1. The New South Wales Council for Civil Liberties

The New South Wales Council for Civil Liberties (CCL) is committed to protecting and promoting civil liberties and human rights in Australia. CCL is a non-government organisation in special consultative status with the Economic and Social Council of the United Nations, by resolution 2006/221 (21 July 2006). CCL was established in 1963 and is one of Australia's leading human rights and civil liberties organisations. Our aim is to secure the equal rights of everyone in Australia and oppose any abuse or excessive power by the State against its people.

2. Executive Summary

a. CCL recommends the introduction into forensic mental health legislation of a broad umbrella term, 'mental condition', encompassing several defined sub-terms, including 'mental illness' and 'cognitive impairment'.
b. CCL supports expansion of the mental illness defence to incorporate cognitive impairment, with the defence renamed appropriately.
c. CCL recommends the inclusion of symptom-based definitions of mental illness and cognitive impairment to aid in interpretation of a defence applying to both of these sets of conditions.
d. CCL is opposed to reforming forensic mental health legislation to allow the defence to be raised without the consent of the defendant or by consent of both parties.
e. CCL recommends expanding on the conditions that the criminal court may attach to an order for conditional release, including an express option to set a time limit on such an order such that the person would be unconditionally released on the expiry of the specified time period.
f. CCL is concerned that forensic patients are not allowed sufficient opportunity to challenge their treating teams' opinion, or access independent expert opinion, about their condition and situation, and recommends policy development to achieve cultural change in this respect. CCL supports inclusion of a provision allowing forensic patients to apply for a review of their case.
g. CCL is of the view that forensic patients should not be subject to compulsory treatment unless the civil standard for compulsory treatment is satisfied and that in

all other cases forensic patients' right to exercise informed consent to treatment should be respected.

h. CCL is concerned that forensic patients are subject to forensic orders for far longer than is necessary in light of their psycho-social support needs and supports inclusion of a principle of least restriction applying to all decisions made about forensic patients as one measure to address this problem.

3. Consultation Paper 5

AN UMBRELLA TERM WITH DEFINED SUB-TERMS

Issue 5.1

CCL is of the view that a broad umbrella *term* encompassing several defined sub-terms should be included in the MHFPA. CCL, however, proposes that the new umbrella term should be 'mental condition' rather than 'mental impairment'. This would involve recasting the term 'mental condition' currently used in the MHFPA and changing its meaning, so that it becomes the umbrella term encompassing mental illness, cognitive impairment and other mental conditions dealt with by the Act. The reason for this terminology preference is that the term 'mental condition' is a less stigmatising and arguably more accurate umbrella term. This term would address arguments that people with mental illnesses, cognitive impairments (or disabilities), and other relevant mental conditions should not be thought of as 'impaired'.

The practical impact of this new approach would be to increase certainty and consistency in use of definitions and terms in the Act. It may at times be appropriate to refer collectively to the various mental conditions with which the Act is concerned, in which case the term 'mental condition' could be employed. At other times, the specific defined sub-terms could be employed, when the different mental conditions in question need to be dealt with in different ways. This approach could make it clear, for example, that 'mental illness' is a specific sub-term that equates to the term 'mental illness' in s 4 of the *Mental Health Act 2007* (NSW).

Issue 5.2

It would be appropriate to state that the umbrella term 'mental condition' (or 'mental impairment to use the term preferred by the Commission) includes mental illness and cognitive impairment, however and whenever caused, whether congenital or acquired.' The sub-terms should then be broadly defined, to avoid excluding any mental condition that may need to be covered.

CCL does not have specialist knowledge of different types of mental conditions and is therefore mindful of the fact that additional terms (beyond mental illness and cognitive impairment) may need to be listed under the umbrella term to avoid excluding any mental condition that should trigger the provisions of the Act. CCL is of the view, however, that personality disorder should not be separately referred to under the banner of 'mental condition'. If the definitions of mental illness and cognitive impairment suggested at 5.5 are adopted, personality disorders may in some instances, especially when coupled with another mental condition, nonetheless fall within the terms of these definitions.

Issue 5.3

Use of the term 'mentally ill' in Pt 4 of the MHFPA is unnecessarily narrow. This term should be replaced with 'mental condition' to make it clear that mental conditions other than mental illness may lead to a verdict of not guilty within the meaning in Pt 4 of the Act (as discussed below at 6.20-6.21).

Issue 5.4

As stated above, CCL is of the view that the term 'mental condition' should become the new umbrella term to cover several defined mental condition sub-terms. Relevant aspects of the concept of 'developmentally disabled' (i.e. developmental disabilities involving cognitive impairment) would be subsumed under the new definition of 'cognitive impairment' and need not be expressly referred to.

Issue 5.5

CCL is of the view that each sub-term (under the umbrella term 'mental condition') should be defined. 'Mental illness' should be defined as in s 4 of the Mental Health Act 2007 (i.e. not the s 14 definition of 'mentally ill person'). CCL supports the definition of 'cognitive impairment' suggested by the Commission ("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 mind") because it is a lay definition that covers a range of conditions, some of which the Act may currently be considered as excluding. CCL understands that 'cognitive impairment' would be a new legal or policy category intended to cover a wide variety of conditions, having a definition that distinguishes it from the specific medical or scientific concept of 'cognitive impairment'. Such a term could encompass: intellectual disability, autism, dementia, acquired brain injury and neurological disorders.

CCL suggests that 'cognitive impairment' be further defined by a non-exhaustive listing of specific medical conditions intended to fall within the meaning of this term, to avoid arguments having to be made about whether particular established conditions are included. For example, the proposed definition could include the following additional sentence: 'Cognitive impairment includes intellectual disability, autism, dementia, acquired brain injury, neurological disorders …'. The broad definition suggested by the Commission should still be relied on in all cases and has the advantage that it is flexible and can therefore meet the needs of unique cases which may not clearly fit into an established medical category but nonetheless call for treatment under the MHFPA and can accommodate new developments in medical and scientific knowledge in this area.

CCL does not have specialist knowledge of different types of mental conditions and is therefore mindful of the fact that additional terms beyond those suggested might need to be listed as intending to be covered by the term 'cognitive impairment'.

Additional comments

CCL understands that the terms 'mental condition' and 'mental impairment' may be associated with mental illness to the exclusion of other conditions such as intellectual disability. We are of the view, however, that 'mental condition' (or 'mental impairment' to use the Commission's preferred term) is an appropriate umbrella term because it is a lay term rather than a scientific term, which can logically be connected to a range of mind and brain-related conditions. For the proposed reforms to be successful, it is perhaps most crucial that those who use the Act are aware of the broadened application of the MHFPA and the specific intention to cover a range of conditions, especially over and above mental

illness. Reform of the Act should therefore be accompanied by initiatives to educate those who use the Act on a daily basis about the reforms and their meaning.

It would in fact be appropriate to change the title of the Act to make clear its broad application. The current wording ('Mental Health') implies that the Act pertains only to mental illnesses.

4. Consultation Paper 6

THE MENTAL ILLNESS DEFENCE – EXTENSION TO INCLUDE COGNITIVE IMPAIRMENT

Issue 6.20

The defence of mental illness should not be replaced with an alternative way of excusing defendants from criminal responsibility such as by directing them into compulsory treatment for mental health problems. It is critical that there is a trial to determine whether a defendant whose criminal responsibility is suspected of being diminished due to mental illness (or cognitive impairment) is guilty of the offence or otherwise.

Issue 6.21

CCL is of the view that cognitive impairment should also be a basis for acquitting a defendant in criminal proceedings. It would be appropriate for the mental illness defence to be extended to include cognitive impairment, but for the defence to be renamed appropriately (i.e. the mental condition defence or mental impairment defence) to ensure that it has far broader scope.

Issue 6.22

CCL does not support express extension of the mental illness defence to include personality disorder. The current formulation is sufficient to capture cases of personality disorder which, in combination with other factors, may satisfy this defence.

A SYMPTOM-BASED APPROACH TO DEFINING MENTAL ILLNESS

Issue 6.24

The mental illness defence should be available in some cases of mental illnesses characterised by the presence of delusions. If a symptom-based definition of mental illness were incorporated into the MHFPA as suggested at 6.25 below (such as that in s 4 of the *Mental Health Act 2007*), delusions would automatically be one of the symptoms to which the court would have regard when considering whether the person had a mental illness at the time of committing the offence. When considering a defendant acting under a delusional belief, the criminal responsibility of the defendant should not be measured as if the facts were really as the defendant believed them to be. A person may be acting either 'rationally' or 'irrationally' under delusions – a person behaving irrationally under delusional beliefs should not necessarily be excluded from the mental illness condition. In fact, a person behaving irrationally under delusional beliefs is arguably more likely to warrant a finding that they are not guilty by reason of mental illness.

Take the example of a person who has for years held the delusional belief that their sister is an imposter and who one day kills their sister because of this belief. This is an example which, as the Commission suggests, involves a delusional belief that has 'so deeply impaired their sense of reality and judgment that they simply cannot be held responsible for their actions'. A rational person comparator would not be logically tenable in many cases of delusional belief. The court should be considering whether the delusion has had the effect of preventing the person from understanding the nature or wrongness of their conduct, or rendering them incapable of reasoning with a moderate degree of calmness about the moral quality of their actions.

Issue 6.25

CCL in part supports Peter Shea's proposal regarding defining mental illness according to symptoms rather than syndromes. The same argument could perhaps be made in relation to cognitive impairment. The mental illness defence as formulated in the MHFPA should make it clear that both mental illness and cognitive impairment may attract these defence provisions by including t he definitions of 'mental illness' and 'cognitive impairment' as used to elaborate on the umbrella term of 'mental condition' (see 5.5 above). The current definition of 'mental illness' in s 4 of the *Mental Health Act 2007* (NSW) is a symptom-

rather than syndrome-based approach to defining mental illness, as is the definition of cognitive impairment proposed by the Commission (at 5.5).

The intention in including these two *defined* terms would be twofold: to extend the categories of conditions to be covered to include some that are currently problematic (namely cognitive impairment including intellectual disability and delusions); and to override to some degree the existing outdated common law concept of 'disease of the mind'. CCL is mindful of the fact that some physical diseases may also need to be covered by these defence provisions and that there may need to be an additional defined term to accommodate these.

Issue 6.26

If the *M'Naghten* rules were reformulated in legislation, the legislation should make it clear that the concept of disease of the mind is to be understood with reference to defined terms including 'mental illness' and 'cognitive impairment' (as per the suggestions at 6.25 above).

PROCEDURAL ASPECTS OF THE MENTAL ILLNESS DEFENCE

Issue 6.32

The MHFPA should not be amended to allow the prosecution, or the court, to raise the defence of mental illness without the defendant's consent. The common law is sufficient to cover situations in which the prosecution raises the issue and the exceptional cases in which a trial judge is able to call evidence of mental illness on their own initiative.

Article 3.a of the Convention on the Rights of Persons with Disabilities[1] provides that a paramount principle of the Convention is 'respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons'. Article 17 provides that '[e]very person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.'

[1] Opened for signature 30 March 2007, 993 UNTS 3 (entered into force 3 May 2008).

A person should not be compelled to raise the defence of mental illness. It should be a person's right to choose their path through the criminal justice and forensic mental health systems as far as possible, acting on the competent advice of a legal representative.

Issue 6.33 and 6.35

CCL is opposed to amending the MHFPA to allow for a finding of 'not guilty by reason of mental illness' to be entered by consent of both parties. As stated above, this is an issue that should be the subject of a trial with evidentiary and procedural protections provided. A process other than an ordinary trial is not appropriate to determine a matter of this magnitude affecting individual liberty.

Issue 6.34

If the defence raises the defence of mental illness, then the court should have the power to order an independent assessment of the defendant for the purpose of determining whether they are entitled to a defence of mental illness.

ORDERS FOR PEOPLE FOUND UNFIT TO BE TRIED and NOT GUILTY BY REASON OF MENTAL ILLNESS

Issue 6.47

The MHFPA should at a minimum be amended to provide an express option to set a time limit on the period of time for which conditions under a conditional release order should apply or for which a person may be detained as a forensic patient, a discretion which should always be exercised with reference to a principle of least restriction (as discussed at 6.99).

CCL is of the view that additional statutory elaboration – in broad non-exhaustive terms, similar to the conditions which the MHRT may attach to an order for leave or release under s 75 of the MHFPA – as to conditions that the criminal court may attach to an order for conditional release (or detention) would be beneficial. However, any new provisions in this regard would need to be flexible, especially given the range of different mental conditions that people who are UNA and/or NGMI may have (especially if the defence of mental illness is expressly extended to cover cognitive impairment or a separate defence

of cognitive impairment is established) and given that conditions need to be tailored to the circumstances of individual cases.

Issues 6.53-6.55

When it comes to possible kinds of "harm" to others/the public that should be relevant to decisions by the court to detain or release persons who are UNA or NGMI, physical harm should be the only kind of harm which is included. The other kinds of harms suggested for inclusion by the Commission are not serious enough to warrant the severe restrictions involved in a forensic order.

Issue 6.74

A forensic patient should be able to apply for a review of his or her case. This would be an important protection for forensic patients where new issues arise in relation to their treatment conditions in between regular reviews, such as developments in treatment plans or (restrictions on) leave privileges.

Issues 6.75 and 6.78

In CCL's experience, decision-making regarding leave and conditions of treatment and support are effectively shared between service providers and the MHRT. Service providers may unilaterally grant leave. In relation to conditional release orders, it appears that the conditions are often set by the service provider and then adopted by the MHRT rather than the MHRT being involved in shaping the conditions in question. This makes sense given that similar conditions (such as weekly contact and drug testing) are effectively set by the service without intervention by the MHRT in relation to detention.

This overlapping jurisdiction is of benefit to the extent that it allows each decision-maker to respond to individual needs as they arise. However, CCL is of the view that there is some lack of acknowledgment (culturally on the part of both service providers and the MHRT) of the MHRT's authority to make final determinations regarding leave and the setting of conditions for conditional release orders. This is understandable given that the forensic service provider has most frequent contact with the person in question and is best placed in many respects to know their condition and their personal and social situation and to liaise with other service providers and facilities in the development of care plans. Nonetheless, there should be more scope for the MHRT to make decisions which differ

from those of service providers, in particular where the forensic patient themselves wishes to request leave or conditions which are not suggested by the service provider.

It should be made clearer in legislation that there is the option of making time-limited conditional release orders, whereby the conditional release order sets a time-period after which (if conditions have been satisfied during the specified period) the person is automatically unconditionally released. This option appears to be underutilised at present. This may be due to the somewhat confusing wording of s 51(1)(b) of the MHFPA, which provides for such an option.

One questionable existing practice is for service providers (in tandem with forensic patients) to be treated as the de facto applicants for conditional and unconditional release orders. The support of treating teams will often be critical in terms of bringing sufficient evidence (which is unfortunately generally confined to clinical opinion) to support a person's release; in effect, successful conditional release applications are likely to be brought, practically speaking, 'by consent' of both the service provider and patient.

There appears, however, to be little understanding that there is the possibility for the person to bring their own conditional or unconditional release application with independent evidence in support. Although the MHFPA makes reference to the use of independent expert opinion (in s 74(d)), at present such opinion is always provided by the same team of forensic psychiatrists within Justice Health. CCL is concerned that there are no systems in place for ensuring forensic patients have access to a wider range of independent experts in this area, to enable a person to contest their treating team's characterisation of their condition and needs in some cases. The development of policy guidelines and lists of willing experts may be useful measures to assist in making a person's progress through the forensic system a course which they have greater ability to direct themselves.

Issue 6.92 Compulsory treatment of forensic patients should be excluded unless the civil standard is satisfied

Forensic patients should only be subject to compulsory treatment if they meet the civil standard for compulsory treatment (i.e. satisfy the definitions of a 'mentally ill person' or 'mentally disordered person' under the *Mental Health Act 2007* (NSW)). In any other

case, the treatment of a forensic patient should be subject to the usual principles of informed consent. Treatment should rather be determined through a process of consultation and collaboration as between service provider and forensic patient, and a patient's right to refuse treatment should be respected.

Issue 6.99 A principle of least restriction

A principle of least restriction should apply to all decisions regarding forensic patients. Sections 39 of the MHFPA (for the Court) and 43 and 49 (for the MHRT) in particular set a threshold that is almost impossible for forensic patients to meet (i.e. that 'the safety of the patient or any member of the public will not be seriously endangered by the patient's release'). Their effect is that people are detained or subject to forensic orders for far longer than is necessary to meet their psychosocial support needs. Unconditional release orders should become a viable, rather than dead letter, alternative to detention and conditional release orders for the court when making initial orders, and the Court and the MHRT should more frequently make them.

The inclusion of a principle of least restriction as an umbrella principle applying to the exercise of all decisions regarding forensic patients (and all decisions made pursuant to the MHFPA) to guide the exercise of discretion would be a critical step in legislative reform to ensure that the MHFPA serves therapeutic, recovery and diversionary goals. CCL recommends including a requirement to apply a principle of least restriction at different points throughout the Act, such as in relation to final orders made by the court for people who are UNA and/or NGMI, and for ongoing forensic patient reviews conducted by the MHRT, to make it clear that this principle must be implemented in the exercise of specific decision-making functions and is not an intangible aim which need not be strictly applied.