The New South Wales Bar Association

10/200

29 July 2010

Mr Paul McKnight
Executive Director
NSW Law Reform Commission
DX 1227 SYDNEY

Dear Mr McKnight

People with cognitive and mental health impairments in the criminal justice system

I have enclosed the New South Wales Bar Association's submission in response to the Commission's Consultation Papers 5-8 released as part of its reference on People with cognitive and mental health impairments in the criminal justice system.

I hope the Bar's comments will be of assistance. Please do not hesitate to contact me should you require any clarification of the issues raised in the submission.

Yours sincerely

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New South Wales Bar Association Submission to the New South Wales Law Reform Commission in Response to Consultation Papers 5,6,7 & 8 of 2010

'People with cognitive and mental health impairments in the criminal justice system'

The New South Wales Bar Association wishes to commend the NSW Law Reform Commission's efforts in producing these excellent Consultation Papers. It is very clear that it has taken a vast amount of work and that it is of the highest quality.

The problems of the cognitively and mentally impaired in the criminal justice system are significant and require additional attention by the legislature, and significant increases in resources being allocated, particularly in the creation of community programs and facilities (such as support, care, treatment, accommodation and employment opportunities).

We will address each of the issued raised in the Consultation Papers, adopting the scheme of numbering used by the Commission.

Issue 5.1

Should a broad umbrella definition of mental health impairment, incorporating mental illness and cognitive impairment, be included in the MHFPA? What practical impact would this have?

We agree that the current variety of descriptions of mental and cognitive conditions, as highlighted in [4.39] of the discussion paper, is confusing and inconsistent across various pieces of legislation, and there would be merit in a general review of the use of such terms to introduce consistency of meaning.

Whilst we are of the view that the list of conditions in s32 MHFPA should be expanded to include cognitive impairments including acquired ones, we do not support the use of an 'overarching' term for 'threshold' purposes, as this would introduce a high risk of over-inclusiveness. It is important that the conditions qualifying for diversion under the MHFPA should be very clearly set out in the

Act, so that they are consistently and correctly applied by magistrates. To create too broad a 'threshold' will result in inconsistent and unequal treatment, as too many discretionary factors would be left to individual magistrates. Clear guidance is what is required on the initial question of which conditions will qualify for diversion.

We are opposed to the inclusion of 'personality disorders' per se – these are simply classifications of personality types regarded as deviating markedly from the normal parameters of acceptable behaviour in our culture, and which lead to distress or impairment (see DSM IV TR[1] at 685). There are eleven different kinds of personality disorders referred to in DSM IV TR (see p. 685). When these fall short of a genuine cognitive impairment or a mental illness, they should in no way excuse a person from compliance with the law and conforming to the basic minimum standards acceptable in society – they do not impact sufficiently upon the person's capacity to make free choices about the conduct that they will or will not engage in. However, a personality disorder, in combination with other conditions (such as severe depression) may qualify as a mental illness – this should remain a question to be determined by appropriate medical evidence in any given case.

Personality disorders are quite common within the general population: Kaplan and Saddock estimate that 10–20 per cent of the general population has personality disorders.[2] A personality disorder will often be present with other factors which do qualify as 'a disease of the mind' and will clearly have an impact on the person's behaviour in a given context. These disorders may have more significance in the context of the partial defence of substantial impairment. They are frequently very relevant to the sentencing process, and it may well be that the sentencing process is where the most appropriate recognition can be given to the mitigating effects of such disorders, and where any therapies and treatments that might be available can be given effect.

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[1] *Diagnostic and Statistical Manual of Mental Disorders (Text Revision)*, American Psychiatric Association, 2000

2H I Kaplan and B J Saddock, *Concise Textbook of Clinical Psychiatry*, 3rd edition, Wolters Luwer/Lippincott Williams & Wilkins (2008) page 375.By comparison, a UK study suggests that the presence of personality disorder in the general population was 4.4%; another study in 2002 suggested that 65% of orisoners in the UK had personality disorders - see studies quoted in M. McMurran, *'Personality Disorders'* Chapter 15 in K. Soothill & Ors. (eds) *'Handbook of Forensic Mental Health'* Willan Publishing, 2008 at p 381.

However, sentencing and diversion are very different things, and we do not consider that personality disorders, without more, should qualify for diversion.

Nor do we consider that transient cognitive impairment from drugs and/or alcohol should be included. Nor should substance dependency or addiction that falls short of having produced a genuine cognitive impairment (such as Korsakoff's syndrome).

We note that s 61H Crimes Act 1900 was amended in 2008 to define 'cognitive impairment' for the purposes of s 66F (unlawful sexual intercourse with someone with cognitive impairment); whilst the policy of this section serves a particular purpose, the definition reflects modern trends as to the kinds of conditions that are sufficiently 'vulnerable' to warrant this special protection of the law. S 61H(1A) defines 'cognitive impairment' thus:

(1A) For the purposes of this Division, a person has a ***cognitive impairment*** *if the person has:*
(a) an intellectual disability, or
(b) a developmental disorder (including an autistic spectrum disorder), or
(c) a neurological disorder, or
(d) dementia, or
(e) a severe mental illness, or
(f) a brain injury,
that results in the person requiring supervision or social habilitation in connection with daily life activities.

With the deletion of (e) and also the deletion of the last two lines (both of which we have underlined), this could also be a good definition for the kinds of conditions, in addition to *a mental illness for which treatment is available in a mental health facility*, that could qualify for diversion under s 32 MHFPA, and would introduce much needed consistency in the legislation.

Issue 5.2

If an umbrella definition were to be adopted, would it be appropriate to state that mental impairment includes

a mental illness, cognitive impairment, or personality disorder, however and whenever caused, whether congenital or acquired?

See answer to 5.1

Issue 5.3

Should the term "mental illness" as used in Part 4 of the MHFPA be replaced with the term "mental impairment"?

No. See answer to 5.1. In our submission, it is important to specify the particular conditions to which diversion is applicable.

Issue 5.4

Should the MHFPA continue to refer to the terms "mental condition" and "developmentally disabled"? If so, in what way could the terms be recast?

See answer to 5.1. In addition, we consider that 'Mental condition' on its own is a too broad and unclear a term. However, the MHFPA currently qualifies this by including as a criterion under s 32 a 'mental condition *for which treatment is available in a mental health facility*'. The essence here is that the condition is treatable (but not necessarily 'curable'). To qualify here, there should need to be evidence to satisfy the magistrate that there is a genuine treatment that had some realistic prospect of alleviating the condition at least to some extent. It is considered that this is an appropriate gate to leave open for an array of unspecified conditions, in order to give the section some flexibility to accommodate appropriate conditions that may arise in special cases, based upon the appropriate expert evidence given before the magistrate. It is possible that, in some cases, severe personality disorder or severe ADHD might qualify.

It is hard to strike a workable balance between clear definiton and flexibility. However we consider an approach such as we have suggested is an approporiate one.

The problems with the term 'developmentally disabled' referred to at consultation paper [4.52] would, we believe, be overcome by the use of the definition suggested in 5.1 above.

Issue 5.5

Alternatively, should the MHFPA include a definition of cognitive impairment or disability? If so, should that definition be "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"?

The proposed definition here is much too vague and broad and would be over-inclusive. We prefer the definition discussed in 5.1 above based on s 61H(1A) Crimes Act.

Issue 5.6

Should the MHFPA be amended to create a general power of the court to order an assessment of an offender at any stage during proceedings?

If so,

(a) who should conduct the assessment?

(b) what should an assessment report contain?

(c) should any restrictions be placed on how the information contained in an assessment report should be used?

We fully support the creation of a general power of the court to order an assessment at any stage of the proceedings – it is a sensible and practical suggestion. However, this will need to be done in a manner that is consistent with the adversarial nature of proceedings.

An important related question arises as to who may request such a report. Currently, for example, in NSW the prosecution cannot (except in certain very technical circumstances) raise the mental illness defence unless mental state is first raised by the defence. The position in many jurisdictions is that this issue can be raised by the prosecution with the leave of the court. Any power of the court to order a report would need to be consistent with how this question is dealt with. In our view, it would be appropriate for there to be a power for the prosecution to raise the issue of mental illness, with the leave of the court, if the court determines that this is in the 'interests of justice'. see also our response to 6.32 below.

We agree with the Commission's suggestion that assessments should be conducted by private practitioners who have appropriate specialist qualifications in the relevant discipline appropriate to the particular case. We support the suggestion that there should be a list of suitable experts, updated regularly, from which persons can be drawn to do assessments. The list should be appropriately inclusive, rather than exclusive, to ensure and a healthy pool of experienced persons. Nor should practitioners who work with Justice Health necessarily be excluded if they have private practices as well – there are many fine and experienced practitioners who work with Justice Health but who also maintain private practices.

The issues to be addressed will vary from case to case. However, an empowering section might include a non-exhaustive list of matters, as a guide to assist the court. The assessment would usually be expected to contain an assessment of the nature and degree of the relevant condition, as well as its impact on the person's behaviour (and whether or not it may be causally linked to the commission of the alleged offence). In some cases a treatment proposal would be appropriate, including an estimate of the likelihood of improvement in the condition.

We do not consider that there should be any special rules as to the use of the report, which should be governed by the existing law. It should be made available to all parties to the proceedings concerned with the relevant issue in respect of which the report has been ordered. The issue of admissibility of contents should be left to the rules of evidence. For example, confessional statements made to the person doing the assessment by the person being

assessed, should not necessarily be excluded. An important related issue, that the Commission may need to consider in this regard, is whether or not a court appointed expert, doing such an assessment, would be regarded as a 'person in authority' and whether the taking of a history would be regarded as 'official questioning' for the purposes of the *Evidence Act 1995*. In our view such assessments ought not be so regarded, as the panel will be independent practitioners, although chosen from an approved list by the court.

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?

No. The current provisions are sufficient. It is well established that a trial of a person that proceeds when the person is, in fact, unfit, is a nullity, and courts should be sufficiently aware of the need for vigilance to be on the lookout for the presence of unfitness. However, it is not always in the best interests of an accused for fitness to be raised – especially in relation to relatively minor charges. In addition, the legal practitioners in the case are in a better position to assess the need to raise the issue.

Issue 6.2

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

The Commission has proposed at [1.17]:

> *...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* (underlining added).

However, the Commission also at [1.16] notes that Smith J in *Presser* indicated that the *Presser* criteria should be applied in *'a reasonable and commonsense fashion' and not in 'any over-literal*

sense' and notes that:

> *The standards are articulated in terms that are capable of allowing courts to take into account, in determining the defendant's understanding or capacity, his or her ability to make rational decisions in relation to participation in the trial proceedings. 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. Our preliminary view is that this is unsatisfactory because it sets the requirements for a fair trial too low.*

The Commission also indicates that the Scottish approach of requiring capacity for *'effective participation'* could be over-inclusive.

The Commission at [1.14] also refers to the position in the United States where:

> *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".*

In determining what is considered appropriate in the NSW context, we consider that due regard must be had to the important role that counsel has to play in assisting an accused person to obtain a fair trial. This is recognised in the decision of the majority in the High Court in ***R v Ngatayi*** (1980) 147 CLR 1. The High Court majority cited *Presser* with approval, agreeing that the test of capacity or fitness needs to be applied in a 'commonsense fashion' and that the accused 'need not have the mental capacity to make an *able* defence or to act wisely in his own best interest' (at 8). The majority considered that:

> *in deciding whether an accused is capable of understanding the proceedings so as to be able to make*

> *a proper defence it is relevant that he is defended by counsel. If the accused is able to understand the evidence, and to instruct his counsel as to the facts of the case, no unfairness or injustice will generally be occasioned by the fact that the accused does not know, and cannot understand, the law. With the assistance of his counsel he will usually be able to make a proper defence.*

The court was of the view that as Ngatayi's counsel had explained to the jury the relevance of intoxication upon the question of intent, and the trial judge had given directions on this issue, the fact that Ngatayi could not understand the law under which he was tried did not mean that he was not able to make a proper defence with the assistance of counsel.

In our submission, there is sufficient flexibility in the application of the Presser criteria as interpreted by the High Court, to ensure that cases where there is a genuine risk of a trial being unfair will be identified.

We agree with the Commission that the introduction of a test of 'effective participation' would be over-inclusive and further, we consider that the introduction of a test that focuses on 'rational understanding' would also be over-inclusive; the concept of what is 'rational' is very rubbery and difficult to pin down, and the introduction of this concept would lead to uneven application of standards. The Presser criteria are useful in focussing on the practical components of a trial.

In the absence of any empirical research indicating that persons who are being found fit under the current Presser crtieria are not, in fact, getting a fair trial, we would be reluctant to see any major changes to the Presser approach, as interpreted and explained by the High Court.

Issue 6.3

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?

No – see response to 6.2 above.

Issue 6.4

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?

No – see response to 6.2 above

Issue 6.5

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

In our view this criterion has been effectively added by the case law – see *Kesavarajah v The Queen* (1994) 181 CLR 230 where the High Court stated at 245 per Mason CJ, Toohey and Gaudron JJ:

> *In the context of a trial, fitness to be tried is to be determined by reference to the factors mentioned by Smith J in Presser and by reference to the length of the trial. It makes no sense to determine the question of fitness to be tried by reference to the accused's condition immediately prior to the commencement of the trial without having regard to what the*

accused's condition will or is likely to be during the course of the trial (at 246).[3]

Similarly, it is important to consider the particular issues relevant to the particular case in hand, as some consideration of the complexity of the issues involved may be relevant in applying the *Presser* criteria to the case. The *Presser* criteria are sufficiently flexible to incorporate this.

Issue 6.6

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

No.

Issue 6.7

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

The Commission, at [1.38] – [1,39] of the Consultation Paper, proposes as follows:

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.

3Deane and Dawson JJ, in a separate joint judgment, dissented on this point and considered that the question of the accused's fitness is to be determined at the time the question arises and the future condition of the accused should not be considered — to do so would be a 'radical departure from accepted practice' (at 249).

(4) If the person is found to be unfit, then:

(a) the court may adjourn the proceedings for a specified period of time 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 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. 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.

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. Further, an

unfit defendant could be removed more swiftly from the criminal justice system and into the forensic mental health system where he or she could be appropriately managed according to clinical and risk management (rather than punitive) principles.

This proposal is a sensible one that would ensure a more efficient use of the referral process by the court to the MHRT to avoid unnecessary duplication and will ensure faster processing in appropriate cases. The expertise of the MHRT has much to offer.

There is another attractive alternative that we would urge the Commission to consider, namely, the introduction of a dedicated Mental Health Court in the Sydney Metropolitan area that could act as a referral court to which, inter alia, all fitness hearings arising in the Sydney Metropolitan Area could be referred for determination by other courts. Such a court could have a forensic psychiatrist in attendance, who could, in most cases, do an assessment of fitness on the day of referral so that the matter could be processed efficiently and quickly. Such courts have been used to great effect elsewhere (a notable example being the Mental Health Court in Toronto, Canada). We make suggestions about a Mental Health Court at the end of this submission.

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?

See response to 6.7

Issue 6.9

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

In our view this is not an appropriate area for consent orders. Whilst both parties can indicate that they consider the accused to be unfit, the final determination of such an important issue ought to be the subject of proper scrutiny by the court, given the potentially very significant consequences of a finding of unfitness. There is still a significant inconsistency in the standard of medical reports presented in cases such as this and there are still experts who are, in effect, 'hired guns'. Requiring the court to make the final

decision will ensure proper scrutiny of the process.

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?

No. The Appeal Court ought not be burdened with this potentially complex determination. A verdict of 'guilty' in a 'normal' trial held at a time that the appellant's unfitness was not recognised, is a flawed and insufficient evidentiary basis for an appellate court to find any judgment about what the result ought to have been – such an unfit accused at trial may have been severely prejudiced by the process and the only proper way that an appeal court could determine the matter would be by taking possibly substantial additional evidence, which ought not be its role. Such matters should be returned back to the court below for a new trial, and should in the normal course be expedited.

Issue 6.11

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

The diversionary provisions available to the Local Court will be sufficient in the vast majority of cases to dispose of matters where an accused is unfit. However, in cases where summary diversion is not considered appropriate, there ought to be some procedure for determining the issue of fitness. The Commission suggests the possibility, at [1.48], of a 'simplified' fitness procedure being introduced into the Local Court, although few details as to how this might work are suggested.

The suggestion that a Local Court ought be able to order that a person become a 'forensic patient' subject to the supervision of the MHRT would not be appropriate in many cases, particularly less serious matters.

It may be appropriate to consider introducing a power similar to that contained in s 10(4) of the MHFP Act for dismissal of minor matters without the need for holding a fitness inquiry.

In our view, it would not be appropriate to have a 'simplified' fitness procedure in the Local Court. The determination of fitness can be complicated, and the test should be consistently applied regardless of the jurisdiction.

A possible solution would be to consider establishing a Mental Health Court that could take referrals from all jurisdictions and determine matters of fitness, where uniform procedures would apply. We discuss this at the end of these submissions.

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?

In relation to the issue of fitness being raised in committal hearings, the suggestion the Commission puts forward in [1.54] is a sensible suggestion – namely, that legislation could provide that where the magistrate determines (perhaps on the limited evidence presented at the committal) that there is sufficient evidence for the accused to be put on trial, the matter could be referred directly to the MHRT for determination of fitness, from where the matter could be forwarded to the District/Supreme Court as in the case of an indictable matter referred to the MHRT by a superior court.

As another alternative, we raise the possibility of a Mental Health Court that could apply uniform standards and take fitness referrals of any kind of matter from any court.

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?

In our view the special hearing procedure should continue, as it affords the best opportunity for the unfit accused to present such evidence as can be presented to bring about an acquittal. It also allows for jury trial in appropriate cases, which at times may be of great importance, and an accused should retain this right (as should the prosecution on behalf of the community). However,

there should be some modification of the workings of 'limiting terms' (which we discuss later in these submissions).

Alternatives in the other jurisdictions referred to in the discussion paper are not free from problems, and it is difficult to completely avoid some artificial quality in proceedings brought against an unfit person.

Further, the special hearing procedure not only provides the best avenue for acquittal of an unfit accused, but it also serves the important function of bringing some measure of finality to the matter from the point of view of the community and the victim/s involved. This aspect of special hearings should not be overlooked.

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?

No. See response to 6.13 above.

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?

No. In our view fitness is an aspect of procedural fairness that needs to be determined first before the other aspects of the proceedings should be considered.

Issue 6.16

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

We agree with the thrust of the suggestions in [2.28] of the consultation paper to the effect that the procedures ought to be sufficiently flexible to accommodate the needs of an unfit accused from the point of view of fairness. However, the process should not be so informal as to diminish the significance of the proceedings from the point of view of the community and victim/s.

Issue 6.17

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

There should be such a power, but it should be clearly defined and used only when circumstances necessitate it, such as where there would be undue distress caused to the defendant or the defendant's condition would be utterly disruptive of the conduct of the proceedings. It would be imperative that the defendant be legally represented.

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]"?

The Commission's proposal is a sensible one that more accurately reflects the reality of what is happening. Care would need to be taken not to in any way diminish the rights of victims to compensation from the state victims compensation scheme, because of any changes to the wording of this.

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?

The mental illness defence should continue to be available at special hearings and is often the most appropriate outcome and in some cases is sought by the defence. If a person subsequently becomes fit, there ought perhaps be a provision enabling them to have a proper trial, but there should be a threshold test that such a person would need to satisfy; for example, that there is a genuine issue they can point to that they were possibly prevented from raising at the special hearing due to their being unfit at the time.

Time spent detained as a forensic patient would need to be taken

into account in any sentence.

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?

There is clearly a continuing need for the defence of mental illness. The current process has sufficient flexibility to ensure persons found NGMI are treated and released, when appropriate, by the MHRT or by the court, after considering the issue of risk to the community.

There may be some merit in considering a diversionary power in the superior courts, where strict criteria are satisfied. For example, this may need to be limited to offences carrying no more than a maximum of 7 years imprisonment, where it can be established that it is in the best interest both of the accused and the community for diversion to occur.

Such a jurisdiction might also be an appropriate one to be devolved to a specialist Mental Health Court, discussed at the end of this submission.

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?

Yes. Cognitive impairment should qualify, in the same way as disease of the mind, under the M'Naghten Rules, provided it is still established that the person did not know the nature & quality of their act, or that it was wrong.

Issue 6.22

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?

No. Personality disorder per se should not qualify. See our response to 5.1 above.

In *Willgoss v The Queen* (1960) 105 CLR 295, evidence was given that the appellant was a gross psychopath who, whilst able to intellectually appreciate that it was wrong to kill the victim, was incapable himself of knowing that it was wrong, in the sense of appreciating its wrongness due to his lack of appropriate feeling. The High Court held that this refinement on the concept of 'knowing' that the act was wrong was not one that the law would recognise in the context of the mental illness defence. Nor is there anything in the report to suggest that the court categorically accepted that gross psychopathy, per se, is a 'disease of the mind'

In ***R v Hodges*** (1985) 19 A Crim R 129 the appellant had unsuccessfully raised the mental illness defence at trial where the trial judge held that anti-social personality disorder not a "state of mental disease or natural mental infirmity" within *Criminal Code Act 1913* (WA) s 27. It was argued on appeal that the trial judge's ruling was erroneous. The Western Australia Court of Appeal dismissed the appeal. Burt CJ (with whom Smith J agreed) stated:

> *No witness suggested that the condition would or that it did have any effect upon the appellant's capacity to understand what he was doing or upon his capacity to know that he ought not to do the act. All the evidence was directed to the appellant's capacity to control his actions.*
> *Upon that evidence which relevantly provides the dictionary for ascertaining the meaning to be given to the expression "anti-social personality disorder" I think that the trial judge was right in directing the jury that it was not a state of mental disease or natural mental infirmity within the meaning of those words as used in s 27 of the Code. The evidence simply established that by reason of that condition the appellant was an impulsive man lacking self-*

control. That is quite a different thing from mental disease and natural mental infirmity within the meaning of s 27 of the Code: see Porter (1933) 55 CLR 182 at 188, per Dixon J.

I would dismiss the appeal.

This is not to say that a personality disorder is necessarily irrelevant to the mental illness defence; there may be evidence of additional features which, in combination with a personality disorder, may amount to mental illness.

Bronitt & McSherry[4] write:

...the weight of psychiatric opinion appears to be that antisocial personality disorder, the disorder most 'linked' to criminal conduct, should not be equated with mental illness or mental impairment...[M]odern psychiatrist see mental illness as leading to a failure in 'reality testing'. Those with antisocial personality disorders have no problem dealing with reality.

...The concept of excusing an accused of an offence by virtue of his or her background is one that has not generally been accepted at law. This is because of the dominance of 'free-will' as a basis for explaining crime rather than 'determinism'.

For these reasons, it is of grave concern that the Model Criminal Code Officers Committee's conception of mental impairment has been so broadened as to excuse those suffering from severe personality disorders from criminal responsibility.'

Issue 6.23

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

No.

Irresistible impulse has been included in the formulations of the mental illness defence in a number of jurisdictions, including several states in Australia and the United States. Whereas the

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[4] S. Bronitt & B. McSherry, *Principles of Criminal Law* (2nd edition) Thomson Lawbook Co. (2005) p. 217.

M'Naghten rules are limited in their scope to cognitive matters (knowing the 'nature and quality' of the act' or that it is 'wrong'), the concept of irresistible impulse involves a lack of volitional and emotional control caused by disease of the mind.

It has been observed that *"the defence undermines the requisite volitional element of the actus reus rather than operating upon the mens rea."*[5] Whereas such matters may be relevant in New South Wales to the partial defence of substantial impairment[6], they do not fall within the M'Naghten Rules and so cannot be relied upon to establish the mental illness defence.

One of the significant problems with the concept, is that it is said to be virtually impossible to ascertain whether the impulse is irresistible or has simply not been resisted. One pair of commentators[7] note that:

'Respected UK philosopher Anthony Kenny argues[8] that since the occurrence of an irresistible impulse is generally admitted to be something that cannot be established by science, it is clearly not something that expert testimony can speak on with authority. The difference between the unresisted and the irresistible impulse is not a contemporary and contingent one that progress in science can remove. He believes that the notion of irresistible impulse is an incoherent piece of nonsense'.

The so-called *'but for the policeman-at-the elbow'* test (would the accused still have acted if there was a policeman there ready to arrest him if he did), used in some US jurisdictions, is one attempt that has been used to illustrate the concept and to assist in the process of ruling out the possibility that the 'impulse was deliberately not resisted'. Neverthesless the concept is an extremely elusive one.

There may be cases where the inability to resist an impulse is a function or component of a mental illness that would fall within the

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[5] H. Bloom & R. Schneider *'Mental Disorder and the Law'* Irwin Law, 2006 at p. 149

[6] And see the leading English case of *R v Byrne* [1960] 2 QB 396 where the appellant, a sexual psychopath, had strangled a girl when he was affected by apparently uncontrollable/irresistible violent sexual urges.

[7] S. Allnutt, A. Samuels & C O'Driscoll, *'The Insanity Defence: from Wild Beasts to M'Naghten'* in *Australian Psychiatry* Vol. 15, No. 4, 292 (2007).

[8] Referred to in Neu J, 1980, 'Book review: Freewill and responsibility by Anthony Kenny, *The Philosophical Review*, vol. 89, no. 3, pp. 477-479; the quotation is from S. Allnutt & ors., ibid.

M'Naghten Rules, a possibility that is recognised in the Privy Council decision in *Attorney General for South Australia v Brown* [1960] 1 All ER 734.

Bronitt & McSherry[9] note that in those Australian States where a volitional test of this kind exists, it is very rarely relied upon in practice; they point out that:

> *"Loss of control tests assume that a person can know what he or she is doing is wrong, yet be unable to control his or her actions. In reality, such tests assume that cognition remains completely unaffected, and thus contradicts not only the holistic standpoint of modern psychology but also the view that the ability to reason plays as essential part in controlling conduct.*

[9] *Principles of Criminal Law* (2nd edition) Thomson Lawbook Co. (2005) at 221

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?

This is a very difficult issue that raises the so-called M'Naghten Rule of delusions. The better view is that it is anachronistic.

This 'rule on delusions' has been said to be generally regarded as 'redundant' since it merely re-states a principle provided by the other components of the M'Naghten Rules, and that it 'can safely be ignored'[10]. However, it remains a part of the common law and it continues to be included in a number of statutory codifications of the rules[11]. The flexible application of the 'knowledge of wrong' aspect of the M'Naghten Rules pursuant to the High Court decisions in *Porter* (1936) 55 CLR 182 and *Sodeman* (1936) 55 CLR 192 at 215 makes it inevitable that most cases involving delusions will fall to be considered in the context of their rendering it impossible for the person *'to reason with some moderate degree of calmness in relation to the moral quality of what he is doing'* and the rule on delusions will not come into play at all[12].

In our view there is no need in NSW to retain the Rule on Delusions nor to make any specific reference to them in the definition of the mental illness defence.

Since the power of release of forensic patients is now vested in the MHRT, the nature and gravity of a delusion of someone found NGMI can be taken into account in the question of their release. The real question is the risk to the community; a delusion that is well controlled by medication or that is unlikely to recur in the same circumstances as led to the crime, will present a lower risk.

Issue 6.25

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

In our view the M'Naghten Rules work sufficiently well as not to require any significant change. This is because of the flexible interpretation that has been given to then, primarily in the seminal judgments of Sir Owen Dixon in *Porter* and in *Sodeman*.

Dixon J's inclusion, in the explanation of 'not knowing what he is doing is wrong', of the words *'impossible…to reason with some moderate degree of calmness in relation to the moral quality of what he is doing'* offers a yardstick of common sense with a reasonable degree of elasticity that has been invaluable in accommodating cases, seen by the court or jury as appropriately deserving, within the scope of the mental illness defence. This is in marked contrast to the UK, where the 'knowledge of wrong' test is much less flexible, since 'wrong' has been

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[10] See Card, Cross & Jones, *Criminal Law*, 18th edition, Oxford University Press, 2008 at 647.

[11] Criminal Code 1913 (WA) s 27; Criminal Code, 1899 (Qld) s 27(2); Criminal Code 1924 (Tas) s 16(3)

[12] For example, see *R v Huy Pham* [2007] NSWSC 1313 (James J) and *R v Biggs [2007] NSWSC 932* (Bell J)

consistently interpreted in the UK courts as meaning 'legally wrong'[13] and even grossly disturbed persons generally know that murder, for example, is a crime[14]. It is largely for this reason that the M'Naghten Rules, as applied in Australia, have remained adaptable and responsive to advances in the mind sciences. Criticisms of the rules that emanate from other jurisdictions that have a less flexible approach to them, need to be considered in this light. Of Dixon's test in *Porter*, Fairall and Yeo perceptively point out[15]:

> *'By bringing together the descriptors of 'sense' and 'composure' , his Honour was acknowledging the interaction between thought and feeling processes. This holistic approach sits well with contemporary clinical science which contends that there can eb no serious impairment of one mental function without some from of impairment of the others.'*

Finding a better formula than the M'Naghten Rules (as interpreted and clarified through case law over nearly two centuries) has proved elusive. In the Federal sphere in the United States, attempts at reform have effectively gone full circle. This is illutrated by the following brief chronological summary of various attempts to replace the M'Naghten rules that shows that these attempts have simply ended up back with the M'Naghten Rules. The experiments in-between included:

- the so-called *'product rule'* (if the criminal conduct is the product of mental disease then the defence applies)[16]; this attempts to be more inclusive of conditions that might qualify for the defence, by looking simply at the question whether the criminal conduct was the result of the mental illness. The difficulties with this include that it implies that mental disease simpliciter causes the behaviour, whereas this may vary depending on such factors as the nature of the illness (which may be very complex) and how it impacts on the individual's bahaviour controls (which may infintiely vary); the product test, being essentially a causation test, also tends to place the ultimate determination of the issue into the hands of experts, and removes any requirement to assess the capacity for knowledge of moral wrongness that is present in the M'Naghten Rules. As Judge Warren Burger noted *"No rule of law can possibly be sound or workable which is dependent upon the terms of another discipline whose members are in profound disagreement about what those terms mean".*[17]

- the product rule coupled with a 'but for' test[18] - an attempt to sharpen the

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[13] *R v Windle* [1952] 2 QB 826 CCA; see also *R v Johnson* [2007] EWCA Crim 1978; [2008] Crim LR 132

[14] See Card, Cross & Jones, *Criminal Law*, 18th edition, Oxford University Press, 2008 at 646, citing the *Report of the Committee on Mentally Abnormal Offenders (The Butler Committee)* Cmnd 6244 (1975) at [18.8].

[15] P.Fairall & S. Yeo *'Criminal Defences in Australia'* (4th edition) Lexis Nexis, 2005 at [13.26].

[16] The 'product rule' was first propounded by Isaac Ray in '*A Treatise on the Medical Jurisprudence of Insanity*' in 1838; however, it was only embraced by the New Hampshire Supreme Court in *State v Jones* (1871) but was not adopted in any other US jurisdiction apart from the District of Columbia in *Durham v United States* 214 F.2d 862 (DC Cir, 1954) where it was applied until 1972. For a discussion of *Durham* and its subsequent rejection in *US v Brawner* and the difficulty of finding appropriate criteria for what should constitute mitigating mental conditions, see Daniel Robinson *"Wild Beasts & Idle Humours: the insanity defence from antiquity to the present"* (1996) Harvard University Press, Chapter 6.

[17] See *Blocker v United States* 274 F. 2d 572 (1959)

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

focus of the product rule by requiring a determinative causal link to be established between the illness and the conduct. This was criticised on the basis that it *"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."*[19]

- the Model Criminal Code test adopted by the Supreme Court in *United States v Brawner*[20] (mental disease caused lack of capacity to '*appreciate*' the criminality of the conduct or to conform conduct to the requirements of the law - this was a blending of the M'Naghten Rules with the concept of 'irresistible impulse'); this is problematic in that the use of the potentially ambiguous word *'appreciate'* rather than *'know'* (as in M'Naghten) widens the inquiry beyond a merely cognitive one to a potentially vast inquiry into the nature and degree of the defendant's understanding; which may be over-inclusive.

- Finally, returning to a strict version of the M'Naghten Rules, limited in their application to *'severe mental disease or defect'* and excluding any component of 'irresistible impulse' by amendments to the Federal legislation in1984[21] that were brought about in the aftermath of the fierce debate that arose about the insanity defence in the United States after the acquittal (on the grounds of mental illness) of John Hinckley of the attempted assassination of President Reagan.[22]

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?

The expression *'Defect of reason'* probably does not add anything to the test for the mental illness defence and could safely be omitted.

It would be helpful to define the concept of 'disease of the mind' to include all relevant conditions that might lead to 'not knowing the nature and quality of an act/omission or that it is wrong' that are considered appropriate. This might include cognitive impairment, but should not include personality disorder.

Issue 6.27

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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[19] *United States v Brawner*, 471 F.2d 969, 1019

[20] *United States v Brawner*, 471 F.2d 969 (DC Cir, 1972).

[21] *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."*

[22] For an excellent discussion of this case and the evolution of the M'Naghten Rules in the United States, see R. Bonnie & Ors. *'A Case Study in the Insanity Defence: the trial of John Hinckley Jr'* (third edition) Thomson West (2008)

The current M'Naghten Rules in NSW depend on simple 'knowledge' in the sense of cognitively knowing. It is in our view appropriate that it remain so. To introduce the notion of 'capacity to know' would unnecessarily restrict the availability of the defence.

Issue 6.28

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?

Any statutory formulation should accurately reflect the current law in NSW including Sir Owen Dixon's interpretation (referred to in response to 6.25 above) as to 'lack of capacity to know' – see also response to 6.27.

Issue 6.29

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?

No. See previous responses above.

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?

Only if it triggers an underlying mental condition that is a 'disease of the mind' (which may be extended to include cognitive impairments if the submission in 6.21 above is accepted). The current law that the mental illness defence requires some underlying 'disease of the mind' to be 'triggered' by the substance (the effects of which would otherwise only be transient) is adequate. The line needs to be drawn somewhere, and it seems appropriate that the existence of an underlying disease of the mind, however caused (i.e., even if caused by chronic substance abuse over time) achieves the best policy balance. Addiction per se is not an underlying condition, but if as a result of an addiction a person develops a genuine underlying disease of the mind that can be triggered by substance abuse, giving rise to an active mental illness, the effect of the substance can no longer be said to be transitory.

The vast majority of cases of drug-induced psychosis will be transient; to extend the mental illness defence to these cases would potentially work a great mischief against the firm policy that NSW has had for some time since the introduction of Part 11A of the *Crimes Act 1900*, to limit the circumstances in which intoxication can be relied upon as a defence.

Persons who have a transient psychosis caused by substance intoxication will still be able to raise the defence of intoxication in crimes of 'specific intent'.

The case of *Sebalj* [2003] VSC 181 and [2004] VSC 212 cited in the Consultation Paper at [3.95] may not in truth be an anomaly; if the accused in that case at no time could be said to have had any underlying condition (apart from an addiction), and the psychosis was only brought on by the transient effects of withdrawal, it is entirely consistent with the law as it stands that he ought not be acquitted. If the effects of withdrawal had triggered an underlying condition, then one would expect this to qualify for the mental illness defence.

We would raise another aspect of this whole question. Considering the extent of drug use in the community, it may be time to give consideration to the question of the drug user who knows that they have an underlying condition that will be triggered by drug use, giving rise to an active mental illness. If it could be established that the person was aware of their condition, and foresaw a real risk of harm being caused to others, but went ahead anyway and knowingly, or recklessly, 'triggered' the mental illness (rather like uncaging an angry lion) then perhaps the law should hold that person responsible for the consequences that occurred during the period that the mental illness, so triggered, is operating. This could act as an exception to the general mental illness defence. An appropriate statutory provision could act as a strong deterrent to such persons.

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?

Yes. In our view the current law is appropriate and it would **not** be appropriate for automatism caused by a mental illness to result in an outright acquittal, for the policy reasons of public safety referred to in the discussion paper at [3.103]. Now that the MHRT has the power to release persons found NGMI, the best way to address the individual circumstances of any given case (and they vary so much) is to rely on the Tribunal (or the court if the court determines to release the person) to accurately assess the risk. All this is in place now since the recent amendments to the MHFP Act.

There is some attraction in adopting the approach of the joint judgment of Mason CJ, Brennan & McHugh JJ in *Falconer's Case*, but this puts the onus on the accused (on the balance of probabilities) to establish that the malfunction of the mind was:

(a) transient;
(b) was caused by trauma, whether physical or psychological, and which the mind of an ordinary person would not be likely to have withstood; and
(c) was not prone to recur.

Nevertheless, it is one thing to place an onus on the accused in relation to establishing the defence of mental illness; but issues of voluntariness are inherently matters that the Crown ought be required to prove, once a real question of involuntariness arises (which is the current law and the approach of the majority in *Falconer*).

As a practical matter, these cases are ones where the power of a court to order an

independent medical assessment of an accused, would be of assistance. Also, as the Crown ultimately bears the onus of proof of voluntariness, it may also be helpful if the court had power to order that an accused make themselves available for an examination by a specialist engaged by the Crown.

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?

Yes, but with the leave of the Court (which would accord with many other jurisdictions in Australia as referred to in [3.108] footnote 156 of the Consultation Paper), perhaps also with some principles to guide the discretion of the court. In the context of our adversarial system, it is important to recognise that it is, as a general rule the parties who choose the issues upon which the case will be run (see *Ratten v The Queen* per Barwick CJ). It will not always be in the best interests of an accused to raise the mental illness defence, particularly where the offence is a less serious one and the consequences of an indeterminate period of detention (which is subject to the MHRT's regular reviews) may be less in the overall interest of the accused than a determinate sentence. On the other hand, it is important, from a policy point of view, that genuine cases of mental illness be recognised for what they are so that, where appropriate, they can be treated to improve the mental health of the accused and to reduce the risk of re-offending.

We recommend that the court be given a discretion to permit the Crown to raise the mental illness defence if satisfied that it is in the interests of justice to do so. In determining that question, the court should be able to inform itself in such manner as it thinks fit, and have regard to:

(a) the apparent strength of the evidence indicating that the defence of mental illness could be established;
(b) the apparent seriousness of the accused's mental illness and whether or not it is a continuing condition;
(c) the assessment of the degree of possible risk of such mental illness leading to serious criminal conduct in the future, including consideration of whether any past offending by the accused has been the result of a mental illness
(d) the seriousness of the charges.

The court already has a power to raise the issue of its own accord when it is in the interests of justice to do so – see for example *R v Damic* [1982] 6 A Crim R 35 and *R v Issa* NSWSC 16/10/95 per Sperling J. Perhaps the same guided discretion could apply to the court's exercise of this discretion.

In addition, of course, the court retains the obligation to put the defence to the jury if it is fairly raised on the evidence in the trial, whether intentionally or not.

A discretion such as is proposed would go a considerable way to reaching a clear and workable set of parameters to enable the right balance to be achieved for meeting society's need to recognise, and treat, mental illness (both in the interest of the accused and in the interest of the community) when it is clearly appropriate to do so.

Such a provision would also be consistent to the emergence of a more therapeutic approach to mental illness, in line with the power of release of forensic patients now being a matter for the MHRT (or the court under MHFP Act s 39) and no longer a matter for the executive.

It is to be hoped that such an approach will lead to a more enlightened attitude toward mental illness within the community and the legal profession, where the present practice remains not to raise the issue except as a last resort in the most serious cases.

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?

No. For similar reasons as we have given in 6.9 in relation to unfitness, which remarks are equally apposite here:

In our view this is not an appropriate area for consent orders. Whilst both parties can indicate that they consider the accused to be entitled to the defence of mental illness, the final determination of such an important issue ought to be the subject of proper scrutiny by the court, given the potentially very significant consequences of such a finding. There is still a significant inconsistency in the standard of medical reports presented in cases such as this and there are still experts who are, in effect, 'hired guns'. Requiring the court to make the final decision will ensure proper scrutiny of the process, and its integrity.

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?

Yes. See response to 5.6 above. In addition, the court should also have a power to order that an accused be examined by a specialist on behalf of the Crown, in an appropriate case.

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?

No. The use of the trial process is appropriate in NSW. It is important that the issue should be one that is determined by representatives of the community assisted by the expert evidence in the case. As a matter of policy, it is important that the community remain involved in this process, which ensures a proper level of both scrutiny and engagement by the public in this important area of mental health and crime.

Issue 6.36

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

The current diversionary provisions of the MHFP Act effectively covers most situations where the mental illness defence might otherwise be raised. Indeed, since the amendments to s. 32 of that Act in 2003 which permitted a magistrate to have regard to the condition of the accused *at the time of the offence*, as well as at the time of the appearance before the magistrate, it has had the potential to act as a 'de facto' mental illness defence, provided that the court is persuaded that the case is an appropriate one for diversion. It is only in respect to those cases that are thought inappropriate for diversion that the need for the defence of mental illness really arises.

The defence of mental illness is almost certainly available in the Local Court – see *Horseferry Road Magistrates' Court, ex parte K* [1997] QB 23 DC; [1996] 3 All ER 719 and also *R v McMahon* [2006] NSWDC 81. As there is no clear procedure, such as there is for indictable matters in the Supreme and District Courts under the MHFP Act, the inevitable outcome would be for the defendant to be discharged. Given the level of seriousness of cases now dealt with in the Local Court, this will not always be appropriate.

If a defendant wishes to raise the mental illness defence in the Local Court (and these cases are rare and usually only occur when the magistrate does not consider the case an appropriate one for diversion – for example, where diversion has failed in the past and the defendant continues to offend, or where the matter is too serious) then he or she ought to be able to do so.

In our view the Local Court should be able to enter a special verdict and a defendant found not guilty on the grounds of mental illness ought to be able to be dealt with in the same manner as in the superior courts, namely:

(a) the court should be able to make an order for release, with or without conditions, if 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; or
(b) the court should be able to order that the person be detained and subject to the review of the MHRT following the same procedures that occur in relation to special verdict in the Supreme and District Courts.

It may also be appropriate to limit the maximum period for which such a person could be detained to equate with the limitations upon the maximum period for which the magistrate could have imposed a sentence. Thereafter, if the person remained mentally ill, there should be a procedure for their transfer into the civil system of mental health care under the *Mental Health Act 2007*, where appropriate.

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?

Yes (so long as the other requirements of s 23A are satisfied) but note that we do not agree entirely with the Commission as to what that umbrella definition should include – see response to 5.2 above, particularly our opposition to the inclusion of personality disorder. However, it may be appropriate to consider the inclusion of *severe* personality disorder within the definition of conditions to which the partial defence of substantial impairment could apply, given that the defence only reduces murder to manslaughter, and that it is designed, inter alia, to look at the accused's inability to exercise control.

Issue 6.38

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?

No. The current approach of the section is appropriate.

Issue 6.39

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?

In our view this is sufficiently clear; this formulation was only brought in by way of amendment to the previous s 23A some 13 years ago as the old section was seen as too technical and confusing, not only by limiting the concept of 'abnormality of mind' to a narrow range of origins and causes expressed in terms not altogether conforming with medical concepts, but also because the notion of 'substantial impairment of mental responsibility' was a confusing mix of medical and moral concepts that both juries and medical practitioners had difficulty coming to grips with.

The current section highlights the relationship between the extent of the relevant underlying abnormality of mind, and the appropriate extent of moral culpability. This is a classic issue for a jury to determine in accordance with community standards. We must not get too 'elitist' or technical in how we approach the concept of substantial impairment. It is necessary and important to leave this issue to the jury.

Issue 6.40

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

It should be retained.

The arguments provided in the Consultation Paper at [4.55] – [4.56] for retention are valid and compelling. Nor should this issue be left to the sentencing process where the fact finding is likely to be less rigorous. It is also important for juries to be involved in these matters because they are intimately tied up with community values that should be a factor in considering a reduction in penalty for the many kinds of conditions that might arise under these provisions from time to time.

A key issue is the desirability of keeping the jury involved as the arbiter of community standards for determining what conditions should warrant the reduction of murder to manslaughter. On this issue the Commission comments[23]:

> *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. 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. Furthermore, defendants may be more inclined to plead guilty to manslaughter on the basis of substantial impairment, rather than to murder (which would be the case if the defence were abolished), avoiding the time and expense of a trial*[24].

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[23] Consultation Paper at [4.56] omitting notes.

[24] According to the UK Law Commission, Report No. 304 (2006) *'Murder, Manslaughter and Infanticide'* at [5.96] a very high percentage (70 - 80%) of pleas of guilty to manslaughter by reason of diminished responsibility are accepted by the Crown Prosecution Service, where there is sound medical evidence to back them up.

Not only are the practical considerations raised in this quotation well noted and valid; it is also submitted that it is essential to retain the input of the community, in the form of the jury, on this issue. These cases are among the most serious in the criminal calandar, and the variety of conditions that can be put forward in support of substantial impairment are of many shades and degrees, and many (such as personality disorders and psychopathy) will be highly controversial. Cases may involve syndromes such as 'battered spouse' syndrome that warrant input from representatives of the community as arbiters of what conditions and circumstances might be worthy of considerations of reduced moral culpability. To remove the touchstone of the jury would inappropriately diminish the input that the community ought to have in such matters and would tend also to diminish respect for the criminal justice process and its outcomes.

In the UK, a conviction for murder carries a mandatory life sentence[25]. In its 2006 report *'Murder, Manslaughter and Infanticide'*[26], the UK Law Commission recommended the retention of the defence of diminished responsibility in the UK , which is currently in a form that closely resembles the problematic form that the former s 23A took prior to its amendment in 1997. The Law Commission recommends that the provision be amended in a similar way to the NSW amendments of 1997, but with some modifications, including specifying that the abnormality of mental functioning should arise from *'a recognised medical condition, developmental immaturity in a defendant under the age of eighteen, or a combination of both'*. They would also prefer the wording of the jury's task to require that they be satisfied that the condition *'provides an explanation for the defendant's conduct in carrtying out or taking part in the killing'* (in preference to the NSW wording that the impairment was *"so substantial as to warrant liability for murder being reduced to manslaughter"*).

Card, Cross & Jones[27] note that:

> *Quite apart from arguments based on the existence of the mandatory life sentence for murder, the existence of the defence of diminished responsibility can be supported on the grounds of the importance of 'fair and just labelling', ie that it is unjust to label as murderers those not fully responsible for their actions.*

In New Zealand there is no defence of diminished responsibility, and Brookbanks[28] cites a number of New Zealand cases which he suggests indicate that *"there has been some willingness to concede that the broadening of mental state characteristics in provocation may have effectively admitted diminished responsibility into New Zealand 'through the back door.'"* He also refers[29] to the case of *R v Gordon* (1993) 10 CRNZ 430 in which the Court of Appeal at 441 'hinted' that the New Zealand law may be deficient. This was a 'battered wife' case where such a defence may have been appropriate.

The issues raised above would seem to indicate that there remain very strong theroretical and practical arguments for the retention of the partial defence of substantial impairment.

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[25] *Murder (Abolition of Death Penalty) Act, 1965* s 1(1) (UK); however, by s 1(2) of that Act, a sentencing judge can make recommendations as to the minimum term an offender should serve before being paroled.

[26] UK Law Commission, Report No. 304 (2006) *'Murder, Manslaughter and Infanticide'*. The report considers many of the arguments for and against the retention of substantial impairment. It can be downloaded at www.lawcom.gov.uk/docs/lc304.pdf

[27] *'Criminal Law'* (18th edition) OUP (2008) at [15.64].

[28] W. Brookbanks & S. Simpson 'Psychiatry and the Law' (2007) Lexis Nexis NZ Ltd., at [6.6]

[29] ibid.

Issue 6.41

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

Yes, both should remain. In our view these are special cases that the law should have specific provisions about. The current provisions are appropriate. It is sound that the Crown should have the option of charging infanticide, rather than murder, in an appropriate case. But if murder is charged, then it is necessary for the defence to be available.

The UK Law Commission reviewed the law of infanticide in 2006[30] and considered the history of the infanticide provisions of 1922 and 1938, stating[31]:

> *At the time the original Infanticide Act was passed in 1922, and again in 1938, Parliament recognised and debated its potential flaws and considered alternative options. For example, the phrase "the balance of her mind was disturbed" was challenged and the problems inherent in introducing medical evidence were acknowledged. Similarly, the link between the disturbance of the mind and birth was questioned and a broader basis of disturbance induced by poverty and despair was proposed. The need to ensure unmeritorious cases did not fall within the offence/defence of infanticide was stressed. Problems associated with setting an age limit were also acknowledged – it was recognised that any time limit was ultimately arbitrary to some extent. However, despite these concerns, Parliament decided on the current form of the offence/defence of infanticide as the best means of avoiding the "black cap farce" whereby judges were required to pass a mandatory sentence of death ("with all its dreadful paraphernalia") on mothers who were convicted of murdering their babies, only for the death penalty to be commuted to a lesser sentence.*

Although the Law Commission raised possible changes to the law for discussion - including removing the reference to lactation (on the basis that the link between psychiatric disorder and lactation is unfounded); and raising the age limit of the victim to two years (this would capture almost all instances of child-killing connected to postpartum psychiatric disorder) – in its final report it declined to make any significant alterations to the infanticide provisions[32]. The Commission noted[33]:

> *8.25 Based on our consultation meeting with a range of medical and legal experts on the subject of infanticide, we believe that there is sufficient medical evidence on which to justify the offence/defence of infanticide as it stands. Our belief is supported by the work of Professor Brockington, who provided us with tables categorising the different psychiatric disorders associated with infanticide and the*
> *different types of infanticide. Although no psychiatric disorders (perhaps, bar one) are specific to childbirth, the incidence of certain disorders is higher following childbirth. This temporal connection indicates that some women are more vulnerable to psychiatric disorder in the postpartum period.*

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[30] *Murder, Manslaughter and Infanticide* Law Com No. 304 , 1/11/06

[31] Law Com No. 304, 1/11/06 at page 158 (omitting footnotes).

[32] However, the legislation was amended in 2009 to make it clear that a person could not be convicted of infanticide if the elements of murder were not present; this reform has not yet been taken up in the New South Wales Crimes Act.

[33] At 161-162 (omitting footnotes)

8.26 There is also some evidence to support the lactation theory. A recent study conducted by Dr Marks and her colleagues suggests that lactation may increase dopamine sensitivity in some women, which may trigger psychosis. Although this evidence is not conclusive, we are not aware of evidence that definitively refutes the lactation theory. Thus, on balance, we recommend retaining the reference to lactation.

And further[34]:

According to a number of the medical professionals who attended our meeting on infanticide, most postpartum psychiatric disorders linked to infanticide are resolved within 12 months after birth. The majority of infanticides linked to psychiatric disorder occur within the first three months. Amongst those who attended our meeting, some expressed concern that there is a risk that if the age limit of the victim is increased to two years, then unmeritorious cases (such as cases of ongoing abuse) will fall within the offence/defence of infanticide.

Finally in response to submissions that the offence 'pathologised' motherhood, discriminated against mothers, and that it should be merged with diminished responsibility, the Commission stated[35]:

Further, merger of infanticide with diminished responsibility presents procedural problems concerning the burden of proof. The burden on the defendant to prove psychiatric disorder in order to successfully plead diminished responsibility may be impossible to discharge in neonaticide cases (the killing of a baby within 24 hours of his or her birth). In such cases, the mother may give birth alone and suffer from a transient disorder. At our meeting on infanticide Professor Brockington, Dr Margaret Oates and Dr Marksall expressed concern that neonaticide cases must be covered by a special defence because the mother's culpability is very low. Further, the mother is in a particularly difficult position with regard to discharging the burden of proof.

8.38 The offence/defence of infanticide has caused very few problems in practice, as evidenced by the lack of case law in this area. Further, it involves very few cases. As stated in the Consultation Paper, "it does not seem worth countenancing the perhaps unforeseeable changes that would result from an insistence that such cases be dealt with under section 2 of the Homicide Act 1957.

8.39 Finally, we do not believe that the offence/defence of infanticide "pathologises" women or motherhood. Nor does it reflect or reinforce a perception in law that women are less responsible for their actions. Rather, the offence/defence of infanticide recognises that some women do suffer from psychiatric disorders triggered by childbirth (and very possibly lactation), and as a result may kill their infants. We do not believe it serves the feminist or other causes to increase the severity of the offence these mothers have committed, nor the sentence that they may face, by merging infanticide with diminished responsibility. In this unique situation there is only the surface appearance of discrimination: the substantive offence ensures substantive justice.

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[34] At 164 (omitting footnotes)
[35] At 165 (omitting footnotes)

Issue 6.42

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

No. Both should be retained.

Issue 6.43

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

No. See response to 6.41

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?

Yes. The MHRT should be informed of the court's order under s 27 as the MHRT has a continuing role in reviewing forensic patients given limiting terms. The current provision's failure to require notice is probably a legislative oversight.

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?

Sentencing principles are not irrelevant insofar as there has been a qualified verdict that a crime has been committed, on the limited evidence available. It should not be forgotten that the community has an interest in achieving some degree of closure when a crime has been committed; victims and their families, disrupted communities, and other members of the public generally are entitled to as much closure as can reasonably be obtained. However it is equally important to acknowledge that when an accused is unfit, he or she has never been in a position to run a competent defence, and of course, there is no conviction.

It may be entirely appropriate to modify the 'sentencing principles' to better fit this reality, and a better balance could be achieved than that which presently pertains in NSW. We make some suggestions as to how this could be achieved.

We agree that sentencing principles are relevant at least in putting a 'limit' upon detention (Consultation Paper [6.30]). It perhaps should be required by the legislation that a judge imposing a limiting term should make it expressly clear in the sentencing remarks, precisely what the rationale and purpose of a limiting term is, and that the MHRT has jurisdiction to review and release forensic patients at any time that it is satisfied the relevant criteria under the MHFP Act have been satisfied.

Now that the MHRT has the power to release forensic patients, proper clinical and risk assessment of persons on limiting terms can be made and acted upon, so that the opportunity for a greater therapeutic approach is now in place – a vast improvement from the former requirement that the Minister was required to approve any release. This has significantly reduced the extent of the problem of the 'application of sentencing principles'.

However, one major hurdle, in the way of limiting terms under the MHFP Act working in a way that does not unduly depend on 'sentencing principles' is s 74 (e) of the Act. S 74 is set out in full:

74 Matters for consideration

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 person under this Part:
(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,
(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,
(e) in the case of the proposed release of a forensic patient subject to a limiting term, whether or not the patient has spent sufficient time in custody.

It is the presence of 74(e) that preserves a punitive element in limiting terms, which thereby converts the 'sentencing principles' applied at the time of fixing the limiting term, into something much more akin to a sentence than simply 'capping' the maximum period of time that a person given a limiting term, will remain a forensic patient.

If the patient has never been properly tried and convicted, how important or relevant are the well-established functions of sentencing, namely punishment, deterrence, community protection, rehabilitation, accountability, denunciation and recognition of the harm done to the victim and the community?[36] This is an elusive question.

This criterion should be abandoned altogether by future amendment to the legislation. Risk/community protection will be taken into account before a release decision can be made in any event. Of the remaining functions of sentencing, it is difficult to see the logic or necessity of applying any of these to a forensic patient who is serving a limiting term. Dangerousness/risk to the public or to themselves may in reality be the only criterion that can be justified as a matter of policy.

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[36] See s 3A Crimes (Sentencing Procedure) Act, 1999 NSW. There is case law that holds that the imposition of a limiting term is acknowledged by the terms of the legislation to be 'a penalty' and that the expression 'insufficient time in custody' is indicative of a limiting term being a 'punishment' – see *Smith v R* [2007] NSWCCA 39 at [63] per Hall J (referring to *DPP v. Mills* [2000] NSWCA 236). But see obiter of Basten JA (dissenting) in *Courtney v R* [2007] NSWCCA 195 at [1] where his Honour stated "*The problems faced by the courts in dealing with people who are mentally ill and prone to violent behaviour are perennial and to an extent intractable. If a person's mental condition at the time of an offence is sufficiently serious to constitute insanity, the person cannot be properly dealt with by the criminal justice system, in relation to crimes which involve intentional acts. Where a person is unfit to plead, he or she should not be submitted to a trial in criminal proceedings. In each case, the imposition of punishment, being the usual outcome of conviction for a criminal offence, is inappropriate. Nevertheless, one function of the criminal justice system, namely to protect the community from violent individuals, remains apposite*". See also [12] of his Honour's judgment.

That said, there is a need to ensure that persons who are UNA are periodically assessed as to whether they have become fit, in which case, the state should have the option of putting them to trial – this is provided for by s 28(2) MHFPA. If the requirement of 'sufficient time in custody' under s 74(e) were to be removed from the considerations for release, then it would more often than not be important and appropriate that the MHRT make any release conditional upon the person presenting for assessment of their fitness periodically as required by the Tribunal, up until the date of expiry of the limiting term, or such earlier date as the Tribunal determines to be appropriate. Such 'earlier date' could be fixed, by a statutory formula, as not being less than one half of the limiting term set by the court. Currently such an outcome could in effect be achieved by the MHRT making an order pursuant to s 51 MHFPA, which provides that if a release is subject to conditions, then the person remains a forensic patient until the conditions are fulfilled.

One half of the limiting term would seem to be an appropriate minimum period. In a notional sense, it could be seen as equivalent to a 'non-parole period' that currently is not taken into account in setting a limiting term (which has been controversial) and also as including reduction for a plea of guilty (not currently taken into account) and also special circumstances' (not currently taken into account). It also could be seen as striking a reasonable balance between the need of the community and the victim to have some sense of process and closure that recognises that a crime occurred, and that there was at least a distinct possibility that it was the UNA accused who committed it.

Issue 6.46

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

Yes. Consideration of features such as those referred to in [6.38] of the Consultation Paper could usefully be set out to guide judges considering release orders. Perhaps the MHRT ought, if the judge thinks fit, be asked to make recommendations in respect to release, on referral from the court for this purpose.

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?

Yes. The MHRT has useful guidelines in this regard, available to courts.

Issue 6.48

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

Yes.

The arguments put forward in the Consultation Paper [6.40] – [6.43] seem to move from the premise that the outcomes for NGMI are 'starkly different' from those for UNA (unfit not acquitted). However, now that the MHRT is responsible for the release of forensic patients, the difference in outcome is perhaps more perception than

reality. This will be even more so if the requirement of 'sufficient time in custody' is removed as a criterion for release of persons subject to limiting terms (see response to 6.45 above).

The differences are at the 'input' end – that is, the route by which the matters come through to court to the Tribunal. The current processes for NGMI and UNA are not simply 'labels' – it is important that the criminal justice system properly identify these as separate bases for forensic patient status; unfitness may be temporary and is a brake on further proceedings, whereas NGMI is a final verdict. Where unfitness is not temporary, the special hearing procedure still has important interests to address other than the therapeutic welfare of the accused found NGMI; we have discussed these in the response to 6.45 above.

Issue 6.49

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?

(a)

As the Consultation Paper notes at [6.16]:

Non-Custodial options would 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 (see Crimes(Sentencing Procedure)Act 1999 s 8-1, 14-15, part 7, part 8,) It appears that certain other orders , such as home detention and suspended sentences, might not be aviailable because of application of procedural requirements.

The Commission's suggestion is that, by including UNA persons dealt with by a non-custodial order as falling within the definition of 'forensic patients', their cases would be dealt with by the MHRT for any breaches, instead of by the Court. However, in our view there will be cases that can best be dealt with by non-custodial orders made by the court, with the court retaining power to deal with breaches – continued supervision by the court of its own order will be most effective in some cases.

That said, there would be every reason to add, to the orders that a court can make, a power to direct (if the court considered it appropriate in a given case) that any breaches of the order are to be dealt with by the MHRT rather than by the court.

(b) No. The issue of release at this stage of proceeding ought be left to the MHRT.

Issue 6.50

What orders should be available to the court?

See response to 6.45 - 6.49

Issue 6.51

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

See response to 6.45 – 6.49

Issue 6.52

What orders should result in a person becomes a "forensic patient"?

All orders except unconditional release by the court or the MHRT – see response to 6.45 – 6.49

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?

We agree with the suggestion in [6.59] of the Consultation Paper that, where the only risk is a risk of harm to the person found NGMI or UNA (as distinct from risk of harm to any other member of the public) then that should not prevent the person's release (subject to release otherwise being determined to be the appropriate disposition) into the civil mental health system. There ought to be a clear power for the court to transfer such a person that the court proposes to release, into the civil system of care under the MH Act. This is consistent with the Canadian approach and with the principle of least restriction.

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?

Referral should be to a mental health facility, in a similar manner to the operation of s 33 MHFPA (in relation to orders by magistrates for assessment of persons under the MHA) and with the person and the authorised medical officer reporting back to the court as to the outcome, and if necessary, returning the person to the court. The Court could then consider its final determination. Appropriate liaison mechanisms would need to be established for this to work efficiently and reliably.

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?

The observations in the Consultation Paper at [6.60] – [6.64] are compelling. In our view 'harm' should be defined in the legislation to include bodily and psychological harm, but also significant damage to property (for example by arson).

Issue 6.56

Should "harm" be defined in the MHFPA?

Yes, see response to 6.55

Issue 6.57

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

The formulation in MHFPA s 39(2) of "the safety of the person or any member of the public [being] seriously endangered' is different to the expression 'protection of others from serious harm' used elsewhere in the Act (see s 74(b) and s 43(a)). There should be consistency in this test wherever it occurs. The degree should be 'serious' and the risk should be 'significant' (in the sense of 'not insignificant').

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?

S 39(2) MHFPA, dealing with the orders a court may make after a finding of NGMI, states:

> *The Court is not to make an order under this section for the release of a person from custody 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.*

However, s 43, which deals with orders for release by the MHRT provides:

43 Criteria for release and matters to be considered by Tribunal

The Tribunal must not make an order for the release of a forensic patient unless it is satisfied, on the evidence available to it, 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.

In our view the presumption in favour of detention, unless it is established positively that it is safe to release the person, is appropriate at the court stage of proceedings. Such cases as result in detention will be promptly reviewed by the MHRT, which the court should, in many (but not all) cases, be able to look to as being better placed to make a thorough determination of this issue. That is one of the major purposes of the MHRT, to bring expertise to the area.

However, there is a much stronger argument, based upon the observations in the Consultation Paper at [6.70] – [6.72] that the presumption should be reversed at the Tribunal stage, that is, there should be a requirement that, for detention, the tribunal should be satisfied that unless the person is detained, the safety of the public will be seriously endangered.

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 safety of the community – see also comments made in response to 6.53 regarding mechanism for transfer to the civil system in cases of risk only of harm to self.

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?

Victims should be able to make victim impact statements to the court but these ought not be taken into account in the disposition of the case by the court.

Victims should be permitted to make appropriate representations to the court or the tribunal at least insofar as they may need some 'not to approach' condition or similar kinds of conditions regarding times and places.

The involvement of carers is to be encouraged, but perhaps the most appropriate way for this to be done is as witnesses in appropriate cases. The extent of their involvement can best be determined on a case by case basis by the lawyers involved in the proceedings.

Issue 6.61

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

See response to 6.45; if the suggestion we make were implemented, the court would not need to have regard to factors such as those referred to in the consultation paper at [6.77] – [6.80]. The Tribunal would need to assess risk, and have regard to the possible future fitness for trial in the way we have indicated. The strength of the evidence has already been established by the fact that the jury (or judge if the special hearing was judge alone) will have been satisfied, on the limited evidence available (in the case of UNA) and on the evidence in the case (in the case of NGMI), that the accused's commission of the actus reus has been established beyond reasonable doubt. In our view, the Tribunal should not be making a second assessment of the strength of the evidence, but should accept the finding as having established the risk. The variable factor, which will require a fresh assessment from time to time, will be what additional (greater or lesser) degree of risk is posed by the person's mental (or cognitive) condition.

In NGMI cases where the court is considering release, clearly the issue of safety under s 39 MHFPA needs to be considered.

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?

See response to 6.61 (and 6.45).

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?

See response to 6.61

Issue 6.64

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?

The applicable standard should be on the balance of probabilities in line with the principles in *Brigenshaw v Brigenshaw* (1938) 60 CLR 336.

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?

The court should be able to seek assessments from the MHRT; thought could be given also to a panel of court appointed experts to assist in assessment of risk (this ties in with the general power to order assessments dealt with earlier in this submission). Court liaison services in the Local Court have worked extremely well and there is no reason why these should not be extended to the superior courts. In addition, there should be continuing professional development education for lawyers about these matters to enable them best to fulfill their obligation to assist the court.

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?

Yes.

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?

Each of the anomalies identified and referred to in [6.99] – [6.101] of the Consultation Paper should be corrected.

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?

See response to 6.67

Issue 6.69

Should the Criminal Appeal Act 1912 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?

Yes.

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?

The present forms of appeal provided for are sufficient, subject to the anomalies referred to being rectified.

Issue 6.71

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

Perhaps something along the lines of those suggested in response to 6.65, appropriately adjusted for the appellate environment.

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?

See responses to 6.36 and 6.11

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?

See responses to 6.36 and 6.11

Issue 6.74

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

Yes, but the number of these, within a given period, should be able to be limited if the Tribunal so determines, or perhaps subject to compliance with the statutory obligation of regular reviews.

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?

The current provisions would seem to be adequate & appropriate.

Issue 6.76

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?

These notifications should all remain as a safety net. In addition, the Minister for Health and the Attorney General are entitled to notice as they have rights of appeal. The notification to the Police Minister is not inappropriate as the minister can bring any relevant information held by police to the attention of the Attorney General.

Issue 6.77

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

This would perhaps enhance the general requirement of agency co-operation with the MHRT under s 76K(1).

Issue 6.78

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?

The issues identified and raised in [7.18], and [7.20] (as far as this is practicable), of the Consultation Paper should be addressed.

Issue 6.79

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

The current provisions are adequate.

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?

Generally these are adequate. See however response to 6.60.

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?

See response to 6.60.

Issue 6.82

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

Yes. But see response to 6.45.

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?

Yes. However in appropriate cases the MHRT ought to be able to have these

persons assessed and transferred to the civil mental health system.

Issue 6.84

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

See response to 6.45 above.

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?

Yes, but subject to matters raised in response to 6.45 above.

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?

The current provisions are sufficient.

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?

Yes – there should be clear pathways for re-engagement with the community with proper support from relevant agencies and related associations. There should be appropriate discharge planning before the expiry of the limiting term. Every reasonable assistance should be given to these persons that will assist them to re-integrate.

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?

The anomalies identified in [7.40] – [7.42] of the consultation paper should be rectified and the entitlement to be released clarified, if necessary by amendment to the statute.

Issue 6.89

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

The current appeal provisions are adequate.

Issue 6.90

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

This would be the ideal but may not be possible to achieve within constraints of

resources in the system. Also, some forensic patients express the preference for prison over an authorised mental health facility. However the many unsatisfactory systemic problems within corrections highlighted by the consultation paper at [7.48] – [7.55] should be addressed.

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?

The many unsatisfactory systemic problems with forensic patients in corrections highlighted by the consultation paper at [7.48] – [7.55] should be addressed.

Issue 6.92

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

The compulsory treatment of forensic patients, whose condition would not justify compulsory treatment if the person were not a forensic patient but was a civil patient, should not be permitted. The legislative anomalies noted in at [7.57] – [7.71] should be addressed so that mental illness of forensic patients is treated clinically in the same way, as far as is possible, as those in the civil system.

Issue 6.93

Should different criteria apply to:
different types of treatment; and/or
forensic patients with different types of impairment?

Yes. We agree with the commission's observations that suggest that the current situation is unsatisfactory.

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?

We agree with the Commission's observations that indicate that the current situation is unsatisfactory, and with the Commission's comments about the need for appropriate and specific treatments/interventions for forensic patients with cognitive impairments.

Issue 6.95

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

We agree with the Commission's observations.

Issue 6.96

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

The current provisions are adequate.

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?

Yes. See 6.57 above.

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?

See response to 6.53 above.

Issue 6.99

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

Generally Yes, but the safety/risk factor must be a paramount consideration in determining what is the least restrictive disposition.

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?

It should reflect the concept of least restriction in the MHA but also making appropriate allowance for the paramount consideration of the risk/safety factors.

Issue 6.101

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?

As to UNA, see response to 6.45.
As to NGMI we consider that the current provisions are adequate. There is not the same rationale for 'capping' the term as there is for persons found UNA. The essential issue is that these persons be adequately reviewed and released when it is safe and appropriate to do so. It would be too 'hit and miss' to set an artificial cap for persons found NGMI and then to transfer them to the civil system upon expiry of that term. There may be some argument for capping the term for NGMI if this determination could be made in respect of Local Court matters – see response to 6.36.

Issue 6.102

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

See response to 6.45 above as to UNA. See 6.101 above as to NGMI.

Issue 6.103

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

No. See response to 6.101.

Issue 6.104

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

Yes.

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?

This is probably more a matter for judicial education. The inclusion in s 21A of the suggestion referred to in 6.104 above would be sufficient to set in train an appropriate jurisprudential response through case law.

Issue 6.106

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?

The principles relating to reduced moral culpability and reduced need for deterrence are well established in the case law. We do not consider that a specific statutory expression of these issues is necessary.

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?

It need not be mandatory but is to be encouraged when appropriate. Availability of such reports could be enhanced. Contents should be at the judge's discretionary request. The contents of such reports should be left to practitioners in the field rather than legislative prescription.

Issue 6.108

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?

This is a complex question. NSW needs far better resources to make this work in practice. The ideal would be to have appropriate facilities within the forensic setting – a special place of detention perhaps – where specific and appropriate programs could be tailored for individual prisoners with special cognitive or mental health impairments. The situation in respect of persons with mental health impairments has been significantly improved by the new forensic hospital at Long Bay.

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?

Yes – these are all sensible and practical proposals.

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?

Yes.

Issue 6.111

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

We do not express any particular view on this.

Issue 6.112

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.

Yes. We agree with the comments at [8.79] – [8.80] of the consultation paper.

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?

Amendment should not be required. These are matters of good practice that should be addressed in assessments and in the sentencing process in any event.

Issue 6.114

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.

See response to 6.113.

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?

See response to 6.113.

Issue 7.1

(1) Should a legislative scheme be established for police to deal with offenders with a cognitive impairment or mental illness by way of a caution or a warning, in certain circumstances?

(2) If so, what circumstances should attract the application of a scheme like this? For example, should the scheme only apply to certain types of offences or only to offenders with certain defined forms of mental illness or cognitive impairment?

In our view the current provisions for diversion by police are sufficient. The police force has in recent times introduced a number of initiatives including an MOU with the Health Department and a dedicated Mental Health Intervention Team under which some 1500 officers will be trained in appropriate response and intervention in this regard. There are protocols in the police handbook, in addition the requirements in respect of vulnerable persons under the Law Enforcement (Powers & Responsibilities) Regulations, 2005. No doubt the police should be encouraged to continue expanding these types of initiatives.

Issue 7.2

Could a formalised scheme for cautions and warnings to deal with offenders with a cognitive impairment or mental illness operate effectively in practice? For example, how would the police identify whether an offender was eligible for the scheme?

See response to 7.1.

Issue 7.3

Does s 22 of the MHA work well in practice?

We do not express any strong view on this. We do note that a similar section in the Victorian Mental Health Act has recently been considered by the High Court in *Stuart v Kirkland-Veenstra* [2009] HCA 15 which at least sheds some light on the responsibility and civil liability of officers under such a provision. The NSW provision is wider than the Victorian one, in that in NSW officers can respond under the section if the person 'appears' to be 'mentally disturbed'- a term not defined by the act and

which gives the officers some reasonable latitude, which seems appropriate.

Issue 7.4

Should the police have an express, legislative power to take a person to a hospital and/or an appropriate social service if that person appears to have a cognitive impairment, just as they can refer a mentally ill or mentally disturbed person to a mental health facility according to s 22 of the MHA?

S 22 provides:

2 Detention after apprehension by police

(cf 1990 Act, s 24)

(1) A police officer who, in any place, finds a person who appears to be mentally ill or mentally disturbed may apprehend the person and take the person to a declared mental health facility if the officer believes on reasonable grounds that:
(a) the person is committing or has recently committed an offence or that the person has recently attempted to kill himself or herself or that it is probable that the person will attempt to kill himself or herself or any other person or attempt to cause serious physical harm to himself or herself or any other person, and
(b) it would be beneficial to the person's welfare to be dealt with in accordance with this Act, rather than otherwise in accordance with law.
(2) A police officer may apprehend a person under this section without a warrant and may exercise any powers conferred by section 81 on a person who is authorised under that section to take a person to a mental health facility or another health facility.

If the circumstances were limited to the circumstances set out in s 22, we see no reason why the section ought not be expanded to include a similar appropriate response for persons with cognitive impairments. However, the circumstances for intervention should not be expanded beyond the serious factual situations contemplated by the section.

Issue 7.5

Do the existing practices and policies of the Police and the DPP give enough emphasis to the importance of diverting people with a mental illness or cognitive impairment away from the criminal justice system when exercising the discretion to prosecute or charge an alleged offender?

Yes. Guidelines and protocols are one thing, however, and continuing education and professional development about persons with cognitive and mental impairments in the criminal justice system are very important in ensuring that these are given proper effect to.

Issue 7.6

Do provisions in the Bail Act 1978 (NSW) setting out the conditions for the grant of bail make it harder for a person with a mental illness or cognitive impairment to be granted bail than other alleged offenders?

S 37(2A) of the *Bail Act 1978* provides for some consideration of the ability of a person with intellectual disability to comply with conditions:

(2A)Before imposing a bail condition on an accused person who has an intellectual disability, the authorised officer or court is to be satisfied that the bail condition is appropriate having regard (as far as can reasonably be ascertained) to the capacity of the accused person to understand or comply with the bail condition.

The definition of intellectual disability in the s 37(5) of the Bail Act is somewhat out of date; it provides:

(5) In this section:
'intellectual disability' means a significantly below average intellectual functioning (existing concurrently with two or more deficits in adaptive behaviour) that results in the person requiring supervision or social rehabilitation in connection with daily life activities.

This provision could be expanded by providing a wider definition of 'cognitive impairment' that would include intellectual disability, and possibly also mental illness – see by way of example the definition of cognitive impairment in s 61H(1A) Crimes Act that provides (for the purpose of the relevant sexual assault offence):

(1A) For the purposes of this Division, a person has a ***cognitive impairment*** if the person has:
(a) an intellectual disability, or
(b) a developmental disorder (including an autistic spectrum disorder), or
(c) a neurological disorder, or
(d) dementia, or
(e) a severe mental illness, or
(f) a brain injury,
that results in the person requiring supervision or social habilitation in connection with daily life activities.

This might need to be re-formulated for the context of the Bail Act, but it is a helpful example.

Issue 7.7

Should the Bail Act 1978 (NSW) include an express provision requiring the police or the court to take account of a person's mental illness or cognitive impairment when deciding whether or not to grant bail?

Yes.

Issue 7.8

What education and training would assist the police in using their powers to divert offenders with a mental illness or cognitive impairment away from the criminal justice system?

See response to 7.1.

There are a number of innovative models in other police forces. In Toronto, Ontario, for example, the police have introduced an around the clock scheme whereby there are patrol cars staffed by a police officer specially trained in mental health response techniques, accompanied by a mental health nurse, available to be called in to assist another officer confronted by any scene or disturbance that appears to involve a

person with a mental health issue. The Police have established excellent links with various community facilities and agencies that cater for such persons, and this greatly assists the diversionary process. New South Wales needs significantly more resources in the public and community sectors to assist the whole process.

Issue 7.9

(1) Should the term, "developmentally disabled", in s 32(1)(a)(i) of the MHFPA be defined?

(2) Should "developmentally disabled" include people with an intellectual disability, as well as people with a cognitive impairment acquired in adulthood and people with disabilities affecting behaviour, such as autism and ADHD? Should the legislation use distinct terms to refer to these groups separately?

Yes. See also response to 5.1. It is important that the definitions be consistent, as far as possible, across the various statutes where the terms are used.

Issue 7.10

Is it preferable for s 32 of the MHFPA to refer to a defendant "with a developmental disability" rather than to a defendant who is "developmentally disabled"?

Yes.

Issue 7.11

Should the term, "mental illness" in s 32(1)(a)(ii) of the MHFPA be defined in the legislation?

Yes. It should be the same as the definition in MHA s 4.

Issue 7.12

Should the term, "mental condition" in s 32(1)(a)(iii) of the MHFPA be defined in the legislation?

It is important to retain some flexibility in this term so that it can still be a 'catch-all' for appropriate conditions that warrant diversion. The suggestion in [3.20] of the consultation paper to clarify it to include mental conditions 'for which treatment is available in the community' is sensible, but would be even better if it were 'for which treatment is available in a mental health facility or in the community'. See also response to 5.4.

Issue 7.13

(1) Should the requirement in s 32(1)(a)(iii) of the MHFPA for a mental condition "for which treatment is available in a mental health facility" be changed to "for which treatment is available in the community" or alternatively, "for which treatment is available"?

(2) Should the legislation make it clear that treatment is not limited to services aimed at curing a condition, but can include social services programs aimed at providing various life skills and support?

As to (1) see response to 7.12.

As to (2) Yes.

Issue 7.14

Should the existing categories of developmental disability, mental condition, and mental illness in s 32(1)(a) of the MHFPA be removed and replaced by a general term used to determine a defendant's eligibility for a s 32 order?

See response to 5.1.

Issue 7.15

What would be a suitable general term to determine eligibility for a s 32 order under the MHFPA? For example, should s 32 apply to a person who suffers from a "mental impairment"? How would a term such as "mental impairment" be defined? For example, should it be defined according to an inclusive or exhaustive list of conditions?

See response to 5.1.

Issue 7.16

Are there specific conditions that should be expressly excluded from the definition of "mental impairment", or any other term that is preferred as a general term to determine eligibility under s 32 of the MHFPA? For example, should conditions related to drug or alcohol use or abuse be excluded? Should personality disorders be excluded?

See response to s 5.1

Issue 7.17

Should a magistrate take account of the seriousness of the offence when deciding whether or not to divert a defendant according to s 32 of the MHFPA? Why or why not?

Yes. In our view the Court of Criminal Appeal decision in El Mawas [2006] NSWCCA 154 correctly assessed the place of 'seriousness of the offence' in the exercise of discretion under s 32 MHFPA.

Issue 7.18

Should the decision to divert a defendant according to s 32 of the MHFPA depend upon a direct causal connection between the offence and the defendant's developmental disability, mental illness, or mental condition?

No. It should certainly be a factor that the court can take into consideration, but should not be required or determinative. The fact that the section applies to persons who have one of the requisite conditions at the time they appear before the magistrate (ie, it is not necessary that they had the condition at the time of the offence) makes it clear that causal connection is not necessary.

Issue 7.19

Should the decision whether or not to divert a defendant according to s 32 of the MHFPA take into account the sentence that is likely to be imposed on the defendant if he or she is convicted?

This consideration is an appropriate one to take into account, because it is integral to the magistrate's determination of whether or not it is more appropriate to divert than for the accused to be dealt with by the criminal process. In ***Mantell v Molyneaux***

(2006) NSWLR 955, Adams J in dealing with the correct approach to s 32, noted that, in weighing up the appropriateness of diversion, it is perfectly proper for a magistrate to have regard to the potential likely sentencing outcome for the defendant if dealt with according to law.

Issue 7.20

(1) Should s 32(1)(b) of the MHFPA include a list of factors that the court must or can take into account when deciding whether it is appropriate to make a diversionary order?

(2) If s 32(1)(b) were to include a list of factors to guide the exercise of the court's discretion, are there any factors other than those discussed in paragraphs 3.28-3.41 that should be included in the list? Are there any factors that should be expressly identified as irrelevant to the exercise of the discretion?

The decision of the CCA in *DPP v El Mawas* is sufficient guidance and indicates that this is intended to be a very wide discretion. It is not necessary to include a list of factors.

Issue 7.21

(1) Do the interlocutory orders available under s 32(2) of the MHFPA give the Local Court any additional powers beyond its existing general powers to make interlocutory orders?

(2) Is it necessary or desirable to retain a separate provision spelling out the Court's interlocutory powers in respect of s 32 even if the Court already has a general power to make such interlocutory orders?

We note that Adams J in *Mantell v Molyneux* (2006) 165 A Crim R 83 expressed the view that the magistrate's general power of adjournment could be used to same effect as the adjournment power under s 32(2). The power under s 32(2) 'to make any other order that the magistrate considers appropriate' may add something to the magistrate's general powers. Whilst we do not have a strong view about this, it seems to us there is no need to remove these powers from the section.

Issue 7.22

Are the interlocutory powers in s 32(2) of the MHFPA adequate or should they be widened to include additional powers?

They appear to be adequate.

Issue 7.23

Is the existing range of final orders available under s 32(3) of the MHFPA adequate in meeting the aims of the section? Should they be expanded?

The range of options is adequate. The concept of 'treatment' could be expanded along the lines suggested in [3.54] of the consultation paper.

In relation to discharge into the care of a 'responsible person', there may be some merit in clarifying the role of a responsible person, and who can qualify for that role. Whilst it would be inappropriate to be overly prescriptive about this, as some flexibility is obviously needed here, nevertheless, it may be useful to include in the statute a list of straightforward requirements to qualify as a 'responsible person'. Thought should be given to whether or not the person discharged should have to

consent to the person acting as a 'responsible person' (to overcome any difficulties in family dynamics, for example). Where the discharge is conditional, there may also be some benefit in requiring the responsible person and the discharged person to sign a form of acknowledgement of their duties and responsibilities, and the duration of the arrangement (presumably 6 months) that could be prescribed in the regulations with standard conditions, and provision for special conditions in appropriate cases as the magistrate thinks fit. The standard conditions should be fairly simple and straightforward. These might also include advising the court of any serious breaches – the court perhaps could keep a register of such agreements and provide a liaison and support contact point for 'responsible persons' who need advice, and to whom they can report serious breaches.

Issue 7.24

Are the orders currently available under s 32(3) of the MHFPA appropriate in meeting the needs and circumstances of defendants with a cognitive impairment, as distinct from those with mental health problems?

The concept of 'treatment' could be expanded along the lines suggested in [3.54] of the consultation paper.

Issue 7.25

Should s 32(3) of the MHFPA include a requirement for the court to consider the person or agency that is to implement the proposed order and whether that person or agency is capable of implementing it? Should the legislation provide for any means of compelling a person or agency to implement an order that it has committed to implementing?

The suggestion in [3.58] of the consultation paper is probably worth pursuing. However it should not be required in every case, but only when the magistrate considers it necessary that there be a commitment from an appropriate agency or facility.

Issue 7.26

Should s 32 of the MHFPA specify a maximum time limit for the duration of a final order made under s 32(3) and/or an interlocutory order made under s 32(2)? If so, what should these maximum time limits be?

Diversion is an alternative disposition of a criminal charge that is generally speaking of the less serious kind, and if the six month period were to be extended, it should not be for more than 12 months. The current capacity to use the adjournment power to effectively extend the six months period works but is probably not as transparent as it should be. There is some merit in enabling the magistrate to extend the order for up to 12 months in an appropriate case. The default position should be six months unless the magistrate otherwise orders (with a power to extend for up to 12 months).

Issue 7.27

Should the Mental Health Review Tribunal have power to consider breaches of orders made under s 32(3) of the MHFPA, either instead of or in addition to the Local Court?

No. They should go back to the court making the order.

Issue 7.28

Should there be provision in s 32 of the MHFPA for the Local Court or the Mental Health Review Tribunal to adjust conditions attached to a s 32(3) order if a defendant has failed to comply with the order?

Yes – the Local Court should have this power.

Issue 7.29

Should s 32 of the MHFPA authorise action to be taken against a defendant to enforce compliance with a s 32(3) order, without requiring the defendant to be brought before the Local Court?

The defendant should be brought back to court. The view expressed that coming back to court is too traumatic for such persons is unduly soft. The use of regular reviews of diverted persons is common in jurisdictions that have mental health courts. There is much that is positive in having the structure of court supervision. The court could also review and address any difficulties that have arisen due to unsatisfactory performance by support agencies, or problems in the relationship between the accused and any program to which the accused has been referred as part of the conditions of diversion.

It would be helpful if the Local court had appropriate liaison personnel who could assist such issues as these – for example, a responsible person may be having difficulties with the diverted accused and may need guidance or suggestions as to how to best achieve the goals of the conditions.

Supervision of diverted accused would be another function that could be performed by a Mental Health Court – see the discussion at the end of this submission.

Issue 7.30

Should the MHFPA clarify the role and obligations of the Probation and Parole Service with respect to supervising compliance with and reporting on breaches of orders made under s 32(3)? What should these obligations be?

There obviously needs to be a clear way to supervise orders when necessary and that breaches can be reported without the need to damage the therapeutic relationship between the diverted accused and their responsible person or case manager. In our view a dedicated centralised liaison staff at the Local Court (or, ideally, a mental health court) including trained social workers and/or mental health nurses would be better placed to perform this role. The involvement of Probation and Parole may appear in some cases to be somewhat heavy handed, although this is better than nothing.

Issue 7.31

Are there any other changes that should be made to s 32(3A) of the MHFPA to ensure the efficient operation of s 32?

We are attracted to the idea of a dedicated mental health court being responsible for this. See below where we set out proposals for a mental health court at the end of this submission.

Issue 7.32

Is there a need for centralised systems within the Local Court and the NSW Police for assessing defendants for cognitive impairment or mental

illness at the outset of criminal proceedings against them?

Yes. These could be achieved by the establishment of a mental health court, that would act as a convergence point for all agencies involved in these issues. This would foster the recognition of mental and cognitive impairments at an early stage of proceedings. See our submission below about a mental health court.

The current liaison service provided by Justice Health has been effective and could be extended to include persons with cognitive impairments.

Lawyers also need professional development training about identifying and dealing with clients with mental health and cognitive issues, and how best to present these matters to the court.

A mental health court would be a major force in advancing systemic improvements in how the criminal justice system deals with these kinds of matters, and in promoting best practice.

Issue 7.33

(1) Should the MHFPA expressly require the submission of certain reports, such as a psychological or psychiatric report and a case plan, to support an application for an order under s 32?

(2) Should the Act spell out the information that should be included within these reports? If so, what are the key types of information that they should contain?

There is no 'one size fits all' but, in many cases, it would be sensible to have a treatment plan and also to have a list of the kinds of issues that magistrates might request be addressed in the plans and also in any assessment reports thought necessary. These should not be universal requirements, as some cases will be self evident and clear. However, there should be a power for a magistrate to require these before making a diversion order.

In terms of delay caused by requests for reports, this problem could be vastly improved if a dedicated mental health court were to be introduced. The Toronto Mental Health Court, for example, has a forensic psychiatrist, as well as a team of suitably qualified social workers present at court to promptly assess and address such matters on the first appearance. The Vancouver Downtown Community Court has a regular presence of professionals including psychiatrists, psychologists, mental health nurses, police liaison officers and social workers available on the premises or at short notice, to prepare assessments and plans.

It is important that assessments be done without significant delays and adjournments, so that the problems can be addressed and an appropriate management plan commenced. In addition, experience has shown that many persons are lost to care or deteriorate if left to make their own way to keeping appointments with specialists etc., for the purpose of assessment.

Issue 7.34

Should the MHFPA allow a defendant to apply for a magistrate to disqualify himself or herself from hearing a charge against the defendant if the same magistrate has previously refused an application for an order under s 32 in respect of the same charge?

No. The old provisions were too problematic. The question of judicial bias should be left to the case law, which is well developed.

Issue 7.35

(1) Should there be alternative ways of hearing s 32 applications under the MHFPA rather than through the traditional, adversarial court procedures? For example, should there be opportunity to use a conferencing-based system either to replace or to enhance the current court procedures?

(2) If so, should these alternative models be provided for in the legislation or should they be left to administrative arrangement?

These matters could be addressed by the introduction of a dedicated mental health court, which could adopt a less formal procedure, although some appropriate structure that retains the authority of a court is necessary as is a certain degree of adversarial process.

The Mental Health Court in Washington DC is conducted in a very simple, small courtroom, that does not accommodate great numbers of people and is therefore quite intimate. The accused sits at the bar table with their lawyer (usually legal aid) and the judge is only a short distance away on the bench. The approach tends to be more conversational than argumentative. The advocates are specialists in this area and achieve the benefits of an adversarial system with a minimum of aggression and confrontation, particularly where an agreement has for diversion has been negotiated by the parties before court, for the court's approval.

The San Francisco Mental Health Court, on the other hand, sits in a standard large courtroom and most of the defendants on any given day are sitting in court when each matter is dealt with, and are encouraged to applaud good outcomes. There is an astonishing sense of community in this court. Significantly, it has pre-court conferences that all relevant stakeholders attend to discuss the best disposition options with the judge. Present are the relevant case manager, the lawyers, representatives from relevant agencies including housing, employment, social security, probation and parole, and other support agencies in the community with which the court has established a working relationship.

See our proposal for a mental health court below.

Issue 7.36

Should s 33 of the MHFPA require a causal connection between the defendant's mental illness and the alleged commission of the offence?

It should not be forgotten that S 33 is essentially designed to get persons believed to be mentally ill persons under the MHA to an authorised mental health facility for treatment – that will be the primary concern over & above the secondary concern of progressing their case before the court. If the person is mentally ill, but not such a danger as to fall within the definition of 'mentally ill person' in the MHA, then they can be dealt with under s 32.

There is no inconsistency between s 32 and s 33 – they serve different purposes.

A causal connection should not be required. As with s 32, it should certainly be a

factor that the court can take into consideration, but should not be required or determinative (see response to 7.18).

If the hospital returns the person to court with a finding that the person is not a mentally ill person needing involuntary care, the court can still deal with the person under s 32 if the court considers the person still has one of the requisite conditions.

Issue 7.37

Are the existing orders available to the court under s 33 of the MHFPA adequate and are they working effectively?

Many of the same issues arise here that arise under s 32 and we refer to our submissions in relation to those matters above.

The extensive co-operation required between the court and relevant service providers in order to effectively use Community Treatment Orders, could be vastly improved and streamlined if a mental health court were introduced; CTO's may well be underused by magistrates as a result of the effort required, in the context of a busy local court list, to bring one about.

Issue 7.38

Should legislation provide for any additional powers to enforce compliance with an order made under s 33 of the MHFPA?

Many of the comments we have made above in relation to enforcement of conditions imposed under s 32 equally apply to s 33.

Issue 7.39

Is it preferable to abolish s 33 of the MHFPA and broaden the scope of s 32 of the MHFPA to include defendants who are mentally ill persons?

No. S 33 is an important provisions enabling mentally ill persons to be assessed and, if necessary treated, promptly. This power is not expressly set out in s 32 and it is important that s 33 remains. The power to order a CTO in this and other contexts (see MHA s 35(5) and 53) generally requires that the person be a mentally ill person, (or in danger of relapsing into a state of mental illness).

Issue 7.40

Does 10(4) of the MHFPA provide the superior courts with an adequate power to divert defendants with a mental illness or cognitive impairment?

No.

S 10(4) was considered by the Court of Criminal Appeal in ***Newman v The Queen*** (2007) 173 A Crim R 1; [2007] NSWCCA 103.

In that case, the applicant was the subject of a fitness hearing in respect of charges against him for three counts of assault and one count of malicious wounding. The charges arose out of two incidents when the accused attended at the office of the principal of a public high school and assaulted the principal and deputy principal. He was scheduled under the *Mental Health Act* shortly after his arrest. At the fitness hearing, his counsel submitted it was an appropriate case for dismissal under s 10(4). This was rejected by the judge. The applicant then appealed under s 5F of the Criminal Appeal Act, 1912 (which relates to appeals from interlocutory judgments or

orders – the court held that it had jurisdiction under this section). It was argued on appeal that the trial judge had not had proper regard to the 'diversionary' and 'disability' purposes of the Act and had approached the s 10(4) issue as if it was a sentencing exercise. The Court rejected this argument, holding that s 10(4) was analagous to the power of a court to dismiss charges without recording a conviction, even where a charged is proved (per Spigelman J (Bell and Price JJ concurring) at [36] – [46]).

In our view it seems somewhat arbitrary that diversion should effectively be unavailable simply because of the level of Court that the charges are pending in. Sometimes even comparatively serious indictable matters will warrant consideration for diversion. In San Francisco, the mental health court will accept sentenced felons serving prison time for serious crimes (but there are some excepted crimes such as murder and rape), into its programs, provided there is an acknowledgement of guilt and they are assessed as suitable candidates. This assessment process is rigorous, but it enables persons whose past crimes have been largely the result of their untreated illness, to be salavaged from the brink and rehabilitated through the intensive program offered by the court. The successes in that court have been remarkable.

We support the introduction of diversion in the superior courts, although the manner in which this could best be done will require considerable thought. In some cases involving indictable matters that can be dealt with summarily, it may be appropriate for the matter to be remitted to the Local Court.

Again, this is an issue that could be squarely addressed by the establishment of a Mental Health Court, to which matters considered possibly suited for diversion by the court, could be referred for assessment, and, if determined appropriate by the Mental Health Court, for diversion. If assessed as unsuitable, they could be sent back to the referring court.

Issue 7.41

Should s 32 and 33 of the MHFPA apply to proceedings for indictable offences in the Supreme and District Courts as well as proceedings in the Local Court?

Yes. However the difficulty will be in ensuring there is sufficient back up and support from stakeholders and relevant agencies. This is another way in which a mental health court could assist; by concentrating professional psychiatric, psychological, nursing and social work resources and connections and liaisons with stakeholder and agencies under one roof, the best and most efficient co-ordination of resources could be achieved in the Sydney metropolitan area. Supervision and enforcement avenues would be enhanced, and the court would become a centre for excellence in standards of practice & procedure.

Issue 7.42

(1) Should there be a statement of principles included in legislation to assist in the interpretation and application of diversionary powers concerning offenders with a mental illness or cognitive impairment?

(2) If so, what should this statement of principles include?

A statement of principles would be helpful. It should contain a clear statement of the purpose of diversion and the factors that should be considered in the decision whether or not to divert. However, these should not be over-prescriptive, as flexibility is required.

Issue 8.1

Should the Crimes (Forensic Procedures) Act 2000 (NSW) be amended to require the destruction as soon as practicable of forensic material taken from a suspect following a diversionary order under s 32 or s 33 of the Mental Health (Forensic Provisions) Act 1990 (NSW), or should the legislation be amended in some other way referable to the particular order made?

In the absence of any conviction, forensic material should not be retained beyond the period of currency of the diversionary order. However, if there is a breach, and proceedings are recommenced, this should be retained in the usual way. If, however, diversion is extended to the Superior Courts dealing with more serious cases, then there may be a stronger argument for retention of the forensic material, particularly if the threshold test is that the court requires a finding of at least a prima facie case.

The destruction should be delayed pending the expiry of any period (up to 12 months) in which the diversionary order could be dealt with for breach, plus a further period (perhaps 6 months) to allow for the continuation of proceedings if diversion has failed.

Issue 8.2

Should the Crimes (Forensic Procedures) Act 2000 (NSW) be amended to require the destruction as soon as practicable of forensic material taken from a suspect following a verdict of not guilty on the ground of mental illness?

No. Our view in this regard is different from our response to 8.1. In relation to NGMI there has been a finding at least that the actus reus of the offence has been attributed to the accused. There is a genuine issue of public safety from possible future offending by the individual found NGMI, and the issues referred to in [1.7] of the consultation paper are of increased importance.

Issue 8.3

Should the Crimes (Forensic Procedures) Act 2000 (NSW) be amended to require the destruction as soon as practicable of forensic material taken from a suspect following:

(a) a decision by the Director of Public Prosecutions not to continue with the proceedings, or

Yes – as there has been no conviction.

(b) a finding at a special hearing that, on the limited evidence available, the defendant has committed an offence?

No. Here again the issue of public protection against future offending is relevant.

If so, in what way?

N/A

Issue 8.4

Should the Crimes (Forensic Procedures) Act 2000 (NSW) be amended to require the compulsory retention of forensic material in any of the following cases, namely:

(a) persons who, because of cognitive or mental health impairment, are diverted from the criminal justice system under s 32 or s 33 of the Mental Health (Forensic Provisions) Act 1990 (NSW);

No.

(b) persons found not guilty by reason of mental illness;

No.

(c) persons, having been found unfit to be tried, are found, on the limited evidence available at a special hearing, to have committed an offence?

Yes. If the person becomes fit, a trial may take place and the material should be retained for this contingency.

If so, in what way should the legislation be amended?

N/A

A Proposal for a Mental Health Court

In response to a number of the issues raised in the Consultation Paper, we have noted the possible role that could be played by a dedicated Mental Health Court.

We think that some kind of mental health court model would make a very effective contribution in NSW and would have overwhelming support in the community. A pilot court could be established in the inner city of Sydney, and in time further courts could be established in major regional centres of the greater Sydney metropolitan area.

We note that Victoria has a pilot community court in Collingwood, and has recently commenced a mental health diversion court (for summary matters) in Melbourne. South Australia has a Magistrate's Court running a mental health diversion program (adopting a 'problem solving approach) and so does Tasmania (based largely on the South Australian model).

Whilst s 32 & s 33 of our *Mental Health (Forensic Provisions) Act 1990* have evolved into a pretty good resource for magistrates and should continue, we consider that in a large city like Sydney, there would be a good deal to be gained by establishing a mental health court that could draw on the best aspects of a number of models available for such courts, and make it appropriate to the Sydney context, bringing together timely, expertly informed, well supervised dispositions and diversion with appropriate liaison and involvement with relevant public and community services and agencies.

The experience of various mental health courts in North America is that they can be highly effective. The key is to combine legal solutions in the court with hard-hitting and reliable community based programs whose services can be marshalled through, and in co-operation with, the court, with ongoing supervision by the court for a sufficient period of time to ensure optimum outcomes.

A Mental Health Court in Sydney could perform the following functions:

- Fitness Hearings (these could be referred from all courts); the court would acquire an expertise in these. On first appearance the defendants could be referred to a duty forensic psychiatrist present at court, for the purpose of assessment. This happens, by way of example, in the Mental Health Court in Toronto Ontario, as well as in the Ottawa Mental Health Court.
- Acceptance of Guilty Pleas and sentencing in relation to persons with relevant mental conditions.
- Diversion/supervision in appropriate matters (including summary and identified/select indictable matters), as well as dealing with breaches, with a power to remit the matter back to the original referring court, where appropriate.
- Send back to referring court if there is to be a trial/special hearing.

The Toronto Court does all of these things with great effect. In addition, that court has a team of permanent social workers who liaise with community services to link defendants to critical services in the community, including drug & alcohol services, accommodation, employment, welfare, psychological services etc., as well as ongoing case management.

In San Francisco, a different but highly effective model is currently in operation, using two days per week of an existing superior court's sitting, with a very well informed judge on these issues, Judge Mary Morgan. The court's link to community services is extraordinarily good; the court employs a conferencing system where all relevant stakeholders are present at a meeting chaired by the judge. The defendant is not present, but their lawyer is, and the prosecutor also. Generally the judge is informed about the case and any proposed diversion agreement considered suitable by the prosecutor in consultation with the defence lawyer (and in accordance with the court's guidelines for diversion agreements); for ongoing supervision of cases, a case worker updates the judge on the progress a defendant is making in the program; the representatives of the community network of relevant services also have their input at the table (as to housing, employment, progress with counselling etc.); generally, a suitable disposition for the defendant is thus worked out in this intense, holistic, consultative way, so by the time the judge comes onto the bench, he or she knows what the case is about (including significant background about the defendant) and is well placed to make an appropriate disposition.

The model may call for some amendment to certain procedures. For example, participants in a number of North American Diversion schemes, such as in San Francisco and in Vancouver, will often need to sign an agreement that agencies can share information about them, in order to assist agencies in working out an efficient plan in co-ordinating their efforts. Participants in San Francisco have to agree to the process of case conferencing by the Judge with the lawyers and various agency stakeholders, in the absence of the accused participant.

We consider that New South Wales should establish a mental health court in Sydney, and those with cognitive and mental health impairments in the criminal

justice system could benefit greatly from this. Such a court would need to incorporate the features that are common to the many models available for this kind of court, which generally include:

- Agreements/contracts between the diverted person and the court or the prosecuting agency, allowing for:
    - Sharing of information/privacy waiver
    - Treatment and program implementation and compliance
    - Avoidance or reduction of penalty/conviction
- Regular monitoring/review
- High intensity of support services
    - Psychiatric/psychological assessment
    - 'Triaging'/assessment of suitability for program/diversion
    - Co-ordinated multiple agency involvement & follow up with real delivery of relevant services in accordance with an appropriate treatment plan
- Diversion, which may also include provision for
    - Community service
    - Dismissal of charges
    - restitution
- Follow up & sustainability in the community
- Specialised and well trained personnel
- Maintaining of Statistics/academic research & assessment

Consideration should also be given to vesting such a court with the jurisdiction to determine the question of an accused person's fitness for trial in indictable matters, adopting the efficient and timely approach similar to that of the Toronto Mental Health Court. Then all metropolitan Superior Courts where this issue is raised could refer the matter to the court, which could deal promptly and efficiently with this issue, utilising on-site psychiatric assessments.

Whilst the existing scheme in New South Wales under s 32 and s 33 of the *Mental Health (Forensic Provisions) Act* offers a diversionary alternative to traditional criminal justice, the fact that this jurisdiction is exercised by magistrates in local courts located in a great many locations, works against the integration and concentration of the resources necessary (be they mental health professionals, support agencies, specialist judges and advocates, or others) to truly address this problem. Whilst local mental health care services can be excellent, they rarely provide the immediate and 'wrap around' services at a level of intensity needed for optimum results in these difficult cases. The Local Court jurisdiction is summary only, and this prevents the use of specialist diversion in felonies that cannot be dealt with summarily, whereas diversion may often be appropriate in these cases. Whilst magistrates should retain their powers under s 32 and s 33, we recommend

that they also be given power to refer the more complicated and/or intractable cases to a specialist mental health court where the aforesaid resources, skills and supports would be available to properly address these matters.

Research on the efficacy of mental health courts is starting to accumulate – in a recent article[37] Judge Richard Schneider (who presides at the Toronto Mental Health Court) states:

> *There are now studies that support the previously intuitive projection that mental health courts do indeed reduce recidivism rates[38]. Studies are showing that participation in mental health court programs is associated with longer time without new criminal charges, or charges for violent crimes[39]. In addition to reducing the probability of future arrests, data are confirming that those who complete their mental health programs do better than those who do not[40]. Other reports confirm that mental health courts improve access to care[41], save the taxpayers money by keeping mentally ill individuals out of prison, reducing drug abuse, improve overall level of functioning[42], and should no longer be funded on a 'pilot project' basis[43].*

Among the stated goals of the Washington DC Mental Health Court is the reduction of the rate of gaol detention and involuntary forensic hospitalisation for program participants, thus reducing the overall costs in the Criminal Justice System, noting that the cost of one day in gaol (as at October 2007) was US$115.00 and one day at St. Elizabeth's Mental Hospital was US$650.00.

There is a mounting and compelling body of evidence that Mental Health Courts work; indeed, they have been established, in one form or another, in a number of countries but could be established in a great many more. In jurisdictions where the lack of concerted programs for the support of the mentally and cognitively impaired in the community keeps the 'revolving door' to the gaols going around, governments have an obligation to act. The establishment of mental health courts staffed by appropriate persons and backed up by proper, adequate and integrated support from government and community agencies is a proven way forward.

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[37] R. Schneider *"Mental Health Courts"* in Current Opinion in Psychiatry, Vol. 22(3), May, 2009

[38] Kaplan A., *"Mental Health courts reduce incarceration, save money"* Psychiatry Times 2007; 24:1-3

[39] McNeil D. & Binder R., op. cit.

[40] Moore M. & Hiday V., *Mental Health Court Outcomes: a comparison of re-arrest and re-arrest severity between mental health court and traditional court participants*- Journal of Law & Human Behaviour 2006; 30:659 - 674

[41] Boothroyd & Ors., *"The Broward Mental Health Court: process, outcomes, and service utilisation,* International journal of Law & Psychiatry 2003; 26:55-71

[42] Kuchn B., *"Mental Health Courts Show Promise"* Medical News Perspective 2007; 279:1641 - 1643

[43] Acquaviva, G., *"Mental Health Courts: no longer experimental"* Seaton Hall Law Review 2006; 36:971 - 1013