NSW LAW REFORM COMMISSION

Consultation Paper 5

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

January 2010

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Terms of Reference

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

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

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The closing date for submissions is 28 May 2010

Confidentiality and use of submissions

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

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

ABBREVIATIONS

COAG: Council of Australian Governments.

CP 5: Consultation Paper 5.

CP 6: Consultation Paper 6.

CP 7: Consultation Paper 7.

CP 8: Consultation Paper 8.

CP 9: Consultation Paper 9.

CROC: Convention on the Rights of the Child.

CTO: Community Treatment Order.

DSM-IV: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th edition, 2000).

HREOC: Human Rights and Equal Opportunity Commission.

ICCPR: International Covenant on Civil and Political Rights.

MHA: *Mental Health Act 2007* (NSW).

MHCPA: *Mental Health (Criminal Procedure) Act 1990* (NSW).

MHFPA: *Mental Health (Forensic Provisions) Act 1990* (NSW).

MHRT: Mental Health Review Tribunal.

MOU: Memorandum of Understanding.

NSWLRC: New South Wales Law Reform Commission.

ISSUES

Issue 5.1 - *see page 70*

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?

Issue 5.2 - *see page 70*

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?

Issue 5.3 - *see page 71*

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

Issue 5.4 - *see page 73*

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

Issue 5.5 - *see page 73*

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"?

Issue 5.6 - *see page 82*

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?

PREFACE

0.1 Issues regarding mental illness and intellectual and other cognitive disabilities are among the most difficult concerns for law and policy makers to address. As a progressive, civilised society, we seek to provide adequate care and support services for those who are most vulnerable. People with mental illness and cognitive impairments unquestionably fall into this category.

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

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

THE COMMISSION'S APPROACH

0.4 The Commission's approach throughout this review is to identify the key concepts concerning people with cognitive and mental health impairments who come into contact with the criminal justice system. Perhaps the most fundamental question is what should happen to people with cognitive and mental health impairments who commit crimes?

0.5 In determining the answer to this question, we need to ensure the integrity of the criminal justice system by balancing a just outcome for

society generally, and for victims of crime, with a fair outcome for the perpetrators. In situations where the perpetrator has a mental illness or cognitive impairment, what best meets the interests of justice may differ from the outcome that would be appropriate in ordinary circumstances. This is particularly the case where an offender's criminal actions can be attributed wholly or partially to his or her impairment.

0.6 In undertaking this task, we are cognisant of the significant number of reviews relating to this, and similar, subject matter that have preceded us.[1] Constant themes have emerged pointing to a lack of appropriate services and treatment options for people with cognitive and mental health impairments, both in and out of prison, coupled with the need for greater legislative consistency and coordination between agencies responsible for mental health service provision.

0.7 While it is not within the scope of this inquiry to make recommendations concerning the availability of services and resources, we acknowledge the impact that this may have on the likelihood of people with cognitive and mental health impairments coming into contact with the criminal justice system, and the consequences that may follow.

0.8 From our initial research, we see the issues of consistency and coordination as being particularly significant in the following respects:

- the lack of consistency in terminology used in the relevant legislation to describe the concepts of mental illness, other mental conditions, and intellectual or cognitive impairments;
- the difference in the powers that may be exercised by the Local Court, as distinct from the District and Supreme Courts, when dealing with offenders with cognitive and mental impairments;
- the different legislative recognition of mental illness and cognitive impairment; and
- the coordination between the courts and agencies responsible for the implementation of court orders with regard to offenders with cognitive and mental health impairments.

We ask questions throughout this review on these and other matters.

1. See the overview of past inquiries at [1.57]-[1.66].

A series of consultation papers

0.9 The task before us is daunting and multi-faceted. Our terms of reference require us to investigate issues relating to people with cognitive and mental health impairments across the spectrum of the criminal justice system. The Commission recognises that while these issues are interrelated to an extent, they also raise separate and discrete questions. With this in mind, rather than publishing a single, longer consultation paper, we have chosen to publish separate papers on the various subject areas coming within the terms of this reference in order to present the issues more clearly for the purpose of consultation. People with an interest and expertise in a specific area can then focus their attention on the paper dealing with that topic.

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

1. **Consultation Paper 5** – presents a background and overview of the laws affecting people with a mental illness or a cognitive impairment when they become involved as defendants in the criminal justice system.

2. **Consultation Paper 6** – considers the laws determining the nature and extent of criminal responsibility in relation to offenders with cognitive or mental health impairments, primarily in relation to Supreme and District Court proceedings, and the consequences that may follow. In particular, Consultation Paper 6 deals with:

   - fitness for trial and the options for dealing with offenders found unfit but not acquitted;
   - the elements of the defence of mental illness and how the criminal justice system should respond to offenders found not guilty on the ground of mental illness;
   - the partial defence of substantial impairment;
   - infanticide; and
   - sentencing principles and options.

3. **Consultation Paper 7** – examines the laws relating to the diversion of offenders with a mental illness or cognitive impairment away from the criminal justice system, focusing on the diversionary mechanisms available to the Local Court.

4. **Consultation Paper 8** – looks at the use of forensic samples taken from a defendant who has been diverted from the criminal justice system, or found unfit to be tried or not guilty by reason of mental illness;

5. **Consultation Paper 9** – considers issues specific to young offenders with a mental illness or cognitive impairment.

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

Structure of this Paper

0.11 This Paper provides the background for the current review, offering an historical perspective, and outlining the genesis of our Terms of Reference and the relationship of this review to previous inquiries. It contextualises our task by explaining the concepts of cognitive and mental health impairments and the incidence of those impairments in the community generally, and within the criminal justice system. Chapter 2 presents an overview of the relevant legislation, while the way in which the current system works in practice is set out in Chapter 3.

0.12 Chapter 4 notes the inconsistent legislative approach to defining mental illness, cognitive impairment and other mental conditions and seeks views on how to overcome the difficulties caused as a result. For the criminal justice system to respond effectively to offenders with cognitive or mental health impairments, the offender needs to be identified as having such an impairment. In Chapter 5, the Commission discusses the mechanisms currently available to a court to determine whether an offender has a cognitive or mental health impairment, and asks whether there should be a general power to order a medical and/or psychiatric assessment at any stage during proceedings relating to the prosecution of a criminal offence.

Preliminary consultations

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

Submissions and further consultation

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

1. Context of this review

- Historical perspective
- Background to the reference
- The review in context

HISTORICAL PERSPECTIVE

1.1 Questions concerning the extent to which criminal responsibility should be borne by those with a reduced mental capacity, and the consequences that should follow, are not new. A brief examination of how this aspect of the law has evolved helps to underscore the rationale of the current law.

1.2 Historically, people with a mental illness or intellectual impairment were largely ignored or institutionalised. Little was known about psychiatric conditions. Mental illness and intellectual disability were often conflated, and viewed with fear and prejudice. Much of the burden fell on relatives to accommodate and care for the mentally ill and impaired, either at home, or, for those wealthy enough to afford it, in private "madhouses". For those less well off, vagrancy was a common result.

1.3 From early on, the common law of England also provided for people with mental impairments to be forcibly detained, often in public asylums, such as the infamous Bedlam, or in prison.[1] Justices of the Peace were able to order the confinement of people "deprived of their reason … till they recovered their senses, without waiting for the forms of a commission or other special authority from the crown".[2] No distinction was made between those who had committed crimes and those who had not.

1.4 It is perhaps fair to say that the only time people with a mental illness or intellectual impairment attracted public attention was when they presented a public nuisance, or came into contact with the criminal

1. By all accounts, there was little difference between prisons and psychiatric institutions, since both had a custodial, rather than a remedial, focus. For a comprehensive historical account of mental illness and criminal justice in England, see N Walker, *Crime and Insanity in England, vol 1: The Historical Perspective* (1968, Edinburgh University Press).
2. W Blackstone, *Commentaries on the Laws of England: In Four Books* (1765-1769), Book 4, ch 2 (viewed at « http://www. lonang.com/exlibris/blackstone/bla-000.htm»). The *Vagrancy Acts* of 1714 and 1744 (12 Anne c 23, and 12 George II c 5, respectively) are thought to be the first statutes empowering Justices of the Peace to apprehend people who, "by lunacy, or otherwise, are furiously mad, and dangerous", and confine them for as long as "such lunacy or madness shall continue". See also; J Bennett, "Comment: Historical Notes on the Law of Mental Illness in New South Wales" (1962-64) 4 *Sydney Law Review* 9, 51-52.

justice system.[3] English courts and commentators recognised the impact that "insanity" could have on criminal responsibility. The question was not so crucial in the case of minor misdemeanors, since the consequences of a guilty verdict, being imprisonment or institutionalisation, were not that different from the general treatment received by the mentally ill.[4]

1.5 The difficulty lay with those indicted for more serious offences, such as murder or treason. Punishment for those found guilty of such crimes was generally death: either on the gallows, or, for those convicted of treason, the barbaric practice of being hanged, drawn and quartered. Given the injustice of condemning the "insane" to such a fate, courts developed the means of finding mentally ill or impaired defendants unfit to stand trial for serious felonies, or, alternatively, of exculpating them from criminal liability, or at least reducing the degree of liability and/or the consequences of a finding of guilt.

1.6 Medieval courts determined that a trial could not take place if the defendant was unable to enter a plea, or to consent to a trial by jury.[5] Recalcitrant defendants who refused to plead were imprisoned and starved, and, after 1406, crushed by weights until they either died or entered a plea. Before imposing this punishment, courts empanelled juries to ascertain whether the defendant was "mute of malice" or "mute by the visitation of God".[6] The latter category included both deaf/mute defendants, who may or may not have had an accompanying mental impairment, and those thought to be "insane on arraignment". A trial would not take place if a jury decided that a defendant had a mental impairment that rendered him or her unfit to plead.[7] In the case of a

3. That contact generally came through attempts to kill or injure members of the aristocracy or the Royal family.

4. This historical difference in approach between misdemeanors and felonies helps to explain why the procedures for diversion in the Local Court today differ from the unfitness provisions in the Supreme and District Courts: see [3.9]-[3.19], Consultation Paper 6 ("CP 6"), ch 1 and 2, and Consultation Paper 7 ("CP 7") for more detail.

5. Historians note that this was motivated as much by the desire not to frustrate the trial process and the possibility of securing a conviction as by any concern about fairness to the accused: see Walker, 220. See also D Grubin, "What Constitutes Fitness to Plead?" [1993] *Criminal Law Review* 748, 749-750, and *R v Mailes* [2001] NSWCCA 155, [112].

6. Grubin, 750.

7. Grubin, 750-751.

defendant found to be "insane on arraignment", fairness dictated that the trial should be postponed, with the accused held in prison until such time as he or she sufficiently recovered.[8]

1.7 Discussion of these issues reached its zenith in the 18th century, by which time a defendant's competency to stand trial, or to receive the full punishment of the law, turned on whether or not he or she was totally deprived of reason. One of the most colourful and influential expositions of this criterion became known as the "wild beast" test, which stated that, to be "exempt from the punishment of the law", a "man must be totally deprived of his understanding and memory, and doth not know what he is doing, no more than an infant, than a brute or a wild beast".[9]

1.8 The rigidity of the "wild beast" approach was questioned in the famous case of James Hadfield, who was tried for treason in 1800 for firing a shot at King George III.[10] Hadfield experienced delusional episodes that caused him to believe that he needed to die in order to save humanity. Prevented from committing suicide by his religious beliefs, Hadfield was convinced that he must engineer his death by other means. Hence, his attempt on the life of the monarch, and the subsequent charge of treason and death upon conviction, seemed, to him, a reasonable course of action. The court heard testimony to the fact that Hadfield had served with distinction in the army, and sustained a head injury that contributed to his delusions. However, his "madness" was not constant or generalised, and could not therefore be said to constitute a "total" deprivation of reason. Nevertheless, Hadfield was acquitted of treason, with the jury specifically grounding the decision on the basis of his insanity.

1.9 The Hadfield acquittal occurred in the same years as the first legislative statement in England concerning the impact of insanity on criminal responsibility. The floridly titled *Criminal Lunatics Act* of 1800,[11] expressly provided that insanity may be relied upon as a defence to certain serious felonies. The Act also responded to doubt expressed

8. Grubin, 751.

9. This test was articulated by Justice Tracy in the 1724 case of Edward Arnold, tried for shooting Lord Onslow: see Walker, 56.

10. *R v Hadfield* (1800) 27 State Trials 1281. See also Walker, ch 4, and R Moran, "The Origin of Insanity as a Special Verdict: The Trial for Treason of James Hadfield (1800)" (1985) 19 *Law and Society Review* 487.

11. 40 George III c 94.

during Hadfield's trial over the court's ability to order the detention of someone after they had been acquitted due to insanity, but who still presented a danger to society. In Hadfield's trial, the Court was of the view that, if such a power existed, the Court was only able to order that the defendant be detained in the place in which he had previously been remanded, being Newgate prison.

1.10 The *Criminal Lunatics Act* did more than clarify the power of a court to order the detention of a person found to be unfit, or acquitted due to insanity. It stated that, following a finding of unfitness, or a special verdict of acquittal by a jury, a court *must* order the defendant to be kept in strict custody, in such a manner as it thinks fit, until the King's pleasure be known.[12]

1.11 These examples of early case law, legislation and commentary reveal much of the philosophy underpinning forensic mental health legislation today: embodying the often competing notions of fairness, justice, risk, responsibility, dangerousness, and indefinite confinement. The ensuing two centuries have seen certain refinements made to the law in NSW, stemming in large part from a greater medical and social awareness of mental health issues, and of the distinction and overlap between mental illness and cognitive impairments. Greater recognition has also been given to viewing mentally ill and cognitively impaired offenders through a human rights lens, and acknowledging the impact of other factors, such as homelessness and lack of support services, on the disproportionately high rate of incarceration.

1.12 However, in many respects, the law has remained amazingly similar for hundreds of years.[13] Offenders in NSW with mental illnesses or cognitive impairments are housed in prison for far longer than their counterparts without illness or impairment, in some cases indefinitely. This review presents an opportunity to examine current law and practice

12. See O Dixon, "A Legacy of Hadfield, M'Naghten and Maclean" (1957) 31 *Australian Law Journal* 255, 255.

13. For a discussion of the impact of early cases and legislation on the development of Australian law, see CR Williams, "Development and Change in Insanity and Related Defences" (2000) 24 *Melbourne University Law Review* 711. See also F Walker, "Out of the Darkness and into the Light" (opening remarks at the Schizophrenia Fellowship of NSW Inc Symposium, 2003) «http://www.sfnsw.org.au/SAW/SAW2003_walker.pdf».

in light of recurring themes and endemic problems, with a view to setting directions for future reform.

BACKGROUND TO THE REFERENCE

1.13 In December 2006, the Commission's Chairperson, the Hon James Wood AO QC, wrote to the then NSW Attorney General, the Hon Bob Debus MP, advising that the Commission proposed to undertake research into two projects concerning mental health issues. The impetus for this research stemmed from a recommendation of the Criminal Justice Research network, which comprises representatives from government criminal justice agencies.

1.14 The first project involved an evaluation of the effectiveness of the orders made under s 32 and 33 of the *Mental Health (Criminal Procedure) Act 1990* (NSW) ("the MHCPA").[14] Those sections provide a mechanism enabling magistrates to divert defendants who appear to be "developmentally disabled", or who have a mental illness or disorder, away from the criminal justice system in certain circumstances.[15] These diversionary mechanisms apply only to defendants appearing before the Local Court, where the statutory provisions concerning a defendant's fitness to stand trial do not apply.[16] Part of the Commission's review involves looking at whether similar provisions should be extended to the District and Supreme courts.

1.15 The second project was a broader review of sentencing policy and procedures as they relate to people with mental health and cognitive impairments. Initially, the Commission planned to conduct a separate review of each project. However, after commencing research, it became clear that limiting the terms of reference to questions of sentencing only, precluded consideration of other relevant and significant issues, such as the criteria for determining if a defendant is fit to stand trial, and the elements of the defence of mental illness.

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14. Note that this legislation is now known as the *Mental Health (Forensic Provisions) Act 1990* (NSW) ("the MHFPA"). See [1.22]-[1.23].
15. See [1.26]-[1.33] and ch 4 regarding the types of conditions that fall within the scope of this reference.
16. See [3.16]-[3.19] and CP 7 for a discussion of s 32 and s 33 of the MHFPA. The fitness provisions, contained in MHFPA pt 2, are discussed at [3.9]-[3.15] and CP 6, ch 1 and 2.

1.16 It also became apparent that there was significant overlap between the two projects. Assessing the effectiveness of the diversionary mechanisms in Local courts, and the possibility of extending these to the District and Supreme courts, necessarily involves examining the provisions that apply to determining the fitness of defendants to stand trial in the superior courts. Accordingly, the Commission decided to collapse the two reviews together, and ask the Attorney General, the Hon John Hatzistergos, MLC, to expand the terms of reference to make the review more comprehensive.

Terms of reference

1.17 The terms of reference now provide for a general consideration of the criminal law and procedure as it applies to people with cognitive and mental health impairments. In particular, the Commission was directed to have regard to:

- s 32 and 33 of the MHCPA;
- the fitness to be tried provisions;
- the defence of "mental illness"; and
- sentencing practice and procedure.

1.18 In July 2008, the terms of reference were further expanded to include consideration of the impact of Part 10 of the *Crimes (Forensic Procedures) Act 2000* (NSW) on people with cognitive or mental health impairments dealt with under the first three dots points above. Section 88 of that Act provides for the destruction of forensic material taken from a suspect in circumstances where that person has been found to have committed the offence, but no conviction has been recorded, or where the person has been acquitted of the offence. Since no conviction is recorded where offenders are diverted under s 32 or 33, or found unfit to stand trial or not guilty due to mental illness, any forensic samples would be destroyed under s 88. The Commission has been asked to consider whether or not this practice should continue to apply in such circumstances.[17]

17. See Consultation Paper 8 ("CP 8").

Relationship to previous reviews by this Commission

1.19 In the 1990s, this Commission conducted a review of *People with an Intellectual Disability in the Criminal Justice System*. That review saw the release of seven publications, culminating in the final Report in 1996.[18] Despite the intervening 12 years, many of the problems highlighted and recommendations made remain valid and relevant.[19] Some of the recommendations have been implemented, most notably in the 2005 amendments to the MHCPA.[20] The Report's influence on other reviews and administrative policy is undeniable. While intellectual disability and mental illness are different concepts, they share many related issues in terms of their intersection with the criminal justice system. Consequently, the findings of the 1996 Report serve as a valuable reference point for the current review.

1.20 1996 also saw the release of the Commission's Report on *Sentencing*.[21] The general principles recommended in that Report are relevant to the more particular issues discussed in Consultation Paper 6 ("CP 6") concerning the nature and duration of disposition options for offenders with a mental illness or cognitive impairment.

1.21 In Chapters 4 and 5 of CP 6, we discuss the partial defence of substantial impairment and infanticide, respectively. The Commission previously considered these areas of the criminal law in 1997.[22] Finally, the Commission's 2005 Report on *Young Offenders* is relevant to discussion in Consultation Paper 9 ("CP 9") regarding the special position

18. NSW Law Reform Commission, *People with an Intellectual Disability in the Criminal Justice System*, Report 80 (1996) ("NSWLRC Report 80").
19. The continuing relevance of NSWLRC Report 80 was endorsed in the Hon G James, QC, *Review of the NSW forensic mental health legislation*, Report (2007), [3.19] ("the James Report").
20. Made by the *Mental Health (Criminal Procedure) Amendment Act 2005* (NSW). See also NSW, *Parliamentary Debates*, Legislative Assembly, 8 November 2005, 19214 (the Hon Alison Megarrity, MP).
21. NSW Law Reform Commission, *Sentencing*, Report 79 (1996).
22. NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility*, Report 82 (1997); NSW Law Reform Commission, *Partial Defences to Murder: Provocation and Infanticide*, Report 83 (1997).

of young people with mental health impairments who appear before the courts.[23]

Recent developments

1.22 In late 2008, the *Mental Health Legislation Amendment (Forensic Provisions) Act 2008* (NSW) passed through NSW Parliament, receiving assent on 5 November 2008. That Act made a number of significant changes to the MHCPA and the *Mental Health Act 2007* (NSW).[24] In particular, the amendments eliminated the decision-making role of the executive government with regard to the care, treatment, detention and release of forensic and correctional patients,[25] in favour of orders made by a specialist division of the Mental Health Review Tribunal ("the MHRT").[26]

1.23 The amendments took effect on 1 March 2009, and changed the name of the MHCPA to the MHFPA.

THE REVIEW IN CONTEXT

1.24 The issues discussed in this review cannot be seen in isolation. Rather, they must be seen in the various contexts in which they exist. For example, we need to examine briefly the types of cognitive and mental health disorders that may be relevant to the criminal justice context, and the incidence of those disorders within the general, and prison, populations. We also need to consider the international picture in terms of the human rights obligations to which Australia is subject pertaining to people with a disability, and to prisoners.

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23. NSW Law Reform Commission, *Young Offenders*, Report 104 (2005). CP 9 is expected to be released in early 2010.
24. That Act is the result of a review of the forensic provisions of NSW mental health legislation, conducted by the Hon Greg James, QC: see [1.66].
25. Forensic patients are those whose status in the criminal justice system is determined by the presence of a mental illness or cognitive impairment, generally referring to people found unfit for trial, or not guilty on the ground of mental illness, and ordered to be detained. "Correctional patient" is a new term introduced by the 2008 amendments to refer to people transferred to a mental health facility while in prison or on remand: see MHFPA s 42 and 41(1), and [2.24]-[2.26].
26. The amendments made by the 2008 legislation are discussed in detail throughout this review.

1.25 Another important consideration is the legislative context in NSW within which the mental health system operates. This is clearly necessary in terms of the law governing the criminal justice system and its dealings with offenders with mental health and cognitive impairments. However, it is also relevant to compare the way the system deals with civil, as opposed to forensic patients, since offenders may transition from one system to another. Finally, any reform of this area of the law needs to be considered in light of other relevant reviews that have been recently conducted.

What do we mean by cognitive and mental health impairments?

1.26 Concepts such as "mental illness" and "cognitive impairment" are multi-faceted, and encompass medical, scientific and social criteria. The most commonly accepted tools for diagnosing and categorising mental illness worldwide are the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (or "the DSM-IV"),[27] and the *International Classification of Diseases*, (endorsed by the World Health Organisation).[28]

1.27 The DSM-IV adopts a "multiaxial" approach to classifying mental illness, recognising that each disorder does not exist in isolation, but is affected by other disorders, or other aspects of a person's life, including "psychosocial stressors" such as the death of a loved one.[29] Indeed, it is acknowledged in the introduction to the DSM-IV that no definition can adequately specify precise boundaries for the different types of mental illness, and it is common for people to experience more than one condition. Nor can it be assumed that everyone with the same disorder will manifest the same symptoms or behave in the same way.[30]

27. See American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, 2000) ("DSM-IV").

28. Known as the ICD-10. For details of the ICD-10, see World Health Organisation, *International Statistical Classification of Diseases and Related Health Problems* (10th ed, 2007) « http://www.who.int/classifications/icd/en».

29. For a synopsis of the categorisation used in the DSM-IV, see All Psych Online, *Diagnostic and Statistical Manual of Mental Disorders* (4th Ed, 2000) « http://www.allpsych.com/disorders/dsm.html».

30. See quotation in Judicial Commission of NSW, *Diverting Mentally Disordered Defendants in the NSW Local Court*, Monograph 31 (2008), 25.

1.28 In practical terms, a mental illness or disorder is a dysfunction affecting the way in which a person feels, thinks, behaves and interacts with others.[31] The term covers a vast group of conditions, ranging in degree from mild to very severe, episodic to chronic. Common forms of mental disorder include depression, anxiety, personality disorders, schizophrenia and bipolar mood disorder. People who experience these illnesses acutely often perceive reality in ways completely different from others. They may experience hallucinations, severe mood swings, or lose their ability to rationalise their thoughts, emotions or behaviour.[32]

1.29 The DSM-IV does not refer to cognitive or intellectual impairments, but uses the term "mental retardation", which is defined to mean:

- significantly sub-average intellectual functioning (an IQ of approximately 70 or below); and
- concurrent deficits or impairments in adaptive functioning in at least 2 of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety; and
- onset before age 18 years.[33]

1.30 Generally, a cognitive impairment or disorder means a loss of brain function affecting judgment, resulting in a decreased ability to process, learn and remember information.[34] A cognitive impairment may manifest itself in conditions such as Alzheimer's, dementia, autism and autistic spectrum disorders, multiple sclerosis, and acquired brain injury. The

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31. See Australian Health Ministers, *National Mental Health Plan 2003-2008* (July 2003), 7; Council of Australian Governments, *COAG National Action Plan on Mental Health 2006-2011* (July 2006), 1. See also Commonwealth Department of Health and Ageing, *What is Mental Illness?* « http://www.health.gov.au /internet/main/publishing.nsf/Content/mental-pubs-w-whatmen».

32. See K Freeman, "Mental Health and the Criminal Justice System" *Crime and Justice Bulletin: Contemporary Issues in Crime and Justice*, Bureau of Crime Statistics and Research, No 38 (October 1998), 2

33. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, (4th ed, APA Press, 2000).

34. See Foundation for Aids Research, «< http://www.amfar.org»; « http://www.jobaccess.gov.au/JOAC/Advice/Disability/Cognitive_Impairment.htm»; and Cancer Web « http://www.cancerweb.ncl.ac.uk». See also Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk: A Framework for Compulsory Care*, Report (1993), [1.7], Recommendation 82.

term also encompasses intellectual disability, interpreted to mean a permanent condition of significantly lower than average intellectual ability,[35] or a slowness to learn or process information.[36]

1.31 The concepts of cognitive impairment and mental illness are often confused and conflated. An important difference is that "intellectual disability is not an illness, is not episodic and is not usually treated by medication".[37] Having said that, people with one or more cognitive impairment may also have a mental illness. Indeed, people with an intellectual disability are reportedly more at risk of developing mental health problems than the general population.[38] The capacity of the civil and forensic mental health systems to deal adequately with the interaction within and between mental disorders, cognitive impairments and substance abuse is crucial to people receiving appropriate and effective treatment.[39] This issue is explored further throughout this review.

1.32 The difficulty inherent in pinning down fluid concepts such as mental illness and cognitive impairment is compounded when attempted in a legal context. In Chapter 4, we discuss the definitions currently contained in the MHFPA and the MHA, with a view to assessing their adequacy and consistency. These definitions are important for identifying the types of conditions that are relevant in this context, and for establishing the scope of legislative coverage. However, the crucial factor from the perspective of this inquiry is not the medical nature of the

35. See NSWLRC Report 80, [3.2]. See also *Crimes Act 1900* (NSW) s 66F(1).

36. Judicial Commission of NSW, *Equality Before the Law Bench Book* (June 2006), [5.2.2.4.]

37. Intellectual Disability Rights Service, in conjunction with the Council on Intellectual Disability and Criminal Justice and the NSW Council for Intellectual Disability, *Enabling Justice: A Report on Problems and Solutions in relation to Diversion of Alleged Offenders with Intellectual Disability from the NSW Local Courts System* (2008), 30.

38. See K Vanny, M Levy and S Hayes, "People with an Intellectual Disability in the Australian Criminal Justice System" (2008) 15 *Psychiatry, Psychology and Law* 261, 262.

39. The inability of the current mental health system to deal effectively with dual diagnoses of mental disorders and impairments has been a constant theme in past reviews: see, eg, Commonwealth, Senate Select Committee on Mental Health, *A National Approach to Mental Health – From Crisis to Community*, First Report, (March 2006), [1.24], [2.29] ("Senate Select Committee on Mental Health, First Report").

particular impairment, since the type, or mere existence, of a mental illness or cognitive impairment will not necessarily bring the issues discussed in this review into play.[40] Rather, our concern is with the effect that such an impairment has on the capacity of an offender to be tried, and on the degree of criminal responsibility, if any, that should attach to his or her actions, and the appropriateness of the current criminal justice response.

1.33 Accordingly, we use the terms "cognitive" and "mental health" impairment to refer to a broad spectrum of conditions that can result in a reduced capacity for mental functioning or reasoning. Those conditions may be congenital or acquired. The terms encompass both permanent and chronic episodic conditions, as well as those that may resolve or improve over time with treatment.

Incidence of cognitive impairments and mental illness

1.34 According to the Australian Bureau of Statistics, 11% of Australians were reported as having a mental or behavioural disorder in 2004-2005, the most common being depression/mood disorders (3%), followed by developmental disorders (2%), and nervous tension or stress (2%).[41] This represented an increase of 5% from 1997.[42] Of that 11%, it is estimated that approximately 2-3% of people experience a severe disorder, primarily a psychotic illness, such as schizophrenia or bipolar disorder.[43]

1.35 Mental and behavioural problems were more likely to be experienced by women than by men,[44] and were more prevalent in people

40. As Chief Justice Spigelman pointed out in *R v Lawrence* [2005] NSWCCA 91, the mere fact that an offender has an identifiable mental illness will not, of itself, automatically mitigate against the severity of a sentence: [22]-[23].

41. Australian Bureau of Statistics, *Year Book Australia 2007*, cat no 1301.0 (24 January 2007).

42. Australian Bureau of Statistics, *Mental Health in Australia: A Snapshot 2004-05*, cat no 4824.0.55.001 (30 August 2006).

43. See Australian Health Ministers' Conference, *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2006-2007* (February 2008), 13.

44. 11.4% of women, compared to 10% of men. Women were also more likely than men to report high/very high levels of psychological distress (15% compared to 10%): ABS, *Mental Health in Australia: A Snapshot, 2004-05*.

from socioeconomically disadvantaged areas,[45] and in people aged between 18-24 years.[46]

Statistics concerning the numbers of Australians with intellectual disabilities are harder to come by. In 1996, approximately 2-3% of Australians were reported to have an intellectual disability.[47] Of those, approximately one third also reportedly had a major mental health problem.[48]

1.36 When those figures are compared with the number of offenders with a mental illness or cognitive impairment, the degree of their over-representation in the criminal justice system becomes apparent. A survey of the NSW prison population revealed that almost half (46%) of all reception inmates and 38% of sentenced inmates, had experienced at least one mental disorder in the year prior to interview.[49] When the broader category of "any psychiatric disorder" was applied, 78% of all reception prisoners were found to have had a psychiatric disorder in the 12 months prior to interview.[50]

1.37 Intellectual disability is also substantially more common among prisoners than among the general population.[51] Estimates show that

45. In socioeconomically disadvantaged areas, 16% of adults reported mental or behavioural problems, compared to 9% of adults from less disadvantaged areas. Similarly, 20% reported high/very high levels of psychological distress compared to 8%: ABS, *Mental Health in Australia: A Snapshot, 2004-05*.
46. COAG National Action Plan for Mental Health 2006-2007, 13.
47. NSWLRC, Report 80, [2.5].
48. Referred to as a dual diagnosis: see NSW Legislative Council, Select Committee on Mental Health, *Mental Health Services in NSW: Final Report*, Parliamentary Paper No 368 (2002), 187 ("NSW Legislative Council Select Committee on Mental Health, Final Report").
49. T Butler and S Allnutt, NSW Corrections Health Service [now Justice Health], *Mental illness among NSW prisoners* (2003), 17 ("Butler and Allnut"). The study uses the term "mental disorder" to refer to psychosis, anxiety disorder or affective disorder.
50. Butler and Allnutt, 15. The term "any psychiatric disorder" refers to any psychosis, anxiety and affective disorders, as well as substance use disorder, personality disorder and neurasthenia. The 12 month prevalence was higher for women than for men (86% vs 72%), and for reception prisoners compared with sentenced inmates (80% vs 64%).
51. NSW Legislative Council Select Committee on the Increase in Prisoner Population, *Report of Proceedings*, (27 March 2000), 2-6.

approximately 20% of the adult prison population has an intellectual disability, with between 10% and 13% of young people meeting the criteria for intellectual disability.[52] In 1996, this Commission conducted a study of people appearing before Bourke and Brewarrina Local Courts. The results show 36% of people had an intellectual disability, with a further 20% of borderline intellectual ability.[53]

1.38 Consequently, our review is not a "boutique" inquiry, but one involving a major aspect of criminal law and practice that affects a significant proportion of the population. A number of factors contribute to the high incidence of cognitive or mental health impairments among prisoners. Socioeconomic factors contributing to contact with the criminal justice system include homelessness,[54] lack of family and social support, and limited educational, training and employment opportunities.[55]

Mental and/or cognitive impairment and substance use disorders

1.39 Substance use disorders refer to the abuse of, and dependence on, drugs, alcohol, and/or other substances, to the extent that a person's functioning is affected.[56] This is distinguished from casual substance use or intoxication. Statistics show a high correlation between mental illness and substance use disorder.[57] There is also a causal link between acquired brain injury, which is a permanent cognitive impairment, and substance abuse, including petrol sniffing.[58]

1.40 Substance use disorders were found to be substantially more prevalent among prison inmates than in the general population;[59] with

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52. See D Kenny, P Nelson, T Butler, C Lennings, M Allerton and U Champion, *Young People on Community Orders Health Survey 2003-2006* (2006), 24; and NSW Department of Juvenile Justice, *2003 Young People in Custody Health Survey* (2003), 21.
53. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*: *Two Rural Courts*, Research Report 5 (1996), 1.
54. See NSW Legislative Council Select Committee on Mental Health, Final Report, ch 7 especially [7.91]-[7.106].
55. NSWLRC Report 80, [2.17].
56. Butler and Allnut, 30.
57. Butler and Allnutt, 2, 45, 49.
58. This has posed a significant problem in Indigenous communities: see Australian Human Rights Commission, *Preventing Crime and Promoting Rights for Indigenous Young People with Cognitive Disabilities and Mental Health Issues* (2008), 20.
59. Butler and Allnutt, 33.

65.7% of reception prisoners, and 38% of sentenced inmates, having been diagnosed with a substance use disorder in the past 12 months.[60] There is also definite evidence of "co-morbid" substance use disorder among prisoners who also have a mental disorder,[61] with some considering this to be the expectation rather than an anomaly.[62]

1.41 Where this dual diagnosis of substance use disorder and mental illness occurs, there is an increased likelihood of contact with the criminal justice system.[63] Substance use can reduce a person's compliance with their treatment regime and/or compromise the effectiveness of psychiatric medications, and increases the risk of violent psychiatric symptoms being induced or exacerbated.[64] Substance abuse may also create difficulties for people trying to access psychiatric treatment facilities, since some facilities are reluctant to treat people who are obviously using drugs, while drug rehabilitation programs will not treat mental illness.[65]

Human rights obligations

1.42 The human rights of people with cognitive and mental health impairments are recognised in international law, and, to a varying extent, in Australian domestic law, policy and procedure.

1.43 An overarching statement of human rights is contained in the *International Covenant on Civil and Political Rights* ("the ICCPR"), which provides that all people are equal before the law and shall be equal before the courts and tribunals.[66] The ICCPR also provides that all people deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.[67]

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60. Butler and Allnutt, 30, 31.
61. 47.5% of men and 66.7% of women: Butler and Allnutt, 2, 45, 47.
62. Senate Select Committee on Mental Health, First Report, 365.
63. Senate Select Committee on Mental Health, First Report, 368.
64. Butler and Allnutt, 49.
65. NSW Legislative Council Select Committee on Mental Health, Final Report, [10.31]-[10.75].
66. *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976), art 26 and art 14(1), respectively. The ICCPR forms the basis of the *Human Rights and Equal Opportunity Commission Act 1986* (Cth): see sch 2 of that Act.
67. ICCPR, art 10(1).

1.44 In relation to children under the age of 18, the *Convention on the Rights of the Child* ("the CROC") states that parties must recognise "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health", and "shall strive to ensure that no child is deprived of his or her right of access to such health care services".[68] CROC also states that "every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age".[69]

1.45 The *Declaration on the Rights of Disabled Persons* specifically provides that people with a disability have the "same civil and political rights as other human beings", including the right to "medical, psychological and functional treatment" and "social rehabilitation".[70] People with a disability must be "protected against all exploitation" and "all treatment of a discriminatory, abusive or degrading nature".[71] The Declaration also provides that, in judicial proceedings against a person with a mental condition, his or her condition, or "degree of mental responsibility" must be fully taken into account".[72] The *Declaration on the Rights of Mentally Retarded Persons* provides similar protections.[73]

1.46 In 2007, Australia signed the *Convention on the Rights of Persons with Disabilities*. The *Convention* provides for equality before the law for all people. It also identifies obligations to protect people with disabilities (including intellectual and psychiatric disabilities) from cruel, inhuman or degrading treatment or punishment, and from exploitation, violence and

68. *Convention on the Rights of the Child*, GA Res 44/25, opened for signature 20 November 1989,GA Res 44/25, (entered into force 2 September 1990) art 24(1).
69. CROC, art 37 (c).
70. *Declaration on the Rights of Disabled Persons*, GA Res 3447 (XXX), UN Doc A/10034 (1975), art 4 and art 6, respectively.
71. *Declaration on the Rights of Disabled Persons*, art 10.
72. *Declaration on the Rights of Disabled Persons*, art 11.
73. *Declaration on the Rights of Mentally Retarded Persons*, GA Res 2856 (XXVI), UN Doc A/8429 (1971), art 6 provides: "The mentally retarded person has a right to protection from exploitation, abuse and degrading treatment. If prosecuted for any offence, he shall have a right to due process of law with full recognition being given to his degree of mental responsibility".

abuse; and to provide appropriate training for police and prison staff to ensure effective access to justice.[74]

1.47 The *United Nations Principles on the Protection of People with a Mental Illness and the Improvement of Mental Health Care* provide that "all persons have the right to the best available mental health care" and that "all persons with a mental illness… shall be treated with humanity and respect".[75] Additionally, "all persons with a mental illness… have the right to protection from … physical or other abuse and degrading treatment" and discrimination on the grounds of mental illness is prohibited.[76] The *Principles* expressly apply to people serving sentences of imprisonment "to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances".[77]

1.48 The *Principles* also provide that people with a mental illness have the right to treatment "in the least restrictive environment… appropriate to the patient's health needs and the need to protect the physical safety of others".[78] Free and informed consent to treatment is required, including in the case of prisoners.[79]

1.49 The *Standard Minimum Rules for the Treatment of Prisoners* states that people found to be "insane" shall not be detained in prisons and "arrangements shall be made to remove them to mental institutions as soon as possible".[80] Further, the Standard Rules provide that "prisoners

74. *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, 61st session, UN Doc A/61/611, opened for signature 30 March 2007, GA Res 61/106, 61st session, UN Doc A/61/611 (entered into force on 12 May 2008). See art 13, art 15, and art 16.
75. *Principles on the Protection of People with a Mental Illness and the Improvement of Mental Health Care*, GA Res 46/119, 46th session, UN Doc A/46/49 (1991), art 1(1) and art (2).
76. *Principles on the Protection of People with a Mental Illness and the Improvement of Mental Health Care*, art 1(3) and art (4).
77. *Principles on the Protection of People with a Mental Illness and the Improvement of Mental Health Care*, art 20(2).
78. *Principles on the Protection of People with a Mental Illness and the Improvement of Mental Health Care*, art 9(1).
79. *Principles on the Protection of People with a Mental Illness and the Improvement of Mental Health Care*, art 1; art 20(4).
80. *Standard Minimum Rules for the Treatment of Prisoners*, adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Geneva (1955), [82(1)].

with other mental diseases or abnormalities shall be observed and treated in specialised institutions under medical management", and, while in prison, shall be placed under the "special supervision of a medical officer".[81] The Standard Rules also state that "it is desirable" to take steps to ensure the "continuation of psychiatric treatment after release and the provision of social-psychiatric after-care, where necessary".[82]

1.50 Ratification of international treaties does not mean that their provisions are automatically incorporated into Australian law.[83] Many of the instruments mentioned above have been directly incorporated into legislation, most notably through disability discrimination laws. Nevertheless, the principles stated in international human rights instruments should act as best practice measures for all mental health legislation, in both the civil and criminal fields. As stated in the Preliminary Observations to the *Standard Minimum Rules for the Treatment of Prisoners,* human rights principles should "serve to stimulate a constant endeavour to overcome practical difficulties in the way of their application, in the knowledge that they represent, as a whole, the minimum conditions which are accepted as suitable by the United Nations".[84] This has been acknowledged by the Council of Australian Governments ("COAG") in the *National Statement of Principles for Forensic Mental Health.* That Statement provides that State and Territory forensic mental health legislation must comply with the ICCPR and with the *United Nations Principles on the Protection of People with a Mental Illness and the Improvement of Mental Health Care.*[85]

National mental health policy

1.51 In 1992, cognisant of the need for a national approach to the provision of mental health services, the Commonwealth and State and

81. *Standard Minimum Rules for the Treatment of Prisoners*, [82(2)], [82(3)].
82. *Standard Minimum Rules for the Treatment of Prisoners*, [83].
83. See generally GD Triggs, *International Law: Contemporary Principles and Practices* (Butterworths, 2006).
84. *Standard Minimum Rules for the Treatment of Prisoners*, [2].
85. Coalition of Australian Governments, *National Statement of Principles for Forensic Mental Health* (2002), Principle 13. See also NSW Department of Health, *Charter for Mental Health Care in NSW*, which states that "every person in NSW has the right to mental health services that … respect human rights": art 1 (accessed at « http://www.health.nsw.gov.au/policy/cmh/legal/mhcharter.pdf»).

Territory governments developed and endorsed the National Mental Health Strategy. The Strategy aims to:

- promote the mental health of the Australian community;
- where possible, prevent the development of mental disorder;
- reduce the impact of mental disorder on individuals, families and the community; and
- assure the rights of people with mental disorder.[86]

1.52 Part of that Strategy involves the making of National Mental Health Action Plans that set five-year policy and funding priorities. The 2003-2008 Action Plan has the following four priorities:

- promoting mental health and preventing mental health problems and mental illness;
- increasing service responsiveness;
- strengthening quality; and
- fostering research, innovation and sustainability.[87]

Each State and Territory Government is responsible for funding and implementing the Strategy and the Action Plans.[88]

1.53 In addition, COAG agreed to a National Action Plan for Mental Health in 2006.[89] The COAG Action Plan emphasises "coordination and collaboration between government, private and non-government providers" aimed at building a "more connected system of health care" for people with a mental illness.[90] The Action Plan concentrates on the following five areas:

- Promotion, prevention and early intervention;

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86. See Australian Health Ministers, *National Mental Health Plan 2003-2008* (July, 2003), 10.
87. *National Mental Health Plan 2003-2008*, 13.
88. For details of funding levels up to 2005, see National Mental Health Strategy, *National Mental Health Report 2007: Summary of Twelve Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2005*, Tenth Report (2007) «accessed at http://www.health.gov.au».
89. See COAG, *National Action Plan for Mental Health 2006-2011*, «accessed at http://www.coag.gov.au».
90. See Australian Health Ministers' Conference, *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2006-2007* (February 2008), 2.

- Integrating and improving the health care system;
- Participation in the community and employment, including accommodation;
- Increasing workforce capacity; and
- Coordinating care.[91]

1.54 In undertaking to implement the Action Plan, NSW has committed to a number of initiatives, including:

- the expansion of early intervention services for young people with mental health problems;
- enhancing community mental health emergency care services;
- expanding the statewide adult and adolescent forensic mental health services to provide case management for people with a mental illness who come into contact with the criminal justice system; and
- achieving better integration between mental health, and drug and alcohol, services.[92]

1.55 Integral to the improvement of mental health capital projects is the construction of a new 135 bed forensic hospital just outside the grounds of the Long Bay correctional centre.[93]

1.56 Furthermore, the NSW Government's State Plan includes measures aimed at improving the availability and delivery of mental health services. That Plan outlines the Government's commitment to inject $940 million of additional funding into mental health services over five years.[94] One measure of particular significance to this inquiry is the expansion of the Mental Health Court Liaison Service to "ensure the early referral of suitable defendants into mental health and drug and alcohol treatment".[95]

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91. COAG National Action Plan Progress Report 2006-2007, 2.
92. COAG National Action Plan Progress Report 2006-2007, 31.
93. The hospital was officially opened on 18 February 2009 « http://www.justicehealth.nsw.gov.au». See also [3.33].
94. See NSW Government, *State Plan – a new direction for NSW* (2006), Priority F3, 75. See « http://www.nsw.gov.au/stateplan».
95. NSW Government, *State Plan* (2006), 75.

Past reviews

1.57 Any problems associated with the provision of mental health services in Australia are not due to a lack of review. The number of inquiries over recent decades that have examined the availability and delivery of mental health and disability services, nationally, and within NSW, are too numerous to mention. The key inquiries most relevant to this review are discussed here.

1.58 The historical practice of housing people with a mental illness or disability in large psychiatric institutions continued for most of the 20th century. In 1983, a report by the NSW Department of Health, chaired by the Department's Secretary, David Richmond, is widely credited with starting the process of closing those institutions, in favour of a system of community-based support and treatment. In reality, however, the process of deinstitutionalisation began in the early 1960s, and was largely complete by the end of the 1970s.[96] The move away from housing large numbers of patients in institutions coincided with greater recognition of the rights of people with mental illness and intellectual impairments, concerns about abuse and neglect of patients, and the escalating costs of maintaining the institutions. Furthermore, pharmacological developments enabled many people with mental illnesses to manage their symptoms without requiring long stays in hospital.[97]

1.59 The Richmond Report, as the document became known, provided a framework for consolidating and funding the continuing transition from a custodial system of mental health service provision, to one where people could receive treatment and support in the general community.[98] While the Richmond Report advocated further deinstitutionalisation in favour of integrated community services and follow up support, it did not recommend the wholesale closure of all large psychiatric hospitals,

96. See NSW Parliamentary Library Research Service, *Mental Health in NSW: Current Issues in Policy and Legislation*, Briefing Paper No 21/96 (1996), 9-10 ("NSW Parliamentary Briefing Paper"). See also NSW Legislative Council Select Committee on Mental Health, Final Report, [2.2].

97. NSW Parliamentary Briefing Paper, 7.

98. NSW, Department of Health, *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled* (1983) ("the Richmond Report").

recognising that full-time residential care is necessary for some people.[99] The key recommendations of the Richmond Report included:

- progressively decreasing the size and number of mental hospitals;
- reducing in-patient treatment and expanding and integrating community networks;
- separating developmental disability services from mental health services; and
- changing funding arrangements to reflect the different service structure.[100]

1.60 Despite being adopted as Government policy in 1984, sufficient funding for community support services that were to replace institutionalised care did not eventuate, seriously undermining the Report's objectives. Ten years later, in 1993, the Human Rights and Equal Opportunity Commission ("HREOC") delivered its flagship report entitled *Human Rights and Mental Illness*, known as the Burdekin Report.[101] Using the *United Nations Principles on the Protection of People with a Mental Illness and the Improvement of Mental Health Care* as a "basic benchmark" by which human rights of mentally ill people should be assessed,[102] the Burdekin Report considered the availability and provision of support services to be "abysmally inadequate".[103]

1.61 The Burdekin Report found that none of the essentials for a successful transition from institutionalised care to community service provision had occurred. In addition to "endemic underresourcing", the Report criticised the chronic lack of planning, organisation, and coordination between mental health services, and the lack of procedures

99. For an account of the practical effect of the Richmond Report on the NSW mental health system, see M Sainsbury, "Richmond Revisited", address to the Scientific Meeting of the Medico-Legal Society of NSW (November 2005), accessed at « http://www.medicolegal.org.au/index2.php?option=com_content&do_pdf=1&id=46».
100. See NSW Legislative Council Select Committee on Mental Health, Final Report, [2.1].
101. Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness* (1993) ("the Burdekin Report").
102. Burdekin Report, 31.
103. Burdekin Report, 298.

to involve families and carers.[104] Evidence before the inquiry also pointed to an increase in homelessness among people with a mental illness, following the reduction in the number of psychiatric beds available, without a commensurate increase in supported community living facilities.[105]

1.62 The Report also addressed the issue of people with a mental illness in the criminal justice system, noting their over-representation, and the fact that they are "frequently denied the health care and human rights protection to which they are entitled".[106]

1.63 The concerns and shortcomings highlighted in the Burdekin Report were endorsed nearly a decade later by the NSW Legislative Council Select Committee on Mental Health, which reported in 2002. The Select Committee heard evidence to suggest that the division of responsibility between different government departments, and the increasing reliance on non-government organisations ("NGOs") to fill gaps in service provision, has resulted in poor management, integration and coordination of services.[107] The Select Committee Report commented that "deinstitutionalisation, without adequate community care, has resulted in a new form of institutionalisation: homelessness and imprisonment".[108] Indeed, the issue of prisons becoming surrogate or de facto psychiatric institutions was a major issue of concern raised in evidence before the inquiry.[109]

1.64 Subsequent reports reveal similar findings.[110] A 2005 Report by the Mental Health Council of Australia and the Brain and Mind Research

104. Burdekin Report, 281-283.

105. Burdekin Report, 337.

106. Burdekin Report, 940.

107. Legislative Council Select Committee on Mental Health, Final Report, [3.3]-[3.7]. The National Mental Health Report 2007 shows that funding to NGOs more than quadrupled between 1993 and 2005, reflecting the growing importance of community based support services: see *National Mental Health Report 2007: Summary of Twelve Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy1993-2005*, 5.

108. NSW Legislative Council Select Committee on Mental Health, Final Report, xv.

109. NSW Legislative Council Select Committee on Mental Health, Final Report, [14.101]. This concern has also been raised in media reports: see R Pollard, "Out of mind", *Sydney Morning Herald* (Sydney), 12 February 2005.

110. See, eg, Mental Health Council of Australia and the Brain and Mind Research Institute, *Not For Service: Experiences of Injustice and Despair in Mental Health Care*

Institute, in conjunction with HREOC, noted that the short-term effects of insufficient funding and coordination result in a "failure to provide basic medical and psychological health care". Over the longer term, however, the impact may include:

> deteriorating mental health and wellbeing, suicide, higher rates of homelessness, prolonged unemployment, incarceration or increased financial burden and poverty. Failure to attend to the urgent needs of those with severe mental disorders on a systemic basis may also lead to infringements of the wider rights of the community to reside in a safe and secure environment.[111]

1.65 It is not within the terms of the current inquiry to examine and evaluate the availability of services for people with cognitive or mental health impairments. However, the issue is relevant to the Commission's review in terms of context, as well as the effective operation of the criminal justice system in relation to such people.

1.66 The recent review of forensic provisions of NSW mental health legislation, conducted by the Hon Greg James QC, Chairperson of the MHRT, is highly relevant to the Commission's present purpose. The Report made 34 recommendations related primarily to:

- eliminating the role of executive decision-making with regard to forensic patients;[112]
- establishing a specialist Forensic Division of the MHRT to take over the decision-making functions of the executive;[113]
- procedures for appeals against MHRT determinations, and for regular MHRT reviews of forensic cases;[114]
- leave and release provisions;[115] and
- participation by victims in the review process.[116]

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in Australia, in association with HREOC (Canberra, 2005); and Senate Select Committee on Mental Health, First Report.

111. *Not For Service* Report, 12, 13.
112. James Report, recommendation 12.
113. James Report, recommendations 12-14.
114. James Report, recommendations 15, 19-21.
115. James Report, recommendations 22-28.
116. James Report, recommendations 32-34.

As noted above, most of the recommendations of the James Report were implemented by the *Mental Health Legislation Amendment (Forensic Provisions) Act 2008* (NSW).[117]

117. See [1.22]-[1.23].

2. Legislative overview

- Introduction
- Mental Health Act 2007 (NSW)
- Mental Health (Forensic Provisions) Act 1990 (NSW)

INTRODUCTION

2.1 The *Mental Health (Forensic Provisions) Act 1990* (NSW) ("the MHFPA") and the *Mental Health Act 2007* (NSW) ("the MHA") are the major pieces of legislation in NSW that deal specifically with mental health issues. Broadly speaking, the former Act governs the delivery of mental health services, while the latter sets out the procedures for dealing with people with mental illness, or other mental health impairments, when they come into contact with the criminal justice system. The Mental Health Review Tribunal ("the MHRT")[1] is established under the MHA, but has power and responsibilities under both the MHA and the MHFPA.

2.2 Both laws are descended from the *Dangerous Lunatics Act 1843* (NSW), which was the first Australian piece of mental health legislation, based on the UK's *Criminal Lunatics Act* of 1800.[2] The 1843 legislation provided for the "safe custody of, and prevention of offences by persons dangerously insane, and for the care and maintenance of persons of unsound mind".[3]

2.3 Since that time, mental health laws have been subject to many reviews and amendments. Most recently, the 2007 version of the MHA overhauled the *Mental Health Act 1990* (NSW), following a review process commenced in 2004.[4] The 2007 amendments were characterised by a response to the need expressed in consultations for greater inclusion of carers in treatment decisions, more flexibility in community treatment options, and enhanced inter-agency cooperation in service delivery and information sharing.[5]

2.4 The 2007 amendments also resulted in the provisions of the MHA concerning forensic patients being transferred to the *Mental Health*

1. See [3.29]-[3.31] for a discussion of the role of the MHRT.
2. See [1.1]-[1.12] for an historical perspective on mental health legislation.
3. See NSW, Department of Commerce, State Records Authority of NSW, *Archives Investigator*, «http://www.investigator.records.nsw.gov.au».
4. NSW Health, *Carers and Information Sharing and the operation of the Mental Health Act*, Discussion Paper 1 (February 2004); and NSW Health, *The Mental Health Act 1990*, Discussion Paper 2 (July 2004).
5. See NSW, *Parliamentary Debates*, Legislative Assembly, 22 November 2006, 4611 (the Hon Cherie Burton, MP); and NSW, *Parliamentary Debates*, Legislative Assembly, 9 May 2007, 156 (the Hon Paul Lynch, MP).

(Criminal Procedure) Act 1990 (NSW) ("the MHCPA").[6] As noted in the previous chapter,[7] the MHCPA was renamed as the MHFPA by the *Mental Health Legislation Amendment (Forensic Provisions) Act 2008* (NSW), which took effect in March 2009. That amending legislation also transferred decision-making powers concerning the care, treatment, control and release of forensic patients from the executive government to a specially constituted Forensic Division of the MHRT, presided over by a sitting or retired judge. It is envisaged that this judicial supervision will overcome the lack of accountability and transparency associated with executive discretion,[8] and ensure "an appropriate degree of regard for the law, legal processes and the public interest".[9]

MENTAL HEALTH ACT 2007 (NSW)

Scope

2.5 The MHA applies only to people who have a mentally illness, as defined in s 4 of the Act, or who are "mentally disordered". In addition to defining mental illness, the MHA provides that a person is mentally ill if, due to the presence of a mental illness, there are reasonable grounds to believe that care, treatment or control of the person are necessary for that person's protection, or the protection of another, from serious harm.[10] The Act also states that a person is "mentally disordered", irrespective of the presence of a mental illness, if his or her behaviour is so irrational as to justify the conclusion, on reasonable grounds, that care, treatment or control of the person are necessary for that person's protection, or the protection of another, from serious harm.[11]

2.6 The MHA does not apply to the broader category of people with cognitive impairments, including intellectual disability. The effect of this limitation, and the adequacy of these legislative definitions, is discussed in Chapter 4.

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6. See MHA, sch 7.7.
7. See [1.22]-[1.23].
8. See Consultation Paper 6 ("CP 6"), ch 6 and 7.
9. NSW, *Parliamentary Debates*, Legislative Assembly, 27 June 2008, 9540 (the Hon Paul Lynch, MP).
10. MHA s 14.
11. MHA s 15.

2.7 Since 2007, the MHA largely operates to govern the provision of mental health services, in treatment facilities or in the community, to civil, rather than forensic, patients.[12]

Principles and objectives

2.8 The objects of the MHA are:

> (a) to provide for the care, treatment and control of persons who are mentally ill or mentally disordered; and
>
> (b) to facilitate the care, treatment and control of those persons through community care facilities; and
>
> (c) to facilitate the provision of hospital care for those persons on a voluntary basis where appropriate and, in a limited number of situations, on an involuntary basis; and
>
> (d) while protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care; and
>
> (e) to facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care, treatment and control.[13]

2.9 In addition, the MHA contains the following statement of principles to guide the provision of care and treatment of people with a mental illness or mental disorder:

> (a) people with a mental illness or mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given,
>
> (b) people with a mental illness or mental disorder should be provided with timely and high quality treatment and care in accordance with professionally accepted standards,
>
> (c) the provision of care and treatment should be designed to assist people with a mental illness or mental disorder, wherever possible, to live, work and participate in the community,

12. However, the MHA still has limited application to forensic patients in terms of appropriate treatment options and aspects of review by the MHRT.
13. MHA s 3.

(d) the prescription of medicine to a person with a mental illness or mental disorder should meet the health needs of the person and should be given only for therapeutic or diagnostic needs and not as a punishment or for the convenience of others,

(e) people with a mental illness or mental disorder should be provided with appropriate information about treatment, treatment alternatives and the effects of treatment,

(f) any restriction on the liberty of patients and other people with a mental illness or mental disorder and any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances,

(g) the age-related, gender-related, religious, cultural, language and other special needs of people with a mental illness or mental disorder should be recognised,

(h) every effort that is reasonably practicable should be made to involve persons with a mental illness or mental disorder in the development of treatment plans and plans for ongoing care,

(i) people with a mental illness or mental disorder should be informed of their legal rights and other entitlements under [the MHA] and all reasonable efforts should be made to ensure the information is given in the language, mode of communication or terms that they are most likely to understand,

(j) the role of carers for people with a mental illness or mental disorder and their rights to be kept informed should be given effect.[14]

Voluntary admission of civil patients

2.10 The provisions of the MHA apply to people who receive care and treatment either on a voluntary, or involuntary, basis. A voluntary patient is one who admits him or herself to a treatment facility in accordance with ch 2 of the MHA.[15] A person may be admitted to a mental health facility as a voluntary patient irrespective of whether he or she has a mental illness or disorder.[16] However, an authorised medical officer may refuse to admit a voluntary patient if he or she is of the opinion that the

14. MHA s 68.

15. Or, in the case of a person subject to a guardianship order, where the guardian admits the person to a mental health facility: see MHA s 7.

16. MHA s 5(3).

person is not likely to benefit from care or treatment.[17] The patient may discharge him or herself at any time, or may be discharged by an authorised medical officer if the officer considers that the patient is not likely to benefit from further care or treatment as a voluntary patient.[18] The MHRT may also order that a voluntary patient be discharged, when conducting a review of the patient's case.[19]

Involuntary admission to a mental health facility or treatment in the community

2.11 The MHA also makes provision for people to be admitted to mental health facilities, or to receive treatment in the community, on an involuntary basis. Unlike the situation with voluntary patients, a person must not be admitted involuntarily or detained in a mental health facility, unless an authorised medical officer is of the opinion that the person is a mentally ill or disordered person.[20] The medical officer must also be of the view that no other care of a less restrictive kind that is consistent with safe and effective care is appropriate and reasonably available to the person.[21]

2.12 A patient may initially be admitted on an involuntary basis to a mental health facility by a medical practitioner, an ambulance or police officer, a primary carer, relative or friend, or by order of a magistrate.[22] If, after a series of assessments, an authorised medical officer is of the view that a person detained involuntarily is mentally ill, the person must be brought before a magistrate for a mental health inquiry.[23] If the magistrate agrees with that assessment, he or she may order that the person:

- be discharged into the care of the person's primary carer;

17. MHA s 5(2).
18. MHA s 8.
19. MHA s 9.
20. As defined in MHA s 14 and 15, respectively. See also [4.7]-[4.11].
21. MHA s 12.
22. See MHA s 18, 19, 20, 22, 24, 26. See also MHFPA s 33 and Consultation Paper 7 ("CP 7"), regarding the powers of a magistrate to refer defendants suspected of being mentally ill to mental health facilities.
23. See MHA s 34. See MHA sch 2 for provisions relating to the conduct of a mental health inquiry.

- receive a community treatment order;[24] or
- continue to be detained in a mental health facility as an involuntary patient for up to three months, if of the opinion that less restrictive care of a safe and effective nature is unavailable or inappropriate.[25]

2.13 The MHRT must review the case of each involuntary patient at the end of that three month period of detention, and regularly from then on, with a view to determining whether or not the patient's involuntary detention should continue.[26] In addition to these reviews, an authorised medical officer must examine each involuntary patient at least every three months to determine if their involuntary status remains necessary.[27]

2.14 If, after assessment, an authorised medical officer finds a person mentally disordered, but not mentally ill, the person may be detained in a mental health facility, but not for a continuous period of more than three days.[28] The case of a mentally disordered person must be reviewed by an authorised medical officer at least once every 24 hours.[29] A person must not be admitted to and detained in a mental health facility on the grounds that the person is a mentally disordered person on more than three occasions in any one calendar month.[30]

2.15 Involuntary treatment may also be received in the community, if ordered by a magistrate or the MHRT.[31] A Community Treatment Order ("CTO") may be made whether or not a person is already detained in a

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24. An authorised medical officer must discharge an involuntary patient from a mental health facility if a community treatment order is made. However, that person remains an involuntary patient, and nothing prevents that person's re-admission to a mental health facility while subject to a community treatment order: see MHA s 41.
25. MHA s 35(5). In 2007, magistrates conducted 11,971 mental health inquiries in NSW. Of those, more than half were adjourned, 3,091 involuntary patient orders, and 1,452 Community Treatment Orders, were made, 595 patients were reclassified from involuntary to voluntary, and 169 patients were discharged: see Local Courts of NSW, *Annual Review 2007*, 27.
26. MHA s 37, 38.
27. MHA s 39.
28. MHA s 27(e), 31(2).
29. MHA s 31(3).
30. MHA s 31(5).
31. MHA s 51. A magistrate may only make a CTO in relation to people considered to be mentally ill: MHA s 53(4).

treatment facility.[32] For the purpose of determining whether or not a CTO should be made, a magistrate, or the MHRT, must consider the proposed treatment plan, and the efficacy of the proposed CTO, in light of any current or prior orders.[33] A CTO may be made in circumstances where:

- no other care of a less restrictive kind is appropriate or available and the CTO would be beneficial as the least restrictive form of treatment consistent with safe and effective care; and
- a mental health facility has an appropriate treatment plan and is capable of implementing it;[34] and
- a person previously diagnosed with mental illness has a history of refusing to accept treatment.[35]

A CTO must not be made for a period exceeding 12 months.[36]

2.16 In the event of a person refusing to comply with a CTO, he or she may be taken to a mental health facility and treated there.[37] At the mental health facility, the person may be treated in accordance with the CTO,[38] or may be reviewed by a medical officer and admitted as an involuntary patient.[39] The person may be detained in a mental health facility until the CTO expires, or the person is discharged.[40] The person must be discharged if the authorised medical officer thinks it is appropriate, or if

32. MHA s 51(3). However, the CTO has no effect while the person is detained in a mental health facility: MHA s 56(3).
33. MHA s 53(2).
34. A treatment plan must outline, in general terms, the proposed treatment, counselling, management, rehabilitation, etc, and the method by which the services would be delivered, together with their frequency and location: MHA s 54.
35. MHA s 53(3). See MHA s 53(5) for the criteria that satisfy a refusal to accept medical treatment.
36. MHA s 53(6), 56(2). In determining the length of a CTO, the MHRT or magistrate must consider the time required to stabilise the person's condition, and to establish, or re-establish, a "therapeutic relationship" between the person and his or her psychiatric case manager: MHA s 53(7).
37. MHA s 58. The assistance of a police officer may be sought: MHA s 59.
38. And released if appropriate: MHA s 60(2).
39. MHA s 60(1). An authorised medical officer must review the person's condition within 12 hours of his or arrival at the mental health facility and determine if the person is mentally ill or disordered: MHA s 61(2).
40. MHA s 61(5). In the case of a mentally disordered person who is not mentally ill, a three day limitation on detention applies: see MHA s 31(2).

the officer determines that the person is not mentally ill or disordered, or is of the view that other less restrictive care is available and appropriate.[41]

2.17 A person detained in a mental health facility due to a breach of a CTO must have his or her case reviewed by an authorised medical officer,[42] and the MHRT, at least every three months.[43] On review, the MHRT is to determine whether the person is a mentally ill person for whom no other care is appropriate or reasonably available.[44] Depending on the circumstances, the MHRT may determine that the person remain in the mental health facility until the end of the CTO, be admitted as an involuntary patient, be discharged, or be subject to a further CTO.[45]

2.18 A patient's involuntary status will end if and when an authorised medical officer, a magistrate, or the MHRT determines that the person is no longer mentally ill and should be discharged from a mental health facility, or upon the lapse or revocation of a CTO.[46] An authorised medical officer may discharge an involuntary patient from a mental health facility following an application made by that patient,[47] or by the patient's carer, provided that the carer gives a written undertaking that the person will be properly cared for, and the officer is satisfied that adequate measures will, so far as is reasonably practicable, be taken to prevent the person from causing harm to himself or herself or others.[48] An involuntary patient may appeal to the MHRT against a medical officer's decision to refuse a discharge application.[49]

2.19 An involuntary patient may be reclassified as a voluntary patient at any time, provided that an authorised medical officer is of the opinion that the patient is likely to benefit from care or treatment, and the person, or his or her guardian, agrees to be so classified.[50] Similarly, a voluntary patient may be detained in a mental health facility on an involuntary

41. MHA s 62(1).
42. MHA s 61A.
43. MHA s 63(1).
44. MHA s 64(1).
45. MHA s 64(3), 64(4).
46. MHA s 56, 65, 66.
47. MHA s 42.
48. MHA s 43.
49. MHA s 44.
50. MHA s 40.

basis if an authorised medical officer believes that the person is mentally ill or disordered.[51]

MENTAL HEALTH (FORENSIC PROVISIONS) ACT 1990 (NSW)

2.20 As the title suggests, the MHFPA governs the application of the criminal law to offenders with mental health impairments. In terms of scope, the MHFPA is both broader and narrower than the MHA. It is broader in terms of the types of impairments to which it applies. The MHFPA adopts the same definition of "mentally ill person" as the MHA, and also refers to the wider term "mental condition", defined as meaning a "condition of disability of mind not including either mental illness or developmental disability of mind".[52]

2.21 Also, the MHFPA is more narrowly focused than the MHA in the sense that it applies specifically to forensic patients, being people whose cognitive or mental health impairment is relevant to their involvement in the criminal justice system.

2.22 While the MHFPA sets out the procedure for dealing with issues such as fitness to be tried and the defence of not guilty due to mental illness, the common law continues to give meaning to what constitutes the concept of fitness and the elements of the mental illness defence.[53]

2.23 The recent changes introduced by the *Mental Health Legislation (Forensic Provisions) Amendment Act 2008* (NSW) are also noteworthy. While many of the provisions in the old MHCPA have been carried over into the renamed MHFPA, there are significant changes. In particular, the MHFPA includes a new Part 5, setting out the MHRT's enhanced role in reviewing the care, detention, and release of forensic and correctional patients.[54]

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51. MHA s 10(1).
52. MHFPA s 3(1). The adequacy of these definitions is discussed in ch 4.
53. See, eg, *R v Presser* [1958] VR 45 concerning fitness; and *Daniel M'Naghten's Case* (1843) 10 Cl & Fin 200 regarding the elements of the defence of mental illness. For a detailed discussion of fitness to be tried and the defence of mental illness, see CP 6, ch 1 and 3, respectively.
54. See [2.25]-[2.26] for an explanation of the term "correctional patient".

Forensic patient

2.24 The term "forensic patient" refers to a person who enters the mental health system via certain criminal justice pathways. A person will become a forensic patient where:

- the person is unfit to be tried for an indictable offence, and is ordered by a court to be detained in a mental health facility, a prison, or other place; or
- the person is found not guilty by reason of mental illness of an offence and the court orders that the person be released on conditions, or detained in such a manner as it thinks fit.[55]

Correctional patient

2.25 The MHFPA introduces a new category of "correctional patient", which is defined to mean:

> a person (other than a forensic patient) who has been transferred to a mental health facility while serving a sentence of imprisonment, or while on remand, and who has not been classified by the [MHRT] as an involuntary patient.[56]

2.26 Under the previous MHCPA, correctional patients were included within the definition of forensic patient.

Objects

2.27 Part 5 of the MHFPA contains a statement of objects with specific reference to forensic and correctional patients. Section 40 states that the objects of Part 5 are:

> (a) to protect the safety of members of the public,
>
> (b) to provide for the care, treatment and control of persons subject to criminal proceedings who are suffering from a mental illness or mental condition,
>
> (c) to facilitate the care, treatment and control of any of those persons in correctional centres through community treatment orders,

55. MHFPA s 42.
56. MHFPA s 41(1).

(d) to facilitate the provision of hospital care or care in the community through community treatment orders for any of those persons who require involuntary treatment,

(e) to give an opportunity for those persons to have access to appropriate care.[57]

57. This provision was introduced into the MHFPA in 2008. Note that the previous MHCPA did not contain a statement of objects with regard to forensic patients.

3. The current system in practice

- Overview
- First point of contact – the police
- The courts
- The Mental Health Review Tribunal
- Justice Health

OVERVIEW

3.1 In practice, the criminal justice response to offenders with cognitive or mental health impairments depends on the type of offence committed, and the forum in which the matter is heard, since Local Courts have different powers from those exercised by the District and Supreme courts. The nature of the offender's illness or impairment may also be a factor, as some outcomes are either not available to, or less appropriate for, people with an intellectual disability than for those with a mental illness.

3.2 The particular pathway through the criminal justice system taken by an offender with a mental illness or cognitive impairment will also depend on the responses of certain key players. This chapter provides an overview of the various points of contact with criminal justice agencies an offender with mental impairments may encounter, and the potential results.

FIRST POINT OF CONTACT – THE POLICE

3.3 An offender's initial experience with the criminal justice system is most likely to be with the police. Under the *Mental Health Act 2007* (NSW) ("the MHA"), a police officer may apprehend a person who appears to be mentally ill or mentally disturbed and take them to a declared mental health facility if the officer has reasonable ground to believe that:

- the person is committing, or has recently committed, an offence, or that the person has recently attempted, or will probably attempt to kill or harm him or herself, or another person; and
- it would be beneficial to the person's welfare to be dealt with in accordance with the MHA rather than under the criminal law.[1]

3.4 Consequently, police have an initial discretionary power to divert mentally ill or disturbed offenders down a clinical treatment, rather than a criminal justice, path. Police may also be required to assist in taking a person to a mental health facility for initial or continuing detention on an involuntary basis.[2]

3.5 According to the NSW Legislative Council Select Committee on Mental Health, police reported an increasing demand for their

1. MHA s 22. Note that this does not apply to people with intellectual disabilities.
2. See MHA s 19, 20, 21, 23, 32, 48, 49, 58, 59.

intervention in incidents involving people with a mental illness or impairment. They expressed concern about the use of police resources to transport mentally ill patients to and from hospitals, and the need to supervise patients while waiting for psychiatric assessments to be conducted because of a lack of hospital security.[3]

3.6 Police also noted that, on many occasions, hospitals or mental health facilities refused to admit people, either because there were no available beds, or their condition was assessed as not being a mental illness, or not an illness that would benefit from treatment, and therefore not the responsibility of a mental health facility. For example, hospitals and mental health facilities are reluctant to admit people they suspect are drug or alcohol affected, even though they may have an underlying mental illness, or people with personality disorders. Yet, these are the people with the highest risk of coming into contact with the criminal justice system. Consequently, police are frequently called to a succession of incidents involving the same person. Police saw inadequate access to mental health services as a major barrier to their ability to perform their duty.[4]

3.7 In order to articulate and coordinate the respective roles and responsibilities of NSW Police, NSW Health and the Ambulance Service of NSW with regard to mental health issues, a Memorandum of Understanding (MOU) has been developed.[5] In accordance with the MOU, NSW Police and NSW Health acknowledge that people should be treated with dignity, receive timely access to specialist emergency mental health assessment and care, receive that care in the least restrictive environment consistent with clinical needs, safety and available resources.[6]

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3. NSW Legislative Council, Select Committee on Mental Health, *Mental Health Services in NSW: Final Report*, Parliamentary Paper No 368 (2002), [14.10]-[14.11] ("NSW Legislative Council Select Committee on Mental Health, Final Report").
4. NSW Legislative Council Select Committee on Mental Health, Final Report, [14.24], [14.28]-[14.35].
5. NSW Health, Ambulance Service of NSW, NSW Police Force, *Memorandum of Understanding: Mental Health Emergency Response* (July 2007).
6. NSW Health, Ambulance Service of NSW, NSW Police Force, Memorandum of Understanding, [3].

THE COURTS

3.8 Offenders with mental illnesses or cognitive impairments who come before the courts may be dealt with in a number of different ways, depending on the court and the nature of the offence committed. Broadly speaking, offenders fall into the following four categories:

- those appearing before the District or Supreme courts who are not fit to be tried;
- those appearing before a Local Court whose circumstances make them suitable for diversion away from the criminal justice system;
- those whose mental state is such that they cannot be held legally responsible for their actions; or
- those who are tried and found guilty, but whose responsibility for the offence is lessened due to their mental or cognitive impairment (either by substituting a finding of manslaughter for one of murder, or by taking the impairment into consideration as a factor during sentencing).

Fitness proceedings - District and Supreme courts

3.9 Under the common law an offender must be "fit to be tried", that is, capable of participating fully in the court process, before he or she can be dealt with by a court of law. Mental illness and cognitive impairment is one of many factors that may affect a person's ability to comprehend the court process, to give instructions to lawyers and to give evidence in court. The procedure for dealing with the issue of fitness to be tried is governed by the *Mental Health (Forensic Provisions) Act 1990* (NSW) ("the MHFPA"). Different procedures apply to the Supreme and District courts from those used in the Local Courts.

3.10 In the Supreme or District courts, determining a defendant's fitness involves a complex series of referrals between the court and the Mental Health Review Tribunal ("the MHRT"). A defendant's fitness may be questioned by any party to proceedings before the court, or by the court itself.[7] The issue may be raised at any time before or during criminal proceedings, and on more than one occasion.[8] If the court determines that an inquiry into the defendant's fitness should occur, or, if the question of

7. MHFPA s 5.
8. MHFPA s 7, 8, 9.

fitness was raised after the defendant's arraignment, the court must conduct a fitness inquiry.[9]

3.11 A fitness inquiry is conducted before a judge alone, in a non-adversarial manner, and is to be determined on the balance of probabilities.[10] If the defendant is found fit to be tried, criminal proceedings may re-commence or continue in the usual way.[11] If found unfit to be tried, the defendant is referred to the MHRT,[12] which must determine whether the defendant will become fit within 12 months of the finding of unfitness, and whether or not he or she has a mental illness or a mental condition for which treatment is available.[13] If the MHRT determines that the person will become fit to be tried, it must notify the court, and may make recommendations as to care and treatment.[14] The court may then order the person's release on bail, or detention in a mental health facility or other place for a period not exceeding 12 months.[15] If the MHRT finds that the person will not be fit to be tried within 12 months, it must notify the Director of Public Prosecutions ("the DPP").[16] The court must hold a "special hearing" unless the DPP advises an intention not to take further action against the person.[17] In the latter case the person must be released.[18]

3.12 The "special hearing" is intended as an opportunity for the defendant to be acquitted, unless it can be proved "to the requisite criminal standard of proof that, on the limited evidence available, the person committed the offence charged".[19] Despite the defendant's

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9. MHFPA s 10. The Court must only conduct an inquiry if the question of unfitness was raised in good faith: s 10(2). Before conducting the inquiry, the Court may adjourn proceedings, grant bail, remand the defendant in custody for up to 28 days, request that the defendant undergo psychological testing, or that a psychological report be prepared, make any other order, or discharge the defendant: MHFPA s 10(3), 10(4).
10. MHFPA s 6, 11(1), 12(2).
11. MHFPA s 13.
12. MHFPA s 14(a).
13. MHFPA s 16(1), 16(2).
14. MHFPA s 16(3), 16(3A).
15. MHFPA s 17.
16. MHFPA s 16(4).
17. MHFPA s 19.
18. MHFPA s 20.
19. MHFPA s 19(2).

unfitness for trial, the special hearing is to be conducted as nearly as possible as a criminal trial.[20] It is to be conducted by a judge alone, unless the defendant elects to have a jury,[21] and the defendant is presumed to have pleaded not guilty.[22]

3.13 If a finding of guilt is made, the matter is referred back to the court for sentencing. The court must indicate the sentence, if any, it would have imposed if the special hearing had been a normal trial with a finding of guilt. Where the court would have imposed a sentence of imprisonment, it must nominate a term, referred to as a "limiting term", being the best estimate of the sentence that would have been imposed had the matter proceeded to a normal trial.[23] The MHRT then has to make a determination as to whether the defendant has a mental illness or not and notify the court of its determination,[24] following which the court can order that the defendant be detained in a mental health facility or another place.[25] In practice, the only alternative in NSW is prison, even though this generally will be inappropriate for such a person.[26]

3.14 The MHRT must review a person's case as soon as possible after the court has made a detention order, and at regular six monthly intervals.[27] After reviewing a case, the MHRT may make an order as to the person's continued detention, care or treatment, or may order the person's release, either conditionally or unconditionally.[28] The MHRT must not make an order for a person's release unless satisfied that the safety of that person, or any other person, will not be endangered, and that other care of a less restrictive kind, consistent with safety and

20. MHFPA s 21.
21. MHFPA s 21A.
22. MHFPA s 21(3)(a).
23. MHFPA s 23. If the court would not have imposed a sentence of imprisonment, it may impose any penalty or make any order it thinks fit: s 23(2).
24. MHFPA s 24.
25. MHFPA s 27.
26. See Consultation Paper 6 ("CP 6"), ch 6 and 7 for a discussion concerning the disposition options for defendants found unfit but not acquitted.
27. MHFPA s 45, 46. In the case of a forensic patient in a correctional centre subject to a Community Treatment Order, the MHRT must conduct a review every three months: s 46(3).
28. MHFPA s 47.

effectiveness, is appropriate and reasonably available, or unnecessary in the circumstances.[29]

3.15 The concept of the limiting term was introduced in 1983 as a means of ensuring that people found unfit were not detained indefinitely, and "forgotten" by, or lost in, the system.[30] However, statistics show that unfit defendants serving limiting terms are detained for longer than other offenders sentenced for similar crimes. In Chapters 1 and 2 of Consultation Paper 6 ("CP 6"), we discuss the fitness provisions in detail, and query how successfully they are operating.

Local Court diversion

3.16 In Local Court proceedings, questions as to fitness do not apply, with magistrates having no power to hold a fitness inquiry. Instead, magistrates may divert certain defendants away from the criminal justice system if it appears to them that this would be a more appropriate course of action than to proceed with the matter in the usual way. The diversionary provisions apply in relation to defendants charged with summary offences, or indictable offences capable of being dealt with summarily.

3.17 Under s 32 of the MHFPA, if a magistrate is of the opinion that a defendant is "developmentally disabled", has a mental illness, or another mental condition for which treatment is available in a mental health facility, he or she may adjourn proceedings, grant bail, or make any other order. The magistrate may also dismiss the charge and discharge the defendant, either unconditionally, or with conditions as to their treatment and supervision.[31]

3.18 In the case of a mentally ill defendant, a magistrate may discharge the person, either conditionally or unconditionally, make a Community

29. MHFPA s 43. This procedure is different from the one that existed previously in the *Mental Health (Criminal Procedure) Act 1990* (NSW), which was replaced by the MHFPA in March 2009: see [1.22]-[1.23]. Under the previous Act, the MHRT was unable to make orders concerning forensic patients, but could only make recommendations to the Minister for Health.

30. The *Crimes (Mental Disorder) Amendment Act 1983* (NSW) sch 1, cl 3, inserted s 428P into the *Crimes Act 1900* (NSW) (subsequently transferred to the MHFPA). This was based on a recommendation by the NSW Health Commission, *Mental Health Act Review Committee Report* (1974), 89.

31. MHFPA s 32(3).

Treatment Order (" a CTO") in accordance with the MHA,[32] or order that the defendant be taken by a police officer to, and detained in, a mental health facility for assessment.[33] If the defendant is found on assessment at the mental health facility not to be mentally ill or disordered, he or she may be brought back before a magistrate.[34]

3.19 Well over 90% of criminal cases are dealt with in the Local Courts. However, only a small percentage of defendants appearing before Local Courts are diverted under s 32 and s 33 of the MHFPA. In 2007, 241,896 charges were finalised in Local Courts. Of these, only 3,941 (or 1.6%) were dealt with under the diversionary provisions of the MHFPA.[35] Some of the reasons for magistrates not exercising their discretion to divert defendants away from the criminal justice system include:

- concerns about eligibility and the imprecision regarding the types of mental disorders that are covered under s 32;[36]
- confusion over the distinction between mental illness and intellectual disability, and over the extent to which defendants with an intellectual disability are eligible for diversion;[37]
- the narrow focus in s 32 on diverting defendants with mental disorder "for which treatment is available in a mental health facility" ignores broader community treatment options;[38]
- the lack of adequate community resources to which defendants may be referred undermines any attempt at diversion;[39]
- magistrates who refer defendants who appear to be mentally ill to a mental health facility for assessment under s 33 report frustration

32. See [2.15]-[2.17] regarding CTOs.
33. MHFPA s 33(1), 33(1A).
34. MHFPA s 33(1)(b).
35. Bureau of Crime Statistics and Research, *NSW Criminal Courts Statistics 2007* (2008), Table 1.2.
36. Judicial Commission of NSW, *Diverting mentally disordered offenders in the NSW Local Court*, Monograph 31 (2008), 25.
37. Judicial Commission of NSW, Monograph 31, 27. Intellectual Disability Rights Service, in conjunction with the Council on Intellectual Disability and Criminal Justice and the NSW Council for Intellectual Disability, *Enabling Justice: A Report on Problems and Solutions in relation to Diversion of Alleged Offenders with Intellectual Disability from the NSW Local Courts System*, (May 2008), 30, 31.
38. Judicial Commission of NSW, Monograph 31, 28.
39. Judicial Commission of NSW, Monograph 31, 31.

when the defendant is refused admission to the facility and reappears before them.[40]

These reasons are discussed in detail in Consultation Paper 7 ("CP 7").

Defence of mental illness

3.20 The MHFPA governs the application of the defence of mental illness, stating that a jury may return a "special verdict" of not guilty by reason of mental illness where the defendant is found to have done an act or made an omission, but at the time was mentally ill so as not to be responsible according to law.[41] The MHFPA thus adopts and preserves common law test for the defence derived from the rules laid down in the 1843 case of Daniel M'Naghten:

> to establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.[42]

3.21 If the jury returns such a verdict, the court may release the person from custody, either conditionally or unconditionally, or may order that the defendant be detained "in such place and in such manner as the court thinks fit until released by due process of law".[43] Consequently, a verdict of not guilty due to mental illness results in indeterminate detention in a mental health facility, or in prison. Due to the uncertain duration of detention, this defence is usually only raised in relation to serious offences.[44]

3.22 The MHRT must review the person's case as soon as practicable after he or she is ordered to be detained following a finding of not guilty due to mental illness, and must review the case every six months.[45] After

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40. NSW Legislative Council Select Committee on Mental Health, Final Report, [14.76]-[14.77].
41. MHFPA s 38.
42. *Daniel M'Naghten's Case* (1843) 10 Cl & Fin 200, 210.
43. MHFPA s 39(1). A person who has been found unfit to stand trial may also be found not guilty due to mental illness at a "special hearing". This finding has the same effect as a special verdict under s 39: MHFPA s 22(1)(b), 25.
44. Although it is available in relation to any offence.
45. MHFPA s 44, 46.

reviewing a case, the MHRT may make an order as to the person's continued detention, care or treatment, or may order the person's release, either conditionally or unconditionally.[46]

3.23 The defence of mental illness is discussed in CP 6.[47]

Partial defence of substantial impairment

3.24 In NSW, a defendant, who would otherwise be liable for murder, may seek to have that liability reduced to manslaughter if he or she can prove a substantially impaired mental capacity to understand or control his or her actions at the time of the killing, by reason of some "abnormality of mind".[48] Substantial impairment is a partial defence in that it does not exonerate the defendant from liability altogether, but operates to reduce that liability from murder to manslaughter.

3.25 Other jurisdictions have considered and rejected a defence of substantial impairment, preferring instead to address mental illness and impairment as potentially mitigating factors in sentencing. In CP 6, Chapter 4, we consider whether or not the defence should be retained in NSW.

Infanticide

3.26 Under the *Crimes Act 1900* (NSW), infanticide refers to the situation where a woman wilfully causes the death of a child under the age of 12 months, in circumstances where "the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child, or by reason of the effect of lactation consequent the birth".[49] Infanticide operates as both an offence and a partial defence to murder, since, if successfully established, it enables conduct that would otherwise amount to murder to be punished as manslaughter.[50]

3.27 Infanticide is discussed further in CP 6.[51]

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46. MHFPA s 47.
47. See CP 6, ch 3.
48. *Crimes Act 1900* (NSW) s 23A.
49. *Crimes Act 1900* (NSW) s 22A.
50. *Crimes Act 1900* (NSW) s 22A(2).
51. See CP 6, ch 5. See also [4.33]-[4.34].

Sentencing issues

3.28 When an offender with cognitive or mental health impairments is convicted of an offence, normal sentencing principles and options established by the common law, and set out in the *Crimes (Sentencing Procedure) Act 1999* (NSW), apply. However, the way in which those principles are applied may need to be considered in view of the offender's impairment. For example, the offender's moral culpability may be reduced because of the particular impairment, and the principle of deterrence may not be as relevant. Similarly, the offender's prospects of rehabilitation may be lessened, and dangerousness may be a significant consideration. Sentencing issues are discussed in CP 6, Chapter 8.

THE MENTAL HEALTH REVIEW TRIBUNAL

3.29 The MHRT is a quasi-judicial body established under the MHA.[52] It sits as a three member expert panel, which includes a lawyer, a psychiatrist and another suitably qualified person. It plays a significant role in making orders and recommendations, and reviewing decisions made concerning treatment and care in relation to both civil and forensic patients. In fulfilling its functions, the MHRT seeks to further the principles and objects of the MHA. In making its decisions, the MHRT seeks to balance several sets of often competing rights, such as:

- the individual's right to liberty and safety and to freedom from unnecessary intervention;
- the individual's right to treatment, protection and care; and
- the right of the community to safety and protection.[53]

52. See MHA ch 6.

53. See the MHRT's website for more information: «http://www.medicolegal.org.au/index2.php?option=com_www.mhrt.nsw.gov.au».

3.30 MHRT hearings are informal and non-adversarial in nature, and the MHRT is not bound by the rules of evidence, but may inform itself of any matter in such a manner as it thinks appropriate.[54] Both civil and forensic patients are entitled to legal representation at a hearing before the MHRT, with forensic patients required to have such representation, unless they refuse.[55] Forensic patients are entitled to free legal representation, provided by the Mental Health Advocacy Service.[56]

3.31 The 2008 amendments which accompanied the renaming of the MHFPA significantly expanded the role of the MHRT, providing it with the power to make final orders concerning the care, treatment, detention and release of forensic patients.[57]

JUSTICE HEALTH

3.32 Justice Health, formerly known as Corrections Health, is a statutory corporation formed under the *Health Services Act 1997* (NSW). Its function is to provide health care services to adult and juvenile inmates in the NSW correctional system, including forensic patients.[58] Justice Health administers the Statewide Mental Health Directorate, which provides mental health care to offenders in prisons, hospitals, courts and in the community. Initiatives provided by the Directorate include the Statewide Community and Court Liaison Service,[59] the Community Forensic Mental Health Service,[60] and Mental Health

54. MHA s 151.
55. MHA s 154.
56. See MHRT, Forensic Procedural Note (updated January 2008), 1. Viewed at «http://www.mhrt.nsw.gov.au/pdf/forensicproceduralnotejan2008.pdf».
57. Subject to an appeal to the Supreme Court: see MHFPA s 77A.
58. See «http://www.justicehealth.nsw.gov.au/».
59. This service operates in 17 courts in NSW, and facilitates court-based options diverting offenders into treatment and away from the criminal justice system. For an analysis of its effectiveness, see D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services*, NSW Bureau of Crime Statistics and Research (2009) «http://www.lawlink.nsw.gov.au/bocsar».
60. This service provides specialist forensic assessments and advice for offenders with a serious mental illness, and has an ongoing role in monitoring and reviewing forensic patients who have been conditionally released.

Screening Units at the Metropolitan Remand and Reception Centre and Silverwater Women's Correctional Centre.[61]

3.33 Justice Health jointly operates the prison hospital at Long Bay in conjunction with the Department of Corrective Services. In early 2009, the new Justice Health Forensic Hospital opened in Malabar, just outside the Long Bay complex. The hospital is a first for NSW, operating as a 135 bed high security mental health facility distinct from a prison environment.

61. The screening units assess offenders' suitability for diversion, assist in determining custodial placement, and in discharge planning to ensure continuity of care.

4. Legislative concepts of cognitive and mental health impairments

- Terminology
- The Mental Health Act
- The Mental Health (Forensic Provisions) Act
- The Crimes Act 1900 (NSW)
- Model Criminal Code
- Issues for discussion

TERMINOLOGY

4.1 The relevant legislation and case law dealing with offenders with cognitive and mental impairments employs a number of definitions to refer to those impairments, each with varying shades of meaning. For example, the *Mental Health Act 2007* (NSW) ("the MHA"), and the *Mental Health (Forensic Provisions) Act 1990* (NSW) ("the MHFPA") refer variously to "mental illness", "mentally ill person", "mentally disordered person", "mental condition" and "developmental disability". The *Crimes Act 1900* (NSW) ("the Crimes Act") invokes different terminology again when referring to the partial defence of substantial impairment and infanticide.

4.2 To some extent, these variations are to be expected because of the different focus or objectives of the relevant provisions. However, the lack of consistency between the legislative definitions may have some practical drawbacks. In Consultation Papers 6 and 7 ("CP 6" and "CP 7"), we discuss the impact of the existing definitions on the specific operation of the defences of mental illness, substantial impairment and infanticide, and Local Court diversionary mechanisms.

4.3 In this chapter, we take a more global view, outlining the various definitions relevant to the criminal justice context and ask whether there would be any benefit in clarifying or standardising the terminology. We also raise for consideration the issue of whether the relevant legislation should contain an overarching definition covering cognitive and mental health impairments.

THE MENTAL HEALTH ACT

"Mental illness"

4.4 For the purpose of the MHA, "mental illness" is defined as:

> a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:
>
> (a) delusions;
>
> (b) hallucinations;
>
> (c) serious disorder of thought form;

(d) a severe disturbance of mood;

(e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a) - (d).[1]

4.5 This definition was first introduced in the 1990 version of the MHA. It represented the first attempt in NSW to codify the concept of mental illness, based on criteria accepted by psychiatric experts worldwide.[2] Other jurisdictions adopt a similar approach, defining "mental illness" as a mental condition or dysfunction characterised by particular symptoms, such as a disturbance of mood, thought, perception, memory or volition.[3]

4.6 This definition of mental illness is a legal rather than a medical construct. It does not seek to define exhaustively all categories and symptoms of mental illness from a clinical treatment perspective. Rather, it serves the specific purpose of establishing the criteria on which people may be detained or treated involuntarily under the MHA. As such, certain conditions for which treatment on an involuntary basis may not be effective or available, such as dementia or personality disorders, are not specifically included within the definition.

"Mentally ill" and "mentally disordered" person

4.7 For the provisions of the MHA concerning involuntary treatment to apply, a person must not only have a condition that falls within the definition of mental illness, but must also be a "mentally ill person". The MHA provides that a person is "mentally ill" if, due to the presence of a mental illness, there are reasonable grounds to believe that care, treatment or control of the person is necessary for that person's protection, or the protection of another, from serious harm.[4]

4.8 The involuntary treatment provisions also apply to a "mentally disordered" person, defined as being someone whose behaviour for the time being is so irrational as to justify a conclusion, on reasonable

1. MHA s 4.
2. See NSW, *Parliamentary Debates*, Legislative Assembly, 22 March 1990, 888 (Peter Collins QC MP).
3. See. eg, *Mental Health Act 1986* (Vic) s 8(1A); *Mental Health Act 1996* (WA) s 4(1); *Mental Health Act 1996* (Tas) s 4(1); *Mental Health Act 2000* (Qld) s 12(1); *Mental Health and Related Services Act* (NT) s 6(1).
4. MHA s 14.

grounds, that care, treatment or control is necessary for that person's protection, or the protection of another, from serious harm, irrespective of whether or not that person is suffering from a mental illness.[5]

4.9 The MHA also provides that a person is *not* a "mentally ill person" or a "mentally disordered" person merely because of any one or more of the following:

(a) the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular political opinion or belief,

(b) the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular religious opinion or belief,

(c) the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular philosophy,

(d) the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular sexual preference or sexual orientation,

(e) the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular political activity,

(f) the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular religious activity,

(g) the person engages in or has engaged in a particular sexual activity or sexual promiscuity,

(h) the person engages in or has engaged in immoral conduct,

(i) the person engages in or has engaged in illegal conduct,

(j) the person has developmental disability of mind,

(k) the person takes or has taken alcohol or any other drug,

(l) the person engages in or has engaged in anti-social behaviour,

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5. MHA s 15. The maximum continuous period for which a "mentally disordered" person may be detained is 3 days, and a person may not be admitted and detained in a mental health facility on more than 3 occasions in a calendar month: see MHA s 31.

(m) the person has a particular economic or social status or is a member of a particular cultural or racial group.[6]

4.10 Consequently, a person whose only impairment results from a developmental disability of mind, or who displays anti-social behaviour characteristic of a personality disorder, does not fall within the definition, and cannot be treated under the provisions of the MHA. Interestingly, alcohol or drug use does not of itself render a person mentally ill or disordered under the MHA definition. However, the MHA also states that nothing in the Act prevents the "serious or permanent physiological, biochemical or psychological effects of drug taking from being regarded as an indication that a person is suffering from mental illness or other condition of disability of mind".[7]

4.11 Apart from these references to people who may be "mentally ill" or "mentally disordered", the MHA also refers to people who appear to be "mentally disturbed"[8] or to have had a "mental condition".[9] These terms are not defined, but appear to appear to embrace a somewhat broader group of people than those who would fall within the statutory definition of "mentally ill" or "mentally disordered".

THE MENTAL HEALTH (FORENSIC PROVISIONS) ACT

4.12 The long title of the MHFPA describes it as an "Act with respect to criminal proceedings involving persons affected by mental illness and other mental conditions". The duality of concepts embraced accommodates its application to those who may be unfit for trial or eligible for diversion due to the existence of a "mental condition" not amounting to a "mental illness", as well as to those who were found to be mentally ill at the time of the alleged offence and eligible for a special verdict of not guilty by reason of mental illness.

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6. MHA s 16. Similar provisions exist in other jurisdictions: see, eg, *Mental Health Act 2000* (Qld) s 12(2); *Mental Health Act 1996* (Tas) s 4(2); *Mental Health Act 1996* (WA) s 4(2); *Mental Health And Related Services Act 1998* (NT) s 6(3); *Mental Health Act 1986* (Vic) s 8(2).
7. MHA s 16(2). See similar provisions in *Mental Health Act 2000* (Qld) s 12(3); and *Mental Health Act 1986* (Vic) s 8(2).
8. See MHA s 20(1), 22(1).
9. See MHA s 33. Note that this term is also used in relation to Local Court diversion: see MHFPA s 32, [4.17]-[4.18] and CP 7.

"Mental illness" and "mentally ill persons"

4.13 The MHFPA does not contain a specific definition of "mental illness", but refers to "mentally ill person",[10] with this expression having the same meaning as in the MHA.[11] The context in which the expression "mental illness" is used in the MHFPA can provide its content. For example, in order to qualify for the special verdict of not guilty by reason of mental illness, for which provision is made in s 38, the defendant must come within the rules in *M'Naghten's Case*.[12] In short, those rules provide that, in order to satisfy the test for the defence, the defendant must have a qualifying mental condition, referred to as a "disease of the mind", that causes a "defect of reason" so that the defendant does not "know the nature and quality of the act he was doing or, if he did know it, that he did not know what he was doing was wrong".[13] Courts have held that a "disease of the mind" can amount to a mental illness, covering conditions such as schizophrenia and other psychoses.[14] Whether or not it also includes intellectual disability and other cognitive impairments has not been conclusively determined.

4.14 Other references to mental illness in the MHFPA appear to refer to the MHA definition. For example, the Mental Health Review Tribunal ("MHRT") exercises functions in relation to those who have been referred following a finding of unfitness to be tried for an offence; and in circumstances where the court has nominated a limiting term after a special hearing. In each instance, the MHRT must determine whether the person is suffering from a "mental illness" or a "mental condition for which treatment is available in a mental health facility", and notify the court of its determination, after which the court can make consequential orders.[15] While the link to the MHA meaning is not explicitly drawn in these sections, there would appear to be a sufficient nexus given that the

10. See MHFPA s 32, 33, 46, 51, 52, 53.
11. MHFPA s 3.
12. *Daniel M'Naghten's Case* (1843) 10 Cl & F 200.
13. See CP 6, ch 3 for a discussion of *M'Naghten* and the defence of not guilty by reason of mental illness.
14. See *R v Falconer* (1990) 171 CLR 30, and CP 6, ch 3 for further discussion.
15. See MHFPA s 16, 24, 17, 27. The presence or absence of a "mental illness" or a "mental condition for which treatment is available in a mental health facility" is also relevant for the transfer of a person between a correctional centre and a mental health facility and *vice versa*: MHFPA s 55, 56.

MHA and the MHFPA are cognate pieces of legislation, as well as the context in which it is necessary to establish the existence of a mental illness: namely, to determine whether an order should be made to detain the defendant in a mental health facility.[16]

4.15 Mental illness is also a ground on which a magistrate may divert a defendant away from the criminal justice system.[17] Diversion is potentially available under s 32 of the Act in relation to a defendant who is, or was at the time of the alleged offence, "developmentally disabled", or "suffering from a mental illness", or "suffering from a mental condition for which treatment is available in a mental health facility" but who is not a "mentally ill person".[18] However, diversion under s 33 of the Act is confined to a person who, at the commencement of or during the course of the hearing of the proceedings, appears to the magistrate to be a "mentally ill person".[19]

4.16 Apart from the need to distinguish, for the purposes of these provisions, a person who appears to be suffering from a mental illness but is not a mentally ill person, and a person who appears to be a mentally ill person, it may be noted that s 32 also embraces those who appear to be "developmentally disabled" or to be suffering from 'a mental condition for which treatment is available in a mental health facility", while s 33 introduces an additional concept of a "mentally disordered person".[20]

"Mental condition"

4.17 The expression "mental condition" referred to above is defined in the MHFPA to mean a "condition of disability of mind not including either mental illness or developmental disability of mind".[21] The term has been interpreted broadly as a "catch-all" provision to recognise a wider range of mental states than those covered under the MHA.[22] For example,

16. See *R v Mailes* (2001) 53 NSWLR 25.
17. A "mentally ill person" may be diverted under MHFPA s 33, while someone who has a mental illness, but is not a "mentally ill person" for the purposes of the MHA, may be dealt with under MHFPA s 32(1)(a)(ii).
18. MHFPA s 32(1).
19. MHFPA s 33(1).
20. MHFPA s 33(1)(b) and 33(10(d).
21. MHFPA s 3. The term does not occur at all in the MHA.
22. See *Perry v Forbes* (Unreported, Supreme Court of NSW, Smart J, 21 May 1993).

it has been held to include severe mood disturbances, uncontrolled anger or emotions, irresistible impulse and acquired brain injury.[23] Although originally intended to encompass drug and alcohol dependency,[24] we are unaware of any cases involving this as the sole cause of a mental condition.[25]

4.18 As noted above the presence of a "mental condition for which treatment is available in a mental health facility" is one of the qualifying conditions for diversion under s 32 of the MHFPA.[26] In Report 80, this Commission considered that the qualification limiting the application of s 32 only to people with a mental condition for which treatment was available, was unduly restrictive.[27]

"Developmental disability"

4.19 As noted above, the diversionary power contained in s 32 may also be used in relation to defendants who appear to a magistrate to be "developmentally disabled", a term which is not defined in the MHFPA, or used elsewhere in the Act. It is also not a term for which a comprehensive clinical definition exists.

4.20 The terminology gained currency in the wake of the Richmond inquiry into health services for the "psychiatrically ill and developmentally disabled".[28] The Richmond Report noted the difference between mental illness and "developmental disability", and advocated the need for such differences to be reflected in the provision of specialised

23. See, eg, *Confos v Director of Public Prosecutions* [2004] NSWSC 1159. For an example of a case involving adult acquired brain injury as a "mental condition", see *Director of Public Prosecutions v Sami El Mawas* [2006] NSWCA 154, [20]-[22].
24. NSW, *Parliamentary Debates*, Legislative Council, 24 April 1986, 2674 (the Hon Barrie Unsworth, MP).
25. Although drug and/or alcohol dependency has been a compounding factor in cases where the defendant has another mental condition: see *Confos v Director of Public Prosecutions* [2004] NSWSC 1159, and *Mantell v Molyneux* [2006] NSWSC 955.
26. The steps a magistrate may take include adjourning the proceedings, granting bail, discharging the defendant, either conditionally or unconditionally, or making any other order the magistrate considers to be appropriate: see MHFPA s 32(2), 32(3).
27. NSWLRC, *People with an Intellectual Disability in the Criminal Justice System*, Report 80 (1996), [5.78] ("NSWLRC Report 80").
28. See [1.58]-[1.59].

services and funding arrangements.[29] That report characterised "developmental disability" as a severe chronic disability, evident before 18 years of age, that may be attributed to an intellectual and/or physical disability and results in substantial functional limitations in three or more specific areas of major life activity, namely, self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.[30]

4.21 Although no guidance is given in the MHFPA regarding the definition of developmental disability, and there is no detailed discussion of the meaning of the concept in case law, it has been interpreted as including conditions that arise during the developmental phase,[31] stemming from either an intellectual or a physical cause.[32] It would seem capable of including conditions such as cerebral palsy, attention deficit hyperactivity disorder, learning or communication disorders, autism or Asperger's syndrome, and intellectual disability,[33] but not conditions that develop later in life, such as dementia, or acquired brain injury.[34]

4.22 By contrast, in Victoria, the term "developmental delay" is used in the *Disability Act 2006* (Vic) to mean:

> a delay in the development of a child under the age of 6 years which:
>
> (a) is attributable to a mental or physical impairment or a combination of mental and physical impairments; and
>
> (b) is manifested before the child attains the age of 6 years; and

29. NSW, *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled* (1983) ("Richmond Report").
30. Richmond Report, Part 2, 9-12.
31. That is, usually before the age of 18 years,
32. See NSWLRC, *People with an Intellectual Disability and the Criminal Justice System: Courts and Sentencing*, Discussion Paper 35 (1994), [2.5] ("NSWLRC DP 35"). See also *R v Mailes* [2001] NSWCCA 155, where the term "developmentally disabled" was said to apply equally to a person whose disability is of a "cognitive kind that was caused by accident or physical disease": [95].
33. See Judicial Commission of NSW, *Diverting Mentally Disordered Offenders in the NSW Local Court*, Monograph 31 (2008), 26. See also NSWLRC DP 35, [2.5].
34. In *DPP v Albon* [2000] NSWSC 896, the court considered the application of the term "developmental disability" in relation to a defendant with acquired brain injury. It is not clear from the case, however, if the brain injury was the sole cause of the defendant's impairment, or at what age he acquired the injury.

> (c) results in substantial functional limitations in one or more of the following areas of major life activity
>
> (i) self-care;
>
> (ii) receptive and expressive language;
>
> (iii) cognitive development;
>
> (iv) motor development; and
>
> (d) reflects the child's need for a combination and sequence of special interdisciplinary, or generic care, treatment or other services which are of extended duration and are individually planned and coordinated.[35]

4.23 The term is sometimes used synonymously with intellectual disability[36] or "intellectual impairment" but doubt exists as to whether these concepts cover the same ground.[37] "Intellectual disability" has been defined in the *Bail Act 1978* (NSW) to mean:

> a significantly below average intellectual functioning (existing concurrently with two or more deficits in adaptive behaviour) that results in the person requiring supervision or social rehabilitation in connection with daily life activities.[38]

4.24 This accords with the definition recommended by this Commission in Report 80, although that definition omitted the qualification that the person require supervision or social rehabilitation.[39]

4.25 The *Community Welfare Act 1987* (NSW) defines "intellectual impairment" to mean "any defect or disturbance in the normal structure and functioning of the person's brain, whether arising from a condition subsisting at birth or from illness or injury".[40] Elsewhere, definitions of intellectual disability have incorporated age limits. For example, the clinical definition of "mental retardation", referred to in Chapter 1 of this Paper, requires the condition to have manifested before the age of 18

35. *Disability Act 2006* (Vic) s 3(1).
36. See *R v Mailes* [2001] NSWCCA 155, where the term "developmentally disabled" was used interchangeably with "intellectually disabled": [95].
37. See Judicial Commission of NSW, Monograph 31, 26-27.
38. *Bail Act 1978* (NSW) s 37(5).
39. See NSWLRC Report 80, recommendation 1.
40. *Community Welfare Act 1987* (NSW) s 3(1).

years.[41] A legislative example can also be found in the *Disability Act 2006* (Vic), which provides that intellectual disability, "in relation to a person over the age of 5 years, means the concurrent existence of a significant sub-average general intellectual functioning; and significant deficits in adaptive behaviour, each of which became manifest before the age of 18 years".[42]

4.26 A somewhat wider concept of "cognitive impairment" is recognised by the *Crimes Act 1900* (NSW) for the purpose of establishing the offence of sexual assault on people with cognitive impairments. Section 61H(1A) provides that a person has a cognitive impairment if the person has:

> (a) an intellectual disability, or
>
> (b) a developmental disorder (including an autistic spectrum disorder), or
>
> (c) a neurological disorder, or
>
> (d) dementia, or
>
> (e) a severe mental illness, or
>
> (f) a brain injury,
>
> that results in the person requiring supervision or social habilitation in connection with daily life activities.[43]

4.27 The *Criminal Procedure Act 1986* (NSW), when dealing with the capacity of a person with cognitive impairment to give evidence, contains a similar definition, without the requirement that the person need supervision or social habilitation.[44] This definition replaced the narrower concept of intellectual disability, and was seen as a preferable term to

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41. See [1.29].
42. *Disability Act 2006* (Vic) s 3(1).
43. See *Crimes Act 1900* (NSW) s 61H(1A), inserted by *Crimes Amendment (Cognitive Impairment-Sexual Offences) Act 2008* (NSW) sch 1 [1]. While this Act applies only to people with a cognitive impairment who are victims rather than offenders, it is useful from a definitional point of view. This amendment was the result of response to a Discussion Paper produced by the Criminal Law Review Division of the NSW Attorney General's Department: see NSW Attorney General's Department, Criminal Law Review Division, *Intellectual Disability and the Law of Sexual Assault* (Discussion Paper, June 2007) 6-7.
44. *Criminal Procedure Act 1986* (NSW) s 306M(2).

cover those who, because of their disability, were vulnerable to sexual assault, but who were not covered by the previous definition.[45]

4.28 In Victoria, cognitive impairment is defined more simply and inclusively as an impairment due to "mental illness, intellectual disability, dementia or brain injury".[46] The term has also been used to describe a "significant and long-term disability in comprehension, reasoning, learning or memory that is the result of any damage to, or any disorder, imperfect or delayed development, impairment or deterioration of the brain or mind",[47] or "an inability to access, process or remember information, irrespective of the age at which the disability was acquired".[48]

THE CRIMES ACT 1900 (NSW)

4.29 There are two specific relevant provisions in the Crimes Act which employ terms other than those used above.

Substantial impairment

4.30 A defendant charged with murder may be acquitted of that offence and found guilty of manslaughter if he or she can prove that, at the time of the acts or omissions causing death, his or her capacity to understand events, to judge right from wrong, or to control himself or herself was "substantially impaired by an abnormality of mind arising from an underlying condition". That impairment must be so substantial as to warrant liability for murder being reduced to manslaughter.[49]

4.31 The expression "underlying condition" is defined to mean a "pre-existing mental or physiological condition other than a condition of a

45. See NSW, *Parliamentary Debates (Hansard)*, Legislative Council, 26 June 2008, 9425 (the Hon John Hatzistergos, MLC). A similar provision exists in Victoria: see *Crimes Act 1958* (Vic) s 50. This followed a recommendation by the Victorian Law Reform Commission in *People with Intellectual Disabilities at Risk: A Framework for Compulsory Care*, Report (2003), recommendation 82.
46. *Crimes (Criminal Trials) Act 1999* (Vic) s 3; *Evidence Act 1958* (Vic) s 3(1).
47. Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk—A Legal Framework for Compulsory Care: Report* (2003), recommendation 82.
48. Intellectual Disability Rights Service, *Enabling Justice* (2008) 28.
49. Crimes Act s 23A. The defence does not apply other than in a case charging murder.

transitory kind".[50] It has been held that it does not matter whether the abnormality of mind arises from an inherited or environmental cause,[51] although temporary abnormal states arising from the use of alcohol or drugs will not qualify.[52]

4.32 The partial defence of substantial impairment, and the qualifying mental states, are discussed in CP 6, Chapter 4.

Infanticide

4.33 Infanticide provides for the situation where a woman causes the death of a child under the age of 12 months, in circumstances where, at the time of the death, "the balance of her mind was disturbed" by reason of her not having fully recovered from the effect of giving birth to the child, or of the effect of lactation.[53] In such a case what would otherwise amount to murder constitutes infanticide and is punishable as manslaughter, although the possibility of a special verdict of "not guilty by reason of insanity (mental illness)" remains open.[54]

4.34 In 1997, this Commission recommended the repeal of the infanticide provision conditional upon preserving and reformulating the defence of diminished responsibility (now known as substantial impairment).[55] Infanticide is discussed in CP 6, Chapter 5.

50. Crimes Act s 23A(8).
51. *R v McGorvic* (1986) 5 NSWLR 270.
52. *R v Ryan* (1996) 90 A Crim R 191, 196; *R v De Souza* (1997) 95 A Crim R 1, 20; and See Crimes Act s 23A(3).
53. Crimes Act s 22A.
54. Crimes Act s 22A(3). Infanticide may operate as both an offence and a partial defence to murder, although most often the latter is the case: see NSWLRC, *Partial Defences to Murder: Provocation and Infanticide* Report 83 (1997) ("NSWLRC Report 83") [3.8]-[3.13].
55. NSWLRC Report 83, [3.14].

MODEL CRIMINAL CODE

4.35 In contrast to the special verdict of "not guilty by reason of mental illness" in relation to offences under State laws, which depends upon the existence of a "defect of reason" from "disease of the mind",[56] a codification of the circumstances in which "mental impairment" will exclude criminal responsibility for offences under federal law, is provided by the *Criminal Code Act 1995* (Cth).

4.36 The Code provides as follows:

> A person is not criminally responsible for an offence if, at the time of carrying out the conduct constituting the offence, the person was suffering from a mental impairment that had the effect that:
>
> (a) the person did not know the nature and quality of the conduct; or
>
> (b) the person did not know that the conduct was wrong (that is, the person could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong); or
>
> (c) the person was unable to control the conduct.[57]

4.37 The Act provides that, in this section, "mental impairment" includes "senility, intellectual disability, mental illness, brain damage and severe personality disorder",[58] and that the reference in this definition to "mental illness" is a "reference to an underlying pathological infirmity of the mind, whether of long or short duration and whether permanent or temporary, but does not include a condition that results from the reaction of a healthy mind to extraordinary external stimuli. However such a condition may be evidence of a mental illness if it involves some abnormality and is prone to recur".[59]

4.38 Most other Australian jurisdictions have adopted a broad definition of mental impairment for the purpose of establishing the target group of offenders who may qualify for the defence of mental

56. See [4.13].
57. *Criminal Code Act 1995* (Cth) s 7.3(1).
58. *Criminal Code Act 1995* (Cth) s 7.3(8).
59. *Criminal Code Act 1995* (Cth) s 7.3(9).

impairment.[60] Those definitions are based to varying degrees on the Model Code, but there are some differences between them. For example, the South Australian, Western Australian and Northern Territory definitions do not cover personality disorders, while the Western Australian provision also excludes brain injury.[61] Further, the Northern Territory definition specifically covers involuntary intoxication.[62]

ISSUES FOR DISCUSSION

4.39 As can be seen from the foregoing, depending on the context, consideration may need to be given to the mental state of a person brought within the criminal justice system, by reference to whether he or she:

- is mentally ill;
- has a mental illness;
- is mentally disordered;
- is mentally disturbed;
- has a condition of disability of the mind;
- has a mental condition;
- has a disease of the mind that causes a defect of reason;
- is developmentally disabled;
- has a developmental disability of mind;
- has an intellectual disability or intellectual impairment;
- has a cognitive impairment;
- was in a state where the balance of (her) mind was disturbed;
- had an abnormality of mind arising from an underlying condition; or
- had a mental impairment.

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60. See, eg, *Criminal Code Act 1995* (Cth) s 7.3(8); *Criminal Law Consolidation Act 1935* (SA) s 269A(1); *Criminal Code Act Compilation Act 1913* (WA) s 1; *Criminal Code 2002* (ACT) s 27(1); and *Criminal Code Act* (NT) s 43A.
61. See *Criminal Law Consolidation Act 1935* (SA) s 269A(1); *Criminal Code Act* (NT) s 43A; and *Criminal Code Act Compilation Act 1913* (WA) s 1.
62. *Criminal Code Act* (NT) s 3A.

4.40 An issue arises as to whether the lack of a consistent, legislatively prescribed approach to defining the target group in relation to offenders with mental health and cognitive impairments can undermine the fair and effective administration of justice, and, in particular, whether it does not adequately cater for some people, for example, those with an intellectual disability.[63] Since, at present, different outcomes may occur at each stage of a criminal proceeding depending on how a defendant's impairment is classified, the issue can be a crucial one.[64]

4.41 If the current terminology used in the MHA and MHFPA does have this effect, then consideration may need to be given to:

- introducing an inclusive umbrella term covering the full range of impairments that could potentially affect a defendant's degree of criminal responsibility, covering mental illness, intellectual disability and other cognitive impairments; or
- redrafting the existing definitions, or developing new ones, to achieve greater consistency both within and between the MHA and the MHFPA, and to bring the definitions in those Acts into line with modern terminology.

An overarching definition?

4.42 Having regard to the numerous concepts and terms used in the MHA and MHFPA, a question arises as to whether it would be beneficial to develop an overarching definition of mental impairment for the MHFPA that would encompass mental illness and cognitive disability.

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63. See, eg, Intellectual Disability Rights Service, *Enabling Justice: A Report on Problems and Solutions in Relation to Diversion of Alleged Offenders with Intellectual Disability from the New South Wales Local Courts System* (2008) 30-31. See also NSWLRC DP 35, [10.11]-[10.18] (in relation to the question of whether intellectual disability is covered under the defence of mental illness).

64. At present, a defendant may be considered mentally ill for purposes of diversion, but not qualify for the defence of mental illness. See discussion on this point in the Hon G James, QC, *Review of the Forensic Provisions of the Mental Health Act 1990 and the Mental Health (Criminal Procedure) Act 1990*, Discussion Paper (2007), 16. See also Council of Social Service of NSW (NCOSS), *Submission to the Review of the Forensic Provisions of the Mental Health Act 1990 and the Mental Health (Criminal Procedure) Act 1990* (2007) 6: see «http://ncoss.org.au/bookshelf/health/submissions/review-forensic-provisions-mental-health-act-1990.pdf».

4.43 As noted above, the Model Criminal Code defines "mental impairment" inclusively to cover "senility, intellectual disability, mental illness, brain damage and severe personality disorder".[65] In developing the Code, the Criminal Law Officers Committee of the Standing Committee of Attorneys-General favoured a broad definition of mental impairment, leaving it for the jury to determine its existence based on expert medical testimony.[66]

4.44 While the Model Code only applies this definition to the defence of mental impairment, it could apply more broadly to other circumstances where a defendant's mental state is relevant to his or her criminal responsibility. We note that decisions concerning how best to define mental impairment, and the types of conditions that a broad term should include, can be controversial. That controversy generally surrounds the issue of whether or not to include conditions such as brain injury, personality disorders, and drug or alcohol related conditions. It is important to remember, however, that while there may be clinical reasons for excluding such conditions from the scope of a general definition, the issues concerning the nature and degree of criminal responsibility are "moral rather than medical".[67] As such, it may be preferable for a general definition to be inclusive and open-ended.

4.45 A definition of mental impairment that includes "a mental illness, cognitive impairment, or personality disorder, however and whenever caused, whether congenital or acquired" would, for example, cover senility, acquired brain injury, and drug and alcohol abuse to the extent that it has caused a mental illness, personality disorder or cognitive impairment. Such a proposed definition, by applying to an impairment regardless of how and when it was caused, would also overcome the difficulties currently associated with the term "developmentally disabled". Mental illness could then be defined to have the same meaning as in the MHA, and cognitive impairment could be separately defined.

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65. See, eg, *Criminal Code Act 1995* (Cth) s 7.3(8); *Criminal Law Consolidation Act 1935* (SA) s 269A(1); *Criminal Code Act Compilation Act 1913* (WA) s 1; *Criminal Code 2002* (ACT) s 27(1); and *Criminal Code Act* (NT) s 43A.

66. Criminal Law Officers Committee of the Standing Committee of Attorneys-General, *Model Criminal Code: Chapters 1 and 2, General Principles of Criminal Responsibility*, Report (1992) ("Model Criminal Code"), [302], 33.

67. Model Criminal Code, [302.1], 37.

4.46 A definition along these lines would only be for the purpose of establishing the threshold criteria for identifying those defendants whose mental impairment may warrant special consideration during sentencing, or would act as a qualifying condition for diversion, or for consideration of unfitness, or of the defences of mental illness or substantial impairment. Defendants would still need to meet the eligibility criteria that would have to be specified for each of those tests and defences. For example, to satisfy the test for the defence of mental illness, a defendant would need to prove not only that he or she had a mental impairment, but also that there is a qualifying nexus between the impairment and "defect of reason" that rendered the defendant incapable of knowing the nature of his or her actions, or that those actions were wrong.[68]

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?

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?

Clarifying and updating existing definitions

4.47 An alternative approach would require some redefinition of existing terms in the MHFPA and/or the MHA.

Mental illness

4.48 The term "mental illness" is used in the MHA and MHFPA to refer to different types of impairments in different contexts. At times it is conflated with intellectual or developmental disability, and at other times it is distinguished from a broader range of mental impairment. Any resulting confusion is exacerbated by the lack of precise definitions for the other forms of mental impairments that may exist.

68. See CP 6, ch 3 for a discussion of the defence of mental illness.

4.49 The term "mental illness" has two meanings with regard to forensic provisions. The first is the clinical definition used in the MHA. Where an offender may be a "mentally ill person", as defined in the MHA, the option exists to detain the offender involuntarily in a mental health facility in accordance with the MHA provisions.

4.50 The second sense in which mental illness is used in the MHFPA is in relation to the defence of mental illness. In this context, the term is used somewhat inappropriately since the defence has been interpreted to apply more broadly than to the clinical conditions covered by the MHA definition. It is arguable that different terminology should be used since the intention of the defence is not to categorise the particular type of mental impairment for the purpose of medical treatment, but to absolve the defendant of criminal responsibility in circumstances where his or her mental state justifies such a finding.

4.51 In Report 80, we recommended that the defence be renamed the defence of "mental impairment" to clarify its application not only to mental illness, but also to conditions falling outside of the clinical definition in the MHA.[69] If the term "mental illness" in s 38 and s 39 were replaced with "mental impairment", then the only references to mental illness in the MHFPA would accord with the MHA meaning.

Issue 5.3

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

69. NSWLRC Report 80, recommendation 25.

Other uncertain terminology

4.52 The current terms used in the MHFPA referring to impairments other than mental illness are inadequately defined. The term "mental condition" is so vague as to be meaningless. Although useful as a catch-all term, it would not be necessary if a broad definition of mental impairment were introduced. The difficulties with the term "developmentally disabled" most notably concern the lack of a definition and the likely interpretation that the disability must have manifested during childhood,[70] which would exclude conditions such as dementia and adult acquired brain injury.

4.53 A preferable approach may be to substitute a more inclusive term that would accord better with modern terminology. While "intellectual disability" could be used, that term is likely to exclude conditions such as autism or Attention Deficit Hyperactivity Disorder ("ADHD") that do not necessarily have an intellectual disability element. The broader term "cognitive impairment" or "cognitive disability" could, however, encompass the types of conditions covered by both intellectual disability and developmental disability.

4.54 Neither the MHA, nor the MHFPA refer to or define cognitive, intellectual or developmental disability, although, as noted above, a definition of cognitive impairment is provided in the *Crimes Act 1900* (NSW) and in the *Criminal Procedure Act 1986* (NSW).[71] In Victoria, cognitive impairment is defined inclusively as an impairment due to mental illness, intellectual disability, dementia or brain injury.[72]

4.55 For the purposes of its report on a legal framework for the compulsory care of people with intellectual disabilities at risk, the Victorian Law Reform Commission offered, as a definition of cognitive impairment or disability, "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".[73] This definition would include people with an

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70. See [4.19]-[4.21].

71. See [4.26]-[4.27].

72. *Crimes (Criminal Trials) Act 1999* (Vic) s 3; *Evidence Act 1958* (Vic) s 3(1). See [4.28].

73. Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk—A Legal Framework for Compulsory Care: Report* (2003) recommendation 82.

intellectual disability, autistic spectrum disorders, brain injury, dementia, and drug or alcohol related brain damage, including foetal alcohol syndrome. It could also include people with learning difficulties and neurological disorders.

4.56 It would not, however, cover mental illness. For the reasons outlined above,[74] we agree with this approach, and consider that the term "mental illness" should be restricted to the meaning in the MHA.

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?

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"?

74. See [4.50]-[4.51].

5. Identifying the existence of a cognitive or mental impairment

- Introduction
- Existing mechanisms
- A general power to order assessments

INTRODUCTION

5.1 While having a clear, comprehensive definition of mental illness and cognitive impairment is undoubtedly helpful, it is generally necessary for a court to rely on expert assessment of the defendant's condition. Where it appears to a court that a defendant may have a mental illness or a cognitive impairment such that it may affect his or her criminal responsibility or ability to stand trial, it may be advantageous for a court to be able to order that a defendant undergo an examination to ascertain his or her mental state, either at the time of offending conduct or during court proceedings. While there are a number of isolated circumstances in which a court may request that an offender be referred for assessment, there is no general legislative power in NSW to make an order that such an assessment occur.

5.2 In this chapter, we consider whether such a power should be introduced into the *Mental Health (Forensic Provisions) Act 1990* (NSW) ("the MHFPA").

EXISTING MECHANISMS

5.3 Currently, if a question of fitness is raised in the District and Supreme Courts, the court may "request", but not order, that a defendant undergo a psychiatric or other examination, or that a psychiatric or other report be obtained.[1] No equivalent provision exists if the defences of mental illness or substantial impairment are raised.[2] When sentencing an offender with a cognitive or mental health impairment, the Local, District and Supreme Courts have a power to adjourn sentencing that can be used, for example, to allow time for the offender to undergo a psychological or psychiatric assessment.[3] Additionally, a court may, and in some circumstances must, order a pre-sentencing report, prepared by the Department of Corrective Services.[4]

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1. MHFPA s 10(3)(d)-(e).
2. MHFPA pt 4.
3. *Crimes (Sentencing Procedure) Act 1999* (NSW) s 11.
4. As to the discretion to order a pre-sentence report, see *R v Majors* (1991) 27 NSWLR 624; *R v Olive* [2006] NSWCCA 329, [12]-[19]. The CSPA requires pre-sentence assessments before the imposition of a sentence of periodic detention, home detention and community service orders: see pt 5 div 3, pt 6 div 3, pt 7 div 3, and *Crimes (Sentencing Procedure) Regulation 2005* (NSW) reg 15, 20.

5.4 In the Local and Children's Courts, there are two mechanisms by which a defendant might be referred by the court for such an assessment. The first mechanism is an informal one. The magistrate, legal representative or other criminal justice system personnel might refer the person to the Statewide Community and Court Liaison Service. Referrals are made informally. The Service conducts a mental health screen, and may refer the person for a psychiatric assessment where screening results indicate that one is necessary.

5.5 The only formal mechanism that exists is under s 33 of the MHFPA in relation to diversion of mentally ill offenders.[5] A magistrate can order that a defendant be taken to a hospital for assessment and/or treatment, if the person appears to have a mental illness within the meaning of the *Mental Health Act 2007* (NSW) ("the MHA"). However, s 33 only applies to offenders with a mental illness, and not to those with a developmental disability, intellectual disability or cognitive impairment. Some preliminary submissions suggested that s 32 of the MHFPA should be amended to empower the court to make assessment orders with respect to a broader range of defendants with cognitive impairments.[6]

5.6 Since the diversion provisions currently only apply to Local or Children's Court proceedings, this power does not extend to the District or Supreme courts. It also excludes committal proceedings.[7] It was also suggested in preliminary submissions that an assessment power similar to that in s 33 should be available in respect of committal proceedings and/or proceedings in the District and Supreme Courts.[8]

Other jurisdictions

5.7 In several jurisdictions the court has a power to order that the defendant undergo a psychiatric or psychological examination and that

5. See Consultation Paper 7 ("CP 7") for a comprehensive discussion of the diversion provisions contained in s 32 and 33 of the MHFPA.
6. The Shopfront Youth Legal Centre, *Submission*, 3; Law Society of New South Wales, *Submission*, 2-3.
7. MHFPA s 31; *Children's (Criminal Proceedings) Act 1987* (NSW) s 27.
8. See, eg, Director of Public Prosecutions, *Submission*, 2; Intellectual Disability Rights Service, *Submission*, 6; Shopfront Youth Legal Centre, *Submission*, 2-3; Law Society of New South Wales, *Submission*, 2.

the results of the examination be put before the court.[9] Some jurisdictions have assessment provisions similar to s 33, but applicable to a broader range of offenders,[10] or to courts other than the Local Court.[11] In the Australian Capital Territory, if a question of fitness is raised in the Magistrates or Supreme Court, the court may require the defendant to be examined by "a psychiatrist or other health professional" or may call evidence on its own initiative.[12] Similar provisions apply in South Australia,[13] Western Australia,[14] and Tasmania.[15]

5.8 A further, more general provision exists in South Australia, empowering the court to require the defendant to "undergo an examination by a psychiatrist or other appropriate expert and require the results of the examination to be reported to the court."[16] The power may be exercised on the application of either party, or on the judge's own initiative if he or she "considers the examination and report necessary to prevent a possible miscarriage of justice".[17]

5.9 In Queensland, if a person is charged with a simple or minor indictable offence, and becomes subject to an involuntary mental health

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9. *Crimes Act 1900* (ACT) s 315A(1)(b); *Criminal Code Act 1983* (NT) s 43P(3); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 11(1)(b); *Criminal Law Consolidation Act 1935* (SA) s 269K(1); *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 11(1); *Criminal Code*, RSC 1985 (Canada) pt XX s 672.11-12.
10. For example, in the ACT, if a magistrate has reasonable grounds to believe that the defendant "needs immediate treatment or care because of mental impairment", it may order the defendant to be transported to a health facility for assessment: *Crimes Act 1900* (ACT) s 309.
11. In the Northern Territory, the Magistrates and Supreme Courts have a power to make an "assessment order" for a defendant who appears to be "mentally ill" or "mentally disturbed" to be detained for up to 72 hours for admission to and treatment in a mental health facility: *Mental Health and Related Services Act 1998* (NT) s 74(1). The court may also make an admission order, being an order that the defendant be admitted and detained in a treatment facility for diagnosis, assessment and treatment, with or without additional conditions. Proceedings may be adjourned for up to 15 days, or other period agreed to by the parties: *Mental Health and Related Services Act 1998* (NT) s 75.
12. *Crimes Act 1900* (ACT) s 315A(1)(b).
13. *Criminal Law Consolidation Act 1935* (SA) s 269K(1).
14. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 12(1), s 12(2)(a).
15. *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 4(1), s 11(1).
16. *Criminal Law Consolidation Act 1935* (SA) s 269F(A)(1)(b), 269G(B)(1)(b).
17. *Criminal Law Consolidation Act 1935* (SA) s 269F(A)(2), 269G(B)(2).

treatment order or to a forensic order, the Director of Mental Health must refer the matter to the Mental Health Court.[18] The person undergoes a psychiatric examination to ascertain his or her mental condition, its relationship (if any) to the alleged offence, the likely prognosis and the person's fitness to be tried.[19] Additionally, in any Mental Health Court proceeding, the *Mental Health Act 2000* (Qld) requires that each party must give the registrar a copy of any expert's report the party has relating to the matters to be decided by the Mental Health Court.[20]

5.10 Some jurisdictions also make specific provision for assessment orders prior to sentencing. In Victoria, if a person is found guilty of an offence and appears to be mentally ill, the court may make an assessment order, detaining the person in a mental health facility for up to 72 hours, to determine the person's suitability for mental health sentencing options.[21] If the person appears to have an intellectual disability, the court may request the Department of Human Services to prepare a statement that the person has an intellectual disability, a plan of available services and a pre-sentence report.[22] Similar powers specifically relating to assessment orders prior to sentencing exist in the ACT[23] and Queensland.[24] In England and Wales, the court is *obliged* to obtain and consider a medical report before imposing a custodial sentence on an offender who is, or appears to be, mentally disordered.[25]

5.11 In other jurisdictions, there is a single power to order an assessment of the defendant in relation to all stages of proceedings. In New Zealand, if a person is in custody at any stage of proceedings against the person in relation to an offence, a court, on application by the defence or prosecution or on the court's own initiative, may order that a

18. *Mental Health Act 2000* (Qld) s 240, s 247(1)(c).
19. *Mental Health Act 2000* (Qld) s 238(2)-(3). When the matter is referred to the Mental Health Court, the psychiatrist's report must be attached: s 242(2).
20. *Mental Health Act 2000* (Qld) s 265.
21. *Sentencing Act 1991* (Vic) s 90; *Sentencing Act 1995* (NT) s 79(1). As to mental health sentencing options, see ch 8.
22. *Sentencing Act 1991* (Vic) s 80(1).
23. *Crimes Act 1900* (ACT) s 331. See also *Crimes Act 1900* (ACT) s 309; *Mental Health (Treatment and Care) Act 1994* (ACT) s 41, 41A (power similar to *Mental Health (Criminal Procedure) Act 1990* (NSW) s 33).
24. *Mental Health Act 2000* (Qld) s 61-62. A plea of not guilty may be entered and proceedings adjourned: s 62.
25. See *Criminal Justice Act 2003* (UK) s 157.

"health assessor" prepare an "assessment report" on the person.[26] The purpose of an assessment report is to assist the court in determining whether the person is unfit to stand trial, whether the person is "insane" within the meaning of the *Crimes Act 1961* (NZ), the type and length of sentence that might be imposed on the person, and/or the conditions or requirements that the court might impose under a sentence or order.[27]

5.12 In Canada, the court has a similar power to make an assessment order at any stage of proceedings, on its own motion, or on application by the defendant or the prosecution.[28] An assessment report must be filed with the court and copies of the report provided to the prosecutor, the accused, and counsel for the accused.[29]

A GENERAL POWER TO ORDER ASSESSMENTS

5.13 The creation of a single general power for a court to order an assessment of a defendant's cognitive or mental state holds a number of attractions. It would be less unwieldy than having separate powers for different stages of proceedings, and would avoid the possibility of the power not being available when needed. The power could be available for a range of purposes, such as determining whether:

- the defendant has a cognitive or mental health impairment sufficient for diversion from the local court under s 32 or 33 of the MHFPA;

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26. *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 38(1). The health assessor must prepare an assessment report, in consultation with any carer and/or welfare guardian of the person, each parent or guardian if the person is a child or young person and the person's family: s 39(2).
27. *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 38(1). Health assessor is defined: s 4(1).
28. *Criminal Code*, RSC 1985 (Canada) s 672.1(1), 672.12-672.16. An assessment order must specify where and by whom the assessment is to be made; whether the accused is to be detained while the order is in force, and the duration of the order, which is limited to 30 days. An assessment order cannot include a requirement that psychiatric or other treatment be administered, or that the defendant submit to such treatment: s 672.19. If an application for an assessment is made by the prosecution, the court may make the order only if the defendant has raised the defence of mental disorder or if the prosecution satisfies the court that there are reasonable grounds to doubt the defendant's capacity or criminal responsibility (respectively): s 672.12.
29. *Criminal Code*, RSC 1985 (Canada) s 672.2(1)-(4).

- the defendant is fit to be tried;
- the defence of mental illness, or the partial defence of substantial impairment, is available;
- factors that may be relevant to sentencing offenders found guilty of an offence,[30] or appropriate disposition options following a finding of unfitness or not guilty by reason of mental illness.

Issues to consider

5.14 Apart from the question of whether the power should exist at all, there are other issues that require attention. For example:

- who should conduct the assessment?
- what information should the assessment contain?
- how should the information obtained from an assessment be used?

5.15 In most jurisdictions where such a powers exists, including the power in s 33 of the MHFPA, the assessment is carried out independently of the court, usually at a mental health facility by an independent practitioner. However, specialists at mental health facilities deal only with mental illness, and not with cognitive disabilities. Another possibility is for the court to appoint a practitioner from a list of mental health or cognitive disability specialists. In NSW, there is the option of requesting assessments to be conducted by Justice Health or by the Mental Health Review Tribunal ("the MHRT"). This option has limitations in that Justice Health deals only with offenders already in custody, while the MHRT only has jurisdiction over forensic and correctional patients.[31] While these limitations could be overcome by extending the jurisdiction of the MHRT and Justice Health, at this stage we favour the assessment being conducted by an independent practitioner. Where appropriate, this could be conducted at a mental health facility or other specialist facility for cognitive disability.

5.16 The second issue relates to the content of the assessment report. Should the assessor be required to report only on the nature and degree of the defendant's impairment and the impact that the impairment has on his or her behaviour, or should the report also contain a statement of

30. Specific issues arise concerning pre-sentence reports: see discussion in Consultation Paper 6 ("CP 6"), ch 8.

31. See [3.29]-[3.33].

suggested and/or available treatment services, or a treatment plan, as occurs in some other jurisdictions.

5.17 The third issue is somewhat related to the second, since the content of the assessment report would be likely to guide the way in which the report is used. For example, if the report contained suggestions of available and appropriate treatment options, it could be used to develop a treatment plan.

5.18 The question of admissibility of the assessment report into evidence also needs to be addressed. For example, should the report be admissible as documentary evidence alone, or should it only be available where the author is available and willing to provide oral evidence? It may be that the answer to this question may depend on the circumstances of each case, and the court should have a broad discretion to rule according to the circumstances.

5.19 Of particular concern would be the admissibility of any statements made by the defendant during the course of the assessment, particularly if they could be self-incriminating. In Queensland, the *Mental Health Act 2000* (Qld) requires that each party must provide to the Mental Health Court any expert report relevant to the matters to be decided, even if giving the report would "disclose matter detrimental to the case of the person the subject of the reference."[32] We seek views on these matters.

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?

32. *Mental Health Act 2000* (Qld) s 265. However, there are limits placed on the use and admissibility of such evidence in both the Mental Health Court and other proceedings: s 314-318.