a degeneration of brain cells. “Mind” is said to be something different from brain, a reference to the faculties of reason, memory, and understanding.<sup>20</sup> It is a legal concept, rather than a medical one.<sup>21</sup> A disease of the mind has been held to include major mental diseases or psychoses such as schizophrenia or severe mood disorders, as well as physical diseases such as psychomotor epilepsy, arteriosclerosis (involving a hardening of the arteries), and cerebral tumour.<sup>22</sup>

*“Did not know the nature and quality of the act”*

3.27 The *M’Naghten* rules require that, because of a defect of reason caused by a disease of the mind, the defendant either did not know the nature and quality of the act, or did not know that what he or she was doing was wrong.

3.28 To satisfy the first alternative of this second limb, a failure to know the nature and quality of the act, the defendant must be shown not to

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18. See *R v Radford* (1985) 42 SASR 266, 274, cited with approval in *Falconer v The Queen* (1990) 171 CLR 30, 53-54, 78, 85.

19. See Melton, cited in Howard and Westmore at 162.

20. See *R v Sullivan* [1984] AC 156, 172, approved in *R v Falconer* (1990) 171 CLR 30, 50.

21. See *Falconer v The Queen* (1990) 171 CLR 30, 49-54, 60, 68-69, 71, 74, 84-85; *R v Sullivan* [1984] AC 156, 172; *Bratty v Attorney General (Northern Ireland)* [1963] AC 386, 412.

22. See *R v Kemp* [1957] 1 QB 399; *Bratty v Attorney-General for Northern Ireland* [1963] AC 369; *R v Falconer* (1990) 171 CLR 30.

appreciate the physical character of the act, rather than its moral character.<sup>23</sup> This includes not appreciating the implications of the physical act, such as where a person has so little capacity for understanding the nature of life and the destruction of life, that to kill another means no more than breaking a twig or destroying an inanimate object.<sup>24</sup>

*“Did not know that the act was wrong”*

3.29 The second alternative requires that the defendant did not know that what he or she was doing was wrong. To establish the defence under this alternative, the defendant must be shown not to know that the act in question was wrong according to the standards of what ordinary people would consider to be wrong.<sup>25</sup> A person may know that an act is illegal but still not know that it is wrong according to the standards of ordinary people in order to satisfy this requirement.<sup>26</sup> A defendant will not know that the act was wrong if he or she could not think rationally of the reasons that, to ordinary people, make the act right or wrong or could not reason about the matter with a moderate degree of sense and composure.<sup>27</sup> In cases where an act is committed in a state of frenzy or uncontrolled emotion, so that it is impossible for the defendant to reason with a moderate degree of calmness about the moral quality of what he or she is doing, then it may be inferred that he or she does not know that what he or she is doing is wrong.<sup>28</sup>

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23. See *R v Codere* (1916-17) 12 Cr App R 21, 27.

24. See *R v Porter* (1933) 55 CLR 182, 188.

25. See *Stapleton v The Queen* (1952) 86 CLR 358, 367-375; *R v Porter* (1933) 55 CLR 182, 189-190.

26. See, eg, *The Trial of James Hadfield, at the Bar of the Court of King’s Bench, for High Treason* (1800) 27 State Tr 1281. Hadfield believed that he was Jesus Christ, that the world was coming to an end, and that he must sacrifice himself for the world’s salvation. He planned to achieve that sacrifice by assassinating the King so that he would be hanged for treason. Because of his delusions, Hadfield believed that his plan to assassinate the King was the *right* thing to do, although he knew – indeed intended – that it was illegal. Hadfield was acquitted of treason on account of “insanity”.

27. See *R v Porter* (1933) 55 CLR 182, 189-190.

28. See *Sodeman v The King* (1936) 55 CLR 192, 215; *Wilgoss v The Queen* (1960) 105 CLR 295, 301; *R v S* [1979] 2 NSWLR 1.

### Applying the test to particular mental conditions

3.30 There are certain mental conditions that have repeatedly been shown up in the case law as problematic or controversial in their ability to satisfy the criteria for mental illness under the *M’Naghten* rules. These are:

- intellectual disability
- personality disorder
- irresistible impulse, and
- delusional beliefs.

3.31 It could be argued that the difficulties encountered with respect to these conditions highlight the shortcomings inherent in the rules in their insistence on categorising mental impairment according to rigid criteria. In contemplating possible reforms to the test for the defence of mental illness, it is worth considering the extent to which the existing test is able to accommodate these particular mental conditions within its framework, and the extent to which they *should* be brought within the scope of the defence.

#### *Intellectual disability*

3.32 Although intellectual disability may, in theory, amount to a “disease of the mind” for the purposes of raising the defence of mental illness,<sup>29</sup> in practice it appears that this rarely occurs.<sup>30</sup> A defendant’s intellectual disability may often mean that he or she is unable to give an account of his or her mental state at the time of the offence, which could

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29. Hayes and Craddock have observed that “the law needs to be reformed so that intellectual disability does not continue to be defined as an illness for the purpose of defences to criminal charges. Quite apart from the questions of principle involved, it is ludicrous that during a trial the jury will hear from the experts that intellectual disability is not an illness and then be directed by the trial judge that they must consider it as such for the purpose of determining whether to return a special verdict of not guilty by reason of mental illness”: SC Hayes and G Craddock, *Simply Criminal* (2nd ed, 1992), 141-141 quoted in NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Discussion Paper 35 (1994) (“NSWLRC DP 35”) [10.16].

30. Although see the recent decision of the Privy Council, which held that evidence of a defendant’s learning disability may provide a basis for a finding of insanity: see *Pitman v State* [2008] UKPC 16.

impede proof that he or she did not know the nature and quality, or wrongness, of his or her act.<sup>31</sup>

3.33 The Public Interest Advocacy Centre has submitted that, in light of the inherent differences between mental illness and intellectual disability, and the different needs of people with an intellectual disability, consideration should be given to formulating a separate defence of intellectual impairment with appropriate disposition options.<sup>32</sup>

3.34 In most other Australian jurisdictions, legislation expressly recognises intellectual disability, along with other cognitive impairments such as brain damage and senility, as conditions that may qualify a defendant for the defence of mental illness.<sup>33</sup> As a question of policy, it is difficult to see why a person's intellectual disability, or other cognitive impairment, should not potentially provide as sound a basis as another's mental illness for finding him or her not responsible for a criminal act.

#### Issue 6.21

Should legislation expressly recognise cognitive impairment as a basis for acquitting a defendant in criminal proceedings?

If yes, should the legislation expressly include cognitive impairment as a condition coming within the scope of the defence of mental illness, or is it preferable that a separate defence of cognitive impairment be formulated as a ground for acquittal?

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31. See NSWLRC DP 35, [10.11]-[10.18] and NSWLRC Report 80 (1996) [6.5]-[6.6].
32. See Public Interest Advocacy Centre, *Time for Change: Response to the Consultation Paper: Review of the Forensic Provisions of the Mental Health Act 1990 and the Mental Health (Criminal Procedure) Act 1990*, 20, provided to NSWLRC at Consultation, 30 May 2007. In his recent review of the forensic mental health legislation, the Hon Greg James QC noted the shortcomings of this legislation in meeting the needs of defendants with an intellectual disability, and recommended that further legislative and administrative action be taken to deal with the special circumstances surrounding defendants with an intellectual disability: see James Report [3.10]-[3.20].
33. See *Criminal Code 1995* (Cth) s 7.3(8); *Criminal Code 2002* (ACT) s 27(1); *Criminal Code 1913* (WA) s 1; *Criminal Code 1983* (NT) s 43A; *Criminal Law Consolidation Act 1935* (SA) s 269A. See too *United States Code* Tit 18 Pt 1, s 17(a); *Crimes Act 1961* (NZ) s 23(2); *Criminal Code RSC 1985* (Canada) Pt 1 s 16(1).

### *Personality disorder*

3.35 There is uncertainty about whether the defence of mental illness applies to personality disorders, including psychopathy. In several cases, it seems to have been accepted that these conditions fall within the meaning of the term “disease of the mind”.<sup>34</sup>

3.36 The main obstacle to establishing the defence in this context is the difficulty in proving that, because of the personality disorder, the defendant did not know the nature and quality or the wrongness of his or her act.<sup>35</sup> The courts have held that a person can know that an act is wrong (and so fail to establish the defence of mental illness) even though he or she suffers from a personality disorder involving an inability to feel empathy for others and to appreciate the effect of his or her actions on others. It seems that inability to feel empathy is insufficient in itself to ground the defence.<sup>36</sup>

3.37 There is some debate about whether or not personality disorders should give rise to a defence of mental illness. “Severe personality disorder” is expressly included in the definition of “mental impairment” for the defence of mental impairment in Commonwealth and ACT legislation.<sup>37</sup> This legislation is based on the recommendations of the Model Criminal Code Committee, which considered the question of personality disorder “too complex to be resolved by a blanket exclusion”.<sup>38</sup> Instead, it considered that a jury should be allowed to determine whether, in a particular case, a defendant’s personality disorder produced a mental state consistent with a defence of mental

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34. See, eg, *Willgoss v The Queen* (1960) 105 CLR 295; *Stapleton v The Queen* (1952) 86 CLR 358, 360-367; *Jeffrey v The Queen* (1982) 7 A Crim R 55; *Attorney General (South Australia) v Brown* [1960] AC 432; *Attorney General (Northern Ireland) v Gallagher* [1961] 3 All ER 299. But compare *Hodges v The Queen* (1985) 19 A Crim R 129 (anti-social personality disorder not a “state of mental disease or natural mental infirmity” within *Criminal Code Act 1913* (WA) s 27).

35. See, eg, *Willgoss v The Queen* (1960) 105 CLR 295; *Attorney General (South Australia) v Brown* [1960] AC 432; *Attorney General (Northern Ireland) v Gallagher* [1961] 3 All ER 299. Compare *Stapleton v The Queen* (1952) 86 CLR 358, 360-367.

36. See *Willgoss v The Queen* (1960) 105 CLR 295.

37. See *Criminal Code 1995* (Cth) s 7.3(8); *Criminal Code 2002* (ACT) s 27.

38. See Criminal Law Officers Committee of the Standing Committee of Attorneys General [now Model Criminal Code Officers Committee], *Model Criminal Code Chapters 1 and 2: General Principles of Criminal Responsibility*, Report (1992) (“Model Criminal Code Report”) 37.



impairment.<sup>39</sup> The descriptor “severe” was included “to emphasise the degree of the disorder”.<sup>40</sup>

3.38 The Law Reform Commission of Western Australia recently expressed the view that, unlike intellectual disability, senility and brain damage, personality disorder should not “automatically qualify” as a “mental impairment” for the purposes of the defence but that it should not be specifically excluded.<sup>41</sup>

3.39 One difficulty with including personality disorder within the defence of mental illness is that mental health professionals have traditionally regarded personality disorder as untreatable.<sup>42</sup> Detention of people with personality disorder within a hospital environment is seen as inappropriate and may put other patients at risk.<sup>43</sup> Additionally, if there is no prospect of improvement in a person’s condition, the effect of a finding of not guilty by reason of mental illness might be lifelong detention or supervision.<sup>44</sup> On the other hand, recent evidence suggests that, while personality is essentially fixed, its manifestations can be modified or managed using behavioural therapy and/or medication.<sup>45</sup>

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39. In addition to lack of knowledge of the nature and quality or the wrongness of the conduct, loss of self control is a basis for the defence in both jurisdictions: see *Criminal Code 1995* (Cth) s 7.3(1); *Criminal Code 2002* (ACT) s 28(1).

40. See Model Criminal Code Report 37. See discussion in S Yeo, “Commonwealth and international perspectives on the insanity defence” (2008) 32 *Criminal Law Journal* 7, 10.

41. See Western Australia, Law Reform Commission, *Review of the Law of Homicide*, Final Report (2007) 230. See also Victoria, Law Reform Commission, *Defences to Homicide*, Discussion Paper (2003) [5.96].

42. See Victoria, Law Reform Commission, *Defences to Homicide*, Discussion Paper (2003) [5.90]-[5.96]; Victoria, Law Reform Commission, *People with Intellectual Disability at Risk: A Legal Framework for Compulsory Care*, Report (2003) [6.11]-[6.13]; United Kingdom, House of Commons Select Committee on Home Affairs, *First Report: Managing Dangerous People with Severe Personality Disorder* (2001) [15]-[17], [57]-[58].

43. See Victoria, Law Reform Commission, *Defences to Homicide*, Discussion Paper (2003) [5.96]; United Kingdom, House of Commons Select Committee on Home Affairs, *First Report: Managing Dangerous People with Severe Personality Disorder* (2001) [18].

44. As to considerations affecting the release of people found not guilty by reason of mental illness, see ch 6 and 7.

45. See United Kingdom, House of Commons Select Committee on Home Affairs, *First Report: Managing Dangerous People with Severe Personality Disorder* (2001)

Moreover, it is not suggested that other conditions that are essentially permanent and which are not amenable to hospital- or medication-based treatment, such as intellectual disability, should be excluded from the defence on those grounds. Specialised facilities could be established to provide management and treatment in appropriate ways. The Victorian Law Reform Commission has pointed out that “it is unfair to prevent people with personality disorders from relying on a mental impairment defence, simply because we do not yet know how to treat them.”<sup>46</sup>

3.40 Whether psychopathy and other personality disorders should be included within the scope of the defence of mental illness essentially involves a policy decision about who should be excused from criminal responsibility. If a person suffers from a condition which makes it genuinely difficult to empathise and appreciate the impact of his or her actions on others, should that person be held responsible for his or her conduct? Concerns about community protection may argue in favour of bringing them within the scope of the defence, if the defence is to continue to provide a means of separating those from the community who pose a threat to public safety by means of an order for indeterminate detention. On the other hand, it should be remembered that personality disorders occur when aspects of personality fail to develop or to develop fully, and that this may be caused by genetic factors or early childhood experiences. Is there a basis then for excusing defendants with a personality disorder from criminal responsibility but not excusing those who, though without a personality disorder, can point to bad childhood experiences or a deprived background as directly contributing to his or her criminal conduct?

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[57]-[58], [92]; SC Wond, A Gordon and D Gu, “Assessment and treatment of violence-prone forensic clients: an integrated approach” (2007) 190(supp) *British Journal of Psychiatry* 66; P Mullen, “Dangerous and severe personality disorder and in need of treatment” (2007) 190(supp) *British Journal of Psychiatry* 3, 5-6; A Maden, “Dangerous and severe personality disorder: antecedents and origins” (2007) 190 *British Journal of Psychiatry* 8, 9-10.

46. Victoria, Law Reform Commission, *Defences to Homicide*, Discussion Paper (2003) [5.96].

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**Issue 6.22**


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Should the defence of mental illness be available to defendants with a personality disorder, in particular those demonstrating an inability to feel empathy for others?

*Irresistible impulse*

3.41 In NSW, a person cannot claim the defence of mental illness on the basis that he or she was unable to control his or her actions, but may be able to establish a partial defence of substantial impairment, which reduces murder to manslaughter.<sup>47</sup> For example, in *Heatley*,<sup>48</sup> the defendant, a remand prisoner, killed an inmate who was placed in his cell.<sup>49</sup> At the time, Heatley was known to be experiencing homicidal urges. Heatley himself protested against another inmate being placed in his cell.<sup>50</sup> Psychiatric evidence supported Heatley's claim that he was experiencing homicidal urges at the time of the killing.<sup>51</sup> The court found that Heatley's mental illness impaired his ability to control his urges but, even so, he knew the nature of his acts and that they were wrong.<sup>52</sup> Consequently, the defence of mental illness was not available. Heatley was convicted of manslaughter (rather than murder) on the basis of substantial impairment.

3.42 There are a couple of grounds on which it could be argued that the defence of mental illness should be available to a defendant who lacks the ability to control his or her actions. First, it is consistent with the principle of community protection that underlies the defence to separate a person from the general public if that person is experiencing violent impulses and provide him or her with treatment, rather than sentencing him or her to a term of imprisonment that is unlikely to allow for the provision of sufficient therapeutic interventions to reduce the risk posed by the person to the community.

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47. As to the defence of substantial impairment, see *Crimes Act 1900* (NSW) s 23A(1)(a) and discussion in ch 4.

48. See *R v Heatley* [2006] NSWSC 1199. See too the cases of *Veen* (1979) 143 CLR 458; (1988) 164 CLR 465 and [2000] NSWSC 656; and *Adams* [2001] NSWSC 773; [2001] NSWSC 1042; [2002] NSWCCA 448; [2003] NSWSC 142.

49. See *R v Heatley* [2006] NSWSC 1199, [27]-[44], [80]-[87].

50. See *R v Heatley* [2006] NSWSC 1199, [40] quoting Heatley's statement to police.

51. See discussion of psychiatric evidence in *R v Heatley* [2006] NSWSC 1199, [46]-[62].

52. See *R v Heatley* [2006] NSWSC 1199, [75].

3.43 Secondly, it is consistent with another fundamental basis of the defence to exonerate from blame those who are not responsible for their actions to the extent that they cannot control them. In *Heatley*, there was no evidence of any actual malice towards the victim, other than the malice that is *presumed* to accompany acts which, when committed by a person who is presumed to be sane, are presumed to be voluntary. In *Heatley*, those presumptions were potentially invalid. To attribute criminal responsibility in those circumstances is arguably unjust.

3.44 On the other hand, the notion of total lack of self control, or “irresistible impulse”, has been criticised as being inherently flawed, because of the impossibility of distinguishing between an impulse that *could not* be resisted and one that simply *was not* resisted.<sup>53</sup> In response, it could be argued that this difficulty is an evidentiary one, rather than a substantive basis for excluding from the scope of the defence an inability to exercise control, and that it should be left to the trier of fact to decide whether a particular defendant did not or could not control himself or herself.

3.45 A number of Australian jurisdictions recognise an inability to control an impulse as a valid basis for claiming the defence of mental illness and include this “third limb” in their formulations of the defence.<sup>54</sup> In these jurisdictions, the view is taken that there are mental illnesses that affect volition or self-control, rather than cognition, and that impaired self-control can negate criminal responsibility as readily as impaired cognition.<sup>55</sup>

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53. See P Shea, “M’Naghten Revisited – Back to the Future? (The mental illness defence – a psychiatric perspective)” (2001) 12 *Current Issues in Criminal Justice* 347, 357.

54. See *Criminal Code 1995* (Cth) s 7.3(1)(c); *Criminal Code 2002* (ACT) s 28(1)(c). It is likely that, in those jurisdictions, a defence of mental impairment would have been available to Adams and Heatley. See also *Criminal Code 1983* (NT) s 43C(1)(c); *Criminal Code 1899* (Qld) s 27(1); *Criminal Law Consolidation Act 1935* (SA) s 269C(c); *Criminal Code 1913* (WA) s 27; *Criminal Code 1924* (Tas) s 16(1)(b).

55. See Western Australia, Law Reform Commission, *The Criminal Process and Persons Suffering from Mental Disorder*, Discussion Paper (1987) [3.9]. But see the opposing view taken by the Victorian Law Reform Commission, which decided against recommending the introduction of a volitional element to the defence of mental impairment in Victoria. The VLRC concluded that the defence was sufficiently flexible to cover some cases where defendants were unable to control their actions, where they could satisfy the other requirements of the

## Issue 6.23

Should the defence of mental illness be available to defendants who lack the capacity to control their actions?

*Delusions*

3.46 The courts have struggled over the years with applying the *M'Naghten* rules to acquit defendants who have acted as a result of a delusion. In some instances, they have held that a delusional defendant's criminal responsibility should be determined on the basis that the facts were as the defendant believed them to be.<sup>56</sup> In other instances, they have found that a delusion has had the effect of making a defendant incapable of understanding the wrongness of his or her conduct,<sup>57</sup> or incapable of reasoning with a moderate degree of calmness about the moral quality of his or her actions.<sup>58</sup>

3.47 The problem with trying to satisfy the *M'Naghten* test for defendants who act under a delusion is that they might know what they were doing and that, objectively speaking, what they were doing was wrong, but their delusional belief may have so deeply impaired their sense of reality and judgment that they simply cannot be held responsible for their actions.

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defence, and that there was no justification for broadening the scope of the defence. It referred to the difficulties that would be involved in distinguishing in any particular case between an impulse that could not be controlled and one that simply was not controlled: see Victoria, Law Reform Commission, *Defences to Homicide: Final Report* (2004) [5.27]-[5.33].

56. See *Daniel M'Naghten's Case* [1843] 10 Cl & Fin 200, 212; 8 ER 718, 723. And see for example *The Trial of James Hadfield, at the Bar of the Court of King's Bench, for High Treason* (1800) 27 State Tr 1281 But this approach has not been followed in subsequent cases: see *R v Gooma* (Unreported, Supreme Court of NSW, Badgery-Parker J, 27 April 1994); *R v Issa* (Unreported, Supreme Court of NSW, Sperling J, 25 October 1995); *R v Biggs* [2007] NSWSC 932; *R v Pham* [2007] NSWSC 1313. But cf *R v Walsh* (1991) 60 A Crim R 419; and cf also *R v Resnik* [2007] ACTSC 96 where Resnik was acquitted outright of murder on the ground of self-defence, despite experiencing, at the time of the killing, delusions in relation to the deceased and the threat that he posed.
57. See *R v Gooma* (Unreported, Supreme Court of NSW, Badgery-Parker J, 27 April 1994).
58. See *R v Issa* (Unreported, Supreme Court of NSW, Sperling J, 25 October 1995); *R v Darmadji* [2008] NSWSC 1308.

3.48 A number of Australian jurisdictions have tried to address the problem of accommodating delusional beliefs by statute. Two such statutory formulations of the defence specify that, where a defendant is affected by delusional beliefs, his or her criminal responsibility is to be determined as if the real state of things had been as he or she believed them to be.<sup>59</sup> This approach does not necessarily overcome the problem of requiring “sane” or “normal” reactions by those whose mental capacity is seriously impaired. According to this formulation, a person who suffers a paranoid delusion will be excused from responsibility for hurting or killing another whom he or she believes is persecuting him or her, only if the delusional belief, if it were real, could give rise to a claim for self-defence. It may be argued that it is unfair to measure a deluded person’s culpability according to the ordinary reactions of someone unaffected by delusions.<sup>60</sup>

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#### Issue 6.24

Should the test for the defence of mental illness expressly refer to delusional belief as a condition that can be brought within the scope of the defence? If yes, should the criminal responsibility of a defendant who acts under a delusional belief be measured as if the facts were really as the defendant believed them to be?

## REFORMING THE TEST FOR THE DEFENCE OF MENTAL ILLNESS

### Is there a need for reform?

3.49 In deciding whether the level of criticism surrounding the *M’Naghten* rules points to a need for reform, consideration should be given to the following issues:

- Does the current test adequately support the underlying rationale or principles of the defence as discussed in paragraphs [3.3]-[3.5]?

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59. See *Criminal Code 1913* (WA) s 27; *Criminal Code 1899* (Qld) s 27(2); *Criminal Code 1924* (Tas) s 16(3).

60. See Canada, Law Reform Commission, *Report on Recodifying Criminal Law* (Report 31, 1987), 426. But see *R v Walsh* (1992) 60 A Crim R 419; and Howard and Westmore [5.40]-[5.41].

- Although dated, has the current test developed a sufficient body of case law to allow it to be understood and applied with relative certainty, consistency, and ease?
- Does the current test work well in practice or does it wrongly include defendants in or exclude them from the scope of the defence?

3.50 We seek your views on these issues in order to determine the value in reforming the current law.

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#### Issue 6.25

Should the current test for determining the application of the defence of mental illness be retained without change?

#### Reform based on the *M’Naghten* rules

3.51 There are two broad approaches that could be taken to reforming the test for the defence of mental illness, if it were decided to do so. The first is to retain a test based on the common law *M’Naghten* rules but expanding their scope and/or making clarification in legislation.<sup>61</sup> The second is to replace the *M’Naghten* rules with a completely new approach.

3.52 Except for NSW, every Australian jurisdiction provides for a statutory formulation of the defence of mental illness, based on the *M’Naghten* rules.<sup>62</sup> Many jurisdictions overseas do the same,<sup>63</sup> and NSW could follow suit. It would need to be decided whether a statutory formulation based on the *M’Naghten* rules would codify the defence of

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61. In 1996, this Commission recommended that the existing formulation of the defence be retained but renamed as the defence of “mental impairment” to make it clearly applicable to people with an intellectual disability. That recommendation was made on the basis that it was beyond the terms of that particular reference to undertake a more comprehensive review of the whole defence and that the Commission should instead work within the existing framework of the defence: see NSWLRC Report 80 recommendation 25, [6.23]-[6.27], Appendix C (draft bill s 93-98).

62. See *Criminal Code 1995* (Cth) s 7.3(1); *Criminal Code 2002* (ACT) s 28; *Criminal Code 1983* (NT) s 43C; *Criminal Code 1899* (Qld) s 27; *Criminal Law Consolidation Act 1935* (SA) s 269C; *Criminal Code 1924* (Tas) s 16; *Criminal Code 1913* (WA) s 27; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 20(1).

63. See, eg, *Crimes Act 1961* (NZ) s 23(2); *Criminal Code*, RSC 1985 (Canada) pt 1 s 16(1); *United States Code* tit 18 pt I ch 1 §17(a)

mental illness, in substitution for the common law, or supplement it.<sup>64</sup> The formulation could retain the three existing elements of the *M’Naghten* test and clarify some of the uncertainties that have arisen about their interpretation. It could also introduce additional alternatives to the three existing elements in order to allow for a wider range of mental health problems to be brought within the meaning of “mental illness”. The discussion below outlines some of the changes that could be made.

#### *Defining “disease of the mind”*

3.53 Legislative formulations of the defence of mental illness vary in the extent to which they define or clarify the common law concept of a “disease of the mind”. Some jurisdictions provide little guidance beyond modernising the language, adopting terms such as a “state of mental disease or natural mental infirmity” without further definition.<sup>65</sup> In contrast, other formulations define the notion of a disease of the mind according to a list of conditions, either exhaustively or inclusively.<sup>66</sup> Most commonly, the list is expressed to include “senility, intellectual disability, mental illness, brain damage and severe personality disorder”.<sup>67</sup> These formulations generally pick up the common law concept of “disease of

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64. The Victorian legislation specifies that the common law defence of insanity is abrogated: see *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 25.

65. See *Criminal Code 1899* (Qld) s 27. See too the Tasmanian formulation, which uses the phrase “mental disease”, defined only as including “natural mental imbecility” (*Criminal Code 1924* (Tas) s 16), and the Victorian formulation, which refers to “mental impairment” (*Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 20). Overseas, the New Zealand formulation refers to “natural imbecility or disease of the mind” (*Crimes Act 1961* (NZ) s 23(2)) and the Canadian formulation uses the term, “mental disorder”, meaning a “disease of the mind” (see *Criminal Code*, RSC 1985 (Canada) pt 1 s 1, 16(1)).

66. The trend is to provide an inclusive list, although South Australia restricts the meaning of the term “mental impairment” (the term used instead of disease of the mind) to those conditions listed in the legislation: see *Criminal Law Consolidation Act 1935* (SA) s 269A(1). The Western Australian formulation does the same: see *Criminal Code 1913* (WA) s 1(1).

67. See *Criminal Code 1995* (Cth) s 7.3(8), 7.3(9); *Criminal Code 2002* (ACT) s 27(1), 27(2); *Criminal Code 1913* (WA) s 1(1), s 27 (the Western Australian formulation does not include severe personality disorder); *Criminal Code 1983* (NT) s 43A (the Northern Territory formulation does not include severe personality disorder, but does include involuntary intoxication); *Criminal Law Consolidation Act 1935* (SA) s 269A, 269C (the South Australian formulation does not include brain damage or severe personality disorder)



the mind” by defining “mental illness”, within their list of conditions, as an underlying pathological infirmity of the mind, whether of long or short duration and whether permanent or temporary, but not including a condition that results from the reaction of a healthy mind to extraordinary external stimuli. In this way, the statutory restatements follow the traditional approach of excusing only those whose capacity is impaired by some internal cause, rather than by external or environmental causes.

3.54 None of these statutory formulations retain the common law requirement that the disease of the mind (however termed) produces a “defect of reason”.

3.55 If NSW were to introduce a statutory formulation based on the *M’Naghten* rules, it would need to be decided to what extent the concept of a “disease of the mind” ought to be defined in the legislation. If the legislation were to provide a definition of the term, to what extent should it adopt the approach of the majority of Australian jurisdictions, which is to provide a list of conditions included within the term? Consideration would also have to be given to the possibility of expressly including or excluding certain mental conditions that, in the past, may have been contentious or unclear in their application to the common law defence, conditions such as intellectual disability, brain damage, and personality disorders. Of course, questions about whether to define the notion of a disease of the mind in legislation, and the way in which it should be defined, are necessarily linked to the larger question raised in Consultation Paper 5 of whether general, umbrella terms should be adopted in the legislation.

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#### Issue 6.26

If the *M’Naghten* rules were reformulated in legislation, should the legislation define the concept of a disease of the mind? If so, how should it be defined? Should the common law requirement for a “defect of reason” be omitted from the statutory formulation?

#### *Knowledge of the nature and quality of the act*

3.56 All Australian statutory formulations of the defence of mental illness retain, in some form, this second limb of the *M’Naghten* test. There is some variation in wording, with the majority of formulations following the common law by requiring that the defendant “did not know the

nature and quality of the conduct”.<sup>68</sup> In a couple of states, the focus is on capacity to know, rather than actual knowledge: their formulations require that the defendant’s mental impairment deprived him or her of the capacity to understand what he or she was doing.<sup>69</sup>

#### Issue 6.27

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If the *M’Naghten* rules were reformulated in legislation, should the legislation recognise, as one way of satisfying the defence, a lack of knowledge of the nature and quality of the act? If so, should the legislation provide for a lack of actual knowledge, or a lack of capacity to know?

#### *Knowledge of wrong*

3.57 In a number of Australian jurisdictions, the statutory formulation qualifies the phrase, “did not know that the conduct was wrong”, as meaning that “the person could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong”.<sup>70</sup>

3.58 A problem with this approach is that it is based on an assumption that, in ordinary circumstances, a person acts (or refrains from acting) only after a reasoned assessment of the rights and wrongs of behaving in a certain way. It is at least open to question whether human behaviour is planned at this conscious, rational level, or whether, in fact, it is largely regulated by the subconscious suppression of inappropriate impulses. An ordinary person may refrain from doing a wrongful act, not by a process of reasoning, but because doing the act would not occur to him or her or, if it did, a feeling of disapproval or revulsion would prevent that person from doing it. In many cases where the defence of mental illness is based on a claim that the person did not know that the act was wrong, it is the extinction or impairment of subconscious regulation, not an inability to

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68. See *Criminal Code 1995* (Cth) s 7.3(1)(a); *Criminal Code 2002* (ACT) s 28; *Criminal Code 1983* (NT) s 43C(1)(a); *Criminal Law Consolidation Act 1935* (SA) s 269C(a); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 20(1)(a).

69. See *Criminal Code 1913* (WA) s 27; *Criminal Code 1899* (Qld) s 27(1); *Criminal Code 1924* (Tas) s 16(1)(a)..

70. See *Criminal Code 1995* (Cth) s 7.3(1)(b); *Criminal Code 2002* (ACT) s 28(2); *Criminal Code 1983* (NT) s 43C(1)(b); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 20(1)(b). This formulation follows the direction of Dixon J in *R v Porter* (1933) 55 CLR 182, 189-190.

reason calmly, which accounts for the act being done (or, more correctly, the person's failure to refrain from doing it).

3.59 In New Zealand, this approach is not adopted. Instead, the defence is available if the defendant's mental state was such that he or she was rendered "incapable of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong".<sup>71</sup>

3.60 In Queensland, Western Australia and Tasmania, the provisions refer to the defendant's lack of "capacity to know that [he or she] ought not to do the act or make the omission".<sup>72</sup>

3.61 It is possible that this formulation is slightly broader than the common law. For example, in *Willgoss*, where the accused was diagnosed with psychopathy, the High Court rejected the proposition that, as a matter of law, there is a distinction between intellectual and "emotional" knowledge of "wrong".<sup>73</sup> Under the Code provisions, however, *Willgoss* might have been able to argue that his condition deprived him of the capacity to know that he *ought not to do* the act.<sup>74</sup>

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#### Issue 6.28

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If the *M'Naghten* rules were reformulated in legislation, should the legislation recognise, as one way of satisfying the defence, a lack of knowledge that the criminal conduct was wrong? If so, should the legislation provide any guidance about the meaning of this alternative? For example, should it require that the defendant could not have reasoned with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong? Should the legislation require a lack of capacity to know, rather than a lack of actual knowledge?

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71. See *Crimes Act 1961* (NZ) s 23(2)(b). See S Yeo, "Commonwealth and international perspectives on the insanity defence" (2008) 32 *Criminal Law Journal* 7, who argues that this is more meaningful than the *Porter* formulation which gives rise to the undefinable notions of "a moderate degree of sense" and "a moderate degree of composure": 12-13.

72. See *Criminal Code 1899* (Qld) s 27(1); *Criminal Code 1913* (WA) s 27; cf *Criminal Code 1924* (Tas) s 16(1).

73. See *Willgoss v The Queen* (1960) 105 CLR 295.

74. But compare S Yeo, "Commonwealth and international perspectives on the insanity defence" (2008) 32 *Criminal Law Journal* 7, who argues that a test of lack of "capacity" is stricter than a test based on lack of knowledge: 11.

### *Inability to control the conduct*

3.62 The statutory formulations of most Australian jurisdictions allow a defendant to claim the defence of mental illness based on an inability to control his or her actions.<sup>75</sup> This additional alternative refers back to the notion of an “irresistible impulse” which we discussed in paragraphs [3.41]-[3.45], where we noted that the law in NSW does not currently recognise an inability to control oneself as a valid basis for the defence of mental illness. Issue 6.23 raised the question whether NSW should recognise an inability to control conduct as a basis for the defence of mental illness. Depending on the conclusion that is drawn in response to that question, NSW could introduce a statutory formulation based on the *M’Naghten* rules that added this third alternative.

### *Delusional beliefs*

3.63 In paragraphs [3.46]-[3.48], we referred to the problem of accommodating delusional beliefs within the existing framework for the defence of mental illness. We noted that defendants may have difficulty in satisfying the criteria for the defence if they knew the nature and quality of their acts and knew that their acts were wrong, but their judgment and sense of reality were nevertheless seriously impaired by their delusional beliefs. We mentioned that a number of Australian jurisdictions have included within their statutory formulations of the defence an express reference to the effect of delusional beliefs on criminal responsibility and we raised the question in Issue 6.24 whether NSW should follow this approach. A move to introduce a statutory formulation of the defence in this state would need to take account of the views expressed in response to Issue 6.24.

## Finding a new approach

3.64 An alternative approach to reforming the defence of mental illness is to abandon the *M’Naghten* rules altogether in preference for a different approach to determining those defendants to whom the defence applies. A number of alternative approaches are suggested below.

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75. See *Criminal Code 1995* (Cth) s 7.3(1)(c); *Criminal Code 2002* (ACT) s 28(1)(c); *Criminal Code 1913* (WA) s 27; *Criminal Code 1983* (NT) s 43C(1)(c); *Criminal Code 1899* (Qld) s 27(1); *Criminal Law Consolidation Act 1935* s 269C(c). The Tasmanian formulation is more specifically worded, requiring that, in order to satisfy this alternative, the act or omission was done under “an impulse which, by reason of mental disease, he was in substance deprived of any power to resist”: see *Criminal Code 1924* (Tas) s 16(1)(b).

*The “product rule”*

3.65 In *Durham v United States*,<sup>76</sup> the District of Columbia Circuit of the United States Court of Appeal referred to criticisms of the *M’Naghten* rules.<sup>77</sup> The Court noted that, by requiring expert witnesses to testify about concepts inconsistent with modern clinical practice (“irresistible impulse” and “knowledge of right and wrong”), the *M’Naghten* formulation “often and typically [led expert witnesses to feel] that they were obliged to reach outside of their professional expertise”.<sup>78</sup> The Court rejected the *M’Naghten* formulation and instead applied the following test:

[A]n accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect.

We use disease in the sense of a condition which is considered capable of either improving or deteriorating. We use “defect” in the sense of a condition which is not considered capable of either improving or deteriorating and which may be either congenital, or the result of injury, or the residual effect of a physical or mental disease.<sup>79</sup>

3.66 A jury, in considering whether the accused person’s conduct was the product of a “mental disease” or “defect”, would not be prohibited from considering the “nature and quality of the act” and “knowledge of right from wrong” formulations, but it would not be limited to considering only those criteria.<sup>80</sup>

3.67 In *Carter v United States*,<sup>81</sup> Judge Prettyman explained what is required to establish that the accused person’s act was the “product” of the relevant “mental disease or defect”.

...[W]e mean that the facts on the record are such that the trier of the facts is enabled to draw a reasonable inference that *the accused would not have committed the act he did commit if he had not been diseased as he was*. There must be a [critical] relationship between the disease [or defect] and the act ... By “critical” we mean decisive, determinative, causal; we mean to convey the idea inherent in the phrases “because

76. See *Durham v United States*, 214 F.2d 862 (DC Cir, 1954).

77. See *Durham v United States*, 214 F.2d 862, 871.

78. See *United States v Brawner*, 471 F.2d 969, 976, see also 1014-1016.

79. See *Durham v United States*, 214 F.2d 862, 874-875 (DC Cir, 1954) (emphasis added).

80. See *Durham v United States*, 214 F.2d 862, 876 (DC Cir, 1954).

81. See *Carter v United States*, 252 F.2d 608 (DC Cir, 1957).

of”, “except for”, “without which”, “but for”, “effect of”, “result of”, “causative factor”; the disease made the effective or decisive difference between doing and not doing the act.<sup>82</sup>

3.68 By replacing the “knowledge of right and wrong” and “nature and quality of the act” tests with a simpler “but for” requirement, the Court sought to identify an appropriate basis to distinguish between cases where the defendant ought, and ought not, to be held criminally responsible for his or her conduct.<sup>83</sup>

3.69 However, the *Durham-Carter* “product rule” formulation was perceived as creating new problems. First, the “but for” approach “invited experts and juries to speculate about the defendant’s character, and convict him on the ground that he would have been ‘bad’ if he had not been sick.”<sup>84</sup>

3.70 Secondly, by failing to provide more than a bare definition of “mental disease or defect”, the courts left the question to be determined by expert witnesses, essentially in medical terms.<sup>85</sup> In *McDonald v United States*,<sup>86</sup> the Court distinguished between medical and legal concepts of “mental disease or defect”, and held that “the jury should be told that a mental disease or defect includes *any abnormal condition of the mind which substantially affects mental or emotional processes and substantially impairs*

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82. See *Carter v United States*, 252 F.2d 608, 617 (DC Cir, 1957) (emphasis added).

83. See *United States v Brawner*, 471 F.2d 969, 1022 (DC Cir, 1972).

84. See *United States v Brawner*, 471 F.2d 969, 1019 (DC Cir, 1972). There was also a risk that it would create a double standard: “We cannot allow either the experts or the jury to speculate about where on [the spectrum of ‘normality’] the defendant would belong if he were not mentally ill. That sort of speculation is especially pernicious because it is likely to discriminate systematically against inner-city slum residents... since violent unlawful behaviour is more common in the slums than in middle class neighbourhoods. To regard behaviour as the product of illness in the suburbs but ‘normal’ in the slums is to establish an odious double standard of morality and responsibility”: 1020.

85. See *United States v Brawner*, 471 F.2d 969, 977-979, 1011 (DC Cir, 1972). A striking example of this “trial by label” (the majority at 978) occurred in *In re Rosenfield*, where the applicant had been described as a “sociopath”. On Friday afternoon, a psychiatrist from the forensic mental health facility testified that a sociopathic personality was not regarded as a mental disease. The following Monday, the facility’s policy was revised, with the result that sociopathic personality was classified as a mental disease: *United States v Brawner*, 471 F.2d 969, 978 (DC Cir, 1972).

86. See *McDonald v United States* 312 F.2d 847 (DC Cir, 1962).

*behaviour controls*. Thus the jury would consider testimony concerning the development, adaptation and functioning of these processes and controls.”<sup>87</sup>

3.71 An additional perceived problem was that *Durham* led expert witnesses to testify as to the “ultimate issue”, namely, whether the person’s “mental disease or defect” at the time of the offence was such that criminal responsibility should not attach to his or her conduct.<sup>88</sup> (Note that the “ultimate issue rule” has been abrogated by statute in NSW.<sup>89</sup>) The Court repeatedly attempted to limit expert testimony to “[d]escription and explanation of the origin, development and manifestations of the alleged disease”,<sup>90</sup> leaving the ultimate question of whether the act in question was, at the time of the act, a “product” of the “mental disease or defect” described by the expert.<sup>91</sup> Those judicial pronouncements proved futile.<sup>92</sup>

3.72 As a result of these perceived difficulties, the “product rule” was abandoned in *United States v Brawner*,<sup>93</sup> in favour of the following test.

[A] jury shall bring in a verdict of not guilty by reason of insanity if, at the time of the criminal conduct, the defendant, as a result of mental disease or defect, either *lacked substantial capacity to conform his conduct to the requirements of the law, or lacked substantial capacity to appreciate the wrongfulness of his conduct*.<sup>94</sup>

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87. See *McDonald v United States* 312 F.2d 847, 851, 861 (DC Cir, 1962). See also *Carter v United States*, 252 F.2d 608, 617-618 (DC Cir, 1957).

88. See *Carter v United States*, 252 F.2d 608, 617-618 (DC Cir, 1957); *United States v Brawner*, 471 F.2d 969, 978-979, 1011, 1014, 1017-1019 (DC Cir, 1972). The same problem arose under the *M’Naghten* formulation: *United States v Brawner*, 471 F.2d 969, 1010-1011 (DC Cir, 1972).

89. See *Evidence Act 1995* (NSW) s 79-80.

90. See *Carter v United States*, 252 F.2d 608, 617 (DC Cir, 1957).

91. See *Carter v United States*, 252 F.2d 608, 617-618 (DC Cir, 1957); *Washington v United States*, 390 F.2d 444 (DC Cir, 1967) referred to in *United States v Brawner*, 471 F.2d 969, 979, 1011 (DC Cir, 1972).

92. See for example *United States v Brawner*, 471 F.2d 969, 1013-1014, 1017-1019.

93. See *United States v Brawner*, 471 F.2d 969 (DC Cir, 1972).

94. See *United States v Brawner*, 471 F.2d 969, 1008 (Appendix B: Suggestion for [jury] instruction on insanity, appended to majority judgment). The *McDonald v United States* definition of “mental disease or defect” was retained.

3.73 The rule in *Brawner* was abrogated by statute in 1984, and replaced with a defence in terms that are essentially a modern restatement of the *M’Naghten* rules.<sup>95</sup>

*Shea’s proposal – based on symptoms and presumed causation*

3.74 Psychiatrist Peter Shea argues that the common law requirement for a “disease of the mind” has led courts and psychiatrists to apply the defence on the basis of whether the defendant had a particular psychiatric syndrome. He argues that *symptoms*, not syndromes, are a preferable basis for defining a defence of mental illness, because “[m]ost psychiatrists, presented with the same clinical evidence, would agree upon whether particular symptoms were present”<sup>96</sup> whereas they might be less likely to agree on whether the symptoms constituted a particular *syndrome*. Moreover, a specific diagnostic label, “by itself ... tells us nothing about the connection between the illness and the crime.”<sup>97</sup>

3.75 Shea proposes that “delusions, hallucinations, severe mood disturbance (depression or elevation) and severe impairment of intellect” are the symptoms to which the defence should be directed. Other psychiatric evidence should, in his view, be reserved for mitigation in sentencing.<sup>98</sup>

3.76 To define the requisite connection between the symptoms and the offending conduct, Shea argues that the trier of fact should examine the evidence to determine whether or not “other factors that might have contributed to the offender’s behaviour apart from the identified symptoms, such as evidence of conscious and rational decision-making, environmental factors, need, greed, anger, revenge, self-defence, provocation, etc” were present. If not, it is reasonable to assume a

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95. See *Insanity Defense Reform Act of 1984*, tit II, §402(a) 98 Stat 20 57 §20, recodified at *United States Code* tit 18 pt I ch 1 §17(a) provides: “It is an affirmative defense to a prosecution under any Federal statute that, at the time of the commission of the acts constituting the offense, the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his acts. Mental disease or defect does not otherwise constitute a defense.” The provision “is, at its core, a modern version of the *M’Naghten* Rule”: *United States v McBroom* 124 F.3d 533, 545 (3rd Cir, 1997).

96. See P Shea, “M’Naghten Revisited – Back to the Future? (The mental illness defence – a psychiatric perspective)” (2001) 12(3) *Current Issues in Criminal Justice* 347, 357-358.

97. See Shea at 347, 357-358.

98. See Shea at 347, 358.



causative link between the symptoms and the offending conduct, and a defence of mental illness should be available. If other factors were present, the defence should not be allowed and the symptoms would be relevant only to sentencing.<sup>99</sup>

3.77 Shea considers that the responsibility for making that assumption should be the jury's, since it is not a matter of psychiatric expertise. The expert's role would be limited to informing the court whether (i) the defendant was suffering from one or more of the relevant symptoms at the time of the offence and (ii) the degree of severity of the symptoms.<sup>100</sup>

3.78 Shea proposes the following formulation:

A person has a mental illness defence if he or she was suffering from any one or more of four symptoms – delusions, hallucinations, severe disturbance of mood or severe intellectual impairment – at the time of the offence and the symptom or symptoms were directly causally related to the criminal act and were the only [or, the only significant] causal factors related to the act.<sup>101</sup>

3.79 The Victorian Law Reform Commission (“VLRC”) recently considered,<sup>102</sup> but rejected,<sup>103</sup> Shea's proposal. The VLRC noted that Shea proposes only a limited set of symptoms, many of which are already sufficient to support a defence under the *M'Naghten* rules, and does not include conditions such as personality disorder. However, the VLRC acknowledged that “by requiring a causal link rather than cognitive incapacity, the definition moves away from the much criticised *M'Naghten* requirement that an offender be unable to understand his or her actions.”<sup>104</sup>

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99. See Shea at 347, 359-360.

100. See Shea at 347, 360.

101. See Shea at 347, 360.

102. See Victoria, Law Reform Commission, *Defences to Homicide*, Options Paper (2003) [5.75]-[5.78].

103. Victoria, Law Reform Commission, *Defences to Homicide*, Report (2004) recommendation 37. The VLRC recommended that the common law defence be retained.

104. Victoria, Law Reform Commission, *Defences to Homicide*, Options Paper (2003) [5.77]-[5.78].

3.80 Since Shea’s formulation does not involve consideration of *how* the symptoms arose, it might produce different results from the existing law in cases involving the use of drugs and other substances.<sup>105</sup>

*Yannoulidis’ approach – cognitive competency*

3.81 Yannoulidis<sup>106</sup> argues that, while the common law’s focus on the defendant’s cognitive faculties (ability to know what he or she is doing, and to assess whether it is wrong) is sufficient for some cases, it is inadequate to deal with instances of impaired volitional control. “[N]on-cognitive disorders, such as the compulsive’s inability to control his or her behaviour where this does not accord with his or her desire, pose conceptual difficulties ... A person may be able to distinguish between right and wrong and yet not be able to choose between them.”<sup>107</sup>

3.82 Yannoulidis argues that the defence of mental illness should include (but not necessarily be limited to) the following formulation.

A person is responsible for his or her actions where he or she had adequate cognitive competency to think of the reasons which people are expected to regard as sufficient grounds for refraining from commission of the offence.

Such reasons are: the prohibited nature of the conduct; the risk of punishment and the absence of offsetting advantage; and the ability to exercise choice.<sup>108</sup>

3.83 Yannoulidis argues that this formulation has two main advantages. First, the common law requirement for “knowledge of wrongness” rule is replaced with a test of whether the person was capable of understanding the imperative of compliance.<sup>109</sup> Second, because the formulation emphasises capacity, and not mental impairment, policy-based decisions to exclude, for example, drug-induced hallucinations from the defence would have to be made explicitly.<sup>110</sup>

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105. See discussion of the relationship between the defences of intoxication and mental illness at [3.89]-[3.98].

106. See S Yannoulidis, “Mental illness, rationality and criminal responsibility (Tropes of insanity and related defences)” (2003) 25 *Sydney Law Review* 189.

107. See Yannoulidis at 218-219. See, eg, *R v Heatley* [2006] NSWSC 1199.

108. See Yannoulidis at 219.

109. See Yannoulidis at 219.

110. See Yannoulidis at 219.

*Defence of “impaired mental state”*

3.84 Another possibility is to provide a defence of “impaired mental state”. This would accurately reflect what the law is in fact concerned with, namely, the defendant’s mental state at the time of the offence, rather than the presence or absence of a “disease of the mind”. The defence could be defined as follows.

A person is not criminally responsible for conduct if, at the time of the conduct, the person was experiencing an impaired mental state such that:

- (a) the person could not appreciate that the conduct was wrong, having regard to the commonly accepted standards of right and wrong; or
- (b) the person could not appreciate the physical nature, or the likely consequences, of his or her conduct; or
- (c) the person could not control his or her conduct; or
- (d) the person believed in the existence of, and the conduct was in response to, a state of affairs that did not in fact exist.

3.85 The reference in limb (b) to the “likely consequences” of the conduct is intended to cover situations where the person has, for example, an intellectual disability which prevents him or her from foreseeing the likely effect of his or her actions. For example, the person might throw pebbles from a bridge, not realising that the pebbles could cause harm to people walking below.

3.86 Limb (d) is intended to cover cases involving delusions where the defendant might retain the capacity to appreciate that it is wrong, for example, to kill, but sees no other way to escape from his or her perceived situation.

3.87 The following definition of “impaired mental state” is proposed.

*Impaired mental state* means one that arises:

- (a) from a cognitive or mental health impairment such as mental illness, intellectual disability, acquired brain injury, senility or personality disorder; or
- (b) from some other medical condition that affects the functioning of the brain; or
- (c) from the acute or chronic ingestion of a psychoactive substance;

but does not include a mental state that arises solely due to a transient external cause.

3.88 “Mental illness” is used in the medical sense of the word. Part (b) of the definition would cover conditions such as brain tumour and epilepsy. If it is thought inappropriate to include substance-induced mental states (part (c) of the definition), the definition should expressly exclude them.

#### Issue 6.29

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Should the approach for determining the application of the defence of mental illness under the *M’Naghten* rules be replaced with a different formulation? If so, how should the law determine the circumstances in which a defendant should not be held criminally responsible for his or her actions due to mental illness or other impairment of mental function?

## INTOXICATION AND THE DEFENCE OF MENTAL ILLNESS

3.89 Whether or not the test for determining mental illness under the defence of mental illness is reformed, separate consideration should be given to the relevance of intoxication.

### Intoxication in the law generally

3.90 Intoxication is not, strictly speaking, a defence to a criminal charge, but evidence that a defendant was intoxicated may raise a reasonable doubt about whether he or she had the capacity to form, and did form, the intention that is required to prove the offence in question.<sup>111</sup>

3.91 The law in NSW divides offences into “offences of specific intent”, where an intention to cause a specific result is required,<sup>112</sup> and other offences (known at common law as offences of “basic intent”). The law also makes a distinction between intoxication that is self-induced and intoxication that is not self-induced (referred to here as “involuntary intoxication”).<sup>113</sup>

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111. See *R v O’Connor* (1980) 146 CLR 64, 71, 94-98, 106, 114, 117-118, 122-123, 131-132.

112. See *Crimes Act 1900* (NSW) (“Crimes Act”) s 428A, 428B.

113. The Crimes Act s 428A defines “self-induced intoxication” as “any intoxication except intoxication that: (a) is involuntary, or (b) results from fraud, sudden or

3.92 The law stipulates that evidence of involuntary intoxication is relevant to the mental element of all types of offences.<sup>114</sup> It can also be used to negate the voluntariness of conduct.<sup>115</sup> Self-induced intoxication can be taken into account only in relation to the mental element of offences of “specific intent”.<sup>116</sup> It cannot be used to deny the voluntariness of acts.<sup>117</sup> For example, if a defendant kills while under the influence of self-induced intoxication and could not form the requisite intention for murder, he or she might be acquitted of murder (an offence of specific intent<sup>118</sup>) but might be convicted of manslaughter.<sup>119</sup> In contrast, if the defendant’s intoxication is not self-induced, he or she might be acquitted of both murder and manslaughter.<sup>120</sup>

### Intoxication that produces a state of mind consistent with the *M’Naghten* rules

3.93 Earlier common law cases regarded “temporary insanity” due to intoxication as sufficient for the defence of mental illness to be raised, at least in cases involving offences of specific intent.<sup>121</sup> However, later cases have required that the “insanity” be due to an underlying “disease of the mind” in order to be brought within the scope of the defence.<sup>122</sup> The reaction of a healthy mind to “extraordinary external stimuli” – including psychoactive substances – could not, of itself, constitute a “disease of the mind”.<sup>123</sup> If there is an “underlying pathological infirmity of the mind”<sup>124</sup>

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extraordinary emergency, accident, reasonable mistake, duress or force, or (c) results from the administration of a drug for which prescription is required in accordance with the prescription of a medical practitioner [including a nurse, midwife, or dentist], or of a [non-prescription] drug ... administered for the purpose, and in accordance with the dosage level recommended, in the manufacturer’s instructions.”

114. See Crimes Act s 428C, 428D(b).

115. See Crimes Act s 428G(2).

116. See Crimes Act s 428C, 428D(a), 428E(a), 428F(1).

117. See Crimes Act s 428G(1).

118. See Crimes Act s 428C(1).

119. See Crimes Act s 428E(a).

120. See Crimes Act s 428C(1), 428D(b), 428E(b).

121. See *Director of Public Prosecutions v Beard* [1920] AC 479.

122. See, eg, *R v Meddings* [1966] VR 306, 310.

123. See, eg, *R v Martin* (2005) 159 A Crim R 314; *Re LIH* [2002] QMHC 14.

that is triggered by intoxication, producing a mental state consistent with the *M’Naghten* rules, the defence is available.<sup>125</sup>

3.94 Consequently, if the defence of mental illness is raised in a case where the accused was intoxicated at the time of the offence, the court must determine whether the defendant’s mental state was due to the intoxicant alone, or due to the combination of the intoxication and an underlying mental condition.<sup>126</sup> The distinction is not always an easy one to draw, and usually turns on expert evidence.<sup>127</sup>

3.95 In *Bromage*, the prolonged effects of involuntary intoxication (organophosphate poisoning) were held to be an underlying mental condition that, in combination with voluntary alcohol consumption, produced a state of mind sufficient to support a defence of “insanity”.<sup>128</sup> In *Eadie*, chronic psychosis associated with long-term (voluntary) use of amphetamines was held to constitute an underlying mental condition.<sup>129</sup> However, in *Sebalj*, a psychosis caused by physiological withdrawal from

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124. See *R v Falconer* (1990) 171 CLR 30, 53-54, 60, 78, 85; *R v Radford* (1985) 42 SASR 266, 274-275.

125. See *Stapleton v The Queen* (1952) 86 CLR 358, 360-365; *Sodeman v The King* (1936) 55 CLR 192, 193-194; *R v Derbin* [2000] NSWCCA 361; *R v McMahon* (2006) 3 DCLR(NSW) 398; [2006] NSWDC 81; *Director of Public Prosecutions v Taleski* [2007] VSC 183; *Director of Public Prosecutions v Whelan* [2006] VSC 319; *R v Kucma* (2005) 11 VR 472; *Re Bromage* [1991] 1 Qd R 1. But compare *Attorney General (Northern Ireland) v Gallagher* [1961] 3 All ER 299, where Gallagher, diagnosed with psychopathy, formed an intention to kill, then consumed alcohol producing a mental state consistent with the *M’Naghten* rules. The House of Lords held that he could not, in those circumstances, rely on the effect of the alcohol on his mental state to support a defence of “insanity”: at 310, 313-315.

126. See, eg, *R v Martin (No 1)* (2005) 159 A Crim R 314; *R v McMahon* (2006) 3 DCLR(NSW) 398; [2006] NSWDC 81; *Director of Public Prosecutions v Taleski* [2007] VSC 183; *Director of Public Prosecutions v Whelan* [2006] VSC 319.

127. See Tasmanian Law Reform Institute, *Intoxication and Criminal Responsibility*, Final Report No 7 (2006), [4.2.22]-[4.2.24]. See, eg, *R v McMahon* (2006) 3 DCLR(NSW) 398, [39]-[42], [46]-[71]; *R v Martin (No 1)* (2005) 159 A Crim R 314, 316-317; *Director of Public Prosecutions v Whelan* [2006] VSC 319, [25]-[31].

128. See *Re Bromage* [1991] 1 Qd R 1.

129. See *Re Eadie* (Unreported, Queensland Mental Health Tribunal, De Jersey J, 1 June 1995) in R Scott and W Kingswell, “Amphetamines, psychosis and the insanity defence: disturbing trends in Queensland” (2003) 23 *The Queensland Lawyer* 151, 155-156.

amphetamines, following cessation of long-term use of the drug, was held not to be a “disease of the mind”.<sup>130</sup>

3.96 It is arguably illogical to deny a mental illness defence to a person who is acutely psychotic, having voluntarily consumed a psychoactive substance for a *short* period of time, but to allow a person who experiences a similar, but chronic, psychotic state due to *chronic* voluntary substance use to rely on the defence.<sup>131</sup> Additionally, it is inconsistent to regard chronic psychosis arising from chronic drug *use* as a “disease of the mind”, but not a psychosis induced by *withdrawal* from a chronically used drug.<sup>132</sup>

3.97 The fundamental question also remains as to whether, as a matter of policy, it is appropriate to continue to exclude from the scope of the defence those people whose mental states are impaired by voluntary substance or alcohol use. On the one hand, it could be argued that such people should not escape criminal liability for the consequences of their own choices. On the other hand, the defence of mental illness could

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130. See *R v Sebalj* [2003] VSC 181 and [2004] VSC 212.

131. For example, in *Re Eadie* (Unreported, Queensland Mental Health Tribunal, De Jersey J, 1 June 1995), De Jersey J observed: “If the patient at the beginning of [the] six-month period had committed these offences having ingested amphetamines, and then being mentally disordered, he would not have had a defence of unsoundness of mind because the situation would truly be described as ‘transient’... The oddity is that through persisting with drugs over that six-month period, and no doubt appreciating the likely consequences of his doing that, the patient gets himself a defence of unsoundness of mind, even though he wilfully persists in that unlawful activity in circumstances where he should be alive to the consequences”: quoted in R Scott and W Kingswell, “Amphetamines, psychosis and the insanity defence: disturbing trends in Queensland” (2003) 23 *The Queensland Lawyer* 151, 155-156.

132. For example, Sebalj, above, was convicted of murder: *R v Sebalj* [2004] VSC 212. In contrast, had the same offence been committed by a person who was psychotic having wilfully persisted in the use of amphetamine over a long period, that defendant would be entitled to a defence of mental illness: see *Re Eadie* (Unreported, Queensland Mental Health Tribunal, De Jersey J, 1 June 1995). Even a defendant who experiences a temporary drug-induced psychosis, not amounting to a disease of the mind, is in a better position than Sebalj, because consumption of drugs near the time of the offence gives rise to a defence of intoxication, resulting in a conviction for manslaughter instead of murder: see for example *R v Martin* [2005] VSC 497; *Re LIH* [2002] QMHC 14. Sebalj is arguably the least blameworthy (see [2004] VSC 212, [29]) yet receives the harshest outcome.

provide a means of providing them with appropriate treatment for alcohol or drug problems (which often coincide with the existence of mental impairment or mental illness)<sup>133</sup> and in this way potentially break the cycle of substance use and involvement in crime. As for the issue of involuntary intoxication and the defence of mental illness, it seems clear enough that there should be a defence to criminal conduct carried out as a result of an intoxicant that the defendant did not voluntarily consume. However, at this stage we take the view that considerations relating to mental illness and involuntary intoxication are part of a wider issue and go beyond the scope of this paper.

3.98 Other Australian jurisdictions differ in their treatment of the relationship between intoxication and the defence of mental illness. In South Australia, all forms of “intoxication” are excluded from the definition of “mental impairment”.<sup>134</sup> Intoxication is defined as “a temporary disorder, abnormality or impairment of the mind that results from the consumption or administration of intoxicants and will pass on metabolism or elimination of intoxicants from the body.”<sup>135</sup> In the Northern Territory,<sup>136</sup> Queensland<sup>137</sup> and Western Australia, intentional intoxication is excluded, but unintentional intoxication is included, in the respective defences of mental illness.<sup>138</sup> In Tasmania, the defence of “insanity” “shall apply to a person suffering from disease of the mind caused by intoxication.”<sup>139</sup>

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133. See J Simpson, M Martin and J Green, *The Framework Report: Appropriate Community Services in NSW for Offenders with Intellectual Disabilities and Those at Risk of Offending* (2001), 46-47; Senate Select Committee on Mental Health, *A National Approach To Mental Health – From Crisis To Community*, First Report (March 2006), [13.134]-[13.138] and ch 14.

134. See *Criminal Law Consolidation Act 1935* (SA) s 269A(1).

135. See *Criminal Law Consolidation Act 1935* (SA) s 269A(1).

136. See *Criminal Code Act 1983* (NT) s 43A, 43C.

137. See *Mental Health Act 2000* (Qld) s 10, sch 2; *Criminal Code 1899* (Qld) s 27-28.

138. See *Criminal Code 1913* (WA) s 28.

139. See *Criminal Code 1924* (Tas) s 17(1).



## Issue 6.30

Should a defendant's self-induced intoxication or withdrawal from an intoxicant be able to form a basis for claiming that the defendant is not guilty of a charge by reason of mental illness and, if so, in what circumstances?

## DISTINGUISHING THE DEFENCE OF MENTAL ILLNESS FROM THE DEFENCE OF AUTOMATISM

3.99 Reference should be made to the problems that can arise in distinguishing between the defence of mental illness and the defence of automatism.

3.100 The defence of automatism operates to exonerate a defendant where his or her actions constituting the crime in question were carried out involuntarily. For example, a defendant may act involuntarily as a result of a spasm or reflex action,<sup>140</sup> or an epileptic fit,<sup>141</sup> or after suffering from concussion,<sup>142</sup> or while in a dissociated state brought on by severe psychological trauma.<sup>143</sup> A successful claim of automatism results in an outright acquittal without the prospect of indefinite detention, unlike the situation following a finding of not guilty by reason of mental illness.<sup>144</sup> Since the prosecution in criminal proceedings bears the burden of proving all the elements of the criminal offence in question, it is for the prosecution to prove beyond a reasonable doubt that a defendant acted voluntarily once the defendant has adduced some evidence of involuntariness.<sup>145</sup> By contrast, the burden of proving that a defendant is not guilty by reason of mental illness rests on the defendant, to be established on the balance of probabilities.<sup>146</sup>

140. See *Ryan v The Queen* [1969] 121 CLR 205, 215.

141. See *R v Sullivan* [1984] 1 AC 156; *R v Yousseff* (1990) 50 A Crim R 1.

142. See *Re Wakefield* (1958) 75 WN (NSW) 66; *R v Wogandt* (1988) 33 A Crim R 31.

143. See *R v Falconer* [1990] 171 CLR 30.

144. See *Bratty v Attorney General for Northern Ireland* [1963] AC 386; *R v Falconer* [1990] 171 CLR 30, 45.

145. See *R v Yousseff* (1990) 50 A Crim R 1. The Crown bears the legal burden of proving that the act was done voluntarily once the defendant has discharged the evidentiary burden of producing evidence from which it could be inferred that there is at least a reasonable possibility that the act was involuntary.

146. See *R v M'Naghten* (1843) 4 St Tr (NSW) 847; *Woolmington v DPP* (1935) AC 462.

3.101 The courts have been concerned to make a clear distinction between the application of the defence of automatism and the defence of mental illness. In brief, it seems that if there is evidence that an act was committed involuntarily, it must be decided whether that involuntary act was caused by a disease of the mind, or whether it was caused by some other, external factor. If it was caused by a disease of the mind, then it is considered to be an act of “insane automatism”, and falls within the scope of the defence of mental illness, resulting in a special verdict and the likelihood of the defendant’s indefinite detention. If it is found not to have been caused by a disease of the mind, then it is considered an act of “sane automatism”, and falls within the scope of the defence of automatism, resulting in an outright acquittal.<sup>147</sup>

3.102 The courts have struggled to find appropriate ways of deciding whether an involuntary act is caused by a disease of the mind or by some other, external factor. The problem has been most acute in cases where a defendant has claimed to have acted involuntarily as a result of a mental malfunction caused by severe psychological trauma. Judges have adopted different approaches to deciding whether a mental malfunction of this kind is caused by a disease of the mind (giving rise to a claim of not guilty by reason of mental illness) or caused by an external force acting on a sane mind (giving rise to a claim of automatism). It has been suggested that if the malfunction of the mind can be said to be transient, caused by trauma (whether physical or psychological) of a kind which the mind of an ordinary person would not be likely to have withstood, and is not prone to recur, then the involuntary act falls within the category of sane automatism.<sup>148</sup> While the “ordinary person test” has not been universally adopted, the courts have been generally unwilling to extend the defence of sane automatism to people who suffer from a low stress threshold or who surrender to anxiety, suggesting that some form of objective standard is to be applied to deciding whether a person’s volition has been overcome because of a disease of the mind or an external force.<sup>149</sup>

3.103 The law relating to the defence of automatism is extremely complex and it is outside the terms of this reference to conduct an

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147. See *R v Falconer* [1990] 171 CLR 30, 45; *Bratty v Attorney General for Northern Ireland* [1963] AC 386, 410.

148. See *R v Falconer* [1990] 171 CLR 30, 56-58 (Mason CJ, Brennan and McHugh JJ).

149. See *R v Falconer* [1990] 171 CLR 30, 73-74 (Toohey J), 85 (Gaudron J).

exhaustive review of this area. Its relevance to our discussion is limited to its interaction with the defence of mental illness, and the difficulties that are involved sometimes in distinguishing between the two. On the one hand, it might be asked why it is necessary at all to continue to distinguish between involuntary acts that are a result of a disease of the mind or a result of an external cause. It might be argued that any involuntary act, no matter how it is caused, should not attract liability, but should result in an outright acquittal. On the other hand, it could be argued that, for policy reasons, an involuntary act that is the result of a mental disease or impairment and is likely to recur raises concerns about public safety and should give rise to the possibility of separating the defendant from the community. Whether these policy considerations are sufficient justification for continuing to classify some involuntary acts as acts attracting the defence of mental illness, and whether legislation should provide some means for assessing whether an involuntary act falls within the scope of the defence of mental illness rather than the defence of automatism, are questions on which we seek your views.

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#### Issue 6.31

Should the defence of mental illness apply to a defendant's involuntary act if that involuntary act was caused by a disease of the mind? If yes, should legislation provide a test for determining involuntary acts that result from a disease of the mind as opposed to involuntary acts that come within the scope of the defence of automatism, and if so, how should that test be formulated?

## PROCEDURAL ASPECTS OF THE DEFENCE OF MENTAL ILLNESS

### Who may raise the defence?

3.104 The MHFPA does not specify who – defence, prosecution or the court – may raise the issue of mental illness.<sup>150</sup> Consequently, the common law applies in NSW.

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150. The MHFPA s 38(1) provides that a verdict of not guilty by reason of mental illness can be returned if “it is *given in evidence* on the trial of the person for the offence” and “if it *appears to the jury*” “that the person was mentally ill, so as not to be responsible, according to law, for his or her action at the time when the act was done or omission made” (emphasis added).

3.105 At common law, since mental illness has historically been regarded as a *defence*, the prosecution cannot commence by raising it. However, the prosecution may raise the issue of mental illness to counter a defence of substantial impairment<sup>151</sup> or automatism raised by the defendant.<sup>152</sup>

3.106 A trial judge is, in general, obliged to put to the jury any defences raised on the evidence, including the defence of mental illness, even if the accused objects to the defence being raised.<sup>153</sup> In exceptional cases, where evidence as to mental illness is not led by the defence or prosecution, a trial judge is able to call evidence of mental illness of his or her own initiative in order to prevent a miscarriage of justice.<sup>154</sup>

3.107 If mental illness is not raised by the defendant but he or she is found not guilty by reason of mental illness, the acquittal and “any order to keep the person in custody” is subject to appeal in the same way as if the acquittal were a conviction and the order were a sentence.<sup>155</sup>

3.108 In contrast to NSW, legislation in most Australian and several overseas jurisdictions provides that the “defence” of mental illness may be raised by the defence, prosecution and/or the court.<sup>156</sup> Several

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151. See Crimes Act s 23A(7); see ch 4.

152. See *R v Meddings* [1966] VR 306, 306-307; *R v Ayoub* (1984) 2 NSWLR 511, 516. If the prosecution raises the “defence” in those circumstances, it must establish “mental illness” on the balance of probabilities: see *R v Ayoub* (1984) 2 NSWLR 511, 513-516.

153. Irrespective of whether an accused claims or disputes a defence, the trial judge may be required to put it to the jury if it is raised on the evidence: see *Pemble v The Queen* (1971) 124 CLR 107, 117-118, 133. The principle applies to the defence of mental illness: see *R v Ayoub* (1984) 2 NSWLR 511, 515; *R v Hawkins* (1994) 179 CLR 500, 517.

154. See, eg, *R v Damic* (1982) 2 NSWLR 750, 753-755, 760-763; *R v Issa* (Unreported, NSW Supreme Court, Sperling J, 16 October 1995 and 25 October 1995). See also *Whitehorn v The Queen* (1983) 152 CLR 657, 663-665 (Deane J), 675-687 (Dawson J).

155. See *Criminal Appeal Act 1912* (NSW) s 5(2); *Peterson v The Queen* [2007] NSWCCA 227.

156. See *Criminal Code 1995* (Cth) s 7.3(4) (prosecution may raise if court gives leave); *Criminal Code 2002* (ACT) s 28(6) (prosecution may raise if court gives leave); *Criminal Code 1983* (NT) s 43F(1) (may be raised by court on application by prosecution or on own initiative); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 22(1) (may be raised by prosecution if court gives leave) and 22(2) (if admissible evidence raises the issue, judge must direct the jury to consider); *Criminal Law Consolidation Act 1935* (SA) s 269E(1)(b) (may be raised

jurisdictions also expressly provide that a finding of mental illness may be entered by consent of the parties.<sup>157</sup>

3.109 In the Victorian case of *Alford*, Justice Hollingworth considered an application by the prosecution, pursuant to a legislative provision, to raise the “defence” of “mental impairment” against the wishes of the accused.<sup>158</sup> Justice Hollingworth found that “it is likely that there will be admissible evidence which may be capable of supporting a verdict of not guilty on the grounds of mental impairment”,<sup>159</sup> and granted the application out of the “need to ensure a fair trial.”<sup>160</sup>

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#### Issue 6.32

Should the MHFPA be amended to allow the prosecution, or the court, to raise the defence of mental illness, with or without the defendant’s consent?

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#### Issue 6.33

Should the MHFPA be amended to allow for a finding of “not guilty by reason of mental illness” to be entered by consent of both parties?

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#### Issue 6.34

Should the court have the power to order an assessment of the defendant for the purpose of determining whether he or she is entitled to a defence of mental illness?

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by prosecution, or by court of own initiative “in the interests of the proper administration of justice”); see *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 20(4) (judge, on own initiative, may require jury to consider the defence if raised on the evidence); *Criminal Code*, RSC 1985 (Canada) s 16(2)-(3) (party that raises the issue of mental disorder bears the burden of establishing the defence).

157. See *Crimes Act 1900* (ACT) s 321(1)-(2); *Criminal Code 1983* (NT) s 43F(3)-(4), 43H; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 21(4); *Criminal Law Consolidation Act 1935* (SA) s 269F(A)(5), 269G(B)(5); *Criminal Procedure Act 2004* (WA) s 93(1); *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 20(1).

158. See *R v Alford* [2005] VSC 405; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 22(1).

159. See *R v Alford* [2005] VSC 405, [15].

160. See *R v Alford* [2005] VSC 405, [12].

## Process for determining the facts

3.110 In most jurisdictions, the question of whether or not a defendant is not guilty by reason of mental illness is determined through the ordinary trial process. However, some jurisdictions adopt special procedures.

3.111 In South Australia, a determination is made as to whether the “objective elements”<sup>161</sup> of the offence charged are established, beyond a reasonable doubt, by the prosecution evidence.<sup>162</sup> No consideration is given to possible defences.<sup>163</sup> A second, separate determination is made as to whether the defendant was “mentally competent” at the time of the offence.<sup>164</sup> Both are made by a jury (or juries) unless the defendant elects for determination by a judge alone.<sup>165</sup>

3.112 The rationale for separate determinations is to avoid confusing the trier of fact, by separating the issue of mental impairment from other questions that may be at issue.<sup>166</sup> A secondary reason is to make sure that the court finds the accused guilty beyond reasonable doubt of the objective elements of the offence.<sup>167</sup>

3.113 In Queensland, a Mental Health Court<sup>168</sup> determines whether a person was of unsound mind when an alleged offence was committed.<sup>169</sup>

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161. The *Criminal Law Consolidation Act 1935* (SA) s 269A provides that “objective element of an offence means an element that is not a subjective element”. “Subjective element” means “voluntariness, intention, knowledge or some other mental state that is an element of the offence”.

162. See *Criminal Law Consolidation Act 1935* (SA) s 269F(B), 269G(A).

163. See *Criminal Law Consolidation Act 1935* (SA) s 269A(1) (definition of “defence” and “defensible”), 269F(B)(4), 269G(A)(3).

164. See *Criminal Law Consolidation Act 1935* (SA) s 269F(A), 269G(B).

165. See *Criminal Law Consolidation Act 1935* (SA) s 269B(1). The same jury may determine both matters “unless the trial judge thinks there are special reasons to have separate juries”: s 269B(2).

166. South Australia, *Parliamentary Debates*, House of Assembly, 21 November 1995 (Hon SJ Baker, Deputy Premier), 618.

167. South Australia, *Parliamentary Debates*, House of Assembly, 23 November 1995 (Ms White), 738. See also *R v S* (1979) 2 NSWLR 1, 37-38 regarding the origins of an earlier practice of finding defendants “guilty but insane”.

168. The Mental Health Court is constituted by a Supreme Court judge assisted by one or more psychiatrists: see *Mental Health Act 2000* (Qld) s 382. It is not bound by the rules of evidence: s 404.

169. See *Mental Health Act 2000* (Qld) s 267(1)(a).

The Mental Health Court is prohibited from making a finding as to unsoundness of mind if there is a reasonable doubt that the person committed the alleged offence, unless the doubt “exists only as a consequence of the person’s mental condition”,<sup>170</sup> or if “a fact that is substantially material to the opinion of an expert witness is so in dispute it would be unsafe to make the decision.”<sup>171</sup> A “substantially material fact” may be “something that happened before, at the same time as, or after the alleged offence was committed; or something about the person’s past or present medical or psychiatric treatment.”<sup>172</sup>

### Issue 6.35

Should a process other than an ordinary trial be used to determine whether a defendant is not guilty by reason of mental illness?

## APPLICATION OF THE DEFENCE TO THE LOCAL COURT

3.114 It is unlikely that the legislative scheme governing the operation of the defence of mental illness in Part 4 of the MHFPA applies to Local Court proceedings. The defence of mental illness as provided for in s 38(1) of the MHFPA is limited to indictable offences. Clearly, s 38(1) does not apply to proceedings for summary offences in the Local Court. It is arguably less clear whether s 38(1) applies to indictable offences that are heard summarily in the Local Court.<sup>173</sup> The reference in s 38(1) to “the jury” would appear to limit the application of the section to jury trials (which are not available in the Local Court), although cases have not been excluded from the operation of the subsection where proceedings have been heard by judge alone.<sup>174</sup>

170. See *Mental Health Act 2000* (Qld) s 268(1), (2). If the elements of the offence in respect of which there is a reasonable doubt are also the elements of another offence, subsections (1) and (2) do not prohibit the Mental Health Court from making a finding in respect of that other offence: s 268(3). If the Court makes such a finding, the proceedings for the original offence are discontinued: s 268(4).

171. See *Mental Health Act 2000* (Qld) s 269(1).

172. See *Mental Health Act 2000* (Qld) s 269(2).

173. Certain indictable offences can now be heard summarily in the Local Court: see *Criminal Procedure Act 1986* (NSW) ch 5.

174. In *Mantell v Molyneux* (2006) 165 A Crim R 83, it was noted that the legislative provisions relating to fitness to be tried do not apply to the Local Court and as a

3.115 Assuming that Part 4 of the MHFPA does not apply to proceedings in the Local Court, the common law is then left to govern the operation of the defence of mental illness in these proceedings (or at the very least, proceedings for summary offences). There is no real distinction to be made between the legislation and the common law in so far as both apply the *M'Naghten* Rules for determining whether a defendant is not guilty by reason of mental illness. The important distinction between the legislation and the common law lies in the difference in outcomes that are available to deal with defendants once they are found not guilty by reason of mental illness. The legislation sets out a carefully constructed set of procedures governing the detention and release of people found not guilty under s 38(1), whereas for people found not guilty in proceedings governed by the common law, it is not clear what procedures apply and whether the court has any power to detain them.<sup>175</sup>

3.116 If the defence is to be made applicable to the Local Court by statute, it would be necessary for there to be a clear regime for subsequent management of cases where the defence was made out. That could be the same scheme that applies in the Supreme and District Courts, or a simplified scheme. This is dealt with in Chapter 6.

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#### Issue 6.36

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Should the defence of mental illness be available generally in the Local Court and, if so, should it be available in all cases?

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result there is a gap in the law for defendants in Local Court proceedings who are clearly not fit to stand trial. However, the fitness provisions are in a separate Part of the legislation from the provisions relating to the defence of mental illness and that Part (containing the fitness provisions) is clearly restricted to criminal proceedings in the Supreme and District Courts: see MHFPA s 4. It is questionable whether an analogy can be drawn from the *Mantell* case to the provisions relating to the defence of mental illness. Recently in the District Court, Judge Berman found that the legislation governing the detention of a person found not guilty by reason of mental illness did not apply to the particular defendant in that case who originally faced charges in the Local Court: see *R v McMahon* (2006) 3 DCLR (NSW) 398 and unreported transcripts (District Court, Berman DCJ, 3 November 2006 and 10 November 2006). However, those charges related to a summary offence, being aggravated cruelty to animals, under *Prevention of Cruelty to Animals Act 1979* (NSW) s 6(1).

175. See *R v McMahon* (2006) 3 DCLR(NSW) 398 and unreported transcripts (District Court, Berman DCJ, 3 November 2006 and 10 November 2006).



## 4. **The partial defence of substantial impairment**

- Introduction
- Background to the current provisions
- Elements of the defence
- Should the defence continue to operate?

## INTRODUCTION

4.1 In NSW, a defendant who would otherwise be liable for murder, may seek to have that liability reduced to manslaughter, if he or she can prove a substantially impaired mental capacity to understand or control his or her actions at the time of the killing by reason of some “abnormality of mind”.<sup>1</sup> This is the essence of the defence of substantial impairment, previously known as diminished responsibility. Substantial impairment is unique to the crime of murder. This defence is distinct from the defence of mental illness, which has different criteria for its operation and applies to all offences.<sup>2</sup>

4.2 This chapter outlines the background to the current law of substantial impairment in NSW. We discuss judicial commentary on the main elements of the defence, and examine the factors that judges must consider when sentencing offenders who have successfully invoked it. Finally, we look at whether the defence should be reformulated, or continue to operate at all in NSW. In this context, we examine developments in other jurisdictions.

### Current provisions

4.3 Section 23A of the *Crimes Act 1900* (NSW) provides that

- (1) A person who would otherwise be guilty of murder is not to be convicted of murder if:
  - (a) at the time of the acts or omissions causing the death concerned, the person’s capacity to understand events, or to judge whether the person’s actions were right or wrong, or to control himself or herself, was substantially impaired by an abnormality of mind arising from an underlying condition, and
  - (b) the impairment was so substantial as to warrant liability for murder being reduced to manslaughter.

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1. *Crimes Act 1900* (NSW) s 23A.

2. While many of the psychiatric conditions that may be relied upon by defendants claiming substantial impairment may overlap with mental illness, the defence of diminished responsibility may also be relied on by a defendant whose “abnormality of mind” does not amount to mental illness in the legally accepted sense: see ch 3.

- (2) For the purposes of subsection (1)(b), evidence of an opinion that an impairment was so substantial as to warrant liability for murder being reduced to manslaughter is not admissible.
- (3) If a person was intoxicated at the time of the acts or omissions causing the death concerned, and the intoxication was self-induced intoxication (within the meaning of s 428A),<sup>3</sup> the effects of that self-induced intoxication are to be disregarded for the purpose of determining whether the person is not liable to be convicted of murder by virtue of this section.
- (4) The onus is on the person accused to prove that he or she is not liable to be convicted of murder by virtue of this section.
- (5) A person who but for this section would be liable, whether as principal or accessory, to be convicted of murder is to be convicted of manslaughter instead.
- (6) The fact that a person is not liable to be convicted of murder in respect of a death by virtue of this section does not affect the question of whether any other person is liable to be convicted of murder in respect of that death.
- (7) If, on the trial of a person for murder, the person contends:
  - (a) that the person is entitled to be acquitted on the ground that the person was mentally ill at the time of the acts or omissions causing the death concerned, or
  - (b) that the person is not liable to be convicted of murder by virtue of this section,

evidence may be offered by the prosecution tending to prove the other of those contentions, and the Court may

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3. *Crimes Act 1900* (NSW) s 428A defines self-induced intoxication to mean any intoxication except intoxication that:
    - (a) is involuntary, or
    - (b) results from fraud, sudden or extraordinary emergency, accident, reasonable mistake, duress or force, or
    - (c) results from the administration of a drug for which a prescription is required in accordance with the prescription of a medical practitioner, a person authorised under the *Nurses and Midwives Act 1991* (NSW) to practise as a nurse practitioner or a midwife practitioner, or dentist, or of a drug for which no prescription is required administered for the purpose, and in accordance with the dosage level recommended, in the manufacturer's instructions.

give directions as to the stage of the proceedings at which that evidence may be offered.

(8) In this section:

‘underlying condition’ means a pre-existing mental or physiological condition, other than a condition of a transitory kind.

4.4 The defendant must prove that all elements of the defence have been satisfied in order to avoid a conviction of murder. The standard of proof required is the balance of probabilities.<sup>4</sup>

## BACKGROUND TO THE CURRENT PROVISIONS

### History of diminished responsibility

4.5 Until the middle of last century, the mandatory punishment for murder in NSW was death. Following the abolition of the death penalty in 1955, murder was punishable by a mandatory sentence of life imprisonment.<sup>5</sup> This continued until 1982 when judges were given limited discretionary powers when sentencing for murder.<sup>6</sup> By contrast, judges in NSW have always been able to exercise discretion in sentencing for manslaughter, up to the maximum penalty prescribed by statute, as in the case of other offences.<sup>7</sup>

4.6 Consequently, until 1982, the only way for a defendant charged with murder, but alleging reduced mental functioning, to avoid the gallows or life imprisonment if convicted was to plead the “insanity” defence (as it was known) or to attempt to have the charge reduced from murder to manslaughter. As discussed in Chapter 3, if a defence of mental illness is successful, then the accused is “acquitted” of the offence, but may be detained for an indefinite period in a mental health facility or

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4. *Crimes Act 1900* (NSW) s 23A(4). See also *R v Dunbar* [1958]1 QB 1.

5. See *Crimes Act 1900* (NSW) s 19, as amended by the *Crimes (Amendment) Act 1955* (NSW).

6. See *Crimes Act 1900* (NSW) s 19 as amended by the *Crimes (Homicide) Amendment Act 1982* (NSW). See also *R v Bell* (1985) 2 NSWLR 466. Those discretionary powers were broadened further in 1990: see *Crimes Act 1900* (NSW) s 19A, inserted by the *Crimes (Life Sentences) Amendment Act 1989* (NSW).

7. This is currently 25 years: see *Crimes Act 1900* (NSW) s 24.

a prison.<sup>8</sup> The defence of mental illness is still based on the common law defence, formulated in *Daniel M’Naghten’s Case* in 1843, which is established only if, at the time of the offence, the defendant was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act or not to know that the act was wrong.<sup>9</sup>

4.7 The defence of diminished responsibility was first developed by Scottish courts not long after the *M’Naghten* decision, as a means of avoiding murder convictions for those offenders who did not satisfy the test for the “insanity defence”, but whose mental state was nevertheless impaired at the time of killing. The United Kingdom later enacted legislation providing for the defence.<sup>10</sup>

### Introduction of diminished responsibility in NSW

4.8 In 1974, the NSW Parliament decided to follow the United Kingdom formulation of diminished responsibility.<sup>11</sup> The Report of the Criminal Law Committee, which led to the introduction of the defence in NSW, stated its reasons for recommending diminished responsibility to be the “continuation of the mandatory life sentence for murder, and the comparative inflexibility of the *M’Naghten* rules”.<sup>12</sup> Further, the Report noted that it seemed “reasonable to allow the ‘abnormal’, but guilty, accused some degree of reduction in law... of the position whereby he is confronted by either life imprisonment or detention at the Governor’s pleasure”.<sup>13</sup>

4.9 The defence was originally formulated as follows:

Where, on the trial of a person for murder, it appears that at the time of the acts or omissions causing the death charged the person was suffering from such abnormality of mind (whether arising from

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8. See *Mental Health (Forensic Provisions) Act 1990* (NSW) (“the MHFPA”) s 39.

9. *Daniel M’Naghten’s Case* (1843) 10 Cl & Fin 200, 210. See ch 3.

10. *Homicide Act 1957* (UK) s 2.

11. By the *Crimes and Other Acts (Amendment) Act 1974* (NSW) s 5(b), which inserted the original s 23A into the *Crimes Act 1900* (NSW). See NSW, *Parliamentary Debates*, Legislative Assembly, 13 March 1974, 1356, (the Hon John Maddison, MP).

12. NSW, *Report of the NSW Criminal Law Committee on Proposed Amendments to the Criminal Law and Procedure*, (September 1973), 6.

13. NSW, *Report of the NSW Criminal Law Committee on Proposed Amendments to the Criminal Law and Procedure*, (September 1973), 6.

a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for the acts or omissions, he shall not be convicted of murder.

4.10 If successfully argued, a defendant lacking mental capacity would be convicted of manslaughter rather than murder, thereby avoiding the mandatory life penalty.

*Cause of controversy*

4.11 The defence of diminished responsibility has not operated without controversy. For some, the defence was seen as a soft option, allowing killers to escape a murder conviction by claiming an abnormality of mind. This controversy was highlighted in the tragic case of *Veen*.<sup>14</sup> The defendant was a male prostitute who suffered from brain damage brought about by long-term alcohol abuse. After drinking heavily, he killed a client in a frenzied knife attack. Able to prove to the satisfaction of the Court that his mental functioning was substantially impaired at the time of the killing, Veen was convicted of manslaughter, but sentenced to life imprisonment.<sup>15</sup> On appeal to the High Court, Veen's sentence was reduced.<sup>16</sup> He was eventually released on parole after 8 years, only to kill again within the year.<sup>17</sup> Veen again successfully relied on diminished responsibility to reduce the charge of murder to manslaughter, and was sentenced to life imprisonment due to the danger he presented to society. The subsequent appeal was rejected by the High Court.<sup>18</sup>

4.12 Opponents of diminished responsibility consider that cases such as *Veen* highlight the drawbacks of the substantial impairment defence, since Veen's degree of culpability for the killings was arguably greater than the conviction for manslaughter would suggest. These concerns gained momentum after the 1982 abolition of the mandatory life penalty for murder. Given that the mandatory penalty had been one of the major

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14. *Veen v The Queen* (No 1) (1979) 143 CLR 458.

15. This was an unusually severe penalty for manslaughter, but deemed appropriate by the trial judge, who considered Veen to present a continuing danger to society: see *Veen v The Queen* (No 2) (1988) 164 CLR 465, 468.

16. On the basis that it was not proportional to the defendant's degree of culpability: *Veen v The Queen* (No 2) (1988) 164 CLR 465.

17. See *Veen v The Queen* (No 2) (1988) 164 CLR 465.

18. See *Veen v The Queen* (No 2) (1988) 164 CLR 465.

drivers for introducing the partial defence of diminished responsibility, questions were raised as to the need to retain the defence.

4.13 The defence, as originally drafted, was also considered by many to be confusing, generating significant disagreement among medical experts as to the nature, cause and effect of any abnormality.<sup>19</sup> In *Chayna*,<sup>20</sup> seven psychiatrists offered varying opinions as to the defendant's mental condition at the time she killed her two daughters and sister-in-law: ranging from schizophrenia, to severe depression, to an acute dissociative state, with one expert witness doubting the presence of any mental impairment at all. The trial judge directed the jury that the evidence of this last witness supported a conviction of murder. The jury found the defendant guilty of murder, and the matter went to the Court of Criminal Appeal. It was there that Chief Justice Gleeson expressed concern over the confusion caused by conflicts in medical opinion which the old s 23A was prone to generate. He noted that the defence of diminished responsibility relied on "concepts which medical experts find at least ambiguous and, perhaps, unscientific", with the place of the defence in the criminal law being a subject "ripe for reconsideration".<sup>21</sup>

### Review by New South Wales Law Reform Commission

4.14 Against this background, the New South Wales Law Reform Commission received a reference to review the defence of diminished responsibility.<sup>22</sup> In 1997, we delivered a Report, entitled *Partial Defences to Murder: Diminished Responsibility*, recommending that the defence be reformulated rather than abolished.<sup>23</sup> In reaching this conclusion, we noted that the defence did not exist in some other Australian jurisdictions,<sup>24</sup> where substantial impairment of mind did not reduce murder to manslaughter but was considered only as a mitigating factor in sentencing. We also conceded that the original impetus for the defence no

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19. NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility*, Report 82 (May 1997) ("NSWLRC Report 82") [3.3].

20. *R v Chayna* (1993) 66 A Crim R 178.

21. *R v Chayna* (1993) 66 A Crim R 178, 189 and 191.

22. The Terms of Reference also extended to the other partial defences to murder: namely infanticide and provocation. See ch 5 for a discussion of infanticide as it relates to the current reference.

23. NSWLRC Report 82, Recommendations 2 and 4.

24. For example, Victoria, South Australia, Tasmania and Western Australia.

longer existed since the abolition of the mandatory life sentence for murder. However, the Commission at that time was firmly of the view that, irrespective of the issue of sentencing, defendants with a reduced mental capacity should not be convicted of murder, which carries with it a higher degree of blameworthiness than manslaughter. The principle reason for the recommendation to retain the defence was the “vital importance of involving the community, by way of the jury, in making decisions on culpability and hence enhance community acceptance of the due administration of criminal justice (including acceptance of sentences imposed)”.<sup>25</sup> We considered that diminished responsibility provided “flexibility to determine responsibility according to degrees of mental impairment, rather than according to a strict contrast between sanity and ‘insanity’”.<sup>26</sup>

4.15 However, we noted certain problems with the formulation of the defence. For example, the vague nature of the term “abnormality of mind”, and the need to specify the cause of that abnormality, were areas that caused unnecessary confusion and needed clarification.<sup>27</sup> Further, the need for the accused to prove a substantial impairment of “mental responsibility” was problematic, since it was not sufficiently clear that this was an issue for the jury to determine rather than medical experts.<sup>28</sup>

4.16 Consequently, we recommended that the defence be reformulated to provide that an abnormality of mental functioning,<sup>29</sup> which causes a substantial impairment of the defendant’s capacity to understand or control his or her actions or to understand the events surrounding the killing, needed to be due to an underlying condition. The impairment must be so substantial as to warrant reducing the defendant’s liability for murder to manslaughter.<sup>30</sup> We also recommended that expert medical evidence should be irrelevant to the issue of whether the defendant’s culpability should be so reduced, since this is not a medical question but one of liability, to be determined by the trier of fact.<sup>31</sup>

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25. NSWLRC Report 82, [3.11].

26. NSWLRC Report 82, [3.19].

27. NSWLRC Report 82, [3.33]-[3.40].

28. NSWLRC Report 82, [3.41]-[3.43].

29. The recommendation to recast “abnormality of mind” as “abnormality of mental functioning” was the only aspect of NSWLRC Report 82 not implemented.

30. NSWLRC Report 82, [3.47]-[3.58].

31. NSWLRC Report 82, [3.60]-[3.63].



4.17 The NSW Government accepted the recommendations, implementing Report 82 with the passage of the *Crimes Amendment (Diminished Responsibility) Act 1997* (NSW). That legislation replaced the old s 23A with the current formulation.

### Incidence of the defence

4.18 Figures from the Judicial Commission of NSW indicate that between January 1990 and September 2004, a total of 126 offenders raised diminished responsibility/substantial impairment as a defence. Of these, 84 (or 67%) were successful in establishing the defence and were convicted of and sentenced for manslaughter. The remaining 42 (33%) received murder convictions.<sup>32</sup>

4.19 Of the 84 offenders noted above, 11 were sentenced to non-custodial alternatives. These included bonds,<sup>33</sup> suspended sentences and periodic detention.<sup>34</sup> With regard to full-time custodial sentences handed down between 1990 and 2004, terms ranged from two to 25 years, with non-parole periods ranging from 17 months to 18 years.<sup>35</sup> The Judicial Commission also noted that the proportion between the non-parole periods and the total sentence was, on average, significantly less than the provisional statutory ratio.<sup>36</sup>

4.20 There are indications of changing sentencing patterns following the 1997 amendments. A slightly larger percentage of offenders sentenced after the amendments took effect received non-custodial sentences than those sentenced under the old provisions.<sup>37</sup> Where custodial sentences

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32. Judicial Commission of NSW, *Partial Defences to Murder in NSW 1990-2004*, Research Monograph 28 (June 2004) (“Judicial Commission Report”), 15.

33. Meaning good behaviour bonds under the *Crimes (Sentencing Procedure) Act 1999* (NSW) s 9.

34. Judicial Commission Report, 60. See also *R v Sutton* [2007] NSWSC 295.

35. Judicial Commission Report, 63.

36. Judicial Commission Report, 64-65. Ordinarily, the non-parole period is 75% of the term of the sentence, unless special considerations exist: see NSW, *Parliamentary Debates*, Legislative Assembly, 28 October 1999, 2293 (the Hon Bob Debus, MP, Minister for the Environment, Minister for Emergency Services, Minister for Corrective Services, and Minister Assisting the Premier on the Arts) 2326. The term of the sentence must not exceed one third of the non-parole period: *Crimes (Sentencing Procedure) Act 1999* (NSW) s 44(2).

37. At the time of the 2004 Judicial Commission Report, six out of 20 offenders received non-custodial sentences since the 1997 amendments, while only five

were imposed, the prison terms were significantly shorter than under the diminished responsibility regime.<sup>38</sup> The Judicial Commission Report notes that this trend appears to confirm the view that the new formulation provides a stricter test:<sup>39</sup>

Only those cases in which the impairment is severe, or the moral circumstances are highly compelling, appear to be accepted. A greater proportion of these offenders are assessed as being poor vehicles for punishment and deterrence, of greatly reduced culpability, or presenting a low level of threat to the community.<sup>40</sup>

### *Judge alone trials*

4.21 A defendant accused of an indictable offence may elect to have the matter dealt with by a judge alone, in the absence of a jury, subject to the consent of the Director of Public Prosecutions (“the DPP”).<sup>41</sup> Given the importance of the role of the jury in making a moral assessment of the degree of the defendant’s impairment based on community values, the decision to consent to a judge alone trial where the defence of substantial impairment is raised should be carefully considered. In his Second Reading Speech introducing the 1997 amendments into NSW Parliament, the then Attorney General noted his intention to ask the DPP to amend the Prosecution Guidelines to ensure that community values are to be taken into consideration by a prosecutor when deciding whether to consent to a judge alone trial.<sup>42</sup>

4.22 According to the DPP’s current Prosecution Guidelines, consent to judge alone trials will be granted on the merits of each case, noting that

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out of 64 offenders received non-custodial sentences prior to that date: Judicial Commission Report, 62.

- 38. Prior to 1997, the range of custodial sentences imposed on offenders convicted of manslaughter on the basis of diminished responsibility was between 48 and 300 months. After the 1997 amendments, the range was 24 to 144 months: Judicial Commission Report, 65.
- 39. As claimed in the Second Reading Speech: New South Wales, *Parliamentary Debates*, Legislative Council, 25 June 1997, 11064, (the Hon JW Shaw, QC, MLC, Attorney General and Minister for Industrial Relations) 11064.
- 40. Judicial Commission Report, 62.
- 41. *Criminal Procedure Act 1986* (NSW) s 132(1) and (3).
- 42. New South Wales, *Parliamentary Debates*, Legislative Council, 25 June 1997, 11064, (the Hon JW Shaw, QC, MLC, Attorney General and Minister for Industrial Relations), 11066. This implemented Recommendation 3 of NSWLRC Report 82.

the community has a role to play in the administration of justice by serving as jurors, and that those community expectations are not to be lightly disregarded.<sup>43</sup> Further, the Guidelines state that where a prosecutor is considering accepting a plea of guilty in relation to manslaughter based on the defence of substantial impairment, the community values inherent in the requirements of s 23A(1)(b) must be taken into consideration.<sup>44</sup>

4.23 The Judicial Commission noted that, as of September 2004, the percentage of jury trials involving the defence of substantial impairment had not changed since the 1997 amendments:

Under the old regime, there were 43 jury trials out of 95 cases (45%). With the introduction of substantial impairment, there have been 14 jury trials out of 31 cases (45%). However, plea rates have increased. Under diminished responsibility, the Crown accepted a plea of guilty to manslaughter in 40 out of 95 cases (42%). Under substantial impairment, the Crown accepted guilty pleas in 17 out of 31 cases (55%).<sup>45</sup>

## ELEMENTS OF THE DEFENCE

4.24 Section 23A currently provides that the defence of substantial impairment may operate to reduce a defendant's liability for murder to manslaughter in circumstances where:

- the defendant was suffering from an abnormality of mind; and
- that abnormality arose from an underlying mental or physiological condition; and
- that abnormality substantially impaired the defendant's capacity to control his or her actions, or to know that they were wrong; and
- that "the impairment was so substantial as to warrant liability for murder being reduced to manslaughter".

We examine each of these elements in turn.

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43. Office of the Director of Public Prosecutions (NSW), *Prosecution Guidelines*, (2007) <<http://www.odpp.nsw.gov.au/guidelines/guidelines.html>>, Guideline 24.

44. Office of the Director of Public Prosecutions (NSW), *Prosecution Guidelines*, (2007) <[www.odpp.nsw.gov.au/guidelines/guidelines.html](http://www.odpp.nsw.gov.au/guidelines/guidelines.html)>, Guideline 20.

45. See Judicial Commission Report, 17.

## Abnormality of mind

4.25 The quintessential definition of “abnormality of mind” was articulated by Lord Parker CJ in *Byrne*,<sup>46</sup> as follows:

‘Abnormality of mind’ ... means a state of mind so different from that of ordinary human beings that the reasonable man would term it abnormal. It appears to us to be wide enough to cover the mind’s activities in all its aspects, not only the perception of physical acts and matters, and the ability to form a rational judgment as to whether an act is right or wrong, but also the ability to exercise will power to control physical acts in accordance with that rational judgment.<sup>47</sup>

4.26 As noted by the Commission in Report 82, the concept of an abnormality of mind is quite vague, and has neither a medical nor a legal basis.<sup>48</sup> The term assumes that there is an ascertainable range within which the mind functions “normally”, with any functioning “beyond the limits marked out by the variety of people encountered in daily life” capable of falling within the definition.<sup>49</sup> An abnormality of mind can also be difficult to categorise, and may overlap with, or be linked to, a mental illness.<sup>50</sup> Some psychiatric conditions that may be relied upon by defendants claiming substantial impairment overlap with those relied upon to support a defence of “mental illness”. However, this is not a requirement for a successful defence of substantial impairment.<sup>51</sup>

4.27 It is not uncommon for expert opinions to differ markedly regarding the existence and diagnosis of psychiatric conditions that would constitute an abnormality of mind.<sup>52</sup> It is not necessary for a

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46. *R v Byrne* [1960] 2 QB 396.

47. *R v Byrne* [1960] 2 QB 396, 403. This definition has been cited with approval: see *Rose v The Queen* [1961] AC 496, 507; *R v Tumanako* (1992) 64 A Crim R 149, 159; *R v Chayna* (1993) 66 A Crim R 176, 190-191.

48. NSWLRC Report 82, [3.34].

49. *R v Rolph* [1962] Qd R 262, 288; *R v Whitworth* [1989] 1 Qd R 437, 445; *R v Trotter* (1993) 35 NSWLR 428, 430.

50. It is open to a defendant to invoke the partial defence of substantial impairment as well as the defence of mental illness: see *Crimes Act 1900* (NSW) s 23A(7). See also the comments of Chief Justice Spigelman in *R v Cheatham* [2000] NSWCCA 282.

51. See ch 3 for a discussion of the defence of mental illness.

52. See *R v Chayna* (1993) 66 A Crim R 178, discussed at par 4.XR above. Note that it is for the jury, and not the experts, to determine whether the defendant suffered

precise diagnosis to be made, or for there to be agreement on the exact nature of the impairment, provided that some abnormality of mind existed at the time the offence was allegedly committed.

4.28 The types of conditions found by the courts to amount to an abnormality of mind include personality disorders,<sup>53</sup> post-traumatic stress disorders,<sup>54</sup> severe depression,<sup>55</sup> paranoia,<sup>56</sup> schizophrenia, epilepsy,<sup>57</sup> and intellectual disability.<sup>58</sup> According to the Judicial Commission, the defence of substantial impairment captures the most severe cases of mental dysfunction, with schizophrenia, personality disorders and depression among the most commonly cited conditions in cases where the defence was successfully raised between 1990 and 2004.<sup>59</sup> However, the Judicial Commission also noted that the 1997 amendments have applied a different filter to the types of conditions that have been successfully raised as defences, noting a significant fall in the number of defendants with personality disorders able to persuade the court of the existence of an abnormality of mind in the relevant sense.<sup>60</sup> The Judicial Commission attributed this to the common incidence of personality disorders in the general population, possibly leading to a community perception that such disorders are not sufficiently “abnormal”.<sup>61</sup>

### An “underlying condition”

4.29 Section 23A provides that an underlying mental or physiological condition means “a pre-existing mental or physiological condition, other

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from an abnormality of mind that impaired his or her reasoning substantially enough to satisfy the requirements of s 23A: see [4.40]-[4.42].

53. *R v Whitworth* [1989] 1 Qd R 437; *R v McGarvie* (1986) 5 NSWLR 270; *R v Turnbull* (1977) 65 Cr App R 242; *R v Heatley* [2006] NSWSC 1199.

54. *R v Neilsen* [1990] 2 Qd R 578.

55. *R v Chayna* (1993) 66 A Crim R 178; *R v Neilsen* [1990] 2 Qd R 578.

56. *R v Chayna* (1993) 66 A Crim R 178; *R v Fenton* (1975) 61 Crim App R 261.

57. *R v Dick* [1966] Qd R 301.

58. *Walton v R* [1978] AC 788.

59. Judicial Commission Report, 18-21.

60. Judicial Commission Report, 21-22. See also *R v Maxwell* [1999] NSWSC 1085; and *R v Matheson* [2001] NSWSC 332. Note the concerns raised in relation to the inclusion of personality disorders within the scope of diminished responsibility: see NSWLRC Report 82, [3.35].

61. Judicial Commission Report, 21.

than of a transitory kind”.<sup>62</sup> Consequently, the exact cause of the abnormality of mind need not be substantiated, unlike the requirement in the old defence of diminished responsibility. In Report 82, this Commission noted that the term was intended to “link the defence to a notion of a pre-existing impairment requiring proof by way of expert evidence”.<sup>63</sup> The condition may be a treatable one and need not be permanent (provided it was present at the time of the killing), but must be more than “disabling passions of an ephemeral kind”.<sup>64</sup> So, for example, a severe depressive illness that may be treated by medication could fall within the meaning of an underlying condition,<sup>65</sup> but rage resulting from self-induced steroid abuse would not.<sup>66</sup>

### *Intoxication*

4.30 Section 23A(3) provides that the effects of self-induced intoxication are to be disregarded in assessing whether or not the defence of substantial impairment is applicable. This provision adopted the common law position that the effects of self-induced intoxication do not amount to an abnormality of mind in the relevant sense.<sup>67</sup>

4.31 However, a defendant who was intoxicated at the time of the killing may be able to rely on the defence if prolonged use of alcohol or drugs has led to brain damage or disease that substantially impaired the defendant’s ability to control his or her actions. In such cases, the defendant must prove that it is the brain damage (being the underlying condition) that caused the abnormality of mind resulting in the substantial impairment of mental capacity, and not the short-term effects of the intoxication.<sup>68</sup>

### A standard definition of mental impairment?

4.32 The disadvantages of the current terminology used in s 23A could be avoided if the terms “abnormality of mind” stemming from an

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62. *Crimes Act 1900* (NSW) s 23A(1)(a) and (8).

63. NSWLRC Report 82, [3.51].

64. *R v Purdy* [1982] 2 NSWLR 964, 966; and *R v Tumanako* (1992) 64 A Crim R 149, 149.

65. See *R v Sutton* [2007] NSWSC 295.

66. *R v De Souza* (1997) 41 NSWLR 656.

67. See, eg, *R v Jones* (1986) 22 A Crim R 42; *R v De Souza* (1997) 41 NSWLR 656.

68. *R v Jones* (1986) 22 A Crim R 42, 44; *R v Ryan* (1995) 90 A Crim R 191, 197.

“underlying condition” were replaced by a clearer definition of mental impairment. In Consultation Paper 5, we discuss whether there should be an umbrella definition of mental impairment in the *Mental Health (Forensic Provisions) Act 1990* (NSW) (“the MHFPA”), that could apply in any circumstances where a defendant’s mental state is relevant to his or her criminal responsibility.<sup>69</sup> This would include determinations of fitness to stand trial, suitability for diversion from local court proceedings, eligibility for the defences of substantial impairment and mental illness, and sentencing considerations.

4.33 We suggest that mental impairment could be defined as a “mental illness, cognitive impairment, or personality disorder, however and whenever caused, whether congenital or acquired”. We also suggest that mental illness should have the same meaning as in the *Mental Health Act 1990* (NSW), and cognitive impairment could be separately defined.<sup>70</sup> Note that this definition would cover senility, brain injury, and drug/alcohol abuse to the extent that it has caused a mental illness, personality disorder or cognitive impairment.<sup>71</sup>

4.34 If such a definition were to be applied to the defence of substantial impairment, it would only be a threshold test. A defendant would still need to demonstrate that his or her mental impairment resulted in a diminished capacity to understand events, control his or actions, or to judge whether they were right or wrong, with that impairment being so substantial as to warrant reducing liability for murder to manslaughter.

#### Issue 6.37

If the umbrella definition of cognitive and mental impairment suggested in Consultation Paper 5, Issue 5.2 were to be adopted, should it also apply to the partial defence of substantial impairment?

4.35 In the event that an overarching definition of cognitive and mental impairment is not adopted, the Commission invites views as to whether

69. See Consultation Paper 5 (“CP 5”), [4.42]-[4.46].

70. In CP 5, we favour defining “cognitive impairment” to mean “a significant disability in comprehension, reason, judgment, learning or memory, that is the result of any damage to, or disorder, developmental delay, impairment or deterioration of, the brain or mind”: see CP 5, [4.53]-[4.56] and Issue 5.5.

71. See [4.30]-[4.31] regarding substantial impairment and intoxication.

the mental state required to invoke the defence of substantial impairment should be clarified and, if so, how.

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### Issue 6.38

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As an alternative to an umbrella definition of cognitive and mental impairment, should the mental state required by s 23A be revised? If so, how?

## Substantial impairment

4.36 Proving the existence of an abnormality of mind at the relevant time will not ensure a defendant's success in relying on the defence of substantial impairment. As the name suggests, the crucial issue in determining if the defence is applicable is one of degree.

4.37 The term "substantial impairment" is inherently vague. Substantial does not mean total, in that the defendant's capacity to control or understand his or her actions, or the events surrounding the victim's death, need not be completely impaired. Nor may the degree of impairment be trivial. Rather, it must exist on a sliding scale somewhere in between.<sup>72</sup> Exactly where the level of impairment lay, at the time of the offence, is a matter for the jury to determine based on the circumstances of each case.<sup>73</sup>

4.38 The requirement that the impairment be so substantial as to warrant liability for murder being reduced to manslaughter is even more vague. It offers no criteria on which that judgment is to be exercised.

4.39 We seek views on whether the current formulation of the partial defence of substantial impairment is sufficiently clear, and what alternatives may be preferable.

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72. *R v Lloyd* [1967] 1 QB 175; *R v Ignjatic* (1993) 68 A Crim R 333; *R v Trotter* (1993) 35 NSWLR 428; *R v Ryan* (1995) 90 A Crim R 191; *R v Majdalawi* (2000) 113 A Crim R 241.

73. See [4.40]-[4.42] for a discussion of the role of the jury in assessing substantial impairment.



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**Issue 6.39**


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Is the requirement in s 23A of the Crimes Act that the impairment be “so substantial as to warrant liability for murder being reduced to manslaughter” sufficiently clear? If not, how should it be modified?

### The role of the jury

4.40 As noted above, the key role played by the jury, in determining whether or not the defence of substantial impairment by way of abnormality of mind has been established, was the overriding factor supporting the Commission’s recommendation in Report 82 to retain the defence.<sup>74</sup> While medical evidence is generally adduced in order to establish that the defendant suffered from some abnormality of mind, there is no legal requirement that such evidence be offered. It is open to the jury to infer from all of the circumstances that the defendant was experiencing such a condition at the time of causing the victim’s death.<sup>75</sup> Where medical evidence is offered as to the nature of the defendant’s condition, the jury is not bound to accept it if it is outweighed by other, conflicting evidence.<sup>76</sup> This can be a particularly challenging in cases with numerous, conflicting expert opinions.<sup>77</sup>

4.41 However, while medical evidence may be relevant in establishing the first limb of the defence, it is not to be considered when determining the crucial question of whether the abnormality of mind caused an impairment substantial enough to warrant reducing the defendant’s culpability from murder to manslaughter. This was stated clearly in the 1997 amendments, which provide that expert evidence purporting to offer an opinion as to the whether or not the defendant’s impairment was substantial enough for the defence to succeed is inadmissible in relation to the latter inquiry.<sup>78</sup>

4.42 This provision essentially clarified the position that existed prior to the amendment, where courts had stressed that the question of the degree of substantial impairment is a moral, and not a medical, judgment, and as

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74. See [4.14].

75. See *R v Byrne* [1960]2 QB 396; *R v Purdy* [1982] 2 NSWLR 964; *R v Tumanako* (1992) 64 A Crim R 149; *R v Majdalawi* (2000) 113 A Crim R 241.

76. *R v Byrne* [1960]2 QB 396; *R v Purdy* [1982] 2 NSWLR 964; *R v Tumanako* (1992) 64 A Crim R 149; *R v Trotter* (1993) 35 NSWLR 428.

77. See, eg, in *R v Chayna* (1993) 66 A Crim R 178.

78. *Crimes Act 1900* (NSW) s 23A(2).

such, is for the jury to assess in accordance with common sense community standards.<sup>79</sup> Indeed, Chief Justice Gleeson warned against juries placing heavy reliance on the conclusions of medical experts when deciding the “ultimate issue” of a case.<sup>80</sup>

### Factors judges consider when sentencing offenders with substantial impairments

4.43 In sentencing offenders convicted under s 23A, the courts have consistently pointed out that, while the offender’s capacity may be diminished, this does not detract from the fact that he or she is guilty of wilfully taking a human life.<sup>81</sup> It does not necessarily follow that offenders with an impaired capacity will receive a light sentence.<sup>82</sup>

4.44 As the High Court stated in *Veen (No 2)*, considerations of mental impairment can have two competing influences on the sentence to be imposed on an offender convicted of manslaughter pursuant to s 23A, one towards a shorter sentence and the other towards a longer one.<sup>83</sup> Factors tending towards a shorter sentence may be the severity of the impairment that, coupled with detrimental social circumstances, may significantly reduce an offender’s moral culpability for the crime. These considerations, which were at play in all of the cases discussed above where non-custodial sentences were imposed,<sup>84</sup> may also provide little basis for punishment or deterrence.<sup>85</sup>

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79. *R v Trotter* (1993) 35 NSWLR 428, 431; *R v Tumanako* (1992) 64 A Crim R 149, 160.

80. *R v Chayna* (1993) 66 A Crim R 178, 188. This is not to say that the jury is entitled to make perverse findings contrary to overwhelming and unanimous medical evidence indicating a severe abnormality of mind in the absence of any other compelling evidence that throws doubt on the medical opinions: see *R v Dick* [1966] Qd R 301; *Taylor v The Queen* (1978) 45 FLR 343; *R v Tumanako* (1992) 64 A Crim R 149.

81. See *R v Low* (1991) 57 A Crim R 8; *R v Blacklidge* (Unreported, NSW Court of Criminal Appeal, Gleeson CJ, Grove and Ireland JJ, 12 December 1995); *R v Dawes* [2004] NSWCCA 363; *R v Adams* [2002] NSWCCA 448.

82. *R v Low* (1991) 57 A Crim R 8, 19.

83. *Veen v The Queen (No 2)* (1988) 164 CLR 465, 477.

84. See [4.19]-[4.20].

85. See *R v Jiminez* [1999] NSWCCA 7; *R v Israil* [2002] NSWCCA 255; *R v Pearson* [2004] NSWCCA 129; *R v Hemsley* [2004] NSWCCA 228; *R v Haines* [2004] NSWCCA 295; *R v Wicks* [2005] NSWCCA 213; *R v Hughes* [2005] NSWCCA 117; and *R v Sutton* [2007] NSWSC 295.

4.45 Alternatively, the offender’s mental condition may cause him or her to present a future danger to the community, so that the need to protect the community outweighs other mitigating circumstances.<sup>86</sup> In such cases, a longer sentence may be appropriate, provided that it does not exceed a sentence that is proportionate to the objective circumstances of the offence.<sup>87</sup>

4.46 General considerations regarding sentencing of offenders with cognitive and mental health impairments are discussed in Chapter 8.

## SHOULD THE DEFENCE CONTINUE TO OPERATE?

4.47 Apart from NSW, a defence of substantial impairment or diminished responsibility also exists in Queensland,<sup>88</sup> the Northern Territory,<sup>89</sup> and the Australian Capital Territory.<sup>90</sup> Recently, Law Reform Commissions in Victoria and Western Australia have recommended against the introduction of the defence.<sup>91</sup>

4.48 It has been more than a decade since NSW has considered the need for retaining the defence of substantial impairment or diminished responsibility. The reforms introduced in 1997 appear to have resulted in a stricter application of the defence, yet the controversy over whether it is necessary at all remains.

### Recent developments in other jurisdictions

#### *Victoria and Western Australia oppose introducing the defence*

4.49 As noted earlier, both the Victorian Law Reform Commission (“VLRC”) and the Law Reform Commission of Western Australia (“LRCWA”) recommended against introducing the defence. Objections in

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86. *Veen v The Queen (No 2)* (1988) 164 CLR 465, 478; *R v Adams* [2002] NSWCCA 448, [74]-[76]; *R v Heatley* [2006] NSWSC 1199 [113]-[114].

87. *Veen v The Queen (No 2)* (1988) 164 CLR 465, 448. See discussion of sentencing principles in ch 8.

88. *Criminal Code Act 1899* (Qld) s 304A.

89. *Criminal Code* 1983 (NT) s 159.

90. *Crimes Act 1900* (ACT) s 14.

91. Victorian Law Reform Commission, *Defences to Homicide: Final Report*, Report No 6 (2004), Recommendation 45 (“VLRC Report”); and Law Reform Commission of Western Australia, *Review of the Law of Homicide: Final Report*, Report No 97 (2007) Recommendation 39, (“LRCWA Report”).

both jurisdictions were based on the view that the reduced mental capacity of a defendant at the time of the killing should be a factor to be taken into account during the sentencing phase, and should not be left to the jury. The VLRC expressed the view that judges are better placed than jurors to assess degrees of criminal responsibility, particularly because judges, unlike jurors, must give reasons for their sentences which may be scrutinised on appeal. This was seen to be a fairer and more consistent approach.<sup>92</sup>

4.50 Further, the VLRC and the LRCWA noted that reducing the charge of murder to manslaughter and imposing a prison sentence may not be the best sentencing option. In some cases, a hospital disposition may be more appropriate, while in other cases involving dangerous offenders, a longer sentence than would be appropriate for manslaughter may be called for.<sup>93</sup> The LRCWA referred to the *Veen*<sup>94</sup> cases as illustrative of a situation where the defence of substantial impairment does not accurately reflect the culpability of the accused or the seriousness of the offence. The LRCWA argued that, if the defence of substantial impairment were not available, defendants such as Veen would either be convicted of murder and sentenced accordingly, or “acquitted” on account of unsoundness of mind and placed in an appropriate psychiatric facility.<sup>95</sup>

4.51 This raises the related issue of flexible sentencing dispositions for defendants with mental impairments.<sup>96</sup> Both the VLRC and LRCWA considered that ensuring the existence of a range of appropriate disposition and treatment options for offenders with mental impairments offers a better solution than the introduction of a diminished responsibility defence.<sup>97</sup> The VLRC was of the view that the *Sentencing Act 1991* (Vic) provides sufficient flexibility in sentencing to make the

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92. VLRC Report, [5.126]-[5.127]. See also LRCWA Report, 257-258.

93. VLRC Report, [5.129]-[5.130].

94. *Veen v The Queen* (No 1) (1979) 143 CLR 458; and *Veen v The Queen* (No 2) (1988) 164 CLR 465. See discussion at [4.11]-[4.12].

95. LRCWA Report, 259.

96. See ch 8.

97. VLRC Report, [5.129]; LRCWA Report, 258.

introduction of a diminished responsibility defence unnecessary and undesirable.<sup>98</sup>

4.52 Both the VLRC and LRCWA also agreed that there was no satisfactory way of formulating the defence. They considered the existing formulations of the defence to be problematic, given their reference to vague notions such as “abnormality of mind”, which is not an easy concept to understand, diagnose or apply, as it has no psychiatric or clinical meaning.<sup>99</sup>

*United Kingdom recommends reformulation*

4.53 The Law Commission of the United Kingdom has also recently reviewed the defence of diminished responsibility, expressing the view that the defence remains valid, but is out of date and needs to be reformulated to make it clearer and “better able to accommodate developments in expert diagnostic practice”.<sup>100</sup> The Law Commission favoured redrafting the provision in terms similar to s 23A, but with the term “abnormality of mental functioning”, instead of the more vague “abnormality of mind”.<sup>101</sup> Further, the Law Commission recommended that the substantial impairment by an abnormality of mental functioning should be restricted to a “recognised medical condition, developmental immaturity in a defendant under the age of eighteen, or a combination of both”.<sup>102</sup>

4.54 The Law Commission argued that the provision regarding developmental immaturity was included due to its interrelationship with an abnormality of mental functioning. A defendant would be able to prove developmental immaturity by reference to biological factors, such as “poor frontal lobe development”, as well as social and environmental influences.<sup>103</sup> The Law Commission acknowledged that this

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98. VLRC Report, [5.129]. The VLRC also noted that introducing diminished responsibility would conflict with its recommendation to abolish the partial defence of provocation.

99. See VLRC Report, [5.113], [5.132]; and LRCWA Report, 250-252.

100. United Kingdom Law Commission, *Murder, Manslaughter and Infanticide*, Report No 304 (2006) [5.107].

101. United Kingdom Law Commission, Report No 304, [5.112]. Note that this was also recommended in NSWLRC Report 82, Recommendation 4.

102. United Kingdom Law Commission, Report No 304, [5.112].

103. United Kingdom Law Commission, Report No 304, [5.128], [5.131]-[5.132].

recommendation is controversial,<sup>104</sup> but considered that it is needed to meet the requirements of justice in the rare cases to which it would apply.<sup>105</sup>

### Arguments for retaining the defence of substantial impairment

4.55 The partial defence of substantial impairment reflects the continuum of mental illness.<sup>106</sup> This sliding scale recognises that an offender's impairment may be less than total, and fail to satisfy the strict test established under the complete defence of mental illness, but may nevertheless be significant.<sup>107</sup> As the Judicial Commission study revealed, the defence of substantial impairment captures the most severe kinds of mental impairment.<sup>108</sup> In these circumstances, a murder conviction, carrying with it a high degree of blameworthiness, is arguably inappropriate. Substantial impairment also provides an alternative for offenders with significant impairments, but who do not wish to rely on the mental illness defence due to the indeterminate length of detention.<sup>109</sup>

4.56 As noted earlier, the key factor that led this Commission to recommend retaining the defence in 1997 was that it facilitates community involvement, by means of the jury, in making a moral judgment as to the level of criminal responsibility that should attach to the offender's conduct. The Commission considered that this involvement would promote community acceptance of sentencing decisions for offenders convicted of manslaughter by reason of substantial impairment.<sup>110</sup> It is also arguable that, if the defence were to be abolished, juries may be reluctant to find offenders with significant impairments guilty of murder and, perversely, acquit them instead.<sup>111</sup> Furthermore, defendants may be more inclined to plead guilty to manslaughter on the basis of substantial impairment, rather than to murder (which would be

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104. United Kingdom Law Commission, Report No 304, [5.129].

105. United Kingdom Law Commission, Report No 304, [5.137].

106. See VLRC Report, [5.108]-[5.109].

107. See comments of Kirby J in *R v Jennings* [2005] NSWSC 789, [25], [29].

108. See Judicial Commission Report, 20.

109. See ch 7 for a discussion of indeterminate detention.

110. See [4.14].

111. United Kingdom Law Commission, *Partial Defences to Murder*, Final Report (2004), [5.22].

the case if the defence were abolished), avoiding the time and expense of a trial.<sup>112</sup>

### Arguments for abolition

4.57 In addition to the objections raised in the VLRC and the LRCWA Reports, the following arguments may be made against the defence of substantial impairment, as presently formulated:

- The imprecise definition of elements of the defence, in particular “abnormality of mind”, may lead to inconsistency and the possibility of abuse.<sup>113</sup>
- The provision that the impairment be so substantial as to warrant liability for murder being reduced to manslaughter is so vague as to detract from the rule of law and brings the law into disrepute.
- There is a conflict in some cases between a verdict of diminished responsibility, leading to a reduction in the maximum available penalty, and the need to protect the community from violent offenders.<sup>114</sup>
- As a matter of principle, if the intent element for murder is established (as they must be before the defence of substantial impairment arises), the accused should be convicted of murder.<sup>115</sup>
- Problems associated with expert evidence – such as inadequate time and opportunities for thorough psychiatric assessment, and the contorting of expert testimony to enable it to fit within the terminology of the defence – could be avoided if expert evidence were relevant only to sentencing rather than to the verdict.<sup>116</sup>

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112. New Zealand Law Commission, *Battered Defendants: Victims of Domestic Violence Who Offend*, Preliminary Paper 41 (2000) (“New Zealand Law Commission, Preliminary Paper 41,”), [130].

113. VLRC Report, [5.113]; LRCWA Report, 250-252; New Zealand Law Commission, Preliminary Paper 41, [114]-[116]; United Kingdom Law Commission, *Partial Defences to Murder*, [5.44], [5.54]-[5.56], [5.71]-[5.85]; United Kingdom Law Commission, Report No 304, [5.112] (recommending a revised definition of the defence).

114. New Zealand Law Commission, Preliminary Paper 41, [134].

115. UK Law Commission, *Partial Defences to Murder*, Final Report (2004), [5.19]; LRCWA Report, 256-257.

116. UK Law Commission, *Partial Defences to Murder*, Final Report (2004), [5.30]-[5.31], [5.44]-[5.46]; UK Law Commission, *Murder, Manslaughter and Infanticide*,

4.58 Additionally, the argument that the defence enables community participation, via the jury, in determining the degree of culpability carries less weight than when Report 82 was published. Statistics collated by the Judicial Commission reveal that almost half of diminished responsibility cases are not tried before a jury.<sup>117</sup>

4.59 The use of the defence in domestic violence cases has also been criticised. Some commentators believe that recognising a moral distinction between murder and manslaughter allowed a just outcome in cases where battered women killed their abusive partners.<sup>118</sup> However, there is a counter argument that the concentration on a female defendant's "abnormality of mind" in domestic violence cases "pathologises", rather than criminalises, the issue.<sup>119</sup> Further, the defence of substantial impairment has also been relied on by perpetrators of domestic violence who kill their partners, leading to diminished public confidence in the criminal justice system.<sup>120</sup>

### The Commission's preliminary view

4.60 Broadly speaking, there are two main options for reforming the defence of substantial impairment. The first is to retain the defence, either in its current form, or with some amendment. The second is to abolish the partial defence and recognise a defendant's impaired mental capacity only in the sentencing process.

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Report No 304 (2006), [5.92]-[5.93]. See also NSWLRC Report 82, [3.92]-[3.95], [3.99]-[3.102].

117. Judicial Commission Report, 5-17. Between 1990 and 2004, a plea of guilty to manslaughter on the basis of diminished responsibility was accepted by the prosecution in 45% of cases where the defence was raised: Judicial Commission Report, 6-8, 15-16. See also [4.23] above.

118. See UK Law Commission, *Partial Defences to Murder*, Final Report (2004), [5.18], [5.20], [5.22]; New Zealand Law Commission, Preliminary Paper 41, [127].

119. New Zealand Law Commission Preliminary Paper 41, [135] and see VLRC Report, [5.115]-[5.121]; Law Commission (UK), *Partial Defences to Murder*, Final Report (2004), [5.23]-[5.28]. This argument is not always borne out in practice, as such defendants do not necessarily fulfil the requirement of an "abnormality of mind": see LRCWA Report, 257-258; New Zealand Law Commission Preliminary Paper 41, [136].

120. VLRC Report, [5.115]-[5.121]; LRCWA Report, 252; New Zealand Law Commission Preliminary Paper 41, [135]-[136].



4.61 As the Commission acknowledged in Report 82, the original rationale for the introduction of diminished responsibility has gone. It is no longer necessary for the law to provide a mechanism to enable offenders with significant impairments that fall short of complete mental illness to escape a mandatory life sentence for murder. Discretionary sentences now apply for both murder and manslaughter.<sup>121</sup> In fact, some sentences for murder are less severe than some for manslaughter.

4.62 Therefore, it is fair to say that there is no legal imperative for the existence of the partial defence of substantial impairment. The same considerations regarding the effects of impaired mental functioning that operate to commute a charge of murder to a conviction for manslaughter are taken into consideration in the sentencing process.<sup>122</sup> It is arguable that the outcome for offenders with mental impairments, in terms of the length of sentence, would be roughly the same regardless of whether the conviction was for murder or manslaughter.

4.63 Rather, the issue of whether the partial defence of substantial impairment should remain hinges on two questions more concerned with philosophy than with law, namely:

- should people with significantly impaired mental capacity who kill, but do not meet the requirements of the M’Naghten defence of mental illness, be convicted of manslaughter or the more “blameworthy” charge of murder; and
- should the question relate to verdict, and therefore be open for determination by a jury, or be a matter pertinent to sentencing alone?

4.64 These questions in turn involve consideration of other matters such as:

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121. Although s 61(1) of the *Crimes (Sentencing Procedure) Act 1999* (NSW) provides for a mandatory sentence of life imprisonment upon conviction for murder, discretionary elements still apply. For example, s 61(1) states that a life sentence is only mandatory where the court considers the “level of culpability in the commission of the offence is so extreme that the community interest in retribution, punishment, community protection and deterrence can only be met through the imposition of that sentence”. Furthermore, s 61(1) is subject to the general power of the court to reduce a penalty of mandatory life imprisonment to a specified term: see *Crimes (Sentencing Procedure) Act 1999* (NSW) s 21(1).

122. See ch 8.

- should the distinction between murder and manslaughter remain in NSW; and
- whether the current sentencing options for murder and manslaughter are appropriate for offenders with significant mental impairments who kill.

4.65 These issues must be assessed in the broader context of reform in the areas of sentencing, fitness for trial, and the defence of mental illness.<sup>123</sup>

*The murder/manslaughter distinction*

4.66 Any consideration of a partial defence to murder involves examining the distinction that exists in NSW between murder and manslaughter. In Report 82, we considered a proposal for reform that involved abolishing the distinction between the two offences, and replacing it with a single category of “unlawful homicide”.<sup>124</sup> Within that category, differences in the degree of culpability for an unlawful killing would be taken into account in the sentencing phase, together with any mitigating or aggravating circumstances.

4.67 We stated that the advantage of such a proposal would be to remove the artificial distinction between murder and manslaughter, which can often give rise to unnecessary legal complexity, and to recognise instead that both offences are in fact degrees of a single offence of unlawful killing. We also noted the conflict and inconsistency that can occur in terms of moral and legal culpability. In some cases, the legal classification of a killing as murder does not reflect community views as to the level of moral responsibility. Cases in point include euthanasia and where the offender has a significant mental impairment. In these circumstances, the sentencing court is arguably better placed than a jury to assess the appropriate degree of culpability.<sup>125</sup>

4.68 However, the Commission was persuaded by the arguments in favour of retaining the distinction. Those arguments included the fact that, although complex, the legal distinction between murder and manslaughter has been developed by the courts to a sufficient level of clarity, and is recognised by the community to reflect degrees of moral condemnation. Further, we noted that abolishing the distinction could

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123. See ch 8, 1 and 3, respectively.

124. NSWLRC Report 82, [2.9].

125. NSWLRC Report 82, [2.10]-[2.15].

have the perverse effect of increasing the sentences for manslaughter, as reliance on sentencing patterns alone may not be adequate to differentiate between cases involving different degrees of culpability. The Commission also expressed the view that the fact-finding process may be less rigorous in sentencing than during the trial phase, providing less protection for the offender. The factor that held the most sway was the argument that the abolition of the murder/manslaughter distinction would take the function of determining the level of culpability away from the jury and place it completely within the control of the sentencing judge.<sup>126</sup>

4.69 Clearly, if the distinction between murder and manslaughter were to be removed in favour of a single category of unlawful homicide, this would remove the need for the partial defence of substantial impairment.

4.70 In light of the above discussion, we seek views as to whether the partial defence of substantial impairment remains valid.

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#### Issue 6.40

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Should the defence of substantial impairment be retained or abolished?  
Why or why not?

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126. NSWLRC Report 82, [2.16]-[2.19].



## 5. **Infanticide**

- Overview
- Current operation of infanticide
- NSW Law Reform Commission Report 83
- Issues for discussion

## OVERVIEW

5.1 Infanticide refers to the killing of a child by its mother in circumstances where the mother’s mental state is disturbed. As such, it is relevant to our current inquiry. In NSW, a woman may be charged with the offence of infanticide, or may be charged with murder and raise infanticide as a defence to have the charge commuted to manslaughter. In the latter respect, it resembles the partial defence of substantial impairment.<sup>1</sup>

5.2 Section 22A of the *Crimes Act 1900* (NSW) (“Crimes Act”) provides for both the offence,<sup>2</sup> and partial defence,<sup>3</sup> of infanticide. That section allows a conviction for infanticide rather than murder where a mother kills her baby, aged less than 12 months, while suffering from a mental disturbance resulting from the birth of that child, or from the effects of lactation. The woman is sentenced as if she had been found guilty of manslaughter, the maximum penalty for this offence being penal servitude for 25 years.<sup>4</sup> The infanticide provisions do not prevent the court finding a woman not guilty on the ground of mental illness, provided the requirements for that defence can be satisfied.<sup>5</sup> While the offence of infanticide exists elsewhere,<sup>6</sup> NSW is the only jurisdiction where it operates both as an offence and a partial defence to murder.<sup>7</sup>

5.3 Infanticide provisions were originally introduced in NSW in 1951<sup>8</sup> to offer an appropriate means for women who killed their babies while “temporarily deranged” from the after-effects of childbirth to avoid a conviction for murder and the consequent mandatory punishment of

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1. See ch 4.
  2. *Crimes Act 1900* (NSW) (“Crimes Act”) s 22A(1).
  3. *Crimes Act* s 22A(2).
  4. *Crimes Act* s 24.
  5. See *Crimes Act* s 22A(3). See also [5.6] and ch 3.
  6. See, eg, *Crimes Act 1958* (Vic) s 6; *Criminal Code Act 1924* (Tas) s 165A, 333; *Infanticide Act 1938* (UK) s 1; and *Criminal Code* (Can) s 233. The infanticide provisions in the *Criminal Code Compilation Act 1913* (WA) s 281A and s 287A were repealed by the *Criminal Law Amendment (Homicide) Act 2008* (WA) s 13.
  7. NSW is also the only Australian State to have both infanticide and substantial impairment as partial defences to murder: see [5.29]-[5.31] and ch 4.
  8. By the *Crimes (Amendment) Act 1951* (NSW) s 2(d).

death.<sup>9</sup> The provisions were modelled on United Kingdom legislation developed in the early 20th century, when infant mortality rates were high, illegitimacy was a social stigma, and child killing was not infrequent. Offenders were typically young rape victims or unmarried or deserted mothers experiencing chronic economic hardship. Public sentiment tended towards leniency in such circumstances, with juries refusing to convict the women of murder given the social and economic context of their actions. In the rare event of a guilty finding, pleas for clemency generally resulted in the mandatory death penalty being commuted.<sup>10</sup>

5.4 The *Infanticide Act 1922* (UK) was aimed at preventing the circumvention of the due process of law with regard to women who killed their children, while bringing the law more into line with the public attitude that such crimes should be treated with greater leniency than a prosecution for murder would allow.<sup>11</sup> The Act enabled a woman who killed her newborn child to be tried for manslaughter rather than murder, where she suffered from “puerperal psychosis”, being a severe form of mental disorder associated with childbirth.<sup>12</sup> As such, the 1922 Act provided a psycho-medical rationale for what was essentially a crime contextualised by social and economic factors.

5.5 The 1922 Act was revised and replaced by the *Infanticide Act 1938* (UK), which applied to the death of children up to 12 months old at the hand of their mother, and extended the qualifying mental disorder to disturbances associated with lactation, presumably to justify increasing

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9. NSW, *Parliamentary Debates (Hansard)* Legislative Assembly, 26 September 1951 at 3225.

10. See NSW Law Reform Commission, *Partial Defences to Murder: Provocation and Infanticide*, Report 83 (1997) (“NSWLRC Report 83”) [3.2]-[3.3]. For a more detailed account of the origin of the infanticide provisions, see N Walker, *Crime and Insanity in England* (University Press, 1968) ch 7; R Lansdowne, “Infanticide: Psychiatrists in the Plea Bargaining Process” (1990) 16 *Monash University Law Review* 41 at 43-47; P Bergin, “The Crime of Infanticide: A Case for its Abolition in New South Wales” (Paper submitted for the Research Paper Unit, Faculty of Law, The Australian National University, 7 June 2004); and A Wilczynski, *Child Homicide* (Greenwich Medical Media, 1997) ch 6.

11. Although the perception that the *Infanticide Act 1922* (UK) afforded greater leniency may be more illusory than real, since women were rarely prosecuted or convicted anyway: see Bergin, 7-8.

12. NSWLRC Report 83 [3.6].

the ambit of the provisions beyond newborn babies.<sup>13</sup> The current formulation of the NSW provision draws directly from the 1938 United Kingdom legislation, and has not been amended since its introduction more than half a century ago.

## CURRENT OPERATION OF INFANTICIDE

5.6 Section 22A provides as follows:

(1) Where a woman by any wilful act or omission causes the death of her child, being a child under the age of twelve months, but at the time of the act or omission the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent upon the birth of the child, then, notwithstanding that the circumstances were such that but for this section the offence would have amounted to murder, she shall be guilty of infanticide, and may for such offence be dealt with and punished as if she had been guilty of the offence of manslaughter of such child.

(2) Where upon the trial of a woman for the murder of her child, being a child under the age of twelve months, the jury are of opinion that she by any wilful act or omission caused its death, but that at the time of the act or omission the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to such child or by reason of the effect of lactation consequent upon the birth of the child, then the jury may, notwithstanding that the circumstances were such that but for the provisions of this section they might have returned a verdict of murder, return in lieu thereof a verdict of infanticide, and the woman may be dealt with and punished as if she had been guilty of the offence of manslaughter of the said child.

(3) Nothing in this section shall affect the power of the jury upon an indictment for the murder of a child to return a verdict of manslaughter or a verdict of not guilty on the ground of insanity,<sup>14</sup> or a verdict of concealment of birth.<sup>15</sup>

5.7 Accordingly, the following elements must be present for infanticide to be established:

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13. NSWLRC Report 83 [3.6].

14. This refers to the special verdict of not guilty on the ground of mental illness: see *Mental Health (Forensic Provisions) Act 1990* (NSW) s 38. See also ch 3 for a discussion of the defence and options for reform.

15. See *Crimes Act* s 85.



- the accused must be the natural mother of the victim;
- the victim must be less than twelve months old;
- the accused must have wilfully caused the death of her child; and
- at the time of the killing, the accused must have been suffering from a mental disturbance, which resulted from her not having fully recovered from giving birth, or from the effect of lactation consequent upon the birth.

### Wilful act or omission

5.8 Section 22A requires the commission of a wilful act or omission on the part of the mother resulting in the death of the child. It is silent on the question of whether that act or omission must amount to an intention to kill. Where raised as a partial defence to a charge of murder, this point is of academic significance only, since all elements of murder must be established before the defence is available, including intention to kill or cause grievous bodily harm, or reckless indifference to human life. Where used as a substantive offence, the situation is more problematic. However, it would seem likely that some form of intention would be presumed to be an element of the offence.<sup>16</sup>

### Onus of proof

5.9 Where a woman is charged with the offence of infanticide, the onus of proving the requisite elements beyond a reasonable doubt rests with the prosecution.<sup>17</sup> By contrast, where the accused raises infanticide as a defence, the legislation makes no reference to whether it is the prosecution who must disprove, or the accused who must prove, that the defence is established. In Report 83, we noted that placing the burden of proof on the accused for establishing the defence would be consistent with the defences of mental illness and diminished responsibility, and the presumption of sanity.<sup>18</sup> There is no case law on the point, presumably because s 22 is mostly used as a defence accompanied by a guilty plea.<sup>19</sup>

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16. See NSWLRC Report 83 [3.11]; Paul Ames Fairall and Stanley Yeo, *Criminal Defences in Australia* (4<sup>th</sup> ed, Lexis Nexis, 2005) [16.9].

17. *R v Hatty* [1953] VLR 338, 339.

18. See NSWLRC Report 83 [3.12] note 11. See also Fairall and Yeo [16.13].

19. See [5.10].

## Incidence and outcomes

5.10 The infanticide provisions are rarely used, with only four convictions under s 22A recorded between July 2001 and June 2008.<sup>20</sup> In practice, infanticide operates more often as a defence to a charge of murder rather than being prosecuted as a substantive offence.<sup>21</sup> Convictions are generally obtained via the prosecution’s acceptance of a plea of guilty to infanticide following an indictment for murder, rather than by a jury’s verdict following a trial.<sup>22</sup> Although running counter to the High Court’s instructions that infanticide should be prosecuted as an offence rather than used as a defence,<sup>23</sup> it has been suggested that prosecutors pursue this path because of the difficulty of establishing the elements of the offence to a sufficient degree.<sup>24</sup>

5.11 Despite the maximum penalty being 25 years imprisonment, there are no examples of women convicted of infanticide receiving a custodial sentence. Offenders generally receive a good behaviour bond<sup>25</sup> or community service order.<sup>26</sup> For example, in *R v Cooper*,<sup>27</sup> the defendant, who suffered from a depressive psychosis, received a four year good behaviour bond for killing her seven month old daughter. Simpson J took pains to explain the justification for imposing a non-custodial sentence for a crime involving the death of a child. She noted that the loss of a life must be treated with the utmost gravity, with the courts under an obligation to recognise the sanctity of life and to punish offenders who wrongfully take it.<sup>28</sup>

5.12 However, Simpson J noted the equal responsibility of the court to recognise infanticide as a “form of homicide having particular characteristics and a particular genesis which therefore justifies, in an appropriate case, a different approach to sentencing”, notwithstanding

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20. Figures obtained from the Judicial Commission of NSW’s Judicial Information Research System.

21. See NSWLRC Report 83 [3.13].

22. See, eg, *R v Cooper* [2001] NSWSC 769; and *R v Pope* [2002] NSWSC 397.

23. *R v Hutty* [1953] VLR 338, 339.

24. See Fairall and Yeo [16.14]; and Lansdowne, 48.

25. Imposed under the Crimes (*Sentencing Procedure*) Act 1999 (NSW) s 9. See *R v Cooper* [2001] NSWSC 769; and *R v Pope* [2002] NSWSC 397.

26. See *The Queen v Azzopardi* [2004] VSC 509.

27. [2001] NSWSC 769.

28. [2001] NSWSC 769 [5].

the maximum penalty being the same as that for manslaughter.<sup>29</sup> Her Honour found the case before her to be one which justified a concessional sentence, as the defendant’s background, mental state, and display of remorse and contrition were such that “little real culpability” could be attributed to her.<sup>30</sup>

5.13 A similar outcome occurred in the case of *R v Pope*,<sup>31</sup> where Greg James J stated that the “objective gravity of the crime must be considered in the light of the limited culpability of an offender who bears so little responsibility for their acts”.<sup>32</sup> Further, His Honour expressed the view that any criminal sanction would be an additional burden to the defendant, who would remain stigmatised by her conviction.<sup>33</sup>

## NSW LAW REFORM COMMISSION REPORT 83

5.14 This Commission previously considered infanticide in its 1997 review, entitled *Partial Defences to Murder: Provocation and Infanticide* (Report 83). After considering the arguments for retention and abolition, and the position in other jurisdictions, the Commission recommended that s 22A should be repealed.<sup>34</sup> However, that recommendation was conditional on the partial defence of diminished responsibility,<sup>35</sup> contained in s 23A of the Crimes Act, being retained and reformulated as recommended by the Commission in Report 82.<sup>36</sup>

5.15 The Commission considered that women in a state of mental disturbance who kill their children should be convicted of a less serious offence than murder, given that the often tragic circumstances usually reduce the defendant’s degree of culpability.<sup>37</sup> Nevertheless, we

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29. [2001] NSWSC 769 [6].

30. [2001] NSWSC 769 [6], [18], [24], and [28].

31. [2002] NSWSC 397.

32. [2002] NSWSC 397 [38].

33. [2002] NSWSC 397 [40]. Mrs Pope received a three year good behaviour bond for killing her 12 week old daughter while experiencing a severe post-natal psychotic episode.

34. See NSWLRC Report 83 recommendation 3.

35. As it was then known.

36. See NSWLRC, *Partial Defences to Murder: Diminished Responsibility* Report 82 (1997); and see ch 4.

37. NSWLRC Report 83 [3.15].

considered that infanticide should not remain as a stand-alone offence or partial defence for the following reasons:

- infanticide is no longer necessary to mitigate culpability for murder because the defence of diminished responsibility is capable of covering the same circumstances;<sup>38</sup> and
- the defence of diminished responsibility is a more appropriate means of reducing culpability than infanticide, because infanticide is based on unsound and outmoded notions of mental disturbance, reflects an anachronistic view of women, and is arbitrarily restrictive.<sup>39</sup>

## ISSUES FOR DISCUSSION

5.16 Over the years, a number of law reform and other agencies have debated the merits of infanticide provisions, presenting arguments for both their retention and abolition. Those arguments are summarised below.

### Arguments for retention

5.17 Arguments for retaining infanticide include:

- the benefit of having a separate, gender-specific provision;
- the fact that other offences or defences may not be available or appropriate;
- possible procedural advantages; and
- the possibility that sentences may increase if infanticide were abolished.

#### *A gender-specific provision*

5.18 One advantage of retaining infanticide as a separate offence and/or defence is the benefit of having gender-specific provisions that recognise women's experiences in terms of childbirth and child-raising.<sup>40</sup> In Report 83, we stated that women commonly suffer post-natal depression caused by a number of factors, and that, although expressed narrowly in s 22A in medical terms, the provision operates to allow other social,

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38. NSWLRC Report 83 [3.18]-[3.26].

39. NSWLRC Report 83 [3.27]-[3.30].

40. See NSWLRC Report 83 [3.38]-[3.41].

emotional and economic contributors to a woman's post-natal mental state to be considered.<sup>41</sup> In arguing for the retention of an infanticide offence, the Victorian Law Reform Commission noted that it is “a distinctive kind of human tragedy which required a distinctive response”.<sup>42</sup>

*Inappropriateness of other offences/defences*

5.19 If infanticide were to be abolished as an offence, women who kill their children would be prosecuted for murder, if at all. If convicted, their mental state, along with other objective and subjective factors, would be considered as either aggravating or mitigating factors in sentencing.<sup>43</sup> Given the tragic and unique nature of infanticide, there has been widespread criticism of the practice of prosecuting women for murder in such cases.<sup>44</sup> As long ago as 1953, Barry J instructed a jury to acquit an unmarried 19 year old woman of murder, and instead consider whether she was guilty of manslaughter or infanticide. His Honour expressed hope that “in future, where the facts are of the kind that have been revealed by the evidence here, the Crown will not present a woman upon the charge of having murdered her child”.<sup>45</sup>

5.20 A woman, who would otherwise rely on infanticide, may be able to rely on the defence of substantial impairment, if she can prove that her mental capacity was impaired to the extent that she was unable to understand or control her actions at the time of the killing, or to know that they were wrong, by reason of some “abnormality of mind”.<sup>46</sup> In such cases, the charge of murder would be reduced to manslaughter, achieving the same outcome as an infanticide defence. While substantial impairment can, and does, cover many situations currently dealt with

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41. NSWLRC Report 83 [3.39].

42. Victorian Law Reform Commission, *Defences to Homicide: Final Report* (2004) [6.19], [6.22].

43. See ch 8 for a discussion of sentencing principles and options concerning offenders with cognitive and mental health impairments.

44. See Victorian Law Reform Commission, *Defences to Homicide: Final Report* (2004) [6.21].

45. *R v Hatty* [1953] VLR 338, 339-340. Note, however, views opposed to contention that women who kill their children do not warrant having a charge of murder laid: see Bergin, 25-26.

46. Crimes Act s 23A and ch 4.

under the infanticide provisions,<sup>47</sup> some argue that it may not be appropriate in all circumstances.<sup>48</sup> In Report 83, we noted that subsuming infanticide into the defence of substantial impairment would focus attention on the woman’s individual mental state rather than the broader social and economic context that generally characterises infant homicide.<sup>49</sup>

5.21 Alternatively, in the absence of the infanticide provisions, a woman could rely on the complete defence of mental illness.<sup>50</sup> However, to qualify for the defence, her mental state would need to be significantly more impaired than the “disturbance” of mind required under s 22A.<sup>51</sup> Also, it may be a less attractive or appropriate option given the fact that, currently, an acquittal on the ground of mental illness usually results in indeterminate disposition in prison.<sup>52</sup>

#### *Procedural benefits*

5.22 In Report 83, we put forward the view that, in theory, there may be procedural advantages for the accused in having separate infanticide provisions.<sup>53</sup> If a woman were to be charged with the offence of infanticide, she would avoid the arguably greater trauma that would accompany an indictment for murder, and the burden of proving the offence would rest with the prosecution. If infanticide were abolished and the accused had to rely on the defence of substantial impairment, she

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47. See [5.25] and [5.30] for a discussion of cases involving mothers who kill their children relying on the defence of substantial impairment.

48. NSWLRC Report 83 [3.40]-[3.41].

49. NSWLRC Report 83 [3.41]. We also noted that, while the infanticide provisions reflect gender-specific concerns, the broader social and economic context in which infanticide operates could be considered under the defence of substantial impairment: see also [5.29]-[5.31].

50. Note that a special acquittal on the ground of mental illness is currently available even where the defence of infanticide is argued: see s 22A(3).

51. See ch 4 for a discussion of the defence of mental illness. Note, however, that it is possible for a woman to have a mental condition that would satisfy the test for both infanticide and the defence of mental illness. For example, in the cases of *R v Cooper* [2001] NSWSC 769 and *R v Pope* [2002] NSWSC 397, discussed at [5.11]-[5.13], both women had a severe psychosis which would arguably have been a qualifying condition for the defence of mental illness.

52. For the Commission’s options for reform regarding the detention of people found not guilty on the ground of mental illness, see ch 7.

53. NSWLRC Report 83 [3.42].

would bear the burden of proving that, at the time of the killing, her mental state was so diminished as to rob her of the capacity to control her actions, or to know that they were wrong.<sup>54</sup>

5.23 We note, however, that this has more academic than actual significance, since infanticide is rarely prosecuted as an offence.<sup>55</sup>

*Danger of more severe sentences*

5.24 A further argument in favour of retaining the infanticide provisions is the concern expressed by some commentators that sentences might increase if the provisions were abolished.<sup>56</sup> Indeed, while infanticide carries the same maximum penalty as manslaughter, there is no record of a woman receiving a custodial sentence for infanticide.<sup>57</sup> The same cannot be said for manslaughter.

5.25 There are examples of women who have killed their children and were convicted of manslaughter on the basis of substantial impairment receiving custodial sentences.<sup>58</sup> In *R v RG*,<sup>59</sup> Buddin J imposed a custodial sentence on a woman who drowned her 7 month old daughter. After considering all of the mitigating factors and sentences for comparable infanticide cases, His Honour noted that “nothing less than a full-time custodial sentence can be countenanced”. He noted that this was consistent with a plea of manslaughter, which acknowledged that a human life had been taken “as a consequence of a deliberate and voluntary act, performed either with an intent to kill or to cause grievous bodily harm or with reckless indifference to human life”.<sup>60</sup>

5.26 However, there is not always a disparity between sentences for infanticide and those for manslaughter. A number of examples exist of

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54. See ch 4 for a discussion of the elements of the defence of substantial impairment.

55. See [5.10] and NSWLRC Report 83 [3.42].

56. See Lansdowne, 60; and NSWLRC Report 83 [3.44]-[3.47].

57. See [5.11] for a discussion about the sentencing patterns for infanticide.

58. See *R v Sette* [2000] NSWSC 648 (two year suspended sentence); and *R v RG* [2006] NSWSC 21 (three year sentence with 15 month non-parole period). See also *R v Dawes* [2004] NSWCCA 363, where the majority of the Court of Criminal Appeal considered the trial judge to have erred in law in not imposing a full-time custodial sentence on the offender for the manslaughter of her 10 year old son.

59. [2006] NSWSC 21.

60. [2006] NSWSC 21 [52].

women convicted of manslaughter on the basis of substantial impairment receiving non-custodial sentences similar to those received in infanticide cases. These are discussed further at paragraph [5.30] below.

## Arguments for abolition

### *Unsoundness of underlying medical basis*

5.27 Section 22A is based on the finding of a mental disturbance in the accused caused by either childbirth or lactation. Both of these factors are widely disregarded as a causative basis for mental disorder.<sup>61</sup> In particular, the notion of “lactational insanity” is not supported by any medical basis.<sup>62</sup> While post-natal depression has increasingly been recognised, there is no evidence to suggest that it can be attributed to the after-effects of childbirth.<sup>63</sup> Women may experience symptoms of depression, stress and anxiety for a number of reasons following the birth of a child, including physical, social, cultural, emotional, and economic factors.<sup>64</sup> In Report 83, the Commission expressed the view that in practice, medical experts may be forced to distort their diagnoses to point to a causative link between childbirth and mental disturbance.<sup>65</sup>

### *Outmoded ideological basis*

5.28 The infanticide provisions were developed at a time when “madness” and criminality in women was seen as connected to the female reproductive system, with women depicted as “victims of their own biology”.<sup>66</sup> As such, coupled with its dubious medical validity, s 22A can be seen as an anachronistic relic that has little relevance outside of its original historical context.<sup>67</sup> In Report 83, we considered that the benefit to women afforded by a gender-specific provision capable of recognising the physical, social and economic circumstances experienced by women

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61. See B McSherry, “The Return of the Raging Hormones Theory: Premenstrual Syndrome, Postpartum Disorders and Criminal Responsibility” (1993) 15 *Sydney Law Review* 292; NSWLRC Report 83 [3.27]-[3.30]; and Victorian Law Reform Commission, *Defences to Homicide: Final Report* (2004) [6.32].

62. As a result, references to lactation were removed from the Victorian legislation: see *Crimes Act 1958* (Vic) s 6.

63. See Bergin, 18.

64. NSWLRC Report 83 [3.29]; and Victorian Law Reform Commission, *Defences to Homicide: Final Report* (2004) [6.33]-[6.34].

65. NSWLRC Report 83 [3.30].

66. Bergin, 12; and Fairall and Yeo [6.16].

67. NSWLRC Report 83 [3.31].



who have recently given birth, is outweighed by the discriminatory basis of the provision and its misplaced assumptions.<sup>68</sup> We also questioned the “wider consequences of a law which makes specific concessions to women based on a notion of inherent ‘disabilities’”.<sup>69</sup>

*Separate provisions are unnecessary*

5.29 The fact that the infanticide provisions are rarely used is, perhaps, the best argument pointing to their lack of utility. However, it is also significant that the infanticide provisions were introduced in NSW over two decades before the partial defence of substantial impairment. Consequently, infanticide was, at that time, the only way of ensuring that women who killed their children while experiencing some form of mental disorder could be convicted of something other than murder. However, a strong argument can be made that the infanticide provisions are now unnecessary, since the substantial impairment defence is capable of covering the same ground. As noted at paragraph [5.14]-[5.15] above, this argument swayed the Commission to recommend the abolition of the infanticide provisions in 1997.

5.30 Substantial impairment has been used as a defence in circumstances which closely resemble those that would satisfy the infanticide test, with the main difference being the age of the child.<sup>70</sup> In most cases, the woman received a similar non-custodial penalty to that received by offenders who relied on s 22A.<sup>71</sup>

5.31 In Chapter 4, we discuss substantial impairment and ask whether the defence should be retained. In the event that both substantial impairment and infanticide were abolished, the contextual factors surrounding the killing of children by their mothers could be considered during the sentencing phase. In performing their sentencing functions, judges exercise a considerable discretion that requires them to consider a range of circumstances, such as the offender’s background and mental state at the time of the offence. Given that the maximum penalty for infanticide and substantial impairment is the same as that for murder and manslaughter, it is arguable that consideration of the subjective circumstances of the offender during sentencing could achieve the same

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68. NSWLRC Report 83 [3.31]-[3.33].

69. NSWLRC Report 83 [3.32].

70. That is, the child was older than 12 months.

71. See, eg, *R v Li* [2000] NSWSC 1088; and *R v Richards* [2002] NSWSC 415.

outcome as if the infanticide or substantial impairment provisions were available.

5.32 It should also be remembered that the complete defence of not guilty on the ground of mental illness may still be relied upon in certain circumstances if the infanticide provisions were abolished.

### Options for reform

5.33 There are two main options for reforming the law of infanticide: namely, abolish s 22A, or retain the section, with or without revision. Western Australia recently abolished its infanticide provision following a recommendation by the Law Reform Commission of Western Australia.<sup>72</sup> That Commission considered that there is “sufficient room within its recommended sentencing and defences framework to appropriately show mercy”.<sup>73</sup> Abolition was also recommended by the Model Criminal Code Officers Committee in 1998.<sup>74</sup>

5.34 Alternatively, s 22A could be retained and/or revised. The options for reformulating the provision include:

- removing the arbitrary restriction on the 12 month age restriction;<sup>75</sup>
- removing the outdated reference to lactation;<sup>76</sup>
- revising the qualifying mental state, including removing the need for the disturbance to be caused by the birth;
- extending the application of the provision beyond that of the natural mother; and/or
- consideration of lowering the maximum penalty.<sup>77</sup>

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72. The *Criminal Code* (WA) s 281A and 287A were repealed by the *Criminal Law Amendment (Homicide) Act 2008* (WA) s 11. See Law Reform Commission of Western Australia, *Review of the Law of Homicide: Final Report* Project no 97 (2007) recommendation 13.

73. Law Reform Commission of Western Australia, *Review of the Law of Homicide: Final Report* Project no 97 (2007) 117.

74. See Model Criminal Code Officers Committee, *Fatal Offences Against the Person* Discussion Paper (1998) ch 5.

75. See, eg, *Crimes Act 1958* (Vic) which provides for a 2 year age limit: s 6(1)(a); and *Crimes Act 1961* (NZ) which applies to children under 10 years: s 178.

76. See, eg, *Crimes Act 1958* (Vic) s 6; and *Criminal Code Act 1924* (Tas) s 165A.

5.35 We seek views as to whether s 22A should be abolished, retained, or reformulated, and if so, how.

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**Issue 6.41**

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Is there a continuing need for infanticide to operate, either as an offence in itself, or as a partial defence to murder?

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**Issue 6.42**

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Should the continued operation of the infanticide provisions be conditional on the retention of the partial defence of substantial impairment?

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**Issue 6.43**

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If infanticide is to be retained, should it be recast? If so, how?

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77. Eg, in Victoria, the maximum penalty for infanticide is 5 years, as opposed to 25 in NSW.



6. **Powers of the court following a qualified finding of guilt at a special hearing or a verdict of not guilty by reason of mental illness**

- Introduction
- Historical development
- Orders made during the court process
- What orders should be available?
- What principles and factors should the court consider?
- Ancillary issues

## INTRODUCTION

6.1 In Chapters 1 and 2, we consider the meaning of fitness to be tried and the “special hearing” procedure which is adopted in lieu of an ordinary trial in cases where the accused person is unfit to be tried. In Chapter 3, we review the defence of “mental illness”. In this chapter we examine the orders that the court may make in cases where the accused person is unfit to be tried and is not acquitted at the special hearing, or is found not guilty by reason of mental illness.

6.2 The legislative provisions relating to unfitness and the defence of mental illness apply only in the District and Supreme Courts. The more limited powers of the Local Court in such cases are discussed towards the end of the chapter.

6.3 A feature which is common to both groups – those who are unfit and “guilty” on the limited evidence available, and those who are “not guilty by reason of mental illness” – is the absence of established criminal responsibility. In the case of the unfit, that is because the person cannot be afforded a fair trial so that his or her criminal responsibility is not fairly and conclusively established. In cases where the person is found “not guilty by reason of mental illness”, it is because the evidence proves that the person, at the time of the alleged offence, was not responsible in law for his or her conduct.

6.4 In this chapter, we outline:

- the historical development of the current law, from which the rationales of various features of the present system can be discerned;
- the orders currently available to the court following a limited finding of guilt at a special hearing, or a verdict of not guilty by reason of mental illness;
- options for reforming the current range of orders;
- the relevant principles and discretionary considerations, in particular, the concept of “risk of harm”; and
- ancillary matters, including procedures to assist the decision-making process, appeals, and the powers of the Local Court.

6.5 In most instances, when a court orders detention or conditional release of a person who has been found unfit to be tried and not acquitted, or not guilty by reason of mental illness, the person becomes a

forensic patient and is subject to the jurisdiction of the Forensic Division of the Mental Health Review Tribunal (“the MHRT”). This chapter is, therefore, intended to be read in conjunction with Chapter 7, which examines certain aspects of the forensic mental health system, including the powers of the MHRT in respect of forensic patients. Those powers relevantly include: the power to order release (and conditions thereof) or detention (including the place of detention), and to require the person to undergo medical treatment even if the person does not consent (“compulsory treatment”).

## HISTORICAL DEVELOPMENT

6.6 In 1800, the English Parliament passed *An Act for the Safe Custody of Insane Persons Charged with Offences* (“the 1800 Act”).<sup>1</sup> The 1800 Act provided that, if a person charged with high treason, murder or felony was acquitted on the basis of “insanity” at the time of the offence, the court was required to order the person to be detained in “strict custody, in such place and in such manner as to the court shall seem fit, until his Majesty’s pleasure shall be known”.<sup>2</sup> The 1800 Act made similar provision for the detention, at the Sovereign’s pleasure, of accused people who were unfit to plead or unfit to be tried. The latter provision applied to all indictable offences.<sup>3</sup> Those provisions largely reflected the practice that had developed at common law, but additionally, and for the first time, gave courts a power to determine the initial place and manner of detention.<sup>4</sup>

6.7 Two relevant rationales can be discerned from those and other provisions of the 1800 Act.<sup>5</sup> First, implicit acceptance of the idea,

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1. *An Act for the Safe Custody of Insane Persons Charged with Offences 1800*, 39 & 40 Geo III, c 94.
  2. *An Act for the Safe Custody of Insane Persons Charged with Offences 1800*, 39 & 40 Geo III, c 94, s 1.
  3. *An Act for the Safe Custody of Insane Persons Charged with Offences 1800*, 39 & 40 Geo III, c 94, s 2. Contrast s 1, which applied only to cases of “high treason, murder or felony”.
  4. See *The Trial of James Hadfield* (1800) 27 State Tr 1281, 1353-1356; M Hale, *History of the Pleas of the Crown* (1736) vol 1, 34-36; N Walker, *Crime and Insanity in England* (1958) vol 1, 80-81.
  5. The Act also provided for a Justice of the Peace to issue a warrant for the detention of a person “discovered and apprehended under circumstances that denote a derangement of mind and a purpose of committing some crime for

developed by the common law, that there may be circumstances in which a person cannot be fairly tried because of a cognitive or mental health impairment subsisting at the time of the trial, or circumstances in which a person cannot be held criminally responsible (and therefore punishable) because of an impairment existing at the time of the offence. Secondly, by providing for detention of such persons, the Act evinced an intention to ensure the safety of the community.<sup>6</sup>

6.8 The 1800 Act, being an act of the Imperial Parliament, applied in NSW until local laws were made which essentially copied its provisions.<sup>7</sup> The framework established by the 1800 Act – automatic, indefinite detention at the discretion of the executive government – was preserved by subsequent enactments.<sup>8</sup>

6.9 The *Crimes (Mental Disorder) Amendment Act 1983* (NSW) (“the 1983 Act”) established, for the first time, a different regime for persons who were found unfit to be tried. The 1983 Act introduced the special hearing procedure, to afford the unfit person an opportunity for acquittal.<sup>9</sup> It also introduced the sentencing-based limiting term in relation to unfit persons who are found, at a special hearing, to have committed an offence.<sup>10</sup> Like the special hearing, the limiting term sought to reduce the potential for unfairness in a system under which unfit people, who may have been innocent, were detained indefinitely without trial.<sup>11</sup> The limiting term was

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which, if committed, such person would be liable to be indicted”, with restrictions on the grant of bail to persons so detained: s 3 (compare *Mental Health Act 2007* (NSW) s 22); and for the detention, on executive order, of “insane” persons who appeared to pose a threat to the Sovereign’s life: s 4.

6. See *The Trial of James Hadfield* (1800) 27 State Tr 1281, 1354-1355 (Lord Kenyon CJ), the case which precipitated the passage of the 1800 Act.
7. See *Lunacy Act 1878* (NSW) 42 Vic No 7, s 58, 59, sch 1; H B Bignold, *Imperial Statutes in Force in New South Wales*, Vol 1 (Law Book Company of Australasia Ltd, 1913), 110-111; L Craze, *The Care and Control of the Criminally Insane in New South Wales: 1788-1987*, (D Phil Thesis, UNSW, 1993) 394.
8. See *Lunacy Act 1878* (NSW) s 58, 59, sch 1; *Lunacy Act 1898* (NSW) s 65, 66, sch 1; *Mental Health Act 1958* (NSW) pt 7 especially s 23, 24, 26, 29; and see generally J H McClemens and J M Bennett, “Historical Notes on the Law of Mental Illness in New South Wales” (1962)-(1964) 4 *Sydney Law Review* 49.
9. See ch 2 for a discussion of the special hearing.
10. *Crimes (Mental Disorder) Amendment Act 1983* (NSW) s 3, sch 1 cl 3 inserting *Crimes Act 1900* (NSW) s 428P, 428Q (now repealed).
11. Dr G Edwards, Chair, NSW Health Commission Mental Health Act Review Committee, *Report* (1974) 89-91; *Crimes (Mental Disorder) Amendment Act 1983*



intended to ensure “that the person should not be detained for an offence because of his unfitness for any period in excess of that [for] which he would have been detained had he been of sound mind and found guilty of a similar offence”.<sup>12</sup>

6.10 Another important development in 1983 was the establishment of the MHRT, with responsibilities including an obligation to review periodically persons who had been found not guilty by reason of mental illness or who were unfit to be tried, and to make recommendations to the executive government concerning each patient’s treatment, detention or release.<sup>13</sup> Previously, there had not been any adequate system for regular review of persons detained at the Governor’s pleasure, leading to instances of people being “forgotten” by the executive.<sup>14</sup> Release by the executive was also subject to arbitrary political considerations,<sup>15</sup> which led to prolonged detention of many persons who no longer posed a risk to the community.<sup>16</sup>

6.11 In 2003, the *Mental Health (Criminal Procedure) Act 1990* (NSW) (“the MHCPA”) was amended to provide the court with a discretion to order a person’s release, with or without conditions, in cases where he or she was found not guilty by reason of mental illness, instead of mandatory detention. The provision was amended in 2005 to prohibit the court from ordering the person’s release unless satisfied “that the safety of the person or any member of the public [would] not be seriously

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(NSW) s 3, sch 1 cl 3 inserting *Crimes Act 1900* (NSW) s 428P(1)(b); see also Hon Greg James QC, *Review of the Forensic Provisions of the Mental Health Act 1990 and the Mental Health (Criminal Procedure) Act 1990*, Consultation Paper (2006) 10, 28-29.

12. NSW, *Parliamentary Debates*, Legislative Assembly, 24 November 1982, 3005-3006 (the Hon Laurie Brereton, MP). An amended version of the Bill was passed in 1983: see Legislative Assembly, 22 November 1983, 3089-3090, 3110-3112.
13. *Mental Health Act 1983* (NSW) pt 3, pt 7.
14. Craze, 197-201, 287-289, 690-702.
15. See *State of South Australia v O’Shea* (1987) 163 CLR 378, 388-389 (Mason CJ), 402, 405 (Wilson and Toohey JJ), 410-411 (Brennan J); Craze, ch 5-6.
16. Hon Greg James QC, *Review of the NSW Forensic Mental Health Legislation*, Report (2007) [5.10], [5.31]-[5.33], [5.38]-[5.41] (“the James Report”); NSW Law Reform Commission, *People with Intellectual Disability and the Criminal Justice System*, Report No 80 (1996) [5.45] (“NSWLRC Report 80”); Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness*, Report of the National Inquiry into the Human Rights of People with Mental Illness (1993) 799-800.

endangered”.<sup>17</sup> The 2003 and 2005 amendments reflected a legislative intention to balance the safety of the community, on the one hand, with the right to liberty of the person who has been found not guilty by reason of mental illness, on the other.

6.12 The *Mental Health Legislation Amendment (Forensic Provisions) Act 2008* (NSW) commenced on 1 March 2009. It renamed the MHCPA as the *Mental Health (Forensic Provisions) Act 1990* (NSW) (“the MHFPA”). Under the MHFPA there is no change to the orders available to the court in cases where the person is unfit or is found not guilty by reason of mental illness. However, there are a number of changes to the management of forensic patients. The most significant is the establishment of a special Forensic Division of the MHRT which has the power – previously held by the executive government – to make orders for the care, detention and release of forensic patients.<sup>18</sup> The functions and powers of the Forensic Division of the MHRT are considered in Chapter 7.

## ORDERS MADE DURING THE COURT PROCESS

6.13 In this part of the chapter we outline the orders that the District or Supreme courts may make in relation to people who are unfit to be tried and who are found, on the limited evidence available at a special hearing, to have committed an offence. We also examine the provisions applying to people found not guilty by reason of mental illness at a trial or special hearing; and we highlight the major differences between the arrangements for those two groups.

### People unfit to be tried and not acquitted at a special hearing

6.14 If a person is unfit to be tried in the District or Supreme Court, the court may hold a “special hearing”, which is a substitute trial procedure intended to afford the accused an opportunity for acquittal.<sup>19</sup> At a special hearing, there are three possible outcomes. The person may be acquitted or found not guilty by reason of mental illness, both of which have the

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17. *Mental Health (Criminal Procedure) Amendment Act 2005* (NSW) sch 1 [23].

18. See *Mental Health (Forensic Provisions) Act 1990* NSW (“the MHFPA”) pt 5 especially s 73. Previously, the MHRT could only make recommendations about forensic patients to the Minister for Health. Orders relating to care, treatment, detention or release of forensic patients were made by the “prescribed authority”, being either the Governor or the Minister for Health.

19. See detailed discussion in ch 4.

same effect as if the finding had been made at an ordinary trial.<sup>20</sup> The third possibility is that the court may find that, “on the limited evidence available, the accused person committed the offence charged” or an offence available as an alternative.<sup>21</sup>

6.15 Here, we discuss the orders that the court may make in respect of the third category, to whom we refer as “persons unfit to be tried and not acquitted” (“UNA”).<sup>22</sup> First, we consider the orders available to the court, and secondly, the principles which the court must apply when deciding what order to make.

*Orders the court may make*

6.16 If a person is UNA, the court must indicate whether, at an ordinary trial, it would have imposed a sentence of imprisonment.<sup>23</sup> If the court would not have imposed a sentence of imprisonment, the court “may impose any other penalty or make any other order it might have made on conviction of the person for the relevant offence in a normal trial of criminal proceedings”.<sup>24</sup> The non-custodial orders available to the court include: dismissing the charge; recording the finding with no other penalty imposed; deferral of sentencing for up to two years for the purpose of the offender’s rehabilitation, participation in an intervention program or for any other purpose the Court considers appropriate; a fine; a good behaviour bond; and a community service order.<sup>25</sup> It appears that

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20. If the person is acquitted, he or she is free to go: see MHFPA s 22, 26, 52(1)(a), 54. If the person is found NGMI, the orders available are the same as if the finding had been made at an ordinary trial: s 22(1)(b), (2).

21. MHFPA s 22(1)(c)-(d), (3); and see ch 1.

22. The description “unfit to be tried and not acquitted” requires some explanation, in two respects. First, it does not include people found NGMI following a special hearing (working on the premise that NGMI is an acquittal, albeit not an outright one), unless specific reference is made to that context. Secondly, the use of this phrase is compatible with two possible reforms, raised for consideration in previous chapters, namely: (i) that the finding that “on the limited evidence available, the accused person committed” an offence be changed to a finding that “the person was unfit to be tried and not acquitted”: see [2.35] and Issue 6.18; and (ii) that the special hearing be substantially modified or even abolished: see [2.12]-[2.18].

23. MHFPA s 23(1).

24. MHFPA s 23(2).

25. *Crimes (Sentencing Procedure) Act 1999* (NSW) (“CSPA”) s 8-11, 14-15, pt 7, pt 8.

certain other orders, such as home detention and suspended sentences, might not be available because of applicable procedural requirements.<sup>26</sup>

6.17 If the court makes a non-custodial order, the court must notify the MHRT.<sup>27</sup> However, the person does not then become (or cease to be) a forensic patient.<sup>28</sup> If the person breaches a condition of a non-custodial order, the court must reapply the provisions of the MHFPA, rather than dealing with the breach according to the provisions of the relevant sentencing legislation.<sup>29</sup> Later in the chapter, we consider whether the definition of “forensic patient” should be amended to include a person who is UNA and in respect of whom a non-custodial order is made.<sup>30</sup>

6.18 If the court would have sentenced the person to imprisonment, it must nominate a “limiting term”, being the best estimate of the sentence the court would have imposed if the person had been fit to be tried and had been found guilty of the offence at an ordinary trial.<sup>31</sup> The limiting term is equivalent to the *total* sentence that would have been imposed, that is, the total of the non-parole period and the balance of the term.<sup>32</sup> The court cannot set a minimum term (equivalent to the non-parole

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26. The power to order periodic detention, home detention, drug treatment detention and suspended “sentences” arises only after a sentence of imprisonment is imposed: see CSPA s 5A, 6(1), 7(1), 12(1); *Dinsdale v The Queen* (2000) 202 CLR 321, 329-330, 346. If a person is UNA, the power to make an order under the CSPA does not arise if the court determines that a sentence of imprisonment is warranted: see MHFPA s 23(1)-(2), 24, 27 (previously MHCPA s 23(1)-(2), 24, 27); *Warren v The Queen* [2009] NSWCCA 176, [19]-[20]; but compare G James, J Feneley and S Hanson, “The *Mental Health Legislation Amendment (Forensic Provisions) Act*” (2009) 21(3) *Judicial Officers Bulletin* 19, 21. Consider also the interaction between MHFPA s 22(3)(a) and CSPA s 10, 10A.

27. MHFPA s 23(7).

28. MHFPA s 42, 52(1)(b).

29. *Smith v The Queen* [2007] NSWCCA 39, and MHFPA s 23. See and compare the provisions for breach of a forensic patient conditional release order, described at [7.22]-[7.23].

30. See [6.47].

31. MHFPA s 23(1)(b). Setting a limiting term is a somewhat artificial exercise, since it requires the court to impose a sentence of detention in relation to a person whose criminal responsibility cannot be established: see NSWLRC Report 80, [5.41].

32. See MHFPA s 23(1)(b). See also *Mitchell v The Queen* (1999) 108 A Crim R 85, 91-92; *R v Mailes* (2004) 62 NSWLR 181, 186-190.

period, or on some other basis).<sup>33</sup> The rationale is that a person subject to a limiting term is reviewed every six months by the MHRT which may, if satisfied that the person does not present a danger to him or herself or the community, release the person (conditionally or unconditionally) prior to the expiry of the limiting term.<sup>34</sup> Issues relating to the conceptual basis and practical operation of the limiting term are discussed in Chapter 7.

6.19 When a court sets a limiting term, it must refer the person to the MHRT and may make “such order with respect to the custody of the person as the court considers appropriate”.<sup>35</sup> It is not clear what principles or factors the court should have regard to when making that interim order. The MHRT must determine the nature of the person’s cognitive or mental health impairment and notify the court as to whether it can be treated in a mental health facility and, if so, whether or not the person objects to being detained there.<sup>36</sup>

6.20 Upon receiving the MHRT’s recommendations, the court may make an order under s 27 of the MHFPA that the person be detained, and may specify the place of that detention, either in a mental health facility or “a place other than a mental health facility”, which is usually a prison.<sup>37</sup> If the court makes an order under s 27, the person becomes (or continues to be) a forensic patient.<sup>38</sup>

6.21 The court has a discretion not to make an order for detention under s 27, with the result that the person must be released unconditionally.<sup>39</sup> However, that discretion may be more theoretical than real, as it would be rare for the court to regard unconditional discharge as an acceptable

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33. *Mitchell v The Queen* (1999) 108 A Crim R 85, 90-92; MHFPA s 23(6); contrast CSPA pt 4 div 1, especially s 44, 50.

34. *Mitchell v The Queen* (1999) 108 A Crim R 85, 90-92; *R v Mailes* (2004) 62 NSWLR 181, [33]-[41]; and see [7.48]-[7.55].

35. MHFPA s 24(1). If the court orders detention, the person remains or becomes a forensic patient: MHFPA s 42(a)(i).

36. MHFPA s 24(2)-(3). Later in the chapter, we consider whether this mechanism for obtaining recommendations from the MHRT remains necessary: see [6.85]-[6.92].

37. MHFPA s 27; and see *R v AN (No 2)* (2006) 66 NSWLR 523, [45]-[56]. As to the use of prisons as a place of detention for forensic patients, see [7.48]-[7.55].

38. MHFPA s 42.

39. *R v AN (No 2)* (2006) 66 NSWLR 523, [57]-[62]; and see MHFPA s 51(1)(a), 54. See also *Mailes v Director of Public Prosecutions* [2006] NSWSC 267.

outcome in a case where a sentence of imprisonment would have been imposed at an ordinary trial.

6.22 Court orders in cases where the person is UNA are subject to appeal in the same way as a sentence imposed following conviction at an ordinary trial.<sup>40</sup>

6.23 There is currently no express requirement for the court to inform the MHRT of the terms of the court's final orders under s 27 in relation to a person who is UNA.<sup>41</sup> This appears to be a legislative oversight.

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#### Issue 6.44

Should the MHFPA be amended to provide a mechanism and/or requirement for the court to notify the MHRT of the terms of its order under s 27 of the MHFPA?

#### *Principles for decision-making*

6.24 Since the MHFPA requires the court to make the order that it would have made had the person been convicted at an ordinary trial, the choice between a custodial or non-custodial order, what non-custodial order to make, and the length of a limiting term, are governed by sentencing principles.<sup>42</sup> Sentencing considerations include the general principles of retribution, denunciation, objective criminality, proportionality, and parity with co-accused,<sup>43</sup> as well as the special principles that apply when sentencing offenders with cognitive and

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40. See [6.94]-[6.96].

41. Contrast MHFPA s 39(3). See also James Report, [7.5]-[7.9], recommendation 18; and *Inquest into the death of Scott Ashley Simpson* (Unreported, NSW Coroner's Court, Deputy State Coroner Magistrate Pinch, 17 July 2006) 16-17, recommendation 10.

42. *Mitchell v The Queen* (1999) 108 A Crim R 85, 93-95; *R v Mailes* (2003) 142 A Crim R 353; *Courtney v The Queen* [2007] NSWCCA 195, [12]-[18]; see, eg, *Smith v The Queen* [2007] NSWCCA 39, [77]-[90]; *R v Adams* [2002] NSWCCA 448. Different principles apply when the court is deciding what order to make in respect of a person who has been found NGMI: see MHFPA s 39 discussed at [6.32]-[6.35]. See ch 8 for a discussion of sentencing principles and options.

43. See CSPA s 3A; and see generally NSW Law Reform Commission, *Sentencing*, Discussion Paper 33 (1996) ch 3.

mental health impairments.<sup>44</sup> The requirement to apply a sentencing approach suggests that the standard of “reasonable doubt” would apply to matters adverse to the person, and the balance of probabilities to favourable matters.<sup>45</sup>

6.25 The court must consider *only* the subjective features that are in evidence before the court.<sup>46</sup> If the condition that renders the person unfit for trial also limits his or her ability to express remorse or contrition, the court must deal with the case as one where those mitigating features are absent.<sup>47</sup> Similarly, the court may be unaware of other mitigating circumstances relating to the offending conduct because of the person’s inability to give an account of events. Nor is there any possibility of a discount for an early plea of guilty, due to the legislative presumption that the person would have pleaded not guilty.<sup>48</sup>

*Relevance of sentencing principles to the decision whether to detain or release*

6.26 There are two separate questions to be answered by the court when a person appearing before it is UNA. First, should a custodial or non-custodial disposition option be ordered, and secondly, how long should the person be detained? The relevance, if any, of sentencing principles to

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44. The special principles applicable to offenders with cognitive and mental health impairments are discussed in ch 8.

45. *R v Storey* [1998] 1 VR 359, 369; *R v Olbrich* (1999) 199 CLR 270, [27].

46. *Mitchell v The Queen* (1999) 108 A Crim R 85, 95-97. The Court of Criminal Appeal rejected the idea of presumptions in favour of the accused person, apparently on the basis that such presumptions would prevent a sentencing court from taking notice of actual facts.

47. *Mitchell v The Queen* (1999) 108 A Crim R 85, 95-97; *R v Mailes* (2003) 142 A Crim R 353, 362. The importance of subjective features to sentencing are illustrated by the cases of *R v Wilson* [2002] NSWSC 297; [2004] NSWSC 370; [2004] NSWSC 597. At a special hearing on a charge of felony murder, Wilson was “sentenced” to a limiting term of 18 years. He subsequently became fit, pleaded guilty and was able to give evidence of his motives and intentions. He was convicted of murder with intention to cause grievous bodily harm, rather than the more serious charge of felony murder. As a result, he was sentenced to 12 years imprisonment (increased on appeal to 15 years: (2005) 153 A Crim R 257), significantly less than the original limiting term.

48. MHFPA s 21(3); *Mitchell v The Queen* (1999) 108 A Crim R 85, 95-97. See ch 2 for a discussion of the procedures and presumptions that apply to special hearings. As to the sentencing discount to which an offender who pleads guilty may be entitled, see the guideline judgment *R v Thomson; R v Houlton* (2000) 49 NSWLR 383 and see *Criminal Case Conferencing Trial Act 2008* (NSW) pt 4.

each of those questions requires separate examination.<sup>49</sup> In Chapter 7, we consider alternatives to sentencing principles as a basis for setting a limiting term.

6.27 With regard to the first question, a strong argument can be made that sentencing principles are not an appropriate basis for deciding whether or not to detain the person. Sentencing principles exist for the purpose of determining what punishment is appropriate to the particular circumstances of a proven criminal offence. The finding that is returned at a special hearing where the person is not acquitted is a qualified finding that, on the limited evidence available, the accused person committed an offence.<sup>50</sup> Contrastingly, at an ordinary trial, the person is acquitted unless all available evidence establishes, beyond a reasonable doubt, that the person is guilty of an offence.

6.28 It is a fundamental principle of the Australian criminal justice system that no person shall be punished except upon conviction for a criminal offence at a trial which is fair according to law.<sup>51</sup> A person who is UNA has, by definition, not had a fair trial<sup>52</sup> and has not been convicted of any offence.<sup>53</sup> In those circumstances, there is no basis in law to inflict punishment. Arguably, any restrictions on the person's liberty can be justified only by reference to considerations of public safety and, perhaps, a desire to ensure that the person can be brought to trial in the event that he or she becomes fit.<sup>54</sup>

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49. In several jurisdictions, different principles apply to the two decisions: see *Crimes Act 1900* (ACT) s 301-307 (time limit on detention), compare s 308 (decision whether or not to order detention); *Criminal Code Act 1983* (NT) s 43ZM, 43ZN (decision as to what order to make, if at all), compare s 43ZG (fixing of nominal term); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 28 (fixing of nominal term), compare s 39-40 (decision as to what order to make, if at all); *Criminal Law Consolidation Act 1935* (SA) s 269O(2) (time limit on supervision order), compare s 269S-269T (decision as to what order to make, if at all).

50. MHFPA s 22(1)(c)-(d).

51. *Jago v District Court of NSW* (1989) 168 CLR 23, 29-31 (Mason CJ), 56-57 (Deane J), 75 (Gaudron J); *Dietrich v The Queen* (1992) 177 CLR 292, 298-299 (Mason CJ and McHugh J), 325 (Brennan J, dissenting in result), 326, 331-332, 337 (Deane J), 353, 356 (Toohey J), 362-363 (Gaudron J).

52. As to the special hearing procedure, see ch 2.

53. MHFPA s 22(3)(a).

54. See [6.53]-[6.80].



6.29 Secondly, the legislated objectives of the forensic mental health system do not include punishment, but emphasise the protection of the community.<sup>55</sup> However, the present sentencing-based orders do not adequately ensure public safety, for the following reasons:

- the choice between a custodial order or non-custodial order is not based on a clinical assessment of the person's condition, treatment needs and related risks, but on the sentence that would have been imposed at an ordinary trial;
- the sentencing-based approach to disposition is an inherently retrospective exercise, in which the ability of the court to adjust for future risk is constrained by the principle of proportionality;<sup>56</sup> and
- if the court makes a non-custodial order, the person does not become a forensic patient, so the Forensic Division of the MHRT has no jurisdiction to supervise the person and his or her treatment and support arrangements, or to monitor his or her fitness to be tried.<sup>57</sup>

6.30 Sentencing principles may nevertheless have a limited relevance to the question of what order to make in respect of a person who is UNA, as follows. It may be appropriate to continue to restrict the court's power to order detention to cases where the offence is one which would have attracted a sentence of imprisonment upon conviction at an ordinary trial.<sup>58</sup> Sentencing considerations would thereby continue to operate as a limit on, but not a basis for, the court's discretion to detain the person.<sup>59</sup>

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55. See MHFPA s 40.

56. For example, if the person is charged with only minor offending, the court may be forced to conclude that, at an ordinary trial, a non-custodial sentence would have been imposed. In those circumstances, the court would have no power to order that the person be detained, even if there were clear evidence that the person posed a continuing risk to others.

57. As to the forensic mental health system, see ch 7.

58. Currently, the court has no power to order detention of a person who is UNA unless a sentence of imprisonment would have been imposed at an ordinary trial: MHFPA s 23(1)-(2), 24, 27. Such a limitation may be especially necessary if powers to deal with cases of unfitness are extended to the Local Court (see [6.105]-[6.109]), the jurisdiction of which includes many offences for which the maximum penalty does not include imprisonment.

59. See NSW, *Parliamentary Debates*, Legislative Assembly, 24 November 1982, 3006 (the Hon L Brereton, MP).

Such a limitation may, however, unduly constrain the court's power to order detention in the interests of public safety considerations.<sup>60</sup> This is a matter on which we seek submissions.

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#### Issue 6.45

To what extent (if any) should sentencing principles continue to apply to the court's decision whether to detain or release a person who is UNA?

### People found not guilty by reason of mental illness

6.31 A person can be found not guilty by reason of mental illness ("NGMI") at an ordinary trial in the District or Supreme Court. A finding of NGMI is also available in those courts in respect of an unfit defendant at a special hearing.<sup>61</sup> We begin with an outline of the orders the court may make, followed by an examination of the applicable discretionary considerations.

#### *Orders the court may make*

6.32 Section 39 of the MHFPA provides for three types of order following a verdict of NGMI: (i) detention; (ii) conditional release; and (iii) unconditional release.<sup>62</sup>

6.33 If the court orders unconditional release, the effect is the same as a discharge following an ordinary acquittal. Neither the court nor the MHRT retains any supervisory jurisdiction over the person.<sup>63</sup> The Commission is not aware of any reported decisions where this power has been exercised.

6.34 If the court makes an order for conditional release or an order for detention, the person becomes a "forensic patient" under the MHFPA, and is subject to the jurisdiction of the MHRT.<sup>64</sup> The MHFPA does not

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60. Alternatives to the current sentencing-based orders, and other principles that could provide an alternative basis for decision making, are discussed at [6.44]-[6.80].

61. MHFPA s 22(1)(b), (2), 38. For a detailed discussion of the special hearing, see ch 2.

62. MHFPA s 39(1).

63. See MHFPA s 51(1)(a). However, if the person is, or becomes, "mentally ill" or "mentally disordered", the involuntary treatment provisions of ch 3 of the MHA may apply.

64. MHFPA s 42(a)(i). See also ch 7.

specify the types of conditions the court may attach to an order for conditional release. Possible places of detention include a mental health facility (which may be in a community, secure forensic or prison setting), a correctional centre, or any “other place”.<sup>65</sup>

6.35 Unlike the situation regarding people who are UNA, the court has no power to set a limit on the length of time for which the conditions may apply, or for which the person may be detained as a forensic patient.<sup>66</sup> Nor is there any requirement for the court to obtain recommendations from the MHRT,<sup>67</sup> but the court’s registrar must notify the Minister for Health and the MHRT of the terms of whatever order it makes under s 39.<sup>68</sup>

*The exercise of judicial discretion*

6.36 Section 39(2) limits the exercise of judicial discretion by providing that the court must not order the release of a person found NGMI unless it is satisfied, on the balance of probabilities, that the safety of the person or any member of the public will not be seriously endangered by the person’s release.<sup>69</sup> Later in the chapter, we explore what is meant by “safety”, and whether the presumption in favour of detention is appropriate.<sup>70</sup>

6.37 Apart from the precondition in s 39(2) as to safety, the discretion whether to release the person, and if so, subject to what conditions, is unfettered by the MHFPA.<sup>71</sup> The Act specifies no other considerations which must be or may be taken into account. While there is limited case

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65. See MHFPA s 39(1), 44(1), 47(1)(a).

66. A person who has been found NGMI ceases to be a forensic patient if and when either: (i) the MHRT makes order for the person’s unconditional release; or, (ii) the person is released subject to time-limited conditions, and the time specified for compliance with those conditions expires. The merits and disadvantages of time-limited and indeterminate orders are discussed in ch 7.

67. Contrast the situation regarding people who are UNA: see MHFPA s 24, 27.

68. MHFPA s 39(3).

69. Note that this provision is stricter than the provisions in the MHA relating to involuntary detention: see MHA especially s 12, 14-15, 68(a).

70. See [6.55]-[6.76].

71. There is no express legislative guidance regarding the conditions that the court may impose; but see MHFPA s 75. In *R v Line* [2004] NSWSC 1148, Justice Simpson adopted conditions “essentially drawn from those commonly used by the [Mental Health Review] Tribunal”: see [18]-[19].

law on the point,<sup>72</sup> it has been held that, since a person found NGMI is not criminally responsible for the offending conduct, no element of punishment is involved and sentencing principles do not apply.<sup>73</sup>

6.38 In cases where courts have ordered that the person be released, the factors that were considered include:

- the person's diagnosis and response to and compliance with treatment before and after the offending conduct;
- the extent to which the person understands the need for, and is willing to accept ongoing treatment;
- the person's degree of insight into the offending conduct, and the conduct since the offence;
- the recommendations of treating and other psychiatrists;
- accommodation arrangements; and
- the likely effect of a return to custody on the person's condition.<sup>74</sup>

Similar considerations also affect the court's decision as to the place of detention.<sup>75</sup>

6.39 We seek views as to whether the MHFPA should be amended to provide additional guidance to the court in deciding whether to order detention or release of people found NGMI, and in relation to the conditions that may be attached to an order for release. The principles and factors which may be relevant to the court's decision, and for which legislation could provide, are discussed later in the chapter.<sup>76</sup>

#### Issue 6.46

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Should the MHFPA be amended to provide additional guidance to the court in deciding whether to order detention or release of persons found NGMI?

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72. The Commission is aware of only two cases in which the Supreme Court has ordered a person's conditional release under s 39: see *R v Line* [2004] NSWSC 1148; *R v Shan Shan Xu [No 2]* [2005] NSWSC 70. At common law the court had no such discretion.

73. *R v Line* [2004] NSWSC 1148, [17]; see also *R v Percy* (1998) 104 A Crim R 29, 32.

74. See *R v Line* [2004] NSWSC 1148; *R v Shan Shan Xu [No 2]* [2005] NSWSC 70.

75. See, eg, *R v Saba* [2000] NSWSC 827, [37]-[44].

76. See [6.53]-[6.80].

**Issue 6.47**

Should the MHFPA be amended to provide guidance to the court in relation to the conditions that may be attached to an order for conditional release?

**Differences in powers for dealing with persons who are UNA and those who are NGMI**

6.40 The preceding discussion highlights the fact that the range of orders available to the court and the principles which apply to deciding what order to make are significantly different, depending on whether the person is UNA or NGMI. Those differences may give rise to different outcomes, depending on whether the person is UNA or NGMI. Yet the two categories share fundamental similarities. In neither case has criminal responsibility been established, either because the person has not had a fair trial, or has been found to be not responsible in law for his or her actions.<sup>77</sup>

6.41 Further, in both cases, the relevant cognitive or mental health impairment may give rise to a need to impose restrictions on the person's liberty in order to ensure the safety of the community. This point is reflected in the fact that, while very different provisions apply to decision-making by the *court* in respect of persons who are UNA compared with those who are found NGMI, both groups are managed in essentially the same way by the MHRT. The factors which the MHRT must consider, the types of conditions that may be attached to an order for release, and the provisions regarding compulsory medical treatment are the same irrespective of whether a forensic patient was initially UNA or NGMI.<sup>78</sup> To the extent that there are differences, they are supplementary (not alternative) provisions which apply in respect of people who are UNA and which relate to (i) the possibility that the person may eventually become fit and (ii) the practical effect of the sentencing-based limiting term.<sup>79</sup> To the extent that court orders may also need to account for those differences, that could be achieved by way of supplementary provisions, rather than having entirely separate disposition schemes.

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77. The distinction may have a limited relevance to the decision by the court about what to do with a person who is UNA, to address the possibility that the person may one day become fit to be tried: see [6.80].

78. See ch 7.

79. See discussion at [7.29]-[7.34].

6.42 In addition to similarities in principle, the two categories overlap in practice. It is possible that a person may be both unfit to be tried and NGMI,<sup>80</sup> especially if, as discussed elsewhere in this Consultation Paper, people with cognitive impairments are able to rely on the defence of “mental illness”.<sup>81</sup> A finding of UNA does not necessarily mean that the person was not entitled to a defence of “mental illness”, but simply that, on the limited evidence available at the special hearing, the defence could not be established. The starkly different consequences which apply, depending on whether the eventual finding is one of UNA or NGMI, give rise to the possibility that procedural decisions to raise one issue or the other may have a significant impact on the eventual outcome, or even that legal processes may be deliberately manipulated in order to secure a particular result. For example, a defendant may be more inclined to raise the issue of fitness and not the defence of mental illness in order to secure a limiting term rather than an indeterminate order.<sup>82</sup>

6.43 In most Australian and several overseas jurisdictions, the respective legislative frameworks require courts to apply the same principles, and select from the same range of options irrespective of whether the person is UNA or NGMI.<sup>83</sup> In the following parts of the chapter, we consider possible alternative frameworks for the orders

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80. See MHFPA s 22(1)(b), which provides for a verdict of NGMI at a special hearing.

81. See ch 3.

82. See, eg, *R v Mitchell* (1999) 108 A Crim R 85 especially [2], [9]-[11]; and consider *R v Adams* [2001] NSWSC 773.

83. *Crimes Act 1914* (Cth) s 20BC-BH, 20BJ-BN; *Crimes Act 1900* (ACT) s 302-306, 308, 318-319, 323-324, 328-329, 335 and *Mental Health (Treatment and Care) Act 1994* (ACT) pt 4, 8; *Criminal Code Act 1983* (NT) s 43I(2), 43X(2), 43ZM, 43ZN and pt IIA div 5; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 18(4), 23, 39, 40(1), pt 5; *Mental Health Act 2000* (Qld) s 8-9, ch 7 pt 7 div 1-2; *Criminal Law Consolidation Act 1935* (SA) s 269F(B)(3), 269G(B)(3)-(5), 269M(B)(2), 269N(B)(3)-(5) and pt 8A div 4; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 18(2), 21, 24, 29A, 31B, 31C, 34-35; *Criminal Procedure (Insanity) Act 1964* (UK) s 5, sch 1A and *Mental Health Act 1983* (UK) s 37, 41; *Criminal Code*, RSC 1985 (Can) s 672.45, 672.47, 672.54 (except that absolute discharge is available only in respect of persons found NGMI: 672.54(a)); *United States Code*, tit 18 ch 313 §4243, 4246. Exceptions are WA: see *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 16(5), 19(4) (unfit) and compare s 20-22 (NGMI); and New Zealand, where the orders are the same but the provisions as to duration differ: *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 24(1), 25, 30-33.

available to the court and the factors and principles for decision-making, which could apply both in respect of persons who are UNA and in respect of persons who are NGMI.

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#### Issue 6.48

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Is there any reason to retain a distinction between the orders available to the court in cases where the person is UNA or NGMI?

### WHAT ORDERS SHOULD BE AVAILABLE?

6.44 The changes brought about by the MHFPA reduce to some extent the significance of whatever order is made by the court in respect of a person who is UNA or NGMI. In particular, the fact that the MHRT now has the power to order (rather than merely recommend) conditional and unconditional release of forensic patients means that any order of the court remains in force only until the MHRT makes another order.<sup>84</sup> That might occur at the MHRT's first review of the person, which must take place within six months.<sup>85</sup> The court's order is not, however, rendered insignificant: it may give rise to substantial restrictions on the person's liberty in the interim, including imprisonment and/or compulsory medical treatment.

6.45 Based on an examination of legislative provisions elsewhere, the Commission has identified the following four possible models for the range of orders available to the court, and for the balance between its role and that of the MHRT:<sup>86</sup>

- Option A: retain the current framework.
- Option B: give courts a broad discretion.
- Option C: courts select from a range of defined orders.
- Option D: MHRT makes orders following court referral.

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84. There is one exception. The definition of "forensic patient" does not include persons who are UNA and in respect of whom the court makes a non-custodial order. See [6.17].

85. See MHFPA pt 5 div 2 subdiv 1.

86. Issues relating to the MHRT and the forensic mental health system separately from the court process are discussed in ch 7.

### Option A: retain current frameworks

6.46 The first option is to retain the existing framework, namely, the court selects from sentencing-based options for people who are UNA, and makes orders under s 39 in respect of people who are NGMI. Those who become forensic patients would continue to be reviewed every six months by the MHRT. In light of the problems in principle and in practice of applying a sentencing framework to people who are UNA,<sup>87</sup> the Commission does not currently support the option of retaining those arrangements.

6.47 If, however, the present sentencing-based options for people who are UNA are to be retained, it is arguably desirable, for the reasons discussed above, that the definition of “forensic patient” should be amended to include persons who are UNA and in respect of whom the court makes a non-custodial order. If this were to occur, a number of consequences would follow. First, the MHRT would be able to supervise and, if necessary, arrange treatment for such people.<sup>88</sup> Secondly, if the person breaches a condition of the order, he or she would be dealt with by the MHRT rather than being required to return to court. Thirdly, the person’s fitness to be tried would be regularly reviewed, so that he or she could be tried upon becoming fit.<sup>89</sup> Further, the MHRT could, if the person’s condition deteriorated, order that the person be detained,<sup>90</sup> and, if necessary, receive compulsory mental health treatment.<sup>91</sup>

6.48 It might also be desirable, in cases where the person is UNA, to provide the court with a power to order conditional release if an order for detention is not made under s 27.

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87. See [6.26]-[6.30].

88. See MHFPA s 23(2), 23(7), 42, and see ch 7.

89. See ch 7.

90. Currently, if a person is UNA and a non-custodial order is made, an order may subsequently be made by the court (not the MHRT) for the person to be detained if a condition of the order is breached. However, any such order is made according to criminal law principles relating to breaches of community-based sentences, not on the basis of risk or the person’s need for treatment: see *Smith v The Queen* [2007] NSWCCA 39. See also MHA ch 3.

91. See [7.56]-[7.71].



#### Issue 6.49

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If the present frameworks are to be retained:

- (a) should the definition of “forensic patient” be amended to include a person who is UNA and in respect of whom a non-custodial order is made?
- (b) should the MHFPA be amended to provide a power for the court to order conditional release if it does not make an order for detention under s 27?

#### Option B: broad discretion for the court to detain or release persons who are UNA or NGMI

6.49 A second possible model is to provide for three broad discretionary options in respect of both persons who are UNA and those who are NGMI, namely, (i) detention, or (ii) conditional release or (iii) unconditional release. If detained or conditionally released by the court, the person would become a forensic patient. This is the procedure under s 39 of the MHFPA applicable to NGMI cases in NSW, and has been adopted by several Australian and overseas jurisdictions.<sup>92</sup> If adopted, it would more closely align the range of orders available to the court with those available to the MHRT.<sup>93</sup>

#### Option C: court selects from a range of defined orders

6.50 Another option is for the court to select from a range of more detailed orders which would include “civil” mental health orders. A

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92. See *Crimes Act 1914* (Cth) s 20BC(5)-(6), 20BJ(4)-(5); *Mental Health Act 2000* (Qld) s 288, 289 (court may make “forensic order” (detention) and may make accompanying “limited community treatment order”, authorising outpatient treatment); *Criminal Code*, RSC 1985 (Can) s 672.54(b). In Victoria, SA and the NT, the court may release the person unconditionally, or may declare the person “liable to supervision” and make either a custodial or non-custodial supervision order, which is subject to periodic review by the court: see *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 18(4), 23, 26, pt 5; *Criminal Law Consolidation Act 1935* (SA) s 269A(1), 269F(B)(3), 269G(B)(3)(a), 269M(B)(2), 269N(B)(3), 269O(1) and pt 8A div 4; *Criminal Code Act 1983* (NT) s 43I(2), 43X(2), pt 2A div 5. See also *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 16(5), 19(4), 23-38, which provides for a more limited choice between a “custody order” or absolute discharge.

93. See MHFPA s 47, discussed in ch 7.

limited range of “treatment orders” is available in England and Wales.<sup>94</sup> The most developed example of this model is in Tasmania, where six different orders are available.<sup>95</sup> However, the situation in Tasmania differs from that in NSW, since two of the available orders (restriction and supervision orders), are indefinite and can only be imposed and discharged by the Supreme Court.<sup>96</sup> Now that the MHRT in NSW can substitute its orders for those made by the court, it is arguably not worth devoting significant time and resources to the court’s determination.

6.51 Additionally, without clear guidelines or the assistance of expert witnesses and/or court liaison services, the courts may lack the necessary expertise or information about available services to formulate appropriate orders, or may regard the making of such orders as a punitive exercise.<sup>97</sup>

### Option D: court refers person to MHRT which makes the order

6.52 Following a finding that a person is UNA or NGMI, the court could make an order which activates a jurisdiction in the MHRT, to make such orders in respect of the person as the MHRT considers appropriate, with or without particular parameters fixed by the court. For example, in the ACT, the Magistrates or Supreme Court may order that the person be detained in custody until the ACT Mental Health Tribunal orders

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94. The available orders are supervision orders, hospital orders, guardianship orders and restriction orders: see *Criminal Procedure (Insanity) Act 1964* (UK) s 5, 5A, sch 1A cl 1(1), pt 3; *Criminal Procedure (Insanity and Unfitness to be Tried) Act 1991* (UK) s 5, sch 1 cl 2; *Mental Health Act 1983* (UK) s 8, 17-18, 20, 22, 25A-25J, 37-38, 41.

95. The following orders are available: a “restriction order” (detention in a secure mental health facility); a “supervision order” (conditional release under the supervision of the Chief Forensic Psychiatrist); a “continuing care order” (detention in a mental health facility for up to six months, renewable); a “community treatment order” (release on condition of accepting treatment, attending a mental health facility or other conditions, for up to one year, renewable); an order releasing the person on such conditions as the court considers appropriate; or an order releasing the person unconditionally: see *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 18(2), 21, pt 4 div 3, div 5, div 5A.

96. See *Criminal Justice (Mental Impairment) Act 1999* (Tas) pt 4 div 3, div 5; and see for example *CJS v Tasmania* [2008] TASSC 85. The other orders are similar to civil mental health orders.

97. See, eg, *R v Line* [2004] NSWSC 1148, [19] cl (xi); *R v Gardiner* (1999) 23 SR (WA) 70; *R v Gardiner (No 3)* (2000) 24 SR (WA) 136, [11]-[13], [16]-[17].

otherwise, or that the person submit to the jurisdiction of the Tribunal to enable it to make a mental health order.<sup>98</sup> All such orders are subject to review, variation and revocation by the ACT Mental Health Tribunal, including proceedings relating to the breach of an order.<sup>99</sup>

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**Issue 6.50**

What orders should be available to the court?

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**Issue 6.51**

Should the same orders be available both for persons who are UNA and for those who are found NGMI?

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**Issue 6.52**

What orders should result in a person becomes a “forensic patient”?

## WHAT PRINCIPLES AND FACTORS SHOULD THE COURT CONSIDER?

6.53 Two features are common to cases where the person is UNA or NGMI, namely:

- the absence of established criminal responsibility, and therefore the absence of any principled basis for punishment; and
- the possibility that the person’s cognitive or mental health impairment may give rise to a risk of harm, and a consequent need for restrictions on the person’s liberty to ensure the safety of the community and/or the person him or herself.

6.54 The first point is a negative one, which tells us only that punitive considerations have no application in such cases, except possibly to limit the powers of the court.<sup>100</sup> On the other hand, the second point involves positive considerations which can assist in decision-making. In this part of the chapter, we examine the concept of “risk of harm” and the related

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98. See *Crimes Act 1900* (ACT) s 318-319, 328-329, 335. For the orders that may be made by the Tribunal, see: *Mental Health (Treatment and Care) Act 1994* (ACT) pt 4 div 4.4-4.5 and s 30, 31, 36B, 36C.

99. *Mental Health (Treatment and Care) Act 1994* (ACT) Pt 4 div 4.4-4.7.

100. See [6.25].

“principle of least restriction”. We then consider the extent to which the views of victims and carers should be taken into account, any additional discretionary factors which may be relevant to determining the appropriate order, and the standard of proof which should apply.

## Risk of harm

6.55 The concept of “risk of harm” involves consideration of four elements:

- harm to whom?;
- the nature of the relevant harm;
- the degree of harm; and
- the degree of risk that the relevant harm will occur.

### *Harm to whom?*

6.56 Currently, s 39(2) of the MHFPA prohibits a court from ordering the release of a person who has been found NGMI unless it is satisfied that “the safety of the person or any member of the public will not be seriously endangered by the person’s release”. The court is therefore concerned to ensure the safety of the community at large; any individual or class of persons who might be particularly at risk, and the safety of the person the subject of the proceedings. The first two categories would not appear to be controversial. However, where the only threat posed by the person is to him or herself, the question arises as to whether this is a sufficient and appropriate basis for a criminal court to order the person’s detention.

6.57 A number of legislative instruments make provision for the care, supervision and support of people in the general community who, by reason of a cognitive or mental health impairment, are at risk of harming themselves. On one view, there is arguably no reason why this should be different in a criminal context. One of the legislated objects of the NSW forensic mental health system is “to provide for the care, treatment and control” of persons who are UNA or NGMI.<sup>101</sup> Similarly, legislation in several jurisdictions requires the court to have regard to the interests of the person,<sup>102</sup> although in some jurisdictions this is subject to the

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101. MHFPA s 40.

limitation that any restrictions on the person's liberty must be kept to the minimum consistent with the safety of the community.

6.58 On the other hand, an argument can be made that it is inappropriate to use the coercive apparatus of the criminal justice system (and the associated forensic mental health system) solely for the purpose of preventing an offender, who has not been convicted of a crime, from harming him or herself. This is particularly so in light of the detailed civil legislative and administrative arrangements that exist to care, support and supervise people in the general community, and considering the fact that forensic patients in NSW are generally detained in prison.

6.59 Consequently, it may be more appropriate to provide mechanisms for the court to refer a person in need of care and who is no threat to others into the civil mental health system or other care arrangements. This is the view that has been taken in Canada, where the Supreme Court has held that, absent a conviction, "public safety is the only basis for the exercise of the criminal law power", so that restrictions cannot be imposed unless the person represents a threat to the community.<sup>103</sup>

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#### Issue 6.53

To what extent (if any) should the court take into account a risk of harm to the person him- or herself, as distinct from the risk (if any) to other members of the community?

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#### Issue 6.54

Should the court be provided with a power to refer a person to the civil jurisdiction of the MHRT, or to another appropriate agency, if the person poses a risk of harm to no-one but him or herself?

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102. *Crimes Act 1900* (ACT) s 308; *Mental Health Act 2000* (Qld) s 9, 203(6), 204, 288(3), 289; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 40(1)(c); *Criminal Code Act 1983* (NT) s 43ZN(1)(e); *Criminal Law Consolidation Act 1935* (SA) s 269T(1)(c); *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 35(1)(c).

103. *Winko v British Columbia (Forensic Psychiatric Institute)* [1999] 2 SCR 625, [48], see also [33], [47].

*What kind of harm?*

6.60 A question arises as to whether “harm”, for the purposes of decision-making by the criminal court following a finding that a person is UNA or NGMI, should include:

- physical harm (including sexual violence);
- psychological harm;
- financial harm (including damage to property);
- harm to reputation or relationships; and/or
- any other kind of harm.

6.61 “Harm” is not defined in the MHFPA or in the cognate provisions of the MHA. The MHFPA refers to “the safety of the person ... [being] seriously endangered” if an order is made for the person’s release.<sup>104</sup> A risk to the safety of the person strongly implies that bodily harm, and possibly long-lasting psychological harm, is the only kind of harm contemplated by the Act.

6.62 This is the approach taken in Canada, where the Supreme Court has held that restrictions can only be imposed on a person who is UNA or NGMI to guard against physical or psychological harm occasioned by conduct which is criminal in nature.<sup>105</sup> Similarly, in the context of indefinite sentences, the High Court of Australia has held that deprivation of liberty can only be justified for the purposes of protecting the community against *physical* harm (including sexual violence), and that a propensity to commit serious but non-violent offences would not be sufficient.<sup>106</sup>

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104. MHFPA s 39(2) (emphasis added); see also s 43(a), 49(3), 50(2), 74(d); and see ch 8.

105. *Winko v British Columbia (Forensic Psychiatric Institute)* [1999] 2 SCR 625, [57].

106. See *Chester v The Queen* (1988) 165 CLR 611, 618-619. The High Court held that deprivation of liberty could only be justified for the purposes of protecting the community against physical harm (including sexual violence) – a propensity to commit serious property offences would not be sufficient: see also *McGarry v The Queen* (2001) 207 CLR 121, [26]-[27]; *Buckley v The Queen* (2006) 224 ALR 416, [6]-[7]. Similarly, indeterminate sentencing legislation in the UK defines “serious harm” as “death or serious personal injury, whether physical or psychological”: see *Criminal Justice Act 2003* (UK) s 224(3), 225(1), 227(1), 228(1) and especially s 229; and see *R v Lang and other appeals* [2006] 2 All ER 410; *R v Johnson and other appeals* [2007] 1 Cr App R (S) 112.

6.63 The MFHPA also refers, in several provisions, to “serious harm”.<sup>107</sup> For the purposes of applying the civil provisions of the MHA, where the same phrase appears, the MHRT has stated that “serious harm”:

... is interpreted to include: physical harm, financial harm, harm to reputation or relationships, neglect of self [and] neglect of others (including children).

The risk of harm must be related to the person’s mental illness.<sup>108</sup>

6.64 This creates a lower threshold for intervention. We seek views as to whether this threshold is appropriate in a criminal justice context.

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#### Issue 6.55

What kind of possible “harm” should be relevant to decisions by the court to detain or release persons who are UNA or NGMI?

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#### Issue 6.56

Should “harm” be defined in the MHFPA?

#### *The degree of harm and the degree of risk of harm*

6.65 Section 39 of the MHFPA directs the court to consider whether public safety would be “seriously endangered” by the offender’s release. This encompasses concepts of the degree of harm and the degree of risk. Relevant comparisons can also be drawn with other legislative schemes which provide for courts to impose restrictions on liberty, not by way of punishment but because the person poses a risk of harm to others. Most such provisions also require an intertwined consideration of the degree of probability of the harmful conduct and the gravity of the consequences. For example, the forensic provisions of the *Mental Health Act 2000* (Qld) refer to an “unacceptable risk to the safety of the patient or others”.<sup>109</sup>

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107. MHFPA s 68(1)(d), 74(b).

108. Mental Health Review Tribunal, *Civil Hearing Kit Section 1: Extending a Person’s Involuntary Stay in Hospital* (February 2009) [1.2] <[www.mhrt.nsw.gov.au/mhrt/pdf/Sec1Feb09.pdf](http://www.mhrt.nsw.gov.au/mhrt/pdf/Sec1Feb09.pdf)> at 22 April 2009). A similarly low threshold has been applied in the forensic context in Tasmania: see *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 35(1)(b), as applied in *CJS v Tasmania* [2008] TASSC 85, [21], [27]-[28], [35], [47]-[50].

109. *Mental Health Act 2000* (Qld) s 204, 289(4).

6.66 Similarly, in Canada, the applicable provision in cases where the person is UNA or NGMI requires the court to assess whether or not the person would, if released, represent a “significant threat to the safety of the public”.<sup>110</sup> That phrase has been construed as follows:

... [T]he threat posed must ... be “significant”, both in the sense that there must be a real risk of physical or psychological harm occurring to individuals in the community and in the sense that this potential harm must be serious. A minuscule risk of a grave harm will not suffice. Similarly, a high risk of trivial harm will not meet the threshold. Finally, the conduct or activity creating the harm must be criminal in nature. In short, [the Code requires] ... that the individual poses a significant risk of committing a serious criminal offence.<sup>111</sup>

6.67 In the context of indefinite sentences, the High Court of Australia has emphasised that deprivation of liberty for protective purposes is only justifiable if both the likelihood of the harmful conduct and the gravity of its foreseeable consequences are high.<sup>112</sup>

6.68 More generally, the *Bail Act 1978* (NSW) provides that the decision-maker may take into account the “protection and welfare of the community” in deciding whether to grant bail or remand a person in custody. The decision-maker may have regard to the risk that the person will commit a serious offence if released on bail, but only if satisfied that the likelihood of the commission of an offence, together with the likely consequences, “outweighs the person’s general right to be at liberty”.<sup>113</sup>

6.69 A slightly different approach to defining a relevant risk of harm is adopted in the *Crimes (Serious Sex Offenders) Act 2006* (NSW). In that Act, the relevant degree of harm can be derived from the definition of “serious sex offence”.<sup>114</sup> A finding that the person is “likely”, in the absence of a

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110. See *Criminal Code*, RSC 1985 (Canada) s 672.54.

111. *Winko v British Columbia (Forensic Psychiatric Institute)* [1999] 2 SCR 625, [57] (citations omitted). See also *Re Percy, Farrell and RJO* (1998) 102 A Crim R 554, 566.

112. See *Chester v The Queen* (1988) 165 CLR 611, 618-619.

113. *Bail Act 1978* (NSW) s 32(1)(c)(iv), (2). As to the meaning of “serious offence”, see s 32(2A).

114. See *Crimes (Serious Sex Offenders) Act 2006* (NSW) s 5(1).



court order, to commit a “serious sex offence” empowers the court to make an “extended supervision” or “continuing detention” order.<sup>115</sup>

#### Issue 6.57

How should the relevant degree of risk of harm be expressed in the MHFPA? Should it be defined?

#### *The principle of “least restriction”*

6.70 There is a principle, reflected in civil mental health and disability legislation in NSW, that in the provision of care and treatment to people with disabilities, the person should be subject only to the minimum restrictions that are necessary to ensure the safety of the person and/or the community.<sup>116</sup> This “principle of least restriction” derives from human rights law, which permits interference with rights and liberties only to the extent that there is “reasonable proportionality” between the limitations imposed on the rights, and the justifiable and legitimate purpose sought to be achieved.<sup>117</sup>

6.71 Forensic mental health legislation in several jurisdictions requires the court to apply a principle of “least restriction consistent with public safety” when making orders in respect of people who are UNA.<sup>118</sup> In NSW, s 39 of the MHFPA requires the court to order that a person who is NGMI be detained unless it is positively established that it is safe to release the person. If the evidence is evenly balanced, the result will be an order for detention. This reflects the concern of the legislature for public safety, but the presumption in favour of detention is not consistent with a

115. *Crimes (Serious Sex Offenders) Act 2006* (NSW) s 9(2), 17(2)-(3). As to the meaning of “likely”, see *Tillman v Attorney General (NSW)* (2007) 70 NSWLR 448, [73]-[76], [88]-[89]; *Cornwall v Attorney General (NSW)* [2007] NSWCA 374, [20]-[22]; but compare *RJE v Secretary to the Department of Justice* [2008] VSCA 265, [21]-[53], [97]-[113].

116. MHA s 12(b), 68(a). See also *Disability Services Act 1993* (NSW) s 6(1), sch 1 [1](g).

117. *Kracke v Mental Health Review Board* [2009] VCAT 646, [111] and see [98]-[136], [156]-[160]. See also, eg, *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 7(2)(e); *New Zealand Bill of Rights Act 1990* (NZ) s 5; *Canadian Charter of Rights and Freedoms* (Can) s 1.

118. See *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 39; *Criminal Law Consolidation Act 1935* (SA) s 269S; *Criminal Code Act 1983* (NT) s 43ZM; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 34.

principle of “least restriction consistent with the safety of the community”.<sup>119</sup>

6.72 If the principle of least restriction is given its full effect, and assuming there is no other basis for imposing restrictions in the particular case,<sup>120</sup> then a person who is UNA or NGMI is entitled to be unconditionally released unless it is positively established that it would be unsafe to do so. We seek views on this matter.

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#### Issue 6.58

Should a presumption in favour of detention continue to apply when courts are making decisions about persons who are UNA or NGMI?

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#### Issue 6.59

When deciding what order to make in respect of a person who is UNA or NGMI, should the court be required to apply a principle of least restriction consistent with:

- (a) the safety of the community?
- (b) the safety of the person concerned? and/or
- (c) some other object(s)?

### The views of victims and carers

6.73 In NSW, a victim of an offence or alleged offence is entitled to: notification of hearings; information regarding the investigation and prosecution of the offence;<sup>121</sup> counselling and compensation, funded by the state and/or the offender, if convicted;<sup>122</sup> and, if the defendant is

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119. This approach is also followed in Queensland: *Mental Health Act 2000* (Qld) s 204(4), 289(5) but compare s 8-9; the ACT: *Crimes Act 1900* (ACT) s 308, 318(2), 319(2), 323, 324, 328, 329, 335; and the USA: *United States Code*, tit 18 ch 313 §4243(d)-(f), 4246(d)-(e).

120. For example, on the basis that there are other charges pending against the person, or that the person has been found NGMI in respect of one offence but convicted of another.

121. *Victims Rights Act 1996* (NSW) s 6.5.

122. *Victims Support and Rehabilitation Act 1996* (NSW) s 5(1), pt 2 div 3-5 (compensation from Fund), div 8-9 (Fund can recover from offender), pt 4 div 1-2 (orders for offender to compensate victim), pt 5 (compensation levy payable by offender); and see *R v Connor* (2005) 158 A Crim R 389, [41]-[42] (relevant

convicted, to provide a written victim impact statement to the court before it sentences the offender.<sup>123</sup> If the defendant is not convicted, but instead is UNA or NGMI, the victim's notification, counselling and compensation entitlements are the same up to the time of the verdict (or limited finding, in the case of an unfit defendant).<sup>124</sup> Victims' entitlements after that point are less clear. The MHFPA neither requires nor prohibits consideration by the court of the views of victims when determining whether to make a custodial or non-custodial order, or in setting conditions of release, following a finding of UNA or NGMI. It appears that the legislative provisions regarding victim impact statements apply only in the context of sentencing following conviction.<sup>125</sup>

6.74 However, a victim's legitimate concerns as to his or her safety are relevant to the court's decision as to whether people found UNA or MGMI should be released and, if so, on what conditions.<sup>126</sup> In several other Australian jurisdictions, specific provision is made for victims to be notified of, informed about, and to participate (including by submitting a victim impact statement) in proceedings when courts are making orders in respect of persons who are UNA or NGMI.<sup>127</sup>

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considerations for court determining whether or not to order offender to compensate victim).

123. CSPA s 3A(g) and pt 3 div 2. The Act provides for victim impact statements to be received only in relation to certain offences: s 27. In relation to other offences, a statement may be admissible at common law: *Siganto v The Queen* (1998) 194 CLR 656, [29].
124. See *Victims Rights Act 1996* (NSW) s 4, 6 (procedural rights relating to trial not predicated on conviction) but compare s 6.15, 6.16; *Victims Support and Rehabilitation Act 1996* (NSW) s 5(1A) (entitlement to compensation arises from being the victim of an "act of violence", which includes "conduct of a person that would constitute an offence were it not for the fact that the person cannot, or might not, be held to be criminally responsible for the conduct because of the person's age or mental illness or impairment").
125. See CSPA pt 3 div 2; compare MHFPA s 23, 27, 39; and see *Smith v The Queen* [2007] NSWCCA 39, [61]-[63].
126. James Report, [9.20]-[9.21].
127. See *Criminal Code Act 1995* (NT) s 43A, 43ZL(1)-(2), 43ZN, 43ZP; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 38C, 38E, 40(2)(c)-(d), 42-46; *Mental Health Act 2000* (Qld) ch 7A and s 464; *Criminal Law Consolidation Act 1935* (SA) s 269R, 269T(2)-(3), 269Z; *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 33(5); *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 33, 35. See also *Criminal Code*, RSC 1985 (Can) s 672.5(5.1), (14)-(15.1).

6.75 In most Australian jurisdictions, the same or similar provisions also facilitate the involvement of carers in the court process.<sup>128</sup> It is arguably appropriate that carers<sup>129</sup> should have a role in making decisions about persons who are UNA or NGMI. The person's carer may be able to provide the court or the MHRT with information relevant to safety, the person's treatment history, and/or might have concerns for his or her own safety. The role of carers is recognised in the civil provisions of the MHA, which provides that carers have the right to be kept informed,<sup>130</sup> and aims to facilitate their involvement "in decisions involving appropriate care, treatment and control" of mental health patients.<sup>131</sup> Some of those provisions also apply to forensic patients.<sup>132</sup> However, those provisions appear to apply only to the MHRT and to health service providers, not to the court.

6.76 We seek views as to the adequacy of the current provisions regarding participation by victims and carers regarding proceedings involving people who are UNA or NGMI.

#### Issue 6.60

In relation to court proceedings involving people who are UNA or NGMI, are the current provisions concerning notification to, and participation by:

- (a) victims; and
  - (b) carers
- adequate and appropriate?

128. See *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 3(1) ("family member"), 38C-38F, 40(2)(c)-(d), 42-46; *Criminal Law Consolidation Act 1935* (SA) s 269A ("next of kin"), 269R, 269T(2), 269Z; *Mental Health Act 2000* (Qld) s 464, 465 (no entitlement to apply for notification order: see ch 7A); *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 33, 35; *Criminal Code Act 1995* (NT) s 43ZL, 43ZN, 43ZP. In the NT, if the person is a member of an Aboriginal community, the court may also obtain a report outlining the views of that community: s 43ZL(3)(b). See also *Criminal Code*, RSC 1985 (Can) s 675.5(4)-(5).

129. *Mental Health Act 2007* (NSW) s 71, 72 define "primary carer" as the person's parent (if the person is a child), guardian, primary carer nominated by the person, the person's spouse, close relative, friend, or "any person who is primarily responsible for providing support or care to the patient (other than wholly or substantially on a commercial basis)".

130. MHA s 68(j).

131. MHA s 3(e).

132. See MHFPA s 76B; see also s 46(4), 76B, 76G.

## Additional factors

6.77 Some jurisdictions specify other factors for the court to consider, such as a broad “public interest” criterion. Also, in unfitness cases, some jurisdictions require the court to have regard to the strength of the evidence against the accused person, and/or the possibility that the person may eventually become fit for trial.

### *The “public interest”*

6.78 In Western Australia and New Zealand, courts are required to have regard to the “public interest” when making orders about people who are UNA or NGMI.<sup>133</sup> This provision has been applied broadly in Western Australia. For example, courts have held that it was not in the public interest to make a custody order in circumstances where, due to the lack of appropriate facilities, the persons concerned would have been detained in prison, in one case probably for the rest of his life.<sup>134</sup> However, the content of the public interest criterion is unclear and has not been applied consistently.<sup>135</sup>

### *The strength of the evidence*

6.79 The requirement to have regard to the strength of the evidence and, in some jurisdictions, the nature and circumstances of the alleged offence, when determining what order to make in respect of a person who is UNA is discussed in Chapter 2, in the context of affording the unfit accused person an opportunity for acquittal.<sup>136</sup> It may also be relevant to assessing whether or not the person poses a continuing risk to others. In particular, future risk is assessed on the basis of the available evidence which, in cases of unfitness, may be incorrect or incomplete.<sup>137</sup>

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133. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 16(6)(d), 19(5)(d), 22(1)(a); *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 24(1)(c), see also s 33(4)(b).

134. See *GFS v The Queen* [2001] WASCA 219, [25], [62]-[63]; *R v Garlett* (2002) 29 SR (WA) 1, [10]-[12] (release ordered); *R v McKitterick* (2001) 26 SR (WA) 206, [18]-[21] (release ordered); compare *Chang v Turner* [2005] WASC 246, [26]-[30], [32]-[33] (custody order confirmed).

135. See *R v Gardiner* (1999) 23 SR (WA) 70; *R v Gardiner (No 3)* (2000) 24 SR (WA) 136, [13]-[16]; *GFS v The Queen* [2001] WASCA 219, [24]-[26], [51]-[60]; *R v Garlett* (2002) 29 SR (WA) 1, [25]-[26].

136. See [2.19]-[2.23].

137. See, eg, *R v Dunne* [2002] WASC 196, [31]-[32].

*Possible future fitness for trial*

6.80 In cases where the person is UNA, the court's decision as to the appropriate order might legitimately involve considerations such as the desirability of ensuring that the person's fitness for trial continues to be monitored and that, in the event that the person becomes fit to be tried, his or her attendance in court can be assured. It is arguable that such considerations might justify an order requiring the person to comply with certain conditions – such as a requirement to undergo psychiatric or psychological assessment for the purposes of periodic reviews by the MHRT of the person's fitness for trial – even in a case where restrictions are not warranted on any other basis.<sup>138</sup> On the other hand, it would be pointless to require regular reviews of fitness in a case where the person is permanently unfit to be tried.<sup>139</sup> This is an issue on which we seek submissions.<sup>140</sup>

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Issue 6.61

What principles should apply when courts are making decisions about persons who are UNA or NGMI?

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Issue 6.62

What factors should courts be allowed and/or required to take into account when making decisions about persons who are UNA or NGMI?

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138. Consider the cases of *R v Wilson*. Wilson was charged with murder. The commission of the offence caused him to experience a severe reactive depression such that he was, for several years, unfit to be tried: [2000] NSWSC 1104. At the special hearing, he was UNA, and sentencing considerations led to the imposition of a limiting term: [2002] NSWSC 297, [30]. However, there was no evidence that he posed a continuing risk to others: see [32]-[43]. Had sentencing principles not been applicable, "risk of harm to others" might not have provided sufficient grounds for imposing restrictions on his liberty: see [32]-[43] and see [6.56]-[6.59]. It is not clear from the case report whether or not his depressive condition was such that he was at risk of harming himself. Wilson subsequently became fit: [2004] NSWSC 370, and was tried, convicted and sentenced for murder: [2004] NSWSC 597 and see also (2005) 153 A Crim R 257.

139. See, eg, *Mental Health Act 2000* (Qld) s 215, 216(4), 283.

140. See also discussion in ch 7 regarding the length of time for which the MHRT should continue to review the fitness for trial of forensic patients who are UNA.

**Issue 6.63**

In cases where the person is UNA, should the possibility that the person will become fit to be tried be a sufficient basis for the court to make an order of some kind?

**Standard of proof**

6.81 When a court is deciding what order to make in respect of a person who is UNA, the requirement to apply sentencing principles suggests that the standard of “reasonable doubt” would apply to matters adverse to the person, and the balance of probabilities to favourable matters.<sup>141</sup> In cases where the person is NGMI, the MHFPA requires satisfaction on the balance of probabilities in relation to the issue of safety.<sup>142</sup>

6.82 In several jurisdictions, the applicable legislation provides for proof on the balance of probabilities.<sup>143</sup> In those jurisdictions, courts commonly apply the “*Briginshaw* principle”, namely, that “the gravity of the consequences flowing from a particular finding ... must affect the answer to the question [of] whether the issue has been proved”.<sup>144</sup> In the present context, those consequences include, on the one hand, the extensive restrictions placed on the liberty of the person concerned and, on the other hand, the harm which may be occasioned to members of the community (and possibly the person concerned) if the person is released.

6.83 However, it is arguable that, since the order is being made at the conclusion of criminal proceedings and may lead to significant restrictions on the liberty of the person concerned, factual matters adverse to the person should be established to the criminal standard of reasonable doubt.<sup>145</sup> Although risk itself cannot be proved beyond reasonable doubt,

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141. *R v Storey* [1998] 1 VR 359, 369; *R v Olbrich* (1999) 199 CLR 270, [27].

142. MHFPA s 39(2).

143. See *Re Percy, Farrell and RJO* (1998) 102 A Crim R 554; *Mental Health Act 2000* (Qld) s 405(2); *CJS v Tasmania* [2008] TASSC 85, [75]; *Re Schafferius* [1987] 1 Qd R 381. See also MHFPA s 6, which requires proof on the balance of probabilities that a person is unfit to be tried.

144. *Briginshaw v Briginshaw* (1938) 60 CLR 336, 361-362; and see also *Re Percy, Farrell and RJO* (1998) 102 A Crim R 554, 563-567; *CJS v Tasmania* [2008] TASSC 85, [75].

145. In the analogous situation of indefinite sentencing for the protection of the community, the criminal standard applies: compare the discussion in *Re Percy, Farrell and RJO* (1998) 102 A Crim R 554, 559-561.

that is not true of the objective facts which are relied on to establish that a risk exists.<sup>146</sup>

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#### Issue 6.64

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Should legislation specify what standard of proof applies to facts which form the basis of the court's decision as to what order to make in respect of a person who is UNA or who has been found NGMI? If so, what standard of proof should be specified?

### ANCILLARY ISSUES

6.84 In this part of the chapter, we consider three issues. First, whether the court requires ancillary powers or procedures to assist in determining the appropriate order in cases where the person is UNA or NGMI. Secondly, the extent to which, and the manner in which, findings and orders by the court in cases where the person is UNA or NGMI are or should be subject to appeal. Finally, we highlight the limited powers of the Local Court in cases where the person is unfit to be tried or entitled to a defence of “mental illness”, and consider whether additional powers should be provided.

#### Means by which the court may inform itself

6.85 Currently, in cases where the person is UNA and the court has set a limiting term, the MHFPA provides a mandatory mechanism for the court to obtain recommendations from the MHRT regarding the appropriate place of detention.<sup>147</sup> No such mechanism is provided in respect of the initial decision by the court as to whether to make a custodial or non-custodial order, probably because that decision is currently made by reference to sentencing considerations, in respect of which the MHRT has no special expertise. In cases where the person is found NGMI, there is no requirement or legislated mechanism for the court to obtain the assistance of the MHRT. It appears that, in such cases,

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146. Consider *McGarry v The Queen* (2001) 207 CLR 121, [26]-[30], [61]-[67]; *Director of Public Prosecutions (WA) v Mangalamara* (2007) 169 A Crim R 379, [165]-[166]. Consider also *Re Percy* (1998) 104 A Crim R 29, 32-40 and *Re Percy* [2004] VSC 67, [64]-[82], where Percy was considered to pose a continuing risk because of the absence of evidence that the risk had abated.

147. MHFPA s 24, 27.



the court is assisted on an ad hoc basis, by receiving evidence from Justice Health and/or the person's treatment team.<sup>148</sup>

6.86 On the one hand, now that the MHRT has the power to make orders altering the place of detention or conditions of release of a person who is UNA or NGMI,<sup>149</sup> the court's order remains in force until the MHRT makes a different order.<sup>150</sup> It is arguable that procedures such as the current mandatory requirement for the court to refer a person who is UNA to the MHRT for a review and recommendations before making a final order may lead to duplication of functions and unnecessary delays.<sup>151</sup>

6.87 On the other hand, the court's order is not insignificant. It may give rise to substantial restrictions on the person's liberty, including imprisonment and/or compulsory medical treatment.<sup>152</sup> Once a person is detained, there is a process of gradually reducing the level of restrictions in order to assess whether or not the person can safely be released, which necessarily requires the person to spend time in a suitable environment at each stage.<sup>153</sup> Thus, if the court orders detention in a case where it is not in fact necessary, the person may nevertheless remain in detention for a significant period of time.<sup>154</sup>

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148. See James, Feneley and Hanson, 19, 20-21; and see, eg, *R v Line* [2004] NSWSC 1148, [12]-[19]; *R v Shan Shan Xu (No 2)* [2005] NSWSC 70, [51]-[71]; *R v Saba* [2000] NSWSC 827, [32]-[44].

149. See MHFPA s 24, 27 and ch 7.

150. See MHFPA pt 5 div 2 subdiv 1. Previously, there were frequently long delays in altering the arrangements for a person's "care, treatment or detention", largely due to the process involved, namely, a recommendation by the MHRT to the executive government, consideration of that recommendation, which, if accepted, could only be implemented under an order by the "prescribed authority": see MHCPA pt 5 div 2 especially s 48. The court's order is now effectively an interim one: see James, Feneley and Hanson, 19, 20 and see ch 7.

151. See MHFPA s 24, 27. For a discussion of duplication of functions of the court and the MHRT in relation to determinations of fitness, see ch 1.

152. As to the impact of mental health orders on the enjoyment of human rights, see *Kracke v Mental Health Review Board* [2009] VCAT 646, [431]-[432].

153. James Report, [8.17].

154. This is particularly so for forensic patients who are detained in correctional centres, where opportunities to move to a lower level of restriction and/or to participate in rehabilitation may be very limited, further delaying the person's progress through the system: see ch 7.

6.88 Moreover, it appears that the present arrangements are, in practice, somewhat deficient. The President and other members of the MHRT observed in a recent article that:

Generally a judge will not have sufficient information about the availability of places to specify which correctional centre, mental health facility or other place [a person found UNA or NGMI should be detained in]. For this reason, the appropriate course is for the court to order the patient to be returned to their existing place of detention and notify the [Mental Health Review] Tribunal so that a hearing can be held as soon as reasonably practicable. The Tribunal will seek to arrange for the appropriate placement and make the necessary order.

... [I]t is important that the court should not – except in the most exceptional circumstances – attempt to determine a precise place of detention, as all too often there are no resources or facilities available to implement such an order.<sup>155</sup>

6.89 In several jurisdictions, legislated mechanisms exist for the court to obtain information about the person’s cognitive or mental health impairment and the related treatment and risk management requirements and available services and facilities.<sup>156</sup>

6.90 In addition to powers for the court to obtain relevant information, it may be helpful also to provide legislative guidance as to how that and other information should be used by the court to determine the level of risk that the person poses and related risk management requirements.<sup>157</sup>

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155. James, Feneley and Hanson, 19, 21. See also MHFPA s 77C, which permits the Commissioner of Corrective Services or the Director-General of the Department of Juvenile Justice to detain the person in *any* correctional or detention centre, even if the court makes an order specifying a *particular* centre as the place of detention.

156. Those powers are outlined in Consultation Paper 5 (“CP 5”), ch 5.

157. Consider MHFPA s 74, outlined in ch 7. See also *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 40(2), (4); *Criminal Law Consolidation Act 1935* (SA) s 269T(2)-(2a). Also consider the detailed risk evaluation procedures provided by *Crimes (Serious Sex Offenders) Act 2006* (NSW) s 9(3), 17(4); *Dangerous Prisoners (Sexual Offenders) Act 2003* (Qld) s 13(4); *Dangerous Sexual Offenders Act 2006* (WA) s 7(3).

6.91 Some jurisdictions additionally or alternatively provide for less formal procedures,<sup>158</sup> and/or experts sitting with the judge.<sup>159</sup> Similar provisions apply in other contexts in NSW. For example, the MHA provides for expert assessors to sit with and assist the judge in appeals to the Supreme Court against decisions of the MHRT in its civil jurisdiction.<sup>160</sup>

6.92 The court could also be aided by other, less formal mechanisms, such as the establishment of a court liaison service, similar to the Community and Court Liaison Service which operates in Local Courts.<sup>161</sup>

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#### Issue 6.65

What powers or procedures (if any) should be provided to assist the court in determining the appropriate order in cases where the person is UNA or NGMI?

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#### Issue 6.66

Should legislation provide a mechanism for the court to notify the MHRT of its final order in cases where the person is UNA or NGMI?

### Appeals against findings and orders in respect of persons who are UNA or NGMI

6.93 The *Criminal Appeal Act 1912* (NSW) (“the Criminal Appeal Act”) makes provision for appeals against conviction and sentence following an ordinary trial. Without modification, such a provision would not apply to cases where the person is UNA or NGMI. That is because neither the limited finding of guilt at a special hearing nor a verdict of NGMI is in law a “conviction”.<sup>162</sup> Similarly, an order made by the court in respect of a

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158. In Canada, the court may adopt a special procedure called a “disposition hearing”, or otherwise the decision is made by the Review Board: see *Criminal Code*, RSC 1985 (Canada) s 672.45-672.47 and especially s 672.5.

159. *Mental Health Act 2000* (Qld) s 382, ch 11 pt 1, 3, 5. And consider *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) pt 7 div 2-3.

160. MHA s 164(5)-(6), 165. See also MHFPA s 73 and MHA ch 6.

161. See Consultation Paper 7 (“CP 7”).

162. As to the effect of the qualified finding of guilt, see MHFPA s 22(3). A verdict of NGMI is not, in law, a conviction but a special form of acquittal, against which

person who is UNA or NGMI is not a “sentence”. In order to provide for appeals in such cases, the Criminal Appeal Act includes expanded definitions of “conviction” and “sentence” and a special deeming provision. Here, we examine the operation of those provisions of the Act.

*Cases where the person is UNA*

6.94 Section 5(1) of the Criminal Appeal Act provides as follows:

A person convicted on indictment may appeal under this Act to the court:

- (a) against the person’s conviction on any ground which involves a question of law alone, and
- (b) with the leave of the court, or upon the certificate of the judge of the court of trial that it is a fit case for appeal against the person’s conviction on any ground of appeal which involves a question of fact alone, or question of mixed law and fact, or any other ground which appears to the court to be a sufficient ground of appeal, and
- (c) with the leave of the court against the sentence passed on the person’s conviction.

6.95 For the purposes of the Criminal Appeal Act, the definition of “conviction” includes a limited finding of guilt at a special hearing.<sup>163</sup> “Sentence” is defined to include a limiting term or other order made in respect of a person who is UNA.<sup>164</sup> A person who is the subject of a limited finding of guilt at a special hearing may therefore appeal against that finding, and/or against the limiting term or other order made by the court, in the same manner as if he or she had been convicted and sentenced at an ordinary trial.<sup>165</sup>

6.96 Similarly, the Crown may appeal as of right against any such limiting term or order.<sup>166</sup>

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an appeal would ordinarily be incompetent: *R v Foy* (1922) 39 WN (NSW) 20; *Greig v The Queen* (1996) 89 A Crim R 254.

163. *Criminal Appeal Act 1912* (NSW) s 2(1).

164. *Criminal Appeal Act 1912* (NSW) s 2(1)(d).

165. See, eg, *R v Mailes (No 2)* (2004) 62 NSWLR 181.

166. *Criminal Appeal Act 1912* (NSW) s 2(1)(d), 5D(1), 6A. See, eg, *R v Adams* [2002] NSWCCA 448.

*Cases where the person is NGMI*

6.97 The situation is different where a person is found NGMI. The definition of “conviction” in the Act is not expanded to cover cases of NGMI. Instead, a special deeming provision is used. Section 5(2) of the Criminal Appeal Act provides as follows:

For the purposes of this Act a person acquitted on the ground of mental illness, where mental illness was not set up as a defence by the person, shall be deemed to be a person convicted, and any order to keep the person in custody shall be deemed to be a sentence.<sup>167</sup>

6.98 A person found NGMI may, therefore, appeal against the finding in the same manner as an appeal against conviction, but only if the defence was not set up by him or her. The Court of Criminal Appeal has adopted a broad interpretation of that provision, drawing a distinction between the defence being set up for, as opposed to by, the person.<sup>168</sup> In such a case, a person may also appeal against orders under s 39 of the MHFPA for detention or conditional release, in the same manner as an ordinary appeal against sentence.<sup>169</sup>

6.99 However, the limitation in the deeming provision, which enables appeals only in cases where the defence was not set up by the person concerned, has the following apparently unintended consequence. A

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167. *Criminal Appeal Act 1912* (NSW) s 5(2).

168. An appellant may lead evidence to establish that the defence was raised without, or contrary to his or her instructions. For examples of where this was successful, see *R v Williams* [2004] NSWCCA 224, [16]-[20]; *Dezfouli v The Queen* [2007] NSWCCA 86, [39]. Compare the unsuccessful outcomes in *R v Logan* [2004] NSWCCA 101, [31]-[36], [55]-[56], [59]-[60]; *Peterson v The Queen* [2007] NSWCCA 227, [11]-[12]; *R v Foy* (1922) 39 WN (NSW) 20. The fact that defendants in such cases are or may be unfit to give instructions and may be acutely mentally ill at the time of the special hearing, is a relevant consideration and may displace the ordinary rule that a party is bound by the course taken by his or her legal representatives: see *R v Riddell* (2003) 140 A Crim R 549, [21]-[22]; *Dezfouli v The Queen* [2007] NSWCCA 86, [37], [46]; but contrast *Greig v The Queen* (1996) 89 A Crim R 254.

169. See *Criminal Appeal Act 1912* (NSW) s 5(2), 7(4). The Commission is not aware of any cases where a verdict of NGMI has been successfully appealed. However, until 2005, a verdict of NGMI produced a mandatory outcome, namely, a court order that the person be detained in strict custody: see [6.11]. In those circumstances, as soon as the Court of Criminal Appeal determined that the verdict of NGMI should be upheld, the appeal was necessarily dismissed because the Court had no alternative but to confirm the order of the trial court.

person who raised the defence of mental illness and is found NGMI might wish to appeal against an order made by the trial court for detention or conditional release. However, under the current provisions, such a person has no avenue of appeal because the verdict of NGMI in such a case is not deemed to be a conviction. This appears to be inconsistent with the human rights principle that a person who is detained is entitled to judicial review of the lawfulness of detention.<sup>170</sup>

6.100 The Crown may appeal as of right against an order for detention or release in cases where the person is NGMI.<sup>171</sup> However, it does not appear to be possible for the prosecution to appeal against a verdict of NGMI, for example, on the basis that the person was in fact guilty of the offence.<sup>172</sup>

6.101 If a person is found NGMI on an appeal, the Court of Criminal Appeal may make an order for detention, conditional release or unconditional release.<sup>173</sup> However, in contrast with the equivalent power provided to the trial court under s 39 of the MHFPA, the Court of Criminal Appeal is not required to be satisfied that “the safety of the person or any member of the public will not be seriously endangered” before making an order for release.<sup>174</sup>

#### *Powers of the Court of Criminal Appeal*

6.102 The deeming provisions of the Criminal Appeal Act which empower the Court of Criminal Appeal to review cases where the person is UNA or NGMI operate by equating those findings and consequent orders with a conviction and/or sentence in an ordinary case.<sup>175</sup> As a result, other provisions of the Act which specify the manner in which

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170. See *International Covenant on Civil and Political Rights* art 9(4); *Convention on the Rights of the Child* art 40(2)(b); *Beijing Rules* art 7; *European Convention for the Protection of Human Rights and Fundamental Freedoms* art 5(4); *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 21(7); and see discussion in *Kracke v Mental Health Review Board* [2009] VCAT 646, [621], [642]-[645], [663].

171. See *Criminal Appeal Act 1912* (NSW) s 5D(1) and see s 2(1)(e) (definition of “sentence”).

172. This corresponds with the position following an ordinary acquittal.

173. *Criminal Appeal Act 1912* (NSW) s 7(4).

174. *Criminal Appeal Act 1912* (NSW) s 7(4).

175. *Criminal Appeal Act 1912* (NSW) s 2(1) (definitions of “sentence” and “conviction”), 5(2).

ordinary appeals are to be determined also apply to appeals in cases involving people who are UNA or NGMI.<sup>176</sup>

6.103 The law recognises four kinds of appeal: (i) appeal by way of a hearing *de novo*, where fresh evidence may be called;<sup>177</sup> (ii) a more limited appeal by way of rehearing based on the evidence which was before the trial court;<sup>178</sup> (iii) an appeal as to the appropriateness of the exercise of a discretion;<sup>179</sup> and (iv) an appeal limited to questions of law.<sup>180</sup>

6.104 In most jurisdictions, legislation provides for some form of appeal against findings and orders in cases where the person is UNA or NGMI.<sup>181</sup> We invite submissions on whether broader provision should be made for appeals in cases where the person is UNA or NGMI, and the type of appeal that would be most appropriate. We also invite submissions as to whether any ancillary powers should be provided to the Court of Criminal Appeal to assist it in determining such cases.

#### Issue 6.67

In what circumstances (if any) should the *Criminal Appeal Act* provide for the person the subject of the proceedings to appeal against:

- (a) a verdict of NGMI;
- (b) orders by the court in cases where the person is NGMI;
- (c) non-acquittal at a special hearing?
- (d) orders by the court in cases where the person is UNA?

176. See *Criminal Appeal Act 1912* (NSW) s 6 and see supplementary provisions: s 6A, 7(4). Different rules apply depending on whether the proceedings at first instance were before a jury or a judge sitting alone.

177. See *Builders Licensing Board v Sperway* (1976) 135 CLR 616, 176-178, 183-184. See for example MHA s 164 (appeals to Supreme Court against decisions by the MHRT in its civil jurisdiction); and consider MHFPA s 77A(8)-(9).

178. *Warren v Coombes* (1979) 142 CLR 531, 551-553; and consider *Criminal Appeal Act 1912* (NSW) s 6A.

179. *House v The King* (1936) 55 CLR 499.

180. *Victorian Stevedoring and General Contracting Company Pty Ltd v Dignan* (1931) 46 CLR 73.

181. See *Criminal Code Act 1983* (NT) s 43X(3)(c), 43ZB; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 19(3)(c), 19A, 24A, 28A, 34, 34A; *Mental Health Act 2000* (Qld) ch 8 pt 2; *Criminal Law Consolidation Act 1935* (SA) s 269Y; *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 12(4) and *Criminal Appeals Act 2004* (WA) s 25; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 36.

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**Issue 6.68**

In what circumstances (if any) should the *Criminal Appeal Act* allow the prosecution to appeal against:

- (a) a verdict of NGMI?
- (b) orders by the court in cases where the person is NGMI?
- (c) orders by the court in cases where the person is UNA?

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**Issue 6.69**

Should the *Criminal Appeal Act* be amended to require the Court of Criminal Appeal to consider the safety of the person and/or the community prior to making an order for release?

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**Issue 6.70**

What manner of appeal is most appropriate for reviewing:

- (a) findings; and
- (b) consequent orders in cases where the person is UNA or NGMI?

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**Issue 6.71**

Should any ancillary powers be provided to assist the Court of Criminal Appeal in deciding such cases?

## The Local Court

6.105 It is unlikely that the legislative scheme governing NGMI applies to Local Court proceedings. The defence of mental illness as provided for in s 38(1) of the MHFPA is limited to indictable offences. Clearly, s 38(1) does not apply to proceedings for summary offences in the Local Court. It is arguably less clear whether s 38(1) applies to indictable offences that are heard summarily in the Local Court.<sup>182</sup> Instead, the Local Court deals with defendants with cognitive or mental health impairments under its diversionary powers in s 32 or 33 of the MHFPA.<sup>183</sup>

6.106 The present differences between the powers of the Local, District and Supreme Courts with respect to accused people with cognitive and mental health impairments appear to reflect the separate historical development of the respective courts, in particular, the fact that

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182. Certain indictable offences can now be heard summarily in the Local Court: see *Criminal Procedure Act 1986* (NSW) ch 5.

183. As to diversion, see MHFPA pt 3, discussed in CP 7.



magistrates used to deal only with relatively trivial offences.<sup>184</sup> That is no longer the case, since the Local Court now shares jurisdiction with the District Court in respect of a large number of offences which are triable both summarily and on indictment.<sup>185</sup>

6.107 The different powers of the Local, District and Supreme Courts mean that outcomes may differ enormously, with implications not only for the possible duration of the court's order,<sup>186</sup> but also for whether or not the person can be subjected to compulsory treatment.<sup>187</sup> The range of possible outcomes may therefore be significantly affected by extraneous factors, such as discretionary decisions by the defence and/or the prosecution as to the court in which the person should be tried, which might be based on quite mundane considerations such as cost efficiency and the relative workloads of the police and Director of Public Prosecutions.

6.108 To the extent that the Local Court lacks the power to ensure that people who are unfit or NGMI are made subject to the jurisdiction of the MHRT, the current arrangements lead to inadequate protection of the community. The present arrangements also give rise to miscarriages of justice in cases where people are convicted of offences in the Local Court

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184. See *Justices Act 1902* (NSW) pt 4 div 1 (as originally enacted), which confers jurisdiction on Courts of Petty Sessions to hear only committal, but not trial proceedings in respect of indictable offences; see also *Pioch v Lauder* (1976) 13 ALR 266, 271-272; *R v Horseferry Rd Magistrates Court* [2006] 3 All ER 719, 730-736.

185. See *Criminal Procedure Act 1986* (NSW) s 5-7, sch 1.

186. Even in the ordinary case, the Local Court has a more limited sentencing jurisdiction than the District and Supreme Courts, and cannot impose a sentence of imprisonment of more than two years: *Criminal Procedure Act 1986* (NSW) s 267, 268.

187. Consider for example, an assault involving a person with an intellectual disability who is unfit to be tried. In the Local Court, the person could be dealt with by diversion into care and/or treatment to which he or she consents, with a six month period of court supervision (MHFPA s 32), or alternatively by way of conviction and sentence for up to two years' imprisonment, despite the person's unfitness. Conversely, if tried in the District Court, the person would proceed through a special hearing to a limiting term or other disposition. If a limiting term of up to five years were imposed, the person would become a forensic patient and could be subjected to compulsory treatment: see ch 7.

despite unfitness or an entitlement to the defence of mental illness.<sup>188</sup> There does not appear to be any reason in principle why the Local Court should not have powers to deal appropriately with people who are unfit or NGMI. Overall, the Local Court now deals with the vast majority of criminal matters in NSW.<sup>189</sup> The Commission is of the view that it is appropriate that Local Court magistrates should have powers to deal with the full range of circumstances with which they are likely to be confronted.

6.109 In many jurisdictions, legislation provides procedures and powers for cases involving defendants who are unfit or found NGMI in courts of summary jurisdiction.<sup>190</sup> There may be some resource implications if similar provisions were enacted in NSW. However, that would depend on what powers are provided, and could be mitigated by retaining the possibility for the court to divert or discharge the person in relatively minor cases.<sup>191</sup>

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#### Issue 6.72

Is there any reason why Local Court magistrates should not have power to make orders in respect of persons who are UNA or NGMI?

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#### Issue 6.73

If the Local Court should have powers for cases involving persons who are UNA or NGMI, should they be the same as the powers of the District and Supreme Courts? If not, what should be provided?

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188. *Mantell v Molyneux* (2006) 165 A Crim R 83; see also *Police v Goodworth* [2007] NSWLC 2.

189. See NSW Bureau of Crime Statistics and Research, *New South Wales Criminal Court Statistics 2007* (2008) 3, 9, 11. Of 148,974 persons whose criminal matters were finalised in NSW in 2006/2007, the Local Court finalised 91.7% (136,635 persons), the Children's Court finalised 6.1% (9,141 persons) and the District and Supreme Courts together finalised 2.1% (3,198 persons).

190. See *Crimes Act 1900* (ACT) pt 13 div 13.1, 13.2, 13.4, 13.6 (indictable offences only); *Mental Health Act 2000* (Qld) ch 7 pt 4 especially s 256 (indictable offences only); *Criminal Law Consolidation Act 1935* (SA) pt 8A, especially s 269A(1) (definition of "judge"); *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) pt 2-3 and *Criminal Procedure Act 2004* (WA) s 125, 146; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 4(1), pt 2; *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 4(1) (definition of "court").

191. See CP 7.

7.

## **Management of forensic patients following court proceedings**

- Introduction
- The forensic division of the MHRT
- Particular features of the forensic mental health system
- Considerations for decision-making about forensic patients
- Should there be a time limit?

## INTRODUCTION

7.1 If a person is unfit to be tried and is not acquitted at special hearing,<sup>1</sup> or is found “not guilty by reason of mental illness”,<sup>2</sup> the court may make certain orders for the person to be detained or released, some of which have the effect that the person becomes a “forensic patient” within the meaning of the *Mental Health (Forensic Provisions) Act 1990* (NSW) (“the MHFPA”).<sup>3</sup> Those orders, and the principles on which the court determines what order to make, are discussed in the previous chapter. In this chapter, we deal with how the person is subsequently managed within the forensic mental health system, until such time as he or she ceases to be a forensic patient. Consequently, this chapter should be read in conjunction with Chapter 6.

7.2 The forensic mental health system in NSW is established by the provisions of Part 5 of the MHFPA in conjunction with the *Mental Health Act 2007* (NSW) (“the MHA”). The legislative framework provides for the care, treatment, detention and release of forensic patients, overseen by a specialist Forensic Division of the Mental Health Review Tribunal (“the MHRT”). In this chapter, we consider the decision-making functions, powers and procedures of the MHRT in respect of forensic patients after the court process has ended. These include, in particular, the requirement for the MHRT to conduct periodic and ad hoc reviews of the case of each forensic patient, and the Tribunal’s powers to make orders regarding the detention, release, care and treatment of forensic patients.

7.3 We also discuss two significant features of the forensic mental health system, namely, the detention of forensic patients in correctional centres, and the provisions of the MHFPA which empower the MHRT to authorise compulsory medical treatment of forensic patients.

7.4 Furthermore, we examine the principles and factors for decision-making in respect of forensic patients, in particular, the meaning of “safety” and the related principle of “least restriction”. Finally, we consider whether a person who becomes a forensic patient should remain so indefinitely, or whether a time limit should apply and, if so, how any such time limit should be fixed.

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1. See ch 1 and 2.

2. See ch 3.

3. *Mental Health (Forensic Provisions) Act 1990* (NSW) (“MHFPA”) s 42.

## Why do we have a forensic mental health system?

7.5 The forensic mental health system deals with people who engage in conduct that would, or might, ordinarily lead to a criminal sanction were it not for the person's cognitive or mental health impairment. It is therefore to be distinguished both from the penal system, which exists to punish convicted offenders, and from the civil mental health system, which exists to provide for the care, treatment and control of persons in the general community who have a narrowly defined "mental illness" or "mental disorder".<sup>4</sup>

7.6 Part 5 of the MHFPA, which establishes the system for review, detention and release of forensic patients, contains the following statement of objects:

- (a) to protect the safety of members of the public,
- (b) to provide for the care, treatment and control of persons subject to criminal proceedings who are suffering from a mental illness or mental condition,
- (c) to facilitate the care, treatment and control of any of those persons in correctional centres through community treatment orders,
- (d) to facilitate the provision of hospital care or care in the community through community treatment orders for any of those persons who require involuntary treatment, [and]
- (e) to give an opportunity for those persons to have access to appropriate care.<sup>5</sup>

## How does a person become a forensic patient?

7.7 The focus of this chapter is on the management, within the forensic mental health system, of forensic patients in respect of whom the court process, whether a trial or a special hearing, has ended.<sup>6</sup> For the purposes of this chapter, forensic patients are those people who are:

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- 4. MHA s 3.
  - 5. MHFPA s 40. See also MHFPA s 76B which imports certain objects and principles from the MHA, subject to the other provisions of the MHFPA.
  - 6. The powers of the court regarding forensic patients, including the role of MHRT, is examined in detail in ch 6, and is not the subject of discussion in this chapter. Nevertheless, many aspects of the forensic mental health system which

- unfit to be tried and not acquitted at a special hearing (“UNA”), and in respect of whom the court sets a limiting term and makes an order for detention;<sup>7</sup>
- found not guilty by reason of mental illness (“NGMI”) at a trial or special hearing, and in respect of whom the court makes an order for conditional release,<sup>8</sup> or detention.<sup>9</sup>

7.8 The current legislative definition of “forensic patient” does not include people who are UNA and in respect of whom the court makes a non-custodial order.<sup>10</sup> Accordingly, such people are not subject to the forensic mental health system or to the jurisdiction of the Forensic Division of the MHRT.<sup>11</sup>

## THE FORENSIC DIVISION OF THE MHRT

7.9 The Forensic Division of the MHRT was established by the *Mental Health Legislation Amendment (Forensic Provisions) Act 2008* (NSW), which commenced on 1 March 2009.<sup>12</sup> It has the power, previously held by the executive government, to make orders for the care, detention and release of forensic patients,<sup>13</sup> and is responsible for conducting reviews of forensic patients. The Forensic Division is constituted by the President or a Deputy President, an expert member and another member.<sup>14</sup> In this chapter, references to the MHRT should be taken as references to its Forensic Division unless otherwise stated.

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are described in this chapter also apply to persons who become forensic patients during court proceedings.

7. MHFPA s 27, 42(a)(i); see [6.14]-[6.25].
8. MFHPA s 39, 42(a)(i).
9. MFHPA s 39, 42(a)(i); see [6.31]-[6.39].
10. MHFPA s 52(1)(b).
11. The appropriateness of that outcome is considered at [6.17], [6.47].
12. *Mental Health Legislation Amendment (Forensic Provisions) Act 2008* (NSW) s 3, sch 1 [14]; see MHFPA pt 5 div 7.
13. See MHFPA pt 5 especially s 73; see previously and compare MHCPA pt 5 especially s 48, whereby the MHRT only had the power to make recommendations, not orders. Previously, the MHRT could only make recommendations about forensic patients to the Minister for Health. Orders relating to care, treatment, detention or release of forensic patients were made by the “prescribed authority”, which was either the Governor or the Minister for Health.
14. MHFPA s 73.

7.10 The MHRT has six main functions in respect of forensic patients: (i) conducting periodic and other reviews; (ii) making determinations about whether the person is to be released or detained; (iii) if the person is not to be released, where the person is to be detained; (iv) if the person is to be released, or granted leave, setting any conditions to which that release or leave is to be subject; (v) reviewing breaches of conditions of release or leave and making consequent orders; and (vi) authorising compulsory medical treatment.<sup>15</sup>

7.11 In general, the functions of the MHRT with regard to forensic patients are the same irrespective of whether the person was found NGMI or UNA.<sup>16</sup> In this part of the chapter, we examine the functions and procedures of the MHRT in relation to reviews of forensic patients generally; the powers of the MHRT to order and oversee a forensic patient's release or leave of absence from the place of detention, including provisions for dealing with breaches of conditions; and participation by victims and carers in proceedings. The supplementary provisions regarding forensic patients who are UNA are then discussed, followed by an outline of the circumstances in which a person ceases to be a forensic patient. Finally, we consider the provisions for appeals against MHRT decisions.

### Periodic and ad hoc reviews of forensic patients

7.12 As soon as practicable after a court makes an order for the detention or conditional release of a person,<sup>17</sup> the MHRT must review the person's case and make an order as to the person's care, treatment, detention or conditional or unconditional release.<sup>18</sup> After the initial review, the MHRT may review the person's case at any time, but must, in any event, review the person's case at least every six months.<sup>19</sup> Additionally, the MHRT must review the person's case if he or she is apprehended following breach of a condition of leave or release;<sup>20</sup> and

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15. Discussed at [7.12]-[7.23].

16. The MHRT has three additional functions in respect of a forensic patient who is UNA: see [7.29]-[7.34].

17. MHFPA s 27, 39, and see ch 6.

18. MHFPA s 44(2). The provision does not apply if the person ceases to be a forensic patient: subs (3) and see s 51(1)(a).

19. MHFPA s 46(1). This is subject to two exceptions: see s 46(3)-(5), 67.

20. See [7.23].

whenever it is requested to do so by certain authorities.<sup>21</sup> There is, however, no provision for the forensic patient to apply for a review.<sup>22</sup>

#### Issue 6.74

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Should the MHFPA provide for a forensic patient to apply for a review of his or her case?

7.13 On a review, the MHRT may make an order as to the patient's continued detention, care or treatment in a mental health facility, correctional centre or other place, or order the patient's release, either conditionally or unconditionally.<sup>23</sup> The MHRT also has the power to grant periods of leave from any place where a person is detained,<sup>24</sup> but only if satisfied that it is safe to do so.<sup>25</sup> Otherwise, it must order that the person be detained or continue to be detained.<sup>26</sup>

7.14 The factors and principles which the MHRT is required to consider, including the meaning of "safety", are discussed later in the chapter,<sup>27</sup> as are the provisions for appeals against decisions by the MHRT.<sup>28</sup>

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21. The authorities are the Minister for Health, the Attorney General, the Minister for Justice, the Minister for Juvenile Justice, the Director-General of the Department of Health, or the medical superintendent of the mental health facility in which the patient is detained: MHFPA s 46(2).

22. This arguably infringes the recognised human right of a person who is detained to initiate judicial review of the lawfulness of the detention: *International Covenant on Civil and Political Rights* art 9(4); *Convention on the Rights of the Child* art 40(2)(b); *Beijing Rules* art 7; *European Convention for the Protection of Human Rights and Fundamental Freedoms* art 5(4); *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 21(7); and see discussion in *Kracke v Mental Health Review Board* [2009] VCAT 646, [621], [642]-[645], [663]. See also habeas corpus applications by NSW forensic patients: *Mailes v Director of Public Prosecutions* [2006] NSWSC 267; *Commissioner of Corrective Services v Wedge* [2006] NSWCA 271. And compare MHA s 65(2)(a) (right of civil patient to apply for revocation of community treatment order).

23. MHFPA s 44(2), 47(1). On an initial review the MHRT must make an order; on a subsequent review the MHRT may make an order.

24. See MHFPA s 49. The Director-General of the Department of Health also has a limited power to grant leave: s 50.

25. MHFPA s 43.

26. See MHFPA s 44, 47.

27. See [7.78]-[7.88].



## Powers in relation to leave and conditional release

7.15 In cases where the MHRT makes an order for release or leave, the MHFPA provides a non-exhaustive list of enforceable conditions that may be imposed.

### *Conditions which may be imposed*

7.16 The conditions which the MHRT may attach to an order for leave or release include, but are not limited to, conditions in relation to:

- (a) the appointment of a case manager, psychiatrist or other health care professional to assist in the care and treatment of the patient,
- (b) the care, treatment and review of the patient by persons referred to in paragraph (a), including home visits to the patient,
- (c) medication,
- (d) accommodation and living conditions,
- (e) enrolment and participation in educational, training, rehabilitation, recreational, therapeutic or other programs,
- (f) the use or non-use of alcohol and other drugs,
- (g) drug testing and other medical tests,
- (h) agreements as to conduct,
- (i) association or non association with victims or members of victims' families,
- (j) prohibitions or restrictions on frequenting or visiting places, [and]
- (k) overseas or interstate travel.<sup>29</sup>

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### Issue 6.75

Are the provisions regarding the conditions that may attach to leave or release adequate and appropriate? If not, what changes should be made?

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28. See [7.44]-[7.46].

29. MHFPA s 75(1). The MHRT may also impose conditions in relation to other matters: s 75(2).

### *Notification requirements*

7.17 The MHRT must inform the Minister for Police, the Minister for Health and the Attorney General of any order it makes for the release of a forensic patient, including the date of release.<sup>30</sup> The provision appears to be a relic from the days when the executive government could instigate the return to custody of forensic patients who were conditionally released into the community. Previous reviews, including one by this Commission, have recommended that the requirement to notify the various ministers, particularly the Minister for Police, should be removed.<sup>31</sup> However, there may still be a need for notification of the Attorney General and the Minister for Health, both of whom have rights of appeal against decisions of the MHRT.

### Issue 6.76

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Should the MHFPA be amended to abolish the requirement for the MHRT to notify

- the Minister for Police;
- the Minister for Health; and/or
- the Attorney General

of an order for release?

### *Implementation of orders for leave or conditional release*

7.18 Prior to releasing a forensic patient from a mental health facility, the “authorised medical officer” must take “all reasonably practicable steps” to make arrangements for the person’s release or leave, in consultation with the person, the person’s carer (if he or she has one) and relevant agencies.<sup>32</sup> No equivalent requirement applies in respect of forensic patients who are being released from a place other than a mental health facility.<sup>33</sup>

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30. MHFPA s 76A(6). The Attorney General and the Minister for Health may exercise a right of appeal against the decision of the MHRT: see MHFPA s 77A and [7.45].

31. See the Hon Greg James QC, *Review of the NSW Forensic Mental Health Legislation*, Report (2007) [8.44]-[8.52], Recommendation 28; NSW Law Reform Commission, *People with an Intellectual Disability in the Criminal Justice System*, Report No 80 (1996) [5.51], [5.56] (“NSWLRC Report 80”), recommendation 20(c).

32. MHFPA s 76G. See also and compare MHA s 79.

33. For issues relating to the detention of forensic patients in correctional centres, see [7.48]-[7.55].

7.19 The MHFPA provides for the MHRT to impose a condition with respect to “the appointment of a case manager, psychiatrist or other health care professional to assist in the care and treatment of the patient”, who may conduct home visits.<sup>34</sup>

7.20 The MHFPA provisions regarding the content and enforcement of orders for forensic patients are different from the civil provisions of the MHA regarding “community treatment orders”.<sup>35</sup> In cases where a community mental health service is involved in implementing an order for leave or conditional release of a forensic patient, the differences between the two legislative schemes may create uncertainty among staff as to their powers and obligations under the forensic order, and thus impede its effective implementation.

7.21 A new provision in the MHFPA requires the Departments of Health, Corrective Services, Juvenile Justice and “any other government Department or agency responsible for the detention, care or treatment of a forensic patient” to “use their best endeavours to comply with a request made to them under [the] Act by the Tribunal if the request is consistent with the discharge of their responsibilities and does not unduly prejudice the discharge of their functions”.<sup>36</sup> The provision is expressed in very general terms, which may give rise to uncertainty as to the roles and responsibilities of the agencies that agree to provide services. It remains to be seen whether this provision will assist the MHRT to arrange personnel to support, and supervise forensic patients.

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#### Issue 6.77

Should legislation provide specific roles for an agency or agencies in relation to supporting and supervising forensic patients in the community?

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34. MHFPA s 75(1)(a)-(b).

35. See MHFPA s 43 (matters for consideration), 75 (conditions that may be imposed), pt 5 div 6 (enforcement); compare MHA ch 3 pt 3 especially s 53 (matters for consideration), 54 (requirement for treatment plan), 56 (form of order), div 2-3 (enforcement and review).

36. MHFPA s 76K(1), see also s 76J. See *Mental Health (Forensic Provisions) Regulation 2009* (NSW) reg 14; and MHA s 162A.

Issue 6.78

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Are there any legislative changes that should be made in relation to the making and implementation of orders for:

- leave; and/or
- conditional release

of forensic patients?

*Breach of conditions of leave or release*

7.22 If it appears to the President of the MHRT that the person has breached a condition, or “has suffered a deterioration of mental condition and is at risk of causing serious harm to himself or herself or to any member of the public because of his or her mental condition”, the President may make an order for the apprehension of the person by the police.<sup>37</sup>

7.23 When the person has been apprehended, the MHRT must review his or her case. On such a review, the person “may request the Tribunal to investigate the evidence on which the order for the person’s apprehension was made and may adduce other evidence for the consideration of the Tribunal.”<sup>38</sup> The MHRT may either confirm the person’s release or leave (with or without conditions), or may make an order for the person’s detention, care or treatment in a mental health facility, correctional centre or other place.<sup>39</sup>

Issue 6.79

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Are the procedures relating to breaches of orders adequate and appropriate? If not, what else should be provided?

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37. MHFPA s 68-69, 72. It is not clear whether or not other persons, such as medical staff, are or can be empowered to apprehend the person: contrast s 70(1). See also and compare MHA s 48(2), 49, ch 3 pt 3 div 2 (enforcement of community treatment orders), s 81.

38. MHFPA s 69.

39. MHFPA s 68(2), 69(2). See James Report, [8.61]-[8.68], recommendation 31. The factors and principles the MHRT must consider are discussed at [7.72]-[7.77].

## Participation by victims and carers in MHRT proceedings

7.24 The MHFPA recognises that carers and victims of forensic patients may have a legitimate interest in, and/or be able to provide information that is relevant to determinations of the MHRT.<sup>40</sup>

7.25 The MHRT, in conjunction with the Statewide Forensic Mental Health Directorate, recently established administrative arrangements for notifying registered victims of MHRT hearings and providing assistance to victims in attending and participating in the hearings. A victim may make a written submission in relation to the “care, treatment, detention and release” of a forensic patient and any concerns that the victim has for his or her own safety should the forensic patient be released.<sup>41</sup> Those administrative arrangements are now incorporated to some extent in the MHFPA.<sup>42</sup> In particular, a victim of a forensic patient may apply to the MHRT for a “non-association” or “place restriction” condition to be imposed on (or varied in respect of) the forensic patient’s release or leave.<sup>43</sup>

7.26 The MHFPA does not expressly provide for the notification to carers of, or participation by carers in proceedings of the Forensic Division of the MHRT. The views of a carer, family member or other interested person may be taken into account pursuant to a general provision stating that the MHRT may communicate with any persons it thinks fit.<sup>44</sup>

7.27 The MHFPA requires that if a forensic patient is to be released or granted leave from a mental health facility, the authorised medical officer must take all reasonably practicable steps to ensure that “any primary carer of the person [is] consulted in relation to planning the person’s release and leave and any subsequent treatment or other action considered in relation to the person” and that “appropriate information

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40. See MHFPA s 41(1), 46, 76, 76B, 76G, 77A.

41. James Report, [9.3]-[9.4]; and see Mental Health Review Tribunal (NSW), *Forensic Procedural Note* (January 2008) 30-31.

42. See MHFPA s 41(1), 76, 77A(3); MHA s 160(2)(c)-(d); and see James Report, recommendations 32-34.

43. MHFPA s 76. The victim may appeal to the Supreme Court against any determination by the MHRT in respect of such an application: s 77A and see [7.45].

44. MHFPA s 76A(1).

as to follow-up care” is provided to the carer.<sup>45</sup> However, the provision appears to be unenforceable.<sup>46</sup> No equivalent requirement applies to decision-making by the MHRT,<sup>47</sup> nor in respect of forensic patients who are being released from a place other than a mental health facility.<sup>48</sup>

7.28 In contrast, most other Australian jurisdictions provide for the views of victims and/or carers to be taken into account when decisions are being made about forensic patients, particularly in regard to their release.<sup>49</sup>

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#### Issue 6.80

Are the current provisions concerning notification to, and participation by victims in proceedings of the MHRT adequate and appropriate? If not, what else should be provided?

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#### Issue 6.81

Are the current provisions concerning notification to, and participation by carers in proceedings of the MHRT adequate and appropriate? If not, what else should be provided?

### Additional functions regarding forensic patients who are unfit and not acquitted

7.29 In addition to the general factors and principles that the MHRT must consider, it has three additional functions in respect of forensic patients who are UNA. They relate to:

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45. See MHFPA s 46(4), 76B, 76G.
  46. See MHFPA s 76B(5) and MHA s 195.
  47. Carers have no right of appeal against decisions of the MHRT: cf MHFPA s 77A, discussed at [7.44]-[7.46].
  48. For issues relating to the detention of forensic patients in correctional centres, see [7.48]-[7.55].
  49. See *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 3(1) (“family member”), 38C-38F, 40(2)(c)-(d), 42-46; *Criminal Law Consolidation Act 1935* (SA) s 269A (“next of kin”), 269R, 269T(2); *Mental Health Act 2000* (Qld) s 464, 465 (no entitlement to apply for notification order: see ch 7A); *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 33, 35 and *Mental Health Act 1996* (Tas) s 73V(1)(j), (3); *Criminal Code Act 1995* (NT) s 43ZL, 43ZN, 43ZP. In the NT, if the person is a member of an Aboriginal community, the court may also obtain a report outlining the views of that community: s 43ZL(3)(b).

- the possibility that a UNA forensic patient may become fit to be tried;
- a prohibition on releasing a UNA forensic patient until he or she has been detained for a “sufficient” time; and
- the effect of the expiry of the limiting term.

*Possibility of becoming fit*

7.30 Whenever the MHRT reviews a forensic patient who is UNA, it must assess whether or not the person has become fit for trial, or is likely to become fit within the next 12 months.<sup>50</sup> If the MHRT finds that the person has not become fit, or that he or she will not become fit within 12 months, it must notify the court that made the finding of unfitness and the Director of Public Prosecutions (“the DPP”).<sup>51</sup> If the person has become fit but the DPP determines that no further proceedings will be taken in respect of the offence, the person ceases to be a forensic patient and must be released.<sup>52</sup>

7.31 In Chapter 6, we discuss the extent to which the possibility that a person who is UNA may one day become fit is relevant to decision-making by the court.<sup>53</sup> Similarly, it may be that the legal notion of fitness to be tried has limited or no relevance to the more clinically-focused decision-making of the MHRT. In Queensland, the relevant legislation provides for an automatic permanent stay of proceedings if the person is found to be permanently unfit, or if the person remains unfit after a certain amount of time.<sup>54</sup> The permanent stay does not affect the person’s status as a forensic patient.<sup>55</sup>

7.32 In Canada, the Review Board may refer a person who was UNA to the court, which may order a permanent stay of proceedings. A

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50. MHFPA s 45(2), 47(4)-(5).

51. MHFPA s 45(3), 47(5).

52. MHFPA s 29, 52(4)(b), 54. Issues relating to the release provision are discussed at [7.15]-[7.23].

53. See [6.80].

54. Seven years for offences to which a penalty of life imprisonment applies, or three years for all other offences: *Mental Health Act 2000* (Qld) s 215, s 283. Further proceedings cannot be taken against the person for the relevant offence: s 216(3), s 283. As to whether a “permanent” stay of proceedings can be lifted, see *Director of Public Prosecutions v Polyukhovich (No 2)* (Unreported, SA Supreme Court, Cox J, 1-4 March 1993).

55. *Mental Health Act 2000* (Qld) s 216(4).

permanent stay may be ordered if the court is satisfied that: (i) the accused remains unfit to stand trial and is not likely ever to become fit; (ii) the person “does not pose a significant threat to the safety of the public”; and (iii) that “a stay is in the interests of the proper administration of justice.” If the court orders a permanent stay, the person ceases to be a forensic patient and is entitled to be released.<sup>56</sup>

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#### Issue 6.82

Are the current provisions relating to people who are UNA who become fit to be tried adequate and appropriate?

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#### Issue 6.83

Should a person cease to be a forensic patient if he or she becomes fit to be tried and the Director of Public Prosecutions decides that no further proceedings are to be taken?

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#### Issue 6.84

Should legislation specify circumstances in which, or a period after which, fitness ceases to be an issue?

#### *Sufficient time in custody*

7.33 If the MHRT is considering the release of a forensic patient who is UNA, it must have regard to “whether or not the patient has spent sufficient time in custody”.<sup>57</sup> The MHFPA provides no guidance as to the meaning of “sufficient” in this context. There has been only limited judicial consideration of the provision, with a tendency to regard it as being implicitly, although perhaps not exclusively, punitive in intent.<sup>58</sup> If that is correct, then the provision violates the right of the unfit accused person not to be punished other than following conviction at a fair trial.<sup>59</sup>

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56. See *Criminal Code*, RSC 1985 (Canada) s 672.851.

57. MHFPA s 74(e).

58. See *R v AN (No 2)* (2006) 66 NSWLR 523, [64]-[66], [77]; *Director of Public Prosecutions v Mills* [2000] NSWCCA 236, [39], quoted with approval in *Smith v The Queen* [2007] NSWCCA 39, [63]. The provision has been criticised: see James Report, [8.44]-[8.45], [8.50], recommendation 28; NSWLRC Report 80, [5.54], recommendation 20(a).

59. The right not to be convicted of (and consequently punished for) a criminal offence other than after a fair trial is fundamental to the Australian criminal



A punitive approach is inconsistent with the legislated objects of the forensic mental health system, and with MHRT's central role of overseeing the provision of treatment to forensic (and civil) patients with a view to promoting patient recovery and protecting the community from harm.<sup>60</sup>

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#### Issue 6.85

Should the requirement that the MHRT have regard to whether a forensic patient who was UNA has spent "sufficient" time in custody be abrogated?

#### *Effect of expiry of limiting term*

7.34 Whereas a person who has been found NGMI remains a forensic patient indefinitely,<sup>61</sup> a forensic patient who is UNA must be released unconditionally when the limiting term expires (if he or she has not been released earlier).<sup>62</sup> Mechanisms for the continuing care of the person (if required) are discussed under the next heading. The merits and disadvantages of the limiting term, and possible alternative approaches, are discussed at paragraph 7.89-7.111.

#### When a person ceases to be a forensic patient

7.35 In general, a person ceases to be a forensic patient when one of the following occurs:

- the MHRT or a court orders that the person be released unconditionally;<sup>63</sup>
- the person has been released subject to time-limited conditions, and the time limit for compliance with the conditions expires;<sup>64</sup> or
- the MHRT reclassifies the person as a civil "involuntary patient" under the MHA.<sup>65</sup>

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justice system: *Jago v District Court of NSW* (1989) 168 CLR 23; *Dietrich v The Queen* (1992) 177 CLR 292.

60. See MHFPA s 40; MHA s 3, 68.

61. See ch 3.

62. MHFPA s 51, 52(2)(a), 54 and see s 47.

63. MHFPA s 51(1)(a), see also s 39; and *Criminal Appeal Act 1912* (NSW) s 7(4).

64. MHFPA s 51(1)(b).

65. MHFPA s 53(1)(a). See [7.37]-[7.38].

7.36 Additionally, a person who is UNA ceases to be a forensic patient if:

- the limiting term expires;<sup>66</sup> or
- the person becomes fit to be tried and the DPP notifies the court that no further proceedings will be taken.<sup>67</sup>

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#### Issue 6.86

Are the provisions of the MHFPA which define the circumstances in which a person ceases to be a forensic patient sufficient and appropriate? If not, are there any additional circumstances in which a person should cease to be a forensic patient?

#### *Arrangements for continuing care*

7.37 When a person ceases to be a forensic patient, the MHRT may reclassify the person and continue to detain him or her as an “involuntary patient” if the MHA criteria are satisfied.<sup>68</sup> The MHFPA also provides that a person who ceases to be a forensic patient may choose to remain in a mental health facility as a voluntary mental health patient.<sup>69</sup>

7.38 There is no formal mechanism for the MHRT to refer people who have cognitive (as opposed to mental health) impairments into alternative arrangements for their continuing care, for example, a formal referral to disability services or to the Guardianship Tribunal.

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#### Issue 6.87

Should there be provisions for referring a person who is UNA into other care, support and/or supervision arrangements at the expiry of the limiting term? If so, what should they be?

#### *Entitlement to release?*

7.39 It might be assumed that, when a person ceases to be a forensic patient, he or she is entitled to be released into the community unless

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66. MHFPA s 52(2)(a).

67. MHFPA s 52(4)(b), and see s 29, 47(4)-(5).

68. MHFPA s 53; and see MHA ch 3 especially pt 1. It may also be possible to make a Community Treatment Order in respect of the person: see MHFPA s 67(4) and MHA ch 3 pt 3.

69. MHFPA s 76H.

there is some other lawful basis on which to continue to detain the person. However, that is not always so under the provisions of the MHFPA.

7.40 If a person has ceased to be a forensic patient because the MHRT has reclassified the person as an “involuntary patient”, the civil provisions of the MHA provide a lawful basis for the person’s continuing detention.<sup>70</sup> The civil provisions of the MHA do not authorise the detention of involuntary patients in correctional centres. However, if the person is detained in a correctional centre immediately prior to reclassification, the MHFPA only permits, but does not require, the MHRT to order that the person be transferred to a mental health facility.<sup>71</sup>

7.41 Furthermore, where a person ceases to be a forensic patient and is not reclassified as an involuntary patient, the MHFPA requires that he or she must be discharged from a mental health facility.<sup>72</sup> However, there is no equivalent provision in respect of a person who is detained in a correctional centre or “other place” immediately prior to the termination of his or her status as a forensic patient. While this situation could be remedied by the MHRT ordering a patient’s unconditional release,<sup>73</sup> or transfer to a mental health facility from which he or she could be discharged,<sup>74</sup> it appears to be a legislative oversight that should be rectified.

7.42 In addition, if a person ceases to be a forensic patient because he or she was UNA and has become fit and no further proceedings are to be taken, there is no clear provision for his or her discharge from custody. The MHFPA provides as follows:

If the Director of Public Prosecutions advises the Minister for Health that a person will not be further proceeded against, the Minister for Health must, after having informed the Minister for Police of the date of the person’s release, do all such things within the power of the Minister for Health to order the person’s release from detention or to otherwise ensure the person’s release from detention.<sup>75</sup>

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70. See generally MHA ch 3.

71. MHFPA s 53(2).

72. MHFPA s 54.

73. MHFPA s 47(1)(b).

74. MHFPA s 48.

75. MHFPA s 29(3).

This falls short of an absolute entitlement to release.

7.43 The MHFPA may require amendment to clarify the entitlement of the person to be released from detention, wherever detained, when the person ceases to be a forensic patient.

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#### Issue 6.88

Are the provisions regarding the entitlement to be released from detention upon ceasing to be a forensic patient adequate and appropriate? If not, what else should be provided?

### Appeals against MHRT findings and orders

7.44 Decisions by the Forensic Division of the MHRT may be appealed to the Supreme Court or Court of Appeal in circumstances prescribed by the MHFPA.<sup>76</sup>

7.45 A forensic patient may apply for leave to appeal either to the Court of Appeal regarding release, or to the Supreme Court in relation to other determinations.<sup>77</sup> In contrast, the Minister for Health may appeal in either instance as of right.<sup>78</sup> The Attorney General has a right of appeal to the Court of Appeal in relation to a decision by the MHRT regarding the release of a person, but only on a question of law.<sup>79</sup> A victim of a forensic patient may, with leave, appeal against a determination by the MHRT regarding non-association and/or place restriction conditions attached to the patient's release or leave of absence from a mental health facility or other place.<sup>80</sup>

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76. MHFPA s 77A. The appeal provisions of the MHFPA refer to the "Tribunal" and are not limited to its Forensic Division: cf s 3, 41. They should therefore be read in conjunction with the appeal provisions of MHA ch 7 (appeals to the Supreme Court against decisions by the MHRT) especially s 164 (powers of the Court on an appeal).

77. MHFPA s 77A(1), (4).

78. MHFPA s 77A(2), (5).

79. MHFPA s 77A(6).

80. MHFPA s 77A(3).

7.46 The appellate court may affirm the MHRT's determination, may make such order as it considers the MHRT should have made, or may remit the matter to the MHRT for rehearing.<sup>81</sup>

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#### Issue 6.89

Are the provisions for appeals against decisions by the MHRT adequate and appropriate? If not, how should they be modified?

## PARTICULAR FEATURES OF THE FORENSIC MENTAL HEALTH SYSTEM

7.47 In this part of the chapter, we consider two aspects of the way that forensic patients are managed within the forensic mental health system. First, we examine the detention of forensic patients in correctional centres, and secondly, the legislative provisions which authorise compulsory treatment of forensic patients. Both matters involve significant curtailment of the human rights of forensic patients, and thus bear on questions relating to the exercise of the discretion to detain or release the person, and to the duration for which the person should remain a forensic patient.

### Detention of forensic patients in correctional centres

7.48 In the 2007-2008 financial year, approximately one sixth of forensic patients in NSW were detained in correctional centres.<sup>82</sup> A forensic patient may be detained in a prison because:

- the person cannot be safely managed other than in a high security environment;<sup>83</sup>
- no place is available in a mental health facility;<sup>84</sup>

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81. MHFPA s 77A(9) and see MHA s 164, 166, 167. Consider *Builders Licensing Board v Sperway* (1976) 135 CLR 616, 176-178, 183-184; *Warren v Coombes* (1979) 142 CLR 531, 551-553.

82. See data in MHRT, *Annual Report 2007/2008* (2008), Table 25 (54 out of 315 forensic patients).

83. Consider *R v Adams* (2003) 58 NSWLR 1; *Courtney v The Queen* [2007] NSWCCA 195.

84. See, eg, *Inquest into the death of Scott Ashley Simpson* (Unreported, NSW Coroner's Court, Deputy State Coroner Magistrate Pinch, 17 July 2006).

- the person is ineligible for a place in a mental health facility because the person is no longer mentally ill,<sup>85</sup> or the person has an impairment other than a mental illness for which no forensic facilities exist in NSW.<sup>86</sup>

7.49 Previous reviews have identified resource constraints as a reason for the use of correctional facilities for the detention of forensic patients.<sup>87</sup> However, it may also be partly attributable to the mental health focus of the MHFPA, which does not provide a role for state disability support or other service agencies in the “care, treatment and control” of forensic patients.<sup>88</sup> An important consequence of this omission is the absence of any “declared facilities” where forensic patients with cognitive impairments can be detained and appropriately treated or managed, and of infrastructure to assist them in the community in supported accommodation or otherwise, leaving prison as the default option. There is a similar lack of specialist facilities and support for forensic patients with personality disorders.<sup>89</sup>

7.50 Within the correctional system, forensic patients are implicitly included in the definition of “inmate” for the purposes of the *Crimes (Administration of Sentences) Act 1999* (NSW) (“CASA”).<sup>90</sup> The CASA contains no express references to forensic patients. Significantly, a

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85. For example, if the person had acute clinical depression or a substance-related disorder which has resolved. See also MHA s 166(1)(c)-(3) (if Supreme Court finds that a forensic patient is wrongly detained in a mental health facility, the court must order that the person be transferred to a correctional facility).

86. See, eg, *Agha v The Queen* [2008] NSWCCA 153 (intellectual disability); *Mailes v Director of Public Prosecutions* [2006] NSWSC 267, [6] (intellectual disability); *R v Adams* (2003) 58 NSWLR 1 (personality disorder); *Courtney v The Queen* [2007] NSWCCA 195 (personality disorder). See also the Hon Greg James QC, *Review of the Forensic Provisions of the Mental Health Act 1990 and the Mental Health (Criminal Procedure) Act 1990*, Consultation Paper (2006) 14, 42.

87. James Report, [3.16]-[3.17], [3.20]; see also and compare J Simpson, M Martin and J Green, *The Framework Report: Appropriate Community Services in NSW for Offenders with Intellectual Disabilities and Those at Risk of Offending* (2001) 3-5, 56-57; and NSWLRC Report 80, [11.1]-[11.19].

88. See NSWLRC Report 80, [11.27]-[11.29], recommendation 57.

89. See, eg, *R v Adams* (2003) 58 NSWLR 1; *Courtney v The Queen* [2007] NSWCCA 195.

90. See *Crimes (Administration of Sentences) Act 1999* (NSW) (“CASA”) s 3(1), 4(1)(e). See also *Children (Detention Centres) Act 1987* (NSW) s 3(1) (definitions of “inmate” and “detainee”).

person's status as a forensic patient is not part of the information that is required to be recorded when an inmate is received into a correctional centre, nor in an inmate's individual "case plan".<sup>91</sup> No special classification is accorded to forensic patients.<sup>92</sup> The absence of any reference to forensic patients in the CASA creates a risk that forensic patients will be "invisible", for administrative purposes, within the correctional system.<sup>93</sup>

7.51 Since forensic patients who are UNA are not eligible for parole, and since those who have been found NGMI have no fixed release date, they are frequently allocated higher security classifications than comparable convicted inmates.<sup>94</sup> Additionally, many forensic patients are housed in protective custody or even segregation, due to the shortage of appropriate facilities in the correctional system for inmates with cognitive and mental health impairments.<sup>95</sup> The higher security classification and isolated custody arrangements make it difficult for the MHRT to progress the person through various levels of restriction in order to be satisfied that it is safe for the person to be granted leave, and eventually released.<sup>96</sup> Forensic patients may also miss out on rehabilitation and other programs, because the available programs are more limited in higher security and protective custody settings,<sup>97</sup> and/or because of administrative systems

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91. See *Crimes (Administration of Sentences) Regulation 2008* (NSW) reg 5, pt 2.2 div 1 and sch 1.

92. See *Crimes (Administration of Sentences) Regulation 2008* (NSW) pt 2.2 div 2 especially reg 22-23.

93. See James Report, [4.1]-[4.20], [8.16], [8.23]-[8.25], recommendations 8, 9, 22-24; see also the Hon Greg James QC, *Review of the Forensic Provisions of the Mental Health Act 1990 and the Mental Health (Criminal Procedure) Act 1990*, Consultation Paper (2006) 42-44; NSW Legislative Council General Purpose Standing Committee No 3, *Issues Relating to the Operations and Management of the Department of Corrective Services*, Report 17 (2006) [4.127]-[4.135].

94. James Report, [8.23]-[8.25].

95. The Hon Greg James QC, *Review of the Forensic Provisions of the Mental Health Act 1990 and the Mental Health (Criminal Procedure) Act 1990*, Consultation Paper (2006) 14.

96. James Report, [8.17]; and see MHFPA 43(a).

97. See, eg, *R v Adams* (2003) 58 NSWLR 1, [5], [8], [10]-[11], [16]-[17].

which prioritise inmates' access to programs according to parole eligibility dates.<sup>98</sup>

7.52 The MHRT has the power to order that a forensic patient be detained in a particular correctional facility if, for example, specialist facilities or services are available there. However, the MHFPA provides that the Department of Corrective Services or Department of Juvenile Justice may disregard such an order and place the person in a different facility, with no requirement to consider any particular factors or to give reasons for the decision.<sup>99</sup>

7.53 The MHA principles for care and treatment apply to all forensic patients, including those in correctional centres, subject to the provisions of the CASA.<sup>100</sup> However, some MHFPA provisions relating to the management of forensic patients, such as the requirement for pre-release planning, apply only to forensic patients who are detained in mental health (not correctional) facilities.<sup>101</sup>

7.54 Consideration may be given to improving the legislative framework under which forensic patients who are detained in correctional centres are managed within the correctional system. This is a matter on which we seek submissions. However, there is a broader question. Forensic patients are people who, by definition, have not been convicted of any offence. Prisons are places of punishment. Given that the forensic mental health system exists to provide an alternative to penal sanctions for persons who cannot be held legally responsible for their actions, the question must be asked whether it can ever be appropriate for forensic patients to be detained in correctional facilities.

7.55 A comparison can validly be drawn with the civil mental health system, which shares the object of ensuring the protection of the public from people who, by reason of mental disorder, may cause harm to

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98. NSW Legislative Council General Purpose Standing Committee No 3, *Issues Relating to the Operations and Management of the Department of Corrective Services*, Report 17 (2006), [4.127]-[4.135]; and see especially James Report, [4.1]-[4.20], [8.10]-[8.11], [8.16]-[8.17], [8.23]-[8.25], Recommendations 8, 9, 22-24.

99. MHFPA s 77C.

100. MHFPA s 76B(1), 76C, see also s 76D, 77C.

101. *Crimes (Administration of Sentences) Regulation 2008* (NSW) reg 13 provides for (optional) pre-release planning, but has no particular focus on treatment and support requirements related to the person's cognitive or mental health impairment.



others, but which does not provide for the detention of mental health patients in correctional centres. In several jurisdictions, there is either no provision for detaining forensic patients in prisons, or it is expressly prohibited.<sup>102</sup> That position reflects developments in clinical knowledge, and gives effect to human rights and fundamental principles of the criminal law. We seek submissions on whether or not it remains appropriate for forensic patients in NSW to be detained in correctional centres.

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#### Issue 6.90

Should the MHFPA be amended to exclude the detention of forensic patients in correctional centres?

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#### Issue 6.91

If detaining forensic patients in correctional centres is to continue, are legislative measures needed to improve the way in which forensic patients are managed within the correctional system?

### Compulsory treatment

7.56 The MHA defines the circumstances in which a person may be detained as a civil patient in a mental health facility. Once a person is classified as an “involuntary patient”, an authorised medical officer may give, or authorise the giving of, any treatment (including any medication) the officer thinks fit, subject to the provisions of the MHA and the MHFPA.<sup>103</sup> It is the fact of being detained in a mental health facility which renders the person liable to compulsory treatment under the MHA. The

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102. See *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 24; *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 4(1) (definitions of “hospital” and “facility”), *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s 2, pt 4 and especially *Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003* (NZ) s 9(4); *National Health Service Act 2006* (UK) s 4(4), 275 (definition of “hospital”); *Criminal Code*, RSC 1985 (Can) s 672.1(1) (definition of “hospital”), 672.54(c); see also *United States Code*, tit 18 ch 313 §4247(a)(2) (definition of “suitable facility”).

103. MHA s 84 and see generally ch 4. Other limitations can be derived from medical ethics, to which medical practitioners (including psychiatrists) are subject: see generally Australian Medical Association, *Code of Ethics* (revised ed 2006), available at <<[www.ama.com.au/web.nsf/doc/WEEN-6VL8CP](http://www.ama.com.au/web.nsf/doc/WEEN-6VL8CP)>>.

civil provisions of the MHA prohibit detention unless a person is either a “mentally disordered person” or, for longer term detention, a “mentally ill person”, and in need of treatment in order to avert a risk of harm to that person or others.<sup>104</sup>

*Compulsory treatment of forensic patients in a mental health facility*

7.57 For the purposes of the compulsory treatment provisions of the MHA, the definition of “involuntary patient” expressly includes forensic patients.<sup>105</sup> Forensic patients may be detained in mental health facilities by order of the court or the MHRT, or if transferred from a correctional facility. However, the legislative criteria for the transfer and detention of forensic patients in a mental health facility are not consistent with the civil criteria for detention.<sup>106</sup>

7.58 Consequently, some people who would not be treated compulsorily under the MHA are nevertheless subject to compulsory treatment by virtue of being a forensic patient detained in a mental health facility. This could include forensic patients who have intellectual or developmental disabilities,<sup>107</sup> acquired brain injuries, dementia, or personality disorders. It could also include forensic patients who have stable mental illnesses (that is, who are no longer acutely unwell) and less serious mental health disorders that would not ordinarily give rise to detention and compulsory mental health treatment in the community.

*Compulsory treatment of forensic patients in correctional centres*

7.59 The position is different again for forensic patients who are detained in correctional centres. The section of the MHA which authorises compulsory treatment of involuntary patients applies only to those detained in mental health facilities.<sup>108</sup> There is no equivalent general authorisation of compulsory treatment of forensic patients who are detained in correctional centres. Nevertheless, two pieces of legislation provide for forensic patients who are detained in correctional centres to

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104. MHA ch 3 pt 1.

105. See MHA s 82, 87, 98.

106. See MHFPA s 16(2), 17(3), 24(2), 27, 39, 47(1)(a), 48, 56, 59(2), 74 and CASA s 24; contrast MHA s 12(2), 35(3), 38(3), 166.

107. A large proportion of people who are UNA fall into this category. Additionally, if the defence of mental illness is amended to clarify that it includes cognitive impairments, there may be some forensic patients who are NGMI who have cognitive impairments: see discussion in ch 3.

108. MHA s 84.

be treated without consent. First, the CASA provides for treatment of a correctional centre inmate without consent if the Chief Executive Officer of Justice Health considers it necessary to do so in order to save the inmate's life or to prevent serious damage to the inmate's health.<sup>109</sup> Secondly, the MHRT has a range of powers to make orders for compulsory treatment of forensic patients in general. It is to those powers which we now turn.

#### *Powers of the MHRT*

7.60 The MHRT may make orders requiring a forensic patient to undergo specified treatments without the forensic patient's consent. Those provisions can be broadly grouped into two categories.

7.61 First, several provisions of the MHFPA provide the MHRT with a general power to make orders for the "care, detention or treatment" of forensic patients.<sup>110</sup> Also, if the MHRT orders that a forensic patient be granted leave of absence or conditional release, it may attach conditions as to "medication" and "care, treatment and review" of the person by an appointed psychiatrist or other health care professional.<sup>111</sup> In addition to those broad provisions, the MHRT has more narrowly defined powers under the MHA to authorise electroconvulsive therapy, surgery, and "special medical treatment".<sup>112</sup> Certain procedures are prohibited, including deep sleep therapy, insulin coma therapy and psychosurgery.<sup>113</sup>

7.62 Secondly, since the amendments to the MHFPA took effect in March 2009, the MHRT is able to make a "community treatment order" ("CTO") regarding a forensic patient detained in a correctional centre or who is on leave or conditional release in the community.<sup>114</sup> A CTO is an enforceable order under the MHA requiring the person to attend a designated mental health facility to receive treatment in accordance with

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109. CASA s 73. The definition of correctional centre inmate includes forensic patients: CASA s 3(1), 4(1)(e).

110. See MHFPA s 44(2)(a), 47(1)(a), 58(3), 59(1), 68(2)(b). Note that an order that a forensic patient be detained in a mental health facility is synonymous with an order that the person be subject to treatment without his or her consent: see [7.56].

111. See MHFPA s 75.

112. MHA ch 4 pt 2, pt 3, s 98-104; *Mental Health Regulation 2007* (NSW) pt 4 and reg 21. See also CASA s 3(1), 4(1)(e), 73.

113. MHA s 83.

114. MHFPA s 67.

a “treatment plan”.<sup>115</sup> The criteria for making a CTO in respect of a forensic patient under the MHFPA are consistent with the prerequisites specified in the MHA which apply in the civil system.<sup>116</sup> However, even if the criteria for a CTO were not established with regard to a forensic patient, arguably the MHRT could nevertheless make a CTO pursuant to its general powers outlined in the preceding paragraph.

*Safeguards in relation to compulsory treatment*

7.63 The MHFPA adopts some, but not all, of the safeguards in the MHA relating to compulsory treatment.<sup>117</sup> The general law, as well as medical ethics,<sup>118</sup> implicitly constrains the powers of the MHRT, or at least the manner in which its orders are implemented.<sup>119</sup> Nevertheless, the powers of the MHRT in respect of forensic patients appear to be subject to fewer constraints than in its civil jurisdiction.

7.64 Moreover, because compulsory treatment under the MHFPA is not restricted to forensic patients who meet the definition of “mentally ill person” or “mentally disordered person”, the broad powers of the MHRT extend to people who would not, apart from their status as forensic patients, be subject to compulsory treatment under the MHA. In the general community, apart from the provisions of the MHA,<sup>120</sup> a person may be treated without consent only if he or she lacks capacity to give informed consent. In such cases, treatment may be administered only pursuant to the general law, which presumes consent to life-saving treatment in circumstances of medical emergency, or in accordance with

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115. See MHA ch 3 pt 3, especially s 53. See also Consultation Paper 5 (“CP 5”), ch 2.

116. MHFPA s 67 and see s 45(3) (requirement for quarterly review); *Mental Health (Forensic Provisions) Regulation 2009* (NSW) pt 3.

117. See MHFPA s 76B, 76G; MHA s 68, 84-86, ch 4 pt 1. For omitted safeguards, see MHA s 69 (offence to ill-treat patients), 74 (provision of information to person who is involuntarily detained, including following breach of CTO), 75 (requirement to notify carer of person’s detention), 77 (requirement to notify person of procedural rights in respect of detention), 78 (requirement to notify carer of other events).

118. See generally Australian Medical Association, *Code of Ethics* (revised ed 2006), available at «[www.ama.com.au/web.nsf/doc/WEEN-6VL8CP](http://www.ama.com.au/web.nsf/doc/WEEN-6VL8CP)».

119. For a consideration of the legality of compulsory treatment at common law, see *Kracke v Mental Health Review Board* [2009] VCAT 646, [431]-[432], [569]-[570].

120. See also *Drug and Alcohol Treatment Act 2007* (NSW), which provides for the compulsory treatment of persons with substance abuse disorders. However, the Act is still in a pilot phase and does not apply across all of NSW.

the substitute decision-making provisions of the *Guardianship Act 1987* (NSW).

7.65 The adequacy of the safeguards in the NSW legislation is considered later in this chapter.

*Forensic patients who have cognitive impairments and no mental illness*

7.66 There are two further issues relating particularly to forensic patients who have cognitive impairments. First, the MHFPA (and the MHA insofar as it applies to forensic patients) is administered by NSW Health, and is geared towards mental health treatment in a medical framework.<sup>121</sup> The treatments for which the MHFPA and MHA provide may therefore not be targeted to people who have cognitive, as opposed to mental health, impairments. Secondly, and conversely, the provisions of the MHA which govern compulsory treatment do not cover the full range of interventions that may reasonably be required by people who have cognitive impairments. Moreover, even if it had the power to order such interventions, the MHRT might not have adequate expertise to make decisions about appropriate interventions for people with cognitive impairments.

7.67 The present situation has arisen because of the absence of any alternative legislative scheme for the treatment and management of forensic patients who have cognitive impairments, leading to reliance on the mental health system.<sup>122</sup> Recent experience in other jurisdictions illustrates the need for specific provisions for people with intellectual disabilities and/or cognitive impairments.<sup>123</sup> In a number of jurisdictions, this realisation has led to detailed reviews culminating in legislative reform.<sup>124</sup>

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121. *R v Mailes* (2001) 53 NSWLR 251, [201]-[203].

122. See *R v Mailes* (2001) 53 NSWLR 251, [182]-[215].

123. In several cases in WA and Queensland, courts have ordered unconditional release of people with intellectual disabilities because it was inappropriate to detain them in prison and there was no point in ordering detention in a mental health facility. See for, eg, *R v Garlett* (2002) 29 SR (WA) 1, [10]-[12]; *R v McKitterick* (2001) 26 SR (WA) 206, [18]-[21]; *Re JTG* [2002] QMHC 4; *Re Borchert* [2008] QMHC 9; compare *Chang v Turner* [2005] WASC 246, [26]-[30], [32]-[33].

124. See Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care*, Report (2003); *Disability Act 2006* (Vic) (“intellectual disability”; civil, sentencing and forensic contexts); Hon WJ Carter QC, *Challenging Behaviour and Disability: A Targeted Response*, Report to the

*Comparison of the NSW provisions with national and international principles*

7.68 The *National Statement of Principles for Forensic Mental Health* (“the National Principles”) states that “[t]he capacity or right to consent is not forfeited as a result of a history of offending or status as a prisoner.”<sup>125</sup> Principle 7 further states that:

Mental health treatment should always be provided only with the explicit informed consent of the client except in circumstances where the client is unable to give informed consent by virtue of their mental illness or intellectual impairment. In this circumstance, treatment should only be provided [in accordance] with the consent mechanisms outlined in the relevant jurisdictions’ substitute decision making legislation and/or Mental Health Act.

7.69 Inherent in this statement is the principle that a forensic patient should not be subjected to medical treatment without his or her informed consent, and that if such consent cannot be given, then the treatment should only be given in accordance with safeguards which are on par with those that apply to other members of the community.<sup>126</sup> It appears that the NSW forensic provisions do not comply with the National Principles because the MHFPA does not require the MHRT to consider whether or not a forensic patient consents to treatment. It simply

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Minister for Community Disability Services and Seniors (2006); *Disability Services and Other Legislation Amendment Act 2008* (Qld) (“cognitive impairment”; civil, sentencing and forensic contexts); *Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003* (NZ) (“intellectual disability”; sentencing and forensic contexts only; no civil scheme). See also *Mental Health Act 1983* (UK) s 1(2)-(2A), 37, 41, and *Criminal Procedure Act 1964* (UK) s 5(2) (“learning disabilities”; civil, sentencing and forensic contexts).

125. Council of Australian Governments, *National Statement of Principles for Forensic Mental Health* (2002), principle 7.

126. There are emerging trends in the civil mental health context towards recognising capacity, promoting supported decision-making and limiting the use of involuntary treatment: see generally *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, art 12 (entered into force 3 May 2008); Department of Human Services (Vic), *Review of the Mental Health Act 1986*, Community Consultation Report (2009) ch 3, and Government Response to the Community Consultation Report (2009) 2-5; D Rigby and A Smith, “Redeveloping Australian Incapacity Jurisdictions to Remove the Stigma of Mental Health Laws” (paper presented at Australia and New Zealand Association of Psychiatry Psychology and Law Annual Congress, Manly, 23-26 October 2008).

provides for compulsory treatment, irrespective of the person's consent.<sup>127</sup> There is also no provision in the MHFPA requiring informed consent, nor any provision for substitute consent to be given in the event that the person, by reason of his or her cognitive or mental health impairment, is unable to give informed consent.<sup>128</sup>

7.70 In contrast, in Canada, the following provision applies:

No disposition ... shall direct that any psychiatric or other treatment of the accused be carried out or that the accused submit to such treatment except ... where the accused has consented to the condition and the court or Review Board considers the condition to be reasonable and necessary in the interests of the accused.<sup>129</sup>

7.71 A more limited provision applies in NZ. A court that is deciding what order to make in respect of a person who is UNA or has been found NGMI may take into account any undertaking given by, or on behalf of, the person concerning treatment.<sup>130</sup>

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#### Issue 6.92

Under what circumstances, if any, should forensic patients be subject to compulsory treatment?

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#### Issue 6.93

Should different criteria apply to:

- (c) different types of treatment; and/or
- (d) forensic patients with different types of impairment?

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#### Issue 6.94

Is the range of interventions for which the MHA and the MHFPA provide adequate and appropriate for all forensic patients? In particular, are different or additional provisions needed for forensic patients who have cognitive impairments?

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127. See MHFPA s 75(c) (contrast s 67) and MHA s 82, 84, 87, 98. The only references to consent in the MHFPA relate to the place of detention: see MHFPA s 16(2), 17(3), 24(2), 27, 55.

128. Compare, eg, *Mental Health Act 1986* (Vic) s 17A(2).

129. *Criminal Code*, RSC 1985 (Can) s 672.55.

130. *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 25(4).

Are the present safeguards regarding compulsory treatment of forensic patients adequate? If not, what other safeguards are needed?

## CONSIDERATIONS FOR DECISION-MAKING ABOUT FORENSIC PATIENTS

7.72 The MHFPA contains several provisions that guide the Forensic Division of the MHRT when making decisions about forensic patients. In particular, s 74 provides as follows:

Without limiting any other matters the Tribunal may consider, the Tribunal must have regard to the following matters when determining what order to make about a [forensic patient]:

- (a) whether the person is suffering from a mental illness or other mental condition,
- (b) whether there are reasonable grounds for believing that care, treatment or control of the person is necessary for the person's own protection from serious harm or the protection of others from serious harm,
- (c) the continuing condition of the person, including any likely deterioration in the person's condition, and the likely effects of any such deterioration, [and]
- (d) in the case of a proposed release, a report by a forensic psychiatrist or other person of a class prescribed by the regulations, who is not currently involved in treating the person, as to the condition of the person and whether the safety of the person or any member of the public will be seriously endangered by the person's release.<sup>131</sup>

7.73 Section 43 of the MHFPA further provides that the MHRT cannot make an order releasing a forensic patient unless it is satisfied, on the evidence available, that:

- (a) the safety of the patient or any member of the public will not be seriously endangered by the patient's release, and
- (b) other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the patient or that the patient does not require care.

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131. See also s 74(e), discussed at [7.33].



7.74 Like s 39 of the MHFPA, which applies when the court is deciding what order to make in respect of a person who has been found NGMI,<sup>132</sup> s 43 creates a presumption in favour of detention. In a case where the evidence as to risk is evenly balanced, s 43(a) requires that the person must remain in detention.

7.75 There is no general provision as to a standard of proof in MHRT proceedings, but where one is specified it is on the balance of probabilities.<sup>133</sup>

7.76 The principles set out in s 68 of the MHA (“the s 68 principles”) apply to decisions about forensic patients subject to the other provisions of the MHFPA.<sup>134</sup> The s 68 principles include a stipulation that “people with a mental illness or mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given”.<sup>135</sup> The application of that provision to forensic patients is limited, in relation to decisions about release, by the safety requirement expressed in s 43(a) of the MHFPA.<sup>136</sup>

7.77 While these provisions do not preclude the MHRT from taking additional matters into account when making decisions, it may nevertheless be desirable to direct the MHRT with regard to the following:

- the views of the person’s carer, or of any victims;<sup>137</sup> and
- issues concerning consent to treatment, including capacity and reasons for refusal.<sup>138</sup>

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132. See [6.32]-[6.39].

133. As to MHRT proceedings, see generally MHA ch 6 pt 2 (“civil” jurisdiction) and MHFPA pt 5 div 7 (Forensic Division). A standard of proof is specified in MHA s 35(1), 153(1), 166(2) and consider MHFPA s 6, 15, 16(1), 39(2). See also MHFPA s 39(2); and consider *Briginshaw v Briginshaw* (1938) 60 CLR 336, 361-362, discussed at [6.82].

134. See MHFPA s 76B(1).

135. MHA s 68(a); compare MHFPA s 43(b). See also *Disability Services Act 1993* (NSW) s 6(1), sch 1 [1](g).

136. See discussion at [7.78]-[7.88].

137. See [7.24]-[7.28].

138. See [7.56]-[7.71].

Issue 6.96

Should the MHFPA provide any additional factors to which the MHRT must have regard when making decisions about forensic patients?

### Balancing safety, treatment and personal liberty

7.78 The MHFPA is explicit in emphasising the “safety of members of the public” and the “safety of the person” as central considerations in decision-making by the MHRT.<sup>139</sup> In Chapter 6, we explore the concept of “safety” applied by the court when making decisions about the detention and release of people who are UNA or NGMI.<sup>140</sup> In that discussion, we pose several questions, concerning how the relevant harm and degree of risk of harm should be expressed and/or defined, and whether a risk of harm only to the person concerned should be a relevant consideration. Those questions require re-examination in the context of decision-making by the MHRT, in light of the possible differences between the respective roles of the MHRT and the criminal court. Accordingly, the following discussion is intended to be read in conjunction with the parallel discussion in Chapter 6.

#### *The meaning of “harm” and “risk of harm”*

7.79 Risk of harm is a central consideration in decisions about releasing forensic patients from detention and from the forensic mental health system altogether. Arguably, it would be logical to define “harm” and the degree of “risk of harm” for the purposes of decision-making by the MHRT in the same way as is relevant to decisions by a court in respect of persons who are UNA or NGMI.

7.80 It might also seem logical for the MHRT to apply the same concepts of “harm” and “risk of harm” in both its civil and forensic jurisdictions. In practice, many people who become forensic patients also have a history of being treated as patients within the civil mental health system. However, the civil mental health system applies to a more narrowly defined group of people than the forensic system. It is also less restrictive both in terms of the thresholds for release<sup>141</sup> and in that civil mental health patients are not liable to be detained in correctional centres.<sup>142</sup>

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139. MHFPA s 40(a), 43(a), 74(b), (d).

140. See [6.53]-[6.72].

141. See [6.70]-[6.72] and [7.83]-[7.88].

142. See [7.48]-[7.55].

**Issue 6.97**

Should the relevant risk of harm be expressed and defined in the same way for the purposes of decisions by the Forensic Division of the MHRT as it is for the court? If not, how should the provisions relating to the MHRT be different?

*Risk of harm to self in the absence of any risk to others*

7.81 Similar considerations bear on the question of whether the Forensic Division of the MHRT should take into account a risk of harm only to the person concerned, in the absence of any risk to the community. The question is discussed in detail in Chapter 6 in relation to decision-making by the court,<sup>143</sup> and is briefly revisited here in relation to the MHRT.

7.82 On the one hand, the provisions of the MHFPA evince a clear intention to provide for the care of persons who are subject to the forensic mental health system.<sup>144</sup> On the other hand, it is arguable that, if a forensic patient requires care and treatment only for his or her own sake, then he or she should be transferred out of the relatively restrictive forensic mental health system and into the civil mental health system, guardianship or other care arrangements. However, the scope of civil legislation and administrative arrangements is beyond our current terms of reference.

**Issue 6.98**

In what circumstances, and to what extent should the Forensic Division of the MHRT be required to have regard to a risk of harm only to the person concerned, in the absence of any risk to others?

*The principle of least restriction*

7.83 In Chapter 6, we also discuss the principle of “least restriction” and whether some such principle should apply to decisions by courts in cases where the person is UNA or NGMI.<sup>145</sup> The same question requires examination in the context of the MHRT and the forensic mental health system.

7.84 The MHFPA adopts, subject to the other provisions of the Act, the following statement of principle in the MHA:

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143. See [6.56]-[6.59].

144. See especially MHFPA s 40, 43, 74.

145. See [6.70]-[6.72].

[P]eople with a mental illness or mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given.<sup>146</sup>

7.85 This principle of “least restriction consistent with safe and effective care” appears to apply to decisions about the care and treatment of forensic patients, apart from those dealing with detention or release.<sup>147</sup> In those situations, s 43 of the MHFPA provides the following watered-down version of the principle of least restriction:

The [Mental Health Review] Tribunal must not make an order for the release of a forensic patient unless it is satisfied, on the evidence available to it, that: ... (b) other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the patient or that the patient does not require care.

7.86 This provision merely permits, but does not require, the Forensic Division of the MHRT to release a forensic patient from detention in circumstances where a less restrictive alternative is available.

7.87 Two questions then arise for consideration. First, should the MHFPA be amended to require the principle of least restriction to apply to all decisions by the Forensic Division of the MHRT?

7.88 Secondly, in any “least restrictive” provision, the qualification of consistency with some other objective may have to be different depending on the kind of order in question. For example, it may be appropriate to apply a principle of “least restriction that is consistent with safe and effective care” to decisions about treatment, whereas a principle of “least restriction consistent with the safety of the community” may be more apposite to decisions about detention or release. On the other hand, in practice, decisions about “care and treatment” are inextricably intertwined with decisions about detention or release, so that it might be unworkable to apply different principles. If that is the case, then it may be simpler to apply a principle of “least restriction” having regard to listed considerations.

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146. MHA s 68(a); MHFPA s 76B(1).

147. See, eg, MHFPA s 67, 76B.

**Issue 6.99**

Should a requirement to impose only the “least restriction” apply to all decisions regarding forensic patients?

**Issue 6.100**

How should any such principle of “least restriction” be expressed in the MHFPA? Should it be expressed differently for the purposes of different types of decisions?

**SHOULD THERE BE A TIME LIMIT?**

7.89 In this part of the chapter, we consider the various rationales for applying, or not applying, a time limit to the duration for which a person remains a forensic patient. We then consider how a time limit, if one is to apply, should be determined.

7.90 While a person is a forensic patient, the constraints on his or her liberty are significant. In NSW, those constraints may apply indefinitely in respect of forensic patients who have been found NGMI, but only up to the end of a sentencing-based time limit (the “limiting term”) for forensic patients who are UNA.<sup>148</sup> The following discussion contemplates the possibility of imposing some sort of time limit on the detention of people who are NGMI, as well as the alternative possibility of abolishing the time limit applicable to people who are UNA.

7.91 Most other Australian jurisdictions place some form of time limit on the period for which forensic patients may be detained or subject to conditional release. Generally, those time limits apply both to people who are UNA and to those found NGMI. For example, the Commonwealth, the ACT, the NT, SA and Victoria all require the court to set a “limiting term” or “nominal term” for the detention and supervision of forensic patients.<sup>149</sup> There is no provision for any time limit on the detention or supervision of a forensic patient in WA, Queensland, Tasmania, , the UK or Canada.<sup>150</sup> In NZ and the USA, statutory time limits apply to the

148. See [7.34].

149. *Crimes Act 1914* (Cth) s 20BC(2); *Crimes Act 1900* (ACT) s 301; *Criminal Code Act 1983* (NT) s 43ZG; *Criminal Law Consolidation Act 1935* (SA) s 269O(2); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 28(1).

150. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 38(1); *Mental Health Act 2000* (Qld) s 207, s 203, s 206; *Criminal Justice (Mental Impairment) Act 1999* (Tas);

detention or supervision of persons who are UNA, but not to persons found NGMI.<sup>151</sup>

## Rationale

7.92 The limiting term which applies in NSW to persons who are UNA was enacted with the objective of ensuring that a person who is unfit to be tried is not, in consequence, detained or subjected to restrictions for longer than if he or she were convicted of the relevant offence at an ordinary trial.<sup>152</sup> A similar argument, namely, that a person who is not criminally responsible for particular conduct should not be subject to restrictions for longer than a comparable convicted offender who is responsible in law, can be made in respect of persons who are found NGMI, but no “limiting term” currently applies to that group. Moreover, in view of the fact that all forensic patients are subject to the same general legislative arrangements irrespective of whether they were initially UNA or NGMI, it is arguable that the same time limits on detention should apply.

7.93 The question of whether there should be a predetermined limit on the length of time for which a person remains a forensic patient involves answers to the following questions:

- How does the court make decisions concerning orders that result in a person becoming a forensic patient?
- What happens to the person while he or she is a forensic patient and being managed within the forensic mental health system? and
- What are the processes and criteria for deciding whether, and when to make an order releasing the person from the forensic mental health system?

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See *Mental Health Act 1983* (UK) s 40(1)(b), 69-75; *Criminal Code*, RSC 1985 (Can) s 672.81, see also s 672.851.

151. *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 30, cf s 33.

152. NSW Health Commission Mental Health Act Review Committee, *Report* (1974); NSW, *Parliamentary Debates*, Legislative Assembly, 24 November 1982, 3005-3006 and 22 November 1983, 3089-3090, 3110-3112 (the Hon L Brereton, MP). See also historical outline in ch 6.

*How a person enters the forensic mental health system*

7.94 If, following a finding that a person is NGMI or UNA, the court is required to order that the person be detained unless it is safe to order release,<sup>153</sup> or if the court's choice between detention and release is based on inherently punitive sentencing considerations,<sup>154</sup> then it can fairly be said that the constraints on the person's liberty arise as a consequence of the person's involvement in the criminal justice system. That is because different principles would apply under the civil mental health system or other regimes outside the criminal context.<sup>155</sup> If the forensic mental health system is to continue to apply a stricter approach than civil schemes, then it would be discriminatory to require the person to remain subject to it for longer than a person who was convicted and sentenced in the ordinary way for the same conduct.

7.95 Conversely, the comparison with the sentenced offender may have less relevance if the starting point is that a person who is UNA or NGMI, not having been convicted of any offence, is entitled to be released unless the safety of the community or other identified considerations justify the imposition of restrictions on the person's liberty. Under such a system, the person's position is arguably more closely analogous to that of a person in the civil mental health system or a similar scheme.

*How the person is dealt with in the forensic mental health system*

7.96 The second consideration which may bear on the need or otherwise for a time limit is the manner in which forensic patients are managed within the forensic mental health system. If the regime to which forensic patients are subject is punitive,<sup>156</sup> then a sentence-based time limit arguably remains relevant, irrespective of how the initial decision as to the imposition of restrictions is made. In particular, if correctional centres, which are inherently punitive environments, continue to be used as a place of detention for forensic patients,<sup>157</sup> then forensic patients should

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153. As is the case with NGMI under MHFPS s 39 See [6.36].

154. As is the case with people found UNA: see [6.24]-[6.25].

155. See generally MHA ch 3 pt 1; *Guardianship Act 1987* (NSW) s 4; *Disability Services Act 1993* (NSW) s 6(1), sch 1 [1](g); *Drug and Alcohol Treatment Act 2007* (NSW).

156. Elsewhere in this Consultation Paper, we consider whether punishment has any legitimate role in decision-making about and management of forensic patients: see [6.26]-[6.30] and [7.47]-[7.55].

157. See discussion at [7.47]-[7.55] concerning the detention of forensic patients in correctional centres.

not be kept there for longer than people convicted and sentenced in the ordinary way for similar conduct. In this regard it is perhaps significant that, in four of the eight jurisdictions which do not provide for a time limit, persons found UNA or NGMI are not detained in correctional facilities.<sup>158</sup>

7.97 Even if forensic patients are not subject to a punitive regime, the place and manner in which they are managed within the forensic mental health system remain relevant. For example, if the system is sufficiently robust, such that it can safely be assumed that the person’s treatment and support arrangements will be modified regularly in order to progress the person towards eventual release, then the need for a time limit is arguably diminished.

7.98 However, if the regime is such that the person does not have access to treatment or other services which the person requires in order eventually to fulfil the criteria for release, then the system is arguably one of containment, and prolonged detention or restrictions may be regarded as arbitrary.<sup>159</sup> Earlier in this chapter, we draw attention to the difficulties currently experienced by forensic patients in NSW, particularly those detained in prisons, where the limited access to treatment and support services and other factors hinder their progress towards release.<sup>160</sup> Unless and until those systemic issues are addressed, it is arguable that a time limit of some sort remains necessary, both as a safeguard to ensure that the person is not simply locked up forever, and as an incentive to the

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158. See *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 24; *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 4(1) (definitions of “hospital” and “facility”), *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) s 2, pt 4 and especially *Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003* (NZ) s 9(4); *National Health Service Act 2006* (UK) s 4(4), 275 (definition of “hospital”); *Criminal Code*, RSC 1985 (Can) s 672.1(1) (definition of “hospital”), 672.54(c); see also *United States Code*, tit 18 ch 313 §4247(a)(2) (definition of “suitable facility”).

159. Consider *R (on the application of Walker) v Secretary of State for Justice* [2008] 3 All ER 104, [65]-[69], [72], where the House of Lords held that a continuing failure by correctional services to provide rehabilitation opportunities to prisoners serving indefinite sentences might eventually give rise to a situation where reviews would become meaningless, and the detention would then become arbitrary and, as such, unlawful. See also *Wells v Parole Board* [2007] EWHC 1835, [20]-[50]; *R (on the application of James) v Secretary of State for Justice* [2007] EWHC 2027.

160. See [747]-[7.55].



state, in the knowledge that the person will one day return to the community, to ensure that services are provided.<sup>161</sup>

*How the person exits the forensic mental health system*

7.99 The need for a time limit also depends on the processes and criteria for review and release, because it is those processes which ensure that restrictions on the person's liberty are imposed only if, and remain in force only for so long, as they are necessary. The current, relatively strict criteria for release which apply to forensic patients in NSW, in particular, the presumption in favour of detention,<sup>162</sup> could be said to militate in favour of a time limit.

*Inherent advantages and disadvantages of time-limited and indeterminate orders*

7.100 In addition to those considerations, which relate to the particular features of the forensic mental health system, the inherent advantages and drawbacks of each option should be examined.

7.101 For example, anecdotally it appears that the indeterminate order may deter people with mental impairments from relying on the defence of mental illness.<sup>163</sup> If that is correct, then it may lead to outcomes which fail to meet the interests of justice, public safety, or the person's treatment needs.<sup>164</sup> Indeed, the drawbacks of indeterminate detention led this Commission, in 1996, to recommend that people found NGMI should not

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161. But see *R v Adams* (2003) 58 NSWLR 1 especially at 15-22; *Courtney v The Queen* [2007] NSWCCA 195, [19]-[20], [42], [78].

162. See [6.36].

163. James Report, [5.31]; NSWLRC Report 80, [6.29]; Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness*, Report of the National Inquiry into the Human Rights of People with Mental Illness (1993), 801-802. It remains to be seen whether the replacement of the executive discretion with decision-making by the Forensic Division of the MHRT will avoid unnecessarily prolonged detention or other restrictions on liberty, which may decrease the level of reluctance to rely on the defence.

164. Defendants instead plead guilty, rely on unfitness, or, in the event of a murder charge, rely on the partial defence of substantial impairment: see ch 4. For cases where the trial judge raised the defence of mental illness because the defendant refused to, see: *R v Damic* (1982) 2 NSWLR 750; *R v Issa* (Unreported, NSW Supreme Court, Sperling J, 16 & 25 October 1995); appeal against verdict of NGMI where defence raised against the accused person's instructions: *Williams v The Queen* [2004] NSWCCA 224; and, for a case where a guilty plea was accepted despite facts suggesting a possible defence of mental illness, see *Man v The Queen* (1990) 50 A Crim R 79.

be subject to indeterminate detention, and that a limiting term should apply to the duration of their detention in the same way as for people who are UNA.<sup>165</sup>

7.102 On the other hand, time-limited orders inevitably lead to the result in some cases that the person continues to pose a risk of harm to others but must nevertheless be released, unconditionally, at the end of the time limit.<sup>166</sup> However, the same is true of sentenced offenders, who are ordinarily entitled to be released at the expiry of the sentence, even if they still pose a risk to others.<sup>167</sup> Legislation could provide that, at the end of the time limit, a forensic patient who continues to pose a risk to others or to require care may be transferred into the civil mental health system or other care, support and/or supervision arrangements. To the extent that existing civil schemes do not cater for all such people, it may be that further provision is required. That is, however, beyond the scope of the present reference.

#### Issue 6.101

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Should a limit apply to the length of time for which people who are UNA and/or people who are NGMI remain subject to the forensic mental health system?

#### **If there is a time limit, how should it be set?**

7.103 There are two basic models for setting a time limit, either by reference to the hypothetical sentence that would have been imposed had the person been convicted in the ordinary way of the offence charged, or by reference to a statutory formula.

#### *Sentencing-based time limit*

7.104 The sentencing-based time limit applying to persons in NSW who are UNA, is not without difficulties, both conceptually and in practice. In deciding what sentence of imprisonment would have been imposed at an

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165. NSWLRC Report 80, [6.34]-[6.35], recommendation 26; and see James Report, [6.44].

166. See, eg, *R v Adams* (2003) 58 NSWLR 1; *Courtney v The Queen* [2007] NSWCCA 195.

167. See, eg, *Veen v The Queen* (1979) 143 CLR 458 and *Veen v The Queen (No 2)* (1988) 164 CLR 465; but see *Re Percy, Farrell and RJO* (1998) 102 A Crim R 554, 560. And consider *Crimes (Serious Sex Offenders) Act 2006* (NSW).

ordinary trial, in the manner required by the legislation, there are certain respects in which the hypothetical sentence, and hence the limiting term, may be harsher than the sentence which would in fact have been imposed at an ordinary trial in comparable circumstances.

7.105 In particular, the court might not be aware of all the facts which are relevant to exercising the sentencing discretion, because the person's unfitness for trial prevents him or her from bringing those facts to the attention of the court. The person might thus be denied the benefit of relevant mitigating circumstances.<sup>168</sup>

7.106 A further problem with the current provisions for fixing the limiting term in NSW is that the court is required to nominate the *total* sentence that would have been imposed, that is, the total of the non-parole period and the balance of the term. It cannot set a minimum term equivalent to a non-parole period.<sup>169</sup> The rationale is that the person may be released by the MHRT prior to the expiry of the limiting term.<sup>170</sup> However, that rarely occurs in practice, for reasons largely relating to the way that forensic patients are managed, with the result that the person is detained for longer than a comparable sentenced offender, who is likely to be released on parole on the expiration of the non-parole period. The NSW limiting term thus fails to achieve the objective of ensuring that a person who is UNA is no worse off than a comparable convicted offender.

7.107 The sentencing-based limiting term may also create the impression in the minds of judges, legal practitioners and members of the community that the person is being punished, despite not having been fairly tried and convicted of any offence. That effect could be minimised by clearly separating the decision as to what order should be made from the decision as to the length of time for which the order applies, and/or by provisions which clearly articulate the purpose and practical effect of the limiting term.

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168. See ch 8 for a discussion of the relevant sentencing principles and factors to be taken into account.

169. See ch 8 for a discussion of non-parole periods.

170. See MHFPA s 23(1)(b); *Mitchell v The Queen* (1999) 108 A Crim R 85, 90-92; *R v Mailes* (2004) 62 NSWLR 181, 186-190. Contrast *Crimes (Sentencing Procedure) Act 1999* (NSW) pt 4 div 1 especially s 44, 50.

7.108 A final criticism of the “hypothetical sentence” approach is that it is somewhat artificial, particularly when attempting to fix a sentence-based time limit in respect of a person who has been found not responsible in law. The Commonwealth provisions, which apply a sentencing approach to fixing the time limit for persons found NGMI, have been the subject of strong judicial criticism on these grounds.<sup>171</sup> In South Australia, where a sentence-based time limit applies to both groups (UNA and NGMI), the legislature attempted to mitigate the artificiality of a “sentencing” approach by providing that the mental impairment should not be taken into account when determining the hypothetical sentence that would have been imposed.<sup>172</sup> Such an approach appears to require that the determination be made by reference only to the objective circumstances of the offence and the subjective circumstances of the offender, unrelated to his or her mental state. However, it is likely that any hypothetical sentence so determined would be an overestimate, because the person would not have the benefit of the mitigating factors which apply to sentencing persons with cognitive or mental health impairments.<sup>173</sup>

7.109 The sentencing-related approach could nevertheless be retained, with some modifications to counteract these problems. For example, the time limit could be a hypothetical non-parole period rather than the total sentence.<sup>174</sup> Legislation could provide for presumptions concerning mitigating factors when fixing the term, for example, that the person would have pleaded guilty at the first opportunity, and would have expressed remorse.<sup>175</sup> Alternatively, there could be a percentage-based discount for unknown mitigating factors.<sup>176</sup>

#### *Statutory time limits*

7.110 Alternatively, legislation could provide fixed time limits or a formula, such as:

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171. *R v Goodfellow* (1994) 33 NSWLR 308, 311; *R v Robinson* (2004) 11 VR 165, 174.

172. *Criminal Law Consolidation Act 1935* (SA) s 269O(2), Note 1.

173. See [6.26]-[6.30] and see ch 8.

174. See James Report, [6.42].

175. See submissions in *Mitchell v The Queen* (1998) 108 A Crim R 85, [47]-[48]; see also Public Interest Advocacy Centre, *Time for Change: Response to the Consultation Paper: Review of the Forensic Provisions of the Mental Health Act 1990 and the Mental Health (Criminal Procedure) Act 1990* (2007), 19.

176. A percentage-based approach applies to mitigation for a plea of guilty: see *R v Thomson and Houlton* (2000) 49 NSWLR 383.

- the Victorian model: legislation specifies “nominal terms” for murder or treason (25 years); “serious offences” (the maximum term of imprisonment for the offence); certain other offences (half the maximum term of imprisonment for the offence); and for all other offences, a discretionary period set by the court.<sup>177</sup>
- the New Zealand model: 10 years from the date of making the order if the offence is punishable by life imprisonment, or otherwise half the maximum term of imprisonment for the offence;<sup>178</sup>
- the maximum penalty for the offence;<sup>179</sup>
- two-thirds of the maximum term of imprisonment for the offence, or 10 years, whichever is less;<sup>180</sup>
- the standard non-parole period for the offence;
- the average or mid-range sentence for the offence, derived from sentencing statistics;<sup>181</sup>
- or some other formula.

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177. See *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 28(1). If the person was found to have committed more than one offence, the nominal term is calculated by reference to the offence which carries the longest maximum term of imprisonment: s 28(2). A supervision order is, however, indefinite: s 27(1).

178. *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 30(1)-(2) (unfit only; people found NGMI are subject to an indefinite order: s 33). During that period, the executive government has a role in decisions about treatment, management and release: s 31 (unfit), see also and compare s 33(3) (NGMI). At the expiry of the time limit, if the person is still detained, his or her status is changed to “patient” or “care recipient”, and all subsequent decisions about treatment, management or release are made by the health or disability systems: s 31(4).

179. *United States Code*, tit 18 ch 313 §4244(d)-(e) provides for the provisional sentencing of convicted offenders who have a “mental disease or defect for the treatment of which [the offender] is in need of custody for care or treatment in a suitable facility.” A hospitalisation order made at the time of sentencing constitutes a provisional sentence to the maximum period of imprisonment applicable to the offence. If the person recovers sooner, he or she is brought back to court and finally sentenced.

180. Proposed in Dr G Edwards, Chair, NSW Health Commission Mental Health Act Review Committee, *Report* (1974), 89-91. The Edwards Committee did not recommend a time limit in respect of people found NGMI.

181. See James Report, [6.42].

7.111 The Commission has previously expressed reservations about formulaic approaches to determining outcomes in the criminal justice context because, by failing to take into account the circumstances of each case, the relationship between the outcome and the offending conduct ceases to be proportionate and may therefore become arbitrary.<sup>182</sup> This could be avoided by providing a discretion for the court to pronounce a period shorter or longer than the prescribed time limit in a particular case.

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**Issue 6.102**

If there is a time limit, on what basis should it be determined?

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**Issue 6.103**

Should the same approach be used both for persons who are UNA and for those who have been found NGMI?

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182. See NSW Law Reform Commission, *Sentencing*, Report No 79, [9.11], [9.17] and Discussion Paper No 33, [6.46]-[6.66].

## 8. **Sentencing: principles and options**

- Introduction
- Sentencing process
- Sentencing options in NSW

## INTRODUCTION

8.1 Decisions concerning sentencing are arguably the most difficult aspects of the role of a judge or a magistrate. The factors involved in determining whether to deprive an offender of his or liberty, or to curtail it in some way, require careful consideration based on principles articulated in human rights instruments, legislation, and supplemented by the common law. Where sentencing discretion is being exercised in regard to offenders with cognitive or mental health impairments, the task of the court is made even harder.

8.2 The sentencing process involves the determination of the appropriate type and severity of penalty that should be imposed on an offender who has been found guilty of, or has pleaded guilty to, a criminal offence. In reaching such a decision, the court weighs a number of considerations to determine the objective seriousness of the offence, as well as examining any subjective factors relevant to the particular offender which may aggravate or mitigate the sentence. If the court decides in the circumstances that a sentence of imprisonment or a semi-custodial sentencing option is appropriate, it becomes the responsibility of the Department of Corrective Services to implement the sentence. As such, although a critical phase, sentencing represents only a part of an offender's journey through the criminal justice process.

8.3 In undertaking this review, we are cognisant of its limitations, both in terms of the scope of our current inquiry, and the practical "reach" of the sentencing court. Our terms of reference require us to conduct a general review of the "criminal law and procedure" applying to people with cognitive and mental health impairments in relation to a number of aspects of the criminal justice process, including sentencing. The sentencing court has a broad discretion to determine appropriate sentences,<sup>1</sup> taking into consideration the circumstances of each offender. It determines the length of a sentence, whether it is to be served by way of full-time detention or an alternative sentencing option, and the structure in terms of the non-parole period. However, the court is limited in its ability to control the manner in which sentences are implemented. The way in which sentences are carried out, in terms of the day-to-day

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1. Subject to constraints imposed by relevant legislation and case law: see remarks of Kirby J in *Cheung v The Queen* (2001) 209 CLR 1, [99].



treatment and experiences of offenders, involves the discretion of other agencies such as the Department of Corrective Services and Justice Health, and is not part of the sentencing process. Accordingly, while we mention the lack of available options for offenders with mental illness or cognitive impairments, and problems concerning coordination between criminal justice agencies, we do so because these are matters of context. We do not raise these matters for consultation, except where directly relevant to the court's role in the sentencing process.

8.4 In this chapter, we discuss the purposes, principles and other factors that underpin sentencing decisions in NSW, with particular focus on the application of those principles to offenders with cognitive or mental health impairments. We examine the existing sentencing options that apply generally, and the factors that judges and magistrates consider in determining appropriate sentences. In particular, we look at the factors that may make these options more or less appropriate for people with cognitive or mental health impairments. We also look at additional provisions or options that may achieve better sentencing outcomes for people with cognitive or mental health impairments, having regard to the purposes of sentencing, the experience in other jurisdictions, and consistency with the sentencing power of the court. In addition, we consider decisions relating to parole with particular reference to offenders with cognitive and mental health impairments.<sup>2</sup>

## SENTENCING PROCESS

8.5 Sentencing offenders convicted of criminal offences involves a delicate exercise of discretion. It requires the balancing of various factors relating to the objective seriousness of the crime, weighed against other subjective considerations relevant to each particular offender. The main legislative statement on sentencing adult offenders is the *Crimes (Sentencing Procedure) Act 1999* (NSW) ("the CSPA"), which applies to proceedings in the Supreme, District and Local Courts.<sup>3</sup> The *Children*

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2. Decisions concerning parole are instrumental in determining the length of a sentence and the conditions on which an offender is released. Depending on the length of the sentence, parole decisions are made by either the sentencing court or the Parole Authority: see [8.74]. Accordingly, we consider the terms of our inquiry to cover sentencing decisions made by the Parole Authority.
  3. *Crimes (Sentencing Proceedings) Act 1987* (NSW) "CSPA" s 3(1)(a).

*(Criminal Proceedings) Act 1987* (NSW) applies to Children's Court proceedings.<sup>4</sup>

8.6 Sentencing occurs at a specially convened hearing, generally held a few weeks after the trial has concluded. This gives the Probation and Parole Service time to prepare any reports that have been requested by the court, or are required by law, concerning the offender's background. These pre-sentence reports can include, among other things, information concerning the defendant's mental state and prospects of rehabilitation.<sup>5</sup>

8.7 The CSPA articulates the purposes that a sentence should aim to achieve, as well as listing factors that may aggravate or mitigate the severity of the penalty to be imposed. These legislative statements work alongside the common law sentencing principles.

## Purposes

8.8 The CSPA provides that the court may impose a sentence on an offender for the following purposes:

- (a) to ensure that the offender is adequately punished for the offence;
- (b) to prevent crime by deterring the offender and other persons from committing similar offences;
- (c) to protect the community from the offender;
- (d) to promote the rehabilitation of the offender;
- (e) to make the offender accountable for his or her actions;
- (f) to denounce the conduct of the offender; and
- (g) to recognise the harm done to the victim of the crime and the community.<sup>6</sup>

8.9 In some cases these purposes may conflict and overlap. Some purposes, such as the promotion of rehabilitation and protection of the community, may be more relevant than others in relation to sentencing

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4. Issues specifically relevant to children and young people with cognitive impairments and mental illness in the criminal justice system are discussed in Consultation Paper 9 ("CP 9") due for release in early 2010.

5. Pre-sentence reports are discussed further at [8.56]-[8.59].

6. CSPA s 3A. The list appears to be exhaustive.

offenders with cognitive or mental health impairments. This is discussed further at paragraph 8.43.

## Sentencing principles

8.10 When sentencing any offender, judges apply common law principles of sentencing when determining appropriate penalties in each case. For example, judges will consider issues of proportionality, meaning that the punishment must fit the crime,<sup>7</sup> and consistency in terms of avoiding inappropriate disparities between punishments given to co-offenders, or ensuring that the sentence is within the range for similar offences.<sup>8</sup> Another factor is the totality of the sentence where an offender is convicted of more than one offence.<sup>9</sup>

8.11 In addition to the general principles, courts have developed principles specific to sentencing offenders with mental impairments. The most frequently accepted line of authority in NSW culminated in the case of *R v Hemsley*,<sup>10</sup> where Justice Sperling summarised the following ways in which mental illness is relevant in sentencing:

First, where mental illness contributes to the commission of the offence in a material way, the offender's moral culpability may be reduced; there may not then be the same call for denunciation and the punishment warranted may accordingly be reduced...

Secondly, mental illness may render the offender an inappropriate vehicle for general deterrence and moderate that consideration...

Thirdly, a custodial sentence may weigh more heavily on a mentally ill person...

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7. *Veen v The Queen (No 2)* (1988) 164 CLR 465; *Bugmy v The Queen* (1990) 169 CLR 525; and *R v Whyte* (2002) 55 NSWLR 252, [152].

8. See *Lowe v The Queen* (1984) 154 CLR 606; *Postiglione v The Queen* (1997) 189 CLR 295; and *R v Morgan* (1993) 70 A Crim R 368, 371.

9. See *Pearce v The Queen* (1998) 194 CLR 610; *Postiglione v The Queen* (1997) 189 CLR 295; and *R H McL v The Queen* (2000) 74 ALJR 1319. See also CSPA pt 4, div 2.

10. [2004] NSWCCA 228. Courts in NSW commonly rely on the statement of principle in *Hemsley*: see Judicial Commission of NSW, *Sentencing Bench Book* [10-460] («<http://www.judcom.nsw.gov.au>» accessed 5 August 2009).

A fourth, and countervailing, consideration may arise, namely, the level of danger which the offender presents to the community. That may sound in special deterrence...<sup>11</sup>

*Reduced moral culpability: causal relationship between impairment and offence*

8.12 An offender's moral culpability may be reduced where his or her cognitive or mental health impairment is causally related to the commission of the offence. Courts have held that special consideration in sentencing may be justified where an offender's mental condition affects his or her ability to understand the wrongfulness of the offending conduct, diminishes the ability to make reasoned judgments or to exercise appropriate powers of control.<sup>12</sup>

8.13 If an offender asserts that his or her cognitive or mental health impairment contributed to the criminal conduct, the offender must adduce sufficient evidence, usually expert medical evidence, to establish the claimed connection.<sup>13</sup> It is not necessary that the impairment motivated or induced the commission of the offence.<sup>14</sup> The existence or absence of a causal relationship does not automatically result in the sentence being respectively reduced or increased, but is a circumstance to be weighed in each case.<sup>15</sup>

*Deterrence – general and specific*

8.14 One of the principles ordinarily applicable to sentencing is that of general deterrence: that is, sentences should operate not only as a punishment for that particular offender, but to deter others in the community from committing similar crimes. However, it is widely accepted by the courts that the principle of general deterrence should be given less weight when sentencing an offender with a cognitive or mental health impairment for two reasons. First, because "such an offender is not

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11. *R v Hemsley* [2004] NSWCCA 228, [33] - [36] (references omitted). Referred to with approval in *R v Haines* [2004] NSWCCA, [15]; *R v Wicks* [2005] NSWCCA 213, [24]-[26], [33]-[34]; *R v Pham* [2005] NSWCCA 314, [27]-[35]; *R v Hughes* [2005] NSWCCA 117, [24]-[29]; *Withers v R* [2009] NSWCCA 133, [31].

12. *R v Henry* (1999) 46 NSWLR 346, 354; *R v Israil* [2002] NSWCCA 255, [23]; *R v Way* (2004) 60 NSWLR 168, 187. See also *R v Verdins*; *R v Buckley*; *R v VO* (2007) 16 VR 269, [26].

13. *Wilmot v The Queen* [2007] NSWCCA 278, [26]-[33].

14. *R v Letteri* (Unreported, NSW Court of Criminal Appeal, Gleeson CJ, Sheller and Badgery-Parker JJA, 18 March 1993).

15. *R v Engert* (1995) 84 A Crim R 67, 71, 72; *R v Verdins*; *R v Buckley*; *R v VO* (2007) 16 VR 269, [13], [23]-[26].

an appropriate medium for making an example to others”; and secondly, because “the interests of society do not require such persons to be punished as severely as a person without that disability because such severity is inappropriate to their circumstances”.<sup>16</sup>

8.15 The extent to which general deterrence as a consideration should be moderated depends on the circumstances of the case, in particular “upon the nature and severity of the symptoms exhibited by the offender, and the effect of the condition on the mental capacity of the offender”.<sup>17</sup> Weakness or absence of a causal relationship between the offence and the cognitive or mental health impairment may reduce the extent to which general deterrence is moderated.<sup>18</sup> Yet even where no such relationship exists, for example where the impairment manifested after the offence was committed, the weight to be given to general deterrence may still be reduced.<sup>19</sup> However, where the offender acts recklessly, or with knowledge of what he or she is doing, for example, by deliberately neglecting to take medication to prevent psychotic episodes, the mitigation afforded may be reduced or eliminated.<sup>20</sup>

8.16 Specific deterrence refers to the goal of deterring the particular offender from re-offending, and is another aspect of sentencing that may be modified in the case of an offender with a cognitive or mental health impairment.<sup>21</sup> Specific deterrence may be moderated if the cognitive or mental health impairment “is such that the offender may not fully appreciate, or understand, the nature of his or her offending, or of the

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16. *R v Wright* (1997) 93 A Crim R 48, 50-51. See also *R v Engert* (1995) 84 A Crim R 67, 72; *R v Champion* (1992) 64 A Crim R 245, 254-255; *R v Henry* (1999) 46 NSWLR 346, [254]. See also *R v Zeilaa* [2009] NSWSC 532, [15].

17. *R v Verdins*; *R v Buckley*: *R v VO* (2007) 16 VR 269, [32], see also [15]-[22]; see also *R v Letteri* (Unreported, NSW Court of Criminal Appeal, Gleeson CJ, Sheller and Badgery-Parker JJA, 18 March 1993), approved in *R v Engert* (1995) 84 A Crim R 67; *R v Yaldiz* [1998] 2 VR 376, 381, 383; cf *R v Tsiaras* [1996] 1 VR 398, 400.

18. *R v Wright* (1997) 93 A Crim R 48, 51; see also *R v Wiskich* [2000] SASC 64, [22]-[47], [62]; *R v Leach* (2003) 85 SASR 139, 141-142.

19. See, eg, *Adanguidi v The Queen* [2006] NSWCCA 404, and *R v Verdins*; *R v Buckley*: *R v VO* (2007) 16 VR 269, [32], [55]-[93], where schizophrenia manifested between the offence and the sentencing hearing. See also *R v Engert* (1995) 84 A Crim R 67, 71-72; *R v Yaldiz* [1998] 2 VR 376, 381, 383.

20. *R v Wright* (1997) 93 A Crim R 48, 52.

21. *Crimes (Sentencing Procedure) Act 1999* (NSW) s 3A(b)-(c); *Veen v The Queen (No 2)* (1988) 164 CLR 465, 476.

message which the sentence is expected to convey”.<sup>22</sup> The rationale for the rule is similar to the reasons for moderating general deterrence.

8.17 The degree to which specific deterrence should be moderated depends on evidence as to “the nature and severity of the symptoms of the condition as exhibited by the offender, and the effect of the condition on the mental capacity of the offender, whether at the time of the offending or at the date of the sentence or both”.<sup>23</sup>

8.18 It should not be assumed, however, that the sentence will always be reduced in circumstances where the principles of general or specific deterrence are of little significance. The mental health or cognitive impairment that justifies reducing the weight to be attributed to deterrence might also result in *increased* weight being given to other considerations such as protection of the community.<sup>24</sup>

*Sentence might “weigh more heavily” on the offender*

8.19 While the deprivation of liberty is a serious matter for all offenders, it may weigh more heavily on some offenders than others due to subjective factors, that is, factors personal to the offender. The law recognises that a particular sentence might have a greater impact on a person with a cognitive or mental health impairment than a person without that impairment, and that this should be a factor relevant to sentencing.<sup>25</sup>

8.20 The special difficulties a person with a cognitive or mental health impairment might experience in prison include exacerbation of symptoms;<sup>26</sup> interruption or unavailability of treatment;<sup>27</sup> victimisation of

22. *Matthews v The Queen* (2004) 145 A Crim R 445, [23].

23. *R v Verdins; R v Buckley; R v VO* (2007) 16 VR 269, [32].

24. See, eg, *R v Engert* (1995) 84 A Crim R 67, 68; *Veen v The Queen (No 2)* (1988) 164 CLR 465, 476-477; *R v Lawrence* [2005] NSWCCA 91, [24]; *R v Wright* (1997) 93 A Crim R 48. See [8.21]-[8.24] regarding protection of the community.

25. See, eg, *R v Vachalec* [1981] NSWLR 351, 353; *R v Peuna* (Unreported, NSW Court of Criminal Appeal, Badgery Parker J, 15 July 1993); *R v Engert* (1995) 84 A Crim R 67, 71; *Tsiaras v The Queen* [1996] 1 VR 398, 400; *R v Jarman* [2001] NSWCCA 178, [19], [24]; *R v Israil* [2002] NSWCCA 255, [25]; *R v Hemsley* [2004] NSWCCA 228, [35]; *R v Verdins; R v Buckley; R v VO* (2007) 16 VR 269, [27]-[30], [32]; *Withers v R* [2009] NSWCCA 133, [34].

26. *R v Verdins; R v Buckley; R v VO* (2007) 16 VR 269, [27]-[30], [32]; *Jiminez v The Queen* [1999] NSWCCA 7, [23]-[25]; *Du Randt v The Queen* [2008] NSWCCA 121, [46]-[55].

the offender by other prisoners;<sup>28</sup> and the further punitive effects of solitary confinement imposed for the protection of, or from, other prisoners.<sup>29</sup> During the course of our review into people with an intellectual disability in the criminal justice system, we referred to the increased hardship experienced by prisoners with intellectual disabilities occasioned by the disruption to their routine and the consequent diminution of their life skills.<sup>30</sup>

#### *Protection of the community*

8.21 Protection of the community is listed in the CSPA as one of the purposes of sentencing, and is also a relevant principle to consider when sentencing offenders with cognitive and mental impairments.<sup>31</sup> In circumstances where an offender is particularly dangerous, sentencing judges assess the risk that the offender would pose to the community if he or she were at liberty, and weigh this against any mitigating factors in determining the appropriate sentence.<sup>32</sup>

8.22 Attempting to predict future conduct is a risky and difficult exercise, particularly when undertaken in relation to someone with a cognitive or mental health impairment. There is a risk that the “dangerousness” factor permits inaccurate but widely held stereotypes associating mental illness with violence<sup>33</sup> to affect the sentencing

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27. See, eg, *Tsiaras v The Queen* [1996] 1 VR 398, 400; *Mailes v The Queen* (2001) 53 NSWLR 251, 267; Coroner’s Court of NSW, Magistrate D Pinch, Deputy State Coroner, *Inquest into the death of Scott Ashley Simpson* (17 July 2006), 8-13.

28. See, eg, *R v Kilmartin* (1989) 41 A Crim R 22 [Vic CCA]. It is common for offenders with cognitive impairments to be brutalised in prison, including gang rapes leading to the person contracting HIV: Intellectual Disability Rights Service, *Consultation*, 16 April 2007. See also NSWLRC, *People with an Intellectual Disability and the Criminal Justice System: Court and Sentencing Issues* (Discussion Paper 35, 1994), [11.12].

29. See, eg, Coroner’s Court of NSW, Magistrate D Pinch, Deputy State Coroner, *Inquest into the death of Scott Ashley Simpson* (17 July 2006), 15-16 and Recommendation 4.

30. See NSWLRC DP 35, [11.12].

31. CSPA s 3A(c). See also *Veen v The Queen (No 2)* (1988) 164 CLR 465; *R v Engert* (1995) 84 A Crim R 67; and *R v Adams* [2002] NSWCCA 448; *R v Henry* [2007] NSWCCA 90.

32. *Veen v The Queen (No 2)* (1988) 164 CLR 465, 472, 477.

33. A study of 46 legal professionals and 44 community members in Victoria found that both groups “greatly exaggerated the likelihood of a mentally ill person [with schizophrenia or depression] being violent, either to themselves or

discretion, leading to longer sentences.<sup>34</sup> However, courts have held that although predictions of future dangerousness may be difficult and unreliable, they are sometimes necessary and correct.<sup>35</sup>

8.23 While protection of the community from dangerous offenders is a legitimate consideration in sentencing, the principle of proportionality prevents the imposition of a penalty greater than the circumstances of the offence warrant.<sup>36</sup> In determining the weight to be given to protection of the community, the criminal standard of proof does not apply: therefore, the sentencing judge need not be satisfied beyond reasonable doubt that a prisoner will re-offend in the future, provided that a risk of re-offending has been established on the evidence.<sup>37</sup>

8.24 Future dangerousness and the probability of re-offending are related to the mitigating factor concerning the offender's prospects of rehabilitation. The potential for re-offending is likely to be reduced where the offender's rehabilitation prospects are greater. It is certainly arguable that community protection is best achieved by a sentence likely to promote the offender's effective rehabilitation and recovery.<sup>38</sup> This issue is discussed in more detail later in this chapter in the context of sentencing options.

### Aggravating and mitigating factors

8.25 In passing any sentence, the court must have regard to relevant aggravating and mitigating factors, as well as "any other objective or

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others": J Minster and A Knowles, "Exclusion or concern: lawyers' and community members' perceptions of legal coercion, dangerousness and mental illness" (2006) 13(2) *Psychiatry, Psychology and Law* 166, 172. See also Queensland Health, *Review of the Queensland Mental Health Act 2000: Promoting Balance in the Forensic Mental Health System* (2006), 126-127; Mindframe Media and Mental Health Project, *Reporting Suicide and Mental Illness* (2006), 8 «<http://www.mindframe-media.info>» (accessed on 12 August 2009).

34. See, eg, *R v Wright* (1997) 93 A Crim R 48, 52-54. Contrast *R v Welling* [2005] NSWCCA 318, [32]-[38].

35. *Fardon v Attorney General (Qld)* (2004) 223 CLR 575, [12].

36. *Veen v The Queen (No 2)* (1988) 164 CLR 465, 472 and 477, 484-488, 495-496.

37. *R v SLD* (2003) 58 NSWLR 589, 595, 597; *R v McNamara* [2004] NSWCCA 42, [23]-[30]; *R v Harrison* (1997) 93 A Crim R 314, 319.

38. *Hurd v The Queen* (1988) 38 A Crim R 454, 461, 467-468; see also *R v Lewfatt* (1993) 66 A Crim R 451, 460 (substance abuse); but cf *R v Wright* (1997) 93 A Crim R 48, 52-54.



subjective factor that affects the relative seriousness of the offence”.<sup>39</sup> The CSPA contains non-exhaustive lists of aggravating and mitigating factors, which are supplemented by the common law.<sup>40</sup> While only one of the legislated factors mentions “disability”, several others are of practical relevance when sentencing offenders with cognitive and mental impairments. These include:

- the offender’s prospects of rehabilitation;
- the existence of a prior criminal record;
- whether the offence was committed while the offender was on conditional liberty; and
- the occupation of the victim.

*Disability as a mitigating factor*

8.26 A factor that may mitigate the severity of a sentence is where the offender was not fully aware of the consequences of his or her actions because of his or her age or “any disability”.<sup>41</sup> Courts have interpreted this to include “significant mental disabilities of any kind, whether or not they might be regarded in a medical sense as mental illnesses”.<sup>42</sup>

8.27 Courts tend not to regard substance use disorders as equivalent to other cognitive and mental health impairments in terms of sentence mitigation because of “the original element of choice” involved in commencing, and then continuing, to use the substance.<sup>43</sup>

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39. CSPA s 21A(1).

40. CSPA s 21 and s 21A. The court is not compelled to increase or reduce a sentence due to the presence of an aggravating or mitigating factor, and is not required to have regard to any factor if to do so would be contrary to other legislation or the common law: s 21A(4); *R v Way* (2004) 60 NSWLR 168, 183.

41. CSPA s 21A(3). Note that this mitigating factor is narrower in scope than the common law principle discussed at [8.12]-[8.13].

42. *R v Arnold* [2004] NSWCCA 294, [68]; see also *R v Henry* [2007] NSWCCA 90, [28]; *R v Way* (2004) 60 NSWLR 168, 187; *Matthews v The Queen* (2004) 145 A Crim R 445, 449; *R v Arnold* [2004] NSWCCA 294; *R v George* [2004] NSWCCA 247; *R v Letteri* (unreported, NSW Court of Criminal Appeal, 18 March 1993, Gleeson CJ, Sheller JA and Badgery-Parker J).

43. *R v Henry* (1999) 46 NSWLR 346. See also *R v Wright* (1997) 93 A Crim R 48; *R v Matthews* (2004) 145 A Crim R 445, 450 and *R v Verdins*; *R v Buckley*; *R v VO* (2007) 16 VR 269, [22]; *R v Henry* [2007] NSWCCA 90, [29]; *Police v Mitchell* [2008] NSWLC 5. Nevertheless, addiction can be a mitigating circumstance if there is evidence to “suggest that the addiction was not a matter of personal choice but

8.28 The presence of a mental or cognitive impairment will not automatically attract mitigation, unless it can be shown that the nature and extent of the impairment affected the offender sufficiently at the time of the offence to justify the imposition of a less severe sentence than would otherwise apply.<sup>44</sup> Even where a causal relationship between the commission of an offence and a mental disorder can be established, a reduction in sentence will not automatically occur, since the various factors that need to be considered may point in opposite directions. For example, the presence of a cognitive or mental impairment may result in deterrence of others being less significant, but may heighten the importance of protecting the community.<sup>45</sup>

8.29 Courts have also referred to the danger of “double counting” an offender’s liability as a mitigating factor in sentencing in circumstances where the impairment was considered in relation to establishing the offender’s liability for the offence. This could occur, for instance, in cases of substantial impairment where an offender’s mental condition is significant enough to reduce a charge of murder to manslaughter by successfully making out the defence of substantial impairment. In such circumstances, courts have stated that the impairment should only be considered a relevant mitigating factor in sentencing if it is “to a significant degree more than would have been necessary to give rise to the diminution in culpability associated with the lesser charge”.<sup>46</sup>

#### *Prospects of rehabilitation*

8.30 The CSPA recognises prospects of rehabilitation, whether by reason of the offender’s age “or otherwise”, as both a purpose of sentencing and a mitigating factor.<sup>47</sup> The sentencing court may have regard to an offender’s mental condition and the effect it is likely to have

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was attributable to some other event for which the offender was not primarily responsible”: *R v Henry* (1999) 46 NSWLR 346, [184]-[186], [273], [336]-[344]. Examples include cases where the addiction occurred at a very young age, or in a person whose mental or intellectual capacity was impaired, so that their ability to exercise appropriate judgment or choice was incomplete.

44. *R v Lawrence* [2005] NSWCCA 91, [22]-[23]; *R v Verdins*; *R v Buckley*; *R v VO* (2007) 16 VR 269, [7]-[8]; *Withers v R* [2009] NSWCCA 133, [29].

45. See, eg, *Veen v The Queen (No 2)* (1988) 164 CLR 465; *R v Engert* (1995) 84 A Crim R 67; *Car v R* [2009] NSWCCA 138.

46. *R v Paddock* [2009] NSWSC 369, [31]-[33].

47. *Crimes (Sentencing Procedure) Act 1999* (NSW) s 3A(d), s 21A(3)(h).

on his or her prospects of rehabilitation irrespective of whether the mental condition was causally related to the commission of the offence.<sup>48</sup>

8.31 In terms of mitigation, this could mean that a sentence other than imprisonment may be imposed, or, if a custodial sentence is deemed necessary, a shorter term than that which would ordinarily apply may be considered appropriate.<sup>49</sup> There is no general rule that the court should endeavour to select a penalty that is *likely* to promote the offender's rehabilitation or recovery.<sup>50</sup> Nor can the fact that an offender has reasonable prospects for rehabilitation be allowed to overshadow the objective seriousness of the offence committed.<sup>51</sup>

8.32 However, this factor is problematic in relation to offenders with cognitive or mental health impairments, since non-custodial options may not be appropriate,<sup>52</sup> and their prospects of rehabilitation may depend on receiving treatment services that are not available.

#### *Prior criminal record*

8.33 An offender's prior criminal record, or lack thereof, may be relevant as either an aggravating or mitigating factor respectively.<sup>53</sup> Its relevance is to show whether the "instant offence is an uncharacteristic aberration or whether the offender has manifested ... a continuing attitude of disobedience to the law. In the latter case, retribution, deterrence and protection of society may all indicate that a more severe penalty is warranted".<sup>54</sup> The offender's prior criminal history cannot justify a sentence greater than what is proportionate to the offence, but may militate against leniency which might otherwise be afforded.<sup>55</sup> This use of the prior criminal record can be problematic for offenders with cognitive and mental health impairments, because it might effectively disregard the relationship, where one exists, between the impairment and the prior offending.

48. *R v Engert* (1995) 84 A Crim R 166, 71.

49. Also, the non-parole period could be adjusted: see [8.51]-[8.54].

50. *R v Wright* (1997) 93 A Crim R 48, 52-54; see, eg, *Du Randt v The Queen* [2008] NSWCCA 121, [27]-[31], [42]. Contrast *Hurd v The Queen* (1988) 38 A Crim R 454, 461, 467-468; *R v Lewfatt* (1993) 66 A Crim R 451, 460.

51. *R v Wright* (1997) 93 A Crim R 48, 52-54.

52. See [8.102]-[8.106].

53. *Crimes (Sentencing Procedure) Act 1999* (NSW) s 21A(2)(d), 21A(2)(3)(e).

54. *Veen v The Queen (No 2)* (1988) 164 CLR 465, 477, 496.

55. *Veen v The Queen (No 2)* (1988) 164 CLR 465, 496, 477.

8.34 The relationship between an offender’s cognitive or mental health impairment and his or her prior criminal record may be particularly relevant for young adult offenders who have had contact with the criminal justice system prior to adulthood. Adult onset mental illnesses are sometimes preceded by childhood behavioural disorders that may contribute to juvenile offending. For a young adult offender who has recently been diagnosed with mental illness, a prior criminal history would weigh against mitigation for the illness.<sup>56</sup> Yet in some cases it might be that, rather than representing “a continuing attitude of disobedience to the law”, the offender’s prior criminal behaviour reflects, at least in part, early manifestations of their illness.<sup>57</sup> Similarly, adolescent behavioural difficulties, lack of life skills and adequate support, often contribute to offending by young people with intellectual disabilities.<sup>58</sup>

8.35 Similar issues arise in relation to the legislated mitigating factor of prior good character,<sup>59</sup> and the aggravating factor whereby an offence is committed while the offender is on conditional liberty in respect of an earlier offence.<sup>60</sup>

#### *Victims*

8.36 The CSPA provides that it is an aggravating factor if “the victim was a police officer, emergency services worker, correctional officer, judicial officer, health worker, teacher, community worker, or other public official, exercising public or community functions and the offence

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56. See, eg, *R v Wright* (1997) 93 A Crim R 48, 52.

57. Offending by young people whose prior criminal history is of substance abuse-related offending might be particularly likely to be related to mental health problems: see Senate Select Committee on Mental Health, *A National Approach to Mental Health – From Crisis to Community*, First Report (March 2006), Ch 14 especially [14.1]-[14.14], [14.32]-[14.42]. As to the shortage of adolescent mental health services, see NSW Legislative Council Select Committee on Mental Health, *Mental Health Services in New South Wales*, Report (2002), [13.8]-[13.38].

58. J Simpson, M Martin and J Green, *The Framework Report: Appropriate Community Services in NSW for Offenders with Intellectual Disabilities and Those at Risk of Offending* (2001), 11-13.

59. CSPA s 21A(f).

60. CSPA s 21A(2)(j); *R v Readman* (1990) 47 A Crim R 181, 184; *Re Attorney-General’s Application [No 1] under s 26 of the Criminal Procedure Act – R v Ponfield; R v Scott; R v Ryan; R v Johnson* (1999) 48 NSWLR 327, [48]; *Kokaua v The Queen* [2008] NSWCCA 111; *Police v Mitchell* [2008] NSWLC 5.

arose because of the victim’s occupation or voluntary work”.<sup>61</sup> The provision is intended to protect people who perform important services to the community from offences that occur during, and as a result of, that service. It may, however, have a disproportionate impact on offenders with cognitive and mental health impairments because of a combination of two factors.

8.37 First, it is likely that a person with a cognitive or mental health impairment would come into contact with health workers, community workers and emergency services more frequently than people without such an impairment. Contact may occur on a regular basis (such as daily care by a disability worker), and/or at times when the person’s behaviour is most affected by the impairment (such as when a person with a mental illness is behaving in a way that poses a risk of harm and police or ambulance officers are called to transport the person to hospital). Secondly, aggressive behaviour by the person might be a manifestation of the impairment, rather than a malicious act targeted at a particular victim. In cases where the cognitive or mental health impairment is the reason underlying both contact with the community service worker and the offending behaviour, it may be unjust to regard the victim’s occupation as an aggravating factor.

8.38 The CSPA also provides that it is an aggravating factor if “the offence was committed in the home of the victim or any other person”, including the home of the accused.<sup>62</sup> Again, this provision may be particularly problematic for offenders with cognitive and mental health impairments in respect of offences committed against carers or family members.

### Legislative reference to cognitive or mental impairment

8.39 While the CSPA refers to an offender’s disability as a mitigating factor in sentencing, it makes no specific reference to cognitive or mental health impairments as a factor relevant to sentencing. This is perhaps surprising given the longstanding and well-known high incidence of such impairments among the offender population.<sup>63</sup> Although the common

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61. CSPA s 21A(2)(a). See also CSPA s 21A(2)(l) (victim vulnerable because of occupation).

62. CSPA s 21A(2)(eb).

63. See Consultation Paper 5 (“CP 5”), ch 1.

law acknowledges the need to modify sentencing principles to accommodate offenders with cognitive or mental impairments, a legislative statement would carry more weight.

8.40 For example, the mitigating factors in s 21A of the CSPA could specifically refer to “cognitive and mental health impairment” in addition to “disability”.<sup>64</sup> This would codify the common law position, and act as a direct legislative prompt for the court to consider the special issues that may arise when sentencing offenders with mental illness or cognitive impairments. It would also clarify the fact that a cognitive or mental health impairment qualifies as a “special circumstance” for the purpose of setting a shorter non-parole period, since the CSPA provides that a court may adjust the standard non-parole period only for the reasons specified in s 21A.<sup>65</sup>

8.41 In addition, the legislative statement could go further, and reflect the principles articulated in *Hemsley*,<sup>66</sup> by directing the court to consider the specific circumstances of an offender’s impairment when applying the common law sentencing principles, and the effect that such an impairment may have in relation to some of the aggravating and mitigating factors listed in the CSPA. For example, the CSPA could provide that when sentencing an offender with a cognitive and mental health impairment, the court must have regard to the effects of that impairment both in terms of its relevance to the objective seriousness of the crime and the offender’s moral culpability, and the subjective effects of the impairment on the offender.

8.42 In particular, the court should recognise:

- the possibility that a custodial sentence might weigh more heavily on offenders with cognitive or mental health impairments than on other offenders in determining the appropriate sentencing option;
- the impact that the availability (or lack thereof) of appropriate treatment and support services within prisons for offenders who are mentally ill or have other mental or cognitive impairments is likely to have on the offender’s rehabilitation prospects, or on his or her ability to cope with the sentence

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64. CSPA s 21A(3).

65. CSPA s 54B(3).

66. *R v Hemsley* [2004] NSWCCA 228. See [8.11].

- that the application of the aggravating and mitigating factors in the CSPA could operate unfairly unless adequate consideration is taken of the impact that a cognitive or mental health impairment may have on the offender's behaviour and on his or her prior contact with the criminal justice system; and
- the need to consider the risk posed to the public if the offender is not detained, and the fact that risk will not be present in every case.

8.43 It may also be of value to re-examine the legislated purposes of sentencing in relation to offenders with cognitive or mental health impairments, since the interests of justice may require that those purposes be re-focused. Sentencing involves the application of principles such as punishment, deterrence, rehabilitation of the offender and protection of the community. Since sentencing occurs after a finding of guilt in relation to a criminal offence, punishment is a key element in nearly all sentences, either through deprivation of liberty or the curtailment of freedom in some respect. Within that general proposition, however, the other purposes of sentencing have varying degrees of significance. For example, it is generally accepted that deterrence and denunciation carry little weight when sentencing offenders with cognitive and mental health impairments. It is arguable that where an impairment is significant enough to mitigate the severity of a sentence, or to reduce an offender's moral culpability for an offence, the aim of the sentencing process should be to promote the offender's prospects of rehabilitation, to be balanced against the harm done to the victim and the community and protecting the community from any risk likely to be posed by the offender.

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#### Issue 6.104

Should s 21A of the CSPA be amended to include "cognitive and mental health impairment" as a factor in sentencing?

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#### Issue 6.105

Further, should the CSPA contain a more general statement directing the court's attention to the special considerations that arise when sentencing an offender with cognitive or mental impairments? If so, how should that statement be framed?

Should the purposes of sentencing as set out in s 3(1)(a) of the CSPA be modified in terms of their relevance to offenders with cognitive and mental health impairments? If so, how?

## SENTENCING OPTIONS IN NSW

8.44 Consideration by the court of the sentencing purposes and principles feeds directly into decisions concerning whether or not a penalty is appropriate, and if so, what its nature and severity should be. The CSPA provides the Local, District or Supreme courts with the following options if a person pleads guilty, or is otherwise convicted of an offence (listed in increasing order of severity):

- order that the charge be dismissed and discharge the offender without recording a conviction, unconditionally, or on condition of good behaviour, or participation in an “intervention program”;<sup>67</sup>
- record a conviction and impose no other penalty;<sup>68</sup>
- convict the offender and impose a fine;<sup>69</sup>
- convict the offender and impose a good behaviour bond for up to five years, which may include a condition that the offender undergo counselling;<sup>70</sup>
- convict the offender and impose a community service order;<sup>71</sup> or
- convict the offender and impose a sentence of imprisonment, to be served by way of periodic or home detention, or full-time imprisonment.<sup>72</sup>

8.45 In addition, a court has the following ancillary powers:

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67. CSPA s 10.

68. CSPA s 10A. As to the jurisdictional limit of the Local Court in respect of penalties, see *Criminal Procedure Act 1986* (NSW) s 267-268.

69. CSPA s 14, 15.

70. CSPA s 9, pt 8. A court may not, in relation to the same offence, order both a good behaviour bond and community service: s 13.

71. CSPA s 8, pt 7; *Crimes (Administration of Sentences) Act 1999* (NSW) (“CASA”) pt 5. The maximum is 500 hours of community service: s 8(2) and *Crimes (Sentencing Procedure) Regulation 2005* (NSW) reg 22.

72. CSPA s 5.



- to make a place restriction order or a non-association order, in addition to another sentencing option;<sup>73</sup> and
- to defer sentencing for up to two years for the offender’s rehabilitation, participation in an “intervention program” or any other purpose the court considers appropriate.<sup>74</sup>

8.46 The relevance and appropriateness of these options varies in relation to offenders with cognitive and mental health impairments, depending on factors such as the type and severity of the condition, and the risk posed to community.

### Sentences of full-time detention

8.47 Where the court determines that some form of penalty is warranted, it must decide between custodial and non-custodial options. In some circumstances, that choice may be limited by statute, since imprisonment is not available as a choice for all offences. Where a custodial sentence is available, the court should only sentence an offender to prison after having considered all other alternatives.<sup>75</sup> If the court determines that no penalty other than imprisonment is appropriate, it must determine what the length of that sentence should be, and the availability and appropriateness of alternatives to full-time custody.<sup>76</sup>

8.48 It is arguable that the requirement that custodial sentences be imposed only as a “last resort” is even more important in relation to offenders with cognitive and mental health impairments, given the fact that effects of prison are likely to be more detrimental for them than for other offenders.<sup>77</sup> However, since statistics show a high proportion of prison inmates with mental or cognitive impairments, it would seem that prison is the only alternative for many such offenders.

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73. CSPA s 17A.

74. CSPA s 11. The offender must be eligible for bail: s 11(1). As to “intervention programs” see s 3; *Criminal Procedure Act 1986* (NSW) s 3, 346-347; *Criminal Procedure Regulation 2005* (NSW) reg 19, 19A, sch 4, sch 5. See also the general power to adjourn proceedings and remand the defendant in custody: *Criminal Procedure Act 1986* (NSW) s 40.

75. CSPA s 5(1), pt 4; and see *R v Zamagias* [2002] NSWCCA 17, [23]-[31]; *R v Cromarty* (2004) 144 A Crim R 515, 531; *R v Main* [2003] NSWCCA 268, [34].

76. See [8.81]-[8.109] regarding alternatives to full-time custody.

77. See [8.19]-[8.20].

8.49 Certain measures are currently in place which may lessen the impact of a custodial sentence on these offenders. For example, specialist units within some prisons providing for the requirements of offenders with intellectual disabilities, and Justice Health provides health care services in a number of areas, including mental health. Offenders with a mental illness may also be transferred from prison to a forensic hospital for treatment,<sup>78</sup> or may be the subject of a Community Treatment Order (“CTO”) while in prison.<sup>79</sup>

8.50 Much has been written about the need to provide and coordinate treatment and other support services for prisoners with cognitive and mental impairments.<sup>80</sup> This is not only a matter of individual human rights,<sup>81</sup> but also fulfils a public interest in making sure offenders are sufficiently rehabilitated to enable them to safely reintegrate into the community. While it is not within the scope of this review to evaluate services provided to offenders within prison, in this section we look at ways in which the sentencing court can currently address the special requirements of offenders with cognitive and mental health impairments serving sentences of full-time imprisonment, and any additional mechanisms that may be necessary.

*Non-parole period: “special circumstance”*

8.51 When sentencing an offender to imprisonment for a term exceeding six months,<sup>82</sup> a court is first required to set a non-parole period.<sup>83</sup> This refers to the minimum period for which the offender must

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78. See *Mental Health (Forensic Provisions) Act 1990* (NSW) (“MHFPA”), pt 5 div 3.

79. MHFPA s 67. See [8.70].

80. See, eg, NSW, Department of Health, *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled* (1983); NSW Law Reform Commission, *People with an Intellectual Disability in the Criminal Justice System*, Report 80 (1996); NSW Legislative Council, Select Committee on Mental Health, *Mental Health Services in NSW: Final Report*, Parliamentary Paper No 368 (2002); Mental Health Council of Australia and the Brain and Mind Research Institute, *Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia*, in association with HREOC (Canberra, 2005); Commonwealth, Senate Select Committee on Mental Health, *A National Approach to Mental Health – From Crisis to Community*, First Report, (March 2006).

81. See CP 5, ch 1.

82. A court may not set a non-parole period for sentences of less than six months: see CSPA s 46.

83. CSPA s 44(1). A court may decline to set a non-parole period if it considers it to be appropriate because of the nature of the offence to which the sentence relates

be kept in detention in relation to the offence. The court must then set the balance of the term of the sentence. Generally, that balance must not exceed one-third of the non-parole period, unless the court decides that there are special circumstances for increasing it, in which case the court must provide reasons for that decision.<sup>84</sup>

8.52 The courts have found that an offender’s cognitive or mental condition can amount to a “special circumstance” justifying a shift in the balance between the non-parole period and the total sentence.<sup>85</sup> As a result, an offender with a cognitive or mental health impairment may receive a shorter non-parole period due to special circumstances occasioned by the impairment. However, not every cognitive or mental health impairment will amount to a “special circumstance”. Generally, courts have found special circumstances to exist where offenders would be likely to benefit from extended supervision in the community, and require a longer period on parole in order to reintegrate more successfully.<sup>86</sup> Similarly, a shorter non-parole period may be warranted where an offender would benefit from rehabilitation or treatment services in the community.<sup>87</sup>

8.53 Where a court has found that special circumstances exist, the non-parole period must not be reduced below that which is commensurate with the gravity of the crime.<sup>88</sup> Courts have also cautioned against “double counting” an impairment as a special circumstance justifying an adjustment to the non-parole period where it has been considered in determining the overall sentence.<sup>89</sup> However, there will be cases where a mental impairment serves both as a mitigating factor in determining the

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or the antecedent character of the offender, because of any other penalty previously imposed or for any other reason that the court considers sufficient: CSPA s 45(1).

84. CSPA s 44(2).

85. See, eg, *R v Wright* (1997) 93 A Crim R 48, 55; *Alexander v The Queen* (2000) 118 A Crim R 350, 358; *R v Arnold* [2004] NSWCCA 294, [76]; *R v Riley* (Unreported, NSW Supreme Court, Mathews AJ, 2 May 2008); also *R v Way* (2004) 60 NSWLR 168.

86. See, eg, *R v Bonett* [2009] NSWCCA 135, [37].

87. *R v Sims* (1995) 83 A Crim R 1.

88. *R v Henry* [1999] NSWCCA 107, [76].

89. See *R v Zeilaa* [2009] NSWSC 532, [20].

total sentence, and a special circumstance in relation to the non-parole period.<sup>90</sup>

8.54 As noted earlier, the courts are limited in their ability to adjust the standard non-parole period to the factors set out in s 21A of the CSPA.<sup>91</sup> We hold the preliminary view that amending s 21A to include a specific reference to cognitive and mental health impairments, to supplement the more general reference to “disability”, would clarify the court’s power to adjust the non-parole period where appropriate for such offenders.

### Issues for discussion

8.55 Apart from adjusting the non-parole period in the manner discussed above, courts in NSW may be hampered in their attempts to give full effect to the sentencing principles through a lack of flexibility in sentencing options involving the detention of people with cognitive or mental health impairments. We seek views on whether the following measures would assist the court to meet the interests of justice more effectively by improving the custodial experience for offenders with mental impairments.

#### *Mandatory pre-sentence reports*

8.56 In Consultation Paper 5, Chapter 5, we raise the issue of whether the court should have a general power to order an assessment report at any time during proceedings, including sentencing, for the purpose of determining a defendant’s cognitive or mental state.<sup>92</sup> Specific issues arise, however, within the context of sentencing. Currently, the CSPA requires the court to consider the contents of a pre-sentence report before imposing a sentence of periodic or home detention, or a community service order.<sup>93</sup> The matters required to be addressed in those reports are prescribed by legislation, and go towards assessing an offender’s suitability for various custodial and non-custodial options.

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90. See, eg, *Withers v R* [2009] NSWCCA 133 where the offender’s impairment resulted in the length of the total sentence being moderated since it would increase the severity of the custodial experience, in addition to an adjusted non-parole period due to the need for a longer period of supervision in the community to monitor compliance with treatment and medication: [41]; *R v Szabo* [2003] NSWCCA 341, [14]-[16]; *Fisher v R* [2008] NSWCCA 103, [38]-[39].

91. See [8.26]-[8.29].

92. See especially Issue 5.6.

93. See [8.86], [8.90], and [8.94].

8.57 Although courts can (and often do) request a pre-sentence report to be prepared by the Probation and Parole Service when considering imposing a sentence of full-time imprisonment on an offender, there is no legislative requirement for them to do so.<sup>94</sup> Arming courts with as much relevant information as possible before sentencing decisions are made is particularly important with regard to offenders with cognitive and mental health impairments. A pre-sentence report may contain information such as an assessment of the nature and severity of the offender's cognitive or mental state, and the likely impact of incarceration on the offender, the suitability of the offender for various intervention or treatment programs, and the availability of those programs within the criminal justice system. This information would be relevant to the type, length and structure of any custodial sentence.

8.58 This Commission previously examined the issue of whether pre-sentence reports should be mandatory for offenders with an intellectual disability, concluding that they should only be mandatory where an offender was unrepresented and a custodial sentence was a real possibility.<sup>95</sup> The reason for this view was the likelihood of a potentially significant increase in the workload of the Probation and Parole Service, the need to avoid delays in sentencing, and the danger that an offender's disability could be wrongly identified or misinterpreted unless officers of the Probation and Parole Service were appropriately trained.<sup>96</sup> The Australian Law Reform Commission also considered the issue recently in relation to the sentencing of federal offenders, reaching the view that while mandatory pre-sentence reports for all offenders with cognitive and mental impairments are an attractive option, resource implications would require that such reports be mandatory only where there is a "reasonable prospect" of imprisonment.<sup>97</sup>

8.59 We seek views on the likely benefits and disadvantages of requiring courts to obtain a pre-sentence report when it is likely that an

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94. In 2007-08, the Department prepared more than 26,600 pre-sentence reports, assessing the suitability of offenders for various custodial and non-custodial sentencing options: Department of Corrective Services, *Annual Report 2007/08* (2008), 42.

95. See NSWLRC DP 35, [11.19]; and NSWLRC, *Sentencing* Report 79 (1996), [8.57].

96. See NSWLRC DP 35, [11.19].

97. ALRC, *Same Crime, Same Time: Sentencing of Federal Offenders*, Report 103 (2006), [28.98]-[28.99], recommendation 28-11.

offender with cognitive or mental health impairments will receive a sentence of imprisonment. In particular, we seek views on how the difficulties raised in previous inquiries may be overcome.

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Issue 6.107

Should the CSPA be amended to make it mandatory for a court to order a pre-sentence report when considering sentencing offenders with cognitive or mental health impairments to prison?

If so:

- (a) what should the report contain?
- (b) should the contents be prescribed in the relevant legislation?

*Detention in places other than prison*

8.60 The NSW Department of Corrective Services is responsible for 35 correctional facilities housing 9634 inmates.<sup>98</sup> With figures indicating that approximately 38% of sentenced inmates have some form of mental illness or impairment, and 20% have an intellectual disability,<sup>99</sup> the ability to house these inmates elsewhere, such as a secure treatment facility, would not only be of benefit to the offender and ultimately the community, but would also lessen the burden on the prison system enormously.

8.61 However, courts in NSW currently have no power to order that a sentence of imprisonment be served anywhere other than a prison.<sup>100</sup> An inmate in a correctional centre who is found to be “mentally ill”<sup>101</sup> may be transferred to a mental health facility if ordered by the Director General of the Department of Corrective Services,<sup>102</sup> but a court cannot sentence an offender to such a facility directly. This contrasts with other jurisdictions which empower courts to order that a sentence be served in

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98. NSW Department of Corrective Services, *Facts and Figures: Corporate Research, Evaluation and Statistics* (2009) (see «<http://www.dcs.nsw.gov.au>»). Figures correct at June 2008.

99. See CP 5, ch 1.

100. The only example in NSW is for drug treatment detention: see *Drug Court Act 1998* (NSW) s 18C. However, this is not available for people with a mental illness, condition or disorder that is serious or leads the person to be violent: *Drug Court Act 1998* (NSW) s 5A(3).

101. Within the meaning of the *Mental Health Act 1990* (NSW) s 4: see CP 5, ch 2.

102. See MHFPA s 35, 55,

a mental health facility, or a specialist unit for intellectual disability, rather than a prison.

8.62 For example, in Victoria, the Northern Territory, New Zealand and the Commonwealth, an offender may be sentenced to detention in a mental health facility, for a period not greater than the term of imprisonment which would otherwise have been imposed.<sup>103</sup> In Tasmania<sup>104</sup> and the United Kingdom,<sup>105</sup> such orders apply for an indeterminate period. Furthermore, in Victoria and New Zealand, courts may order detention in specialist facilities for offenders with intellectual disabilities.<sup>106</sup>

8.63 In Victoria and the Northern Territory, the court is required to set a non-parole period,<sup>107</sup> while under the Commonwealth provisions, a court may set a “lesser period of detention” during which the person is not eligible for release.<sup>108</sup> At the end of that period, the Attorney General must release the person unless a psychiatric report recommends against it or the person is subject to another federal sentence.<sup>109</sup> In Victoria and New Zealand, if the person recovers during the term of the order, he or she is transferred to prison to serve the remainder as a sentence of

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103. *Crimes Act 1914* (Cth) s 20BS; *Sentencing Act 1995* (NT) s 80(1)(e), (9), (10); *Sentencing Act 1991* (Vic) s 92, 93A; *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 34(1)(a). In Victoria, an indefinite order may be made in cases where an indefinite term of imprisonment would have been imposed: see *Sentencing Act 1991* (Vic) s 18B, 18E.

104. *Sentencing Act 1997* (Tas) s 75, 77; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 24. A person subject to a restriction order is reviewed at least annually by a Forensic Tribunal, and the has effect until discharged by the Supreme Court: *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 24, 26(2), 37(1).

105. *Mental Health Act 1983* (UK) s 41, 42, 43, 70, 71, 73-75.

106. See *Sentencing Act 1991* (Vic) s 80 which provides for offenders to be detained for up to five years under a residential treatment order. See also *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 34; *Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003* (NZ) s 7-8, pt 5 subpt 4.

107. *Sentencing Act 1991* (Vic) s 93A(7); *Sentencing Act 1995* (NT) s 80(1)(e), (9)-(10).

108. *Crimes Act 1914* (Cth) s 20BS(1), (3)-(4).

109. *Crimes Act 1914* (Cth) s 20BS(6), 20BT(1)-(2). The release may be subject to such conditions as the Attorney General considers appropriate, including a condition that the person be released into the care of a specified person, for the balance of the period of the order: *Crimes Act 1914* (Cth) s 20BT(2).

imprisonment, unless released sooner on parole.<sup>110</sup> Commonwealth and Northern Territory legislation provides for the offender to be returned to court for appropriate orders to be made.<sup>111</sup>

8.64 If such an option were to be adopted in NSW, the pre-sentence report<sup>112</sup> could inform the court of the nature and severity of the offender's impairment, and the type and availability of appropriate services. Despite the benefits of detention in specialist facilities rather than in prison, there are two major drawbacks associated with this proposal, both of which are beyond the control of the sentencing court. The first is the question of resources: the lack of suitable, available residential facilities for people with cognitive and mental health impairments is well-documented, and is arguably one of the reasons for their high prevalence within the prison system. This problem would be particularly acute for offenders with a high security classification. The second difficulty is that while the sentencing court can order that an offender be detained in a specialist facility, it could not compel those facilities to house the offender. The success of this option would depend to a large degree on cooperation of, and coordination between, DCS, Justice Health, the MHRT and private sector service providers.

8.65 These problems are clearly not insurmountable, as this option already exists in other jurisdictions. Resolving them, however, is beyond the scope of this review. Nevertheless, the Commission considers that empowering courts to order detention in facilities other than prison would be an important step forward in NSW.

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#### Issue 6.108

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Should the CSPA be amended to give courts the power to order that offenders with cognitive or mental health impairments be detained in facilities other than prison?

If so, how should such a power be framed?

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110. *Sentencing Act 1991* (Vic) s 93A(7); *Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003* (NZ) s 68, 71; *Mental Health (Compulsory Treatment and Care) Act 1992* (NZ) s 47.

111. See *Crimes Act 1914* (Cth) s 20BU; *Sentencing Act 1995* (NT) s 80(6), (7), (11).

112. See [8.56]-[8.59].



*Notification mechanisms*

8.66 Judges and magistrates generally possess information relevant to an offender's impairment that would be beneficial to pass on to DCS, Justice Health and the MHRT with regard to the type of treatment or other support services that the person may require during the course of their sentence. Sentencing courts currently attempt to communicate this information by making recommendations in sentencing remarks about interventions that may assist the offender, or directing that the warrant of commitment be annotated, for example, with a recommendation that the offender be assessed by a psychiatrist as soon as practicable after reception into a correctional centre.<sup>113</sup>

8.67 Another option would be to expand on a procedure that has developed in the Local Court, whereby psychiatric and psychological reports tendered in court are sent to the Justice Health officer at the correctional centre to which the offender is committed.<sup>114</sup> This could be implemented as an addition or an alternative to any sentencing remarks or annotations on the subject. If such a proposal were to be adopted, the Commission is of the view that it should apply to all courts. Consideration should also be given to whether the reports should be sent by the sentencing court to other relevant agencies, such as Justice Health or the Disability Services Unit of the DCS, subject to appropriate privacy protection.

8.68 While it is open to the court to engage in these options currently, there is evidence that information concerning an offender's impairment-related needs is not routinely transmitted from the courts to the correctional facilities,<sup>115</sup> resulting in duplication of resources. Providing for notification in legislation might create an impetus for the establishment of formal, permanent channels of communication between

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113. See for example *Director of Public Prosecutions v Houn* [2008] NSWLC 16.

114. This procedure is established by Local Court Practice Note 4 of 2007: Provision of Psychiatric Reports to Correctional Facilities. The Commission is not aware of any equivalent protocol in the District or Supreme Courts.

115. Auditor General Of NSW, *Performance Audit: Prisoner Rehabilitation: Department of Corrective Services* (2006), 25, 28; J Simpson and M Sotiri, *Criminal Justice and Indigenous People with Cognitive Disabilities*, Discussion Paper for Aboriginal and Torres Strait Islander Services (2004), 32; NSW Legislative Council Select Committee on the Increase in Prisoner Population, *Issues Relating to Women*, Interim Report (2000), [5.108]-[5.120]. See also *Crimes (Administration of Sentences) Regulation 2008* (NSW) reg 5, sch 1 cl 14.

courts and the relevant agencies. However, as noted at paragraph 8.64, it would not be within the power of the sentencing court to order agencies to provide particular treatment services to an offender.

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Issue 6.109

Should the CSPA provide a mechanism for courts to notify other agencies and tribunals of the needs of offenders with cognitive and mental health impairments who are sentenced to imprisonment?

If so, should the legislation state that the sentencing court:

- (a) may make recommendations on the warrant of commitment concerning the need for psychiatric evaluation, or other assessment of an offender's mental condition as soon as practicable after reception into a correctional centre; and/or
- (b) may forward copies of any reports concerning an offender's impairment-related needs to the correctional centre, Justice Health, the MHRT, or the Disability Services Unit within DCS, if appropriate?

*Community treatment orders and sentences of imprisonment*

8.69 When courts impose a community-based sentencing option, such as a community service order or a good behaviour bond, they may attach conditions to the sentence,<sup>116</sup> including that the offender undertake some form of rehabilitation or treatment. However, courts in NSW do not have the power to attach such conditions to a sentence of imprisonment. One of the primary reasons for this is the view taken by the courts that the executive government, and not the sentencing court, has the sole responsibility for decisions about the way in which resources within prisons are allocated and prioritised.<sup>117</sup> As such, consideration of this option is beyond the scope of this review.

8.70 Despite these limitations, there is one mechanism by which the sentencing court could arrange for mentally ill offenders to receive treatment in prison. Since the MFPA came into effect in March 2009, the MHRT may make a CTO in respect of a mentally ill person who is an inmate in a correctional facility, including a remand prisoner.<sup>118</sup> If the

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116. See [8.93]-[8.101].

117. See, eg, *R v Vachalec* (1981) NSWLR 351, 353-354; and *R v Paddock* [2009] NSWSC 369, [34].

118. MHFPA s 67. As to community treatment orders, see *Mental Health Act 2007* (NSW) pt 3, and CP 5, ch 2.

MHRT orders that a CTO be made in relation to an inmate, it must review that person's case every three months.<sup>119</sup>

8.71 While this provision is a step forward for prison inmates with a mental illness, it will only be effective once the DCS or the MHRT have become aware of the illness. In some cases, the sentencing court may be aware of the offender's illness before any of those agencies. In these situations, it may be expedient for the court, when considering imposing a sentence of imprisonment, to request the MHRT to assess the offender with a view to making a CTO pursuant to s 67(1)(d) of the MFPA.

8.72 The attraction of this option is that it taps into an existing legislative and administrative framework. The downside is that it would apply only to offenders with a mental illness as defined in the *Mental Health Act 2007* (NSW). We seek views as to whether similar options can or should be available to offenders with other mental conditions or cognitive impairments.

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#### Issue 6.110

Should the CSPA be amended to empower the court, when considering imposing a sentence of imprisonment on an offender with a mental illness, to request that the MHRT assess the offender with a view to making a community treatment order pursuant to s 67(1)(d) of the MFPA?

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#### Issue 6.111

What similar powers, if any, should the court have with regard to offenders with other mental conditions or cognitive impairments?

### Parole

8.73 Put simply, parole refers to the conditional release of an offender from detention after the minimum term, or non-parole period, has been served. The rationale for parole is that, while still part of the "continuum of punishment",<sup>120</sup> it facilitates an offender's rehabilitation and re-integration into society by enabling the remainder of the sentence to be

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119. MHFPA s 61(3).

120. NSWLRC, *Sentencing* Discussion Paper 33 (1996), [7.4].

served under supervision in the community.<sup>121</sup> Parole is relevant to all custodial sentences, whether served by way of full-time, periodic or home detention.<sup>122</sup>

8.74 An order for parole may be made either by the court at the time of sentencing, or by the Parole Authority at a later date, depending on the duration of the non-parole period. If a court imposes a sentence of imprisonment for a term of three years or less, and a non-parole period has been set,<sup>123</sup> the court must order that the offender be released on parole at the end of the non-parole period.<sup>124</sup> For sentences longer than three years, the offender may be released at the end of the non-parole period if his or her application to the Parole Authority is successful.<sup>125</sup>

#### *Relevant factors*

8.75 The Parole Authority must not make an order for parole unless satisfied, on the balance of probabilities, that “the release of the offender is appropriate in the public interest”.<sup>126</sup> In deciding whether to grant parole, the Parole Authority must have regard to a number of factors, including:

- the need to protect the community, and to maintain public confidence in the administration of justice;
- the nature and circumstances of the offence to which the sentence relates;
- any relevant comments made by the sentencing court;
- the offender’s criminal history;
- the likelihood of the offender being able to adapt to normal life;
- the likely impact on the victim or his or her family;
- any report that has been prepared in relation to the offender; and
- any other matter.<sup>127</sup>

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121. For a discussion of the issues concerning parole, see NSWLRC DP 33 ch 7; NSWLRC Report 79, ch 11; and R Simpson, *Parole: An Overview* NSW Parliamentary Library Research Service, Briefing Paper No 20/99 (1999).

122. See CASA s 125.

123. See [8.51]-[8.54] regarding non-parole periods.

124. CSPA s 50.

125. See CASA pt 6-8; *Crimes (Administration of Sentences) Regulation 2008* (NSW) ch 7.

126. CASA s 135(1).

127. CASA s 135(2).

8.76 To assist the Parole Authority in making its decision, the Probation and Parole Service must prepare a report detailing, among other things, the offender's prospects of adapting to "normal" community life; the risk of re-offending while on parole, the measures that may be taken to reduce that risk or to assist the offender; the willingness of the offender to participate in rehabilitation programs; and the feasibility of complying with any conditions placed on the parole.<sup>128</sup> Parole may be refused before an offender is released if the Parole Authority is of the view that he or she is unable to adapt to community life, or if satisfactory post-release accommodation or other plans have not been made, or are unable to be made.<sup>129</sup>

8.77 A parole order may be made subject to standard conditions, or any additional conditions imposed by the court or the Parole Authority.<sup>130</sup> Conditions may involve supervision, place restriction, non-association, and "conditions relating to residence or treatment".<sup>131</sup>

*Issues for offenders with cognitive and mental health impairments*

8.78 The broad terms of the relevant legislative instruments governing parole provide scope for the special requirements of offenders with cognitive and mental health impairments. For example, the prescribed list of matters that must be included in the report prepared by the Probation and Parole Service could encompass the special requirements of offender's with cognitive and mental health impairments. Similarly, the Parole Authority can consider information about an offender's cognitive or mental health impairment and associated needs, and can order a psychiatric, psychological or medical examination of an offender.<sup>132</sup>

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128. CASA s 135A.

129. *Crimes (Administration of Sentences) Regulation 2008* (NSW) reg 232.

130. See CSPA s 51; CASA s 128, 128A; *Crimes (Administration of Sentences) Regulation 2008* (NSW) reg 224, 225.

131. CASA s 128, 128A; *Crimes (Administration of Sentences) Regulation 2008* (NSW) reg 224, 225; CSPA s 50, 51, 51AA; *Crimes (Sentencing Procedure) Regulation 2005* (NSW) reg 5, 6. Before making an order concerning residence or treatment, the court, or the Parole Authority, must consider a report from a probation and parole officer as to the offender's circumstances, and obtain the consent of any third parties who may be affected: *Crimes (Sentencing Procedure) Regulation 2005* (NSW) reg 6.

132. CASA s 193. The Parole Authority can compel the attendance of witnesses and production of documents, and may require evidence to be given under oath:

However, there is no express reference in the legislation to this group of offenders.

8.79 The lack of a specific reference to offenders with cognitive and mental impairments may result in the Parole Authority having insufficient relevant information on which to make fully informed decisions. There is the danger that this could lead to a refusal to grant parole, or a decision to revoke it, based on misunderstanding concerning the type of supervision and support required to assist an offender to adapt to life in the community. Given that cognitive or mental impairment is accepted as a “special circumstance” justifying longer periods of parole during which an offender may receive supervision, treatment and other support services in the community,<sup>133</sup> it is particularly important that the requirements of such offenders are fully taken into account.

8.80 A legislative requirement that decision-makers consider issues arising due to cognitive and mental health impairments and parole would prompt focus on:

- the effect that the impairment may have on the offender’s ability to make a successful transition from prison to a community environment, and to comply with specific conditions of parole;<sup>134</sup>
- the measures that may be necessary to overcome any difficulties occasioned by an offender’s impairment; and
- the type of conditions that might be attached to a parole order, including the availability and feasibility of appropriate treatment and support options to assist in the offender’s rehabilitation.<sup>135</sup>

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pt 8 div 2. See also provisions regulating disclosure of documents held by the Authority, including medical records: see s 193A, 194.

133. See [8.51]-[8.54].

134. For example, some parole conditions, such as non-association or place restriction conditions, may be difficult for some such offenders to comprehend without careful explanation. Further, significant support may be required to assist offenders to fulfil obligations, for example, teaching an offender with an intellectual disability how to tell the time, read a public transport timetable and buy a ticket, in order to keep reporting appointments with a parole officer: see NSWLRC DP 35, [12.37]-[12.39].

135. This could include offenders who may be subject to a CTO while in prison: see [8.69]-[8.72].

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**Issue 6.112**


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Should provisions regarding parole be amended to refer specifically to offenders with cognitive and mental health impairments? In particular, should the relevant legislation require specific consideration of an offender's cognitive or mental impairment:

- (a) by the Probation and Parole Service when preparing reports for the Parole Authority;
- (b) by the court when setting parole conditions; or
- (c) by the Parole Authority when determining whether to grant or revoke parole, and when determining parole conditions.

### Alternatives to full-time detention

8.81 Depending on the objective seriousness of the crime and the circumstances the offender, a sentence other than full-time detention may be imposed. In cases where a sentence of imprisonment is still appropriate, the court may order that the sentence be served on an alternative basis to full-time detention.<sup>136</sup> In NSW, there are two alternatives to full-time incarceration: periodic and home detention.

8.82 In other cases, generally where the offence in question was of a less serious nature, the court may impose a community-based penalty rather than a sentence of imprisonment. For example, the court may make a Community Service Order (“CSO”), or issue a good behaviour bond. A bond may be imposed on an offender even where no conviction is recorded.

#### *Periodic detention*

8.83 Where an offender is sentenced to imprisonment for a period of not more than three years, the court may direct that the sentence be served by way of periodic detention.<sup>137</sup> Under such a sentence, an offender is released into the community on the condition that he or she attend and

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136. The court is required to undertake a three step reasoning process in deciding to impose a semi-custodial sentence: first, to see if alternatives to imprisonments are available; secondly, to set the term of imprisonment; and thirdly, whether alternatives to full-time imprisonment are appropriate and available: see *Douar v R* [2005] NSWCCA 455, [69]-[72]; *R v Zamagias* [2002] NSWCCA 187, [23]-[28]. It is preferable if the court articulates all three steps: *R v Assaad* [2009] NSWCCA 182, [33].

137. CSPA s 6 and pt 5.

remain at a periodic detention centre for specified periods, for example, two days each week.<sup>138</sup>

8.84 An order for periodic detention may only be made where:

- the offender is at least 18 years of age and is a “suitable” candidate for periodic detention;<sup>139</sup>
- a sentence of periodic detention is appropriate in all of the circumstances;
- adequate accommodation is available at a periodic detention centre;
- suitable arrangements can be made to transport the offender to and from the centre; and
- the offender has agreed to comply with the obligations of the detention order.<sup>140</sup>

8.85 An offender is excluded from periodic detention if he or she has previously served a term of imprisonment for more than 6 months, in NSW or elsewhere<sup>141</sup>, or if the offence for which to sentence is to be imposed is a “prescribed sexual offence”.<sup>142</sup>

8.86 An offender’s suitability for periodic detention is assessed by the Probation and Parole Service, whose report the court must consider when deciding whether or not to make a periodic detention order.<sup>143</sup> That report assesses an offender’s suitability with regard to a number of factors, including the degree of drug or alcohol dependence, the presence of a psychiatric or psychological condition, as well as the offender’s medical condition, criminal history and employment and other personal

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138. As at June 2008, DCS supervised 728 offenders attending 7 periodic detention centres throughout NSW: see NSW Department of Corrective Services, *Facts and Figures: Corporate Research, Evaluation and Statistics* (2009) (see «<http://www.dcs.nsw.gov.au>»).

139. See [8.86] regarding the “suitability” requirement.

140. CSPA s 66(1).

141. CSPA s65A.

142. CSPA s 65B(1). A ‘prescribed sexual offence’ is defined in s 65B(2) as a sexual offence committed against a person less than 16 years of age, or a sexual offence of which sexual intercourse is an element, and related offences.

143. CSPA s 66(2), 69(1).



circumstances.<sup>144</sup> A court may make, or decline to make, a periodic detention order regardless of the contents of the assessment report.<sup>145</sup>

8.87 Since periodic detention is available only in relation to sentences of three years or less, parole is by way of court order rather than an order of the Parole Authority.<sup>146</sup> The court may attach any conditions to the parole order, in addition to the standard orders of supervision by the Probation and Parole Service.<sup>147</sup> The Parole Authority may revoke a detainee's periodic detention order in the case of a breach.<sup>148</sup> Where this occurs, a warrant may be issued for the offender to serve the remainder of the sentence in full-time detention,<sup>149</sup> or an order for the sentence to be completed by way of home detention may be given.<sup>150</sup>

#### *Home detention*

8.88 Where an offender is sentenced to a term of imprisonment of 18 months or less, the court may order that the sentence be served by way of home detention.<sup>151</sup> As the name suggests, the sentence may be served in the offender's home or other approved residence.<sup>152</sup> An offender serving a sentence of home detention is required to remain at the residence at all times unless engaged in approved activities or faced with immediate danger, such as a fire or medical emergency. The home detainee must also submit to electronic monitoring, not consume alcohol or use drugs, authorise his or her medical practitioner, therapist or counsellor to provide information to the supervisor, and engage in personal development activities, counselling or treatment as directed.<sup>153</sup>

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144. *Crimes (Sentencing Procedure) Regulation 2005* (NSW) reg 15. The presence of a major psychiatric or psychological disorder is listed as an indicator of unsuitability.

145. See CSPA s 66(3)-(4).

146. See CSPA s 50, and [8.74].

147. CSPA s 51; CASA s 128, 128A; *Crimes (Administration of Sentences) Regulation 2008* (NSW) reg 224, 225.

148. CSPA s 163.

149. CASA s 181.

150. CASA s 165.

151. CSPA s 7 and pt 6. See *R v Jurisic* (1998) NSWLR 209 regarding the exercise of the court's discretion to make home detention orders.

152. *Crimes (Administration of Sentences) Regulation 2008* (NSW) reg 200(c).

153. See *Crimes (Administration of Sentences) Regulation 2008* (NSW) reg 200. Additional conditions, not inconsistent with the standard conditions, may be

8.89 An offender is not eligible for home detention if he or she has committed certain serious offences,<sup>154</sup> or has a history of committing such offences, or been the subject of an apprehended violence order.<sup>155</sup> The court must be satisfied that the offender is a “suitable person”,<sup>156</sup> and that it is “appropriate in all the circumstances” that the sentence is served by way of home detention.<sup>157</sup> The offender must sign an undertaking to comply with his or her obligations under the order.<sup>158</sup>

8.90 As with periodic detention, the court is required to consider an assessment report prepared by the Probation and Parole Service when deciding whether or not an offender is suitable for a home detention order.<sup>159</sup> The report must take into account the offender’s criminal history, any dependency on illegal drugs, and the likelihood of the offender committing a domestic violence offence. The report must also address whether the offender’s circumstances may inhibit the effective monitoring of the order, the impact of the order on the safety of any person living in the vicinity of the offender, and whether the person with whom the offender resides understands the conditions of the order and is prepared to comply with them to the relevant extent.<sup>160</sup> The consent of any person with whom the offender would reside or continue a relationship must be obtained in writing,<sup>161</sup> and the impact on any child with whom the offender would reside must be particularly considered.<sup>162</sup>

8.91 A court may decline to make a home detention order for any reason, despite a favourable assessment report.<sup>163</sup> However, unlike periodic detention orders, a court may only decide to make a home

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imposed by the court or the Parole Authority: see CSPA s 82, and CASA s 103, respectively.

154. See CSPA s 76. The offences include homicide, certain sexual offences, domestic violence offences, and stalking or intimidation.

155. CSPA s 77. The restriction applies to convictions for some of the offences “at any time”; for other categories, to convictions within the last five years.

156. CSPA s 78(1)(a). See also [8.90].

157. CSPA s 78(1)(b).

158. CSPA s 78(1)(d).

159. CSPA s 78(2)(a), 80.

160. CSPA s 81(2).

161. CSPA s 78(1)(c).

162. *Crimes (Sentencing Procedure) Regulation 2005* (NSW) reg 20.

163. CSPA s 78(3).

detention order if the assessment report declares the offender to be a suitable person.<sup>164</sup>

8.92 The Parole Authority may conduct inquiries into breaches of a home detention order regardless of whether the order has expired.<sup>165</sup> It may also revoke a home detention order if the offender has failed to comply with his or her obligations, or where the offender fails to appear before the Authority when called upon to do so.<sup>166</sup>

#### *Community service orders*

8.93 Section 8 of the CSPA states that court may make a CSO directing an offender to perform a specified number of hours of community service work each week under the supervision of an officer of the Probation and Parole Service, instead of imposing a sentence of imprisonment.<sup>167</sup> Accordingly, a CSO is a non-custodial sentencing option, and is available whether or not a sentence of imprisonment would otherwise have been applicable.<sup>168</sup> Community service work is defined legislatively to mean “any service or activity approved by the Minister, and includes participation in personal development, educational or other programs”.<sup>169</sup> Typically, community service work may include cleaning or gardening.<sup>170</sup>

8.94 A CSO may be made only if the court is satisfied that the offender is a “suitable person” for community service work, that it is “appropriate in all the circumstances”, and that arrangements exist in the offender’s area of residence and work can be provided in accordance with those arrangements.<sup>171</sup> The court may refer an offender to the Probation and Parole Service for assessment of suitability for community service work.<sup>172</sup> The court must have regard to the report of that assessment in deciding

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164. CSPA s 78(4). See CSPA s 66(4)(a), and [8.86] regarding periodic detention.

165. CASA s 166(1), 182.

166. CSPA s 167, 180.

167. The number of hours of community service must not exceed 500, or the maximum number of hours prescribed for particular offences in the regulations: see CSPA s 8(2). See *Crimes (Sentencing Procedure) Regulation 2005* (NSW) reg 22 regarding the prescribed maximum hours.

168. See *R v El Masri* [2005] NSWCCA 167.

169. CASA s 3.

170. Work may also include graffiti removal: see CSPA s 91.

171. CSPA s 86(1), 89(1).

172. CSPA s 88.

whether or not to make a CSO, and may only do so if the offender has been assessed as suitable.<sup>173</sup>

8.95 A significant number standard conditions are attached to a CSO, including requirements that the offender:

- report to a local DCS office as required;
- be free from the influence of drugs or alcohol;
- participate in activities connected with the administration of the order, and perform work as directed by the supervisor;
- submit to a medical examination if required;
- receive home visits from the supervisor in connection with the order;
- comply with standards of dress, cleanliness and conduct; and
- comply with any reasonable direction given by the supervisor, or immediately advise the supervisor of any reasons for the inability to comply.<sup>174</sup>

8.96 The sentencing court may impose any additional conditions it considers appropriate, apart from the requirement to make any payment.<sup>175</sup> Further, an offender has a duty to disclose the details of any medical, physical or mental condition that may substantially increase the risk of injury to the offender while performing work in accordance with a CSO.<sup>176</sup>

8.97 A supervisor may apply to the court to revoke a CSO where the offender has failed to comply with his or her obligations under the order without reasonable excuse, or where the interests of justice would be best served by the revocation of a CSO.<sup>177</sup> If the court agrees to revoke the CSO, it may deal with the offender in any way it could have done had the

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173. CSPA s 86(2), (4). The court may, however, decline to make a CSO even where an offender has been assessed as “suitable”: s 86(3).

174. *Crimes (Administration of Sentences) Regulation 2008* (NSW) reg 211.

175. Conditions may include drug or alcohol testing, and participation in development programs up to three times per week for a total period of up to 15 hours per week: see CSPA s 90.

176. CASA s 123.

177. CSPA s 115(2). An offender may also apply to the court to have a CSO revoked in the interests of justice.

order not been made,<sup>178</sup> taking into account any time spent in custody for the same offence,<sup>179</sup> and any acts of compliance with the CSO prior to the breach.<sup>180</sup>

*Good behaviour bond*

8.98 A court may order an offender to agree to an undertaking, or bond, that he or she will be of good behaviour. A good behaviour bond of up to five years may be imposed instead of a sentence of imprisonment.<sup>181</sup> Where a sentence of imprisonment is imposed, but for a term of less than two years, the court may order that it be suspended in favour of a good behaviour bond.<sup>182</sup> The court also has the option of discharging a person without conviction on condition that he or she enters into a good behaviour bond.<sup>183</sup> A court may not order both a good behaviour bond and a CSO in relation to the same offence.<sup>184</sup>

8.99 The court has a broad discretion as to the conditions that may be attached to a bond, including a requirement that an offender participate in an intervention program.<sup>185</sup> Prior to including such a condition in an order, the court may refer the offender for assessment of his or her suitability to participate in an intervention program.<sup>186</sup> An offender has the right to decide not to participate in an intervention program.<sup>187</sup> Should this occur, the court may require the offender to appear before it and may

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178. CSPA s 115(3).

179. CSPA s 24(a).

180. CSPA s 24(b).

181. CSPA s 9.

182. CSPA s 12.

183. CSPA s 10(1)(b). The NSW Sentencing Council has been asked to review the use of non-conviction orders and good behaviour bonds: see «[http://www.lawlink.nsw.gov.au/lawlink/scouncil/ll\\_scouncil.nsf/pages/scouncil\\_what\\_s\\_new#non\\_conviction\\_orders](http://www.lawlink.nsw.gov.au/lawlink/scouncil/ll_scouncil.nsf/pages/scouncil_what_s_new#non_conviction_orders)».

184. CSPA s 13.

185. CSPA s 95, 95A. That condition may only be placed on a bond where the court is satisfied that an intervention program is available in the area in which the person resides; that the offender is eligible and suitable to participate in the program; and that participation would promote rehabilitation and reduce the likelihood of re-offending: s 95A(2).

186. CSPA s 95B.

187. CSPA s 99A.

vary the conditions attached to the bond, or order its revocation.<sup>188</sup> A failure to appear may result in proceedings for breach of the bond.<sup>189</sup>

8.100 The conditions of a bond must relate to the punishment of the particular crime committed, must be expressed with sufficient certainty to enable compliance and must not be unduly harsh, unreasonable or onerous.<sup>190</sup> The conditions cannot require the offender to perform community service work or to make a payment of any kind.<sup>191</sup>

8.101 If the offender fails to enter into a good behaviour bond, the court may sentence, or convict and sentence, the offender as if the bond had not been imposed.<sup>192</sup> If the court is satisfied that an offender has breached a good behaviour bond, it may take no action, vary or add to the conditions of the bond, or may revoke the bond.<sup>193</sup>

*Issues for offenders with cognitive and mental health impairments*

8.102 Semi-custodial and community-based sentencing options present significant benefits for some offenders with cognitive and mental health impairments. The primary advantage of these options is that they do not expose vulnerable offenders to the risks associated with full-time incarceration. In Report 80, we noted that sentencing options other than full-time detention enable offenders to “model themselves on typical members of the community rather than on prisoners; and may be a more meaningful punishment for a person with an intellectual disability than other options”.<sup>194</sup> Offenders would also be able to maintain their existing living and working arrangements, which is particularly important for offenders with certain mental conditions requiring routine and structure. Further, an offender with cognitive or mental health impairments may benefit from gaining living skills and other support from participation in community service work or intervention programs under a CSO or a good behaviour bond.

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188. CSPA s 99A(5).

189. CSPA s 99A.

190. *Bugmy v The Queen* [2004] NSWCCA 258, [48]-[61].

191. CSPA s 95(c).

192. CSPA s 97.

193. CSPA s 98. In the case of a suspended sentence, the court must revoke the bond unless the breach was trivial or there were good reasons for it: s 98(3).

194. NSWLRC Report 80, [11.32].

8.103 However, a number of drawbacks exist. In relation to periodic detention, its popularity as a sentencing option has declined over recent years, largely due to the lack of available places at detention centres, and its questionable impact on deterrence and rehabilitation.<sup>195</sup> Moreover, the blanket exclusion of offenders who have *ever* served a sentence of imprisonment effectively discriminates against offenders with cognitive and mental health impairments, who are more likely than other offenders to receive prison sentences for minor offences.<sup>196</sup>

8.104 The criterion of “suitability” common to periodic and home detention, as well as CSOs, is problematic in terms of offenders with cognitive and mental health impairments. While such offenders are not automatically excluded,<sup>197</sup> there is perhaps an increased likelihood of them being considered unsuitable because of the greater chance of non-compliance with conditions attached to each type of order.<sup>198</sup> Indeed, the presence of a “major psychiatric or psychological condition” is an indicator of unsuitability for periodic detention.<sup>199</sup> In relation to home detention, an offender’s living arrangements and the possible impact on carers and family members may make him or her unsuitable for an order.<sup>200</sup>

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195. This has led to calls for its abolition and replacement with more flexible community-based monitoring: see, eg, NSW Sentencing Council, *Review of Periodic Detention* (2007); and Attorney General and Minister for Justice, *An Intensive Corrections Order for NSW*, Consultation Paper (2008).

196. The reasons for this include social disadvantage associated with the impairment and a lack of support to assist such offenders to access community-based sentencing options: see NSW Legislative Council Standing Committee on Law and Justice, *Community Based Sentencing Options for Rural and Remote Areas And Disadvantaged Populations* (2006), 53-57, 101-104, 210-212 and Recommendations 22, 38; and NSW Legislative Council, *Select Committee on the Increase in Prisoner Population*, Final Report (2001), [6.147].

197. See, eg, NSW Sentencing Council, *Review of Periodic Detention* (2007), [3.35].

198. NSW Legislative Council Standing Committee on Law and Justice, *Community Based Sentencing Options for Rural and Remote Areas and Disadvantaged Populations* (2006), [4.163]-[4.165], [7.161]-[7.170], Recommendation 38; NSW Legislative Council, *Select Committee on the Increase in Prisoner Population*, Final Report (2001), [6.147]. See for example *R v Evans* [2006] NSWDC 89, [1]-[3], [8].

199. *Crimes (Sentencing Procedure) Regulation 2005* (NSW) reg 15. See [8.86].

200. For example, the option of home detention may be a difficult one for an offender living in a homeless shelter or other residential facility.

8.105 Even if an offender is considered to be suitable, his or her ability to comprehend or comply with the conditions of a semi or non-custodial order may also be compromised by a cognitive or mental impairment. For example, some offenders may have difficulty organising themselves to keep appointments with, or accept visits from, Probation and Parole Service officers, or may not be able to make suitable transport arrangements to and from periodic detention centres. They may be denied eligibility for CSOs due to a lack of appropriate work programs for people with mental illness or cognitive disabilities. As noted in DP 35, the factors which lessen the chances of offenders with cognitive and mental health impairments being eligible for bail and parole, “such as poverty, lack of employment options or family and community support, and unstable living conditions, will also decrease the likelihood of receiving such sentences, with a corresponding increase in custodial sentences”.<sup>201</sup>

8.106 It is beyond the scope or capacity of this review to address the underlying problems associated with the ability of offenders with cognitive and mental impairments to access semi and non-custodial sentencing options. Nor do we suggest that these options would be appropriate for every such offender in every circumstance. However, we seek views as to whether there should be some legislative guidance concerning how the suitability requirements should be adapted for offenders with cognitive and mental health impairments who would be appropriate candidates for semi and non-custodial orders, and the types of conditions attaching to such orders.

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#### Issue 6.113

Should the relevant legislation dealing with periodic detention, home detention, community service orders and good behaviour bonds be amended to increase the relevance and appropriateness of these sentencing options for offenders with cognitive or mental impairments?

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201. NSWLRC DP 35, [11.67].



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**Issue 6.114**


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In particular, how could:

- (a) the eligibility and suitability requirements applicable to each type of order; and
- (b) the conditions that may attach to each semi or non-custodial option be adapted to meet the requirements of offenders with cognitive or mental impairments.

### Power to defer sentence

8.107 As noted earlier, s 11 of the CSPA enables the court to defer sentencing by adjourning proceedings for up to 12 months from the date of the finding of guilt, and grant bail for the purpose of:

- assessing the offender's capacity and prospects for rehabilitation or participation in an intervention program; or
- allowing the offender to demonstrate that rehabilitation has taken place; or
- allowing the offender to participate in an intervention program; or
- for any other purpose the court considers appropriate.<sup>202</sup>

This provision applies even if the court considers that a custodial sentence is or may be appropriate.<sup>203</sup>

8.108 The court may make an order concerning an intervention program if satisfied that it would promote the offender's rehabilitation, thereby reducing the likelihood of recidivism.<sup>204</sup> The power to adjourn sentencing proceedings may be particularly useful in cases involving offenders with cognitive and mental health impairments. First, if the offender's impairment was not recognised until it manifested in the offending conduct, it may take some time for a formal diagnosis to be made and the offender's condition to stabilise. Until that occurs, it may be difficult for the court to properly assess sentencing factors such as the offender's prospects of rehabilitation and future risk of re-offending. Deferral

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202. CSPA s 11(1) and see generally *Bail Act 1978* (NSW) s 36A. CSPA s 11 implements NSWLRC Report 79, recommendation 17.

203. *R v Trindall* (2002) 133 A Crim R 199, [62]-[64]; *R v Di Gregorio* [2004] NSWCCA 9, [51]-[55]; *R v Williams* [2004] NSWCCA 64, [17]-[31]; *R v Leahy* [2004] NSWCCA 148, [8]-[16].

204. CSPA s 11(2A).

enables the court to wait for relevant information to become available. Secondly, if it is unclear whether or not a community-based sentence in conjunction with treatment and/or support services will be sufficient to prevent re-offending, deferral of sentencing allows for a “test run” of the arrangements before the court makes final sentencing orders.<sup>205</sup> If the arrangements are shown to be sufficient, that could lead to a determination that a custodial sentence is not warranted, or that a partly custodial option such as home detention will suffice.

8.109 While s 11 refers to “rehabilitation”, there is no express mention of intervention or treatment programs for offenders with cognitive and mental health impairments.<sup>206</sup> We seek views as to whether that provision should be amended to direct the court’s attention to the power to defer sentencing in order to refer an offender with cognitive or mental health impairments to treatment or intervention programs in appropriate circumstances.

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#### Issue 6.115

Should s 11 of the CSPA concerning deferral of sentencing be amended to refer expressly to rehabilitation or intervention programs for offenders with cognitive or mental health impairments?

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205. See, eg, *R v Pantelakis* [2008] NSWCCA 265.

206. See also *Sentencing Act 1991* (Vic) s 80(1)(c), (2) which expressly provides for adjournment of sentencing and implementation of services to offenders with intellectual disabilities.