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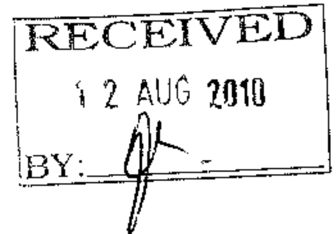

Joint submission to the NSW Law Reform Commission: people with cognitive and mental health impairments in the criminal justice system

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1. INTRODUCTION

The Brain Injury Association of NSW and Blake Dawson welcome the opportunity to make submissions to the NSW Law Reform Commission (**Commission**) on the issues raised in Consultation Papers 5-8 on people with cognitive and mental health impairments in the criminal justice system (**Consultation Papers**).

Through these submissions we aim to bring to the Commission's attention the distinct characteristics of acquired brain injury (**ABI**) as a cognitive impairment, the inadequacy of aspects of the criminal law in dealing with the culpability and suitability for diversion of people with ABI and make recommendations on a number of the issues raised in and by the Consultation Papers.

Unfortunately, due to limited time and resources, we have not been able to consult with members and with other organisations to develop views on a number of issues raised in the Consultation Papers. We would be grateful for the opportunity to comment as consideration of the issues raised continues and recommendations are developed for reform of the criminal justice system as it affects people with ABI.

2. SUMMARY OF RECOMMENDATIONS

In addition to responding to certain issues raised in the Consultation Papers, we have four overarching recommendations:

Recommendation A

That all threshold criteria used to determine those defendants whose mental impairment may warrant special consideration in the criminal justice system specifically include acquired brain injury.

Recommendation B

That people involved at all points in the criminal justice system, including police, lawyers, judicial officers, and corrective services receive training on the effects of ABI.

Recommendation C

That all people entering prison and all people who have ongoing contact with the criminal justice system after the conclusion of their matter due to the conditions of their sentence or diversionary release be screened for ABI.

Recommendation D

a) That the NSW Government develop a whole-of-government approach to planning and resourcing people with ABI in the community which takes into account reducing the risk of involvement of people with ABI in the criminal justice system and reducing the risk of recidivism.

b) That the NSW government funds an independent advocacy services for people with an ABI in the criminal justice system.

c) That Corrections staff involved in planning and implementing post release programs are resourced to provide quality post-release programs for people with an ABI leaving prison.

3. THE BRAIN INJURY ASSOCIATION OF NSW

The Brain Injury Association of NSW is the peak advocacy body for people affected by ABI in NSW. Its primary role is to represent the needs and experience of people affected by ABI to government and policymakers, with a view to improving to services and legislation. The Association also provides individual advocacy for people with an acquired brain injury, an information and referral service, and a range of awareness-raising activities including training, education, and media advocacy. The Association has over 600 members, including people with an ABI, carers, service providers, and members of the community.

The Brain Injury Association of NSW considers that the criminal law in NSW, as it applies to people with mental illness and cognitive impairment, does not recognise the specific cognitive and behavioural effects of ABI which are relevant to the culpability and suitability for diversion of a person with ABI. As such, people with ABI are often disadvantaged, even in comparison with people with mental illness and other cognitive impairments, in their interaction with criminal justice system.

4. BLAKE DAWSON'S EXPERIENCE ACTING FOR PEOPLE WITH COGNITIVE IMPAIRMENT AND/OR MENTAL ILLNESS

Blake Dawson is a national (and international) law firm. For the last decade a focus of our pro bono program has been assisting people with mental illness and/or cognitive impairment and their carers.

In NSW, our practice includes:

- seconding a lawyer full-time to the Intellectual Disability Rights Service;
- acting for people with cognitive impairment and/or mental illness in a range of matters including on criminal charges, in apprehended violence order applications as both complainants and defendants, to defend applications for substitute decision-makers, to apply to revoke a substitute decision-maker, to make a Power of Attorney or Appointment of Enduring Guardian, tenancy, in *Family Provision Act* claims, in credit and debt matters, to apply for victims' compensation, in discrimination and employment claims and in negotiating with the NSW Trustee and Guardian;
- giving talks to parents, carers and caseworkers for people with cognitive impairment and/or mental illness, including on criminal law issues; and
- liaising with and supporting a number of not-for-profit service providers and their clients including Brain Injury Australia, the Intellectual Disability Rights Service, the Disability Discrimination Legal Centre, Disability Advocacy NSW, People with Disability Australia, Ability First and Northcott.

In addition to the work outlined above, Blake Dawson conducts a legal clinic each week at Lou's Place (a day centre for women in crisis in Kings Cross) and the Exodus Foundation at Ashfield. Well more than half our clients at each clinic have a cognitive impairment and/or a mental illness.

Conservatively, we have acted for more than 1,500 people with a cognitive impairment and/or mental illness and their carers in NSW in the last 10 years. Our submissions are based on our experience in undertaking the work outlined above and on the general feedback we receive from our pro bono clients with cognitive impairment and/or mental illness, their carers and the not-for-profit organisations which work with them.

5. ABOUT ACQUIRED BRAIN INJURY

5.1 What is ABI?

ABI refers to the multiple disabilities arising from any damage to the brain that occurs after birth.[1] ABI results in deterioration in cognitive, physical, emotional and/or independent functioning.

Common causes of ABI include physical trauma, stroke, brain tumour, infection, poisoning, lack of oxygen, alcohol and other drug abuse and degenerative neurological disease such as Parkinson's, Alzheimer's and Multiple Sclerosis.

Traumatic brain injury (**TBI**) is the form of ABI which occurs when an external force traumatically injures the brain. TBIs are commonly caused by motor vehicle accidents, assaults (such as blows to the head and "shaken baby syndrome"), contact sport and falls. The majority of people with an ABI who come in contact with the criminal justice system will have sustained a TBI.

ABI is often called the "hidden disability" because it affects intangible processes like thinking and behaviour. It is less readily identified and recognised than mental illness and other forms of cognitive impairment such as intellectual disability.

5.2 Incidence of ABI in Australia

ABI is common in Australia. In 2003, the Australian Bureau of Statistics estimated that 432,700 people (2.2% of the population) had an ABI with "activity limitations" or "participation restrictions" due to their disability. Approximately 160,000 of those people had "severe or profound core activity limitations".

Breaking down those figures further:

- almost three out of every four people were aged under 65 years
- two in three acquired their injury before the age of 25
- three out of every four were men
- stroke was the leading cause of ABI, then accident or other trauma.

The sample of 14,000 households from which the above numbers derive excluded people in gaols and correctional institutions, living in rural and remote areas and people who are homeless. All these groups have a high prevalence of people with ABI. Because of the deficiencies in the Australian Bureau of Statistics' sampling, Brain Injury Australia estimates that over 500,000 Australians have an ABI.

5.3 Symptoms of ABI

People with ABI experience a range of disabilities which affect them physically and in the way they think, feel and behave.

Brain injury is different and unique for each person. Each person with ABI has different impairments and different capacity to recognise and compensate for those impairments. Table 6.3 on page 5 lists many of the effects of ABI.

The nature and extent of the changes in a person depends on the type of ABI, the severity of the injury, the location of the injury and how well the person is integrated back into the community.

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[1] National Community Services Data Dictionary Version 4

People with ABI commonly have multiple disabilities. The 2003 Bureau of Statistics Survey found one in four people with ABI had four or more disability groups (as against one in 18 for all people with disability) and one in three had five or more health conditions (as against one in eight of all people with disability).

While recovery is different for everyone, generally a person with ABI experiences the greatest improvement in the first two years following the incident causing their ABI with limited improvement thereafter.

The May 2004 *Brain Injury Outcomes Study* considered 180 people with severe TBI sustained between 1999 and 2001. Three years after their trauma most had made a good recovery in the physical domain, with only 10% having continuing significant impairment which interfered with everyday functioning and mobility. However, for many clients, clinically significant impairment persisted in cognitive and behavioural domains. For example, 61% continued to have memory deficits and 52% continued to have difficulty with problem-solving three years later.[2]

In understanding ABI and in considering whether or not a person's ABI is likely to be relevant to his or her criminal culpability or justify his or her diversion from the criminal justice system, it is important to understand a little about the brain and forms of brain injury.

The brain is comprised of two *hemispheres*. The left hemisphere regulates speech and language, and the right, visual perception and interpretation of non-verbal information. Each hemisphere is divided into 4 lobes.

The *frontal lobes* are involved in problem-solving, planning, making judgments, abstract thinking and regulating how people act on their emotions and impulses. An injury to the frontal lobe is most likely to be relevant when a person with ABI comes in contact with the criminal justice system.

The *temporal lobes* are involved in receiving and processing auditory information including speech, long comprehension, visual perception, memory, learning, organising and categorising information. An injury to the temporal lobe is likely to be relevant in determining whether or not a person is fit to be tried.

The *parietal lobes* are responsible for sensation and body position and understanding time, recognising objects and judging the position of objects.

The *occipital lobes* are responsible for receiving, integrating and interpreting visual information about colour, shape and distance.

A brain injury may be diffuse or focal. A *diffuse* brain injury (which often occurs when a person's head is shaken, for example when babies are shaken or in motor vehicle accidents) manifests with little apparent damage in neuroimaging studies, but lesions can be seen with microscopic techniques post-mortem. A *focal* injury, (which is generally acquired from a blow to the head, for example from an assault or fall) often produces symptoms relating to the function of the damaged area. The most common areas to have focal lesions are the orbitofrontal cortex and the anterior temporal lobes. These areas are associated with social behaviour, emotional regulation, sense of smell and taste and decision-making.

For two in every three people with an ABI 'challenging behaviours' are the most disabling consequence of their injury. Many experience increased irritability, poor impulse control, verbal and physical aggression and disinhibition.

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[2] Cameron, Tate et al, *Brain Injury Outcomes Study*, University of Sydney, 2004 (http://www.lifetimecare.nsw.gov.au/Brain_Injury.aspx

Table 6.3 Effects OF ABI

Cognitive Effects
• Difficulty processing information (decreased speed, accuracy and consistency) • Shortened attention span • Inability to understand abstract concepts • Impaired decision-making ability • Inability to shift mental tasks or follow multi-step directions • Poor concentration • Memory loss or impairment • Language deficit (difficulty expressing thoughts and understanding others) • Problems learning new information • Reduced memory for new information • Problem-solving, planning and organisational difficulties • Fixed patterns of thinking • Difficulty interpreting social cues
Perceptual Effects
• Changes in vision, hearing and sense of touch • Loss of sense of time, space and spatial orientation • Disorders of smell and taste • Altered sense of balance • Increased pain sensitivity

Physical Effects
• Persistent headache • Extreme mental and/or physical fatigue (exacerbating poor memory, concentration, planning etc) • Disorders of movement: gaiting, ataxia, spasticity and tremors • Seizure activity (traumatic epilepsy) • Impaired small motor control • Sensitivity to light and/or noise • Sleep disorders • Paralysis • Speech that is unclear due to poor condition of muscles in the lips, tongue and jaw and/or poor breathing pattern • Weakness and clumsiness • Chronic pain
Behavioural and Emotional Effects
• Irritability and impatience • Impulsivity • Self-centredness • Lack of insight • Reduced tolerance for stress • Lack of initiative – apathy • Dependant (failure to assume responsibility for one's actions) • Denial of disability • Lack of inhibition (may result in aggression, swearing and inappropriate sexual behaviour) • Inflexibility (causing difficulty recognising and changing thoughts and behaviour) • Flattened or heightened emotional responses and reactions • Sadness and/or grief • Depression and/or anxiety • Loss of self esteem • Change in personality including difficulty in emotional control • Uses of substances such as alcohol and other drugs

5.4 Differences between ABI, intellectual disability and mental illness

ABI is often mistaken for or conflated with intellectual disability and/or mental illness.

According to the Intellectual Disability Rights Centre, an intellectual disability primarily affects the way you learn. To be diagnosed with an intellectual disability a person must have acquired the disability before the age of 18, have an IQ of 70 or under and have deficits in at least 2 areas of adaptive behaviour.

A person with ABI, on the other hand, generally retains their level of intellectual functioning, may or may not have acquired their disability before the age of 18 and may or may not have deficits in the areas of adaptive behaviour relevant to a diagnosis of intellectual disability.

A mental illness is an abnormality in the functioning of the brain which does not arise from a physical condition. In contrast, an ABI is an observable abnormality in the structure of the brain; that is, a physical condition which causes a change in function. A mental illness is characterised by the presence of symptoms including, delusions, hallucinations, serious disorder of thought form, severe disability of mood, sustained or repeated irrational behaviour. Mental illness is generally episodic and a person with a mental illness can generally be assisted by medication to cope with their disability. An ABI is permanent, and, while some effects may be relieved in part or whole by medication and/or ongoing rehabilitation, many are not treatable.

5.5 Co-morbidity of ABI and mental illness

While ABI is different from mental illness, there is evidence of a strong association between ABI and mental illness.

ABI causes mental illness. After an ABI an individual has a 4 in 5 likelihood of developing a diagnosable mental illness. The disadvantage experienced by a person with an ABI is compounded by the onset or pre-existence of a mental illness or mental disorder.

A 2006 study by the Australian Institute of Health and Welfare found that, when compared with all disability groups, people with ABI were more likely to have multiple conditions including mental health problems.[3]

The example of James Hadfield in Consultation Paper 5 is a good example of a person with an ABI who also developed a mental illness.

5.6 Treatment and services for people with ABI

A person with an ABI will require different treatments and have different support needs depending on his or her condition. Services for rehabilitation and long-term care of people with ABI is limited, with few accommodation options beyond family care or aged care facilities. Some ABI sufferers, though physically fit, are psychologically and socially disabled with unique and individual care needs that are not met by generic or aged care services. Many people with ABIs remain highly dependent on either their families and/or community services for ongoing care, regular supervision and support.[4]

While some people with ABI may end up living in psychiatric hospitals because of changes to their psychosocial functioning brought on by their injury and/or a lack of assistance and ongoing support, treatment provided by mental health facilities is seldom appropriate for

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[3] Grimshaw, L, *Complexities of co-morbidity (acquired brain injury and mental illness) and the intersection between health and community service systems*, 2007 (http://www.braininjuryaustralia.org.au/docs/FaCSIA%20-%20ABI%20-%20Mental%20illness%20Dual%20DisabilityPaper-%202007_final.pdf

[4] Brain Injury Association of Queensland, *Synapse*, March 2003, p15.

people with ABI. One-third of clients in mental health services have an ABI and this compromises their treatment. Others with ABI who require mental health services have difficulty accessing these services as people with ABI often do not meet the entry criteria for the service, the service is not able to assist people with dual diagnosis or the person is refused admission due to a belief that it is not possible to have an ABI and a psychiatric condition.[5] Where people first experienced mental health concerns after the onset of an ABI, they found it particularly hard to access mental health services.

In NSW we have a fragmented and inadequate community-based disability support system, which (while slowly improving), historically has not supported people with an ABI. This undoubtedly contributes to people's involvement in the criminal justice system as they may be unsupported, in unstable accommodation, without adequate care or behaviour management, and / or socially isolated. This is important in understanding the environment that leads to people with an ABI into the criminal justice system and remaining stuck within the system once there.

6. ABI AND THE CRIMINAL JUSTICE SYSTEM

6.1 Overview

> *I got 3 years for assault. It's kind of ironic. I got my brain injury from being assaulted myself. I went from being this pretty chilled out kind of guy to blowing my stack at everything. It can take the smallest thing to set me off. The problem is once the rage kicks in, there's no way I can turn it off. It doesn't matter if the guy is bigger than me or there are cops around ...*
>
> *Boz in Synapse* – the magazine of Brain Injury Association of Queensland, 2005

People with an ABI are more likely to come in contact with the criminal justice system due to their behaviours, their social situation and the treatment and misunderstanding of others. While everyone with an ABI is different, there are common behaviours which make them more vulnerable to engaging in criminal behaviour either wittingly or unwittingly. Once in the system, there is little understanding of the effects of ABI and how it has contributed to the person's contact with the criminal justice system. The system is not equipped to recognise a person has an ABI and the implications of their ABI on their culpability, eligibility for diversion and ability to advocate their interests within the system.
People with ABI may further incriminate themselves due to their response to their environment and/or misunderstood behaviour.

Given the high incidence of assault in prisons in NSW, all people who are imprisoned are at increased risk of acquiring an ABI, and people with an ABI are at risk of acquiring another ABI.[6]

When a person with ABI leaves the criminal justice system, particularly the prison system, they are likely to have difficulty in transitioning back to community life. Many get caught in a cycle of recidivism, due in part to their difficulty transitioning and in part due to effects of their ABI (such as fixed thinking, disinhibition and poor decision-making) for which they receive no support.

The criminal justice system is often inadequate in taking into account the needs of a person with ABI in diversion or sentencing. In addition to the impact on the person with ABI, the community loses the opportunity for rehabilitation and/or support to reduce the risk of recidivism.

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[5] Brain Injury Australia, *Fact Sheet 8: Acquired brain injury and mental health services*, 2010.

[6] See for example http://www.smh.com.au/pdf/jails.pdf

6.2 Prevalence of people with ABI in the criminal justice system

The high prevalence of ABI among people in custody has been recognised in a number of studies. In 2006, Schofield, Butler et al screened 200 people entering the criminal justice system in the Hunter region of NSW for a history of TBI[7]. They collected details of past blows to the head and any associated loss of consciousness. They also took measures of mental health. The study found that 82% of those entering the criminal justice system endorsed a history of head injury, with 65% having a history of head injury with loss of consciousness and 43% having four or more head injuries (with an average of three prior head injuries). In contrast, across the general community 8-9% of people are likely to have sustained a TBI. Of those coming into the criminal justice system with a head injury, a quarter were assaulted, a slightly lower percentage received their head injury through contact sport and then through a motor vehicle accident.

In the 2009 national study by the Australian Institute of Health and Welfare on the health of prisoners, 43% of people entering prison reported receiving a blow to the head with loss of consciousness in their past. [8]

The reasons for the high incidence of people with ABI in the criminal justice system include the coincidence of risk factors for offending with the risk factors for TBI, and the effects of ABI itself. The risk factors which increase the likelihood of a person ending up in prison are also risk factors for receiving a TBI. The risk factors for TBI include that the person is male, in their late teens or early twenties, with a psychiatric illness, is of lower socio-economic status and/or has been engaged in substance abuse.

Many symptoms of ABI also predispose people to contact with the criminal justice system. People with ABI, particularly those whose frontal lobes are affected, may exhibit impulsive behaviour, anger and aggression, poor self-monitoring, poor concentration, an inability to read social cues and memory loss.

6.3 Ignorance of ABI as a distinct form of cognitive impairment

In the experience of the Brain Injury Association of NSW there is widespread ignorance of ABI as a distinct form of cognitive impairment at all levels of the criminal justice system.

In his paper "*Acquired Brain Injury and Criminal Behaviour*", Inés Manguio (psychiatrist) notes the nature and impact of brain injury are not well understood or acknowledged by policy makers in the community at large.

Manguio proposes that the reasons for this include that, in spite of recognition that, in all its complexity, the brain rules automatic and voluntary behaviour, people are reluctant to connect that clinical knowledge and its forensic application when the brain is injured. He speculates this may be due to the highly regarded and valued tradition of "free will", without which, he says, "the foundation of social responsibility and even morality would tremble".

Manguio further notes that frontal lobe disorders are the most often undiagnosed disorders in medical and forensic cases and such disorders cause symptoms which are subtle and not easily quantifiable. The only way to identify ABI, unless it has been documented through hospital records, is through full neuro-psychological assessment which is very expensive. The expense may be a further impediment to correct and timely diagnosis.

Finally, people with ABI frequently have anosognosia (an inability to recognise or admit the person's disability). People with ABI, particularly when they have made a good physical recovery, may present well. They may be unable or unwilling, however, to recognise and advise the police, their lawyer or the court of their ABI.

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[7] Schofield, P. Butler T. et al, "Neuropsychiatric correlates of Traumatic Brain Injury among Australian prison entrants," *Brain Injury* Volume 20, 13-14 December 2006, pp 1409-14118

[8] http://www.aihw.gov.au/publications/phe/123/11012-c03.pdf

6.4 Impact of ABI for a person in the criminal justice system

A person with ABI is disadvantaged in relation to the criminal justice system in three ways. The effects of ABI increase the likelihood of a person with ABI becoming involved in the criminal justice system. Once involved in that system, the symptoms of ABI mean the person is disadvantaged in their ability to advocate for themselves within the system. Finally, the provisions of the criminal law in NSW dealing with culpability and diversion from the system for people with mental illness and/or cognitive impairment do not apply or apply inadequately to people with ABI.

(a) *Effects of ABI which increase the likelihood of contact with the criminal justice system*

The effects of ABI which particularly increase the likelihood of a person with an ABI becoming involved in the criminal justice system include:

- Impulsivity
- Difficulty processing information
- Impaired decision-making and planning ability and lack of insight
- Unclear speech and problems with gait (which may cause people to assume the person is intoxicated)
- Lack of inhibition (which may result in aggression, swearing and inappropriate sexual behaviour)
- Uses of substances such as alcohol and other drugs
- Difficulty interpreting social cues and in understanding and communicating
- Inflexibility in thoughts or action which may be misread as uncooperative, aggressive or obstructive

(b) *Effects of ABI which increase the likelihood of a person with ABI being found unfit to be tried*

For a person who is involved in the criminal justice system, ABI has an impact on their fitness to be tried and their culpability. The *Presser* standards determine whether or not an accused person is fit to be tried.[9] Broadly, the standards require that the accused person is able to understand the charge, plead to the charge and participate in their own defence.

A person with ABI may have difficulty meeting the *Presser* standards due to the effects of their brain injury including:

- Difficulty processing information (decreased speed, accuracy and consistency)
- Shortened attention span
- Inability to understand abstract concepts
- Impaired decision-making ability
- Inability to shift mental tasks or follow multi-step directions
- Poor concentration

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9 R v Presser [1958] VR 45

- Memory loss or impairment (which impedes not only the defendant's ability to recall the events the subject of the charge, but also their ability to follow the trial)
- Language deficit (difficulty expressing thoughts and understanding others)
- Problems learning new information
- Reduced memory for new information
- Mental and/or physical fatigue (exacerbating poor memory, concentration, planning etc)
- Apathy
- Dependance (failure to assume responsibility for one's actions)
- Inflexibility

(c) *Effects of ABI which reduce a person's culpability*

Most offences in NSW require a person to have intended to commit the offence. Manguio suggests that in determining criminal intent, there is a conflict between our deeply held belief in the voluntary nature of our actions and the increased body of knowledge on the brain-behaviour relationship.

Brain injury, especially to the frontal lobe, results in deficits in executive functioning; that is, poor self-monitoring, planning, judgment and forethought. It may also result in rigidity and impulsivity, making it hard for a person to form a criminal intent voluntarily. Damage to the frontal lobe:

- may affect voluntary action;
- may affect the ability to plan;
- may affect the ability to identify, consider and evaluate the consequences of the person's actions;
- may affect the ability to organise events in a sequential manner (necessary for intention); and
- may affect perception.

(d) Effects of ABI which increase the likelihood of recidivism

In addition to the factors which make it more likely that a person with ABI will have contact with the criminal justice system outlined at 7.4(a), other effects of ABI also increase the likelihood of a person reappearing before the courts.

For example, an injury to the orbito-frontal region causes disruption to the emotional content of a person's memory and therefore impedes that basis for learning, especially in terms of right and wrong. You need the attachment of a positive or negative emotion to a memory to learn. There is no learning without reinforcement and without memory there is no reinforcement.

Injury to the medial areas of the frontal lobe affect a person's ability to maintain a cognitive set, leading to the person having problems sustaining a course of action. The person finds it hard to learn new behaviours, and perseveres with old patterns of action.

7. OVERARCHING RECOMMENDATIONS TO ENABLE BETTER UNDERSTANDING AND RECOGNITION OF ABI IN THE CRIMINAL JUSTICE SYSTEM

7.1 Specific inclusion of ABI in any threshold criteria

Recommendation A

That all threshold criteria used to determine those defendants whose mental impairment may warrant special consideration in the criminal justice system specifically include acquired brain injury.

(a) ***Why should ABI be included?***

A person's mental illness and/or cognitive impairment is relevant to their involvement in and treatment by the criminal justice system at many points, from first contact with police to completion of the person's penalty. The various justifications for a person receiving special consideration within the criminal justice system on the basis of their mental illness and/or cognitive impairment apply to many people with ABI.

We recognise that some people with ABI do not have impairments which would reduce their culpability nor justify diverting them from the criminal justice system. However, the same may be said of a person with a mild intellectual disability or mild depression or other mental illness, depending on the charge.

Once a person with ABI meets the threshold, like a person with mental illness or other form of cognitive impairment, they may or may not meet the other criteria for diversion or reduced culpability in determining liability or in sentencing.

(b) **Why we support the specific inclusion of ABI**

The criteria for diversion and reduction of culpability were largely developed to address the issues raised by intellectual disability and mental illness. Accordingly, ABI often meets these criteria uncomfortably or not at all (see, for example, the discussion under Issue 7.9(1)of these submissions).

As discussed at 6.4 of these submissions, ABI is often conflated with mental illness, and, more often, intellectual disability. The danger of this in the criminal law is that laws which are crafted on the basis of the features of intellectual disability may exclude people with ABI who may have an equal claim to special consideration. Without the specific inclusion of ABI as a cognitive impairment the law is likely to continue to develop to accommodate the features of mental illness and intellectual disability, resulting in exclusion of people with ABI from special consideration and/or ambiguity about whether or not people with ABI meet the threshold criteria.

As discussed, there is widespread ignorance of ABI and its effects. Specifically including ABI in any threshold definition would require lawyers and judicial officers to increase their awareness of and turn their mind to ABI. This is likely to result in increased knowledge and recognition of ABI as affecting a person's culpability for their criminality and/or their claim for diversion.

Recommendation B

That people involved at all points in the criminal justice system, including police, lawyers, judicial officers, and corrective services receive training on the effects of ABI.

> *Betty was well known to the local police due to her frequent loud, angry, and confrontational behaviour in public places, which frightened and alarmed people. The police response was generally heavy-handed. They would physically restrain her and at one point were discussing the use of tasers. The Brain Injury Association of NSW worked with the police concerned to change their response to a less confrontational approach, understanding Betty was not actually threatening violence, but was responding to her own frustration and sense of not being understood. This involved reframing her behaviour. The police went from seeing her as a 'difficult' person to be managed and restrained, to understanding her as a person with an ABI who needed to be heard and understood. Once she feels she is being listened to, and when not overwhelmed by a situation, Betty is a highly intelligent person who understands and remembers what she is told, and is able to communicate her needs clearly. Her behaviour can settle quickly and easily.*
>
> Case example from The Brain Injury Association of NSW

Given the widespread ignorance of ABI the presence of a brain injury in a defendant often goes unnoticed. We submit there is a need to educate people within the criminal justice system on ABI.

The training should include, at a minimum:

- What is ABI?;
- Common causes of ABI;
- How is ABI different from mental illness and other forms of cognitive impairment, in particular intellectual disability?;
- How and by whom ABI is diagnosed;
- The common effects of ABI;
- The effect on ABI on volition, reasoning, judgment, memory, learning and behaviour;
- Sources of support and assistance for people with an ABI; and
- Methods for responding to challenging behaviour.

Quality education and training has been developed for people who, in the course of their work, frequently encounter people with ABI who may have challenging behaviours.

Likewise, specific education has been developed and presented for front-line police officers in some other Australian states, as well as overseas. Such education and resources could be readily developed and implemented in NSW.

Recommendation C

That people entering prison and people who have ongoing contact with the criminal justice system after the conclusion of their matter due to the conditions of their sentence or diversionary release be screened for ABI.

Given the high incidence of ABI among people entering the criminal justice system, Schofield, Butler et al argue that all people entering the criminal justice system be

screened for ABI.[10] They argue this is needed given people with ABI may exhibit behaviours deemed to be offensive or anti-authoritarian, which can impact on correctional care management. For example, those with memory loss or a short attention span may not recall instructions from prison officers, leading to an impression they are being uncooperative or defiant.

The Office of the Public Advocate Queensland (2005) states that people with a cognitive disability within the prison system have a higher rule violation rate than other offenders, due to their inability to inhibit behaviour, apply past warnings about consequences to present behaviour, generalise learning, remember what is expected of them, and read non-verbal social cues.

When people coming into custody after sentence are identified as having an ABI, we recommend a comprehensive risk assessment be undertaken, appropriate programs and support be developed for the person while they are in prison and a plan be developed to help reintegrate the person into the community on their release, with referrals back to community-based disability and/or supported accommodation services where necessary.

We further submit that people should be screened for ABI when they are diverted from the criminal justice system with conditions attached to their diversion (for example, a conditional release under s32(3)(a) of the MHFPA) or when they are given a penalty which requires continuing contact with the system (for example a supervised bond or community service order). People with ABI may have impairments such as poor memory, difficulty planning and organising and apathy which make it difficult for them to comply with conditions. If an ABI is identified, the person should be assessed for the support they require to comply with the conditions of their sentence on diversion. For some people with an ABI, imposing conditions without appropriate support to enable them to meet those conditions is setting them up to fail.

Screening should be conducted by people who are appropriately skilled in the use of the screening tools being administered, and policies should be put in place to ensure the person's confidentiality and privacy are respected.

We are aware of screening programs that have been trialled in other states, including Victoria and Queensland, and recommend that similar programs be applied in NSW.[11]

Recommendation D

a) That a whole-of-government approach to planning and resourcing people with ABI in the community is developed which takes into account reducing the risk of involvement of people with ABI in the criminal justice system and reducing the risk of recidivism.

b) That the NSW government funds independent advocacy services for people with an ABI in the criminal justice system.

c) That Corrections staff involved in planning and implementing post release programs are resourced to provide quality post release programs for people with an ABI leaving prison.

While outside the remit of this inquiry, we note the inadequacy of the disability service system in providing the support needed by people with an ABI living in the community in NSW plays a role in the high level of contact of people with an ABI in the criminal justice system. This situation is slowly changing, and we acknowledge the excellent support work being done by under-resourced community services providing a range of disability and supported accommodation services.

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10 Schofield, P. Butler T. et al, "Neuropsychiatric correlates of Traumatic Brain Injury among Australian prison entrants," *Brain Injury* Volume 20, 13-14 December 2006, pp 1409-14118

11 See for example Brain Injury Association of Tasmania (2007), Acquired *Brain Injury* and the *Criminal Justice System: Tasmanian* Issues'

The broader issue of the involvement of people with ABI in the criminal justice system requires a whole-of-government approach. In order to better respond to some of the complex issues referred to in the Consultation Papers, a cross-portfolio approach is required. We recommend that Corrective Services work with the Department of Human Services, Ageing, Disability and Home Care, NSW Health, and Housing NSW to develop an interdepartmental approach to these issues.

Independent advocacy services can provide effective assistance for people with cognitive disabilities in contact with the criminal justice system at all stages. However, the level of awareness of the availability of such services among lawyers, courts, police and corrective services personnel is limited. People with ABI would have a better chance of being treated fairly and appropriately within the criminal justice system, the system would have a better chance of addressing the reasons for the person's offending and the community would be more likely to be protected from criminal behaviour if there was a funded individual advocacy service for people in contact with the criminal justice system. Through such a service, people with an ABI could be linked to an advocate experienced in advocating for people in the criminal justice system. The advocate could work with the person's lawyer (and, where applicable, with police) to ensure the effects of the person's ABI are identified and recognised and to develop a plan to address the person's behaviour which contributed to the person appearing before the court. If the person was incarcerated or received a sentence which involved ongoing contact with the criminal justice system, the advocate could work with Corrective Services and/or Probation and Parole to advocate for the person and ensure their needs are met.

The link between reduced reoffending and the availability of stable housing, employment, and social connections for people being released from prison is well established.[12] The system does not sufficiently identify people with an ABI at risk of recidivism nor the need for secure housing and meaningful social activity. People involved in post-release programs need to be better resourced and supported to provide effective planning and links with community-based services.

Hannah was recently charged and served a sentence for a minor offence for which she had been charged several times before. She continued to commit this offence as she could not remember the previous charges nor the fact that it was 'wrong'. Her behaviour was not aggressive or threatening; it was impulsive, and was in many ways a way of asking for help from the outside world. Eventually, she was incarcerated as there was simply no other way the court could find to stop her engaging in this activity. She is a classic case of the system letting her down. The severity of her ABI was not sufficient to warrant 24 hour care, and she was capable of independent living. However, she required support with behaviour management and somewhere to turn for help when she needed it (which was only sporadically); services which are simply not available in NSW.

Case example from the Brain Injury Association of NSW

8. SUBMISSIONS ON CERTAIN OF THE ISSUES RAISED IN THE CONSULTATION PAPERS

8.1 Limits on the responses in the submission

Given the breadth and detail of the issues raised in the Consultation Papers, and the limited time and resources of the authors, regrettably we are only able to make submissions on certain of those issues.

[12] Office of the Public Advocate Victoria (2004), Correctional services and advocacy

Our submissions are largely limited to attempting to ensure that where the criminal law makes special provision for people with "mental impairment", people with ABI will meet the threshold test for that special provision.

On some issues, our ability to make submissions is constrained as we have not been able, in the time available, to consult with members and clients to arrive at a position on matters which are likely to be controversial.

8.2 Consultation Paper 5: People with cognitive and mental health impairments in the criminal justice system: an overview

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 support a broad umbrella definition of mental health impairment incorporating mental illness and cognitive impairment. We consider that the definition should be included not only in the MHFPA but also at each point in the criminal justice system where it is necessary to identify threshold criteria for determining those defendants whose mental impairment may warrant:

- their diversion from the criminal justice system;
- consideration of their fitness to be tried;
- a reduction in culpability;
- special consideration during sentencing; and/or
- additional support while in prison or otherwise engaged with the criminal justice system while completing their penalty.

The benefits of an umbrella definition for people with ABI include:

- consistency in determining who does and does not meet the threshold for special consideration at each point in the system;
- clarification that people with ABI meet the threshold for special provision in areas where it is unclear; and
- it will enable the law to develop faster and more consistently to clarify the umbrella definition where needed and extend the operation of the law as appropriate as more is discovered about the brain. When the definition is extended in one area of law, that extension will apply in other areas reducing the need to litigate the threshold criteria in relation to each separate provision.

While we support the concept of an umbrella definition incorporating mental illness and cognitive disability we do not support the term 'mental impairment'. It suggests an emphasis on mental illness over cognitive disability. This may influence judges and later legislators to interpret the definition and other aspects of the law in terms of mental health considerations at the expense of cognitive impairment.

We have, however, used the terms 'mental impairment' in the submissions as the umbrella term, consistent with the terminology in the Consultation Papers.

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?

We support a definition which:

- recognises that cognitive impairment may occur at any time throughout a person's life;
- applies regardless of how the impairment was caused; and
- specifically includes ABI.

We would support the proposed definition, however, only if "cognitive impairment" is defined inclusively and specifically includes ABI. The reasons we support the specific inclusion of ABI are set out at 8.1 of these submissions. Given that our knowledge of the brain and cognition is constantly evolving we would oppose an exclusive definition of cognitive impairment.

We therefore support a definition as follows:

"Mental impairment" includes a mental illness, cognitive impairment [or personality disorder – we have no view on whether or not personality disorder should be included], however and whenever caused, whether congenital or acquired.

"Mental illness" means [insert appropriate definition. We have no view on the definition of 'mental illness'].

"Cognitive disability" means a disability in comprehension, reason, judgment, learning, volition or memory, that is the result of any damage to, or disorder, developmental delay, impairment or deterioration of, the brain or mind including

(a) *intellectual disability;*

(b) *acquired brain injury; and*

(c) *[insert other relevant conditions].*

Issue 5.3

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

We support replacing the term "mental illness" in Part 4 of the MHFPA with "mental impairment" if "mental impairment" is defined as discussed at Issues 5.1 and 5.2.

A new and more clearly defined term could overcome the current ambiguity about which conditions are covered by the defence.

As set out at 3.5 of Consultation Paper 6, the defence is grounded in two principles: the recognition of impaired mental functioning as an excuse from criminal responsibility and the protection of the community through the detention of those who, because of their mental illness, pose a threat to themselves or others. To fall within the defence it must be proven that the defendant does not know the nature and quality of his or her act or does not know the act is wrong. In light of the principles behind the defence and the knowledge the defendant requires, the cause of the person's lack of comprehension should not determine whether or not the defence applies.

We submit, however, that as the defence does not only apply in circumstances where the defendant is mentally ill, both the defence and the MHFPA should be renamed. The MHFPA is not an act dealing solely with mental health issues (unlike the MHA) but rather it determines how people with mental impairment (including people with cognitive impairment)

are dealt with in the criminal justice system. The current defence of 'not guilty by reason of mental illness' and the title of the *Mental Health (Forensic Procedures) Act* focus attention on mental illness and the defence is seen through that prism. If the defence applies more widely, both the MHFPA and the defence should be renamed.

Further, given the defence applies more widely than just to people with a mental illness, and particularly if the defence is to be extended by the replacement of 'mental illness' with 'mental impairment' as set out in Issue 5.2, the name and makeup of the Mental Health Review Tribunal should be changed to reflect that it is not just dealing with people with mental illness.

The Mental Health Review Tribunal determines whether or not a person has a mental illness in a variety of contexts such as involuntary admission to a psychiatric hospital and the making of a community treatment order. Reflecting such functions, the Tribunal is comprised of three members: a lawyer, a psychiatrist and a person with other suitable qualifications or experience. The Mental Health Review Tribunal is attuned, therefore, to mental illness above other forms of mental impairment including cognitive disability. It is less likely to have a deep understanding of cognitive impairment, including ABI, and is less likely to understand the treatment, support or rehabilitation available (or unavailable) for people with ABI.

A psychiatrist may be the appropriate expert for a person with an ABI, but, depending on the cause and effects of the person's ABI, the appropriate person may be a neurologist or other expert. Having a psychiatrist as a permanent member of the Tribunal causes the person's condition, treatment and prognosis to be seen through the prism of psychiatry.

We suggest the Mental Health Review Tribunal continues with its current name and composition for its functions under the *Mental Health Act* but is renamed and is differently composed for its functions under the MHFPA.

We note the limited circumstances in which it is appropriate to run the defence of mental illness and the concerns about the consequences of a finding that a person is not guilty by reason of mental illness. We are not able to comment on these nor other broader issues relating to the defence. However, if the defence is to be maintained, we submit it should be available to people with ABI.

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?

In lieu of the terms "mental condition" and "developmentally disabled" in the MHFPA we support an umbrella definition of "mental impairment" as discussed at 5.1 and 5.2.

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"?

We support an umbrella definition of 'mental impairment' which defines mental illness and cognitive disability separately. We support a definition of 'cognitive impairment or disability' within that umbrella definition which specifically includes ABI.

As we support an umbrella definition which would apply whenever special consideration is to be given to a person with mental illness or cognitive disability in the criminal justice system, if the MHFPA was to include a definition of 'cognitive impairment' as set out in Issue 5.5 we would suggested the definition also needs to include a disability in the ability to exercise volition and/or self-control.

We note that the umbrella definition would simply apply a threshold for consideration and for each area of law there would be additional criteria for the diversion, defence or other special provision to apply. It may be unlikely the defence of mental illness would apply to a person who has a significant disability in volition and self-control (to whom the defence of automatism is more likely to apply), but equally it is unlikely the defence would apply to a person who has a significant disability in learning (who would fall within the definition proposed at Issue 5.5) but could understand the nature and quality of his or her act and understand the act was wrong. Given the additional criteria for diversion or reduced culpability, we do not consider it necessary that any impairment or disability be 'significant'. People with more limited or less relevant disabilities would be excluded from the relevant diversion or defence by the additional criteria for that diversion or defence.

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?

There are competing considerations in determining whether or not the MHFPA should be amended to create a general power of a court order the assessment of an offender.

On the one hand, people with ABI may lack insight and/or fail to recognise their condition. On the other, there are significant concerns among some people with ABI on the use to which the information in the report may be put. The coercion required to force a person to submit to such an assessment and the utility of a report obtained without consent are also of concern.

If such a power is created, however, for people with ABI, the appropriate expert depends on how the ABI was acquired and the effects of the ABI on that person. For a person with dementia, for example, a psycho-geriatrician may be the appropriate expert. For a person with a TBI, the assessment may best be conducted by a neurologist or a neuropsychologist.

The contents of the assessment report will depend on the purpose for which it is sought, but it should, at a minimum, contain:

(a) the defendant's diagnosis and prognosis;

(b) any recommended treatment, support and/or rehabilitation;

(c) the effects of the defendant's condition that impact on his or her culpability;

(d) the effects of the defendant's condition that impact on his or her ability to instruct a solicitor and otherwise participate in proceedings;

(e) any recommended plan for treatment, support and/or rehabilitation; and

(f) where relevant, the support the defendant would required to comply with bail conditions or the conditions of any bond or other proposed sentence.

Unless the defendant provides informed consent for other uses, the use of the information in the assessment report should be restricted to consideration by the court of whether or not special provision applies on the basis of the person's mental illness and/or cognitive impairment, and, if the person is subsequently detained or convicted, use by Corrective Services and/or Probation and Parole to determine the support the person requires to complete their penalty.

8.3 Consultation Paper 6: People with cognitive and mental health impairments in the criminal justice system: criminal responsibility and consequences

(a) Fitness to be tried

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?

Given the subtle nature of the effects of an ABI for many people and given that one of the common effects of an ABI is a person's inability to recognise their disability, we support an express requirement for the court to consider the issue of the person's fitness whenever it appears that the accused person may be unfit to be tried.

(b) Defence of mental illness

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?

We do not comment on the appropriateness of the defence; however, if the defence is to continue, it should be a defence of mental impairment rather than a defence of mental illness, and mental impairment should be defined to include ABI.

We strongly support diversion from the criminal justice system for people with ABI.

We note, for the majority of people with an ABI living in the community, there is no appropriate medical 'treatment' available, as they have a permanent disability. Depending on the person's needs, there may be support services which could assist, for example, with behaviour management, and these could be considered as part of any diversion program.

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?

The law should expressly recognise cognitive impairment (and ABI specifically) as a basis for acquitting a defendant in criminal proceedings.

Given the concerns about the nomenclature of the defence of mental illness, the composition of the Mental Health Review Tribunal and the procedure following a finding of not guilty by reason of mental illness discussed at Issue 5.3 we support a separate defence of cognitive impairment as a ground for acquittal. We note the orders generally made following a finding of not guilty by reason of mental illness are inappropriate for a person with ABI who does not also have a mental illness.

Issue 6.23

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

We support extending the defence of mental illness to defendants who lack the capacity to control their actions. Impairment of volition and difficulty with self monitoring and self control are common symptoms of ABI.

The defence is grounded, in part, in the recognition of impaired mental functioning as an excuse from criminal responsibility. This justification applies equally to people who lack the capacity to control their actions.

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?

We submit that if the M'Naghten rules were reformulated in legislation the legislation should define the concept of a disease of the mind using the definition of mental impairment discussed under Issues 5.1 and 5.2.

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 other actions due to mental illness or other impairment of mental functions?

While we do not make submissions on the balance of the formulation of the defence of mental illness and the M'Naghten rules, we submit that in the phrase "the person was mentally ill so as not to be responsible, according to law, for his or her actions at the time when the action was done or omission made"[13] the term 'mentally ill' should be replaced with the term "mental impairment", defined as discussed at Issues 5.1 and 5.2.

We note the discussion in Consultation Paper 6 of other potential tests for the defence to apply. The tests are a good illustration of how ABI is overlooked in formulating definitions of cognitive impairment or mental impairment in the criminal law and why we seek to have ABI specifically included in any definition of mental impairment and/or cognitive impairment.

Shea's formulation, for example, set out at 3.75 of Consultation Paper 6, proposes that the defence should be directed to "delusions, hallucinations, severe mood disturbance (depression or elevation) and severe impairment of intellect". There is no justification for preferring psychiatric symptoms and impairment of intellect over effects of ABI such as impaired judgment, reason, volition and other forms of impaired cognition.

As discussed at 6.4, a person with an ABI may have no reduction in their level of intellectual functioning but may have impaired volition and/or cognition. They may be justified in seeking to avoid or have their culpability reduced due to their brain injury. However Shea's definition would not apply.

Similarly, Yannoulidis's approach, set out at 3.82 of Consultation Paper 6, privileges the cognitive ability to recognise the reasons for refraining from the commission of the offence over, for example, disinhibition with impaired self control.

(c) Substantial impairment

[13] s31(1) of the MHFPA

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?

We support the umbrella definition of mental impairment as set out in our discussion at Issue 5.1 and 5.2 applying to the partial defence of substantial impairment. While ABI is covered by the current formulation for the defence of substantial impairment, we support consistency in the threshold criteria for reduction in culpability and diversion in the criminal law.

(d) Forensic patients

Issue 6.93

Should different criteria apply to:

(a) different types of treatment; and/or

(b) forensic patients with different types of impairment?

The effects of ABI are different for each person. The treatment and support for people with ABI vary markedly from person to person. The differences in types of impairment and types of treatment warrant different criteria.

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 impairment?

The range of interventions under the MHA and MHFPA are inadequate for people with ABI. Additional provisions are needed for forensic patients with cognitive impairments.

Given further time, we would be happy to consider and make submissions on more appropriate criteria and interventions for the range of impairments caused by ABI.

(e) Sentencing

Issue 6.104

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

We support the inclusion in s21(a) of the CSPA of consideration of a person's cognitive and mental health in sentencing. We consider the definition of "mental impairment" discussed under Issues 5.1 and 5.2 should be included, however, rather than the term 'cognitive and mental health impairment' for the reasons discussed under Issue 5.1.

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?

We would need to undertake additional consultation to provide a view on this question. If a person with a cognitive disability is facing possible imprisonment, then a pre-sentence report may be useful, but we would only support this (given its compulsory nature) if it could capture an individual's particular circumstances and needs, including whether prison is appropriate, and whether there are more appropriate. The report would need to be completed by an appropriately skilled and qualified person, taking into account the experience and opinions of existing providers of care and support to the person.

If such a report is to be obtained, the contents should be prescribed by the relevant legislation and should contain the following:

- the defendant's diagnosis and prognosis;
- the effect of the defendant's ABI relevant to the commission of the offence and any reduction in culpability'
- the effect of the defendant's ABI relevant to his or her ability to comply with any alternative penalty to imprisonment;
- the support the defendant would need to comply with any of the alternative penalties to imprisonment and the availability of that support;
- the needs of the defendant arising from his or her disability were the defendant to be imprisoned;
- whether or not the defendant's needs can be met within the prison system;
- a recommendation as to the suitability of the defendant for alternatives to imprisonment; and
- recommendations for treatment and programs if the defendant is imprisoned.

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 the sentencing options for offenders with cognitive or mental impairments?

We support changes to the relevant legislation dealing with periodic detention, home detention, community service orders and good behaviour bonds being amended to increase the relevance and appropriateness of the sentencing options for offenders with cognitive or mental health impairments.

Given that each of these forms of penalty are an alternative to imprisonment and given the lower culpability of many people with ABI, such alternatives should be available.

People with ABI may have difficulty complying with alternatives to imprisonment without support if they have, for example, difficulty with organisation and planning, poor memory, disinhibition and aggression and/or apathy. It is important appropriate supports are in place so the person with an ABI has their best chance of successfully completing the penalty.

A number of the alternatives to imprisonment provide an excellent opportunity to give a person with ABI intensive support to address, where possible, the reasons for the person reoffending and reduce the likelihood of them reoffending.

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?

Given further time, we would be happy to consider and make submissions on these issues as they apply to people with ABI.

Issue 6.115

Should section 11 of the CSPA considering deferral of sentence be amended to refer expressly to rehabilitation or intervention programs for offenders with cognitive or mental health impairments?

While s11 of the CSPA does not exclude rehabilitation or intervention programs for offenders with cognitive or mental health impairments, in practice we have rarely seen them used for offenders with cognitive or mental health impairments.

We strongly support the amendment of s11 to expressly refer to rehabilitation or intervention programs for offenders with cognitive or mental health impairments. This will require judicial officers to turn their mind to the appropriateness of s11 for people with ABI and may allow the causes of the person offending to be addressed.

We prefer that the umbrella term and definition as discussed under Issues 5.1 and 5.2 be used in this context.

(f) s32 and s33 MHFPA

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?

A number of provisions of s 32 *Bail Act 1978 (NSW)* (**Bail Act**) make it harder for a person with ABI to be granted bail than for other offenders.

Section 32 requires the judicial officer to consider certain matters in determining whether or not to grant bail. Those conditions including the likelihood the person will appear to answer their bail having regard to their background and community ties including their residence, employment, family situation, prior criminal record, prior failures to appear and the likelihood the person will appear on bail.

As a result of their ABI, many people with ABI are homeless or have unstable accommodation (see 8.1), many have prior criminal records, many people with ABI are not in employment (see 7.4). A person with ABI may have difficulty meeting their bail conditions as a result of effects of ABI including poor memory, apathy and impaired organisation and planning which increase the likelihood of failing to report on bail or failing to appear.

We note that under s32(b)(v) of the Bail Act, a judicial officer can consider, when determining whether or not to grant bail, any special needs of the defendant arising from his or her intellectual disability or mental illness. People with ABI who do not have an intellectual disability or mental illness are not entitled to have their special needs taken into account, though their needs may equally justify this consideration.

The Bail Act is a further example of where the law has developed taking into account intellectual disability and mental illness but not ABI. This supports our argument for an umbrella definition of mental impairment which specifically includes ABI which applies whenever a person may be eligible for special consideration with the criminal justice system because of their mental impairment. If definitions are determined piecemeal in

each separate piece of legislation it increases the likelihood ABI will be left out as a condition which enables a person to receive special consideration.

We therefore submit that, among other changes, s32(b)(v) of the Bail Act be amended to incorporate the umbrella definition of mental impairment which specifically includes ABI.

Issue 7.9(1)

1. *Should the term "developmentally disabled", in section 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 in people with disabilities affecting behaviour, such as autism and ADHD?*

Should the legislation use distinct terms to refer to these groups separately?

Under the current formulation of s32(1)(a) of the MHFPA, many people with ABI are not eligible for diversion under the section . Under s32, a person may be diverted from the criminal justice system if they have a mental illness, developmental disability, or a mental condition for which treatment is available in a mental health facility. If a person with an ABI does not have a mental illness or developmental disability, they are unlikely to qualify to be dealt with under s32, as for most people with ABI it is unlikely treatment is available from a mental health facility.

We therefore support the introduction of the umbrella term discussed under Issue 5.1 and 5.2 as the qualifying criteria for consideration under s32. We consider that the umbrella definition is appropriate as the criterion to determine whether or not a person is eligible for diversion under s32 and we note our comments at Issue 5.1 on the desirability of a consistent definition.

Issue 7.11

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

See discussion under Issue 7.9(1).

Issue 7.12

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

See discussion under Issue 7.9(1).

Issue 7.13

1. *Should the requirement in section 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?*

See discussion under Issue 7.9(1).

We strongly support the legislation making it clear that treatment is not limited to services aimed at curing a condition but can include social services programs aimed at providing

rehabilitation, behaviour management and life skills and support. We note, however, that given the limited availability of services, particularly for people with dual diagnosis, the requirement for any treatment plan may, through lack of funding, be unable to be met by a person with ABI.

Issue 7.14

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

We support the replacement of the existing categories under s32(1)(a) of the MHFPA being removed and replaced by an umbrella term of "mental impairment" as discussed under Issues 5.1 and 5.2 and Issue 7.9(1).

Issue 7.15

What would be a suitable general term to determine eligibility for a section 32 order under the MHFPA? For example, should section 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?

We support the determination of eligibility for an order under s32 of the MHFPA using the umbrella definition of 'mental impairment' as discussed under issues 5.1 and 5.2. We consider that a number of conditions should be specifically included in the definition, including ABI. The list of conditions should be inclusive, not exhaustive, given our knowledge of the brain and the effect of changes to the brain is growing.

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 section 32 of the MHFPA? For example, should conditions related to drug or alcohol use or abuse be excluded? Should personality disorders be excluded?

We do not support the exclusion of conditions related to the use or abuse of alcohol or other drugs from the definition of 'mental impairment' or any other term to determine eligibility under s32. People are diverted from the criminal justice system under s32 in part because of their reduced culpability due to their impairment. At the point at which a person has a cognitive disability, particularly a permanent disability, the cause of that disability ceases to be relevant. It is the fact of their reduced culpability that entitled them to be considered for diversion, not any moral judgment as to how their disability arose.

As a practical matter, it would be difficult to exclude conditions related to the use or abuse of alcohol or other drugs. If a person acquired their brain injury because they walked onto the road and was hit by a car or fell after they had been drinking, would their condition be said to be related to their alcohol use for the purpose of s32? Further, we note the increased incidence of use and abuse of alcohol and other drugs is a symptom of ABI (discussed at 6.3). It may be difficult to separate the degree to which a person's impairment was due to the original ABI as against the alcohol and other drug abuse.

Issue 7.24

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

Section 32(3) of the MHFPA as drafted allows for appropriate orders for people with ABI. However, as applied, magistrates require the preparation of a treatment plan to address the causes of the offending behaviour or otherwise treat the person's mental impairment.

As discussed under at 6.6 and under Issue 7.13, for many people with ABI there is no ongoing "treatment" available. For many, particularly those with a dual diagnosis of mental illness and ABI, there is limited access to services. Accordingly, it may not be feasible to develop an acceptable treatment plan for some people with ABI.

Issue 7.41

Should sections 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?

We strongly support the introduction of a mechanism to allow the Supreme or District Courts to divert people with mental impairment from the criminal justice system. There are occasions when a person may have a mental impairment which does not render them unfit to be tried nor allow them to meet the threshold of the test for a finding of not guilty by reason of mental illness and yet it may be appropriate to divert the person from the criminal justice system.

The difficulty, however, with applying ss32 and 33 of the MHFPA in the higher courts is that the courts have held that the seriousness of the offence is an appropriate consideration in determining whether or not a matter should be dealt with under s32. It is unlikely, then, that s32 or s33 of the MHFPA would be used with any frequency in the higher courts.

Further, if s32 was to be extended to the higher courts, we would urge the section be amended such that it applied to anyone with a mental impairment in terms as discussed at Issue 5.1 and 5.2 of this submission. We would further urge that the requirements of a treatment plan be clarified as discussed under Issue 7.13.

8.4 Consultation Paper 8: People with cognitive and mental health impairments in the criminal justice system: forensic samples

Broadly we support the introduction of a law, drafted in terms of the Western Australian law, that identifying information of a suspect be destroyed if the charge against the suspect is finalised without a finding of guilt, except if the suspect is found not guilty by reason of unsoundness of mind.[14]

The legislation on forensic samples needs to recognise that a person who is innocent may have elected to apply for diversion from the criminal justice system because of their inability to cope with the demands of a hearing and not just on the basis of reduced culpability.

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[14] *Criminal Investigation (Identifying People) Act* 2002 (WA)