NSW DEPARTMENT OF HEALTH SUBMISSION TO THE LAW REFORM COMMISSION INQUIRY INTO PEOPLE WITH COGNITIVE AND MENTAL IMPAIRMENTS IN THE CRIMINAL JUSTICE SYSTEM

Summary

Under the *Mental Health (Forensic Procedures) Act* 1990 (MHFPA) people with cognitive impairment (including developmental disability, intellectual disability, brain injury and dementia) are not assisted by measures intended to encompass them, but are dealt with by measures which are based on out dated conceptions of mental illness and developmental disability. A clear definition of cognitive impairment separate from mental illness, and a definition which recognised the presence of co-morbid mental illness, are required.

The Department in principle supports a separate defence of cognitive impairment which would provide a clear recognition of the circumstances and needs of people with developmental disability, intellectual disability, brain injury and dementia when they interact with the criminal justice system. However, further consideration is required as to the processes in relation to detention and accommodation that will follow if a person is found not guilty by reason of cognitive impairment.

A defence which recognised the presence of cognitive impairment with co-morbid mental illness should assist in determining the special care needs of this group of people when they come into contact with the criminal justice system.

Existing diversionary mechanisms and orders available to the court are inappropriate for the particular needs and circumstances of people with cognitive impairment.

Definitions

- Existing definitions of "developmentally disabled", "mental illness" and "mental condition" need to be reconsidered as they rarely include people with cognitive impairment. However, should any change to the definition of “mental illness” or “mental condition” be considered necessary, these changes should be confined to the MHFPA. The existing definitions of “mental illness” and “mental condition” in the *Mental Health Act 2007* (MHA 2007) should not be changed.
- A broad definition of cognitive impairment should be set out explicitly in legislation.
- The broad definition of cognitive impairment should be formulated to:
  -include intellectual disability, developmental disability, brain injury and dementia.
  -clearly distinguish between cognitive impairment and mental illness
  -recognise the existence of co-morbid conditions.

Defences

- The Department in principle supports a separate defence of cognitive impairment (as distinct from a defence of mental illness or mental impairment, with recognition of co-morbid conditions) which would provide a clear recognition of the circumstances and needs of people with developmental disability, intellectual disability, brain injury and dementia when they interact with the criminal justice system.
- However, further consideration is required as to the processes that will follow if a person is found not guilty by reason of cognitive impairment. Will such a person be liable for detention following a finding of not guilty by reason of cognitive impairment and if so, where will they be detained and for how long will they be detained. If detention is considered appropriate or necessary, it should be borne in mind that

cognitive impairment is not generally amenable to treatment and so detention in a health facility would not be appropriate.
- In addition, the interaction between a defence of not guilty by reason of cognitive impairment and unfit to be tried needs further consideration. A person who meets the suggested definition of cognitive impairment may in fact meet the definitions of being considered to be unfit to be tried. In which case the person will be subject to a special hearing and limiting term. Further consideration is necessary to fully unpack the interaction between the definition of cognitive impairment, the suggested defence of not guilty by reason of cognitive impairment and the unfit to be tried system.

Diversion mechanisms
- A clear and distinct definition of cognitive impairment will assist police and the courts to recognise and identify people with cognitive impairment and their particular needs.
- The Statewide Community and Court Liaison Service (SCCLS) provides one model for early assessment of cognitive impairment which would assist the courts better identify defendants eligible for diversion.

Orders made by the Court
- The powers of the court to make orders which involve the Mental Health Review Tribunal (MHRT) may not be appropriate for people with cognitive impairment.
- Consideration should be given to having the Guardianship Tribunal perform similar functions to the MHRT with respect to people with cognitive impairment under the MHFPA, although it is recognised that this would constitute a significant and possibly inappropriate expansion of the Guardianship Tribunal's role.
- Consideration should be given to the most appropriate way to make orders for defendants with cognitive impairment and co-morbid mental illness.

1. Introduction

The NSW Interagency Service Principles and Protocols for People with Intellectual Disability and the Criminal Justice System identifies initiatives which aim to prevent criminal behaviour and divert people with intellectual disability from the criminal justice system by providing appropriate support in the community. These initiatives support the existing legislative framework.

It is estimated that a very small proportion of people with intellectual disability who come before the courts are diverted from the criminal justice system. This suggests that the majority of people with intellectual disability appearing before courts are being denied an opportunity to ensure their support needs are met and properly managed.

The current Inquiry makes particular reference to definitional issues and their bearing on mental health legislation and practical impacts. The Inquiry recognises that recommendations concerning the **availability of services and resources** are beyond its scope. However, it acknowledges that the issue is relevant to the Commission's review in terms of context, the effective operation of the criminal justice system in relation to people with cognitive and mental health impairments, the impact that service availability may have on the likelihood of such people coming into contact with the criminal justice system, and the consequences that may follow.[1]

This submission focuses on definitional issues, diversion and the implications for service provision.

2. Definitions

It would be appropriate to move away from the generally narrowly defined term "developmental disability" which generally describes a condition which is manifest during childhood (typically before 16 years). The term "developmental disability" generally fails to recognise the potential for many people with intellectual impairment to go undiagnosed well into adulthood. It also generally excludes other forms of impairment such as brain injury or dementia which may manifest in adulthood.

The Law Reform Commission (LRC) asks whether the MHFPA should include the term cognitive impairment or disability which would be defined as "a significant disability of comprehension, reason, judgement, learning or memory that is the result of any damage to, or disorder, developmental delay, impairment or deterioration of, the brain or mind". This definition is supported in principle as it would capture a greater range of impairment than the current terminology ("developmental disability"). However, as the term will be used as the basis for a defence to criminal conduct, the criteria for the defence should be at a level which ensures that the person is incapable of determining that what they have done is wrong, and that they cannot abrogate responsibility for their actions where the person understands what they have done is wrong.

Any changes to the definition of concepts regarding cognitive impairment or developmental disability should be limited to the MHFPA and should not affect the operation or effect of the MHA 2007.

2.1 Implications for the defence of mental illness

Given that the defence of mental illness is rarely relied upon by people who have intellectual disability the creation of an independent defence of cognitive impairment would in principle be a positive development. The current defence relies on the common law

[1] Law Reform Commission Consultation Paper 5, p xii, p 25.

M'Naughten rules formulated in 1843. Since this time our understanding of mental illness and cognitive impairment has moved ahead. While the M'Naughten rules are still relevant to mental illness, the differences associated with cognitive impairment are now better recognised and understood.

Creating a separate defence should clearly distinguish cognitive impairment from mental illness. This would avoid misconceptions and imprecise thinking about a range of disabilities (intellectual, developmental, brain damage, degenerative disease) which should properly be considered cognitive impairments. The presence of co-morbid mental illness presents a level of complexity which should also be addressed, as there are important implications for appropriate location and type of treatment required.

Provided that the creation of new defence is combined with appropriate powers of the Court and the relevant Tribunal to require defendants to engage with appropriate services, the creation of the new defence could facilitate better recognition of the different needs of people with cognitive impairment, and with co-morbid mental illness. This distinction is of crucial importance when the court comes to assess a defendant's eligibility for diversionary mechanisms, fitness for trial, when making orders following a special verdict and in sentencing. The current merging of developmental disability with mental illness denies people with these conditions access to a range of more appropriate options.

Alternatively, substituting the term "mental illness" with "mental impairment" may indicate that the defence applies to various states where a person's culpability (criminal responsibility) is affected, although this may not necessarily allow for the recognition of co-morbid conditions. It would require that juries and judges are aware of the various elements of mental impairment, which would include as separate elements, mental illness and cognitive impairment. To merge cognitive impairment with mental illness (in existing legal terminology) fails to recognise the different causes of impairment and the different control, care or support options for individual defendants.

Apart from co-morbid mental illness, some people with intellectual disability have co-morbid conditions such as alcohol or other drug misuse/dependence. The existence of co-morbidities adds to the complexity of diagnosis and has implications for eligibility and service needs.

However, while the Department in principle supports the creation of a new defence of cognitive impairment, further consideration is required as to the consequences of a finding that a person is not guilty of an offence by reason of cognitive impairment. Currently if a person is found not guilty by reason of mental illness, that person can be detained in a mental health facility (or other place), treated for their mental illness and released once the MHRT is satisfied that the safety of the person or any member of the public will not be seriously endangered and that other care of a less restrictive kind is available to the person. However, those with cognitive impairment are generally not amenable to treatment and, as such, further consideration needs to be given should a defence of not guilty of an offence by reason of cognitive impairment be pursued. One consideration that needs particular attention is where a person found not guilty of an offence by reason of cognitive impairment would be detained if detention was considered necessary. As cognitive impairment is not generally amenable to treatment, any detention should not take place within a mental health facility or other health facility whose focus in on treating conditions and illnesses.

In addition, should a defence of not guilty by reason of cognitive impairment be based on the Law Reform Commission’s suggested definition of cognitive impairment, serious

consideration needs to be given as to the interaction between the suggested defence and the unfit to be tried provisions in the MHFPA. A person meeting the suggested definition of cognitive impairment is also unlikely to be unfit to be tried for the offence and, as their condition will generally not improve, will be subject to a special hearing and possibly a limiting term. Thus further consideration and work are required to fully unpack the interaction between the suggested definition of not guilty by reason of cognitive impairment and the unfit to be tried system.

2.2 Service availability and delivery

People with an intellectual disability are particularly vulnerable and if not diverted from the criminal justice system their health care needs can be compounded if not properly assessed, resulting in inappropriate placement. This is more problematic where there are co-existing mental disorders or serious mental health problems. There is a need to define what treatment services would comprise for people with co-morbid mental illness and intellectual disability/cognitive impairment within correctional settings.

If mental illness is present, it may be treated in a mental health facility. Co-morbidity might involve cognitive impairment with mental health issues exacerbated by substance abuse.[2] Other intellectually disabled persons, who may be classified forensic, are accommodated in correctional facilities and those who are patients of Justice Health receive care in an ambulatory setting within a correctional centre. A number of the most vulnerable offenders are placed in Corrective Services' Additional Support Units.

The management of intellectually disabled offenders with or without mental illness requires highly specialised programs. Health interventions can be targeted to this group through strong and specialised systems of partnership between Justice Health, Corrective Services, Juvenile Justice and Ageing, Disability and Home Care (ADHC) as well as health and welfare services, to ensure that this population is identified and their health or other functional needs are met.

Planning for new service structures should take into account existing services, identified gaps in service delivery and treatment pathways for cognitive impairment. ADHC has prime responsibility in this area, and would share responsibility with Justice Health for co-morbid mental illness. The provision of step down to community care and supported accommodation are problematic as there is a lack of support services in the community to manage people with cognitive impairment.

Consideration also needs to be given to issues of security requirements. These are addressed in correctional facilities, where programs are offered in partnership with other agencies. Persons who receive a verdict of "not guilty by reason of cognitive impairment" should not generally be held in a prison environment, except where required for reasons of security, but be treated in appropriate external facilities. It is recognised however that the availability of such external facilities is limited.

3. Opportunities for diversion from the criminal justice system[3]

3.1 Eligibility for diversion in the local court

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[2] In this context people with intellectual disability who are also mentally ill are often dealt with at the local court level under s32 and s33 of the *Mental Health (Forensic Provisions) Act* 1990 and associated processes.

[3] See also Part 5 of this Submission – Diversion – for comments on specific issues relating to Consultation Paper 7.

How ever the notion "cognitive impairment" is incorporated in legislation, clear articulation will help ensure people with cognitive impairment are considered eligible for diversionary mechanisms. The current narrow understanding of "developmentally disabled" in conjunction with mental illness does not always empower the court to consider people with cognitive impairment who might otherwise be eligible for diversionary programs.

3.2 Identifying "a developmental disability"

Section 32 (1) of the MHFPA requires that a defendant has been identified as having "a developmental disability" in order to be eligible for diversion at the local court level. Where defendants in local courts are unrepresented, a significant issue of fairness arises, as they are unlikely to know what options are available before the court.

The burden of identifying impairment usually falls on a defendant's legal representative. However, the judge also has the power to order an assessment where it is perceived the defendant may have an impairment which affected them at the time the crime was committed, or which affected their capacity to understand the purpose of the trial. In addition the prosecution may raise the issue of mental illness or impairment in argument against other defences.

Ultimately the burden of identifying a cognitive impairment or a mental illness (or co-morbidity) falls on legal professionals who are not skilled or experienced in making such judgments, in which case specialist advice should be sought.

3.3 An application for diversion

In practice, an application for diversion under s 32 of the MHFPA generally requires an assessment of impairment and a care plan which identifies services and supports to be provided in order to demonstrate to the court that a defendant will not present a risk to themselves or others. It is unlikely that an unrepresented defendant would be able to make an application without assistance. A developmental disability is usually identified at local court level by a defendant's legal representative through a submission for diversion under s 32.

The LRC suggests a centralised assessment process within the local court for assessing defendants for cognitive impairment. The Statewide Community and Court Liaison Service (SCCLS) administered by Justice Health in selected local courts and the Children's Court provides one model, for people with mental illness, which could assist defendants.

Under this scheme the court is assisted by a mental health nurse who is able to diagnose and assess defendants. If it is to address all forms of impairment, this scheme would need to be broadened to include nurses with skills in assessing defendants who potentially have a cognitive impairment. While broader application would address some of these issues, it would not avoid the requirement for legal professionals to identify a defendant who has a cognitive impairment in the first instance.

A more comprehensive screening process would provide a fuller account of the incidence of mental illness and cognitive impairment in the criminal justice system. A screening process for cognitive impairment would ensure that more people eligible for consideration under diversionary mechanisms are identified.

3.4 Resource implications

It is recognised that there are significant resource implications for sufficient numbers of skilled and experienced assessors. Also, expert advice is required on what diversion or

treatment pathways are recommended, and what level of security is required. Additional screening processes and criteria for eligibility would need to be developed and applied. While an excellent model, it is recognised that the SCCLS is only one model of assisting defendants. Evidence from other Australian jurisdictions, and internationally, on the outcomes of the application of other types of comprehensive screening processes would inform this discussion.

Potential cost savings which can be achieved by diverting people with cognitive impairment away from the criminal justice system should be determined. Whole of government planning is required for the operation of an enhanced and cost-effective diversionary system and appropriate models of care.

4. Powers of the Court

4.1 The Mental Health Review Tribunal (MHRT) and cognitive impairment

In circumstances where a verdict of Not Guilty by Reason of Mental Illness for a person with an intellectual impairment is returned, the court may order:

1. detention in any place the court thinks fit until released by due process of law (i.e. detained for an indeterminate period to be reviewed by the MHRT);
2. the release of the person subject to conditions; or
3. the release of the person, without conditions if satisfied there is no risk to personal or public safety.[4]

A defendant found Not Guilty by Reason of Mental Illness becomes a forensic patient and is referred to the MHRT for further assessment.

There is no appropriate place for people with cognitive impairment in the interactions between the court and the MHRT. Processes are not designed to deal with cognitive impairment which is not amenable to treatment or cure. The needs of people with cognitive impairment are very different to the needs of people with mental illness. As its focus is primarily on dealing with the mentally ill, the MHRT may not necessarily be the most appropriate body to determine risk levels for people with cognitive impairment.

4.2 The Guardianship Tribunal and cognitive impairment

As the Guardianship Tribunal currently often deals with the cognitively impaired, the Guardianship Tribunal could be empowered to deal appropriately with people with cognitive impairment who are dealt with in the criminal justice system, but who are found not to be criminally responsible. The Guardianship Tribunal may be able to perform a role parallel to the MHRT and make referral to appropriate services. The question would arise about the powers and expertise of the Guardianship Tribunal to look at proper placement options and security level required.

It would then need to be determined which Tribunal would be responsible for dealing with people with cognitive impairment and co-morbid mental illness.

Without this equivalent system, people with cognitive impairment will be either inappropriately treated in mental health facilities or inappropriately incarcerated.

However, it is also recognised that charging the Guardianship Tribunal with making decisions as to when to release a person who has been found not guilty by reason of

[4] *Mental Health (Forensic Procedures) Act* 1990 s39

cognitive impairment may result in the Guardianship Tribunal making decisions about the cognitively impaired based on risk to the community rather than the best interests of the person. This would represent a radical departure from the current role of the Guardianship Tribunal and it may be that it is not appropriate for the Guardianship Tribunal to fulfil this role. Accordingly, a new Tribunal or other body may need to be established to make decisions about persons who have been found not guilty by reason of cognitive impairment.

5. Diversion

5.1 General Comments

- The Department of Health, through the Justice Health Statewide Community and Court Liaison Service (SCCLS) provides assessments and reports to the local courts on mental health matters and, where appropriate, assists with the diversion of individuals with mental health problems into appropriate mental health services. The Justice Health Adolescent Community and Court Team provides a similar service to the Children's Courts.

- There are some examples of persons being sent into the prison system as a result of the apparent lack of facilities providing safe containment or where no serious consideration of the matter had occurred, leading to those persons being inappropriately detained in prisons. This has affected cognitively impaired older persons with, for example, dementia. On a full and proper assessment provided in the prison environment through Justice Health services, some of these persons have been redirected back into an appropriate placement in the community with appropriate care and or treatment.

  Research indicating the growth in the numbers of such people would support the establishment of a liaison service with the courts that specialises in cognitive impairment in the aged. However this would have significant resource implications, including the provision of facilities to which such persons may be directed.

5.2 Specific Comments

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?

No, because the diagnosis of mental illness or cognitive impairment requires a detailed history and specialist assessment. If a police officer encounters a person with a suspected cognitive impairment or mental illness the most appropriate course of action would be to have the person assessed at a hospital. The existing provisions under s 22 of the MHA 2007 already permit such an action.

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?

As per advice above.

Issue 7.3
Does s 22 of the MHA work well in practice?

No comment.

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?

If the person were not already linked to a service, such as Aging, Disability and Home Care, the police would be unlikely to refer the person. There are very limited services available for people with cognitive impairment and referral to such services requires a detailed assessment from a health professional before a referral would be considered.

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?

This depends on the individual. It is more common in the SCCLS for the request to be made by a defendant's legal representative. Police Prosecutors and DPP should be instructed to seek access, where appropriate.

Issue 7.6
Do provisions in the Bail Act 1978 (NSW) setting out the conditions for the granting of bail make it harder for a person with a mental illness or cognitive impairment to be granted bail than other alleged offenders?

Probably. Many such people are homeless, have no support and have been lost to treatment. There is usually a limit of a three month stay in hostel accommodation. The persons may be banned from hostels due to their poor behaviour or because they owe money. Temporary accommodation may lead to mentally ill persons being lost to mental health services and therefore treatment.

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, in theory, but in practice, it may be difficult for the police to make a determination regarding the person's mental state. The police and the court would require specialist advice on the person's mental state.

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?

Ongoing training for police officers in relation to the identification and nature of mental illness would be of benefit in the execution of their duties. The Justice Health Statewide Forensic Mental Health Service could offer expertise and advice in this area.

Issue 7.9
(1) Should the term, "developmentally disabled", in s 32(1)(a)(i) of the MHFPA be defined?

The term need not be defined, however it should be updated to "intellectual disability".

(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?

No. Clinical definitions of conditions change over time and it would be better to describe conditions in broad terms, leaving it to the discretion of the Magistrate to determine a person's suitability for diversion.

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”?

The term “with a developmental disability” is supported in preference to the term “developmentally disabled”, but the term “with an intellectual disability” should be used for consistency with current practice.

Issue 7.11
Should the term, “mental illness” in s 32(1)(a)(ii) of the MHFPA be defined in the legislation?

The term “mental illness” is already defined in the MHA 2007 and the MHFPA should defer to that definition.

Issue 7.12
Should the term, “mental condition” in s 32(1)(a)(iii) of the MHFPA be defined in the legislation?

The term “mental condition” is already qualified as a condition for which treatment is available in a mental health facility. To more strictly define “mental condition” may serve to exclude potential defendants from being diverted under this section.

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”?

The existing term is acceptable, but it is suggested that “including a community mental health facility” be added.

(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?

People with intellectual disability cannot be provided with treatment as such to cure their condition, but would benefit from services that are aimed at ameliorating and managing their condition and improving the quality of life of the person.

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?

As per previous advice the term “intellectual disability” should replace the term “developmental disability”.

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?

Mental impairment is a broad term. If such a term were to be used, then its application should not be more restrictive than the current options available to people with an intellectual disability, mental condition or mental illness.

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?

Where mental illness, as defined by the MHA 2007 or intellectual disability, are not coexisting with a substance use disorders and personality disorders then these disorders should be excluded.

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. The seriousness of the offence is an important consideration in relation to the safety of the community.

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?

In clinical practice ascribing a direct causal link between an offence and a condition is problematic as offending, and behaviour in general, results from a complex interplay of factors internal (e.g. symptoms, personality) and external (e.g. life circumstances) to the person. As such it might be difficult in practice to show a direct causal relationship under proceedings under s 32.

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?

The decision should be left to the discretion of the Magistrate.

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?

No. The decision should be left to the discretion of the Magistrate. Including a list of factors that the court must take into account could narrow the eligibility criteria or serve to disadvantage potential defendants who may be eligible for diversion. If such a list were to be included the Department of Health would only support its inclusion were it to expand the categories of persons that could be diverted.

(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?

Any inclusion of factors on a list to guide the exercise of the court's discretion should be informed by an evidence base rather than a subjective collection of issues which may appear to have some face validity.

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?

No comment.

Issue 7.22
Are the interlocutory powers in s 32(2) of the MHFPA adequate or should they be widened to include additional powers?

No comment.

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?

No comment.

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?

Whilst the orders may be appropriate in meeting the needs of defendants with a cognitive impairment, the relevant services may not be available or able to meet the needs of such defendants.

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?

An order requiring a person or agency to implement a proposed order should not be made unless the person or agency is capable of implementing the order, and agrees to implement it.

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?

In the interests of the defendant a maximum time limit of six months should be set in order for them to know when their obligations under the order will end.

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?

This section deals with criminal matters and orders made under this section are for the purposes of diversion. The person is not detained and it is not an ongoing review process. The person may not be mentally ill or liable for detention, and therefore there would be no role for the MHRT.

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?

It would not be appropriate for the MHRT to adjust the conditions to the order as the person is diverted under this section. The person is not a forensic patient and involvement of the MHRT would mark a radical departure from its current role.

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?

S 32 does not authorise treatment to be given. It is not the role of the mental health facility to take action to enforce compliance with an order.

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?

No comment.

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?

No comment.

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?

This service is provided at several adult and juvenile courts in NSW through the SCCLS. However Legal Aid initiates most referrals, not the police. The SCCLS is able to assess referred defendants for the presence of a mental illness, but does not have the capacity to assess for cognitive impairment (apart from severe cases). Having a centralised system for the referral of cognitive assessments would be beneficial, but funding for these assessments will be an issue.

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?

This is currently undertaken by the SCCLS in courts where it operates, in order to advise the court exactly what the best treatment options are for each case. There are significant resource implications for expanding the service to other courts.

(*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?*

This issue may be better addressed in the Regulations.

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 comment.

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?

Yes, to enhance current court procedures.

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

It should be left to administrative arrangements, however for consistency of practice it may be better dealt with by regulation or court rules.

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?

See comments in relation to issue 7.18.

Issue 7.37
Are the existing orders available to the court under s 33 of the MHFPA adequate and are they working effectively?

Existing orders are adequate in principal. However the provisions in s 33 do not clearly set out the purpose for which a person is taken to a facility for assessment, and the role of the facility following an assessment, including whether a person should be detained, is also not clear. Consideration should be given to clarifying these provisions to avoid confusion amongst service providers. It is noted that any amendment to s 33 of the MHFPA would likely entail amendment to s 32 of the MHA 2007. Further consultation with the Department should take place if any such amendment is envisaged or proposed.

Issue 7.38
Should legislation provide for any additional powers to enforce compliance with an order made under s 33 of the MHFPA?

See comments in relation to issue 7.37.

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?

A process is needed whereby mentally ill persons may be taken to a facility for assessment. S 33 relates to defendants who appear to a magistrate to be mentally ill and allows for a process whereby the person may be taken to a facility and detained for assessment. Provisions which facilitate the transfer to a facility, of people who appear to be mentally ill, should continue to exist.

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?

This is a complicated matter and the interplay between any diversionary scheme at higher courts and existing mental health provisions such as those dealing with fitness and the defence of mental illness would need to be very carefully considered. The Department of Health would welcome the opportunity to be involved in any discussions which may arise on this matter.

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?

One view is that there are already specific provisions in the legislation for mentally ill persons (s 55 and s 56), unfit persons and persons Not Guilty by Reason of Mental Illness that adequately cater for defendants facing indictable offences. As per comments at issue 7.40, the interplay between any diversionary scheme at higher courts and existing mental health provisions such as those dealing with fitness and the defence of mental illness would need to be very carefully considered.

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?

No, as it appears generally the system is working but in areas of real concern general principles may not assist.