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Report
135

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

Diversion

June 2012
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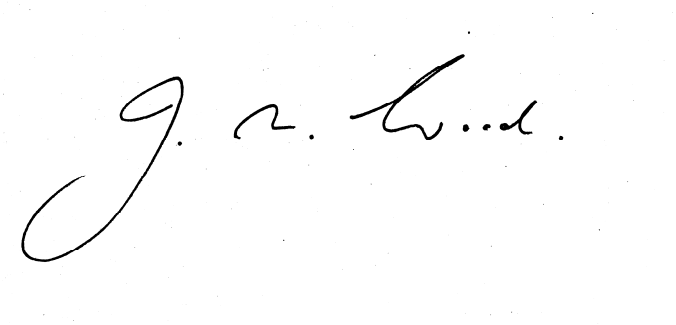
Dear Attorney

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

We make this report pursuant to the reference to this Commission received 17 September 2007.



The Hon James Wood AO QC
Chairperson
June 2012

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The recommendations of this report are the Commission's, and do not necessarily reflect the views of the Expert Advisory Panel.

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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.

[*Reference received 17 September 2007; expanded 7 July 2008*]

Abbreviations

ABI	acquired brain injury
ABS	Australian Bureau of Statistics
ADHC	Ageing, Disability and Home Care
AIHW	Australian Institute of Health and Welfare
BOCSAR	NSW Bureau of Crime Statistics and Research
CALD	Culturally and linguistically diverse
CBSP	CREDIT (Court Referral and Evaluation for Drug Intervention and Treatment)/Bail Support program
CCPA	*Children (Criminal Proceedings) Act 1987* (NSW)
CISP	Court Integrated Services Program
CNC	clinical nurse consultant
CP	Consultation Paper
CPN	Community Psychiatric Nurses
CREDIT	Court Referral of Eligible Defendants Into Treatment
CRIME	NSW Police Force Code of Practice for Custody, Rights, Investigation, Management and Evidence
CRISP	Court Referral for Integrated Service Provision list
CTO	community treatment order
DAGJ	Department of Attorney General and Justice
DSM-IV	American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*
GRAM	Group Risk Assessment Model
ICD-10	World Health Organisation, *International Statistical Classification of Diseases and Related Health Problems, 10th Revision*
IDDP	Intellectual Disability Diversion Program
IDRS	Intellectual Disability Rights Service
K-BIT	Kaufman Brief Intelligence Test
LAC	Local Area Commands
LEPRA	*Law Enforcement (Powers and Responsibilities) Act 2002* (NSW)
LEPRR	*Law Enforcement (Powers and Responsibilities) Regulation 2005* (NSW)
LPC	Local Protocol Committee
MCDP	Magistrates' Court Diversion Program
MERIT	Magistrates Early Referral Into Treatment
MHA	*Mental Health Act 2007* (NSW)
MHC	mental health court
MHFPA	*Mental Health (Forensic Provisions) Act 1990* (NSW)
MHIT	Mental Health Intervention Team
MHRT	Mental Health Review Tribunal
MOU	Memorandum of Understanding
NGMI	not guilty by reason of mental illness
NGO	non-government organisation
NHS	National Health Survey

NSWCAG	NSW Consumer Advisory Group
ODPP	Office of the Director of Public Prosecutions
PACER	Police, Ambulance and Crisis and Assessment Team Early Response
PCL-R	*Psychopathy Checklist – Revised*
PIAC	Public Interest Advocacy Centre
SCCLS	Statewide Community and Court Liaison Service
SMHWB	National Survey of Mental Health and Well Being
TIP	Treatment Intervention Program
VABS	Vineland Adaptive Behaviour Score
WALRC	Law Reform Commission of Western Australia
YCO	Young Conduct Order
YDAC	Young Drug and Alcohol Court
YOA	*Young Offenders Act 1997* (NSW)
YOLR	Young Offenders Legal Referral Scheme
YPICHS	Young People in Custody Health Survey

Executive Summary

Chapter 1: introduction

0.1 This Report is the first of two reports about people with cognitive and mental health impairments in the criminal justice system. Its focus is diversion, and it also makes recommendations to improve consistency of definitions. The second report will deal with issues of criminal responsibility, fitness to plead, the management of forensic patients and certain procedures relating to forensic samples.

0.2 This report is a comprehensive look at the opportunities to enhance diversion at all stages of the criminal justice system for people with cognitive and mental health impairments. This approach reflects the strong and consistent views of stakeholders. It is also consistent with the government's priorities under the *NSW 2021* plan, particularly to prevent and reduce reoffending (Goal 17), and to keep people healthy and out of hospital (Goal 11).

0.3 This report is timely in that it coincides with the establishment of the NSW Mental Health Commission and the National Mental Health Commission. It is also contemporaneous with a number of other reviews, including the current review of the *Mental Health Act 2007* (NSW) by the NSW Ministry of Health.

0.4 Consultation with stakeholders has been extensive. We produced five consultation papers and received 50 submissions. We conducted 32 consultations involving over 200 stakeholders, and organised a symposium on whether NSW should have a mental health court.

Chapter 2: preliminary issues

0.5 There are a number of over-arching issues that are important to this report.

0.6 There is strong evidence (see Chapter 4) that people with cognitive and mental health impairments are over-represented throughout the criminal justice system. But the great majority of people with a cognitive and/or mental health impairment do not offend. The higher rate of offending does not arise from any simple relationship between impairment and crime, but from impairment together with a multiplicity of other factors, such as disrupted family backgrounds, family violence, abuse, misuse of drugs and alcohol, and unstable housing.

0.7 Diversion of people with cognitive and mental health impairments generally involves them engaging with a range of providers of treatment and services that have a rehabilitative focus. The relationship between the criminal justice system (police and courts) and the service sector is crucial to effective diversion. Both are complex systems. Effective diversion relies on connecting offenders with the right services and maintaining that connection when problems arise. Understanding and communication between the criminal justice system and services is crucial for diversion to work well. Significant challenges include: the great multiplicity of agencies providing services; different disciplinary understandings; different perspectives on key issues; gaps in the availability of services; and problems of integrating service delivery for people whose needs are complex.

Chapter 3: assessing diversion

0.8 We have taken a broad view of diversion in this report as including:

- practices that seek to minimise contact with the criminal justice system, such as cautions, conferencing and other types of pre-court diversion
- measures by courts to refer defendants to treatment and/or services that aim to rehabilitate the offender and prevent further offending, and
- "problem solving courts" that combine referral to rehabilitative services with ongoing court monitoring of the defendant's progress.

0.9 The advantages of diversion are many. It can benefit both the offender and the wider community by addressing the causes of offending, and thus reducing offending behaviour. It can reduce involvement in the criminal justice system which may be particularly detrimental for people with cognitive and mental health impairments. There may be potential cost savings associated with diversion, for example reduction in costs of incarceration or hospital readmissions.

0.10 Diversion also has potential disadvantages. It may be unsuitable for serious offences. It may net-widen. A person may make inappropriate admissions to access diversion. The requirement of diversion may be more burdensome than the consequences of being dealt with according to law.

0.11 Taking all the evidence into account, it is our view that diversion can be an effective means of reducing reoffending and producing better outcomes for people with cognitive and mental health impairments. However, diversionary schemes need to be carefully designed to avoid some of the potential drawbacks.

Chapter 4: prevalence

0.12 If we are to improve laws and policies relating to diversion it is important to understand the size and nature of the issue, to understand the implications of change and predict its costs.

0.13 On the basis of available data, the representation of people with cognitive and mental health impairments in the criminal justice system is disproportionately high. This is true for police contact and for Local Court proceedings, though the data is indicative only. It is also true for people in custody, where we have better data. For example the rate of mental health impairment in prisoners appears to be more than triple the rate in the general population, although there can be significant variation depending on the mental health impairments concerned. From available data, there also appears to be an over-representation of people with cognitive impairments in custody. The level of over-representation of young people with a mental health impairment or a cognitive impairment in the juvenile justice centres is particularly high.

0.14 However, the paucity of data means the exact scale of over-representation is unknown. This lack of available, comprehensive and consistent data regarding the representation of, and outcomes for, people with cognitive and mental health

impairments in the criminal justice system has made it very difficult for us to quantify the present deficiencies, in order to evaluate the potential impact of our recommendations.

0.15 We recommend that a working group should develop a strategy to ensure improved data collection and analysis, so that in future there will be a better foundation on which to make policy and to estimate the cost and impact of proposed changes (Recommendation 4.1).

Chapter 5: defining cognitive and mental health impairment

0.16 The definitions of cognitive and mental health impairment used in the criminal law are inconsistent and outdated. Taken as a whole the law lacks a consistent and clear approach to defining cognitive and mental health impairment and this gives rise to unnecessary confusion and complexity. Further, many legal definitions reflect understandings of behavioural science that are no longer current.

0.17 Taking into account these challenges and the views of stakeholder and experts we recommend two separate definitions of cognitive impairment and of mental health impairment (Recommendations 5.1 and 5.2). There was strong stakeholder support for separate definitions, in part because of the need to focus on the particular, and different, requirements of people with cognitive impairment and to ensure that their interests do not become subsumed by a focus on mental health.

0.18 The primary purpose of these definitions is inclusion in the diversionary provisions of s 32 and s 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA) (Recommendation 5.3). We also recommend the use of these definitions in the context of bail and pre-court diversion (Recommendations 5.4, 5.5 and 8.3(1)). We have previously recommended the use of these definitions in a new *Bail Act* (Report 133) and will consider other applications of these definitions as part of our current reference on sentencing.

Chapter 6: bail

0.19 Several aspects of current bail law have been identified as disadvantaging people with cognitive and mental health impairments. However, our Bail Report provides an appropriate and balanced response to those issues, and we make no further recommendations concerning the general law of bail.

0.20 The *Bail Act 1978* (NSW) provides for the use of bail as a diversionary tool under s 36A. This allows some diversionary programs to operate, for example the Magistrates Early Referral Into Treatment (MERIT) drug and alcohol treatment scheme.

0.21 In some other states bail powers are central to diversionary programs. However in NSW, in our view, s 32 of the MHFPA should generally provide a sufficient framework. Our recommendations redefining cognitive and mental health impairment will resolve some definitional problems with s 32, allowing it to be used

in preference to bail conditions. We do not recommend the displacement of s 36A of the *Bail Act* in cases covered by s 32.

0.22 A particular problem arises in relation to bail and s 33 of the MHFPA. Certain provisions of s 33 may be read to mean that a magistrate should make a decision concerning bail when making an order under s 33. However, hospital protocols do not allow admission to a mental health facility if bail is refused. We recommend that s 33 be amended to make it clear that, if a person is taken to a mental health facility for assessment, a bail determination is not to be made unless the person is brought back to court following that assessment (Recommendation 6.1).

Chapter 7: justice system assessment and support services

Identification and assessment

0.23 Unless people with cognitive and mental health impairments are first identified, and assessed, the criminal justice system cannot respond appropriately to them. NSW presently has an assessment service for people with mental health impairments, the Statewide Community and Court Liaison Service (SCCLS.) However this service is available in only 20 of 148 Local Court locations. We recommend the expansion of the SCCLS or other services that provide for identification, assessment and advice: to make them available state-wide and to make assessment services available in relation to defendants with cognitive impairments (Recommendation 7.1).

0.24 Assessment and support services depend on referral. The people who identify and refer are police, lawyers, magistrates, court staff and others. These people need sufficient information to allow them to be effective referral agents. We recommend that the Department of Attorney General and Justice (DAGJ), in consultation with Justice Health, develop and distribute information that supports early identification of people with cognitive and mental health impairments, and referral where necessary. (Recommendation 7.2). Research has identified the key role played by Legal Aid lawyers in representing people with cognitive and mental health impairments. We therefore recommend the provision of particular training and supports for Legal Aid lawyers, to assist them to identify and refer clients with cognitive and mental health impairments (Recommendation 7.3).

Case management

0.25 Where the defendant is to be diverted to services that will deal with the causes of offending, those services must be identified and the defendant connected with them effectively. Problems arise frequently in making and maintaining connections with services, especially for those with complex needs. When problems arise a case manager who can resolve difficulties needs to be available. Presently, despite “treatment plans”, defendants do not connect with services, cannot find appropriate services, encounter problems and disengage. The current system for reporting non-compliance with treatment plans is ineffective.

0.26 NSW currently has a pilot program, Court Referral of Eligible Defendants Into Treatment (CREDIT), that resolves these difficulties and operates in two Local Court locations. CREDIT, and its Victorian equivalent (CISP), have been evaluated

very positively. We recommend that the CREDIT program be expanded, eventually to cover all Local Court locations (Recommendation 7.4). If a whole-of-government perspective is taken, we consider it is likely that the costs of this expansion will be offset by a reduction in offending, and other benefits. This approach is consistent with the *NSW 2021* plan.

0.27 Expansion of SCCLS and CREDIT state-wide, together with the other recommendations in this report, will impact on the way these programs operate. We recommend that the DAGJ review the CREDIT model in light of our recommendations and evaluation of the program by the NSW Bureau of Crime Statistics and Research (BOCSAR) (Recommendation 7.5). We also recommend that DAGJ and Justice Health review the relationship between CREDIT and the SCCLS to ensure seamless operation with each other, and other court based services (Recommendation 7.6). We recommend that the expansion of these programs should be evaluated (Recommendation 7.7).

Chapter 8: pre-court diversion

Crisis response for mentally ill persons

0.28 Police are empowered to take a person who appears to be mentally ill or mentally disturbed to a mental health facility under s 22 of the *Mental Health Act 2007* (NSW) (MHA). Such referrals account for 23% of all requested admissions to mental health facilities but 26% of those persons are not admitted. There are many reasons for this, including that the person does not fit the criteria for involuntary admission. However, numerous stakeholders expressed concerns that other reasons cause refusal to admit, such as the lack of available beds, or inability or unwillingness to deal with violent people. This issue also arises in Chapter 10 in relation to referrals by courts to mental health facilities.

0.29 We recommend that when a person is referred to a mental health facility under s 22 and is not admitted, police should be able to refer the decision to the Mental Health Review Tribunal for review, in accordance with proposals already under consideration by government (Recommendation 8.1). This option may not be used frequently, but will be available to police in cases of particular difficulty.

0.30 Stakeholders also identified significant problems concerning the relationship between the NSW Police Force, NSW Health and the Ambulance Service of NSW. An agreement regarding roles and responsibilities has been subject to re-negotiation for nearly five years. We recommend that the re-negotiation of the memorandum of understanding (MOU) be completed within 6 months, and that the NSW Mental Health Commission should monitor and report on the progress of finalising the MOU (Recommendation 8.2).

Pre-court diversion

0.31 Pre-court diversion is particularly valuable for people with cognitive and mental health impairments as it minimises their contact with the criminal justice system. There was strong stakeholder support for better options for pre-court diversion. We recommend a statutory scheme providing police with a clear power to discontinue

proceedings in appropriate cases in favour of referral to services. In our view, diversion should be available pre-and post charge, should not require admissions, should be available more than once, should not take the place of warnings and cautions and should be supported by procedures developed in consultation between key stakeholders (Recommendations 8.3 and 8.4).

0.32 Police need support in identifying and assessing people with cognitive and mental health impairments. Where they divert a person, that person may already be in receipt of services or there may be an obvious framework for diversion. However, in other cases police need a service to which they can refer defendants to be assessed and a diversion plan developed. We recommend that police should be able to call on the services of existing programs, the SCCLS and CREDIT for these purposes (Recommendation 8.5).

Training

0.33 The high level of police involvement with people with cognitive and mental health impairments justifies an increased investment in training, and we recommend that the NSW Police Force increase the training of Mental Health Intervention Team officers and, further, ensure that all police officers have received training that covers working with people with cognitive and mental health impairments and the operation of pre-court diversion (Recommendation 8.6).

Chapter 9: diversion in the Local Court – s 32

0.34 NSW has "mainstreamed" its diversionary powers for people with cognitive and mental health impairment, making them available to all magistrates in the Local and Children's Courts. Section 32 of the MHFPA is the main diversionary provision. We recommend a number of reforms to broaden the section's scope and improve its operation.

0.35 The terms used to describe cognitive and mental health impairments in s 32 are now outdated and we recommend that the new definitions (Chapter 5) be incorporated into s 32 (Recommendation 9.1). This will extend the scope of the section to the full range of people with cognitive and mental health impairments.

0.36 The current section gives no guidance to a court in deciding whether to divert. We recommend that s 32 include a non-exhaustive list of factors relevant to a decision to divert. Our intention is that courts should be prompted to consider relevant matters, but that their discretion should not be unduly fettered (Recommendation 9.2).

0.37 A number of problems have been identified with s 32. First, it is under-used: about 1% of cases in the Local and Children's Court are dealt with under s 32. Section 32 involves submitting a treatment plan. The challenges of producing a proper plan for defendants who have multiple diagnoses and complex needs are considerable and involve knowledge of the service sector. But this task is carried out by lawyers who usually have no expertise in the service sectors or in the requirements of a satisfactory plan. In addition, orders are presently limited to 6 months, and some stakeholders believe this is too short to be effective. The provisions relating to

breach are ineffective and non-compliance is very rarely reported to the court. We heard from some stakeholders that these problems are barriers to diversion.

0.38 We make a number of recommendations in response to these problems. We have recommended in Chapter 7 that courts be provided with support to assist with assessment and case management of defendants, and to report on compliance with s 32 orders. These supports are central to the successful operation of diversion.

0.39 We recommend amendment of s 32 to increase and clarify the diversionary options available (Recommendation 9.4):

- Option 1: discharge the defendant unconditionally. This may be appropriate where the offending is not serious and the defendant is not likely to reoffend.
- Option 2: discharge the defendant on the basis that a diversion plan is in place. This option may be appropriate if the court is satisfied the defendant is motivated to engage with services.
- Option 3: adjourn the proceedings with a view to later discharge, on condition that the defendant undertake a diversion plan and report to the court in relation to his or her progress in complying with the plan. This option provides for court monitoring of compliance with diversion. Such monitoring may be minimal and simply require a report back to court at the end of the order. Alternatively it may respond to key milestones in the plan. In other cases it may involve more intensive judicial monitoring through regular reports to the court.
- Option 4: where the defendant meets the eligibility criteria, which include imminent risk of imprisonment, the court may refer the defendant to the specialist Court Referral for Integrated Service Provision (CRISP) list. This list is discussed in Chapter 12.

0.40 We recommend removal of the power under s 32 to discharge into the care of a responsible person (Recommendation 9.5). Stakeholders told us that this provision is very rarely used, that the role of a responsible person is ill defined, and that service providers and family members are unwilling to take on the role. In our view, a diversion plan could incorporate care responsibilities, where available and appropriate.

0.41 Diversion plans must set out a program of treatment and/or engagement with services and/or other activities (Recommendation 9.6). The plan must address those matters that appear to give rise, directly or indirectly, to offending behaviour. Depending on the individual, these may include services as diverse as psychiatric treatment, housing, counselling, social supports, drug programs, and educational activities. Diversion plans may be brief and simple documents in appropriate cases.

0.42 Where reporting to the court is required under option 3, a responsible reporter must be nominated (Recommendation 9.7). Where the CREDIT program is available, it will report to the court. In other cases the role may be taken on by a service provider, or a legal representative.

0.43 We recommend that courts have powers to amend plans during their currency, and the power to terminate early. On completion, the court may discharge the person or deal with the person according to law (Recommendation 9.8). We also recommend

that the court should be able to extend the length of a diversion plan beyond 6 months for up to 12 months (Recommendation 9.9).

Chapter 10: diversion in the Local Court – s 33

0.44 Section 33 of the MHFPA provides magistrates with the power to refer a mentally ill person to a mental health facility for assessment. A mentally ill person is someone who is suffering from a mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of that person is necessary whether for the person's own protection from serious harm or the protection of others from serious harm. Section 33 also gives magistrates the power to discharge into the care of a responsible person, or to place a person under a community treatment order.

0.45 Section 33, like s 32, is used infrequently, and there is a high rate of return to court. It is designed for people who appear in court who are acutely mentally ill, and there may be limited numbers of such people. However, we anticipate that the recommendations we make in this report concerning s 33 and s 32, and improvements to assessment and court support, will increase the use of these orders in appropriate cases and will also address problems of recidivism.

0.46 There is presently a difference between the power of the magistrate to refer, which is confined to those who are mentally ill persons, and the authority of the mental health facility to admit, which extends to mentally ill persons and mentally disordered persons. A mentally disordered person is a person who do not have a mental illness, but whose behaviour, for the time being, is so irrational as to justify a conclusion, on reasonable grounds, that temporary care, treatment or control is necessary for the person's own protection, or the protection of others, from serious harm. We recommend that courts should be able to refer for assessment those people who appear to be either mentally ill persons or mentally disordered persons (Recommendations 10.1 and 10.3).

0.47 There is some confusion among stakeholders as to whether the person who is referred to a mental health facility can come back to court to be dealt with and, if so, in what circumstances. We therefore recommend amending s 33 to make it clear that it authorises both a final order or an interlocutory order, at the discretion of the court (Recommendations 10.1 and 10.3).

0.48 We also recommended that the option of discharging the defendant into the care of a responsible person be repealed (Recommendation 10.5).

0.49 One of the major problems reported to us with s 33 is that courts refer people who appear to them to be mentally ill persons to mental health facilities, but they are assessed as not eligible for admission and are returned to court (or discharged onto the streets). In some cases, when the person is assessed by a psychiatrist, they will not fit the definition of "mentally ill person" and will not require hospitalisation. However stakeholders told us that there are other cases where defendants are not admitted, despite being referred on the basis of clinical advice, or cases where defendants were repeatedly taken back and forth between court and a mental health facility in a state of acute ill health until they are ultimately admitted.

Stakeholders suggested that the reasons for not admitting were sometimes related to resourcing problems. Stakeholders also expressed concern that some staff at mental health facilities believe that police or prisons are more appropriate to manage defendants who may be violent. To deal with this problem we propose that when a defendant is not admitted, the mental health facility must provide a short report to the court and that a court should be able to refer a refusal to admit to the Mental Health Review Tribunal for review (Recommendation 10.7).

0.50 Finally, we recommend that the interlocutory power under s 33 should be available to the Local Court in indictable matters (Recommendation 10.8).

Chapter 11: mental health courts

0.51 Specialist courts for people with mental health problems, and sometimes also for people with cognitive impairments, are a growing trend. They were first established in the United States, and that jurisdiction has the most experience with evaluating the success or otherwise of such courts.

0.52 While models differ, mental health courts usually have a distinct list operating separately from regular criminal courts with clear eligibility criteria for defendants. They have a dedicated court team, with consistent judicial officers, dedicated prosecutors and defence lawyers, mental health workers and court staff. A non-adversarial approach to hearings is usually adopted. A plan of treatment and engagement with services is provided for each defendant. Regular court hearings are held to review the defendant's progress. If the defendant does not comply with the treatment plan they are first encouraged, supported and assisted to comply. However if non-compliance is persistent sanctions may be applied, such as increased court appearances or changes to the treatment plan. Repeated non-compliance generally results in termination from the program.

0.53 While mental health courts are not without critics, many evaluations are positive and show, for example, reductions in re-arrest rates, incarceration rates, and associated costs.

0.54 Mental health courts or specialist lists have been established in Australia. Specialist courts or lists are either established or proposed in Queensland, South Australia, Tasmania, Western Australia and Victoria. Evaluations have generally been positive, though evidence of reduction in reoffending is limited. The Victorian program is currently being evaluated.

Chapter 12: Court Referral for Integrated Service Provision list

0.55 The Commission considers that there is a strong case for the introduction of a specialist list in NSW to supplement our recommended enhancements to s 32. There is a great deal of stakeholder support (though not unanimous), and there is good evidence that such an approach can provide substantial benefits, including the reduction of reoffending. Although our recommendations in relation to s 32 will provide suitable diversionary options for many cases, there is a group of defendants in relation to whom a specialist list appears to be the appropriate response.

0.56 We have given the list a name that describes what it does – Court Referral for Integrated Service Provision (CRISP) (Recommendation 12.1). This list would operate in the Local and District Courts.

0.57 A defendant should be eligible for the list if he or she:

- has a cognitive or mental health impairment
- faces a serious prospect of imprisonment
- is not contesting the facts that form the basis of the alleged offence, and
- has a CRISP list geographically accessible. (Recommendation 12.2)

0.58 When court refers a person to CRISP, a specialist team will assess the person for eligibility. The final decisions on entry to the list will be made by the court after hearing from all relevant parties. (Recommendation 12.2)

0.59 Some offences are of such a serious nature that they will be unsuitable for CRISP. However, there are cases where an evaluation of seriousness is ameliorated by the impact of the defendant's cognitive or mental health impairment on capacity to understand the wrongness of the offending behaviour. We therefore recommend that offences that are "indictable only" be excluded from the list. In cases that are indictable triable summarily there would remain a discretion for the case to be rejected as not appropriate for the list (Recommendation 12.3).

0.60 The problem solving approach of the list requires judicial officers who have training, or experience and aptitude for such work (Recommendation 12.4). The list would be supported by a dedicated team who would provide assessments, develop diversion plans, provide case management services to defendants, and report to the court. The skill set for such a staff would be the same as that of the CREDIT team (Recommendation 12.5). Prosecutors and defence lawyers who understand the approach and procedures of the list are also important, and we recommend that dedicated people be allocated to the list (Recommendation 12.5).

0.61 The list would operate in the manner of a problem solving court. It would be informal and not be bound by the rules of evidence (Recommendation 12.6). When a defendant is admitted to the list a diversion plan would be prepared, and the defendant's engagement with services monitored. The CRISP team would deal with any problems. The court would approve the diversion plan and any major changes to it. The defendant would report regularly to court. If the defendant does not comply with the plan, the normal response of the court would be to provide positive reinforcement to encourage compliance. The plan may be amended, for example to increase case management. (Recommendation 12.7) Ultimately however, persistent non-compliance would mean termination of the defendant from the list. At this point the court would deal with the defendant according to law, either in the list or by transferring the case to the referring court. (Recommendation 12.8)

0.62 Successful participation in the list will not entitle the defendant to discharge. It may be appropriate in some cases, for example where the defendant has repeatedly committed minor offences and the program has successfully dealt with the problem behaviour. In other cases participation in the program may persuade the court that a contemplated sentence of imprisonment should not be imposed, but that an

alternative is appropriate. In any case, participation in the program will be taken into account if it is in favour of the defendant, but not if it is to the defendant's detriment (Recommendation 12.8).

0.63 The CRISP list should be evaluated and the evaluation built into the program from its commencement (Recommendation 12.9).

Chapter 13: diversion in the higher courts

0.64 The District and Supreme Courts presently have more limited diversionary options than the Local and Children's Courts. They do not have diversionary powers under s 32 and s 33 of the MHFPA. Stakeholders were generally in favour of extending these powers to the higher courts, although some reservations were expressed about the seriousness of cases in these courts and their suitability for diversion.

0.65 We recommend that diversion under s 32 and s 33 of the MHFPA be available to the District and Supreme Courts (Recommendation 13.2). We expect that they will be rarely used, but may be appropriate and necessary in some cases. Our recommendations in Chapter 9 for amendment of s 32 provide that the court should take into account when deciding if diversion is suitable, the "nature, seriousness and circumstances" of the alleged offence. This addresses concerns about the suitability of diversion for serious offences. We also recommend that the services of the SCCLS and CREDIT should be available in those courts to support diversionary decisions (Recommendation 13.3).

Chapter 14: young people and diversion

0.66 Diversion is already a strong focus of the criminal law and procedure relating to young people. For example the *Young Offenders Act 1997* (YOA) provides for cautions and youth conferences, and diversion under s 32 and s 33 of the MHFPA is available to the Children's Court.

0.67 However, there are a number of ways in which pre-court diversion could be improved to take into account the situations of young people with cognitive and mental health impairments.

0.68 Under the YOA, the present limit of three cautions may cause problems for young people with cognitive and mental health impairments who may not understand that their behaviour is wrong or may have difficulty controlling it. We recommend that it should be possible to exceed the three caution limit when it appears that the young person has a cognitive or mental health impairment (Recommendation 14.3).

0.69 We recommend that our proposed scheme for adult pre-court diversion also apply to young people. This will require integration into the YOA options, and we recommend that further work should be done on this issue. Referral to services at an early stage may the best option for young people with cognitive and mental health impairments. Police should have access to assessment and case management services to assist them in diverting young people to services. (Recommendation 14.4)

0.70 Effective diversion of people with cognitive and mental health impairments requires assessment, effective connection with services, case management and reporting to court. The Adolescent Court and Community Team provides assessment and support in the Children's Court and we recommend that its planned expansion be extended so that a service is provided at all Children's Court locations (Recommendation 14.5). We also recommend that the Children's Court should have access to case management and court support services along the lines of the CREDIT and MERIT programs, and that a government agency be allocated to lead the development of this service (Recommendation 14.5).

0.71 Our recommendations in Chapters 9 and 10 to improve s 32 and s 33 of the MHFPA will benefit young people as well as adults. However, it is harder to justify a specialist list within an already specialised Children's Court. We recommend that consideration of a specialist list for young people with cognitive and mental health impairments in the Children's Court should be delayed until evaluations of the CREDIT program (or equivalent) in the Children's Court, and the CRISP list have been completed (Recommendation 14.6).

Recommendations

	Chapter 4: Prevalence	page
4.1	The Department of Attorney General and Justice should establish a working group including the NSW Bureau of Crime Statistics and Research, relevant criminal justice agencies and non-government research experts to develop a strategy for data collection and analysis about the representation of, and outcomes for, people with cognitive and mental health impairments in the criminal justice system, in particular at the following points: (a) police contact (b) bail (c) court (d) Corrective Services NSW and NSW Juvenile Justice.	101

	Chapter 5: Defining cognitive and mental health impairment	page
5.1	The following definition should be used in legislation where appropriate: (a) Cognitive impairment is an ongoing impairment in comprehension, reason, adaptive functioning, judgement, learning or memory that is the result of any damage to, dysfunction, developmental delay, or deterioration of the brain or mind. (b) Such cognitive impairment may arise from, but is not limited to, the following: (i) intellectual disability (ii) borderline intellectual functioning (iii) dementias (iv) acquired brain injury (v) drug or alcohol related brain damage (vi) autism spectrum disorders.	136
5.2	The following definition should be used in legislation where appropriate: (a) Mental health impairment means a temporary or continuing disturbance of thought, mood, volition, perception, or memory that impairs emotional wellbeing, judgement or behaviour, so as to affect functioning in daily life to a material extent. (b) Such mental health impairment may arise from but is not limited to the following: (i) anxiety disorders (ii) affective disorders (iii) psychoses (iv) severe personality disorders (v) substance induced mental disorders. (c) "Substance induced mental disorders" should include ongoing mental health impairments such as drug-induced psychoses, but exclude substance abuse disorders (addiction to substances) or the temporary effects of ingesting substances.	138
5.3	The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to include the definitions of "cognitive impairment" and "mental health impairment" set out in Recommendations 5.1 and 5.2.	143
5.4	A new *Bail Act* should adopt the definitions of "cognitive impairment" and "mental health impairment" set out in Recommendations 5.1 and 5.2.	145
5.5	If the Government does not proceed with a new *Bail Act*: (a) The *Bail Act 1978* (NSW) should be amended to insert definitions of mental health impairment and cognitive impairment set out in Recommendations 5.1 and 5.2.	147

(b) Section 32(1)(b)(v) of the *Bail Act 1978* (NSW) should be amended to require decision makers to consider any special needs of any person with a cognitive impairment or a mental health impairment.

(c) Section 37 of the *Bail Act 1978* (NSW) should be amended to extend the requirement to consider the capacity to understand and comply with bail conditions to any person with a cognitive impairment or a mental health impairment.

	Chapter 6: Bail	page
6.1	Section 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that if an order is made under that section directing a person be taken to a mental health facility for assessment, a bail determination is not to be made unless the person is brought back to court following assessment.	168

	Chapter 7: Justice system assessment and support services	page
7.1	Services for identification, assessment and advice concerning defendants with mental health impairments and cognitive impairments should be made available to all Local Court locations, through the expansion of the Statewide Community and Court Liaison Service or, where appropriate, through other local arrangements.	198
7.2	The Department of Attorney General and Justice, in consultation with Justice Health, should develop and distribute information that supports the early identification of people with cognitive and mental health impairments in the criminal justice system and supports appropriate responses, including referral where necessary.	199
7.3	The Legal Aid Commission of NSW should provide training and support to Legal Aid lawyers to allow them to identify clients with signs of cognitive and mental health impairments and make appropriate referrals for assessment.	200
7.4	The CREDIT program should be expanded to cover all Local Court locations.	201
7.5	The Department of Attorney General and Justice should review the CREDIT model in light of the recommendations of this report, and the NSW Bureau of Crime Statistics and Research evaluation.	203
7.6	The Department of Attorney General and Justice and Justice Health should review the relationship between CREDIT and the Statewide Community and Court Liaison Service to ensure that those services operate seamlessly with each other, and in relation to other court based services, including support staff of the CRISP list proposed in Recommendation 12.1.	203
7.7	Expansion of the Statewide Community and Court Liaison Service and CREDIT should be accompanied by independent process, outcome and economic evaluation which is supported by adequate data collection from the outset of these expanded services.	206

	Chapter 8: Pre-court diversion	page
8.1	When a person is referred to a mental health facility under s 22 of the *Mental Health Act 2007* (NSW) and is not admitted, the police should be able to refer the decision to the Mental Health Review Tribunal for review.	213
8.2	(1) The renegotiation of the memorandum of understanding between the NSW Police Force, NSW Health and the Ambulance Service of NSW in relation to dealing with people with mental health impairments should be completed within six months. (2) The NSW Mental Health Commission should monitor and report on the progress of finalising the memorandum of understanding.	215
8.3	Legislation should provide for a pre-court diversion option as follows: (a) Where a person appears to have a cognitive impairment or mental health impairment as defined in Recommendation 5.1 and 5.2, a police officer may decline to charge or may withdraw a charge. (b) In making a decision under (a), the police officer should take into account: (i) the apparent nature of the person's cognitive or mental health impairment (ii) the nature, seriousness and circumstances of the alleged offence (iii) the nature, seriousness and circumstances of the person's history of offending, if any, and	232

(iv) any information available concerning the availability of treatment, intervention or support in the community.

(c) This option should:

(i) be available in relation to summary offences and indictable offences that are capable of being dealt with summarily

(ii) be available both pre and post charge

(iii) not require an admission of guilt, and

(iv) not preclude a person from being diverted merely because that person has previously committed offences or been dealt with under this option.

(d) This option should only be used where it is not appropriate to deal informally with the person, such as by warning or caution.

(e) This option does not preclude a police officer from exercising his or her powers under s 22 of the *Mental Health Act 2007* (NSW).

(f) A police officer should make a record where a person has been dealt with under this option.

8.4 The NSW Police Force should develop procedures to support the operation of pre-court diversion of people with cognitive and mental health impairments in consultation with the Courts, relevant government agencies (such as NSW Health and the Department of Attorney General and Justice) and community stakeholders. 233

8.5 (1) The Statewide Community and Court Liaison Service should be expanded to provide assessment, referral and advice to police officers to assist in making decisions in relation to diversion of people with cognitive and mental health impairments. 236

(2) The CREDIT program should be extended to provide services and advice to police to assist them in making decisions in relation to the diversion of people with cognitive and mental health impairments.

8.6 The NSW Police Force should review its current approach to training front line officers in relation to people with a cognitive and mental health impairment to: 244

(a) enhance the resourcing of the Mental Health Intervention Team program to enable a critical mass of officers to be trained in each local area command, including key roles such as custody managers

(b) ensure that all police officers have received training that covers

(i) people with cognitive and mental health impairments, and

(ii) opportunities for diversion

(c) partner with community stakeholders.

Chapter 9: Diversion in the Local Court – s 32 page

9.1 (1) Section 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended so that it applies where it appears to the magistrate that the defendant is, or was at the time of the alleged commission of the offence to which the proceedings relate, suffering from a cognitive impairment or mental health impairment, as set out in Recommendations 5.1 and 5.2. 247

(2) The existing provision in s 32(1) that excludes a mentally ill person from the application of s 32 should be removed.

9.2 (1) Section 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that the court must take into account the factors listed in (2) when making a decision concerning: 253

(a) whether diversion is appropriate

(b) which diversionary option is appropriate for the defendant

(c) the length and nature of a diversion plan, and the frequency of any reporting requirements associated with that plan.

(2) The court must take into account the following factors, together with any other matter that the court considers relevant:

(a) the nature of the defendant's cognitive or mental health impairment

(b) the nature, seriousness and circumstances of the alleged offence

(c) any relevant change in the circumstances of the defendant since the alleged offence

(d) the defendant's history of offending, if any

(e) the defendant's history of diversionary orders, if any, including the nature and quality of the support received during those orders, and the defendant's response to those orders

(f) the likelihood that proposed orders will reduce the likelihood, frequency and/or seriousness of offending

(g) whether or not it is appropriate to deal with the defendant according to law in all the circumstances of the case including:

(i) the options that are available to the court if the defendant is dealt with according to law, and

(ii) any additional impact of the criminal justice system on the defendant as a result of their cognitive or mental health impairment

(h) the defendant's views about any proposed course of action, taking into account the defendant's degree of understanding

(i) the availability of services appropriate to the defendant's needs

(j) the family and community supports available to the defendant

(k) the benefits of diversion to the defendant and/or the community

(l) the desirability of making the order that has the least restrictive effect on the defendant that is appropriate in the circumstances of the case.

(3) In forming a view about (2)(b), the court may rely on an outline of the facts alleged in the proceedings or such other information as the court may consider relevant.

9.3 (1) Section 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should provide that, without limiting the court's power to make interlocutory orders, the court should have the power to adjourn proceedings, for purposes that include: 255

(a) assessment of the defendant's cognitive or mental health impairment

(b) the development of a diversion plan

(c) an opportunity for the defendant to demonstrate engagement with relevant services or with treatment, with a view to dismissing the charge and discharging the defendant unconditionally in accordance with Recommendation 9.4(1).

(2) The court's power to make any orders as to bail should be preserved.

9.4 Section 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should provide that, taking into account the factors set out in Recommendation 9.2, the court may: 264

(1) dismiss the charge and discharge the defendant unconditionally

(2) dismiss the charge and discharge the defendant on the basis that a satisfactory diversion plan is in place and the defendant has demonstrated sufficient likelihood of compliance

(3) adjourn the proceedings, with a view to later discharge, on condition that the defendant undertake a diversion plan and report to the court in relation to his or her progress in fulfilling the plan and substantial compliance with that plan, as required by the court, or

(4) if the defendant meets the eligibility criteria in Recommendation 12.2, refer the defendant to the CRISP list proposed in Recommendation 12.1.

9.5 Section 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to remove the option of discharging the defendant into the care of a responsible person. 265

9.6 (1) A diversion plan must: 267

(a) set out a program of treatment, and/or engagement with services, and/or other activities, appropriate to the circumstances of the case

(b) address those matters that appear to give rise, directly or indirectly, to offending behaviour.

(2) A diversion plan may:

(a) specify the nature, extent and frequency of the treatment, engagement with services or other activities, and who will provide those services and activities

(b) include information relating to the nature and extent of the defendant's cognitive or mental health impairment, such as assessments by psychiatrists, psychologists and other service providers.

9.7 Where an order is made of the type described in Recommendation 9.4(3) the diversion plan should prescribe a responsible reporter who is the person or organisation responsible for reporting to the court concerning the defendant's progress and outcomes under the diversion plan. 270

9.8 Where an order is made of the type described in Recommendation 9.4(3): 272

(a) At any time during a diversion plan the court may:

(i) approve an amendment to that plan, or

(ii) terminate that plan

on the application of the defendant, a responsible reporter or of its own motion.

(b) If the court approves an amendment to the diversion plan, it may extend the period of the plan, so long as the total period of the plan does not exceed 12 months.

(c) Upon termination or expiry of the diversion plan, the court must consider how to deal with the defendant in relation to the relevant charges. In making this decision the court must consider:

(i) whether the defendant has substantially complied with the plan

(ii) the defendant's achievements during the plan

(iii) any significant change in the circumstances of the defendant as a result of his/her engagement with the plan

(iv) any other factors the court considers relevant.

(d) Upon termination or expiry of the diversion plan, the court may:

(i) discharge the defendant, or

(ii) deal with the defendant according to law.

(e) When sentencing a defendant who has engaged in a diversion plan, the court must take into account in favour of the defendant, the extent to which the defendant has participated in that plan.

(f) When sentencing a defendant who has engaged in a diversion plan the court must not take into account the defendant's failure to participate in, or complete, a diversion plan.

9.9 A diversion plan under s 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be for a defined period, sufficient for the plan to operate, of up to six months. That period may be extended in appropriate cases, up to a total of 12 months. 273

	Chapter 10: Diversion in the Local Court – s 33	page
10.1	Section 33(1)(a) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that, where it appears to the court that the defendant is a mentally ill person or a mentally disordered person as defined in the *Mental Health Act 2007* (NSW), the court may make an order dismissing the charge against the defendant and requiring that the defendant be taken to, and detained in, a mental health facility for assessment	283
10.2	Section 33(2) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be repealed.	283
10.3	Section 33(1)(b) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that, where it appears to the court that the defendant is a mentally ill person or a mentally disordered person as defined in the *Mental Health Act 2007* (NSW), the court may order that the defendant be taken to, and detained in, a mental health facility for assessment and that, if: (a) the defendant is found on assessment at the mental health facility not to be a mentally ill person or mentally disordered person, or (b) if the defendant is released following admission to a mental health facility, the defendant must be brought back before the court.	283
10.4	Section 32 of the *Mental Health Act 2007* (NSW) should provide that if a person has been taken to a mental health facility under s 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW), and is apprehended by a police officer on release from the mental health facility, then that person should either	284

be immediately brought before a court or be granted police bail under the *Bail Act 1978* (NSW).

10.5 Section 33(1)(c) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to remove the option of discharging the defendant into the care of a responsible person. 286

10.6 Section 33(1A) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to remove the words "Without limiting subsection (1)(c)". 287

10.7 When a defendant is referred under s 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) to a mental health facility and is not admitted: 291

(a) The mental health facility must provide a report which includes the time and date of the assessment, the name of the assessing officer and a statement that the person has been assessed as "not a mentally ill person or a mentally disordered person."

(b) A court should be able to refer the decision to the Mental Health Review Tribunal for review.

10.8 The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that where: 293

(a) a defendant appears before the court in relation to committal proceedings, or

(b) the defendant is charged with an indictable offence triable summarily and an election has not been made,

the court may make an interlocutory order in accordance with Recommendation 10.3.

Chapter 12: Court Referral for Integrated Service Provision list page

12.1 Legislation should provide for a Court Referral for Integrated Service Provision (CRISP) list to be established in the Local and District Courts at venues to be provided by regulation. 339

12.2 (1) Any court may refer a defendant to a CRISP list if it appears that: 340

(a) the defendant has a mental health impairment or cognitive impairment, as set out in Recommendations 5.1 and 5.2

(b) the facts alleged in connection with the offence, together with the defendant's history of offending and any other information available to the court, indicate that there is a serious prospect that the defendant will be required to serve a sentence of imprisonment if convicted

(c) the defendant is not contesting the facts that form the basis of the alleged offence, and

(d) a CRISP list is reasonably accessible by the defendant having regard to the defendant's personal circumstances and the geographical area in which he or she lives.

(2) When a defendant is referred to a CRISP list, the CRISP support team will first assess the defendant as to:

(a) the nature and extent of the defendant's cognitive or mental health impairment

(b) the likelihood that the defendant will benefit from the list

(c) the defendant's views about being dealt with in the list

(d) the level of support required by the defendant and the availability of those supports, and

(e) any other relevant matter.

(3) If the CRISP support team assesses that the defendant is eligible and suitable for the list, the defendant will appear before the court administering the CRISP list. The court will hear from the prosecution, defence and support team. Taking into account those submissions, the nature, seriousness and circumstances of the offence, and any other relevant matter, if the the court is satisfied that the defendant:

(a) is eligible, and

(b) is appropriately dealt with by the CRISP list

it may accept the defendant onto the list.

12.3 A court may not refer a defendant to a CRISP list if the proceedings relate to an offence that is strictly indictable. 342

12.4 (1) The head of jurisdiction should assign to the CRISP list judicial officers who, by reason of training or experience and aptitude, are suitable to deal with cases in this list. 342

(2) Listing practices should ensure that, so far as possible, the defendant is listed before the same judicial officer.

12.5 (1) Administrative arrangements should be put in place to ensure that the CRISP list is supported by a dedicated support team, with expertise in cognitive and mental health impairment. That team should: 343

(a) assess the defendant

(b) develop diversion plans that:

(i) respond to the needs of the defendant, and

(ii) focus on reducing or preventing further offending behaviour

(c) refer the defendant to other agencies and services

(d) provide case management services to ensure effective engagement of the defendant with relevant services

(e) monitor the defendant's progress and the suitability of services provided to the defendant, and

(f) report to the court.

(2) Specially selected prosecution and defence lawyers should be allocated to the list.

12.6 (1) The CRISP list must exercise its jurisdiction with as little formality and technicality, and with as much expedition, as the proper consideration of the matters before the court permits. 344

(2) Legislation should provide that, in hearing any proceedings in the CRISP list, the court is not bound by the rules of evidence

12.7 (1) When a defendant appears before the court in the CRISP list, the court may: 346

(a) adjourn the proceedings for assessment of the defendant and preparation of a diversion plan

(b) approve a diversion plan

(c) approve any variation to a diversion plan

(d) order that the defendant report to the court on a specified date or at specified intervals

(e) at any time terminate the defendant's participation in the CRISP list

(f) at any time deal with the defendant according to law

(g) make an order in relation to bail in accordance with the *Bail Act 1978* (NSW)

(h) issue a warrant for the arrest of the defendant, and

(i) make other orders as the case may require, necessary or incidental to the exercise of the court's functions in relation to the CRISP list.

(2) Participation in a diversion plan must not exceed 12 months.

12.8 (1) On completion of a diversion plan by a defendant the court must finalise the proceedings. 347

(2) On termination of a diversion plan the court may hear and determine the proceedings or transfer the proceedings out of the list.

(3) If at any stage the defendant indicates an intention to plead not guilty the court must transfer proceedings out of the list.

(4) On completion of a diversion plan the court may discharge the accused without any finding of guilt, or otherwise impose a sentence or disposition in accordance with the law.

(5) When sentencing the defendant, a court must take into account in favour of the defendant the extent to which the defendant participated in the diversion plan.

(6) When sentencing the defendant a court must not take into account adversely to the defendant, the defendant's failure to participate in, or complete, a diversion plan.

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13.2	Sections 32 and 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW), as amended in accordance with Recommendations 9.1-10.8, should be extended to the District and Supreme Courts.	363
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14.5	(1) The Adolescent Court and Community Team should be expanded to provide assessment and support services at all locations where the Children's Court sits. (2) A service for case management and court support for young people with cognitive and mental health impairments should be made available to the Children's Court at all its locations in NSW. (3) The government should allocate a lead agency to develop the service recommended in (2). The Department of Attorney General and Justice, Juvenile Justice NSW, the Children's Court, the NSW Police Force, the Department of Family and Community Services, the Department of Education and Communities, Justice Health and relevant non-government stakeholders should be involved in its development.	385
14.6	(1) The Department of Attorney General and Justice should monitor and evaluate the performance of assessment and court support services provided to the Children's Court, as set out in Recommendation 14.5. (2) In light of this evaluation, and the evaluation recommended in Recommendation 12.9, consideration should be given to the desirability of developing a specialist list within the Children's Court.	397

1. Introduction

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Background to the review

1.1 The Commission received terms of reference for this review in September 2007. The terms of reference require us 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*;[1]
> 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.

1.2 These terms of reference result from our request to the Attorney General to issue consolidated terms of reference combining, and broadening, two smaller separate references about s 32 of the *Mental Health (Criminal Procedure) Act 1990* (as it then was) and sentencing in relation to people with cognitive and mental health impairments. Importantly, the consolidated and expanded terms of reference require us to consider people with cognitive impairment, as well as those with mental health impairment.

1.3 This is the first report in this reference and it responds to the first specific term of reference concerning s 32 and s 33 of the *Mental Health (Forensic Provisions) Act 1990* (MHFPA), as well as looking at the issue of definitions.

1. Now the *Mental Health (Forensic Provisions) Act 1990* (NSW).

1.4 We have taken a broad view. This report is not a technical review of the operation of the two sections named in the terms of reference. Rather it is a comprehensive look at the opportunities to enhance diversion at all stages of the criminal justice system for people with mental health and cognitive impairment. In our view, this approach reflects the strong and consistent views of stakeholders in this sector and is consistent with the government's priorities under the *NSW 2021* plan.

This report in context

NSW 2021 plan

1.5 The *NSW 2021* plan identifies several goals, targets and priority actions that establish enhancing access to diversionary programs for people with cognitive and mental health impairment as a major government priority. The following goals, targets and priority actions are directly relevant to this report, and will be furthered by the implementation of its recommendations.

Goal 17 Prevent and reduce the level of reoffending

1.6 Under this goal the government states

> We will also reduce juvenile and adult re–offending by diverting people with mental health problems away from the criminal justice system and towards the health services they need.[2]

1.7 The first target under this goal is to "[r]educe juvenile and adult re-offending by 5% by 2016." Priority actions for this target include encouraging greater use of non–custodial punishment for less serious offenders, creating availability and access to diversionary programs, and creating effective strategies to deal with juvenile reoffending through improved early intervention.[3]

1.8 The second target is to "increase completion rates for key treatment and intervention programs", and includes the following priority actions:

- Review treatment and intervention programs to identify ways to increase completion rates
- Improve the way government agencies share information to deliver integrated services and management of offenders
- Assist in diverting people with mental health problems out of the criminal justice system and into services which meet their needs.[4]

Goal 11 Keep people healthy and out of hospital

1.9 One of the targets furthering this goal is to improve outcomes in mental health, which includes increasing the number of adults and adolescents with mental illness

2. NSW Government, *NSW 2021: A Plan to Make NSW Number One* (2011) 35.
3. NSW Government, *NSW 2021: A Plan to Make NSW Number One* (2011) 35.
4. NSW Government, *NSW 2021: A Plan to Make NSW Number One* (2011) 35.

who are diverted from court into treatment.[5] This target is supported by the development of the NSW Mental Health Commission charged with working to ensure that people with a mental illness are diverted from the criminal justice system, discussed below.

Other goals

1.10 Broader goals are also relevant to our report**:**

- **Goal 13:** "Better protect the most vulnerable members of the community and break the cycle of disadvantage" is attached to specific targets relating to improving child wellbeing and reducing the rate of people who are homeless. The plan discusses the importance of integrated housing, mental health and drug and alcohol services.[6]
- **Goal 16:** "Prevent and reduce the level of crime" includes the priority action of participation in interagency crime prevention and crime reduction partnerships.[7]
- **Goal 14:** "Increase opportunities for people with a disability by providing supports that meet their individual needs and realise their potential".[8] This goal is relevant to those with a cognitive impairment, and seeks to take a person centred approach to service delivery. Under this goal the government:

> is committed to ensuring that people with a disability, their families and carers are at the forefront of decision making about the services they need. We will deliver individualised and tailored services and ensure that people with a disability have the opportunity to participate in and fully contribute to the life of our society, and enable people to maximise their economic independence, relationships and sense of self worth.[9]

Mental Health Commission

1.11 The NSW Government has recently established a Mental Health Commission for NSW. The role of this body is to monitor, review and improve the "mental health system and the mental health and well-being of the people of New South Wales".[10] The functions of the Commission are provided in the *Mental Health Commission Act 2012 (*NSW).[11]

National Mental Health Commission

1.12 The National Mental Health Commission was also launched in 2012. Its purpose is to "monitor and evaluate the system as a whole", including the development, collation and analysis of data and reports on mental health, and the provision of

5. NSW Government, *NSW 2021: A Plan to Make NSW Number One* (2011) 24.
6. NSW Government, *NSW 2021: A Plan to Make NSW Number One* (2011) 28.
7. NSW Government, *NSW 2021: A Plan to Make NSW Number One* (2011) 34.
8. NSW Government, *NSW 2021: A Plan to Make NSW Number One* (2011) 29.
9. NSW Government, *NSW 2021: A Plan to Make NSW Number One* (2011) 29.
10. *Mental Health Commission Act 2012* (NSW) s 3.
11. *Mental Health Commission Act 2012* (NSW) s 12(1).

policy advice to Government. One of its roles is to administer a "National Report Card on Mental Health and Suicide Prevention".[12]

Concurrent reviews

1.13 There are a number of current or recently completed reviews in areas relating to this report. In particular:

- the current review of the *Mental Health Act 2007* (NSW) by NSW Health[13]
- the current review of the *Young Offenders Act 1997* (NSW) by the Department of Attorney General and Justice[14]
- the Commission's recently completed review of bail,[15] and
- the Commission's review of sentencing, due to report later this year.[16]

Previous reviews

1.14 A number of past reviews have shaped the law and policy landscape in the context of this reference. One of the earliest is the *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled* (The Richmond Report) in 1983. That report 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 community.[17]

1.15 Table 1.1 below provides an overview of the key reviews of mental health and intellectual disability conducted by state-level government bodies and by non-government organisations.

Table 1.1: Chronology of key reviews

Year	Review	Author	Scope/purpose	Key findings or recommendations
1996	People with an Intellectual Disability and the Criminal Justice System.	NSW Law Reform Commission	This review considers law and practice relating to the treatment of people with intellectual disabilities in the	The Report identifies the need for the criminal justice system to respond to the needs of people with intellectual disabilities. Recommendations deal with police procedure, fitness to be tried, evidence, sexual offences and sentencing

12. National Mental Health Commission, *About* <http://www.mentalhealthcommission.gov.au/about/index.cfm>.
13. Under s 201 of the *Mental Health Act 2007* (NSW).
14. Department of Attorney General and Justice, *Review of the Young Offenders Act 1997 and the Children (Criminal Proceedings) Act 1987*, Consultation Paper (2011).
15. NSW Law Reform Commission, *Bail*, Report 133 (2012).
16. We are asked to report on this reference in October 2012: NSW Law Reform Commission, *Sentencing* (24 April 2012) <http://www.lawlink.nsw.gov.au/lawlink/lrc/ll_lrc.nsf/pages/LRC_cref130>.
17. NSW, Department of Health, *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled* (1983).

			criminal justice system.	options for people with intellectual disabilities.[18] Some recommendations have been implemented, most notably in the 2005 amendments to the *Mental Health (Criminal Procedure) Act 1990* (NSW).[19]
2001	The Framework Report: Appropriate community services in NSW for offenders with intellectual disabilities and those at risk of offending.	J Simpson, M Martin and J Green. Report commissioned by Intellectual Disability Rights Service and Council for Intellectual Disability	This report aimed to develop a framework for services for people with intellectual disabilities at risk of offending, or in contact with the criminal justice system.	Reported on the problems faced by people with intellectual disabilities who come in contact with the criminal justice system, in particular, the need for services to prevent reoffending. Key themes included the need for cross-agency cooperation, and for links between services and the justice system.[20] The Framework Report Plus 5 found that much remained to be done in all areas that the original report touched upon.[21]
2002	Mental Health Services in NSW.	NSW Legislative Council Select Committee on Mental Health	A committee was established in 2001 to investigate mental health service provision.	Reported on problems that had arisen in the implementation of the objectives of the Richmond Report. Noted that the community mental health sector in NSW is not sufficiently resourced. [22]
2007	Review of the NSW Forensic Mental Health Legislation (James Report).	The Hon Greg James QC	Provided a review of forensic provisions of NSW mental health legislation.	The Review recommended that decisions about patients made by executive discretion should be replaced by decisions of the Mental Health Review Tribunal. Made further recommendations relating to forensic patients.[23] Most of the 34 recommendations of the James Report were implemented by the *Mental Health Legislation Amendment (Forensic Provisions) Act 2008* (NSW).
2008	Enabling Justice: A Report on Problems and Solutions in Relation to Diversion of Alleged Offenders with Intellectual Disability from the NSW Local Courts System.	Intellectual Disability Rights Service, with Coalition on Intellectual Disability and Criminal Justice, and NSW Council on Intellectual Disability	This review examined problems faced by defendants with an intellectual disability in the Local Court, particularly in relation to s 32 of the MHFPA.	The Report identified a number of issues faced by people with intellectual disabilities, including a limited awareness of their disability by police, court staff, lawyers and magistrates and noted difficulties both in the court process and in linking offenders to services.[24]

18. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996).
19. Made by the *Mental Health (Criminal Procedure) Amendment Act 2005* (NSW).
20. J Simpson, M Martin and J Green, *The Framework Report: Appropriate Community Services in NSW for Offenders with Intellectual Disabilities and those at Risk of Offending* (NSW Council for Intellectual Disability, 2001) v, 1, 15.
21. NSW Council for Intellectual Disability, *Framework Plus Five* (2007) 7.
22. NSW Legislative Council Select Committee on Mental Health, *Mental Health Services in NSW*, Final Report, Parliamentary Paper 368 (2002) iv, xv.
23. G James, *Review of the NSW Forensic Mental Health Legislation* (2007) 2.
24. 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) 4-5.

1.16 We note from this Table that more government attention has been paid, to date, to issues of mental health and mental illness in the criminal justice context and that issues arising from cognitive impairment have received much less attention, most of which has been in relation to intellectual disability. Even in relation to mental health issues, however, the reports show that there is a clear need for more work.

1.17 Taken together these reports provide a picture of ongoing concerns about:

- service provision for people with mental health and cognitive impairment, including services designed to address issues of offending and reoffending, and
- the scope and effectiveness of legal frameworks to deal with people with cognitive and mental health impairments in the criminal justice system.

This picture is confirmed by the material provided to us in submissions and consultations.

Our process

Submissions and consultations

1.18 Subsequent to receiving our terms of reference, the Commission received 25 preliminary submissions.[25] Five Consultation Papers (CPs) were published in 2010:

- People with cognitive and mental health impairments in the criminal justice system: an overview (CP 5).
- People with cognitive and mental health impairments in the criminal justice system: criminal responsibility and consequences (CP 6).
- People with cognitive and mental health impairments in the criminal justice system: diversion (CP 7).
- People with cognitive and mental health impairments in the criminal justice system: forensic samples (CP 8).
- Young people with cognitive and mental health impairments in the criminal justice system (CP 11).

1.19 We received 50 submissions in response to these CPs. These submissions are listed in Appendix A of this report, and are available on our website. We analysed these submissions to identify stakeholder views and any gaps in responses to the CPs.

1.20 We subsequently conducted 32 consultations involving more than 200 people as part of this reference. These consultations took place in Sydney, Kempsey, Morisset, and Melbourne. We consulted with a wide range of stakeholders, including consumers, government agencies, courts, non-government organisations and community legal centres. The consultations took a number of forms, ranging

25. See Appendix B.

from meetings with individuals, round tables, and court observations. These consultations are listed in Appendix C of this report.

1.21 The subject matter of this report requires us to examine the ways in which the criminal justice system interacts with the many sectors that provide services for people with cognitive and mental health impairments. It requires knowledge beyond law into its intersection with behavioural sciences. Ongoing legal expertise is provided by our Division. To provide us with ongoing advice and assistance about behavioural sciences and the operation of the service sectors, we convened an Expert Advisory Panel which has worked with our Division in the process of developing this report.[26]

1.22 As part of our consultation process we held a public symposium, in conjunction with the Sydney Institute of Criminology in April of 2011 at which we asked "Should NSW have a Mental Health Court?" The symposium generated significant public interest, with over 100 people registering. The event was reported by the ABC's Radio National.[27] More information about the symposium is provided in Appendix D.

1.23 We thank our experts, all those who made submissions, who contributed to our consultations, or attended our symposium. Their contributions are part of the fabric of this report and inform and enrich every aspect of it. We also thank the many people who helped to organise consultations and who assisted us (in many and varied ways) to understand the practical operation of the criminal justice system and the related service sectors.

The scope of this report: diversion

1.24 This report, *People with cognitive and mental health impairment in the criminal justice system: diversion,* will focus upon issues raised in CPs 5, 7 and 11.

1.25 There are 14 chapters in this report.

- **Chapter 2** outlines some of the key legal policy issues dealt with in this report. In particular it deals with the relationship between impairments and offending; the relationship of the criminal justice system to the many services that provide for people with cognitive and mental health impairments; and the relationship between impairments and other aspects of identity.
- **Chapter 3** examines what we mean by diversion of people with cognitive and mental health impairment from the criminal justice system. It also assesses the advantages and disadvantages of diversion.
- **Chapter 4** provides a picture of what we know about the nature and extent of contact between people with cognitive and mental health impairments and the criminal justice system in Australia generally, and in NSW specifically.

26. See page xiii.
27. ABC Radio National, *All in the mind: Mental Health Courts and the challenge of therapeutic jurisprudence* (16 April 2011) <http://www.abc.net.au/radionational/programs/allinthemind/mental-health-courts-and-the-challenge-of/2998652>.

- **Chapter 5** examines the definitions of cognitive and mental health impairment currently used in NSW legislation. It identifies inconsistencies in these definitions, and that some are out of date. It recommends new definitions.
- **Chapter 6** provides an overview of the main issues in relation to bail law as it affects people with cognitive and mental health impairments, focussing in particular on the relationship between bail and diversion.
- **Chapter 7** deals with current approaches to court-based assessment and support services, and proposes improvements in relation to these services.
- **Chapter 8** explores the interaction between police and people with cognitive and mental health impairments in NSW, and makes recommendations to support and improve that interaction.
- **Chapter 9** proposes amendments to the orders available under s 32 of the MHFPA to improve and expand the options available to courts in responding to defendants with cognitive and mental health impairments.
- **Chapter 10** addresses issues or problems that arise in the application of s 33 of the MHFPA and recommends improvements.
- **Chapter 11** examines the current trend to establish specialist courts or court lists for people with cognitive and mental health impairments in the criminal justice system. The chapter considers the strengths and weaknesses of these developments. It reviews the development of mental health courts in Australia. This chapter provides background to the recommendations made in Chapter 12.
- **Chapter 12** proposes a specialist list in the Local and District Courts, to be called the Court Referral for Integrated Service Provision list (CRISP), designed to provide a focussed response to those offenders with cognitive and mental health impairments who are immediately at risk of imprisonment.
- **Chapter 13** considers the expansion of diversion provisions under s 32 and s 33 of the MHFPA to the higher courts.
- **Chapter 14** considers diversionary options available to young people with cognitive and mental health impairments, and proposes improvements both in relation to pre-court diversion and court based assessment and support services.

The second report: criminal responsibility

1.26 A second report will follow this one, primarily addressing issues raised in CPs 6 and 8, and addressing in particular:

- the mental impairment defences
- fitness to stand trial and related processes
- the management of forensic patients, and
- aspects of the operation of Part 10 of the *Crimes (Forensic Procedures) Act 2000*.

The Commission will deal with issues related to the sentencing of people with cognitive and mental health impairments in conjunction with its review of sentencing.

2. Preliminary issues

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Introduction

2.1 People with cognitive and mental health impairments are over-represented throughout the criminal justice system. In this chapter, we consider how this comes about by examining the relationship between impairments and offending.

2.2 People do not present to courts with a single, neatly defined, issue of mental health or cognitive impairment. Other aspects of a person's identity or experience, such as their Aboriginality or their age, may impact on court decisions about matters such as diversion, bail or sentencing. The intersection of mental health and cognitive impairments with other aspects of identity creates fresh challenges for the criminal justice system and we briefly outline some of the relevant issues.

2.3 Diversion of people with cognitive and mental health impairments generally involves defendants engaging with a wide range of providers of treatment and services that have a rehabilitative focus.[1] The relationship between the criminal justice system (police and courts) and this service sector is crucial to effective diversion. Throughout the report we refer to the challenges of this relationship and the ways in which it might be improved. We therefore provide an outline of the nature and complexity of both the criminal justice system and service sector and some of the key challenges for effective diversion.

2.4 The important question of how we define cognitive and mental health impairments in the criminal justice system is dealt with in Chapter 5.

The relationship between impairment and offending

2.5 There is clear evidence of over-representation of people with cognitive and mental health impairments at all stages of the criminal justice system. Chapter 4 covers this evidence in detail. In this section we ask: why should this be the case? The answer is not simple.

1. These service providers may be important not only in relation to diversion, but also bail, sentencing and other matters.

2.6 The first point to make is that the common image from the media or popular culture of a person with a mental illness, however serious, or with an intellectually disability or other cognitive impairment, as naturally prone to violence or offending is wrong. There is evidence that a person with a mental health or cognitive impairment has an increased risk of coming into contact with the criminal justice system – this is the implication of the evidence of overrepresentation. But the great majority of people with such an impairment do not offend.

2.7 For example, a metastudy by Mullen reports heightened levels of violent and non-violent offending for individuals with serious mental illness (eg schizophrenia and those who have been in hospital for serious affective disorders). Co-existing substance abuse heightens the risk of offending in both cases. However, in both cases, only a minority of people with these illnesses offend.[2]

2.8 The research suggests that the paths by which a person with a cognitive and mental health impairment might arrive in the criminal justice system is complex and multi-factored. Often the person has complex needs and had faced multiple sources of disadvantage. As an illustration of the complexity, accordingly to the 2009 Inmate Health Survey, prison inmates are characterised as having:

> histories of disrupted family and social backgrounds; abuse, neglect and trauma; poor educational attainment and consequent limited employment opportunities; unstable housing; parental incarceration; juvenile detention; dysfunctional relationships and domestic violence; and previous episodes of imprisonment, all highly prevalent among samples of prison inmates, including that described in the present report. With such multiple risk factors for poor health, it is hardly surprising that prison inmates are further characterised by physical and mental health far below that enjoyed by the general population.[3]

2.9 From this perspective, broader social or structural factors may be important in explaining the complex relationship between cognitive and mental health impairment and offending. According to a 2001 report in relation to intellectual disability:

> the factors most likely to bring people with an intellectual disability into contact with the criminal justice system are related to a number of deficits in life skills due to the lifestyle and the environment in which they grew up, rather than having an intellectual disability itself.[4]

2.10 The Mullen metastudy referred to above reviews a number of studies from the US, Denmark and New Zealand which have attempted to determine the relationship between mental health status and offending by analysing random community samples. These studies have shown that higher rates of offending by people with mental health impairments arise not from any simple correlation between impairment and crime, but from a multiplicity of factors. Violent offending is affected

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2. P E Mullen, *Mental Health and Criminal Justice: A Review of the Relationship Between Mental Disorders and Offending Behaviours and on the Management of Mentally Abnormal Offenders in the Health and Criminal Justice Services* (2001) 8-15.

3. D Indig and others, *2009 NSW Inmate Health Survey: Key Findings Report* (NSW, Justice Health, 2010) 151.

4. J Simpson, M Martin and J Green, *The Framework Report: Appropriate Community Services in NSW for Offenders with Intellectual Disabilities and those at Risk of Offending* (NSW Council for Intellectual Disability, 2001)13.

by a range of factors, including the type of impairment, and is exacerbated by substance abuse.[5]

2.11 Baldry, Dowse and Clarence are undertaking an ongoing study of the pathways by which people with mental health disorders and cognitive disability arrive in prison (Pathways Study). They have found that:

> those with complex cognitive disability (ie comorbidity / dual diagnosis) are significantly more likely to have earlier contact with police, more police episodes, be more likely to have been clients of juvenile justice, have more police episodes through life and more prison episodes than those with single, or no diagnosis and for this high and ongoing contact with the criminal justice system (CJS) to lock them into the CJS very early rather than assist in rehabilitation. Their offences are almost all in the lowest 10% of seriousness.[6]

2.12 To take one factor from the study, homelessness associated with mental health and cognitive impairment adds to risk of offending (and vice versa). The Pathway Study identifies that prisoners with complex needs[7] "experience greater homelessness and housing disadvantage" than people with only one or no diagnosis, and people who have complex needs and are homeless have "higher rates of police contact; higher rates of episodes of custody; [and] lower av[erage] days in custody".[8] Indigenous women who are homeless and who have complex needs "have higher police contacts and higher episodes of custody than anyone."[9] In this context, multiple factors may reinforce each other and create a cycle of offending.

2.13 Some case studies taken from submissions illustrate the points made above.

Case study 2.1

Ms K is a 24 year old Aboriginal woman who has been diagnosed as having an intellectual disability. Ms K experiences a range of social difficulties including difficulty in maintaining appropriate housing, poverty, drug use, poor nutrition and everyday functioning as well as involvement in the criminal justice system. Ms K has a history of childhood neglect and suspected abuse.

Ms K absconded from a diversionary accommodation program, thereby breaking the conditions of a Section 11 bond. Ms K was taken back into custody and a magistrate decided Ms K should not return to the program. Her solicitor was not able to apply for bail until an alternative accommodation option could be found for Ms K in the community. ADHC were unable to identify an accommodation option for several months.

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5. P Mullen, *Mental Health and Criminal Justice: A Review of the Relationship Between Mental Disorders and Offending Behaviours and on the Management of Mentally Abnormal Offenders in the Health and Criminal Justice Services* (2001).
6. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) <www.app.unsw.edu.au/sites/app.unsw.edu.au/files/mhdcdbackgroundoutlaws_conf1.pdf> 14-15.
7. Defined for this study as having dual diagnosis of mental health disorders and cognitive disability
8. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 9.
9. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 9.

Ms K…was finally released from custody several months later to be supported by a CLASP (Comprehensive Lifestyle Accommodation and Support Program) funded by ADHC.[10]

Case study 2.2

[Ms L] had a history of childhood abuse at the hand[s] of her grandfather who she remembers as a large man who wore a uniform. As a result she experienced an irrational fear of uniformed police officers. She also had a history of drug and alcohol problems. She was terrified of being labelled a "lunatic" and believed that, if she sought help to treat her depression and anxiety, she would be immediately "locked up in an institution". Because she did not seek medical treatment, she was never properly diagnosed. She could not even speak to her GP about her condition.

[Ms L] was involved in a number of situations when she could not cope with interacting with police. On one occasion…she [was] arrested for allegedly spitting on a police car. On each occasion she was accused of offensive language, resisting police and assaulting police.[11]

Case study 2.3

Mr R has alcohol related brain damage (Korsakoff's syndrome) and associated dementia, along with cerebral atrophy, chronic airways disease, a minor heart problem, a prostate problem, and occasional gout. Due to his incapacity, he did not know that he had been banned by the NSW and Victorian courts from operating a motorised vehicle. Mr R would frequently drive his vehicles on a suspended licence and while intoxicated simply because he could not remember he was not legally allowed to drive. In addition, due to alcohol induced brain damage, Mr R could not comprehend the laws surrounding operating a vehicle while intoxicated. This frequently resulted in contact with local Police and further criminal convictions.

The Public Guardian has now advocated for Mr R's family to organise the removal of his vehicles so he does not have the means to drive. In addition, the Public Guardian advocated for placement within a dementia specific unit, which would also offer Mr R a period of detoxification and treatment, until suitable and permanent accommodation could be located for him.[12]

Case study 2.4

[Mr J] had an extensive criminal history for a string of petty theft offences. [Mr J]'s personal history was tumultuous and at the time he had substance abuse issues. There was a history of mental illness in his family and his mother suffered schizophrenia. Redfern Legal Centre referred [Mr J] for psychological assessment. The psychiatrist's report concluded that [Mr J] had symptoms consistent with depression and had an intellectual disability.

10. NSW Public Guardian, *Submission MH27*, 21.
11. Redfern Legal Centre, *Submission PMH16*, 2.
12. NSW Public Guardian, *Submission MH27*, 12.

It was not long before [Mr J] was in trouble with police again. He subsequently revealed that he had a cycle which helped explain his convictions. The cycle was explained as follows: his long history of offences had earned him a reputation among local police, who he said, harassed him on a regular basis. Each time [Mr J] was approached or questioned by police, which was frequent, he became agitated, likely to hang around more with drug users, his own drug use escalated and he would shoplift small items like chewing gum or socks, knowing he would be caught.[13]

Case study 2.5

[Ms B] was well known to the local police due to her frequent loud, angry, and confrontational behaviour in public places, which frightened and alarmed people. The police response was generally to physically restrain her and at one point were discussing the use of tasers. The Brain Injury Association of NSW worked with the police concerned to change their response to a less confrontational approach, understanding [Ms B] was not actually threatening violence, but was responding to her own frustration and sense of not being understood. This involved reframing her behaviour. The police went from seeing her as a 'difficult' person to be managed and restrained, to understanding her as a person with an ABI who needed to be heard and understood. Once she feels she is being listened to, and when not overwhelmed by a situation, [Ms B] is a highly intelligent person who understands and remembers what she is told, and is able to communicate her needs clearly. Her behaviour can settle quickly and easily.[14]

2.14 The research and these case studies present a picture of people with complex issues that may reinforce and exacerbate their offending (such as drug use on top of mental illness, or homelessness added to a cognitive impairment). Sometimes there is failure to diagnose a person or engage that person with treatment or services. Sometimes police action or imprisonment, which might be appropriate in other situations, might be ineffective in dealing with the offending of people with a cognitive or mental health impairments and might draw them further into the offending cycle.

2.15 In each case, the mental health or cognitive impairment forms part of the background to offending, and effective intervention to prevent further reoffending requires services outside the criminal justice system, including services that address the mental health or cognitive impairment in context. For some, the intervention may be simple, for instance in case study 2.5, different policing practice assisted; in case 2.3 a car had to be removed, and better accommodation found. We might imagine a case where a person with a mental illness simply needed additional support to assist that person to take their medication. In other cases, multiple services may be required, to deal with the complex needs presented by the person.

13. Redfern Legal Centre, *Submission PMH16*, 3-4. This case study has been edited.

14. Brain Injury Association of NSW, *Submission MH19*, 14. This case study has been edited.

A diverse group

2.16 People with a cognitive or mental health impairment are a diverse group. As will be evident from the cases studies we have chosen, each individual is different.

2.17 First, their impairments differ greatly. Mild affective disorders present different issues than severe psychoses, or schizophrenia. Intellectual disability has a range of severities. Dementia and acquired brain injury present different issues again for those who live with them, and their families and carers.

2.18 In addition, the age, cultural background, family situation, and other life experiences of the person can affect the way their impairment manifests and the best approach to managing the impairment. The following section illustrates this point by exploring some of these issues, by way of example, as they apply to young people, Aboriginal people and Torres Strait Islanders and people from culturally and linguistically diverse communities.

Young people

2.19 A different legal framework governs young people. A young person's cognitive or mental health impairment must be considered alongside law that prescribes varying degrees of criminal responsibility between the ages of 10 and 18.[15] Young people are different from adults in that certain mental health disorders are more prevalent in young people, for instance Attention-Deficit/Hyperactivity Disorder.[16] Conversely, some disorders can only be diagnosed in an individual over the age of 18 years, such as Antisocial Personality Disorder.[17] In addition, as we discuss in Chapter 14 there are challenges involved in the identification of a young person's mental health or cognitive impairment.[18] The combination of a young person's age and their disability (where it is diagnosed) can create challenges for courts.

2.20 A young person with a cognitive or mental health impairment may find it particularly difficult to navigate the criminal justice system. For instance, they may find it difficult to understand and comply with bail conditions.[19] They may need particular types of services, such as those that work with both the young person and their family to address offending behaviour,[20] that are "inclusive, youth friendly and age

15. For more information, see NSW Law Reform Commission, *Young People with Cognitive and Mental Health Impairments in the Criminal Justice System*, Consultation Paper 11 (2010) Chapter 1.
16. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) 89-90.
17. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) 99.
18. Para 14.59-14.60.
19. UnitingCare Children, Young People and Families, *Submission MH33*; Shopfront Youth Legal Centre, *Submission MH41*, 2; Children's Court of NSW, *Submission MH43*,1; Youth Justice Coalition, *Submission MH34*, 10.
20. For instance, the Intensive Supervision Program, and Family Case Management: NSW Law Reform Commission, *Young People with Cognitive and Mental Health Impairments in the Criminal Justice System*, Consultation Paper 11 (2010) [1.64] –[1.65]. See also Justice Health, Victorian Government Department of Justice and the National Justice Chief Executive Officers' Group, *Diversion and Support of Offenders with a Mental Illness: Guidelines for Best Practice* (2010) 80.

appropriate" and that provide continuity between adolescence and adulthood.[21] Recommendations addressing the problems experienced by young people with a cognitive or mental health impairment in the criminal justice system are made in Chapter 14.

Aboriginal people and Torres Strait Islanders

2.21 The overrepresentation of Aboriginal people and Torres Strait Islanders in prison is well documented. As at June 2010, 21.28% of adults incarcerated in NSW were Aboriginal or Torres Strait Islander people.[22] Additionally, there may be a higher incidence of cognitive and mental health impairments in Aboriginal people and Torres Strait Islander communities. However, obtaining accurate statistics on prevalence is problematic, as culture and context may lead to misdiagnosis. For instance, undiagnosed post-traumatic stress disorder, or cultural bias in a test may affect accuracy.[23]

2.22 Some commentators have argued that the incidence of cognitive disability might be twice as high in Indigenous communities as a result of a range of factors including poverty, dispossession, foetal alcohol syndrome and brain damage as a result of alcohol consumption, inhalant use or violence.[24] Furthermore, the NSW Health Aboriginal Mental Health and Wellbeing Policy cites the high prevalence of grief, trauma and loss in Aboriginal communities, as well as a rate of suicide and self-harm that is at least twice the national rate.[25] It has been reported that the rate of mental illness in these communities is affected by "socio-cultural, socio-economic and socio-historical factors".[26]

2.23 A general attitude of mistrust towards government services, inflexible and culturally inappropriate services and services located away from Aboriginal population centres operate as key barriers to accessing mental health services.[27] Labelling people in relation to their impairments may cause stigmatisation[28] and compound the sense of "shame" that is felt by some communities.[29]

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21. Justice Health, Victorian Government Department of Justice and the National Justice Chief Executive Officers' Group, *Diversion and support of offenders with a mental illness: Guidelines for best practice* (2010) 80-81.
22. Department of Attorney General and Justice, *Annual Report 2010/2011* (2011) 121.
23. T Calma, *Preventing Crime and Promoting Rights for Indigenous Young People with Cognitive and Mental Health Issues*, Research Report No 3 (Australian Human Rights Commission, 2008) 46.
24. M Sotiri and J Simpson, "Indigenous People and Cognitive Disability: An Introduction to Issues in Police Stations" (2005-2006) 17 *Current Issues in Criminal Justice* 431, 433.
25. NSW Health, *Policy Directive: Aboriginal Mental Health and Wellbeing Policy 2006 – 2010* (2007) 10, 13.
26. E Johnston, *Royal Commission into Aboriginal Deaths in Custody*, National Report vol 3 (Australian Government Publishing Service, 1991) [23.3.32].
27. NSW Health, *Policy Directive: Aboriginal Mental Health and Wellbeing Policy 2006 – 2010* (2007) 10, 13.
28. This comment was made in relation to young people: T Calma, *Preventing Crime and Promoting Rights for Indigenous Young People with Cognitive and Mental Health Issues* (Australian Human Rights Commission 2008) 66.
29. Aboriginal people and Torres Strait Islanders roundtable, *Consultation MH14.*

2.24 The following case study illustrates the importance of cultural competence in responding to an Aboriginal person in detention.

Case Study 2.6

A 15 year old Aboriginal boy in a detention facility started behaving in a distressed manner. Staff witnessed the young boy talking to himself and crying mournfully, especially during the night. Staff started behaving towards him as though he had a delusional psychosis and were awaiting a mental health assessment by a visiting psychologist in a few days. Meanwhile an Aboriginal Youth Worker at the centre suggested the young boy might benefit from a visit from a family member. The boy's Grandmother came in and spent some time with him. She later spoke with the staff and explained that a relative had passed away recently and her Grandson's distress arose from his talking to spirit. She explained that the spirit of the relative had come to visit the boy and she had counselled him to be strong and listen to what the relative had to say to him. Staff reported that the young boy's [distress] ameliorated and he soon returned to 'normal' behaviour patterns.[30]

Culturally and linguistically diverse people

2.25 People from culturally and linguistically diverse (CALD) communities make up a significant proportion of the NSW population: 16.8% of the population was born in a country in which English was not the main language spoken.[31]

2.26 The Multicultural Disability Advocacy Association of NSW[32] submitted that some people from non-English speaking backgrounds[33] experience barriers to accessing appropriate care prior to contact with the criminal justice system. They may either not be diagnosed or be misdiagnosed.[34] Problems with obtaining an accurate diagnosis can arise from different cultural concepts surrounding disability, language difficulties, culturally inappropriate assessment tools or the masking of an impairment by language and cultural factors.[35]

2.27 These barriers may mean that by the time a person seeks help, "the situation has increased in severity, complexity and impact".[36] Contact with the legal system may compound this situation, as some members of CALD communities have a fear of, or lack knowledge of, the Australian legal system and legal services.[37]

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30. T Calma, *Indigenous Young People with Cognitive Disabilities and Australian Juvenile Justice Systems* (Australian Human Rights Commission, 2005) 28.
31. The term used by the Community Relations Commission is "Born in a Non-Main English Speaking Country": Community Relations Commission of NSW, *The People of NSW 2006, Volume 1* <www.crc.nsw.gov.au/__data/assets/pdf_file/0004/9535/Volume_1_-_Section_2.pdf>.
32. The MDAA's submission was written in response to CP 11. As such, it focused on young people.
33. The term CALD is wider than non-English Speaking Background ("NESB"). NESB is limited to people with communication difficulties, who may require an interpreter: Community Relations Commission, *Terminology and Concepts* <www.crc.nsw.gov.au/eaps/terminology>.
34. Multicultural Disability Advocacy Association of NSW, *Submission MH30*, 4.
35. Multicultural Disability Advocacy Association of NSW, *Submission MH30*, 4.
36. NSW Health, *Policy Directive: Multicultural Mental Health Plan 2008 – 2012* (2008) 11-12.
37. Multicultural Disability Advocacy Association of NSW, *Submission MH30*, 4.

2.28 Certain groups within CALD communities have particular needs that warrant special consideration. For instance some refugees have experienced significant trauma such as torture and may experience post-migration stress. Both of these factors increase vulnerability to mental health impairments.[38]

The criminal justice system and service provision

2.29 The criminal justice system provides a means by which the community responds to offending and holds people who have offended accountable to the community for their acts. It is a complex system.

2.30 A person with a cognitive or mental health impairment may appear before the Local Court, Children's Court, District Court, Drug Court and Supreme Court. The Mental Health Review Tribunal may become involved. The Guardianship Tribunal – though it has no criminal law role - may be involved in some cases, especially in relation to defendants who lack decision making capacity because of cognitive impairments. During the course of their encounter with the system, the person may have contact with a variety of criminal justice agencies including the NSW Police Force, Legal Aid NSW, the Office of the Director of Public Prosecutions, the Public Defenders Office, Corrective Services NSW, Juvenile Justice and Justice Health.

2.31 The focus of this report is the ways in which we divert people away from the criminal justice system, or into processes within the criminal justice system that have rehabilitative goals or a problem solving approach. In Chapter 3 we discuss why this can be an effective response, and this report then goes on to provide possible models of diversion at the court and pre-court stages.

2.32 If diversion is to work, however, it is essential that people have access to effective services that address their criminogenic factors, and prevent further offending. Services that may contribute to these outcomes provide, for example, medical treatment, counselling, education, training, social supports, case management, housing, financial assistance and drug treatment.

2.33 Some services are provided at court, or in conjunction with court. Assessment and support services working directly in the criminal justice system include the Statewide Community and Court Liaison Services (SCCLS); the Newcastle Court Liaison Service; the Court Referral of Eligible Defendants into Treatment (CREDIT) program; and the Magistrates Early Referral Into Treatment (MERIT) program. Discussed further in Chapter 7, these programs provide assessment, advice and case management to people with cognitive and mental health impairments.

2.34 However, other required services operate outside the criminal justice system. Linking into these broader human services is vital to break the cycle of offending and address the needs of the offender with a cognitive and mental health impairment.

38. NSW Health, *Policy Directive: Multicultural Mental Health Plan 2008 – 2012* (2008) 18.

A complex service sector

2.35 The service sector is extremely complex. Some services are provided by government departments, whereas others are provided by local non-government organisations. To give one example, NSW Health provides Area Mental Health Services and these, amongst other things, provide a range of mental health services to the community, including facilities for forensic patients. Justice Health is a statutory health corporation, funded by the Ministry of Health, that provides services to people in contact with the criminal justice system. Justice Health works closely with Juvenile Justice, and with Corrective Services: for instance, it provides the Adolescent Court and Community Team for young people, and provides services to adults in correctional facilities and police cell complexes.[39]

2.36 Ageing, Disability and Home Care (ADHC) supports some people with disabilities, including people with an intellectual disability. The criteria used by ADHC to qualify for services are the criteria in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV), that is: an IQ lower than 70; adaptive functioning deficits in two areas (such as communication and self-care); and the onset occurring before 18 years of age.[40] Services are not available through ADHC for those who do not fall within the scope of this definition. ADHC (through the Office of the Senior Practitioner) provides the Community Justice Program, which caters for people with an intellectual disability who are leaving custody and are at risk of reoffending. ADHC also provides funding for non-government organisations and local governments to deliver disability services.[41]

2.37 Other government departments may provide important services. Above we have noted that inadequate housing or homelessness often form a significant aspect of the complex needs of some people with cognitive and mental health impairments, which contribute to offending behaviour.[42] Housing NSW may therefore provide an important element of rehabilitation. For example, Housing NSW has an agreement to provide a limited amount of housing for Drug Court defendants, it plays a role in CREDIT, and is a partner in a small number of housing support programs for juveniles and adults with disability exiting prison.

2.38 NSW Trustee and Guardian provides financial management services to people with cognitive and mental health impairments that affect their capacity to manage their own financial affairs.[43] The Office of the Public Guardian may be appointed to make other types of decisions for people who lack capacity.

2.39 Non-government organisations also play a role in supporting people with cognitive and mental health impairments, for instance the Salvation Army provides services to

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39. Justice Health, *Year in Review 2010/11* (2011) 6, 7.
40. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) 49. The DSM IV uses the term “mental retardation”.
41. Department of Family and Community Services, *Annual Report 2010/2011* (2011)
42. Para 2.12.
43. NSW Trustee and Guardian, *NSWTG Managed Clients,* <www.tag.nsw.gov.au/summary-intro-page.html>; Public Guardian, *About Us,* <www.publicguardian.lawlink.nsw.gov.au/publicguardian/pg_aboutus.html>.

people in contact with courts and in prison,[44] and the Community Restorative Centre provides services to prisoners and ex-prisoners, including the Targeted Housing and Support Service. This service provides casework to women with complex needs, including intellectual disabilities or mental illness, who are exiting certain correctional centres.[45] Uniting Care provides Lifeline, a 24 hour counselling service, as well as case management services to people with disabilities.[46]

2.40 The Intellectual Disability Rights Service (IDRS) provides a specialist legal service to people with intellectual disabilities.[47] IDRS also provides training for lawyers and parents in relation to advocacy for people with an intellectual disability, for instance training on how to make an application under s 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW).[48] The Aboriginal Legal Service provides representation, advice and referrals to Aboriginal people in the areas of criminal law and care and protection.[49]

2.41 This brief review is by no means complete. It simply provides some examples of services provided by government departments and by NGOs that may be relevant in the context of diversion. It illustrates the complexity of the sector that may engage with defendants who are referred to services by a court, and some of the capacities and skills required of agencies. Where a person has complex needs, and must engage with several services, the service sector may be hard to navigate.

Inter-agency collaboration

2.42 A challenge confronting the government and NGO agencies described above, and an issue that stakeholders raised repeatedly, is that of integrated service provision and working together collaboratively.[50] Agencies were described by stakeholders as working in "silos" to the detriment of clients. Also described in consultations were tendencies to cold-refer clients to other agencies, and to decline to provide services and refer where a client has more than one impairment. Clients with multiple and compounded needs may therefore have particular problems in accessing appropriate services, and as a result may find themselves in the criminal justice system.

2.43 One example of an initiative to provide effective inter-agency collaboration is the Integrated Services Program (ISP) a service administered by ADHC through the Office of the Senior Practitioner, in collaboration with NSW Health and Housing NSW. The ISP "coordinates cross-agency responses" for clients with complex

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44. The Salvation Army, *Court and Prison Services* <www.salvationarmy.org.au/court-and-prison-services.html?s=359409226>; The Salvation Army, *Disability Services,* <www.salvationarmy.org.au/disability-services_65090.html#aue>.
45. Community Restorative Centre, *Targeted Housing and Support Service*, <www.crcnsw.org.au/services/thass>.
46. UnitingCare Children, Young People and Families, *Case management* <childrenyoungpeopleandfamilies.org.au/disabilities/case_management>; UnitingCare NSW.ACT, *Lifeline* <www.unitingcarenswact.org.au/what_we_do/lifeline>.
47. Intellectual Disability Rights Service < www.idrs.org.au/_about/about.html>.
48. Intellectual Disability Rights Service <www.idrs.org.au/>.
49. Aboriginal Legal Service, *About Us* <www.alsnswact.org.au/pages/about-us>.
50. Human Services (Ageing, Disability and Home Care), *Submission MH35*, 45, 50; Law Society of NSW, *Submission MH36*, 2. See further discussion at para 7.107, 7.96, 8.20-8.29.

needs and challenging behaviour, including "assessment, behaviour support, supervision, case-coordination and accommodation".[51] Many ISP clients have contact with the criminal justice system, however an evaluation of this program found that participation resulted in a substantial reduction in this contact.[52]

2.44 We note that the *NSW 2021* plan calls on government services to focus on early intervention and to break cycles of disadvantage and reoffending. Effective interagency service delivery will be vital to achieving these outcomes.[53]

Gaps and resourcing issues

2.45 Effective diversion relies on the availability of services in the community and herein lie practical and resource challenges. These were mentioned repeatedly in submissions and consultations. Gaps, and sometimes larger service holes, are identified throughout this report.[54]

2.46 To give one example, the NSW Consumer Advisory Group (NSWCAG) argues that "resource shortages in the public mental health system contribute to the high prevalence of people with mental illness in the criminal justice system".[55] NSWCAG further submitted:

> Crisis-orientation, lack of community mental health services (particularly in rural and remote areas), high case loads for staff, understaffing and inadequate discharge planning processes combined, create gaps in continuity of care in follow up and share care arrangements. The lack of resources also mean that many consumers who recognise that they are becoming unwell are turned away from services, and fail to receive early intervention support to avert potential offending behaviour. This is also an issue when consumers are placed on diversionary orders where services lack the capacity to provide the care, treatment and support required.[56]

2.47 In particular, NSWCAG identified problems in relation to crisis admissions to mental health facilities, the capacity to respond to crises in the community by services other than police and responses to people with complex needs.[57]

2.48 Similar concerns have been expressed particularly regarding the level and nature of resources available for people with cognitive impairment.[58] Stakeholders noted that

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51. Family and Community Services: Ageing, Disability and Home Care, *Office of the Senior Practitioner* (15 April 2011) <www.adhc.nsw.gov.au/about_us/our_structure/office_of_the_senior_practitioner>.
52. S McDermott and others, *Evaluation of the Integrated Services Project for Clients with Challenging Behaviour: Final Report* (Social Policy Research Centre, 2010) 21.
53. NSW Government, *NSW 2021: A Plan to Make NSW Number One* (2011). See Chapter 1 for discussion.
54. See, eg, Chapters 4, 6, 7, 8, 9 and 11.
55. NSW Consumer Advisory Group, *Submission MH11*, 9-10.
56. NSW Consumer Advisory Group, *Submission MH11*, 10.
57. See, eg, M Carroll, "Mental-health system overburdening police" (Dec 2005) *Police Journal* 18.
58. See L Schetzer and J Henderson, *Access to Justice and Legal Needs - A Project to Identify Legal Needs, Pathways and Barriers for Disadvantaged People, Stage 1: Public Consultations* (Law and Justice Foundation of NSW, 2003) 49; Intellectual Disability Rights Service, *Enabling Justice: A Report on Problems and Solutions in Relation to Diversion of Alleged Offenders with*

"[t]he management of intellectually disabled offenders with or without mental illness requires highly specialised programs".[59] People with borderline intellectual disability may find it particularly difficult to access services,[60] as may people with other forms of cognitive impairment, such as acquired brain injury. Proving that a cognitive impairment was evident, or diagnosed, before the age of 18 was mentioned in consultations as a barrier to gaining disability services for many people.

2.49 Issues of service availability are even more pronounced in rural, regional or remote areas, where people may be unable to access services.[61]

2.50 Furthermore, people with complex needs can "fall through the gaps" between various specialist services in the community. Riches and co-authors have noted that:

> There are a number of complex and sometimes apparently intransigent barriers within the present service system in regard to meeting the needs of individuals with developmental disabilities and mental health needs. First and foremost, most service agencies are structured to serve individuals who have either an intellectual or developmental disability or a mental illness, but not necessarily those with co-morbid conditions. Consequently the special medical, psychiatric, psychological and social needs of this population are often overlooked, inaccurately identified, or ignored altogether…The need for inter-departmental cooperation and collaboration is crucial.[62]

2.51 There are also significant deficits in relation to services for particular groups, for instance culturally appropriate services for Aboriginal people and Torres Strait Islanders. These gaps are partly due to the under-resourcing of services for people with cognitive and mental health impairments. As NSW Legal Aid cautioned, where resources are inadequate, legislative amendment can "only go so far".[63]

2.52 The case of *DPP v Albon*[64] in 2000 is illustrative of multiple and intersecting matters encountered in relation to services and resources and people with cognitive and mental health impairments in the criminal justice system. In this case there was evidence that the defendant had a brain injury with severe cognitive deficits, and was incapable of living independently in the community (a significant issue being his limited capacity to control impulse). The defendant required institutional care, but there were limited facilities available to support him.[65] No detailed treatment plan had been generated for the defendant.[66] At first instance, the magistrate noted that "he is developmentally disabled and the court isn't here to provide a service through the Corrective Services Department and unfortunately that is a problem that the

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Intellectual Disability from the New South Wales Local Courts System (2008) 47 (*Enabling Justice).*

59. NSW Health, *Submission MH15*, 5. See also Ageing, Disability and Home Care, *Submission MH28-1*, 8.
60. See, eg, NSW Council for Intellectual Disability, *Submission MH12*, 1
61. *Enabling Justice*, 47.
62. V Riches and others, "Intellectual Disability and Mental Illness in the NSW Criminal Justice System" (2006) 29 *International Journal of Law and Psychiatry* 386, 393.
63. NSW Legal Aid, *Submission MH18*, 2.
64. *Director of Public Prosecutions v Albon* [2000] NSWSC 896.
65. *Director of Public Prosecutions v Albon* [2000] NSWSC 896 [6].
66. *Director of Public Prosecutions v Albon* [2000] NSWSC 896 [7].

community has to cope with" and "[t]he court system cannot be used as a stop gap and neither can Corrective Services".[67] The defendant was released under s 32 of the MHFPA and directed to keep in contact with his caseworker and the Public Guardian.[68] The determination was quashed (due to errors in the orders made) and remitted to the Local Court to be dealt with "according to law". The Supreme Court noted:

> This, of course, underlines the fact that in our society we do not make proper provisions for people such as the defendant, and busy Magistrates are constantly being placed in a situation of having to deal with impossible cases with inadequate evidence, and in having to deal with matters that society itself has not been adequately prepared to deal with, in terms of appropriate legislation or appropriate institutions.[69]

67. *Director of Public Prosecutions v Albon* [2000] NSWSC 896 [8] quoting Keogh LCM.
68. *Director of Public Prosecutions v Albon* [2000] NSWSC 896 [9].
69. *Director of Public Prosecutions v Albon* [2000] NSWSC 896 [26].

3. Assessing diversion – goals and outcomes

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3.1 The main focus of this report is diversion. Recently, there has been an increasing shift towards the adoption of diversionary programs of various types. They are usually available to offenders with particular vulnerabilities which might cause or contribute to their offending, such as addiction to drugs or mental illness. Offenders may be referred to services in the community or to specialist programs. For example, the Magistrates Early Referral Into Treatment (MERIT)[1] scheme and the Drug Court of NSW[2] provide opportunities for rehabilitation for adult offenders with substance abuse problems. For young people, the Youth Justice Conferencing scheme allows police and Children's Court magistrates to refer young people to conferencing for certain offences, rather than prosecuting them,[3] and the Youth Drug and Alcohol Court aims to assist young offenders with drug and alcohol problems.[4]

3.2 In this chapter we consider the nature, advantages and disadvantages of diversion.

What is diversion

3.3 There is very little consistency in the way that the term diversion is used. It may be deployed very narrowly, or very broadly. A narrow use of the term envisages

1. Local Court of NSW, *Practice Note No 5: Magistrates Early Referral Into Treatment (MERIT) Programme*, 20 August 2002; Magistrates Early Referral Into Treatment Program – Policy Document (April 2002).
2. *Drug Court Act 1998* (NSW); D Weatherburn and others, *The NSW Drug Court: A Re-Evaluation of its Effectiveness*, Crime and Justice Bulletin No 121 (NSW Bureau of Crime Statistics and Research, 2008).
3. *Young Offenders Act 1997* (NSW) Pt 5.
4. Children's Court of NSW, *Practice Note 1: Practice Note for Youth Drug and Alcohol Court (*29 August 2009) 1.

practices that eliminate, rather than minimise, contact with the formal criminal justice system.[5] To characterise diversion in this way is something of a counsel of perfection, in that some police engagement with an alleged offender will take place, even when police deal with a matter by way of a warning or caution. However, many of the diversionary provisions with which we engage in this report involve measures that seek, in one way or another, to minimise contact with the criminal justice system for people with cognitive and mental health impairments. For example we deal with the police power to divert,[6] Local Court powers to divert a defendant pre-plea to engage with services,[7] and cautions and conferences under the *Young Offenders Act 1997* (NSW).[8]

3.4 A rather broader conception of diversion would define it as measures to divert the offender out of the criminal justice system and into treatment or rehabilitation. In Consultation Paper 7 – *People with cognitive and mental health impairments in the criminal justice system: diversion* (CP 7) we noted that progress through the criminal justice system is marked by various stages, including encounters with police, proceedings, including sentencing, in the Local, District or Supreme Courts, and that diversion away from the criminal justice system into treatment or rehabilitation can occur at any of these stages.[9]

> A more complex form of diversion directs offenders away from the formal system into an alternative means of dealing with them, one that focuses on treatment rather than punishment. This form of diversion identifies the underlying causes of the offender's criminal behaviour and seeks to redress them.[10]

The focus on treatment may have the intent or effect of preventing future offending, thus benefiting the offender and society at large (see further below).[11] This view of the scope of diversion is common to many explanations of diversion.[12]

3.5 However, "diversion" also may be used broadly to refer to any "alternative processing option which can occur at any stage of the criminal justice system".[13] In

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5. E Newitt and V Stojcevski, *Mental Health Diversion List: Evaluation Report* (Magistrates Court Tasmania, 2009) 33-34, citing J Wundersitz, *Criminal Justice Responses to Drug and Drug-related Offending: Are They Working?* Technical and Background Paper No 25 (Australian Institute of Criminology, 2007) 31-32.
6. Chapter 8.
7. Chapter 9.
8. Para 14.21-14.45.
9. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) [1.2].
10. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) [1.2].
11. Para 3.35-3.39.
12. See eg D Greenberg and B Nielsen, "Court Diversion In NSW for People with Mental Health Problems and Disorders" (2002) 13(1) *NSW Public Health Bulletin* 158, 158; Nacro, quoted in K Bradley, *The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System* (UK Department of Health, 2009) 15; National Policing Improvement Agency quoted in the *Bradley Report*, 16; D James, "Court diversion in perspective" (2006) 40 *Australian and New Zealand Journal of Psychiatry* 529, 529.
13. E Newitt and V Stojcevski, *Mental Health Diversion List: Evaluation Report* (Magistrates Court Tasmania, 2009) 33-34, citing J Wundersitz, *Criminal Justice Responses to Drug and Drug-related Offending: Are They Working?* Technical and Background Paper No 25 (Australian Institute of Criminology, 2007) 31-32.

this sense, diversion is seen as a process, rather than just an outcome.[14] We have taken a pragmatic approach in this report, and utilised this broad view of diversion.

3.6 For example we deal in this report with "problem solving" courts which, far from diverting the offender out the criminal justice system, engage the offender in intensive court supervision as well as providing services and treatment. Problem solving courts were initially established in the United States in the late 1980s to address the problem of a criminal justice system over-burdened by drug offenders.[15] Drug courts were designed not to punish but to supervise treatment and rehabilitation of offenders with substance abuse problems in an attempt to address the causes of offending. Judges took a hands-on approach in case-managing defendants through their drug rehabilitation.[16] The development of drug courts paved the way for specialist mental health courts that provide a broadly similar approach for offenders who have mental illness, and sometimes also for those with cognitive impairments. These developments are described in detail in Chapter 11.

3.7 All Australian states, except NSW, now operate, or plan to operate, specialised lists for offenders with mental health, and sometimes cognitive, impairments. These developments are also considered in Chapter 11. NSW has taken a different approach, of "mainstreaming" its diversionary efforts so that they are available in the Local Court and Children's Court generally.[17]

3.8 Another important development related to diversion is therapeutic jurisprudence. Wexler and Winick describe therapeutic jurisprudence as "the study of the role of law as therapeutic agent".[18] This means that it "focuses on the law's impact on emotional life and psychological well-being".[19] The goal of therapeutic jurisprudence is to overcome the limitations of the adversarial model traditionally adopted by the criminal justice system, particularly in relation to people with mental health impairments, by focusing on an individual's needs, psychological functioning and emotional well-being.[20] Diversion could be said to fall within the scope of therapeutic jurisprudence because diversionary programs attempt to help an accused person "develop skills that will enable them to act differently in future situations where they may be at risk of committing a crime".[21]

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14. M Parsonage, *Diversion: A Better Way for Criminal Justice and Mental Health* (Sainsbury Centre for Mental Health, 2009) 8.
15. JS Goldkamp and C Irons-Guynn, *Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage* (Bureau of Justice Assistance, 2000) 3-4.
16. JS Goldkamp and C Irons-Guynn, *Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage* (Bureau of Justice Assistance, 2000) 3-4.
17. See discussion in Chapters 9 and 10.
18. D Wexler and B Winick, *Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence* (Carolina Academic Press, 1996) xvii.
19. D Wexler, "Therapeutic Jurisprudence: An Overview" (2000) 17 *Thomas M Cooley Law Review* 125, 125.
20. E Zafirakis, "Curbing the "revolving door" phenomenon with mentally impaired offenders: applying a therapeutic jurisprudence lens" (2010) 20 *Journal of Judicial Administration* 81, 84.
21. J McGuire, "Maintaining Change: Converging Legal and Psychological Initiatives in a Therapeutic Justice Framework (2003) 4 *Western Criminology Review* 108, 110-111 quoted in Intellectual Disability Rights Service, *Enabling Justice: A Report on Problems and Solutions in*

3.9 It would appear that, at the present time, diversion, rehabilitation and therapeutic jurisprudence are all relevant and are inter-related. However these terms may sometimes be confused or used without precision.

Why divert?

3.10 *NSW 2021: A Plan to Make NSW Number One* has identified the availability and use of diversionary programs as a priority action of the Plan's wider goal to reduce adult and juvenile reoffending by 5% by 2016.[22] Accompanying this goal is a target of increasing completion rates for key treatment and intervention programs. The *NSW 2021* plan explains that access to specialised treatment and intervention can help to break the reoffending cycle. One way the Government plans to achieve this is by "diverting people with mental health problems out of the criminal justice system and into services which meet their needs".[23] Other goals of the plan also encompass the use of diversion for people with mental health problems. These are discussed further in Chapter 1.[24]

3.11 At the federal level, in 2006, the Senate Select Committee on Mental Health recommended a:

> significant expansion of mental health courts and diversion programs, focussed on keeping people with mental illness out of prison and supporting them with health, housing and employment services that will reduce offending behaviour and assist with recovery.[25]

3.12 CP 7 listed three reasons that it might be desirable to divert offenders (or alleged offenders) with cognitive and mental health impairments:

- A person's impairment may result in reduced culpability making the application of traditional criminal law processes and penalties unfair or inappropriate.
- People with cognitive and mental health impairments face multiple social disadvantages that make them more likely to offend, and become caught up in a cycle of offending and incarceration. Diversion can assist to break this cycle.
- Traditional criminal justice mechanisms are less likely to succeed in the rehabilitation of people with cognitive and mental health impairments or in preventing future offending, than a diversion program addressing the underlying cause or causes of offending.[26]

Relation to Diversion of Alleged Offenders with Intellectual Disability from the New South Wales Local Courts System (2008) 18.

22. NSW Government, *NSW 2021: A Plan to Make NSW Number One* (2011) 35 (Goal 17).
23. NSW Government, *NSW 2021: A Plan to Make NSW Number One (*2011) 35 (Goal 17).
24. Para 1.5-1.10.
25. Australia, Senate Select Committee on Mental Health, *A national approach to mental health – from crisis to* community, Final Report (2006) [3.48].
26. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) [1.5].

3.13 Underlying these issues is the fact that people with cognitive and mental health impairments are over-represented in the criminal justice system, and that it is desirable to respond to this overrepresentation.[27]

3.14 Diversion may have therapeutic benefits for offenders. It may also be effective in reducing reoffending by people with cognitive and mental health impairments. Finally, reducing reoffending and providing treatment, and other support services for people with cognitive and mental health impairments could result in cost saving and other efficiency benefits for the criminal justice system. These potential benefits – and whether they are supported by the available evidence – are considered below.

Therapeutic benefits

3.15 The available research appears to indicate that, by addressing the needs of people with cognitive and mental health impairments in the criminal justices system, there will be some impact in terms of a reduction in offending behaviour. Diversion also serves to reduce the number of vulnerable people with cognitive and mental health impairments entering a penal system that threatens their welfare and well-being.

3.16 People with cognitive and mental health impairments may, for various reasons, offend repeatedly and become entrenched in the criminal justice system.[28] This is particularly so where the offending behaviour stems from complex needs, such as homelessness or drug or alcohol abuse, associated with cognitive and mental health impairments. As discussed in Chapter 2, it is the co-existence of such factors that is most likely to dispose a person to offend. Linking a person with support services to address these problems can assist preventing future offending.

3.17 Research in NSW, and elsewhere, supports the conclusion that diversion can have beneficial outcomes for offenders with cognitive and mental health impairments. For example, a study of the outcomes associated with offenders diverted under the existing diversionary scheme in s 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA) at the Tamworth Local Court, noted beneficial outcomes for participants, including:

- reduced readmission rates to hospital
- reduced numbers of total hospital bed days, and
- improved treatment adherence and patient-clinician interactions.[29]

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27. Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28-1*, 20; Alcohol and other Drugs Council of Australia, *Submission MH32*, 5-6; T Walsh, "Diverting Mentally Ill Women Away from Prison in New South Wales: Building on the Existing System" (2003) 10 *Psychiatry, Psychology and Law* 227. See also E Zafirakis, "Curbing the 'Revolving Door' Phenomenon with Mentally Impaired Offenders: Applying a Therapeutic Jurisprudence Lens" (2010) 20 *Journal of Judicial Administration* 81, 82, 83.
28. See for example, Department of Human Services NSW (Juvenile Justice), *Submission MH35*, 3; Department of Human Services NSW (Ageing Disability and Home Care), *Submission MH28-1*, 20.
29. L Douglas, C O'Neill and D Greenberg, "Does court mandated outpatient treatment of mentally ill offenders reduce criminal recidivism? A case-control study" (Paper presented at Judicial Commission of New South Wales, Local Court Annual Conference, Sydney, 4 August 2006) 7, cited in T Gotsis and H Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local*

3.18 A 2009 literature review of the outcomes of US diversion programs supports the observations of the NSW research and identifies other positive outcomes for participants, including:[30]

- improvements in independent living skills and reduced substance use[31]
- lower rates of re-arrest, violence, homelessness, and psychiatric hospitalisation,[32] and
- a reduction of the time spent in jail.[33]

The review also notes "similar positive outcomes" resulting from jail and community-based diversion programs.[34] For example, in relation to mental health courts, Schneider has noted:

> reduced homelessness, psychiatric hospitalizations, frequency and levels of substance and alcohol abuse and improvements in psychosocial functioning.[35]

3.19 There is also evidence that diversion can result in improved mental health outcomes for offenders.[36]

3.20 The outcomes above also suggest that the potential therapeutic benefit experienced by the defendant are not restricted to personal benefits, but have a broader public benefit as well. That diversion to treatment for a person with a mental health impairment is a public interest, rather than a private interest of the defendant was

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Court, Monograph 31 (Judicial Commission of NSW, 2008) 29. This study is discussed further below, para 3.35.

30. K Sly and others, "Court outcomes for clients referred to a community mental health liaison service" (2009) 32 *International Journal of Law and Psychiatry* 92, 93.
31. See, eg, M Cosden and others, "Evaluation of a mental health treatment court with assertive community treatment" (2003) 21 *Behavioural Sciences and the Law* 415. See also M Cosden and others, "Efficacy of a mental health treatment court with assertive community treatment" (2005) 23 *Behavioural Sciences and the Law* 199, 211.
32. See, eg, H Lamb, L Weinberger and C Reston-Parham, "Court Intervention to Address the Mental Health Needs of Mentally Ill Offenders" (1996) 47 *Psychiatric Services* 275.
33. See, eg, H Steadman, J Cocozza and B Veysey, "Comparing Outcomes for Diverted and Nondiverted Jail Detainees with Mental Illness" (1999) 23 *Law and Human Behaviour* 615.
34. K Sly and others, "Court outcomes for clients referred to a community mental health liaison service" (2009) 32 *International Journal of Law and Psychiatry* 92, 93 citing R Hoff and others, "The Effects of a Jail Diversion Program on Incarceration: A Retrospective Cohort Study" (1999) 27 *Journal of the American Academy of Psychiatry and the Law* 377; J Lamberti and others, "The Mentally Ill in Jails and Prisons: Towards an Integrated Model of Prevention" (2001) 72 *Psychiatric Quarterly* 63; H Steadman and M Naples, "Assessing the Effectiveness of Jail Diversion Programs for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders" (2005) 23 *Behavioural Sciences and the Law* 163.
35. RD Schneider, "Mental Health Courts and Diversion Programs: A Global Survey" (2010) 33 *International Journal of Law and Psychiatry* 201, 201 citing M Cosden and others, "Efficacy of a Mental Health Treatment Court with Assertive Community Treatment" (2005) 23 *Behavioural Sciences and the Law* 199.
36. M Parsonage, *Diversion: A Better Way for Criminal Justice and Mental Health* (Sainsbury Centre for Mental Health, 2009) 20; K Sly and others, "Court Outcomes For Clients Referred to a Community Mental Health Liaison Service" (2009) 32 *International Journal of Law and Psychiatry* 92, 93.

recognised by the Court of Criminal Appeal in *DPP v El Mawas*.[37] The broader benefits that rehabilitation and treatment may achieve are addressed further below.

Impact of prisons on people with cognitive and mental health impairments

3.21 It may be desirable to divert people with cognitive and mental health impairments because prisons are unable adequately to meet their needs and to ensure that their welfare is not harmed by incarceration. For example, it has been acknowledged by courts that a custodial sentence may weigh more heavily on a mentally ill person.[38]

3.22 In the next chapter, we note that people with mental health impairments and cognitive impairments are overrepresented in the NSW prison population.[39] The 2009 *Inmate Health Survey*, which provides an overview of the state of health of NSW prisoners, noted that prisoners are often subject to multiple forms of disadvantage. The Survey authors comment that:

> With such multiple risk factors for poor health, it is hardly surprising that prison inmates are further characterised by physical and mental health far below that enjoyed by the general population.[40]

Cognitive and mental health impairment are factors that are likely to contribute to that disadvantage in a way that contributes to poor mental and physical health outcomes for prisoners with such impairments.

3.23 Being held in prison could exacerbate the symptoms of pre-existing mental health impairments, or trigger new psychiatric symptoms.[41] For example, in considering the issues relevant to the grant of bail, Howard and Westmore note the potential impact that incarceration can have on some offenders – particularly those who are already vulnerable in some way. They note that:

> Some patients are more vulnerable from a psychological, psychiatric and physical perspective in prison compared with other patients. The stress of incarceration can precipitate acute psychological decompensation, and in some cases, psychotic illness.[42]

3.24 Spending time in prison can increase the chances of reoffending once an inmate is released. We addressed the issue of the criminogenic effect of prison in Report 133 – *Bail*.[43] There, we recognised that the potentially criminogenic effects of incarceration fall into three categories:

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37. *Director of Public Prosecutions v El Mawas* [2006] NSWCA 154; 66 NSWLR 93 [71].
38. *R v Tsiaras* [1996] 1 VR 398, 400; *R v Jiminez* [1999] NSWCCA 7, [25]; *R v Hemsley* [2004] NSWCCA 228, [35].
39. Para 4.109-4.132.
40. D Indig and others, *2009 Inmate Health Survey: Key Findings Report* (NSW, Justice Health, 2010) 151.
41. T Walsh, "Diverting mentally ill women away from prison in New South Wales: Building on the Existing System" (2003) 10 *Psychiatry, Psychology and Law* 227, 228. See also T Perry, "Court Mandated Outpatient Treatment for Mentally Ill Offenders in New South Wales" (2008) 19(3) *Current Issues in Criminal Justice* 369, 371.
42. D Howard and B Westmore, *Crime and Mental Health Law in New South Wales: A Practical Guide for Lawyers and Health Care Professional* (LexisNexis Butterworth, 2nd ed, 2010) 569.
43. NSW Law Reform Commission, *Bail*, Report 133 (2012) [5.18]-[5.22].

- the effects of incarceration itself, including "prisons as 'schools of crime' effects; the fracturing of family and community ties; hardening and brutalisation; and the deleterious effects of imprisonment on mental health"
- post-incarceration crime-producing effects, including "labelling; deskilling; reliance on criminal networks built up in prison; reduced employment opportunities; and reduced access to benefits and social programs", and
- third-party effects, including "crime-producing effects on the families of offenders and their communities".[44]

3.25 A summary of the research relating to the criminogenic effects of prison provided to us by Corrective Services NSW for our review into bail law[45] cited three studies which indicate that incarceration of offenders has some potential to increase offending by inmates following their release.[46] One of these studies was undertaken by the NSW Bureau of Crime Statistics and Research which found that there was some evidence to suggest that prison increases the risk of reoffending in offenders convicted of non-aggravated assault, when compared with offenders receiving non-custodial sentences.[47]

Human rights considerations

3.26 Diversion is also relevant to international human rights obligations, particularly in relation to the *Convention on the Rights of Persons with Disabilities* (the Convention).[48]

3.27 Even before the introduction of the Convention, international human rights instruments, such as the United Nations *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health*,[49] adopted in 1991, influenced a "move towards emphasising rights in Australian mental health laws throughout the 1990s".[50] Human rights have been particularly important in disability

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44. D Brown, "The Limited Benefit of Prison in Controlling Crime" (2010) 22(1) *Current Issues in Criminal Justice* 137, 141. See generally M H Pritikin, "Is Prison Increasing Crime?" (2008) 6 *Wisconsin Law Review* 1049; C Daoust, *The Paradox in Incarceration and Crime* (Justice Action, 2008); T V Kovandzic and L M Vieraitis, "The Criminogenic Effects of Imprisonment: Evidence from State Panel Data, 1974-2002" (2007) 6(3) *Criminology and Public Policy* 589.
45. Corrective Services NSW, Advice, Partnerships and Community Engagement, Offender Services and Programs, *Issue: Law Reform Commission Enquiry in Relation to Bail Legislation Review – Impact of Incarceration on Re-Offending* (Trim D2011/426586, 15 September 2011).
46. P Villettaz, M Killias, and I Zoder, *The Effects of Custodial vs. Non-custodial Sentences on Re-Offending: A Systematic Review of the State of Knowledge*, Campbell Systematic Reviews 13 (The Campbell Collaboration, 2006); P Gendreau and C Goggin, *The Effects of Prison Sentences on Recidivism*, User Report 3 (Solicitor General, Canada, 1999); D Weatherburn, *The Effect of Prison on Adult Re-Offending*, Crime and Justice Bulletin No 143 (NSW Bureau of Crime Statistics and Research, 2010).
47 D Weatherburn, *The Effect of Prison on Adult Re-Offending*, Crime and Justice Bulletin No 143 (NSW Bureau of Crime Statistics and Research, 2010) 10.
48. *Convention on the Rights of Persons with Disabilities*, opened for signature 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008).
49. *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, GA Res 46/119, UN GAOR, 3rd Comm, 46th sess, 75th plen mtg, Agenda Item 98, UN Doc A/RES/46/119 (17 December 1991) 189-192.
50. B McSherry and K Wilson, "Detention and Treatment Down Under: Human Rights and Mental Health Laws in Australia and New Zealand" (2011) 19 *Medical Law Review* 548, 549.

advocacy, both in Australia and elsewhere.[51] For example, the *Mental Health Act 2007* (NSW), which governs the civil mental health regime in NSW, identifies the protection of the civil rights of people with a mental health impairment as one of its objects.[52]

3.28 Several articles of the Convention are potentially relevant. Article 5 provides a general right of equality and freedom from discrimination, including a guarantee that parties to the Convention will take all appropriate steps to ensure the provision of reasonable accommodation to achieve equality.[53] Article 13 guarantees a right to effective access to justice for people with disabilities on an equal basis with others,[54] and Article 14 provides for a right to liberty and security of person, including a right not to be arbitrarily or unlawfully deprived of one's liberty, or deprived of it due to the existence of a person's disability.[55]

3.29 These provisions recognise that it may be necessary to provide adjustments for people with cognitive and mental health impairments in order to ensure that the rights in question are accessible.[56] As a result, the implementation and use of diversionary schemes would align with the rights goals of the Convention, and would assist to promote the rights of people with cognitive and mental health impairments.

Effectiveness of diversion

3.30 There are various ways that the effectiveness of diversionary schemes can be judged. Many of these measures suggest that diversion can have positive outcomes. However, for a range of reasons, much of the evaluative data available is anecdotal or equivocal. In particular, there is a lack of research providing comprehensive evaluations of the outcomes of diversionary programs, particularly evaluations of specific program outcomes.[57] Parsonage points out that much of the available data is only recent because the development of organised diversion schemes is a relatively recent phenomenon.[58] Consequently, a major limitation of many studies is that they lack a longitudinal element allowing us to track their effectiveness over time. There are other common weaknesses. For example, much of the published evidence is descriptive, rather than evaluative. The evaluative data

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51. See eg Mental Health Coordinating Council, *Mental Health Rights Manual: A Consumer Guide to the Legal and Human Rights of People with Mental Illness in NSW* (3rd ed, 2011).
52. *Mental Health Act 2007* (NSW) s 3(d).
53. *Convention on the Rights of Persons with Disabilities*, opened for signature 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008) art 5(3).
54. *Convention on the Rights of Persons with Disabilities*, opened for signature 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008) art 13.
55. *Convention on the Rights of Persons with Disabilities*, opened for signature 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008) art 14.
56. *Convention on the Rights of Persons with Disabilities*, opened for signature 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008) art 13(1), art 14(2).
57. See eg D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 3; K Heilbrun and others, "Community-Based Alternatives for Justice-Involved Individuals with Severe Mental Illness: Review of the Relevant Research" (2012) 39 (4) *Criminal Justice and Behaviour* 351, 415.
58. M Parsonage, *Diversion: A Better Way for Criminal Justice and Mental Health* (Sainsbury Centre for Mental Health, 2009) 12.

that is available often has methodological weaknesses, such as failing to employ matched control groups, or include proper costings or quantified measures of outcome.[59] The diversity of diversion programs, in the United States, the UK and in Australia, also means that it is difficult to generalise about what works from the findings in relation to a particular diversion program.[60]

3.31 As indicated above, there is, nevertheless, data indicating that diversion programs can have "positive outcomes for individuals, systems and communities, with improved access to community based treatments likely to reduce arrests".[61]

3.32 The outcomes of diversion can be classified roughly into the following categories:

- general benefits to the criminal justice system
- reductions in reoffending
- improved health outcomes for those who are diverted
- cost savings, and
- subjective evaluations by participants.

Benefits to the criminal justice system

3.33 Parsonage identifies a range of short-term benefits that diversion offers the criminal justice system.[62] He notes that diversion can assist in improving the general efficiency of the criminal justice system and diversion programs (particularly liaison services, which serve to mediate the links between courts and service providers) can provide support to criminal justice personnel and agencies. In particular, he lists potential benefits as including:

- increasing awareness of mental health issues among criminal justice staff.
- reducing the risk of dangerous or disruptive behaviour in custody through the correct or earlier identification of mental health problems among prisoners.
- reducing the use of remand, for example, by speeding up the transfer of severely ill prisoners to hospital, or helping those with less serious mental health needs to remain in the community on bail.
- reducing delays in the provision of psychiatric assessments.

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59. M Parsonage, *Diversion: A Better Way for Criminal Justice and Mental Health* (Sainsbury Centre for Mental Health, 2009) 12. See also A McGrath, "The Effect of Diversion from Court: A Review of the Evidence" (2008) 15 *Psychiatry, Psychology and Law* 317, 331.
60. M Parsonage, *Diversion: A Better Way for Criminal Justice and Mental Health* (Sainsbury Centre for Mental Health, 2009) 12.
61. K Sly and others, "Court outcomes for clients referred to a community mental health liaison service" (2009) 32 *International Journal of Law and Psychiatry* 92, 93. See also M Parsonage, *Diversion: A Better Way for Criminal Justice and Mental Health* (Sainsbury Centre for Mental Health, 2009)12-22.
62. M Parsonage, *Diversion: A Better Way for Criminal Justice and Mental Health* (Sainsbury Centre for Mental Health, 2009).

- reducing the need for unnecessary formal psychiatric court reports. This may in turn reduce the need for unnecessary remands in custody which often arise because the court is waiting for a psychiatric report.

- facilitating non-custodial sentences for offenders with mental health needs in appropriate cases, thereby reducing the need for prison places.[63]

3.34 The difficulty with judging the extent of these purported benefits is that there is a general lack of research evidence that provides any indication of the magnitude of the benefits that might be gained. Nevertheless, Parsonage notes that research in the UK suggests that diversion and liaison programs can reduce the time spent on remand of accused people with mental health impairments.[64]

Reducing reoffending

3.35 Research in NSW has also indicated that diversion has some impact on recidivism, at least in the short-term.[65] A study on the impact of s 32 diversion on offenders with a mental illness in the Local Court provides some limited support for the conclusion that s 32 diversion can help to reduce recidivism.[66] The study found that the offenders who had been dealt with by s 32 orders were "marginally less likely" to be charged with a new offence than offenders without a mental illness who were dealt with by good behaviour bond.[67]

3.36 Research in other jurisdictions tends to support the conclusion that diversion can reduce recidivism, although some of the studies suffer from methodological issues which may weaken the usefulness of the information gained from the outcomes observed. For example, Parsonage notes several studies of American mental health courts have observed reduced rates of offending following the participation in the mental health court program, but there was no matched control group against which the outcome could be measured.[68] The lack of a control group means that there is

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63. M Parsonage, *Diversion: A Better Way for Criminal Justice and Mental Health* (Sainsbury Centre for Mental Health, 2009) 19. See also discussion in Chapter 7.

64. M Parsonage, *Diversion: A Better Way for Criminal Justice and Mental Health* (Sainsbury Centre for Mental Health, 2009) 19-20, citing D James and L Hamilton, "The Clerkenwell Scheme: Assessing Efficacy and Cost of a Psychiatric Liaison Service to a Magistrates' Court" (1991) 303 *British Medical Journal* 282; P Joseph and M Potter, "Diversion from custody, I: Psychiatric Assessment at The Magistrates' Court" (1993) 162 *British Medical Journal* 325; P Joseph and M Potter, "Diversion from Custody, II: Effect on Hospital and Prison Resources" (1993) 162 *British Medical Journal* 330; T Exworthy and J Parrott, "Evaluation of a Diversion Scheme as Magistrates' Courts" 8 *Journal of Forensic Psychiatry* 406; P Pierzchniak, N Purchase and H Kennedy, "Liaison between Prison, Court and Psychiatric Services" (1997) 29 *Health Trends* 26.

65. See eg D Bradford and N Smith, *An evaluation of the NSW Court Liaison Service* (NSW Bureau of Crime Statistics and Research, 2009), 58-59.

66. D Greenberg, C O'Neill, L Douglas, "Does Court Mandated Outpatient Treatment of Mentally Ill Offenders Reduce Criminal Recidivism? A Case Control Study" (Paper presented at the Demystifying Mental Health Symposium, Sydney, 17 March 2008).

67. D Greenberg, C O'Neill, L Douglas, "Does Court Mandated Outpatient Treatment of Mentally Ill Offenders Reduce Criminal Recidivism? A Case Control Study" (Paper presented at the Demystifying Mental Health Symposium, Sydney, 17 March 2008) 1. These results were also reported in L Douglas, C O'Neill and D Greenberg, "Does court mandated outpatient treatment of mentally ill offenders reduce criminal recidivism? A case-control study" (Paper presented at NSW Local Court Annual Conference, Sydney, 4 August 2006) cited in T Gotsis and H Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local Court*, Monograph 31 (Judicial Commission of NSW, 2008) 29.

68. M Parsonage, *Diversion: A Better Way for Criminal Justice and Mental Health* (Sainsbury Centre for Mental Health, 2009) 14-16 discussing studies of the Clark County, Washington Mental

no way of establishing whether any causal link can be drawn between the participation in the diversion program and the decrease in reoffending.[69]

3.37 On the other hand, studies employing control groups have indicated a discernible drop in reoffending,[70] lending support to the conclusion that the diversion program contributed to this outcome. A 2002 review of evaluations of the effect of rehabilitation programs on reducing crime in the US, found that "the best treatment programs reduced recidivism by as much as 10 to 20 percentage points".[71] While the analysis did not specifically consider the effect of rehabilitation or diversion programs for people with cognitive and mental health impairments, it provides a guide for the sort of impact on reoffending that an effective diversion program can have.

3.38 An evaluation of the Court Integrated Services Program (CISP) in Victoria found that participation in the program resulted in a maximum of 10% reduction in offending in participants, when compared with a control group, 700 days after their exit from the program or sentencing.[72]

3.39 An extensive study undertaken in the UK found that diversion into treatment in hospital had positive effects on the reconviction rates of those diverted.[73] There was a reduction in the number of convictions of those diverted into hospital in the two years following their hospital admission, when compared with the two years prior. The reconviction rate among the diverted group in the two years following their discharge was 28%, which compared with a general reconviction rate of 56% among discharged prisoners and 58% among offenders who received community penalties.[74]

Cost savings

3.40 A reduction in the number of people with cognitive and mental health impairments in the criminal justice system could result in cost savings.

3.41 As Parsonage explains, costs savings could occur through reductions in:

- the number of arrests;

Health Court (H Herinckx and others, "Rearrest and Linkage to Mental Health Services among Clients of the Clark County Mental Health Court Program" (2005) 56(7) *Psychiatric Services* 853) and the Brooklyn New York Mental Health Court (K O'Keefe, *The Brooklyn Mental Health Court Evaluation: Planning, Implementation, Courtroom Dynamics and Participant Outcomes* (Centre for Court Innovation, 2006)).

69. We note the many practical and ethical difficulties of research involving control groups, and we also note that where many factors can impinge on outcomes, that there is a the problem of reliability even for studies employing control groups.

70. See eg, M Cosden and others, "Efficacy of a Mental Health Treatment Court with Assertive Community Treatment" (2005) 23 *Behavioural Sciences and the Law* 199, 211.

71. D L MacKenzie, "Reducing the criminal activities of known offenders and delinquents" in L Sherman and others (ed) *Evidence-Based Crime Prevention* (Routledge, 2002) 330, 385.

72. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 115. CISP is discussed further in para 7.64-7.70.

73. D James and others, *Outcome of Psychiatric Admission through the Courts*, Occasional Paper No 79 (Research Development and Statistics Directorate, 2002).

74. D James and others, *Outcome of Psychiatric Admission through the Courts*, Occasional Paper No 79 (Research Development and Statistics Directorate, 2002) 88.

- the number of prosecutions;
- the use of remand;
- the number of formal psychiatric reports;
- the number of ineffective court hearings and other causes of delay in the administration of justice;
- the number of prison sentences, because of diversion to appropriate community alternatives.[75]

3.42 Other direct cost savings as a result of diverting people to treatment, rehabilitation and support services, might be achieved through:

- reduced need for police investigation of crimes
- reduction in other crime-related costs (loss of property, etc), and
- reduced hospital readmissions.

3.43 Indirect cost savings are likely to be less significant than the kinds of savings identified above. Nevertheless, there are likely to be some derivative benefits that flow from diversion. For example, diverting a person with a mental health impairment to treatment services in their local area in preference to imprisoning him or her, could have the benefit of savings associated with travel by the family for visiting and lost working time required to visit an inmate in prison.

3.44 Diverting people with cognitive and mental health impairments into outcomes other than prison offers one of the most obvious areas for significant cost reduction. As James explains, "it is expensive to keep people in jail, and more expensive with the mentally ill".[76] The higher cost of accommodating prisoners with mental illness compared with the cost for inmates who do not have mental health impairments has been responsible for "a push to develop systems which keep the mentally ill out of jails".[77]

3.45 Data published by Corrective Services NSW in relation to the cost of custody services per inmate per day indicate that in 2009/2010 it cost, on average, $197.99 per day to keep a person in prison.[78] This can be compared with the average daily cost of community-based correctional services, which in 2009/2010 was $21.48 per day.[79] These figures are for community correctional services rather than treatment or rehabilitation services, but they at least suggest that treatment in the community could be a cheaper option than keeping an offender in prison.

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75. M Parsonage, *Diversion: A Better Way for Criminal Justice and Mental Health* (Sainsbury Centre for Mental Health, 2009) 34.
76. D James, "Court diversion in perspective" (2006) 40 *Australian and New Zealand Journal of Psychiatry* 529, 531.
77. D James, "Court diversion in perspective" (2006) 40 *Australian and New Zealand Journal of Psychiatry* 529, 531. James cites figures from Broward County, Florida from 1996 which indicate that the cost of incarcerating an inmate with a mental health impairment was $160 per day, while for a prisoner without a mental illness the cost on was on average $78 per day.
78. Corrective Services NSW, *Research Digest*, No 5 (February, 2011) 1.
79. NSW Department of Corrective Services, *Annual Report 2006/07* (2007) 47.

3.46 A 2003 review of the MERIT scheme found that it achieved cost savings in the range of $2.41 to $5.54 per dollar spent.[80] The analysis considered a range of factors including direct benefits such as savings on probation supervision and prison time, savings related to the police investigation of crimes; savings due to a reduction in hospitalisation and savings from a general reduction in the costs of crime (such as losses caused by property crime). The study indicated that there would be likely indirect cost benefits as well (such as reductions in social service payments), although these were too difficult to assess accurately.[81] The specifics of this particular evaluation should be treated with some care when considering potential savings related to diversion for people with cognitive and mental health disorders since the MERIT scheme provides treatment and rehabilitation support for offenders with substance abuse problems. Nevertheless, this evaluation provides support for the conclusion that diverting certain offenders can result in overall cost savings due to keeping them out of prison, as well as preventing future reoffending.

3.47 Walsh cites figures from the Victorian Department of Human Services which provide some evidence to suggest that the "cost of employing one full time mental health worker per mentally ill woman in prison is less than the amount required for their incarceration".[82] Walsh concludes that there are "far more cost effective options available to governments for the treatment and rehabilitation of mentally ill female offenders than incarceration".[83]

3.48 This conclusion is further supported by an economic evaluation of CISP in Victoria. Noting that the program reduced the recidivism of participants, the economic evaluation calculated the cost savings that might be achieved in three scenarios around the chances of participants reoffending.[84] The first scenario postulated that participants who do not reoffend as a result of their contact with CISP do not reoffend again. The second operated on the basis that the benefits in relation to reoffending lasted five years. The third scenario limited the benefits in relation to reduced reoffending to only two years from program completion. In all three scenarios, however, found that the benefits outweighed the costs, with the extent of the benefit increasing the longer that reoffending was reduced. The benefit to cost ratio ranged from 5.9:1 in the first scenario, to 1.7:1 in the third scenario.[85] The evaluation noted that the primary benefits were largely associated with a reduction in costs associated with incarceration, rather than the direct costs of crime.[86]

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80. M Passey and others, *Evaluation of the Lismore MERIT Pilot Program: Final Report* (NSW Attorney General' Department, 2003) xi, 78.
81. M Passey and others, *Evaluation of the Lismore MERIT Pilot Program: Final Report* (NSW Attorney General's Department, 2003) 79.
82. T Walsh, "Diverting mentally ill women away from prison in New South Wales: Building on the Existing System" (2003) 10 *Psychiatry, Psychology and Law* 227, 228, citing 2001 figures of the Victorian Department of Human Services.
83. T Walsh, "Diverting mentally ill women away from prison in New South Wales: Building on the Existing System" (2003) 10 *Psychiatry, Psychology and Law* 227, 228.
84. PricewaterhouseCoopers, Department of Justice, *Economic Evaluation of the Court Integrated Services Program (CISP): Final report on economic impacts of CISP* (2009).
85. Pricewaterhouse Coopers, Department of Justice, *Economic Evaluation of the Court Integrated Services Program (CISP): Final report on economic impacts of CISP* (2009) 20.
86. PricewaterhouseCoopers, Department of Justice, *Economic Evaluation of the Court Integrated Services Program (CISP): Final report on economic impacts of CISP* (2009) 20.

3.49 However, the diversion of a person with a cognitive or mental health impairment away from incarceration will not necessarily result in overall cost savings. This is because new costs may be incurred through factors such as:

- the provision of assessment, treatment or rehabilitation services
- the provision of case management services, and
- the provision of other support services, such as accommodation support.

These could constitute significant costs, particularly where they have not previously been provided.

3.50 A 2005 analysis of several jail diversion programs in the United States found mixed results in relation to the cost benefits of those programs. It found that:

> jail diversion results in lower criminal justice costs and greater treatment costs, as diverted participants receive more treatment than those not diverted. This additional treatment cost is often higher than the criminal justice savings in the short run.[87]

3.51 That is, although diversion can result in savings for the criminal justice system, shifting a person into community treatment or the health system will result in costs that may outweigh the initial savings. More recent modelling in the United States using data from Travis County, Texas found that that in the short term (the first year after intervention) the costs of diversion were greater, but that in the longer term the costs were recouped by the end of the second year after diversion. In the second year, costs incurred in relation to those who were diverted were lower than the costs incurred in relation to those not diverted.[88]

3.52 On the other hand, modelling undertaken by Parsonage in the UK shows that there are savings to be made in many of the areas listed above. Although the specifics are of little direct assistance, due to the different legal and service delivery context in which the analysis was undertaken, Parsonage's conclusions about the potential benefits that diversion can offer are worth noting, particularly his conclusions in regards to the benefits of avoiding the costs associated with prison:

> The magnitude of [the gains achieved by diversion] cannot be estimated with any precision, but because mental illness and crime impose such large costs on individuals and society, the scale of improvement does not need to be very large to justify substantial investment in diversion on value for money grounds…The case for diversion is particularly strong when it means diverting offenders away from short sentences in prison. Prison is a high-cost intervention which is ineffective in reducing subsequent offending and inappropriate as a setting for effective mental health care.[89]

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87. H Steadman and M Naples, "Assessing the Effectiveness of Jail Diversion Programs for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders" (2005) 23 *Behavioural Science and the Law* 163, 168.
88. D Hughes and others, "A Simulation Modelling Approach for Planning and Costing Jail Diversion Programs for Persons with Mental Illness" (2012) 39(4) *Criminal Justice and Behaviour* 434, 441.
89. M Parsonage, *Diversion: A Better Way for Criminal Justice and Mental Health* (Sainsbury Centre for Mental Health, 2009) 49.

Subjective outcomes

3.53 In addition to quantitative measures of success such as those noted above, the success of diversion programs can be evaluated by examining the opinions of those using the services and those providing and associated with diversion programs.

3.54 Evaluations of the outcomes of mental health courts in a variety of jurisdictions have found, "high levels of satisfaction and feelings of fairness by participants with the procedure and treatment received in a mental health court and low levels of perceived coercion".[90]

3.55 A similar outcome was identified in the 2009 evaluation of the NSW Statewide Court and Community Liaison Service (SCCLS). Most stakeholders interviewed expressed positive views on the impact of the SCCLS and diversion services offered by Justice Health, as discussed in Chapter 7.[91] In general, "most stakeholders felt that the diversion services were either successful in achieving diversion of mentally ill offenders in the community, or were making strong efforts to do so", although stakeholders in the SCCLS evaluation did identify some areas for improvement in the operation of the scheme, such as increasing the availability of services at court.[92]

3.56 Similarly, as discussed in Chapter 7, in an evaluation of the Court Referral of Eligible Defendants Into Treatment program (CREDIT), the majority of participants reported satisfaction with the program and program staff. The vast majority of surveyed participants indicated that CREDIT had had a positive impact on their lives, particularly in relation to improved physical and mental health.[93]

3.57 Many stakeholders in this inquiry expressed support for diversionary schemes for people with cognitive and mental health impairments, either generally or in relation to specific groups (such as young people).[94] Other stakeholders, while not expressing outright support, were open to the possibility of diversion operating.[95]

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90. N Poythress and others, "Perceived coercion and procedural justice in the Broward mental health court" (2002) 25 *International Journal of Law and Psychiatry* 517, cited in R Schneider, "Mental health courts and diversion programs: A global survey" (2010) 33 *International Journal of Law and Psychiatry* 201, 201; para 11.80-11.81.

91. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Service* (NSW Bureau of Crime Statistics and Research, 2009) 59. Para 7.42.

92. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Service* (NSW Bureau of Crime Statistics and Research, 2009) 59.

93. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) pilot program: An evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 15-16. For more detailed discussion see para 7.56-7.63.

94. See, eg, NSW Consumer Advisory Group, *Submission MH11*, 44; Law Society of NSW, *Submission MH13*, 34; Intellectual Disability Rights Service, *Submission MH14*, 3; NSW Health, *Submission MH15*, 5 (supporting diversion for people with intellectual disabilities); Legal Aid NSW, *Submission MH18*, 1; Public Interest Advocacy Centre, *Submission MH21*, 5-6; Aboriginal Legal Service, *Submission MH23*, 3; NSW, Public Guardian, *Submission MH27*, 20; Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28-1*, 18; and, in relation to young people: Department of Human Services NSW (Juvenile Justice), *Submission MH28-2*, 3; Multicultural Disability Advocacy Association, *Submission MH30*, 7; Alcohol and other Drugs Council of Australia, *Submission MH32*, 9; Law Society of NSW, *Submission MH36*, 2; Illawarra Legal Centre, *Submission MH39*, 4; Public Interest Advocacy Centre, *Submission*

Disadvantages of diversion

3.58 Although diversion offers a range of benefits, both for individual defendants and the criminal justice system, some concerns have been raised about diversion and its potential impact on people with cognitive and mental health impairments. Additionally, while diversion may assist some offenders and prevent them reoffending, it may not be appropriate or desirable to divert people with cognitive and mental health impairments in all circumstances. We address these criticisms generally here, although we discuss them in greater detail in relation to the specific diversionary mechanisms we address later in this report.[96]

Net-widening effects and sentence escalation

3.59 Some commentators have raised the concern that diversion could have a net-widening effect. That is, rather than keeping people out of the criminal justice system, diversion could have the paradoxical result of entrenching more people in that system due to a desire to "provide them with programs that would not otherwise be available if they were not charged with criminal offences".[97] Similarly, sentence escalation could occur where a "more severe sentence is imposed than would otherwise be warranted in order to receive the benefits of an intervention program".[98]

3.60 Some commentators have raised concerns about approaches to diversion that are founded on principles of therapeutic jurisprudence, particularly in relation to its application to people with cognitive impairments. For example, the Intellectual Disability Rights Service (IDRS) has argued that, while therapeutic jurisprudence can offer some benefits to people with cognitive impairments in the criminal justice system, it may also have drawbacks. In particular, IDRS argues the understandings of disability on which therapeutic jurisprudence rests locate the "problem" within the individual, in contrast to a model of disability which recognises the role of social factors in disabling a person.[99] Consequently, it promotes "health-based, interventions which concentrate on the internal, psychological causes of offending to the detriment of a thorough consideration of the role of environmental factors".[100] Furthermore, in treating the problems experienced by offenders with cognitive impairments as an individual problem, there is a further risk that:

> the creation of specialist courts and diversionary mechanisms translates a social issue which should be the responsibility of the community and be

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MH40, 6; Shopfront Youth Legal Centre, *Submission MH41*, 2-3, see also Shopfront Youth Legal Centre, *Submission MH7*, 2.

95. See, eg, NSW Police Force, *Submission MH47*, 11; NSW, Public Defenders, *Submission MH26*, 3-5 (supporting a "semi-diversionary scheme").
96. Para 8.69-8.77; Chapter 12.
97. M King and others, *Non-adversarial Justice* (Federation Press, 2009) 175.
98. M King and others, *Non-adversarial Justice* (Federation Press, 2009) 175.
99. See Chapter 5.
100. 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) 18.

> addressed through human services into an individualised, legal and criminal issue.[101]

Serious offending

3.61 Diversion is often regarded as an inappropriate response to serious offending. For example the view may be taken that there are some offences that are so serious that punishment is inevitable, and diversion is not appropriate. Many mental health courts in Australia exclude serious offences of violence or serious sexual offences, for example. However, the difficulty with this approach is that, in some cases, an impairment may have a significant impact on the way in which seriousness is judged.

3.62 In consultation for this reference we were provided with the example of sexual offences committed by people who have dementias and who are, for a period of time, sexually disinhibited. They commit offences, but may not understand their actions or the wrongness of those actions. We were also told of a man with an intellectual disability who was obsessed with 'cops and robbers' television programs. He took a toy gun and "held up" a service station.[102] Offences involving armed robbery are serious offences of violence, but he did not understand the nature and seriousness of his actions. A plea of not guilty in this case would likely have involved him in a trial in the District Court. It is possible that such a defendant might be remanded in custody at some point in the committal proceedings or trial, if not throughout this period. Such a case presents difficult challenges in relation to the discretion to prosecute, and possibly fitness to plead. A diversionary program designed to prevent further offending of this nature might be the most appropriate outcome in such a case, both for the defendant and for society, despite the seriousness of the offence.

3.63 The view that the more serious the crime, the less appropriate diversion will be, has been held in a case considering the appropriateness of diversion under s 32 of the MHFPA.[103] However, the Court of Appeal has held that serious offending does not, of itself, prevent a person being diverted if it is appropriate to do so in all the circumstances. The Court of Appeal indicated that any decision whether to divert would depend on an assessment of whether diverting a person who had committed a serious offence would produce a better outcome for the individual and the community.[104]

3.64 Other interests are clearly relevant in deciding whether to divert an accused person. For example, the impact of offending on a victim may be important. In other cases the need to protect the public is important.[105] However, where diversion provides a way of preventing further offending, the protection of the public may be better

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101. 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) 18. See also L Steele, *Submission MH9*, 6.
102. We discuss this case study in Chapter 13, Case Study 13.1.
103. *Confos v Director of Public Prosecutions* [2004] NSWSC 1159 [17].
104. *Director of Public Prosecutions v El Mawas* [2006] NSWCA 154; 66 NSWLR 93 [79].
105. K Bradley, *The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System* (UK Department of Health, 2009) 15.

secured by diversion than by incarceration. The effectiveness of the diversionary program may weigh in the balance in such a decision.

Coercion and consent

3.65 Some commentators have raised the concern that diversionary schemes may coerce accused people into participating, or participation may place onerous obligations on an accused person, particularly where there has been no finding of guilt. For example, Freiberg claims that lawyers are concerned that in order to gain access to problem-oriented courts, such as mental health courts, "defendants may be encouraged, or feel under pressure, to plead guilty, which may derogate from a proper adjudication of guilt".[106]

3.66 Similarly, a submission to this inquiry raised concerns about diversion if defendants with a cognitive impairment are coerced into participating in treatment programs, particularly in the absence of a finding of guilt.[107]

3.67 The Law Reform Commission of Western Australia (WALRC) responds to this concern by recommending that any person's participation in a diversion program should be voluntary, particularly in cases involving mental health impairments. The WALRC cites the United Nations *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* which state that treatment (including diagnosis or assessment) cannot be given without a person's informed consent.[108]

3.68 To gain consent, it may be necessary to explain to an accused person how a diversion program operates and the consequences of participation, with a legal representative or guardian present.[109] Indeed, as the WALRC has noted, diversion programs are unlikely to be effective unless program participants engage voluntarily, and have the desire to "succeed in addressing the problems underlying their offending behaviour".[110]

3.69 Furthermore, it is appropriate to note the potentially onerous and intensive nature of participation in a diversion program in some cases. Requirements such as drug treatment, counselling and compliance with regimes of medication may present difficult challenges for individuals. Some accused persons may not wish to participate, and may wish to opt to be dealt with according to law.[111]

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106. A Freiberg, "Therapeutic Jurisprudence in Australia: Paradigm Shift or Pragmatic Incrementalism?" (2002) 20 *Law in Context* 6, 19. See also Law Reform Commission of Western Australia, *Court Intervention Programs*, Consultation Paper, Project No 96 (2008) 165.
107. L Steele, *Submission MH9*, 3. See also S Hayes, "A Review of Non-Custodial Interventions with Offenders with Intellectual Disabilities" (2005) 17(1) *Current Issues in Criminal Justice* 69, 70.
108. Law Reform Commission of Western Australia, *Court Intervention Programs*, Final Report, Project No 96 (2009) 80.
109. Law Reform Commission of Western Australia, *Court Intervention Programs*, Final Report, Project No 96 (2009) 80.
110. Law Reform Commission of Western Australia, *Court Intervention Programs*, Final Report, Project No 96 (2009) 80.
111. Law Reform Commission of Western Australia, *Court Intervention Programs*, Final Report, Project No 96 (2009) 80 n 7.

Unfairness, discrimination or disadvantage for participants

3.70 In some cases, the requirements of participation in diversion may be more intrusive and onerous than might be expected if the offender was to be dealt with according to law. For example, participation in a diversion program could involve intensive monitoring by a court or a case manager, attending a service provider, taking medication and so on, over a period of several months. On the other hand, being dealt with according to law might involve a person being placed on a bond, or a dismissal of charges under s 10 of the *Crimes (Sentencing Procedure) Act 1999* (NSW). Furthermore, diversionary programs often impose their requirements in the absence of any finding or admission of guilt.

3.71 While the intentions of the court may be rehabilitative, compliance with the requirements of a diversionary order may be understood or experienced by the defendant as punitive, and going beyond that which would be imposed on a person without impairments. Indeed intervention or diversionary programs which are undertaken prior to any finding of guilt have been criticised "for creating quasi-punitive orders, similar to sentencing powers but without the same protections".[112]

3.72 This unfairness may arise where there are genuine doubts as to whether the accused person with a cognitive or mental health impairment could have formed the relevant mental element of the offence alleged. Despite the possibility that the person could not be found guilty of the alleged offence, the defendant may be diverted, and subjected to requirements to do things that would not be required of another unconvicted defendant. Moreover, a failure to comply with the requirements of the diversion order may prejudice the defendant and expose him or her to sanctions which would not be placed on another defendant who was in a position to secure an acquittal. Lawyers representing defendants with cognitive and mental health impairments may therefore face difficult choices about what course of action they should advise their clients to take.

Need to hold offenders accountable through traditional criminal justice mechanisms

3.73 Finally, it has been suggested that there is some benefit to having a person with a cognitive or mental health impairment being dealt with according to standard criminal justice processes and outcomes.

3.74 We have previously recognised this particular objection to diversion, in relation to people with cognitive impairments in Report 80 – *People with an Intellectual Disability and the Criminal Justice System*.[113] In particular, Report 80 highlighted the argument that a decision by police not to charge a person with an intellectual disability because of a perception that people with intellectual disabilities are not responsible for their actions, is not in the person's interests because the person is denied the right to an open examination of his or her guilt or innocence.[114]

112. M King and others, *Non-adversarial Justice* (Federation Press, 2009) 175.

113. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) [2.40].

114. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) [2.40], citing L M Osman, *Finding New Ways: A Review of Services to*

Additionally, it has been suggested that "at least some of the normal social consequences of breaking the law need to impinge on people with learning disabilities because of the likely social learning that may follow".[115]

3.75 Hayes has reported a Californian research study where, in interviews with criminal justice system personnel, people with disabilities and their carers and families, there was consensus that "'the person with a disability should not be relieved from legal obligations and responsibilities', and must be held accountable for their own good and that of the community".[116]

3.76 Although the view that people with cognitive impairments who commit crimes should be held accountable appears to conflict with a view that promotes diversion away from the criminal justice system, as Hayes points out there is no "substantive conflict when the issue is pursued to the next step".[117] Rather, it is possible to hold a person with intellectual disability or a cognitive impairment accountable without sending them to prison.[118]

Conclusion

3.77 We recognise that there may be drawbacks to diversion in some circumstances, and that there is a range of issues that must be considered in designing diversionary schemes. Taking all the evidence into account, it is our view that diversion can be an effective means of reducing reoffending and producing better outcomes for people with cognitive and mental health impairments. Consequently, in subsequent chapters we recommend diversionary mechanisms for people with cognitive and mental health impairments to operate at various stages of the criminal process. Nevertheless, we have taken account of the potential disadvantages and concerns, discussed above, when framing our recommendations to ensure that our diversionary mechanisms can be used in appropriate circumstances, offer flexibility and do not disadvantage people with cognitive and mental health impairments.

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the Person with Intellectual Disability in the Victorian Criminal Justice System (Office of the Public Advocate, 1988) 19.

115. G Murphy and I Clare, "People with Learning Disabilities as Offenders or Alleged Offenders in the UK Criminal Justice System" (1998) 91 *Journal of the Royal Society of Medicine* 178, 181. See also K Bradley, *The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System* (UK Department of Health, 2009) 15.

116. S Hayes, "Pathways for Offenders with Intellectual Disabilities" in WR Lindsay, JL Taylor and P Sturmey (ed) *Offenders with Developmental Disabilities* (John Wiley and Sons, 2004) 67, 67 citing J Petersilia, *"Doing Justice" The Criminal Justice System and Offenders with Developmental Disabilities* (University of California, 2000). See also K Bradley, *The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System* (UK Department of Health, 2009) 15.

117. S Hayes, "Pathways for Offenders with Intellectual Disabilities" in WR Lindsay, JL Taylor and P Sturmey (ed) *Offenders with Developmental Disabilities* (John Wiley and Sons, 2004) 67, 67.

118. S Hayes, "Pathways for Offenders with Intellectual Disabilities" in WR Lindsay, JL Taylor and P Sturmey (ed) *Offenders with Developmental Disabilities* (John Wiley and Sons, 2004) 67, 68.

4. Prevalence

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Introduction

4.1 This chapter provides a picture of the extent and nature of contact between people with cognitive and mental health impairments and the criminal justice system in NSW. It draws on empirical research and the available institutional statistical data to provide as complete a picture as possible. However the available data is very limited and consequently, the resulting picture is partial.

4.2 We provide this partial and incomplete picture at the outset because of the importance of understanding the size and nature of the issues dealt with subsequently in the report. It is this data that enables legal (and other) policies to respond appropriately, and enables us to understand the implications of change, and to predict their costs.

Problems with available research

4.3 There is a range of problems that mean that existing data may not represent accurately the true picture in relation to the prevalence of people with cognitive and mental health impairments, and their context with the criminal justice system, in Australia and NSW.

4.4 There are several reasons that studies attempting to gauge the prevalence of particular conditions in a population may vary in their estimates. Primarily, variance can be explained by differences in methodology, although other factors may come into play, such as shifts in prevalence over time due to changing demographic factors. The methodological differences, which are likely to have an impact on the reported results relating to both the prevalence of mental health impairments and cognitive impairments, include:

- Variation in the definition applied to an impairment or class of impairments will lead to a larger or smaller estimate depending on the scope of the definition or classification criteria employed. A broader, vaguer or more flexible definition will lead to larger estimates, while conversely narrower, more defined criteria are likely to result in a smaller prevalence rate.[1]
- The nature of the sample: for example, estimates of prevalence can be lower where a sample is tested, compared with higher rates where all members of a population are tested. [2]
- Differences in the way that study participants are assessed: for example, the skill of person conducting an assessment could have some impact; the use of brief screening instruments compared with full diagnostic assessments; the

1. See C Hatton, "Intellectual Disabilities – Classification, Epidemiology and Causes" in E Emerson and others (ed) *Clinical Psychology and People with Intellectual Disabilities* (Wiley-Blackwell, 2nd ed, 2012) 3, 8; S C Hayes and G Craddock, *Simply Criminal* (Federation Press, 2nd ed, 1992) 31, 33.
2. See eg C Hatton, "Intellectual Disabilities – Classification, Epidemiology and Causes" in E Emerson and others (ed) *Clinical Psychology and People with Intellectual Disabilities* (Wiley-Blackwell, 2nd ed, 2012) 3, 8; S C Hayes and G Craddock, *Simply Criminal* (Federation Press, 2nd ed, 1992) 32.

breadth of capabilities tested; or the language and/or culture of test participants could all influence the outcome of a study in different ways.[3]

- Selection bias due to non-response and reliance on self-reporting: in particular, some participants may have been hesitant to reveal a history of mental health impairment due to embarrassment or the stigma that surrounds mental illness.

4.5 Furthermore, many of the available surveys of the health of populations in Australia and NSW relied on here for data did not cover all mental disorders that may be of interest in the context of the criminal justice system, and did not examine cognitive impairments. Consequently, it is likely that these results are an underestimate of the prevalence of both mental health and cognitive impairments in Australia, NSW and in the criminal justice system.

4.6 It becomes even more difficult to get a clear picture of the representation of people with cognitive and mental health impairments in various parts of the criminal justice system because often there is no mechanism available for collecting that data, or because data has been collected in an ad hoc and inconsistent way. As a result we have had to rely, in many cases, on small scale studies, or surveys undertaken once. This provides us with only limited data points. In some cases it is possible to extrapolate from that data, but in many instances, we are not able to consider trends in prevalence or make comparisons, because longitudinal data is not available, and the data sets are incommensurate.

4.7 Finally, there are specific methodological challenges to the collection of reliable prevalence data for Aboriginal people and Torres Strait Islanders with cognitive and mental health impairments. We noted some of these problems in Chapter 2.[4] Parker notes some of the difficulties in collecting reliable data on the prevalence of mental health impairments among Aboriginal people and Torres Strait Islanders.[5] These include:

- Issues of communication between Aboriginal people and Torres Strait Islanders and non-Aboriginal doctors, including language and inter-cultural barriers.
- Problems of stigma around mental illness for Aboriginal people and Torres Strait Islanders.
- Problems related to defining mental illness given the increasing coincidence of mental disorders associated with substance abuse and the problems that this can cause diagnostic systems.[6]

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3. See eg C Hatton, "Intellectual Disabilities – Classification, Epidemiology and Causes" in E Emerson and others (ed) *Clinical Psychology and People with Intellectual Disabilities* (Wiley-Blackwell, 2nd ed, 2012) 3, 8; S C Hayes and G Craddock, *Simply Criminal* (Federation Press, 2nd ed, 1992) 32.
4. Para 2.21-2.23.
5. See R Parker, "Mental Illness in Aboriginal and Torres Strait Islander Peoples" in N Purdie, P Dudgeon and R Walker (ed) *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (Commonwealth of Australia, 2010) 65.
6. R Parker, "Mental Illness in Aboriginal and Torres Strait Islander Peoples" in N Purdie, P Dudgeon and R Walker (ed) *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (Commonwealth of Australia, 2010) 65, 66.

Prevalence of cognitive and mental health impairments in Australia and NSW

4.8 It is only by establishing a baseline for the prevalence of cognitive and mental health impairments in the general population that it is possible for us to determine whether people with cognitive and mental health impairments are over-represented at various stages of the criminal justice process.

4.9 Such a baseline might also allow us to identify where there are possible data gaps. For example, if certain data indicates under-representation of people with cognitive and mental health impairments and there is no apparent reason for this, under-reporting or other problems in data collection may be indicated.

Mental health impairments – Australia and NSW

4.10 The 1997 and 2007 National Survey of Mental Health and Wellbeing (SMHWB)[7], undertaken by the Australian Bureau of Statistics (ABS), provide data on the prevalence of mental health impairments in the general population, both nationally and in NSW. These surveys are the major Australian epidemiological surveys of their kind, producing base-line data on the prevalence of mental health impairments in local and institutional settings. However, they are limited to affective, anxiety, and substance use disorders ("common mental disorders"). Affective disorders include: depression, dysthymia, mania, hypomania, and bipolar disorder. Anxiety disorders include, panic disorder, agoraphobia, social phobia, generalized anxiety disorder, and post traumatic stress disorder. Substance use disorders include: alcohol harmful use (abuse), alcohol dependence and drug use disorders.[8] Both surveys focused on high prevalence disorders, and did not include low prevalence disorders such as schizophrenia and other psychotic disorders.

4.11 The 1997 survey provides information on the prevalence of selected 12-month common mental disorders, whereas the 2007 survey provides lifetime prevalence estimates for mental disorders, and 12-month diagnoses were derived based on the lifetime diagnoses.[9] Furthermore, while the 1997 survey provided the prevalence of mental health impairments in NSW, the 2007 survey only provides the prevalence of mental health impairments in Australia. As such, the ABS indicates that caution must be exercised when comparing data from the 1997 and 2007 surveys.[10]

4.12 The 1997 SMHWB provides estimates of the prevalence of mental health impairments for the general Australian community and a profile of adults in NSW. In the 12 months prior to the survey, 17.4%[11] of people in the NSW adult population

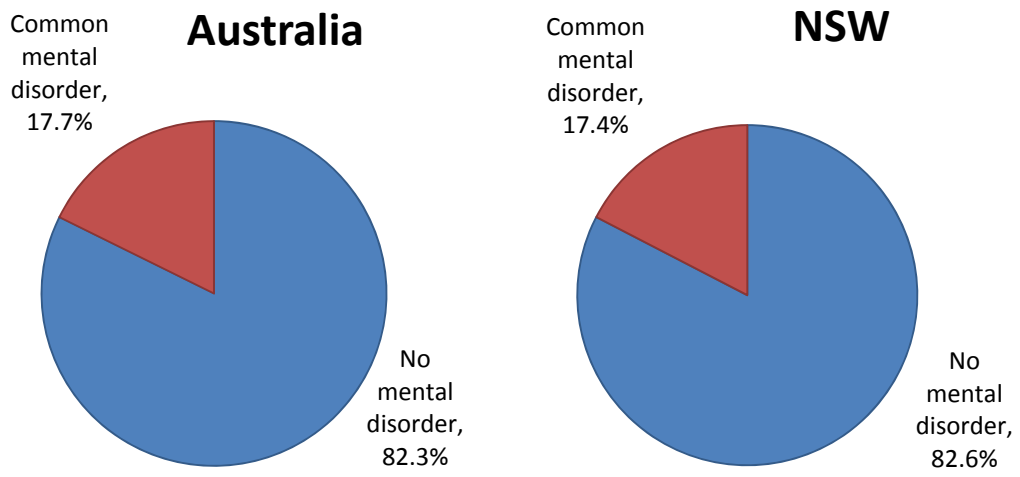
7. Australian Bureau of Statistics, *Mental Health and Wellbeing: Profile of Adults, Australia* (1997).
8. Australian Bureau of Statistics, *Mental Health and Wellbeing: Profile of Adults, Australia* (1997) 3.
9. Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing: Summary of Results* (2007) 6.
10. Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing: Summary of Results* (2007) 75.
11. Australian Bureau of Statistics, *Mental Health and Wellbeing: Profile of Adults New South Wales* (1997) 1.

fulfilled diagnostic criteria for a common mental disorder (compared with 17.7%[12] in the Australian estimate). Figure 4.1, below, represents the prevalence of common mental disorders for NSW and Australia in 1997.

4.13 The 2007 SMHWB found that 45% of Australians had a lifetime common mental disorder, with 20% of Australians having had symptoms in the last 12 months. Figure 4.2, below, indicates the 12-month prevalence of common mental disorders in 2007. The 2007 SMHWB also revealed that 1.4 million Australians (8.5%) had two or more 12-month common mental disorders, and 1.9 million Australians (11.7%) had both a common mental disorder and a physical condition.[13]

4.14 The 2007 SMHWB did not provide a breakdown of findings by state. However, it did provide an updated national picture of the prevalence of common mental disorders and because prevalence rates in the NSW and Australian sample in the 1997 survey were highly comparable, it is reasonable to infer that Australian figures in the 2007 survey are reasonably representative of the NSW population. Therefore, in the 12 months prior to the 2007 survey, the proportion of the NSW population with a common mental disorder is likely to have been around 20%.

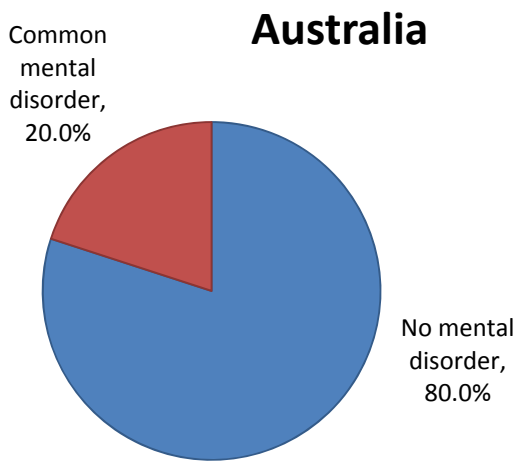
Figure 4.1: 12-month prevalence of common mental disorders (Australia and NSW, 1997)



Source: Australian Bureau of Statistics, Mental Health and Wellbeing: Profile of Adults, Australia (1997) 18; Australian Bureau of Statistics, Mental Health and Wellbeing Profile of Adults New South Wales (1997) 1.

12. Australian Bureau of Statistics, *Mental Health and Wellbeing: Profile of Adults Australia* (1997), 18.
13. Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing: Summary of Results* (2007) 22.

Figure 4.2: 12-month prevalence of common mental disorders (Australia, 2007)



Source: Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing: Summary of Results (2007) 28.

4.15 The 1997 and 2007 SMHWB also provide data in relation to the rates at which people experience multiple coexisting (comorbid) mental health disorders. Table 4.1 sets out the rates of comorbidity in relation to common mental disorders and single disorders in 1997 and 2007.

Table 4.1: Comorbidity of common mental disorders (Australia, 1997 and 2007)[14]

Mental disorder	Year of survey	
	1997	2007
Anxiety only	5.5	9.7
Affective disorder only	2.2	2.2
Substance abuse disorder only	5.4	3
Anxiety and affective only	2.3	3
Anxiety and substance abuse	1.1	1
Affective and substance abuse	0.5	0.4
All three	0.9	0.7
Total	17.7	20.1

Source: Australian Bureau of Statistics, Mental Health and Wellbeing: Profile of Adults, Australia (1997) 29; Australian Bureau of Statistics, National Survey of Mental Health and Wellbeing: Summary of Results (2007) 41.

14. Each of these categories includes aggregated results for common mental disorders and common mental disorders occurring with a physical disability.

4.16 Due to the presentation of results in the 1997 SMHWB for NSW in 1997, it is less clear how many people in NSW had a comorbidity of two or more common mental disorders, however it appears that between 1.2-5.6% of people in NSW had more than one common mental disorder[15] and 7.9% of people had at least one common mental disorder and a physical condition.[16]

4.17 Slightly more recent data about the experience of mental illness in Australia and NSW was reported by Australian Bureau of Statistic's National Health Survey (NHS) published in 2010. The NHS is an Australia-wide review of health issues, conducted several times over the last 30 years and including some data on mental health issues, particularly the experience of "long term mental illness".[17] The survey included 20,800 people of all ages in 15,800 private dwellings across Australia, interviewed face-to-face via computer-assisted interview. Both urban and rural areas in all states and territories were included, but remote areas of Australia were excluded. "Long-term mental illness" was described as a mental illness lasting more than 6 months. More common mental conditions such as anxiety, depression and substance use were prompted in the survey, but other conditions were ascertained by general questions about having "any other long-term illness".[18]

4.18 According to this survey, in 2007-2008, 11.2% of Australians self-reported as currently having a long-term mental condition as identified by a medical professional.[19] For NSW, the proportion of the population with a long term mental condition was 10.9%.[20]

4.19 As part of the 1997 SMHWB, there was some research undertaken into the prevalence of psychotic disorders, which include schizophrenia and related disorders, bipolar affective disorder, depression with psychotic features, delusional disorders, and acute transient psychotic disorders.[21] Two findings from this study are particularly useful for our purposes:

- between 0.4-0.7% of adults (with a weighted mean of 0.47%) aged 18-64 residing in urban areas were in contact with mental health services in any given month for treatment of symptoms of their psychotic disorder,[22] and
- schizophrenia and schizoaffective disorder accounted for over 60% of psychotic disorders, with men and women affected equally.[23]

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15. Australian Bureau of Statistics, *Mental Health and Wellbeing Profile of Adults New South Wales* (1997) 9.
16. Australian Bureau of Statistics, *Mental Health and Wellbeing: Profile of Adults New South Wales* (1997) 9.
17. Australian Bureau of Statistics, *National Health Survey: Summary of Results, 2007-2008* (2010).
18. Australian Bureau of Statistics, *National Health Survey: Users' Guide - Electronic, 2007-2008* (2009) 41.
19. Australian Bureau of Statistics, *National Health Survey*: *Summary of Results, 2007–2008,* ABS Reference: 43640DO003_20072008 (2010) Table 1.3.
20. Australian Bureau of Statistics, *National Health Survey: Summary of Results; New South Wales, 2007-2008*, ABS Reference: 43620DO003_20072008 (2010) Table 3.3.
21. A Jablensky and others, *People Living with Psychotic Illness: An Australian Study 1997-98* (Commonwealth of Australia, 1999) iii.
22. A Jablensky and others, *People Living with Psychotic Illness: An Australian Study 1997-98* (Commonwealth of Australia, 1999) 3, 5.

4.20 More recent research into psychotic disorders appears to support the general findings of the 1997 study above. Schizophrenia and schizoaffective disorders accounted for 64.5% of all psychotic disorders (schizophrenia, 47%; schizoaffective disorder, 17.5%).[24] Additionally, the rates for people in contact with specialist mental health services for a psychotic disorder were similar to those reported in 1997. Table 4.2 sets out the estimated 1 month and 12 month prevalence for people with psychotic disorders in contact with mental health services.

Table 4.2: Estimated 1 month and 12 month treated prevalence of psychotic disorders, people aged 18-64 (Australia, 2010)

	1 month prevalence		12 Month Prevalence	
	%	Estimated number of people	%	Estimated number of people
Males	0.37%	26,600	0.54%	38,859
Females	0.24%	17,215	0.35%	24,674
Total	0.31%	43,815	0.45%	63,533

Source: V A Morgan and others, People Living with Psychotic Illness 2010: Report on the Second Australian National Survey (Commonwealth of Australia, 2011) 22, 24.

4.21 Men had higher rates of psychotic disorder than women generally, and the highest rates of psychotic disorder in both 1 month and 12 month prevalence estimates were in males, aged 25-34 and 35-44.[25] Males aged 25-34 had the very highest estimated 12 month prevalence rate at 0.74%.[26]

Aboriginal people and Torres Strait Islanders

4.22 The *Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2010* report suggests that Indigenous Australians experience mental health issues at a higher rate than the general community. The report presents the results of the 2008 National Aboriginal and Torres Strait Islander Social Survey, which provides recent data for psychological distress among Aboriginal and Torres Strait Islander people. The survey found that:

- In 2008, 31% of Indigenous Australians aged 15 years and over had experienced high/very high levels of psychological distress, more than twice the rate of non-Indigenous Australians.[27]

23. A Jablensky and others, *People Living with Psychotic Illness: An Australian Study 1997-98* (Commonwealth of Australia, 1999) 3, 9.
24. VA Morgan and others, *People Living with Psychotic Illness 2010: Report on the Second Australian National Survey* (Commonwealth of Australia, 2011) 2.
25. VA Morgan and others, *People Living with Psychotic Illness 2010: Report on the Second Australian National Survey* (Commonwealth of Australia, 2011) 22, 24.
26. VA Morgan and others, *People Living with Psychotic Illness 2010: Report on the Second Australian National Survey* (Commonwealth of Australia, 2011) 22, 24.
27. Australian Institute of Health and Welfare, *The Health and Welfare Of Australia's Aboriginal and Torres Strait Islander People: An Overview* (2011) 38.

- In the four weeks prior to the survey, of those who reported high/very high levels of distress, 39% reported alcohol and drug-related problems, 27% reported having a mental illness, and 24% reported having trouble with the police.[28]

4.23 While these results cannot be compared directly to the statistics reported in the SMHWB or the NHS, there appears to be a higher rate of reported mental illness among Aboriginal people and Torres Strait Islanders than in the general population (27% compared with 20% respectively). Furthermore, the higher rate of reported psychological distress (which can include the experience of symptoms of anxiety and depression) when compared with non-Indigenous Australians, could indicate higher rates of mental health problems, although that psychological distress could be the result of other factors, such as living with a long-term health condition.[29] The ABS has also recently reported that in 2010 the suicide rate for Aboriginal people and Torres Strait Islanders was 2.5 times higher than the rate for non-Indigenous males, and 2.4 times higher for non-Indigenous females.[30] This suggests that some mental health outcomes for Aboriginal people and Torres Strait Islanders are poorer when compared with non-Indigenous Australians.

Summary – mental health impairments in NSW

4.24 Taking the results of the above research into account we can conclude the following in regards to the experience of mental illness in NSW. The proportion of people who have experienced a common mental disorder at any time in their lives may be as high as 45% of the population. However, the number of people who have experienced symptoms in the past 12 months is likely to be closer to 20%. The proportion of the population of NSW who have experienced a long-term mental illness appears to be around 11%. Although there are no recent statistics in regards to comorbidity of mental health impairments in NSW, in Australia in 2007 the rate was 5.1% of the population, and it is likely to be similar in NSW. Finally, given the national rates in 1997 and 2010, the rate of psychotic conditions is likely to be low in comparison with other mental health conditions, with less than 1% of the population receiving treatment for schizophrenia or other psychotic disorders.

Cognitive impairment in Australia and NSW

4.25 There is limited data concerning the number of Australians with cognitive impairments generally. Most of the available data focuses on intellectual disability. As we discuss in Chapter 5, intellectual disability is only one type of cognitive impairment.

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28. Australian Bureau of Statistics, "Adult Health: Psychological Distress" in *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2010* (Oct 2010) (ABS ref 4704.0) <www.abs.gov.au/AUSSTATS/abs@.nsf/lookup/4704.0Chapter715Oct+2010>.

29. Australian Institute of Health and Welfare, *The Health And Welfare Of Australia's Aboriginal and Torres Strait Islander People: An Overview* (2011) 38: 43% of people with a disability or long-term health condition reported psychological distress compared with 19% of people without.

30. Australian Bureau of Statistics, *2010 Causes of Death* (2010), 29.

Australia

4.26 According to the Australian Institute of Health and Welfare (AIHW), based on data from the 1998 and 2003 Survey of Disability, Ageing and Carers conducted by the Australian Bureau of Statistics, over 500,000 Australians had an intellectual disability and 61% of these people had "a severe or profound limitation in 'core' activities of daily living".[31]

4.27 The report notes some potential issues with the data. In particular, it suggests that it may be over-inclusive in some areas because it includes people with learning disabilities. It suggests that it might be desirable to treat learning disabilities separately from other intellectual disabilities because they do not always involve impairment in intellectual functions, but that it is difficult to do so because of limitations in the survey data.[32] Additionally, the survey includes dementia-related conditions in some of its analysis because the survey instrument asked questions about a person having "difficulty in learning or understanding". It suggests that a change in wording from "slow at learning or understanding" in a previous study increased the apparent prevalence of intellectual disability in certain categories, particularly children aged 10–14 years and people aged 75 years and over.

4.28 The AIHW reports the following in relation to the prevalence of intellectual disability in the Australian community. In 2003:

- Approximately 588,700 people, or 3% of Australians, had intellectual disability (based on all disabling conditions reported in the survey).
- 436,200 people with intellectual disability were aged under 65 years (2.5% of that population), 152,500 were aged 65 years or older (6.1%).
- Around 351,000 people with intellectual disability had a severe or profound limitation (1.8% of the total population), of whom 215,100 were aged under 65 years (1.2% of the under-65 population).
- For an estimated 165,700 people (0.8% of Australians), intellectual impairment was their main disabling condition and almost all were aged under 65 years…
- The overall prevalence rate for males was higher than for females. The sex difference increased with age up to 10–14 years and then reduced substantially.[33]

4.29 The report notes that excluding dementia-related conditions, reduced the prevalence of intellectual disability among people aged 85 years or over from 20% to 5.7%, and the overall rate is reduced from 3% (588,700 people) to 2.6% (505,700 people).[34]

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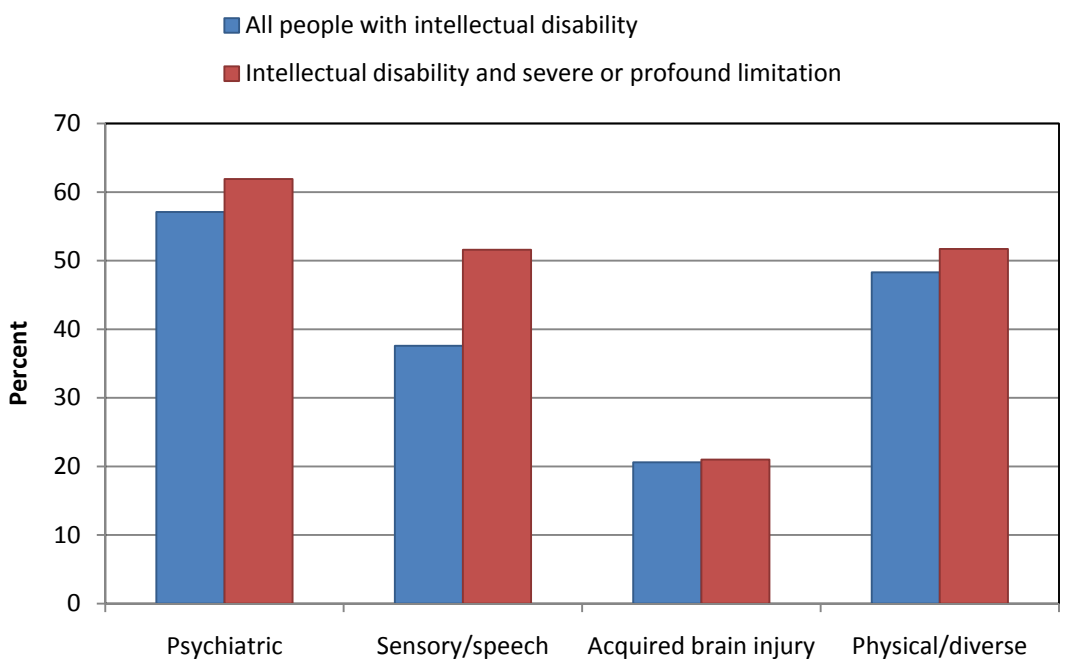
31. X Wen, *Disability in Australia: Intellectual Disability*, Bulletin 67 (Australian Institute of Health and Welfare, 2008) 1.
32. X Wen, *Disability in Australia: Intellectual Disability*, Bulletin 67 (Australian Institute of Health and Welfare, 2008) 8.
33. X Wen, *Disability in Australia: Intellectual Disability*, Bulletin 67 (Australian Institute of Health and Welfare, 2008) 7.
34. X Wen, *Disability in Australia: Intellectual Disability*, Bulletin 67 (Australian Institute of Health and Welfare, 2008) 8.

4.30 From the data presented by the AIHW, it would appear that intellectual disability often occurs in combination with other disabilities. In particular, as Figure 4.3 shows, in 2003 a majority of people under 65 with an intellectual disability had a comorbid psychiatric impairment (57%), while among those people with an intellectual disability and a severe or profound limitation, the rate of comorbidity was even higher (62%).[35]

Figure 4.3: People aged under 65 years with intellectual disability: presence of other types of disability (Australia, 2003)



Source: X Wen, Disability in Australia: Intellectual Disability, Bulletin 67 (Australian Institute of Health and Welfare, 2008) 37.

NSW

4.31 According to the ABS, in NSW, 4.9% of 1,329,200 people with a disability in NSW[36] reported an intellectual or developmental disorder as their main health condition.[37] This amounts to approximately 65,131 people with intellectual and developmental disorders.

4.32 Data collected by the ABS 2003 Survey of Disability, Ageing and Carers and reported by the AIWH provides further detail in regards to rates of intellectual disability in NSW in comparison with rates in Australia as a whole, as set out in Table 4.3 and Table 4.4. Table 4.3 provides the rates for people aged 0-64. This excludes those aged over 65, where there is an increase in rates with age, as a

35. X Wen, *Disability in Australia: Intellectual Disability*, Bulletin 67 (Australian Institute of Health and Welfare, 2008) 11.
36. Australian Bureau of Statistics, *Disability, Ageing and Carers, Australia: State Tables for New South Wales* 2009 (2012) Table 1.
37. Australian Bureau of Statistics, *Disability, Ageing and Carers*, *Australia: State Tables for New South Wales 2009* (2012) Table 14.

result of increases in intellectual impairment associated with dementia. Table 4.4 shows the prevalence rates for all ages which, taking into account the higher rates in those aged over 65, are higher than the rates for those between 0 and 65. Both these tables distinguish between the total rate of people with an intellectual disability, and those with an intellectual disability with a severe or profound limitation.

Table 4.3: Prevalence of intellectual disability, ages 0-64 (Australia and NSW, 2003)

	NSW	Australia
Total with intellectual disability	123500	436,200
Total rate of intellectual disability (%)	2.2%	2.5%
Intellectual disability with severe or profound limitation	51,500	215,100
Rates of intellectual disability with severe or profound limitation (%)	0.9%	1.2%
Total population	5,740,200	17,222,500

Source: X Wen, Disability in Australia: Intellectual Disability, Bulletin 67 (Australian Institute of Health and Welfare, 2008) 13.

Table 4.4: Prevalence of intellectual disability, all ages (Australia and NSW, 2003)

	NSW	Australia
Total with intellectual disability	168,800	588,700
Total rate of intellectual disability (%)	2.6%	3.0%
Intellectual disability with severe or profound limitation	94,800	351,000
Rates of intellectual disability with severe or profound limitation (%)	1.4%	1.8%
Total population	6,597,800	19,719,300

Source: X Wen, Disability in Australia: Intellectual Disability, Bulletin 67 (Australian Institute of Health and Welfare, 2008) 13.

Summary – cognitive impairment in NSW

4.33 On the basis of the available data, it would appear that the rate of intellectual disability in NSW is likely to be somewhere between 2.6% of the total population (if older people with dementia-related conditions are counted) and 2.2% (if the category of people over 65 is excluded). However, these results are likely to be over-inclusive as they include learning disabilities, where there may be no impairment in intellectual functioning. At the same time, the prevalence rates in the study do not include other cognitive impairments. For example, as can be seen from Figure 4.3 above, acquired brain injury (ABI) does not appear to have been included in the coverage of "intellectual disability", as it is recorded separately as a comorbid condition. Therefore, 2.2% is likely to be a minimum, and the true rate of cognitive impairment in NSW is likely to be higher.

Police contact

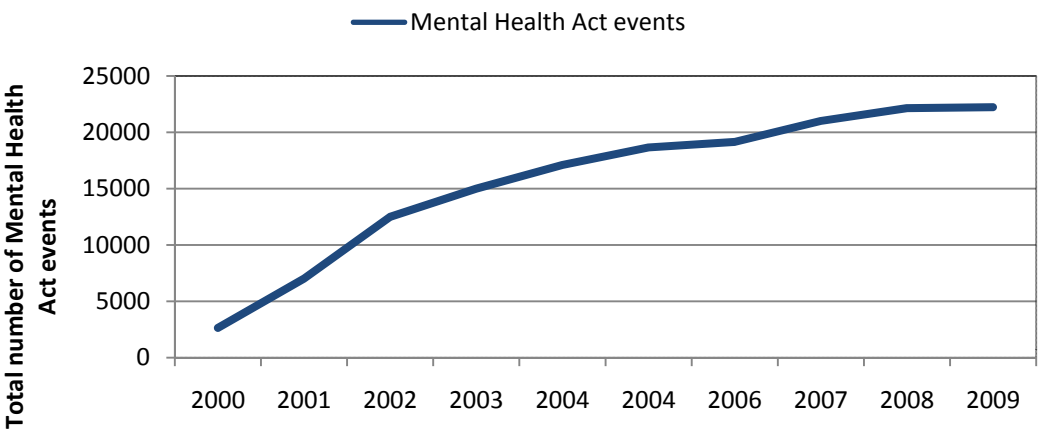
4.34 There is limited empirical data on police interaction both with people with mental health impairments, and particularly for people with cognitive impairments.

Mental health impairments

4.35 A 2002 survey of 131 police officers in Sydney found the reported police time spent dealing with "mentally disturbed people" was an average of 10%, with responses ranging from 0-60%.[38]

4.36 From 1992 to 2003 there was a 500% increase in involuntary admission of individuals brought to mental health facilities by police.[39]

Figure 4.4: Mental Health Act related events as recorded in COPS, 2000-2009



Source: V Herrington and others, The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report (Charles Sturt University, 2009) 15.

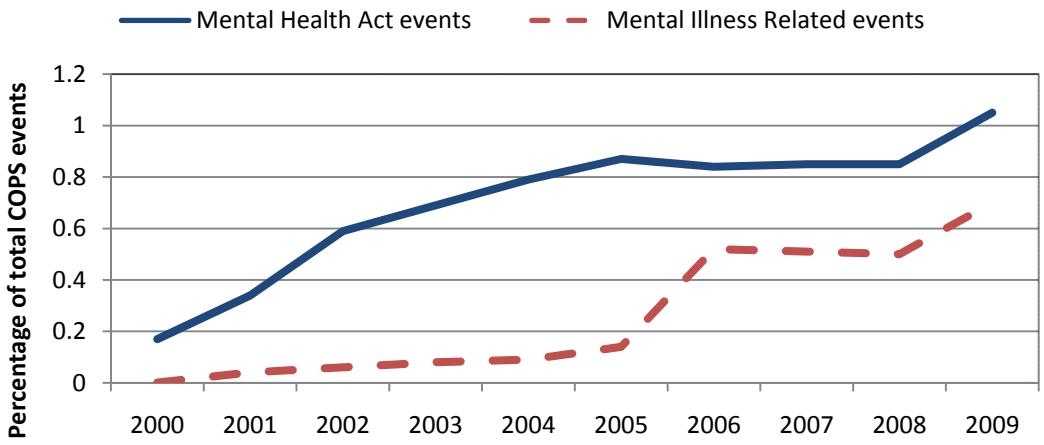
4.37 This increase appears to have continued, with a 2008 review of the NSW Police Force's Mental Health Intervention Team (MHIT) finding that between 2000 and 2009 the number of "Mental Health Act events" (involving delivery by police of a person to a mental health facility under s 22 of the *Mental Health Act 2007* (NSW)) increased from 2,642 in 2000 to 22,234 in 2009,[40] as demonstrated in Figure 4.4. The frequency of Mental Health Act events varied between Local Area Commands, with officers from pilot sites involved in the MHIT reporting figures of approximately 4% of all reported events.[41]

4.38 The 2009 figure of 22,234 accounts for 1.05% of all incidents reported on COPS.

38. A Fry, D O'Riordan and R Geanellos, "Social Control Agents or Front-Line Carers for People with Mental Health Problems: Police and Mental Health Services in Sydney, Australia" (2002) 10(4) *Health and Social Care in the Community* 277, 280.
39. P Garling, *Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals*, Vol 2 (2008) [22.18] citing a NSW Health Briefing, 31 March 2008.
40. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report* (Charles Sturt University, 2009) 15.
41. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report* (Charles Sturt University, 2009) 14.

4.39 The numbers in Figure 4.4 above do not take into account the number of records in COPS identified as "Mental Illness Related" events. These are events recorded on COPS as events where mental illness is a factor, but the individual is not dealt with under the *Mental Health Act*.[42] Mental Illness Related events also increased significantly, from 24 events in 2000 to 14,849 in 2009.[43] Figure 4.5 shows Mental Health Act and Mental Illness Related events as a proportion of all events recorded in COPS.

Figure 4.5: Mental Health Act and Mental Illness Related COPS events as a proportion of all COPS incidents, 2000-2009



Source: V Herrington and others, The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report (Charles Sturt University, 2009) 15.

4.40 Cumulatively, Mental Health Act events and mental illness related events accounted for 1.75% of recorded events in the COPS database in 2009.[44]

4.41 The evaluation of the MHIT suggested that the increases in reported Mental Health Act events and Mental Illness Related events are likely to be due to changes in the awareness and identification of mental illness, and the general increase in recording COPS events.[45]

4.42 The discrepancy between the rates of contact with people with mental illness as reported by police officers in 2002, and the more recent figures reported by the MHIT evaluation could be accounted for, as suggested above, by an under-reporting of events involving people with mental health impairments in the past. For example, incidents involving an impairment may not necessarily be identified or recorded due to difficulties with accurately identifying an impairment. However, it is important to recognise that these two figures represent two different measures of

42. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report* (Charles Sturt University, 2009) 14.
43. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report* (Charles Sturt University, 2009) 14.
44. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report* (Charles Sturt University, 2009) 15.
45. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report* (Charles Sturt University, 2009) 14.

contact. The 2002 figure is the average time spent dealing with people with mental health impairments, while the figure from the COPS database is the percentage of incidents where mental health was a factor.

4.43 It is likely that, although mental health related events make up only a small proportion of events dealt with by police, given police self reports of time spent on mental health related cases, the time dealing with them is disproportionate to their representation in COPS. Information provided by the NSW Police Force seems to support such a conclusion. For example, the NSW Police Force noted during consultations that, in their view, Mental Health Act and mental health related incidents account for at least 10% of police time.[46] Furthermore, the NSW Police Force noted that according to research, 7% of individuals referred to a mental health facility under s 22 of the *Mental Health Act* were responsible for 23% of all mental health contacts in 2005.[47] However, without further data recording and analysis it is not possible to state with any certainty the true extent of police contact with people with mental health impairments.

Cognitive impairment

4.44 There appears to be even less data in relation to contact with police by people with cognitive impairments, than for contact with people with mental health impairments.

4.45 Anecdotal evidence reported by the Intellectual Disability Rights Service (IDRS) in 2008 suggested that although police had brief guidelines on how to identify a person with "impaired intellectual functioning" for the purposes of providing additional safeguards (in relation to matters such as arrest and questioning) and for referral to appropriate human services, many stakeholders had reported that "police were still routinely failing to identify people falling within these guidelines".[48]

4.46 We were informed in consultation that it is often difficult for police to identify people with a cognitive impairment, particularly where there are no family members or support people available. Additionally, the presence of other factors such as drugs or alcohol could make identification of cognitive impairments more difficult.

4.47 Additionally, concerns were raised by stakeholders about the collection of data regarding people with cognitive impairments by police, and the ability of police to access relevant data, particularly given the difficulties noted above.

4.48 In our Report 80,[49] we noted UK research from 1993 which found that 8.6% of 197 suspects apprehended by police at two English police stations had an IQ below 70 (which would qualify them for a diagnosis of intellectual disability), while a further

46. NSW Police Force, *Consultation MH26*, 20 September 2011.
47. Email from G Andrews on behalf of Supt D Donohue, NSW Police Force referring to unpublished research regarding Mental Health Frequent Presenters to Emergency and Mental Health Services, 28 May 2012.
48. 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) 72.
49. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) 429.

42% had IQ scores between 70 and 79 (borderline intellectual disability). As the study noted, a large number of detainees suffer from a significant intellectual impairment.[50]

4.49 Recent research by Baldry, Clarence and Dowse examines the pathways taken by people with cognitive and mental health impairments in, out and through the criminal justice system (the Pathways study).[51] Significantly, unlike other studies, the Pathways study provides very detailed information about the characteristics of cognitive disability and the very high rate of dual diagnosis (complex needs) among prisoners. It is important to note that the sample used in the study was purposive, not representative, so it is not a prevalence study of mental illness and cognitive impairment in the criminal justice system, but rather a description of what this population looks like.[52]

4.50 Using data merged from human services and criminal justice agencies, the study included 2,731 people in prison between 2000 and 2008 and examined how they accessed services in this period.

4.51 The study identified 1463 prisoners in the cohort with cognitive disability (which included intellectual disability, borderline intellectual disability and either of those two categories of impairment with other diagnoses, and acquired brain injury (ABI) with either below 70 or between 70 and 80 IQ).[53] Of the members of this group, approximately two thirds of them had complex needs.[54]

4.52 The Pathways study provides some data relating to police contact with people with cognitive impairments. The study shows the following:

- The average age at first police contact for those with complex diagnoses or comorbid conditions was significantly lower than study subjects with just a single or no diagnosis.[55]
- The Indigenous members of the study cohort had a significantly lower average age of first police contact than the overall cohort.[56]
- For both Indigenous and non-Indigenous groups it was those with complex cognitive disability diagnoses that had the lowest ages at first police contact.[57]

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50. G Gudjonsson and others, *Persons at Risk During Interviews in Police Custody: The Identification of Vulnerabilities*, Research Study 12 (Royal Commission on Criminal Justice, 1993) 19.
51. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012).
52. Purposive sampling is sampling with a particular purpose, or population in mind. In this case, the particular sample was selected in order to examine the pathways of a this population. The outcomes of the study can be used to answer questions about the particular sample but cannot be used to make generalisations about the larger population.
53. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) <www.app.unsw.edu.au/sites/app.unsw.edu.au/files/mhdcdbackgroundoutlaws_conf1.pdf> 7.
54. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 7.
55. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 9.
56. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 10.

Summary – police contact with people with cognitive and mental health impairments

4.53 We can say very little with any certainty about the extent of police contact with people with cognitive and mental health impairments. It would appear that, on average, police spend around 10% of their time dealing with people with mental health impairments. However, this number is possibly significantly higher in some cases. Additionally, although the recorded data indicates that less than 2% of events recorded in COPS involved people with mental health impairments, this data may be under inclusive.

4.54 In relation to police contact with people with cognitive impairments we have no quantitative measure of the extent of such contact in NSW, although there is some indication from overseas that people with cognitive impairments are likely to be over-represented in their contact with police.

4.55 Finally, the data from the Pathways study indicates that cognitive impairment in combination with another comorbid condition makes it more likely that a person will have contact with police at a younger age than a person with no impairment or only a single impairment, but the reasons for this are unclear.

Prevalence in NSW courts

4.56 There is no systematic institutional data available on the extent of representation of people with cognitive and mental health impairments in the NSW criminal court system. However, a number of small scale studies have suggested that this group of people is over-represented, particularly in the Local Court.

NSW Local Courts

Cognitive impairment/intellectual disability

4.57 For our earlier reference on people with intellectual disabilities in the criminal justice system, Professor Susan Hayes undertook a two phase empirical research study to establish the prevalence of intellectual disability among defendants in the NSW Local Court.[58] This research was prompted by the absence of accurate statistics on the representation of people with intellectual disability in the criminal justice system.

4.58 The first phase of the study, undertaken in 1993 examined defendants in the Dubbo, Wagga Wagga, Liverpool and Newtown Local Courts. These locations were chosen because it was considered that they would be as representative as possible

57. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 9-10.

58. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System: Appearance before Local Courts*, Research Report 4 (1993); NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System: Two Rural Courts*, Research Report 5 (1996).

of NSW local courts.[59] The second phase in 1996 examined defendants in two rural courts, Bourke and Brewarrina. These were chosen because it was expected they would have a high representation of Indigenous defendants and a large number of appearances on list days.[60]

4.59 The 1993 study attempted to take a time sample of defendants in the four study courts over a seven working day period. The 1996 study was conducted in both courts during all list days in July 1995. This resulted in a sample of 98% of persons listed for court appearances participating in the study.

4.60 Both studies employed the Kaufman Brief Intelligence Test (K-BIT) to provide a measure of the verbal and non-verbal intelligence of study participants. The test results in a standard score, where mean score is 100 (similar to IQ scores). A standard score of less than 70 indicates possible intellectual disability. A score of between 70 and 79 indicates possible borderline intellectual disability. The K-BIT does not provide a comprehensive diagnosis of a person's cognitive or intellectual functioning. Rather, it is intended for estimating intelligence for large groups of people.[61] Proper diagnosis of intellectual disability would require the application of multiple diagnostic instruments, including an assessment of a person's adaptive functioning. The results of these studies are indicative, rather than definitive.

4.61 The results of the two studies are set out in Table 4.5.

Table 4.5: Rates of intellectual disability in local court defendants (1993 and 1996)

	1993 study		1996 study	
	Number	%	Number	%
Possible intellectual disability	16	14.2%	31	36%
Possible borderline intellectual disability	10	8.8%	18	20.9%
Neither	87	77%	37	43%
Total sample	113	100%	86	99.9%

Source: NSW Law Reform Commission, People with an Intellectual Disability and the Criminal Justice System: Appearance before Local Courts, Research Report 4 (1993); NSW Law Reform Commission, People with an Intellectual Disability and the Criminal Justice System: Two Rural Courts, Research Report 5 (1996).

59. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System: Appearance before Local Courts*, Research Report 4 (1993) [2.1].
60. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System: Two Rural Courts*, Research Report 5 (1996) [2.1].
61. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System: Appearance before Local Courts*, Research Report 5 (1996) [2.14]-[2-16].

4.62 A 2009 study of 60 accused adults[62] appearing before four Local Courts in Greater Sydney[63] found that people with cognitive impairment and/or intellectual disabilities were over-represented in the Local Court.[64]

> Using standardised measures of [intellectual disability] and/or [cognitive impairment], the present study found that the proportion of participants with an IQ score of <70 was more than three times the rate in the general population, whereas the proportion having significant deficits in adaptive behaviour (again a [standard score] of <70) was more than four times that in the general population. The proportion who had deficits in both areas and who therefore met the diagnostic criteria for [intellectual disability] of scores below 70 on both adaptive behaviour and intellectual functioning was 3.5% (although onset prior to the age of 18 could not be absolutely determined), slightly higher than the upper range of population prevalence.[65]

4.63 The study data also indicated that almost one third of the sample may have had a mental health problem. It was noted that this was consistent with the findings of the 2007 study discussed above.[66]

4.64 In the adults with some form of intellectual deficit, 46% had possible comorbid mental health problems. This was higher than that of the general population. It was also higher than previously reported results of possible mental health problems for adults with intellectual disability.[67]

4.65 This study also measured the prevalence of mental health problems in the sample population. The study concluded from these findings that the proportion of participants with an IQ score of less than 70 was more than three times the rate of the general population, while the proportion of participants with significant deficits in adaptive behaviour was more than four times the prevalence in the general population.[68]

Mental health status

4.66 A 2007 study by the Bureau of Crime Statistics and Research (BOCSAR study) surveyed 189 adult defendants appearing for criminal matters in one of two NSW Local Courts. Its findings in relation to mental health impairments are set out in Table 4.6.

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62. The sample of 60 people was identified from an original sample of 250 self-selected individuals, who were screened for ID using the Hayes Ability Screening Index (a brief screening tool, intended to quickly identify the possible presence of intellectual disability) and interviewed): K Vanny and others, "Mental illness and intellectual disability in Magistrates Courts in NSW South Wales, Australia" (2009) 53 *Journal of Intellectual Disability Research*, 289, 291.
63. K Vanny and others, "Mental Illness and Intellectual Disability in Magistrates Courts in New South Wales, Australia" (2009) 53(3) *Journal of Intellectual Disability Research* 289, 290.
64. K Vanny and others, "Mental Illness and Intellectual Disability in Magistrates Courts in New South Wales, Australia" (2009) 53(3) *Journal of Intellectual Disability Research* 289, 293.
65. K Vanny and others, "Mental Illness and Intellectual Disability in Magistrates Courts in New South Wales, Australia" (2009) 53(3) *Journal of Intellectual Disability Research* 289, 294.
66. K Vanny and others, "Mental Illness and Intellectual Disability in Magistrates Courts in New South Wales, Australia" (2009) 53(3) *Journal of Intellectual Disability Research* 289, 295.
67. K Vanny and others, "Mental Illness and Intellectual Disability in Magistrates Courts in New South Wales, Australia" (2009) 53(3) *Journal of Intellectual Disability Research* 289, 295.
68. K Vanny and others, "Mental illness and intellectual disability in Magistrates Courts in NSW South Wales, Australia" (2009) 53(3) *Journal of Intellectual Disability Research* 289, 297.

Table 4.6: Mental health impairments in Local Court defendants, 2007

Condition	Study sample (189 participants)		NSW 2004 (Weighted)[69]	
	Males (%)	Females (%)	Males (%)	Females (%)
Depression	45.4%	47.4%	3.5%	8.6%
Anxiety disorder	19.3%	29%	2.6%	4.1%
Bipolar disorder	9.3%	7.9%	0.6%	0.3%
Schizophrenia	9.3%	2.6%	0.3%	0.2%
Eating disorder	3.3%	7.9%	0.6%	0.9%
Other psychiatric disorders (including post-traumatic stress disorder and attention deficit hyperactivity disorder)	13.3%	10.5%	N/A	N/A

Source: C Jones and S Crawford, The Psychosocial Needs of NSW Court Defendants, Crime and Justice Bulletin No 108 (NSW Bureau of Crime Statistics and Research, 2007) 6.

4.67 The BOCSAR study found that 55% of surveyed defendants suffered from one or more psychiatric disorders. As the results above indicate, there was apparent over-representation of all categories of mental health impairment, when compared with the general rate in NSW, but rates of depression and anxiety disorders were particularly high. Additionally, among the study participants who self-reported having one or more psychiatric disorders, 75% "also met one or more criteria for disordered or dependant substance use".[70]

4.68 The study also identified unmet treatment needs, including in relation to mental health problems experienced by study participants. For mental health, treatment needs had not been met, particularly for depression, anxiety disorders, bipolar disorder and other psychiatric disorders (mainly attention deficit hyperactivity disorder or post-traumatic stress disorder). [71]

4.69 However, the authors of the BOCSAR study noted some qualifications in relation to the data they had collected. In particular, the study did "not employ a validated measurement scale", but relied on self-reporting of mental health conditions by the study participants. As a result, "there may have been a tendency among some participants to overdiagnose particular health problems".[72] Further, as noted in a report by the Judicial Commission, since the population sample in the BOCSAR study was self-selected, it cannot "be used to measure the overall prevalence of

69. NSW subsample of National Drug Strategy household survey reporting being "diagnosed or treated for" those conditions in the preceding 12 months. These data are presented for reference purposes only and do not constitute a proper control group.

70. C Jones and S Crawford, *The Psychosocial Needs of NSW Court Defendants*, Crime and Justice Bulletin No 108 (NSW Bureau of Crime Statistics and Research, 2007) 5.

71. C Jones and S Crawford, *The Psychosocial Needs of NSW Court Defendants*, Crime and Justice Bulletin No 108 (NSW Bureau of Crime Statistics and Research, 2007) 5.

72. C Jones and S Crawford, *The Psychosocial Needs of NSW Court Defendants*, Crime and Justice Bulletin No 108 (NSW Bureau of Crime Statistics and Research, 2007) 6.

these various problems among court defendants".[73] Nevertheless, the study's authors conclude that their findings in relation to mental health are consistent with those in other studies which have found "the prevalence of mental health disorders among criminal justice populations to be very high".[74]

The use of sections 32 and 33 of the Mental Health (Forensic Provisions) Act

4.70 Section 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA) allows a magistrate in the Local Court to divert people with mental illness or intellectual disability if the magistrate considers it appropriate. It is the main diversionary provision for NSW. Section 33 allows a magistrate to send a mentally ill person to a mental health facility to be assessed or treated. As s 33 applies only to people who are seriously mentally ill at the time of their appearance in court, s 32 is the main diversionary provision in Local Courts in NSW.

4.71 Data on the use of s 32 and s 33 of the MHFPA cannot give any indication of the extent of prevalence of people with cognitive and mental health impairments appearing before the Local Court. However, statistics on the use of both sections can give some idea of the extent to which these provisions are used in comparison with the total number of people appearing in the Local Court. Such a comparison can assist us to evaluate whether s 32 and s 33 are being used effectively or whether they are under-used by magistrates.

4.72 The data supplied to us by BOCSAR allows us to examine the overall use of s 32 and s 33 generally and in individual Local Courts in NSW.

4.73 Table 4.7 sets out the data in relation to the use of s 32 and s 33 in all NSW Local Courts. We are unable to include full data for 2011 as that data was not available to BOCSAR at the time we were preparing this Report. The total number of MHFPA-related discharges has remained relatively stable since 2008. Of all the people appearing in the Local Court, approximately 1% of them receive orders under s 32 of the MHFPA. Even combined with orders under s 33, and the "unspecified" category, discharges under the MHFPA account for less than 1.5% of finalisations since 2006.

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73. T Gotsis and H Donnelly, *Diverting Mentally Disordered Defendants in the NSW Local Court*, Monograph 31 (NSW Judicial Commission, 2008) 2, n 8.

74. C Jones and S Crawford, *The Psychosocial Needs of NSW Court Defendants*, Crime and Justice Bulletin No 108 (NSW Bureau of Crime Statistics and Research, 2007) 6, citing T Butler and S Allnutt, *Mental Illness Among NSW Prisoners* (NSW Corrections Health Service, 2003); L A Teplin and others, *Psychiatric Disorders of Youth in Detention* (Office of Juvenile Justice and Delinquency Prevention, US Department of Justice, 2006).

Table 4.7: People discharged with order under MHFPA (NSW Local Court, Jan 2006-Sept 2011)

Type of Outcome		2006	2007	2008	2009	2010	Jan 2011-Sep 2011
MHFPA s 32	Persons	957	1046	1078	1143	1335	1143
	%	0.8%	0.8%	0.8%	0.9%	1.1%	1.3%
MHFPA s 33	Persons	468	516	511	411	130	94
	%	0.4%	0.4%	0.4%	0.3%	0.1%	0.1%
MHFPA, unspecified	Persons	92	91	113	93	26	19
	%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%s
Not a mental health outcome	Persons	122552	125166	128514	129803	117210	86403
	%	98.8	98.7	98.7	98.7	98.7	98.6
Total	Persons	124069	126819	130216	131450	118701	87659
	%	100%	100%	100%	100%	100%	100%

Source: NSW Bureau of Crime Statistics and Research (LcCc1210500mr).

4.74 The figures in Table 4.7 reflect the aggregate experience across all NSW Local Court locations. The number of s 32 and s 33 orders made varies across Local Court locations in NSW. For example, in 2010, a significant number of Local Courts made no orders under s 32/33, while the maximum rate of s 32/33 discharges in 2010 was at the Tamworth Local Court where 3.94% of persons appearing were discharged under the MHFPA provisions.[75]

4.75 Previous research has inquired into the use of s 32 in the Local Court. Most significantly, the Judicial Commission published a study analysing the extent of the use of s 32 by magistrates, from 2004 to 2006, including the nature of the orders made and outcomes in relation to compliance with s 32 orders.[76]

4.76 The Judicial Commission report presented data in relation to the use of various limbs of s 32 to make different diversion orders.[77] However, in our analysis of the data available in relation to s 32 we have identified problems with the way that it was recorded. In particular, the disaggregated statistics relating to the use of various types of orders under s 32 (and s 33) is unreliable. BOCSAR now advises us that due to collection issues, it no longer regards this data as reliable. Consequently, we are unable to explore the use of s 32 in more detail.

75. Data supplied by NSW Bureau of Crime Statistics and Research (LcCc1210500mr).

76. T Gotsis and H Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local Court* (Judicial Commission of NSW, 2008).

77. T Gotsis and H Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local Court* (Judicial Commission of NSW, 2008), 4.

4.77 BOCSAR has also provided data regarding the number of breaches of s 32 orders that have been recorded since 2006. Section 32 of the MHFPA allows a magistrate to call a person who is suspected of failing to comply with a condition of discharge back before the court. As Table 4.8 demonstrates the number of people recorded as having breached a s 32 order has rarely been more than 10 in one year for the whole of NSW.

Table 4.8: Recorded breaches of s 32 orders by number of people (NSW Local Court, Jan 2006-Sept 2011)

	2006	2007	2008	2009	2010	Jan 2011 - Sept 2011
Total recorded breaches	13	11	1	4	9	9

Source: NSW Bureau of Crime Statistics and Research (LcCc1210500mr).

Defendants receiving diversionary orders in the Local Court

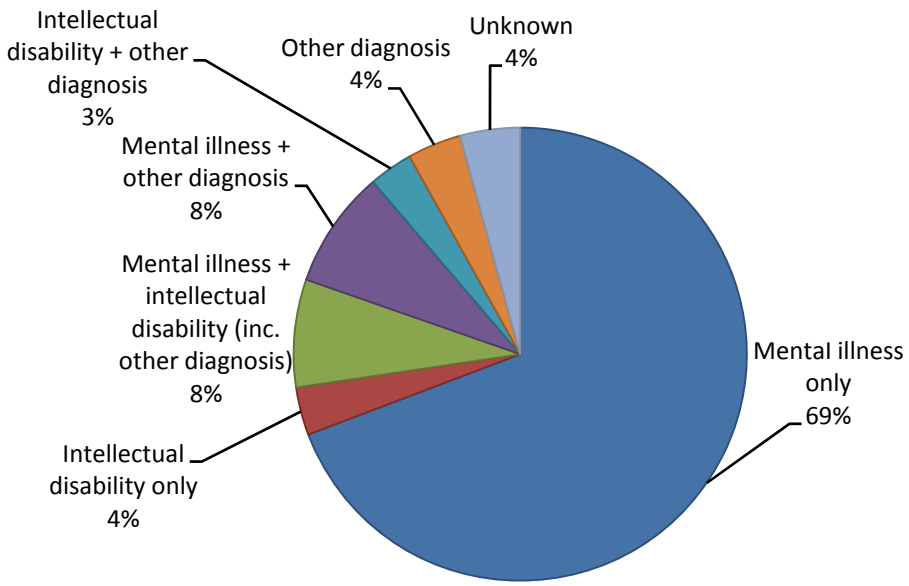
4.78 A study examining 702 finalised case files from four NSW Local Court registries (Burwood, Campbelltown, Penrith and Liverpool), of cases between January 2005 and December 2007, provides some insight into who is being granted orders under s 32 and s 33 of the MHFPA. The study examined the nature of the impairments of the defendants involved, so is particularly useful in revealing the rates at which people other than those with a mental illness receive orders under the MHFPA.[78]

4.79 However, the data for both s 32 and s 33 orders is aggregated so that we are not able to see, for example, the extent to which people with cognitive impairments received s 33 orders. As Figure 4.6 shows, 85.4% of the defendants who received either s 32 or s 33 orders had a mental illness (whether alone or in combination with another impairment).

4.80 Only 6.5% of the defendants (46 people) were people with a cognitive impairment. This included defendants who only had an intellectual disability, as well as an intellectual disability with other cognitive impairments, such as ABI or other cognitive impairment. The study suggests that most of the people with an intellectual disability with a comorbid mental illness were diverted under s 32 because of their mental illness, rather than their intellectual disability, ABI or other cognitive disability. Table 4.9 shows a breakdown of the 6.5% of defendants with cognitive impairments. Half of the 6.5% had only an intellectual disability; the other half had a variety of co-existing cognitive impairments.

78. J McNabb, *S32/33 Research* (NSW Department of Attorney General and Justice, 2011) 19.

Figure 4.6: Breakdown of defendants receiving s 32/33 orders, by impairment (Burwood, Campbelltown, Penrith and Liverpool Local Courts, Jan 2005-Dec 2007)



Source: J McNabb, S32/33 Research (NSW Department of Attorney General and Justice, 2011) 20.

Table 4.9: Comorbidity in defendants with an intellectual disability receiving a s 32/33 order (Jan 2005-Dec 2007)

All Courts	Number	Percent
Intellectual disability + acquired brain injury + other cognitive disability	5	0.7%
Intellectual disability + acquired brain injury	3	0.4%
Intellectual disability + other cognitive disability	14	2.0%
Intellectual disability only	24	3.4%
Sub Total	46	6.5%
Other	646	93.5%
Total	702	100%

Source: J McNabb, S32/33 Research (NSW Department of Attorney General and Justice, 2011) 20.

Reoffending following diversion under the Mental Health (Forensic Provisions) Act

4.81 We have data in relation to the number of people reappearing in the Local Court in the two years following a discharge under the MHFPA. This data may give us some indication of the rates at which people reoffend after a discharge under the MHFPA. As can be seen from Table 4.10, the rate of people not reappearing after a s 32 discharge remains reasonably stable at around 60-67%. The rates at which people receive a conviction or another s 32 discharge are also reasonably stable.

Table 4.10: People with a dismissal under the MHFPA, rates of reoffending (NSW Local Court, Jan 2006 to Sept 2009)

		Type of mental health dismissal at reference appearance					
		MHFPA s 32		MHFPA s 33		MHFPA, unspecified	
		Number	%	Number	%	Number	%
2006	Number of reference appearances	883	100	168	100	90	100
	MHFPA dismissal within two years	132	14.9	51	30.4	4	4.4
	Conviction within two years	272	30.8	78	46.4	31	34.4
	Both conviction and mental health dismissal within two years #	59	6.7	29	17.3	2	2.2
	Neither	538	60.9	68	40.5	57	63.3
2007	Number of reference appearances	973	100	215	100	88	100
	MHFPA dismissal within two years	111	11.4	67	31.2	6	6.8
	Conviction within two years	265	27.2	98	45.6	25	28.4
	Both conviction and mental health dismissal within two years #	49	5.0	36	16.7	1	1.1
	Neither	646	66.4	86	40.0	58	65.9
2008	Number of reference appearances	990	100.0	197	100.0	106	100.0
	MHFPA dismissal within two years	129	13.0	48	24.4	10	9.4
	Conviction within two years	264	26.7	107	54.3	25	23.6
	Both conviction and mental health dismissal within two years #	61	6.2	24	12.2	2	1.9
	Neither	658	66.5	66	33.5	73	68.9
Jan 2009 to Sep 2009	Number of reference appearances	771	100	138	100	67	100
	MHFPA dismissal within two years	106	13.7	32	23.2	2	3.0
	Conviction within two years	208	27.0	60	43.5	12	17.9
	Both conviction and mental health dismissal within two years #	43	5.6	14	10.1	0	0
	Neither	500	64.9	60	43.5	53	79.1

 # People with both a conviction and a mental health dismissal are also counted in each separate category, thus categories do not sum to the total.

Source: NSW Bureau of Crime Statistics and Research (rod12-10501mr).

4.82 This data does not allow us to make any conclusive evaluation of the effectiveness of diversion under the MHFPA, particularly in relation to its impact on recidivism. To do so would require comparison with defendants who were not diverted to establish whether diversion had resulted in a lower rate of reoffending. It would also be necessary to control for other variables which might affect reoffending rates in order to determine the effect of diversion. In the absence of such a control group for comparison, we cannot make any conclusive judgement about the relationship between diversion and reoffending.

4.83 It should be noted, as well, that this data relates only to court appearances, so it does not provide a full picture of the rates of reoffending.

Summary – people with cognitive and mental health impairments in the Local Court

4.84 Based on the limited data provided by the studies undertaken in the Local Court, it would appear that both people with cognitive impairment and people with mental health impairments are over-represented as defendants when compared with the rate of prevalence of those two groups in the general population. However, when it comes to the use of the diversionary provisions in the MHFPA, the rate of discharge of people with cognitive and mental health impairments is less than 2% of all defendants appearing in the Local Court. This suggests that there is scope for the increased use of the diversionary provisions of the MHFPA.

4.85 The analysis of case files of defendants subject to diversionary orders indicates that the bulk of those orders involve mental health impairments. Given that the research undertaken by Hayes suggests that people with intellectual impairments are over-represented as defendants in the Local Court, it would seem that diversion is particularly underused in relation to defendants with intellectual disability and other cognitive impairments.

4.86 Finally, an examination of the statistics in relation to breach of diversionary orders demonstrates that breaches are almost never recorded, suggesting that breaches are either generally not reported or that people do not breach conditions attached to diversionary orders.

Court intervention/support programs operating in NSW

The Magistrates Early Referral Into Treatment Program (MERIT)

4.87 The Magistrates Early Referral Into Treatment Program (MERIT) is a program for people with substance abuse problems.[79] It is a three-month pre-plea diversion scheme based in Local Courts that provides the opportunity for adult defendants

79. To participate in MERIT requires meeting several entry criteria including that the person has a demonstrable illicit drug problem (excluding alcohol as primary substance), has no current or pending matters for violent, sexual or other indictable offences and is deemed by a MERIT team health professional to be suitable for drug treatment: R Lulham, *The Magistrates Early Referral Into Treatment Program*, Crime and Justice Bulletin No 131 (NSW Bureau of Crime Statistics and Research, 2009) 2.

with substance abuse problems to work, on a voluntary basis, towards rehabilitation as part of the bail process.[80]

4.88 A 2009 BOCSAR evaluation of the program has found those participating in the MERIT program had a 12% reduced offending rate, when compared with a similar group who met the criteria for MERIT but did not participate.[81]

4.89 An early evaluation of the MERIT program on the North Coast of NSW, found that 39.1% of 266 participants in the program between 1 July 2000 and 30 June 2002 had a mental health problem. Additionally, 26.3% had previously attempted suicide.[82] It is not clear to what extent these groups overlapped. In the same period, four people were classified as ineligible for participation in the program due to a mental health problem. This accounted for 6% of all refusals.[83] Although a significant proportion of the program participants appear to have experienced mental health issues, mental health problems were found not to be a significant factor affecting program completion.[84] However, the evaluation noted that meeting the needs of those with a concurrent mental health problem was a particular challenge for the program, and recommended several strategies to address this including improved training.[85]

4.90 A subsequent 2007 NSW Health report found that high numbers of MERIT participants had experienced severe levels of psychological distress consistent with a diagnosis of a severe depression and/or anxiety disorder. For example, at program entry 40.8% of women participants scored in the very high range of psychological distress compared to 3.3% in the general population of NSW.[86] Although almost all participants had a lower distress score at program exit, 10% of them still had a score of 30 or above at exit.[87] An audit was performed on a sample of MERIT participants who had a high exit score. This revealed that most of them had longstanding physical or diagnosed mental health issues (for example, chronic anxiety, severe depression, post-traumatic stress disorder) not resolvable within the constraints of the MERIT program.[88]

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80. R Lulham, *The Magistrates Early Referral Into Treatment Program*, Crime and Justice Bulletin No 131 (NSW Bureau of Crime Statistics and Research 2009) 2.
81. R Lulham, *The Magistrates Early Referral Into Treatment Program*, Crime and Justice Bulletin No 131 (NSW Bureau of Crime Statistics and Research 2009) 1.
82. M Passey and others, *Evaluation of the Lismore MERIT Pilot Program: Final Report* (NSW Attorney General's Department, 2003) 14 (Table 3.5).
83. M Passey and others, *Evaluation of the Lismore MERIT Pilot Program: Final Report* (NSW Attorney General's Department, 2003) 16 (Table 3.8).
84. M Passey and others, *Evaluation of the Lismore MERIT Pilot Program: Final Report* (NSW Attorney General's Department, 2003) 20.
85. M Passey and others, *Evaluation of the Lismore MERIT Pilot Program: Final Report* (NSW Attorney General's Department, 2003) 71-72.
86. NSW Health, *The Magistrates Early Referral Into Treatment (MERIT) Program: Health Outcomes* (2007) 24.
87. A person who scores above 24 may need to be reviewed and specialist referral may need to be considered: NSW Health, *The Magistrates Early Referral Into Treatment (MERIT) Program: Health Outcomes* (2007) 20 citing G Andrews, *Outcome Measures Suitable for Patients with Mental Disorders Seen in General Practice* (2007).
88. NSW Health, *The Magistrates Early Referral Into Treatment (MERIT) Program: Health Outcomes* (2007) 20.

Court Referral of Eligible Defendants into Treatment (CREDIT)

4.91 This program commenced in 2009 as a trial program in Tamworth and Burwood Local Courts. It is another pre-plea diversion scheme that provides Local Court defendants with accommodation support, treatment options, services and case-management similar to the MERIT program.

4.92 CREDIT provides support services to people with complex needs including psychiatric and mental health impairments, intellectual disability and other cognitive impairments, including acquired brain injury.[89]

4.93 As we discuss in Chapter 7,[90] BOCSAR has recently completed an evaluation of certain aspects of the CREDIT pilot.[91] The evaluation identified that:

- 31% of program entrants had a "psychiatric disability".[92]
- 0.6% of program entrants were identified as having an intellectual disability, and similarly, 0.6% were identified as having an ABI.
- 5% of program entrants had previously had matters dismissed under s 32 or s 33 of the MHFPA.

Additionally, referrals to mental health services were the most common type of referral with 30.7% of participants in Burwood and 43.6% of participants in Tamworth being referred to such services.[93]

The Statewide Community and Court Liaison Service (SCCLS)

4.94 The SCCLS assists in the identification and assessment of individuals with mental illness, for the purpose of providing information to the court to assist decision-making including in relation to diversion from the criminal justice system into appropriate mental health treatment facilities, or in relation to sentencing/disposition.[94] It operates in 20 NSW Local Court locations.[95]

4.95 Table 4.11 shows the numbers of people screened by the SCCLS, and the results of those screenings in relation to mental health impairments. Of the clients screened in 2008-09, 9.6% were found to have a mental illness and were diverted, and in 2009-10, 8% of clients were found to have a mental illness and were diverted.

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89. For further discussion of CREDIT, including entry criteria see para 7.43-7.54.
90. Para 7.56-7.63.
91. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 9-10.
92. Note that 150 out of 483 program entries were identified as having a psychiatric disability. Program entries include people who have entered the program more than once. The total number of participants was 451. "Psychiatric disability" was not defined in the evaluation.
93. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 11-12.
94. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 2, 7-8.
95. Letter to the NSW Law Reform Commission from Executive Director Forensic and Mental Health and Youth Health Services, Justice Health and Forensic Mental Health Network, 29 May 2012.

Table 4.11: Statewide Community and Court Liaison Service mental health screening outcomes (2008/09-2009/10)

	2008-2009	2009-2010	2010-2011[96]
Total number of clients screened	14,758	14,401	12,887
Number of clients receiving a comprehensive mental health assessment	2,314	2,362	2,066
Number found to have mental illness	1,996	1,920	1,639
Number diverted into community care or inpatient mental health facilities	1,417	1,152	1,229

Source: Justice Health, Year in Review 2008/2009 (2009) 33; Justice Health, Year in Review 2009/2010 (2010) 24; Letter to the NSW Law Reform Commission from Executive Director Forensic and Mental Health and Youth Health Services, Justice Health and Forensic Mental Health Network, 29 May 2012.

4.96 The SCCLS was evaluated by BOCSAR in 2009. This evaluation, and other aspects of SCCLS, are discussed further in Chapter 7.[97] In general, the evaluation by BOCSAR found that:

- In a sample of 320 offenders whose closest finalised court appearance in 2004/2005 resulted in a dismissal under the MHFPA in a SCCLS Local Court, those who had contact with the SCCLS had more contact with the criminal justice system than did the control groups, although this may have been due to selection bias.[98]
- When comparing the change in the mean number of offences in an 18-month period following participants' court appearance and controlling for demographic factors, contact with the SCCLS generally reduced contact with the criminal justice system.[99]
- Contact with the SCCLS reduced the rate of offending for both those who were dismissed under s 32 or s 33, and for those who were not[100] (this second group likely consisted of both mentally ill and not mentally ill persons)

Summary - court intervention programs

4.97 The research evaluating the court intervention programs operating in NSW suggests that they can assist in preventing reoffending by people with cognitive and mental health impairments. However, the focus of the existing court intervention

96. Note that the data for the 2010-11 financial year is taken from a different source to the earlier years, so it may not be directly comparable to the data presented for 2008/09 and 2009/10.
97. Para 7.42.
98. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 57.
99. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) viii, 58-59.
100. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 58-59.

programs has primarily been on people with mental health impairments and substance abuse problems, which has meant that people with cognitive impairments have largely been excluded.

Higher courts

4.98 The higher courts do not presently have diversion powers under s 32 and s 33 of the MHFPA, nor any equivalent power under other legislation. This situation is discussed further in Chapter 13. As a result, there is no data in relation to the diversion of people with cognitive and mental health impairments appearing in the higher courts.

4.99 The second report of this reference will deal more extensively with the defences arguable in the higher courts which involve cognitive and mental health impairments.

4.100 In summary, however, the number of cases in which cognitive or mental health impairments are relevant to a defence is relatively small.

4.101 For example, in 2010/11 there were 40 cases in which the question of whether the defendant was fit to stand trial was raised.[101] In the same period, there were 24 referrals to the Mental Health Review Tribunal following a finding by a court of not guilty by reason of mental illness.[102] Finally, over a 14 year period from January 1990 to September 2004, 126 defendants raised the partial defence of diminished responsibility or substantial impairment. Of this number, 84 cases were successful.[103]

Bail and remand

4.102 There is a lack of data in regard to bail determinations involving people with cognitive and mental health impairments, for example, the rates at which bail is granted or refused, or how often bail refusal by police is overturned when reviewed by a court. Furthermore, there is very limited data about the prevalence of mental health and cognitive impairments in the remand population of NSW.

4.103 The Pathways study provides some bail data in relation to people with cognitive and mental health impairments. However, it must be recognised that because the sample in this study was purposive, rather than representative, it is not possible to make any general statements about the rates at which people with cognitive or mental health impairments are granted or refused bail or the time they are held on remand. Nevertheless, this study provides some insight into the bail experience of a cohort of prisoners with cognitive and mental health impairments. Notably, the study found:

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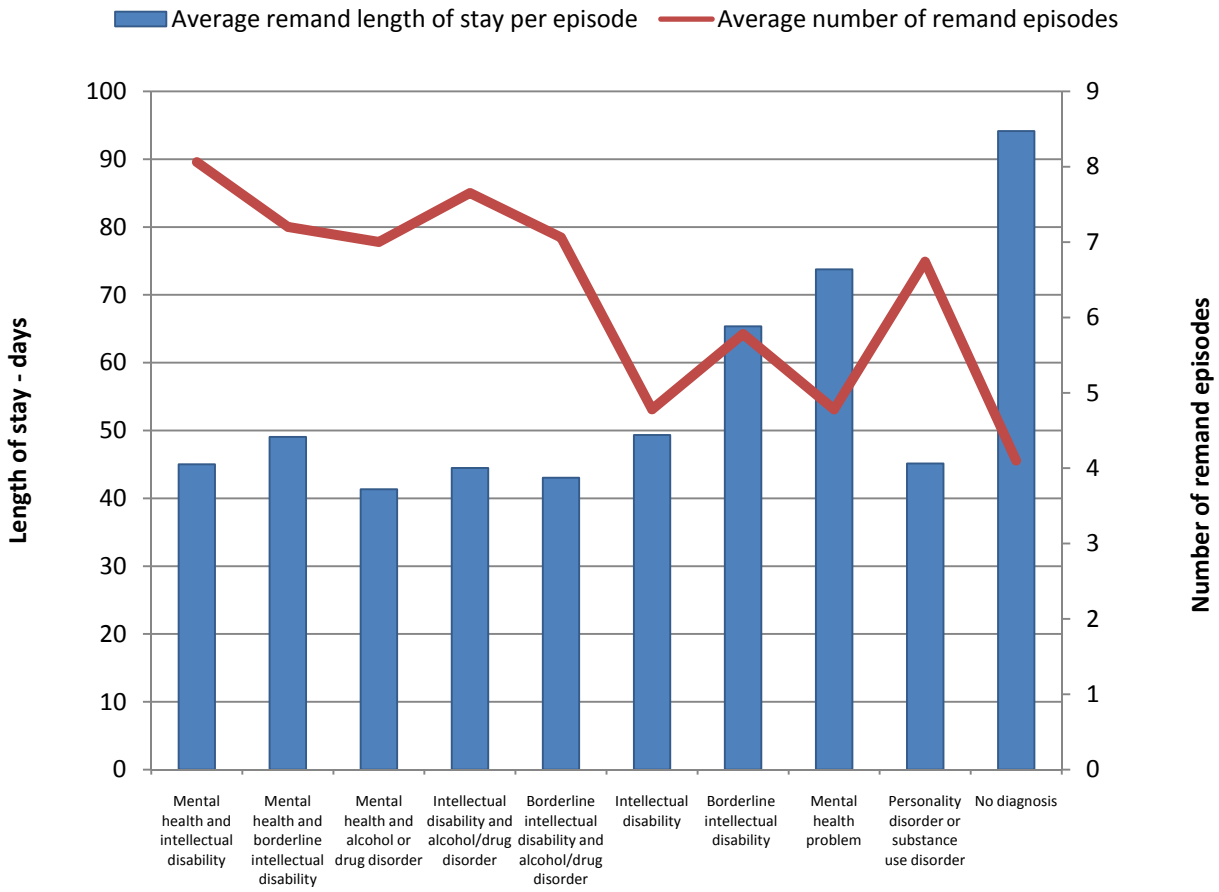
101. Mental Health Review Tribunal, *Annual Report 2010/11*, 34.
102. Mental Health Review Tribunal, *Annual Report 2010/11*, 34.
103. S Indyk, H Donnelly and J Keane, *Partial Defences to Murder in NSW 1990-2004* (Judicial Commission of NSW, 2006) 15.

- For all court finalised matters, 30% of the study cohort had been bail refused and remanded in custody.
- There were differences in bail status among sub-groups in the cohort: for example, a significantly lower proportion of the intellectual disability only group were bail refused than other groups (such as those with co-existing conditions).[104]
- There were significant differences between the sub-groups in the cohort in relation to the average number of episodes of remand and the length of time spent on remand. The groups of people complex needs including a cognitive impairment had significantly higher numbers of episodes of remand than the single and no diagnosis groups, but significantly shorter periods spent in remand for each of those episodes (Figure 4.7).[105]

Figure 4.7: Episodes of and time spent in custody on remand, Pathways study cohort



Source: E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 12.

4.104 Results from elsewhere in Australia are not directly applicable in NSW because of differences in legislation and other factors from state to state. Nevertheless, given

104. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 11.

105. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 11-12.

the paucity of information on NSW, the following studies provide some interesting data.

- A 1999 Victorian study comparing offenders with intellectual disability against the mainstream prison population, found that 27% of the prisoners with intellectual disability were being held on remand, compared with 13% of the general prison population who were on remand.[106] This result suggests an overrepresentation of people with intellectual disability in the Victorian remand population.

- A study published in 2010 of 159 young people aged 13-17 remanded between 2008-09 in South Australia, found that 50.3% showed indications of mental health problems.[107] The study found that there was a statistically significant overrepresentation of a range of mental health impairments in the study group when compared with the rates of the same impairments in adolescents in the community.[108]

- A 2004 study of South Australian remandees found that almost 10% of the sample was found to have intellectual impairments within the intellectual disability range and a further 23% were found to have intellectual impairments in the borderline range.[109]

Summary – bail

4.105 Although there is a lack of clear quantitative data addressing the prevalence of people with cognitive and mental health impairments in custody on remand in NSW, the experience in other jurisdictions suggests that it is likely that there is over-representation of people with cognitive and mental health impairments. This particular conclusion is reinforced when such over-representation can be seen in the prison population, generally, as discussed below.[110]

4.106 The data from the Pathways study suggests that prisoners with cognitive and mental health impairments are likely to have experienced a greater number of remand episodes than prisoners with no diagnosis of impairment, but that the average time in custody is likely to be much shorter than a prisoner with no diagnosis. However, there are differences between the groups, with the intellectual disability only and mental health only groups showing a lower number of remand episodes than other groups, particularly the groups with comorbid conditions.

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106. W Glaser and K Deane, "Normalisation in an Abnormal World: A Study of Prisoners with an Intellectual Disability" (1999) 43 *International Journal of Offender Therapy and Comparative Criminology* 338, 344.

107. M G Sawyer and others, "The Mental Health and Wellbeing of Adolescents on Remand in Australia" (2010) 44 *Australian and New Zealand Journal of Psychiatry* 551, 555.

108. M G Sawyer and others, "The Mental Health and Wellbeing of Adolescents on Remand in Australia" (2010) 44 *Australian and New Zealand Journal of Psychiatry* 551, 554.

109. F Parton, A Day and J White, "An Empirical Study on the Relationship Between Intellectual Ability and an Understanding of the Legal Process in Male Remand Prisoners" (2004) 11 *Psychiatry*, *Psychology and Law* 105, 107.

110. Para 4.109-4.132.

Non-custodial sentencing options

4.107 The 2010 NSW Community Offender Census provides comprehensive statistical data on the presence of mental health issues/treatment and drug and/or alcohol abuse among offenders in the community managed by Corrective Services NSW's Community Offender Services, including offenders on parole, bonds (probation), home detention or community services orders.[111]

- Of the 16,632 offenders in the community, 49.2% had a current mental health issue/treatment at the time of the study, and 66.5% had drug and/or alcohol abuse issues within the past year.[112]
- The Census shows that among those who received bonds, current mental health issues/treatment were reported less often than were drug and/or alcohol abuse issues within the past year (54% compared with 74.3% respectively).[113]
- Similarly, those on home detention orders had lower rates of mental health issues/treatment than drug and/or alcohol abuse issue within the past year (46.8% compared with 55% respectively).[114]
- Those on community service orders also reported current mental health issues/treatment less often than they reported drug and/or alcohol abuse within the past year (27.7% compared with 52.7% respectively).[115]

4.108 The data in relation to offenders on parole is set out below.[116]

Prison

Mental health impairments

4.109 Over the past two decades a number of significant inquiries, surveys and studies have established that people with cognitive and mental health impairments are overrepresented in NSW prisons population. For example:

111. G Van Doorn and A Geyer, *NSW Community Offender Census 2010: Summary of Characteristics*, Statistical Publication 37 (Corrective Services NSW, 2011).
112. G Van Doorn and A Geyer, *NSW Community Offender Census 2010: Summary of Characteristics*, Statistical Publication 37 (Corrective Services NSW, 2011) 9.
113. G Van Doorn and A Geyer, *NSW Community Offender Census 2010: Summary of Characteristics*, Statistical Publication 37 (Corrective Services NSW, 2011) 25. Bonds included supervised good behaviour orders like suspended sentences, extended supervision orders, bail supervision and drug court orders
114. G Van Doorn and A Geyer, *NSW Community Offender Census 2010: Summary of Characteristics*, Statistical Publication 37 (Corrective Services NSW, 2011) 73. In some cases the Court may impose, instead of imprisonment a home detention order.
115. G Van Doorn and A Geyer, *NSW Community Offender Census 2010: Summary of Characteristics*, Statistical Publication 37 (Corrective Services NSW, 2011) 57. The courts may impose an order of no more than 500 hours of community service.
116. Para 4.133-4.138.

- In 2001 the NSW Legislative Council Select Committee on the Increase in Prisoner Population in NSW found that people with intellectual disabilities and people with mental illness are over represented in the criminal justice system.[117]

- In 2002 the NSW Legislative Council Select Committee on Mental Health was presented with evidence suggesting that correctional facilities have become "surrogate institutions" for people with a mental illness.[118]

- In 2006 a study comparing a sample of people in prison with a matched sample of people from the community was published. Results indicated that psychiatric illness was almost three times more common in the prison sample than the community sample.[119]

4.110 The NSW Inmate Health Surveys – taken at various intervals since 1996 – provide useful snapshots of the health of NSW's prison population over time. The most recent NSW Inmate Health Survey (2009) indicates that between 1996 and 2009 the prevalence of mental health problems among inmates has increased.[120] The 2009 survey included 996 randomly selected inmates. Participants were surveyed using a range of validated screening instruments and self-report measures. The methodology was kept as consistent as possible with previous surveys to increase comparability, although it should be noted that some changes were made.

4.111 The 2009 Survey found:

- a steady increase in the proportion of inmates who have ever been assessed or treated by a doctor or psychiatrist for an "emotional or mental problem" from 39% in 1996 to 43% in 2001 to 49% in 2009 (Figure 4.8 and Table 4.12)[121]

- the most common disorders reported by inmates were depressive disorders (35%), anxiety disorders (25%) and drug dependence (21%) (Table 4.14)

- an increased proportion of inmates scored in the moderate to severe depression range, from 24% in 1996, to 26% in 2001 to 36% in 2009

- an increase in the proportion of inmates who reported taking at least one psychiatric medication, from 11% in 1996 to 15% in 2001 to 18% in 2009,[122] and

- an increase in the admission to psychiatric units, from 13% in 1996 to 14% in 2001 to 16% in 2009 (Figure 4.9 and Table 4.13).[123]

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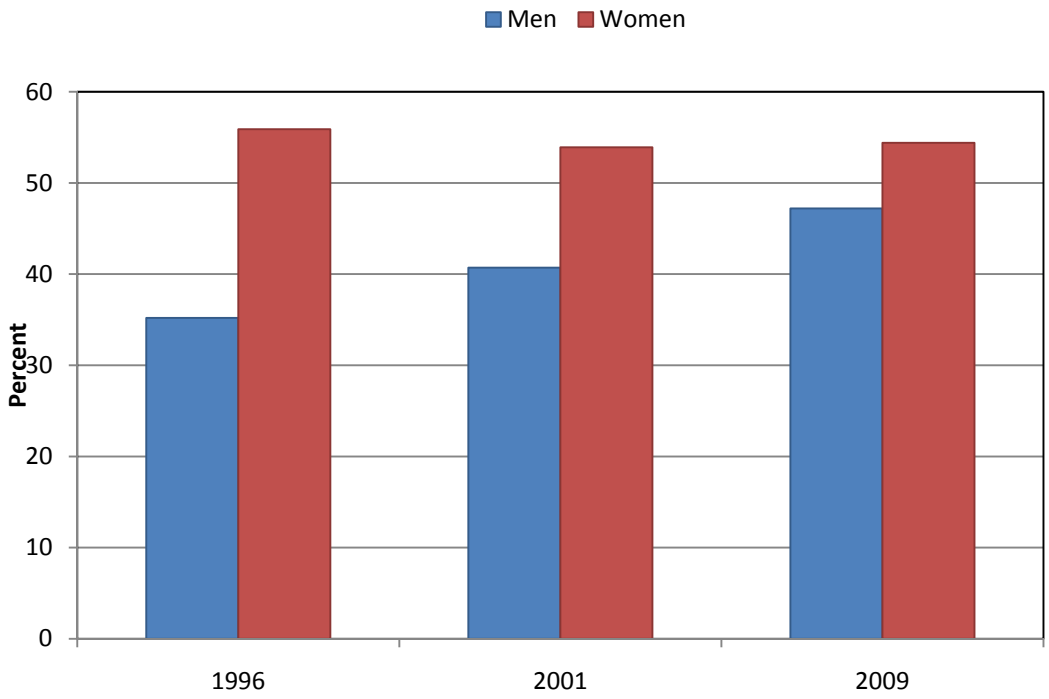
117. NSW Legislative Council Select Committee on the Increase in Prisoner Population, *Final Report*, (2001) xii.
118. NSW Legislative Council Select Committee on Mental Health, *Mental Health Services in NSW*, Final Report, Parliamentary Paper 368 (2002) [14.101].
119. T Butler and others, "Mental disorders in Australian prisoners: a comparison with a community sample" (2006) 40 *Australian and New Zealand Journal of Psychiatry* 272.
120. D Indig and others, *2009 NSW Inmate Health Survey: Key Findings Report* (NSW, Justice Health, 2010) 135.
121. D Indig and others, *2009 NSW Inmate Health Survey: Key Findings Report* (NSW, Justice Health, 2010) 17.
122. D Indig and others, *2009 NSW Inmate Health Survey: Key Findings Report* (NSW, Justice Health, 2010) 54.

Figure 4.8: Proportion of prisoners ever assessed or treated by a doctor or psychiatrist for an emotional or mental problem (NSW, 1996-2009)



Source: D Indig and others, 2009 NSW Inmate Health Survey: Key Findings Report (Justice Health, 2010) 135.

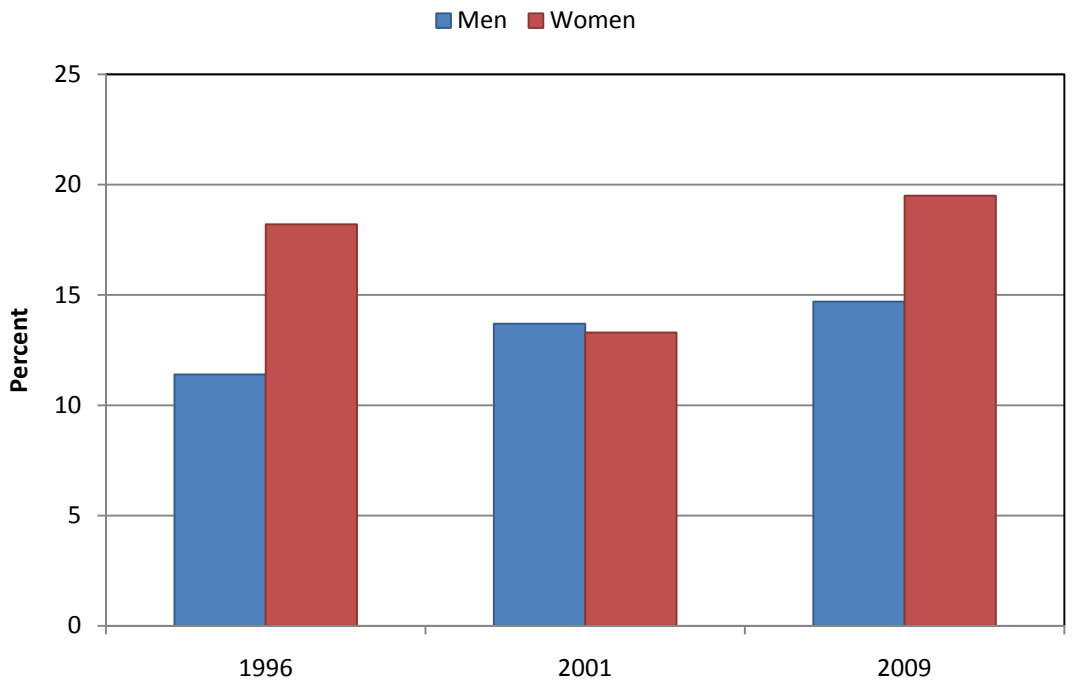
Table 4.12: Proportion of prisoners ever assessed or treated by a doctor or psychiatrist for an emotional or mental problem (NSW, 1996-2009)

	1996			2001			2009		
	Number	Total	%	Number	Total	%	Number	Total	%
Men	218	620	35.2%	286	703	40.7%	373	790	47.2%
Women	66	118	55.9%	82	152	53.9%	106	195	54.4%
Total	284	738	38.5%	368	855	43.0%	479	985	48.6%

Source: D Indig and others, 2009 NSW Inmate Health Survey: Key Findings Report (Justice Health, 2010) 135.

123. D Indig and others, *2009 NSW Inmate Health Survey: Key Findings Report* (NSW, Justice Health, 2010) 137.

Figure 4.9: Proportion of prisoners ever admitted to a psychiatric unit (NSW, 1996-2009)



Source: D Indig and others, 2009 NSW Inmate Health Survey: Key Findings Report (Justice Health, 2010) 137.

Table 4.13: Proportion of prisoners ever admitted to a psychiatric unit (NSW, 1996-2009)

	1996			2001			2009		
	Number	Total	%	Number	Total	%	Number	Total	%
Men	75	657	11.4	95	694	13.7	115	782	14.7
Women	24	132	18.2	20	150	13.3	37	190	19.5
Total	99	789	12.6	115	844	13.6	152	972	15.6

Source: D Indig and others, 2009 NSW Inmate Health Survey: Key Findings Report (Justice Health, 2010) 137.

Table 4.14: Inmate Health Surveys – self-reported mental health conditions

	1996				2001				2009			
	Males		Females		Males		Females		Males		Females	
	n	%	n	%	n	%	n	%	n	%	n	%
Depression	44	6.7	21	15.9	158	22.5	61	40.1	259	33.1	86	44.8
Anxiety	3	0.5	7	5.3	80	11.4	22	14.5	175	22.3	65	33.9
Drug dependence	N/A		N/A		85	12.1	37	24.3	158	20.2	49	25.5
Alcohol dependence	2	0.3	-	-	44	6.3	8	5.3	100	12.8	19	10
Personality disorder/ psychopathic personality	3	0.5	4	3	30	4.3	17	11.2	70	9	29	15.3
ADD/ADHD	2	0.3	-	-	33	4.7	3	2	93	11.8	6	3.1
Manic depressive psychosis	6	0.9	5	3.8	27	3.8	10	6.6	65	8.3	24	12.6
Schizophrenia	17	2.6	3	2.3	32	4.6	5	3.3	69	8.8	17	8.9

Source: D Indig and others, 2009 NSW Inmate Health Survey: Key Findings Report (Justice Health, 2010) 135.

Note that this table omits some results where they were only reported in a single survey.

4.112 A 2003 study by Butler and Allnutt, on behalf of the NSW Corrections Health Service, provides the most extensive picture of the prevalence of mental illness among NSW prisoners. Although almost a decade has passed since the study was published, its findings are still the primary reference point for estimates of the prevalence of mental illness among the NSW prison population. In this study, professional health workers, using a modified version of the Composite International Diagnostic Interview (CIDI), assessed a sample of 1,500 prisoners, divided between prisoners recently received into custody (reception prisoners) and longer-term inmates (sentenced prisoners). This instrument was used because it was the same as that used in the SMHWB and allowed some comparison of results with the wider community, as set out below in Table 4.15.[124]

4.113 The study showed a high level of mental illness among NSW prisoners, which was consistent with international findings:[125]

- 74% of the inmates experienced at least one psychiatric disorder (which included psychosis, affective disorder, anxiety disorder, substance use

124. T Butler and S Allnutt, *Mental Illness among NSW Prisoners* (NSW Corrections Health Service, 2003) 2.

125. T Butler and S Allnutt, *Mental Illness among NSW Prisoners* (NSW Corrections Health Service, 2003) 1.

disorder, personality disorder or neurasthenia)[126] in the 12 months prior to being interviewed for the study.[127]

- On a comparison with the prevalence of psychiatric disorders in the Australian community taken from the SMHWB, the rate among inmates was significantly higher (Table 4.15).[128]
- The most common diagnostic category was substance abuse disorder (with 66% of reception inmates and 38% of sentenced inmates meeting the diagnostic criteria in the past 12 months).[129]
- The prisoners recently received into custody generally had a higher rate of "any psychiatric disorder" than the group of sentenced prisoners (80% compared with 64% respectively) and the rate of any psychiatric disorder was higher among females than males.[130]

4.114 Table 4.16 sets out a comparison of rates of mental health impairment between reception prisoners and sentenced prisoners.

Table 4.15: Comparison of rates of psychiatric disorder in the community and NSW prisoners, 12 month prevalence (2003)

	Any psychiatric disorder	Any mental disorder	Psychosis	Affective disorder	Anxiety disorder	Substance use disorder	Personality disorder	Neuras-thenia
General population rate (Aust)	22%	15%	0.42%	6%	10%	5%	7%	2%
NSW prisoners rate	77%	42%	9%	22%	23%	57%	43%	6%

Source: T Butler and S Allnutt, Mental Illness among NSW Prisoners (NSW Corrections Health Service, 2003) 48.

126. "Neurasthenia is a condition characterised by persistent feelings of fatigue after quite minor mental and physical effort. Common symptoms are muscular aches, dizziness, tension headaches, sleep problems, an inability to relax, and irritability": T Butler and S Allnutt, *Mental Illness Among NSW Prisoners* (NSW Corrections Health Service, 2003) 37.
127. T Butler and S Allnutt, *Mental Illness Among NSW Prisoners* (NSW Corrections Health Service, 2003) 48.
128. T Butler and S Allnutt, *Mental Illness Among NSW Prisoners* (NSW Corrections Health Service, 2003) 48.
129. T Butler and S Allnutt, *Mental Illness Among NSW Prisoners* (NSW Corrections Health Service, 2003) 48.
130. T Butler and S Allnutt, *Mental Illness Among NSW Prisoners* (NSW Corrections Health Service, 2003) 48.

Table 4.16: Rates of mental disorder among prisoners (NSW, 2003)

			Psychosis	Any affective disorder	Any anxiety disorder	Any substance use disorder	Personality disorder	Neurasthenia
Reception prisoners	Male	n	81	158	250	466	303	27
		%	10.7%	21.1%	33.9%	63.7%	40.1%	3.6%
	Female	n	25	56	92	120	94	17
		%	15.2%	33.9%	55.8%	74.5%	57.0%	10.3%
Sentenced prisoners	Male	n	19	55	126	147	166	7
		%	4.2%	12.4%	28.4%	33.6%	36.7%	1.5%
	Female	n	6	21	56	58	40	8
		%	5.7%	20.4%	54.4%	57.4%	38.1%	7.6%

Source: T Butler and S Allnutt, Mental Illness Among NSW Prisoners (NSW Corrections Health Service, 2003) 14.

4.115 Butler and Allnutt point out the demands placed on the system by the presence of such offenders in the prison population. For example, the relatively small percentage of prisoners with psychotic disorders "can make significant demands on resources within the correctional environment"[131] because they need specialized care and treatment. In contrast prisoners with personality disorders do not necessarily require psychiatric treatment, but nonetheless can be extremely difficult to manage.[132]

Cognitive impairment

4.116 The first Inmate Health Survey, undertaken in 1996 and published in 1997, did not collect any specific data in relation to intellectual disability or cognitive impairment.

4.117 Intellectual disability was included as a specific category of inquiry in the 2001 Inmate Health Survey because it had been identified as an area of emerging concern.[133]

4.118 This 2001 Inmate Health Survey employed a screening test on 882 inmates (718 men and 164 women) to identify study participants warranting more comprehensive assessment. 18% of the women and 27% of the men assessed received a score indicating further assessment was needed. This further testing had the results displayed in Table 4.17.

131. T Butler and S Allnutt, *Mental Illness Among NSW Prisoners* (NSW Corrections Health Service, 2003) 21.
132. T Butler and S Allnutt, *Mental Illness Among NSW Prisoners* (NSW Corrections Health Service, 2003) 36.
133. T Butler and L Milner, *The 2001 NSW Inmate Health Survey* (Corrections Health Service, 2003) 10.

Table 4.17: Inmate Health Survey – detailed intellectual disability results (2001)

Intellectual Disability status	Men		Women	
	Number	%	Number	%
No intellectual disability	86	60.1	10	41.7
Functioning in the "borderline" range	52	36.4	11	45.8
Possible intellectual disability	5	3.5	3	12.5
Total	143	100.0	24	100.0

Source: T Butler and L Milner, The 2001 NSW Inmate Health Survey*, (Corrections Health Service, 2003)* 93.

4.119 Based on the results shown in Table 4.17, 7.9% of the men and 8.5% of the women in the original sample were identified with possible intellectual or borderline intellectual disability. The total rate of possible intellectual or borderline intellectual disability was therefore around 8.1%.[134]

4.120 Of the study participants identified as having intellectual disability or borderline intellectual disability, two of the three women and four out of the five men identified as having an intellectual disability, and three out of 11 of the women and seven out of 52 men identified as in the "borderline" range of intellectual functioning were already known to the Disability Unit of the Department of Corrective Services (as it was then known).[135] This would suggest a significant amount of under-identification was occurring.

4.121 Intellectual disability was not included as a category of study in the subsequent Inmate Health Survey undertaken in 2009.[136] However, 5.9% of men and 6.1% of women in the 2009 study self-reported a "neurological disability".[137] This may indicate problems resulting from head injuries and other cognitive impairments. Although neurological disabilities were in the three most common classes of disabilities reported by participants, there was no further analysis of this category, except in relation to head injury. Among participants who had experienced a head

134. The further testing in this study used only an instrument to assess intellectual functioning. For a proper diagnosis of intellectual disability or borderline intellectual disability, adaptive functioning would have had to have been assessed as well. Consequently, the testing indicates only possible intellectual disability or borderline intellectual disability and does not serve as a confirmed diagnosis: T Butler and L Milner, *The 2001 NSW Inmate Health Survey* (Corrections Health Service, 2003) 16.

135. T Butler and L Milner, *The 2001 NSW Inmate Health Survey*, (Corrections Health Service, 2003) 93.

136. D Indig and others, *2009 NSW Inmate Health Survey: Key Findings Report* (NSW, Justice Health, 2010) 22.

137. D Indig and others, *2009 NSW Inmate Health Survey: Key Findings Report* (NSW, Justice Health, 2010) 52.

injury (48.8% of the total cohort),[138] over half reported continuing consequences of those injuries including:

- 45% experiencing continued neurological effects, and
- 32% experiencing ongoing psychological symptoms.

4.122 Although the Inmate Health Surveys provide some limited information in regards to the prevalence of certain cognitive impairments at various points over the last 10 years or so, they do little to provide any clarification in relation to trends in prevalence because of the lack of consistency in their collection of data relating to intellectual disability or cognitive impairment.

4.123 Research conducted by Hayes allows us to observe some apparent changes in the prevalence of intellectual disability in prisoners over time. A 1988 study based on an investigation of 675 prisoners from five NSW prisons (representing 51% of the total population of all five institutions) found a rate of intellectual disability or borderline intellectual disability in prisoners of 8.9% for males and 12.2% for females.[139] The prevalence for men matched the prevalence in the general population. The figures for women exceeded the rates of intellectual disability in the general population by 3.2% indicating an overrepresentation among prisoners.[140] The study concluded that the results for men were likely to be under-estimates, and that a more likely correct estimate of the prevalence of intellectual deficit (including both intellectual disability and borderline intellectual disability) in NSW prisons would be at least 12.5%.[141]

4.124 In 1999 Hayes undertook a pilot study of the Hayes Ability Screening Index (HASI) to test its use in custodial environments. 159 prisoners participated in the HASI, of which 57 completed a full diagnostic assessment using two diagnostic instruments – the K-BIT and Vineland Adaptive Behaviour Scales (VABS).[142]

4.125 The results for the 57 inmates who underwent full diagnostic assessment are set out in Table 4.18.

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138. D Indig and others, *2009 NSW Inmate Health Survey: Key Findings Report* (NSW, Justice Health, 2010) 63.
139. S Hayes and D McIlwain, *The Prevalence of Intellectual Disability in the New South Wales Prison Population: An Empirical Study* (Criminology Research Council, 1988) 45.
140. S Hayes and D McIlwain, *The Prevalence of Intellectual Disability in the New South Wales Prison Population: An Empirical Study* (Criminology Research Council, 1988) 45-46.
141. S Hayes and D McIlwain, *The Prevalence of Intellectual Disability in the New South Wales Prison Population: An Empirical Study* (Criminology Research Council, 1988) 46.
142. See para 4.60 for a description of the K-BIT assessment instrument. The VABS assesses a person's ability to function in a range of common tasks, including communication, daily living skills and socialisation: S Hayes, *Hayes Ability Screening Index: Manual* (2000) 21.

Table 4.18: Results of diagnostic assessment for intellectual disability in prisoners (NSW, 2000)

	Males (n = 40)		Females (n = 17)		Total (n = 57)	
	Number	%	Number	%	Number	%
K-BIT – result below standard score of 70	9	22.5%	2	11.8%	11	19.3%
VABS – result below standard score of 70	8	20.5%	3	18.8%	11	20%

Source: S Hayes, Hayes Ability Screening Index: Manual (2000) 36.

4.126 Results of standard scores less than 70 on the K-BIT and VABS would put a person in the range of a diagnosis of intellectual disability. The results suggest, therefore, relatively high rates of intellectual impairment in the study sample.

4.127 A 2007 study of a UK prison tends to support the limited observations available in relation to the NSW prison population, in relation to the overrepresentation of people with intellectual disabilities.[143] The study found that although only 2.9% of the study sample met the criteria for intellectual disability (which is close to the rate in the general population), 21.7% were assessed as falling into the borderline intellectual disability range.[144] This suggests a relatively high rate of intellectual impairment is also present in the UK prison population.

4.128 The Pathways study, discussed above,[145] noted the following significant issues in relation to people with cognitive disability in prison, including:

- Study subjects with some form of cognitive disability have the worst levels of education in the cohort group (even taking into account the low levels of education in the prison population). The majority of those with cognitive disability in combination with any other diagnosis have either only completed primary school or left school with no qualification.[146]
- Only 23% of those diagnosed with intellectual disability and 4% of those with borderline intellectual disability were clients of Ageing, Disability and Home Care (ADHC), indicating a very high rate of people with cognitive disabilities in prisons not receiving services from ADHC. Many of the people in this group had been first diagnosed and referred to ADHC in prison.[147]
- A majority of the cohort had sought housing assistance at some stage. Those with complex needs had higher rates of seeking assistance, but those who had comorbid mental health and borderline intellectual disability or comorbid

143. S Hayes and others, "The Prevalence of Intellectual Disability in a Major UK Prison" (2007) 35 *British Journal of Learning Disabilities* 162.
144. S Hayes and others, "The Prevalence of Intellectual Disability in a Major UK Prison" (2007) 35 *British Journal of Learning Disabilities* 162, 164.
145. Para 4.49.
146. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 7.
147. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 7.

intellectual disability and substance abuse problems were less likely to have actually received assistance.[148]

- 25% of the cohort is Indigenous,[149] which is roughly in line with the current rates of Indigenous representation in NSW prisons.[150]
- Those with complex needs showed consistently higher rates of homelessness, than those with only one or no diagnosis.[151]
- Indigenous people were overrepresented among those who were homeless in the study cohort, with 28% of those who had experienced homelessness being indigenous, but only 23% of those with housing being Indigenous.[152]
- Indigenous women with complex needs formed the highest proportion of the homeless in the study cohort.[153]

The study noted other significant data for the study group including age at first police contact and first custody, use of Legal Aid services, the use of s 32 of the MHFPA and statistics in relation to bail refusal and time spent on remand. This data is addressed in the relevant sections elsewhere in this chapter.

4.129 Those prisoners with multiple mental health and cognitive impairment diagnoses, appear to have had more disadvantageous interaction with the criminal justice system; they have a higher number of offences, convictions and imprisonments than prisoners with a single or no diagnosis.[154] Significantly, prisoners with complex needs were found to have shorter duration in custody than those with single or no diagnosis. This may be attributable to the fact that their offences are generally low in seriousness,[155] rather than trends in sentencing practices.

Summary – cognitive and mental health impairments in prison

4.130 The data in relation to cognitive and mental health impairments in the prison population is probably the most comprehensive data available to us, largely due to the Inmate Health Surveys undertaken by Corrective Services. However, even with these studies there remain gaps, particularly in relation to the prevalence of intellectual disability and cognitive impairment.

148. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 8.
149. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 6.
150. In 2010, 21.3% of NSW prisoners were Indigenous: S Corben, *NSW Inmate Census 2010: Summary of Characteristics*, Corrective Services NSW (2010) 3.
151. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 8.
152. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 8.
153. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 9.
154. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 9.
155. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 14-15.

4.131 If we rely on Butler and Allnutt's 2003 analysis, it would appear that the rate of mental health impairment in prisoners is more than triple the rate in the general population, with the rate of over-representation varying, in some cases significantly, depending on the actual mental health impairment concerned. For example, the rate of psychosis in sentenced and reception prisoners is much greater than the apparent rate in the general population – possibly as much as 21 times the rate in the general population (see Table 4.15).

4.132 The situation in relation to intellectual disabilities and other cognitive impairments is perhaps a little less clear. One reason for this is that the Inmate Health Survey has not consistently collected data in relation to the rates of intellectual disability in NSW prisons. Further, there are discrepancies in the estimated prevalence between studies. For example, the rates of intellectual disability and borderline intellectual disability identified in the 2001 Inmate Health Survey suggest a combined rate of around 8% of the total prison population. This can be contrasted with Hayes's 2000 study which suggests a rate of intellectual impairment in prisoners closer to 20%. In any case, it would seem that rates of intellectual impairment among prisoners are higher than rates in the general population. Further, when the Inmate Health Survey data in relation to neurological disabilities and head injuries is taken into account, it would seem that there are likely to be prisoners with cognitive impairments about whom we have no clear prevalence data.

Parole

4.133 Parole refers to the conditional release of an offender after serving a minimum term. It provides offenders with the possibility of rehabilitation and reintegration into the community but is still part of the "continuum of punishment".

4.134 The Community Offender Census is an analysis of data relating to offenders in the community managed by Community Offender Services. It is a complement to the custody-based NSW Inmate Census[156] and provides some data in relation to mental health issues experienced by offenders on parole.

4.135 The Community Offender Census shows that of 3533 offenders on parole assessed (constituting 98.6% of the total number of offenders on parole), 51.5% were identified as having current mental health issues or as undergoing mental health treatment and 62.4% were identified with drug and/or alcohol abuse in the previous year. [157] Table 4.19 sets out a breakdown of this data.

156. The most recent Inmate Census was published in November 2010: S Corben, *NSW Inmate Census 2010: Summary of Characteristics*, Statistical Publication No 36 (Corrective Services NSW, 2010).

157. G Van Doorn and A Geyer, *NSW Community Offender Census 2010: Summary of Characteristics, Statistical Publication 37* (NSW Department of Corrective Services, 2011) 41.

Table 4.19: Rates of mental health and drug and alcohol problems among parolees (NSW, 2010)

	Male		Female		Total	
	Number	%	Number	%	Number	%
Offenders Assessed	3214	98.6%	319	98.8%	3533	98.6%
Current mental health issue/ treatment	1604	49.9%	217	68%	1821	51.5%
Drug and/or alcohol abuse within the past year	2008	62.5%	197	61.8%	2205	62.4%
Drug abuse within the past year	1551	48.3%	161	50.5%	1712	48.5%
Alcohol abuse within the past year	1222	38%	95	29.8%	1317	37.3%

Source: G Van Doorn and A Geyer, NSW Community Offender Census 2010: Summary of Characteristics, Statistical Publication 37 (NSW Department of Corrective Services, 2011) 41.

4.136 A 2008 survey of Probation and Parole Officers conducted by BOCSAR found that the Officers nominated mental health treatment, drug and alcohol treatment and secure and affordable accommodation services as "extremely important" to the rehabilitation of offenders.[158]

4.137 There is little information publicly available about people on parole with cognitive impairments. The Community Offender Census does not assess offenders for intellectual disability or cognitive impairment.

4.138 Anecdotal reports suggest that offenders with an intellectual disability may be unlikely to be granted parole. During consultation carried out by the Law and Justice Foundation, a Criminal Justice Support Network worker commented that

> there's no support for them to come out to, so they don't get considered for parole…I couldn't tell you the last time a person with an intellectual disability came up for parole. It just doesn't happen. They always serve their full sentences.[159]

Reoffending and return to prison

Cognitive impairment

4.139 A study of data from the NSW Department of Corrective Services covering the period from 1990 to 1998 indicates that people with intellectual disability are more likely to reoffend and return to prison. In particular:

158. D Weatherburn and L Trimboli, *Community Supervision and Rehabilitation: Two Studies of Offenders on Supervised Bonds*, Crime and Justice Bulletin No 112 (NSW Bureau of Crime Statistics and Research, 2008) 17.

159. A Grunseit and others, *Taking Justice into Custody: the Legal Needs of Prisoners* (Law and Justice Foundation of NSW, 2008) 63.

- Inmates with an intellectual disability were more likely to reoffend compared with the total inmate population (68% compared with 38% respectively).
- For inmates with no prior conviction, the recidivism rate for inmates with an intellectual disability was over twice that of the rate in the total inmate population (60% compared with 25% respectively).
- For inmates with prior convictions, the recidivism rate for inmates with an intellectual disability was 1.48 times greater than the rate in the total inmate population (72% compared with 49% respectively).[160]

4.140 The authors of the study analysing these data comment that:

> Both inmates with and without an intellectual disability have higher recidivism rates if they had a prior conviction. However those with an intellectual disability and no prior convictions had a significantly higher recidivism rate than that of the total inmates population rate. This suggests that a conviction appears not to have a deterrent effect upon this population.[161]

Mental health impairment

4.141 A 2010 BOCSAR study examined the reoffending rate of released prisoners to determine whether prisoners with mental health impairments are at greater risk of reoffending compared with former prisoners without such impairments.[162]

4.142 The study found the following in relation to the impact of mental health impairments on reoffending:

- The rate of reoffending was higher among those prisoners who had comorbid substance and non-substance abuse mental health disorders than among those with no mental health impairment at all or those with only a substance abuse disorder.
- There was no significant difference in reoffending rates between those with no mental health impairment at all, those with a mental health impairment that was not related to substance abuse and those who only had a substance use disorder.

4.143 The study's authors comment that these findings suggest that "rates of reoffending are substantially elevated among those with a mental health disorder only where it involves comorbid substance and non-substance mental health disorders".[163] They point out that:

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160. V C Riches and others, "Intellectual Disability and Mental Illness in the NSW Criminal Justice System" (2006) 29 *International Journal of Law and Psychiatry* 386, 389.
161. V C Riches and others, "Intellectual Disability and Mental Illness in the NSW Criminal Justice System" (2006) 29 *International Journal of Law and Psychiatry* 386, 389.
162. N Smith and L Trimboli, *Comorbid Substance and Non-substance Mental Health Disorders and Reoffending Among NSW Prisoners*, Crime and Justice Bulletin No 140 (NSW Bureau of Crime Statistics and Research, 2010).
163. N Smith and L Trimboli, *Comorbid Substance and Non-substance Mental Health Disorders and Reoffending Among NSW Prisoners*, Crime and Justice Bulletin No 140 (NSW Bureau of Crime Statistics and Research, 2010) 9.

> Unlike some re-offending risk factors which are static and thus cannot be changed (such as the offender's age, gender and criminal history), an offender's mental health status and substance misuse are 'dynamic risk factors' and therefore more amenable to changes with effective treatment.[164]

Representation of young people with mental and cognitive impairments in the NSW criminal justice system

Mental health

4.144 While research suggests an over-representation of this group, establishing the incidence of cognitive and mental health impairments among young people in the criminal justice system is difficult. The Australian Human Rights Commission noted that, unlike other personal and social characteristics routinely measured in statistical studies, cognitive and mental health impairments are not always observable or stable.[165] Furthermore, few criminal justice agencies formally collect this data regularly.[166]

4.145 Legal Aid NSW, analysing the 50 highest users of their services between July 2005 and June 2010, found that 80% were aged 15-19 years, and 46% of those users had been diagnosed with a mental illness.[167]

4.146 The 2009 NSW Juvenile Justice Annual Report shows that young offenders represent a relatively small proportion of the population who come into contact with the criminal justice system. For every 1000 NSW residents aged 10-17, in 2009 13.6 of these had a criminal matter finalised in the Children's Court, 3.8 were given sentences under supervision in their community and 1.1 were sentenced into detention.[168] However, the Report shows that, among young people who were sentenced, approximately 88% in custody and 40% in the community reported symptoms of mental illness consistent with a clinical disorder.[169]

4.147 The most recent Australian comprehensive health study of a juvenile offending population was *The Young People in Custody Health Survey* (YPICHS).[170] The YPICHS took place between August and October 2009 across all nine Juvenile Detention Centres operated by Juvenile Justice and the one Juvenile Correctional Centre operated by Corrective Services NSW. The survey included a psychological

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164. N Smith and L Trimboli, *Comorbid Substance and Non-substance Mental Health Disorders and Reoffending Among NSW Prisoners*, Crime and Justice Bulletin No 140 (NSW Bureau of Crime Statistics and Research, 2010) 9.
165. T Calma, *Preventing Crime and Promoting Rights for Indigenous Young People with Cognitive Disabilities and Mental Health Issues*, Research Report No 3 (Australian Human Rights Commission, 2008) 9.
166. T Calma, *Preventing Crime and Promoting Rights for Indigenous Young People with Cognitive Disabilities and Mental Health Issues*, Research Report No 3 (Australian Human Rights Commission, 2008) 9.
167. Legal Aid NSW, *Submission MH38*, 1.
168. NSW Department of Human Services, *Annual Report 2009-10* (2010) 181.
169. NSW Department of Juvenile Justice, *Annual Report 2008-2009*, 24.
170. D Indig and others, *2009 NSW Young People in Custody Health Survey: Full Report* (Justice Health and Juvenile Justice, 2011).

assessment. A total of 361 young people participated, which represented 80% of all young people in custody.[171]

4.148 The key findings of the YPICHS were as follows:

- 87% of the 2009 YPICHS participants had at least one psychological disorder, and 73% had two or more psychological disorders present.[172]
- 6% of the 2009 YPICHS participants had experienced schizophrenia or another psychiatric disorder.[173]
- 9% of the 2009 YPICHS participants had ever been admitted to a psychiatric unit.[174]
- There was an average of 3.3 past and/or current psychological disorders for each 2009 YPICHS participant.[175]

4.149 The YPICHS also found that, of the young people who came into contact with the criminal justice system, Aboriginal youth had a significantly higher representation. In the year 2009-2010, 48% of the young people in custody surveyed in the YPICHS identified as being of Aboriginal and/or Torres Strait Islander origin.[176] The study reports that Aboriginal young people were significantly more likely than non-Aboriginal young people to have an attention or behavioural disorder (75% compared to 65%) or an alcohol or substance use disorder (69% compared to 58%).[177]

4.150 The 2008 Survey of Young Offenders on Community Orders[178] surveyed 800 young people serving community-based supervision orders (which included supervised good behaviour bonds and probation orders, community service work orders, parole orders and suspended sentences). It reported that:

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171. D Indig and others, *2009 NSW Young People in Custody Health Survey: Full Report* (Justice Health and Juvenile Justice, 2011) 23.The exclusion criteria included those who had an intellectual disability or mental illness that prevented them from consenting to participate in the research. Therefore more severe forms were likely underestimated.
172. D Indig and others, *2009 NSW Young People in Custody Health Survey: Full Report* (Justice Health and Juvenile Justice, 2011) 145.
173. D Indig and others, *2009 NSW Young People in Custody Health Survey: Full Report* (Justice Health and Juvenile Justice, 2011) 147.
174. D Indig and others, *2009 NSW Young People in Custody Health Survey: Full Report* (Justice Health and Juvenile Justice, 2011) 148.
175. D Indig and others, 2009 *NSW Young People in Custody Health Survey: Full Report* (Justice Health and Juvenile Justice, 2011) 144.
176. D Indig and others, *2009 NSW Young People in Custody Health Survey: Full Repor*t (Justice Health and Juvenile Justice, 2011) 29.
177. D Indig and others, *2009 NSW Young People in Custody Health Survey: Full Report* (Justice Health and Juvenile Justice, 2011) 162.
178. The survey assessed young offenders serving community orders with the NSW Department of Juvenile Justice during the study period, October 2003 and December 2005. Data collection took place at Sydney metropolitan and NSW regional and rural Juvenile Justice Community Services (JJCS). Young offenders who were in substance withdrawal, had serious mental health concerns or deemed too aggressive or disruptive to participate were also excluded. Some results may therefore underestimate problems.

- Approximately 40% of young people on community orders experienced severe symptoms consistent with a clinical disorder. These were mostly comprised of substance use disorder and conduct disorder.[179]

- 25% young offenders had high or very high psychological distress.[180]

Cognitive impairment

4.151 The 2009 NSW YPICHS found the following in relation to cognitive impairment:

- 14% of the 2009 YPICHS participants had an IQ score below 70, indicating a possible intellectual disability.[181]

- 32% of the 2009 YPICHS participants scored in the borderline range for intellectual ability, with IQ scores between 70 and 79.[182]

- 31.5% of the 2009 YPICHS participants scored in the low average intelligence range or below (IQ of 80-89).[183]

4.152 A higher proportion of young men than young women (14.8% compared to 5.1%) had an IQ in the below 70 range.[184] The proportion of young Aboriginal people in custody who had an extremely low IQ (below 69), putting them in the category of having a possible intellectual disability, was much higher than non-Aboriginal young people (20.3% compared to 6.8%). 38.5% of young Aboriginal people compared to 25.9% of non-Aboriginal young people scored in the borderline range for intellectual ability.[185] Together, this indicates that more than half of young Aboriginal young people scored at a level consistent with borderline or intellectual disability, compared with a third (33%) for non-Aboriginal young people.

4.153 The YPICHS notes that the majority (77%) of young people tested in the study scored in the low-average range of intellectual functioning or below, and that only four study participants (1%) scored in the high average range of intellectual functioning.[186] Compared with the standard distribution of scores for intellectual

179. DT Kenny, P Nelson and others, *Young Offenders on Community Orders: Health, Welfare and Criminogenic Needs* (University of Sydney, 2008) 7.2.

180. DT Kenny, P Nelson and others, *Young Offenders on Community Orders: Health, Welfare and Criminogenic Needs* (University of Sydney, 2008) 7.4. This study employed the Kessler Psychological Distress Scale. Scores in the very high range are associated with a high probability of having an anxiety or depressive disorder

181. D Indig and others, *2009 NSW Young People in Custody Health Survey: Full Report* (Justice Health and Juvenile Justice, 2011) 155.

182. D Indig and others, *2009 NSW Young People in Custody Health Survey: Full Report* (Justice Health and Juvenile Justice, 2011) 155.

183. D Indig and others, *2009 NSW Young People in Custody Health Survey: Full Report* (Justice Health and Juvenile Justice, 2011) 155.

184. D Indig and others, *2009 NSW Young People in Custody Health Survey: Full Report* (Justice Health and Juvenile Justice, 2011) 155.

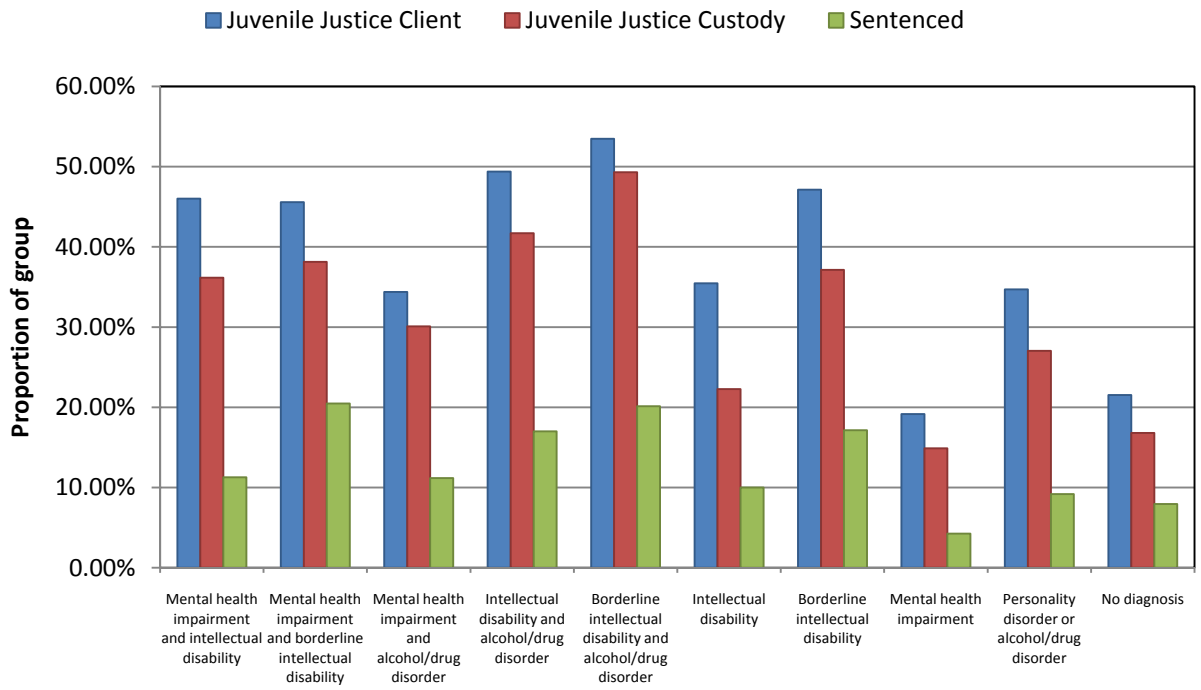
185. D Indig and others, *2009 NSW Young People in Custody Health Survey: Full Report* (Justice Health and Juvenile Justice, 2011) 154.

186. D Indig and others, *2009 NSW Young People in Custody Health Survey: Full Repor*t (Justice Health and Juvenile Justice, 2011) 155.

functioning, the YPICHS cohort showed a markedly skewed distribution to the lower end of intellectual functioning.[187]

4.154 The 2008 Survey of Young Offenders on Community Orders found that 15% of assessed young offenders scored at a level consistent with intellectual disability, with an additional 27% at the borderline level. Overall, 42% of young offenders on community orders were functioning in the borderline range of intellectual functioning or lower.[188]

Figure 4.10: Clients of Juvenile Justice by type and group – Pathways study cohort



Source: E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 12.

4.155 The Pathways Study, discussed above,[189] found that, of its cohort of inmates with cognitive impairments, those people with complex (multiple) cognitive impairments were significantly more likely to have been clients of Juvenile Justice, than those with no diagnosis or only a mental health diagnosis, as shown in Figure 4.10.[190] Those with complex cognitive impairments were also more likely to have contact with police at a younger age than those with only one diagnosis or no diagnosis, while all groups had a higher average number of contacts with police prior to their

187. D Indig and others, *2009 NSW Young People in Custody Health Survey: Full Report* (Justice Health and Juvenile Justice, 2011) 155-156.

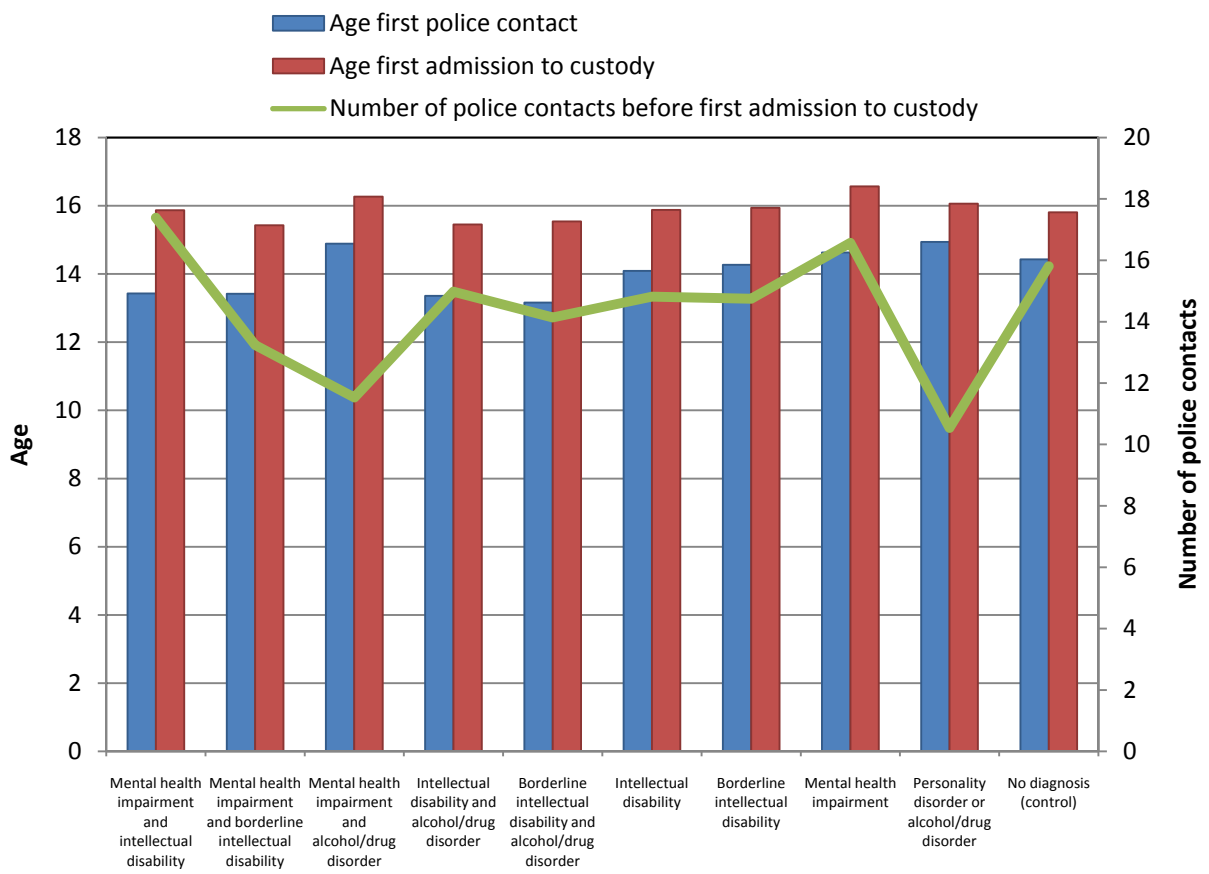
188. DT Kenny, P Nelson and others, *Young Offenders on Community Orders: Health, Welfare and Criminogenic Needs* (University of Sydney, 2008) 6.11 and 6.17.

189. Para 4.49.

190 E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 12.

first custody than the no diagnosis and personality disorder or alcohol or drug groups, as shown in Figure 4.11.

Figure 4.11: Average age at first contact with police and Juvenile Justice – Pathways study cohort



Source: E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 12.

The use of s 32 and 33 MHFPA in the Children's Court

4.156 The diversionary provisions in s 32 and s 33 of the MHFPA, discussed above, are also available in the Children's Court. As can be seen from Table 4.20, between 2006 and September 2011, the use of the MHFPA accounted for between 1.1% and 1.8% of criminal cases finalised in the Children's Court. The rates of usage for both s 32 and s 33 by the Children's Court match those in the Local Court reasonably closely, although in the past three years the use of s 32 appears to have been marginally higher in the Children's Court.

Table 4.20: People discharged with order under MHFPA (NSW Children's Court, Jan 2006-Sept 2011)

Type of outcome		Children's Court					
		2006	2007	2008	2009	2010	Jan 2011 to Sep 2011
MHFPA s32	Persons	64	84	106	114	146	111
	%	0.8%	1.0%	1.1%	1.2%	1.7%	1.7%
MHFPA s33	Persons	18	23	29	30	6	2
	%	0.2%	0.3%	0.3%	0.3%	0.1%	0.0%
MHFPA, unspecified	Persons	6	2	-	3	-	1
	%	0.1%	0.0%	-	0.0%	-	0.0%
Not a mental health outcome	Persons	7801	8125	9394	9369	8300	6294
	%	98.9%	98.7%	98.6%	98.5%	98.2%	98.2%
Total	Persons	7889	8234	9529	9516	8452	6408
	%	100%	100%	100%	100%	100%	100%

Source: NSW Bureau of Crime Statistics and Research (LcCc1210500mr).

4.157 Table 4.21 provides figures in relation to the outcomes for defendants in the Children's Court following a discharge under the MHFPA. In comparison with outcomes for defendants in the Local Court set out above (Table 2.6), the rate of reoffending is higher in the Children's Court. This is reflected in the higher rates of conviction and/or further dismissal under the MHFPA within two years of the reference appearance, than has occurred in the Local Court over the same period.

Table 4.21: People with a mental health dismissal, rates of reoffending (Children's Court, Jan 2006 to Sept 2009)

		Type of mental health dismissal at reference appearance					
		MHFPA s 32		MHFPA s 33		MHFPA, unspecified	
		Number	%	Number	%	Number	%
2006	Number of reference appearances	57	100	3	100	6	100
	Mental health dismissal within two years	19	33.3	1	33.3	1	16.7
	Conviction within two years	19	33.3	3	100	4	66.7
	Both conviction and mental health dismissal within two years #	10	17.5	1	33.3	0	0
	Neither	29	50.9	0	0	1	16.7
2007	Number of reference appearances	66	100	6	100	2	100
	Mental health dismissal within two years	23	34.8	1	16.7	0	0
	Conviction within two years	26	39.4	4	66.7	2	100
	Both conviction and mental health dismissal within two years #	10	15.2	1	16.7	0	0
	Neither	27	40.9	2	33.3	0	0
2008	Number of reference appearances	81	100	8	100	0	0
	Mental health dismissal within two years	25	30.9	3	37.5	0	0
	Conviction within two years	40	49.4	4	50.0	0	0
	Both conviction and mental health dismissal within two years #	13	16.0	1	12.5	0	0
	Neither	29	35.8	2	25.0	0	0
Jan 2009 to Sep 2009	Number of reference appearances	62	100	15	100	1	100
	Mental health dismissal within two years	23	37.1	4	26.7	1	100.0
	Conviction within two years	32	51.6	14	93.3	1	100.0
	Both conviction and mental health dismissal within two years #	13	21.0	3	20.0	1	100.0
	Neither	20	32.3	0	0	0	0

 # People with both a conviction and a mental health dismissal are also counted in each separate category, thus categories do not sum to the total.

Source: NSW Bureau of Crime Statistics and Research (rod12-10501mr).

Summary – young people with cognitive and mental health impairments

4.158 Two key things may be noted from the data presented here in relation to young people:

- First, there appear to be high rates of both mental health impairment and cognitive impairment in young people coming into contact with the criminal justice system. This is demonstrated both by the YPICHS data, but also by the Pathways study which shows the much higher proportion of contact with Juvenile Justice by the prisoners with impairments – particularly multiple impairments.[191]

- Secondly, although there are high rates of both cognitive and mental health impairments in the young people coming into contact with the criminal justice system, the rates of use of the MHFPA diversionary provisions by the Children's Court do not differ significantly from those in the Local Court. As with the Local Court, then, this would suggest that there is scope for increased use of s 32 and s 33 of the MHFPA in the Children's Court.

The Commission's view

4.159 While it is apparent that there is over-representation of people with cognitive and mental health impairments in the criminal justice system, as we have noted above, there is a significant lack of data in relation to the rates of representation of people with cognitive and mental health impairments in specific areas. This paucity of data is more marked in some areas than others. Therefore, in many cases, the exact scale of that over-representation is unknown.

4.160 This lack of available, comprehensive and consistent data regarding the representation of, and outcomes for, people with cognitive and mental health impairments in the criminal justice system has made it very difficult for us to to quantify the present deficiencies, in order to evaluate the potential impact of our recommendations.

4.161 The collection and analysis of data would enable several things. It would provide baseline data which would allow us to understand the current situation more accurately. More importantly it would provide a more rational basis for evaluating the impact of changes in policy and law by, for example, enabling the tracking of changes in the prevalence of people with cognitive and mental health impairments in their contact with various parts of the criminal justice system.

4.162 We have recommended at various points in the report collection of particular data to support the evaluation of our proposed new or expanded programs.[192] However, we also believe that collection of data concerning the representation of people with cognitive and mental health impairment in the system would be of value for the reasons identified above. Most immediately, it would provide a way of evaluating the

191. Note, the exception here is prisoners with mental health impairments only. The Pathways study subjects with only a mental health impairment appeared to have lower contact with Juvenile Justice than even the no diagnosis group, see Figure 4.10, above.

192. See particularly Recommendations 7.7, 12.9 and 14.6.

outcomes of the court and pre-court diversion frameworks we recommend in this report.

4.163 We have identified four main areas where we believe there are significant gaps in the data available, but there are potentially other areas where useful data might be gathered. We recommend the creation of a working group of relevant government and non-government stakeholders, to formulate a strategy for data collection and analysis.

Recommendation 4.1

The Department of Attorney General and Justice should establish a working group including the NSW Bureau of Crime Statistics and Research, relevant criminal justice agencies and non-government research experts to develop a strategy for data collection and analysis about the representation of, and outcomes for, people with cognitive and mental health impairments in the criminal justice system, in particular at the following points:

(a) police contact

(b) bail

(c) court

(d) Corrective Services NSW and NSW Juvenile Justice.

5. Defining cognitive and mental health impairment

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5.1 This chapter deals with the definitions of mental health impairment and cognitive impairment. This is a complex issue because such definitions apply in a wide variety of contexts and a variety of terms are currently in use. Terms and definitions have been inserted into legislation at different times, for different purposes. They have reflected different understandings of behavioural science, or understandings that were current at the time but are now outdated. Taken as a whole the law lacks a consistent and clear approach to defining cognitive and mental health impairment, and this gives rise to unnecessary confusion and complexity. Our aim in this chapter is to identify some basic definitions that may be used widely, and will provide some simplicity and consistency, so far as this is desirable and possible.

5.2 Our main focus in this report is defining terms for use in the context of diversion. We will also give close consideration to terms and definitions in the context of bail law. Further, we flag the proposed definitions for consideration in the context of our sentencing reference. We will give further consideration to the definitions and terms that should apply in the context of criminal responsibility and fitness to plead, which will be the subject of a second report in this reference.

5.3 This chapter is structured in 4 parts:

- First, we set out the range of terms and definitions used currently in legislation.
- Second, we outline the psychiatric and psychological views on terms and definitions, focussing on areas that raise difficult or challenging issues for law.
- Third, drawing on this background material, we propose definitions of cognitive impairment and mental health impairment.
- Finally, we consider the application of these terms and definitions to diversion and bail law, and flag them for further consideration in sentencing law.

Cognitive and mental health impairment: terms used in legislation

5.4 Cognitive and mental health impairments are variously and inconsistently defined and described in relevant legislation in NSW. Sometimes different terms are used in different contexts and sometimes the same, or similar, terms are used but defined differently. In Chapter 4 of our Consultation Paper 5 *People with cognitive and mental health impairments in the criminal justice system: overview* we canvassed NSW definitions with a view to considering whether there would be any benefit in clarifying or standardising the terminology. We asked a series of questions about the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA) which is the main focus of this report, including whether a single umbrella term could be used.

5.5 In this part of the chapter we review legislative definitions in NSW criminal law. We start with the definitions in the *Mental Health Act 2007* (NSW) (MHA) because they provide the most comprehensive set of definitions, and because the MHFPA and the MHA work together and must (at least in some respects) synchronise. However, the MHA is not within our terms of reference and we are not proposing reforms to that Act.

Mental Health Act

5.6 The MHA deals with compulsory (and in some situations voluntary) detention and/or treatment for mental illness. Its focus is therefore on situations where there is a community interest in ensuring that a person is treated.

"Mental illness"

5.7 Section 4 of the MHA defines "mental illness" 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).

5.8 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.[1] Other jurisdictions have adopted 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.[2]

5.9 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".[3]

5.10 This definition serves a specific purpose in that it forms part of the criteria on which people may be detained or treated involuntarily under the MHA. Thus it is deliberately narrow in scope. From a medical perspective the symptoms included would most often be associated with a diagnosis of psychosis. Disorders such as personality disorders, phobias, and addictions would not necessarily be considered "mental illnesses" under the statutory definition.

"Mentally ill" and "mentally disordered" person

5.11 For the provisions of the MHA concerning involuntary treatment to apply, a person must not only have a "mental illness", but must also be a "mentally ill person". A

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1. NSW, *Parliamentary Debates*, Legislative Assembly, 22 March 1990, 888 (Peter Collins).
2. See *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).
3. *Mental Health Act 2007 (*NSW) s 16(2).

person is "a mentally ill person" 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 own protection, or the protection of others, from serious harm.[4]

5.12 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 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]

5.13 The MHA also provides that a person is *not* a "mentally ill person" or a "mentally disordered" person for expressing certain opinions or undertaking activity (for example political or religious opinions/activity). Importantly this "exclusion" list also includes engaging in immoral conduct, illegal conduct or anti-social behaviour, taking alcohol or another drug, or having a "developmental disability of mind". This later phrase is not defined, and appears to be the only type of cognitive impairment referred to in the Act.

Other terms: "mental condition", mentally disturbed"

5.14 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"[6] or to have had a "mental condition".[7] These terms are not defined but appear to embrace a broader group of people than those who would fall within the statutory definition of "mentally ill" or "mentally disordered".

Mental Health (Forensic Provisions) Act

5.15 The MHFPA covers:

- Procedures for determining fitness to be tried in the higher courts – though it does not define who is fit to be tried.
- Diversion in the Local Court.
- Procedures for dealing with the defence of mental illness – though not the coverage of that defence.
- The management of forensic and correctional patients.

"Mentally ill person"

5.16 The MHFPA defines a "mentally ill person"[8] as having the same meaning as in the MHA.[9] This definition is used in s 33 of the MHFPA which provides (among other

4. *Mental Health Act 2007* (NSW) s 14(1).
5. *Mental Health Act 2007* (NSW) s 15.
6. *Mental Health Act 2007* (NSW) s 20(1), s 22(1).
7. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 33; see also (regarding local court diversion) s 32.
8. See *Mental Health (Forensic Provisions) Act 1990* (NSW) s 32, s 33, s 46, s 51-53.

things) that, if it appears to the magistrate that the defendant is a mentally ill person within the definition in the MHA, the magistrate may send the person to a mental health facility for assessment.[10] It is also used in the provisions governing the management of forensic patients.

"Mental illness"

5.17 The MHFPA does not define mental illness. Most references to mental illness in the MHFPA appear to be intended to reflect the MHA definition, since these two Acts are cognate pieces of legislation, and the context of the decision about mental illness is often the same – namely, to determine whether an order should be made to detain the defendant in a mental health facility.[11]

5.18 For example, the Mental Health Review Tribunal (MHRT) exercises functions in relation to those who have been referred to it 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.[12]

5.19 Section 32 allows magistrates to make a number of orders, including an order dismissing the charge and diverting the defendant. The provisions of s 32 apply 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".[13]

Mental illness and the M'Naghten Rules

5.20 The term mental illness is also used in relation to the special verdict under s 38 of the MHFPA – not guilty by reason of mental illness. In this context the meaning of "mental illness" is clearly not meant to be the same as the definition in the MHA. 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*.[14] While this report will not make recommendations about the scope of this defence, it will be considered in detail in our second report, together with the appropriate scope of other aspects of criminal responsibility and fitness to plead.

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9. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 3.
10. For further discussion see Chapter 8.
11. See *R v Mailes* [2001] NSWCCA 155; 53 NSWLR 251.
12. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 16-17, s 24, 27.
13. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 32(1).
14. See NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences*, Consultation Paper 6 (2010) Chapter 3.

"Developmental disability"

5.21 The diversionary power contained in s 32 may be used in relation to defendants who appear to a magistrate to be "developmentally disabled." This term is not defined in the MHFPA, or used elsewhere in the Act.

5.22 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, this Commission and commentators have interpreted the term as including conditions that arise during the developmental phase (that is, before the age of 18 years), stemming from either an intellectual or a physical cause.[15] 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[16] but not conditions that develop later in life, such as dementia or acquired brain injury (ABI).[17]

"Intellectual disability"

5.23 We recommended in Report 80 that a new and uniform statutory definition of intellectual disability be adopted. Specifically, we recommended that the *Crimes Act 1900* (NSW), the MHA, the MHFPA[18] and *Evidence Act 1995* (NSW) be amended to include the following standard definition of "intellectual disability"

> "Intellectual disability" means a significantly below average intellectual functioning, existing concurrently with two or more deficits in adaptive behaviour.[19]

5.24 Notably, manifestation of the disability before the age of 18 was not required for the purposes of this definition. It was formulated to be consistent with the then standard clinical definitions and to incorporate the usual interpretation given to the terms used in the definitions by experts. The report envisaged that a recognised psychometric test of intellectual functioning would be used to determine

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15. See NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System: Courts and Sentencing*, Discussion Paper 35 (1994) [2.5]. See also University of Sydney *Centre for Disability Studies* website: "Developmental disability is a term that refers to a permanent cognitive and/or physical impairment that usually occurs in the early years of life but can occur anytime before the age of 18 years" http://www.cds.med.usyd.edu.au/news-a-information/faqs/48-what-is-developmental-disability. See also *R v Mailes* [2001] NSWCCA 155; 53 NSWLR 251 [9.5], 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".
16. See T Gotsis and H Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local Court*, Research Monograph 31 (Judicial Commission of NSW, 2008) 26. See also NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System: Courts and Sentencing*, Discussion Paper 35 (1994) [2.5].
17. In *Director of Public Prosecutions 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 frm the case, however, whether the brain injury was the sole cause of the defendant's impairment, or at what age he acquired the injury.
18. Formerly the *Mental Health (Criminal Procedure) Act 1990* (NSW).
19. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) Recommendation 1, 52.

"significantly below average intellectual functioning" and a recognised scale of adaptive behaviour to determine "deficits in adaptive behaviour".[20]

5.25 The Commission considered that, for the procedures to which this definition relates, but not necessarily for all criminal justice purposes, it is irrelevant *how* or *when* the condition arose, if the other two criteria (significantly below average intellectual functioning and two or more adaptive deficits) are satisfied. Thus the definition may apply to some people with a brain injury or dementia, as long as the condition manifests these two criteria.[21]

5.26 The definition recommended by the Commission was adopted in the *Bail Act 1978* (NSW), with the added requirement that the person needs supervision and social rehabilitation.[22] However, this definition was not included in the MHA, the MHFPA or any other legislation in the area of cognitive or intellectual impairment, whether in the criminal justice system or otherwise.

"Mental condition"

5.27 The expression "mental condition" is negatively defined in the MHFPA to mean a "condition of disability of mind not including either mental illness or developmental disability of mind".[23] The term has been interpreted as a "catch-all" provision to recognise a wider range of mental states than those covered under the MHA.[24] It has been held to include severe mood disturbances, uncontrolled anger or emotions, irresistible impulse and ABI.[25] 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. In Report 80, this Commission considered that this qualification was unduly restrictive.[26] Further it has been observed that this restriction may not take into account advances in pharmacotherapy and community treatment programs.[27]

Crimes Act

5.28 The *Crimes Act 1900* (NSW) employs a number of terms other than those used above.

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20. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) Recommendation 3.1.
21. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) 52.
22 Para 5.37-5.40.
23. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 3.
24. *Perry v Forbes* (Unreported, Supreme Court of NSW, Smart J, 21 May 1993). See also D Howard and B Westmore, *Crime and Mental Health Law in New South Wales: A Practical Guide for Lawyers and Health Care Professionals* (LexisNexis Butterworths, 2nd ed, 2010) [18.11].
25. 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 El Mawas* [2006] NSWCA 154; 66 NSWLR 93 [20]-[22].
26. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) [5.78].
27. See comments by psychologist Anna Robilliard, reported in T Gotsis and H Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local Court*, Research Monograph 31 (Judicial Commission of NSW, 2008) 28.

Cognitive impairment

5.29 A somewhat wider concept of "cognitive impairment" is recognised in the *Crimes Act 1900* (NSW) in relation to the offence of sexual assault on people with cognitive impairments. The definition relates to people with a cognitive impairment who are victims rather than offenders.

5.30 Section 61H(1A) of the *Crimes Act 1900* (NSW) provides that a person has a cognitive impairment if he or she 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.[28]

5.31 This definition of cognitive impairment was introduced following a recommendation by the Criminal Justice Sexual Offences Taskforce[29] to "reflect a more contemporary understanding of the nature of such disabilities and impairments" and to "provide greater protection to people with a cognitive impairment by addressing the gap between the existing definition and a wide range of people who are vulnerable to such exploitation but are not currently captured by the existing narrow definition".[30] The definition was produced after extensive consultation by the Criminal Law Review Division of the Attorney General's Department of NSW (now the Department of Attorney General and Justice).

5.32 It is noted that the definition encompasses people with "severe mental illness", partly conflating the concepts of "cognitive impairment" and "mental health impairment".

5.33 The requirement of "supervision or social habilitation in connection with daily life activities" was retained from an earlier version of s 66F of the *Crimes Act 1900* (NSW), and was intended to create a threshold to exclude minor impairments,[31] while providing protection for those people whose disabilities are severe enough to affect their capacity to consent. We note that, in Report 80, we recommended the removal of the requirement for social habilitation assistance.[32] By comparison, in

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28. See *Crimes Act 1900* (NSW) s 61H(1A). See also Criminal Law Review Division, *Intellectual Disability and the Law of Sexual Assault*, Discussion Paper (NSW Attorney General's Department, 2007) 6-7.

29 Criminal Justice Sexual Offences Taskforce, *Responding to Sexual Assault: The Way Forward* (Attorney General's Department of New South Wales, 2005) Recommendations 59-62.

30 NSW, *Parliamentary Debates*, Legislative Council, 26 June 2008, 9426 (John Hatzistergos).

31 NSW, *Parliamentary Debates*, Legislative Council, 26 June 2008, 9426 (John Hatzistergos).

32. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) Recommendation 3.1.

Victoria, for the purposes of sexual offences against persons with a cognitive impairment, Part 8D of the *Crimes Act 1958* (Vic) defines cognitive impairment more simply and inclusively as an impairment due to "mental illness, intellectual disability, dementia or brain injury".[33]

5.34 We note that s 306M(2) of the *Criminal Procedure Act 1986* (NSW), which deals with the capacity of a person with cognitive impairment to give evidence, contains a similar definition to that in the *Crimes Act 1900* (NSW) but does not have a requirement in relation to supervision or social habilitation. This element was intentionally excluded from the definition because, unlike the *Crimes Act 1900* (NSW) definition, "these provisions are beneficial in nature and seek to provide support to vulnerable witnesses in giving their evidence, rather than grounding the basis for an investigation and prosecution on the basis that the victim had a serious impairment".[34]

Criminal responsibility

5.35 The *Crimes Act 1900* (NSW) also contains provisions relating to aspects of criminal responsibility. For instance, 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, to control him or herself was "substantially impaired by an abnormality of mind arising from an underlying condition." The impairment must be "so substantial as to warrant liability for murder being reduced to manslaughter".[35]

5.36 Issues of mental illness and cognitive impairment, their definition, and their impact on criminal responsibility will be considered in our second report. The standards for fitness to be tried will also be examined in our second report.

The Bail Act

5.37 Section 32 of the *Bail Act 1978* (NSW) deals with criteria to be considered in making bail determinations. Section 32(1)(b)(v) provides that the court must, in making a determination as to whether to grant bail to an accused person, take into consideration the interests of the person having regard to, among other things, whether the person has an intellectual disability or is mentally ill, as well as any special needs of the person arising from that fact. The terms "intellectual disability" and "mentally ill" are not defined in that section.

5.38 Section 37(2A) of the *Bail Act 1978* (NSW), which deals with restrictions on imposing bail conditions, provides that the officer or court imposing a bail condition on an accused person who has an intellectual disability is to be satisfied that the condition is appropriate having regard to his or her capacity to understand and comply with it. Section 37(5) provides that "in this section"

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33. *Crimes Act 1958* (Vic) s 50.
34. NSW, *Parliamentary Debates*, Legislative Council, 26 June 2008, 9427 (John Hatzistergos); see also *Criminal Procedure Act 1986* (NSW) s 306T(1)(b).
35. *Crimes Act 1900* (NSW) s 23A. The defence is only available to a charge of murder.

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

The application of this definition is limited to s 37. It does not guide decision making under s 32. Mental illness remains undefined.

5.39 In comparison, in Queensland, a person with an "impairment of the mind" may be released without bail into the care of another person who ordinarily has care of the person or with whom the person resides, or the court may permit the person to go at large. The *Bail Act 1990* (QLD) defines a "person with an impairment of the mind" to mean a person who has a disability that:

> (a) is attributable to an intellectual, psychiatric, cognitive or neurological impairment or a combination of these; and
>
> (b) results in –
>
> (i) a substantial reduction of the person's capacity for communication, social interaction or learning; and
>
> (ii) the person needing support.[36]

5.40 The court must also be satisfied that the accused person does not, or appears not to, understand the nature and effect of entering into a bail undertaking and that if the person understood the effect of entering into the bail undertaking, the person would be released on bail.[37]

Crimes (Domestic and Personal Violence) Act

5.41 The *Crimes (Domestic and Personal Violence) Act 2007* (NSW) provides that an apprehended personal violence order or an apprehended domestic violence order may be made where the court is satisfied, on the balance of probabilities, that the person seeking protection has reasonable grounds to fear, and in fact fears, the commission of a personal violence offence or stalking or intimidation.[38] Where, in the opinion of the court, the person seeking protection is "suffering from an appreciably below average general intelligence function," the court need not be satisfied that the applicant in fact fears the commission of such offences.[39]

5.42 The legislation also prescribes the circumstances in which the police must make an application for an order. Sometimes police must decide whether to apply for an order in circumstances where the person in need of protection is reluctant to apply. Section 49(6)(b) provides that such reluctance is not a good reason for a police officer not to make an application if the police officer reasonably believes that "the person has an intellectual disability and has no guardian".[40]

---

36. *Bail Act 1980* (Qld) s 11A(7).
37. *Bail Act 1980* (Qld) s 11A(1).
38. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 16(1), s 19(1).
39. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 16(2)(b), s 19(2)(b).
40. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 27(6)(b), s 49(6)(b).

5.43 The legislation does not provide a definition for either "intellectual disability" or "below average intellectual functioning" and does not explain the distinction between the different terms, which may lead to confusion.

Sentencing

5.44 In NSW the mitigating factors to be taken into account in determining the appropriate sentence for an offence are specified in the *Crimes (Sentencing) Procedure) Act 1999* (NSW). These include that the offender "was not fully aware of the consequences of his or her actions because of his or her … disability".[41] While "disability" is not defined, NSW courts have interpreted disability to include "significant mental disabilities of any kind, whether or not they might be regarded in a medical sense as mental illnesses."[42]

Issues and challenges in defining mental and cognitive impairment

Expert opinion – diversity and change in defining impairments

5.45 The criminal justice system relies upon assessments from experts in the fields of medical, social and behavioural sciences to determine the presence, nature and relevance of cognitive and mental health impairments, and legislation will reflect expert understandings. This relationship between law and behavioural science explains some of the differences and inconsistencies noted in definitions of mental illness and cognitive impairment. First, understandings and terminology in the medical, social and behavioural sciences about health, illness, disability and impairment change (in some cases quite rapidly) as a result of research and scientific developments or changes in approach. It is inevitable that law will require periodic amendment to take account of these developments.[43] Second, there is not necessarily universal agreement on all of the definitional issues among the relevant experts.

5.46 Some of these definitional differences are accounted for by the different approaches of different professional groups. Medical, social and behavioural scientists create definitions for a range of different purposes, and those purposes shape the scope and nature of the definition. Other differences in definitions are a consequence of divergent professional opinion about particular conditions.

Differing perspectives

5.47 Some writers and advocates have argued that a medicalised approach to defining mental and cognitive impairments results in an emphasis on pharmacological approaches and aims to cure mental disorders based on bio-chemical disturbances. These critics are concerned that such an approach stresses:

41. *Crimes (Sentencing Procedure) Act 1999* (NSW) s 21A(3).
42. *R v Arnold* [2004] NSWCCA 294, [68].
43. NSW, Justice Health, *Consultation MH6.*

> Individual rather than collective health; functional fitness rather than welfare; and cure rather than prevention. The central beliefs of this model saw physiological factors ("genes and germs") not psychosocial factors as the main causes of illness. It is a model, which, in policy terms, translates into a prime concern with the treatment and cure of individuals' ill health, especially in acute sector settings.[44]

5.48 Diagnostic definitions are important in the medical model. In Australia and overseas, diagnoses relating to mental health are generally made according to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorder, IV* (DSM-IV) and the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (ICD-10). These classification systems apply to a wide range of mental disorders (for DSM-IV) and mental and physical disorders (for ICD-10).

5.49 In Australia, the National Mental Health Plan defines mental illness as a "clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities".[45] In light of this construction, the Plan states that, given the current state of knowledge, "it is not reasonable to expect that everyone will experience good mental health all the time, nor that the population will ever be totally free of mental health problems and mental illness".[46]

5.50 The medical model has been criticised for focussing on the individual, rather than on the social and contextual aspects of disability. The social model of disability emphasises not only the condition of the individual but the social context in which they live and the ways in which that context frames their disability – for example through attitudes of exclusion or inclusion or through accommodations (or lack of them) to disability.[47] Steele reports that the social model "makes a distinction between impairment and disability".[48] An impairment is the lack of a limb, or a defect in the functioning of the body, while a disability is the disadvantage that results from a social environment that does not cater for those with impairments.[49] Thus, it is not the impairment that causes disadvantage but society's failure to provide appropriate services, accommodate those with impairments and take into account the needs of people with impairments.[50] Steele suggests that shortcomings in both the medical

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44. B Hardy and R Rhodes, "Beliefs and Institutional Change: The UK National Health Service" in I Holland and J Fleming (ed) *Government Reformed: Values and New Political Institutions* (Ashgate, 2003) 71. See discussion in B Burdekin, *Report of the National Inquiry into the Human Rights of People with a Mental Illness* (Australian Human Rights and Equal Opportunity Commission, 1993) ch 5.
45. Australian Health Ministers, *National Mental Health Plan 2003-2008* (Australian Government, 2003) 5.
46. Australian Health Ministers, *National Mental Health Plan 2003-2008* (Australian Government, 2003) 4.
47. T Shakespeare, *Disability Rights and Wrongs* (Routledge, 2006) 9-28; L Steele, "Making Sense of the Family Court's Decisions on the Non-Therapeutic Sterilisation of Girls with Intellectual Disability"" (2008) 22 *Australian Journal of Family Law* 1, 7.
48. L Steele, "Making Sense of the Family Court's Decisions on the Non-Therapeutic Sterilisation of Girls with Intellectual Disability" (2008) 22 *Australian Journal of Family Law*, 7.
49. L Steele, "Making Sense of the Family Court's Decisions on the Non-Therapeutic Sterilisation of Girls with Intellectual Disability" (2008) 22 *Australian Journal of Family Law*, 7, citing T Shakespeare, *Disability Rights and Wrongs* (Routledge, 2006) 13.
50. L Steele, "Making Sense of the Family Court's Decisions on the Non-Therapeutic Sterilisation of Girls with Intellectual Disability" (2008) 22 *Australian Journal of Family Law*, 7, citing M Oliver, *Understanding Disability: From Theory to Practice* (Macmillan, 1996) 32.

model and the social model may be addressed by the interactional model, which accepts that there is a biological basis to disability, but this interacts with social and economic factors to produce disability.[51]

5.51 A human rights perspective is also relevant. 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" and must be "protected against all exploitation" and "all treatment of a discriminatory, abusive or degrading nature".[52] In 2007, Australia signed the *Convention on the Rights of Persons with Disabilities,* which provides for equality before the law for all people and identifies obligations to protect people with disabilities from cruel, inhuman or degrading treatment or punishment, and from exploitation, violence and abuse.[53]

5.52 Acknowledgement of the human rights of people with disabilities, which have been recognised in legislation at both Commonwealth[54] and state level,[55] supports the use of appropriate and respectful language in definitions of disability. Submissions to this inquiry also pointed to the importance of an approach to law reform that is conscious of human rights, and acknowledges that people with cognitive and mental health impairments are not the passive subjects of law but are actors in creating and framing the laws that govern them.[56] Participants in a roundtable discussion concluded that any definition should be inclusive, respectful, informative for non-experts, clear, and take human rights issues into account.[57]

5.53 The use of the term "impairment" was supported as consistent with contemporary approaches:

> In contemporary disability studies the now widely accepted "social model of disability" delineates between the bodily "impairment" and the social consequence/experience of that impairment referred to as the "disability". In keeping with this it is suggested that "cognitive impairment" be the preferred usage and the word disability reserved for usage in "person with a cognitive disability". [58]

Defining mental impairment – psychiatry and law

5.54 The criminal law must frequently engage with psychiatric diagnoses of mental impairment because psychiatrists are called upon to make assessments that impact

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51. L Steele, "Making Sense of the Family Court's Decisions on the Non-Therapeutic Sterilisation of Girls with Intellectual Disability" (2008) 22 Australian Journal of Family Law, 7, 10
52. *United Nations Declaration on the Rights of Disabled Persons*, GA Res 3447 (XXX), UN GAOR, 3rd Comm, 30th sess, 2433rd plen mtg, Agenda Item 12, UN Doc A/RES/3447(XXX) (9 December 1975) 88-89 art 4, art 10.
53. *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force on 12 May 2008) art 13, 15, 16.
54. *Disability Discrimination Act 1992* (Cth).
55. See *Discrimination Act 1991* (ACT); *Anti-Discrimination Act 1977* (NSW); *Anti-Discrimination Act 1996* (NT); *Anti-Discrimination Act 1991* (Qld); *Equal Opportunity Act 1984* (SA); *Anti-Discrimination Act 1998* (Tas); *Equal Opportunity Act 1995* (Vic).
56. L Steele, *Submission MH45*, 3.
57. Cognitive impairment roundtable, *Consultation MH9.*
58. E Baldry, L Dowse, I Webster and P Snoyman, *Submission MH3*, 3. See also L Steele, *Submission MH9*, 14, 19; Cognitive impairment roundtable, *Consultation MH9*.

on the way people are dealt with in the criminal justice system. For example they may decide if a person has a "mental illness" under s 4 of the MHA for the purposes of compulsory treatment, or give evidence in court as to whether a person has a mental illness according to the rule in *M'Naghten's* case. In this section we look at the way in which psychiatrists diagnose mental impairment, the changing landscape of diagnosis, and some categories of diagnosis that present particular problems for the criminal justice system.

5.55 A psychiatric diagnosis of mental illness or disorder involves rigorously identifying a cluster of symptoms according to a standardised classification system. The DSM-IV manual provides a description of the essential and associated features of over 300 mental disorders. A mental disorder is "a clinically significant behavioral or psychological syndrome or pattern" that is associated with distress or disability. The syndrome or pattern is not an expected response to a particular event, but a manifestation of dysfunction.[59]

5.56 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.[60] Nor can it be assumed that everyone with the same disorder will manifest the same symptoms or behave in the same way.[61] The DSM-IV suggests that an accurate diagnosis requires the collection of information in five domains or "axes". Axis I includes clinical disorders such as schizophrenia, bipolar mood disorder and other affective disorders. Axis II includes personality disorders and mental retardation. Axis III (General Medical Conditions) includes physical conditions such as brain injury, Axis IV (Psychosocial and Environmental Problems) captures events in a person's life, such as death of a loved one, marriage and divorce. Axis V (Global Assessment of Functioning) refers to the person's overall level of functioning.[62]

5.57 The World Health Organisation publishes the ICD-10, which has been in use since 1994 and describes itself as "the international standard diagnostic classification for all general epidemiological and many health management purposes".[63] The ICD-10 takes a somewhat different approach to the classification of "mental and behavioural disorders".[64] However, according to the DSM-IV, "those preparing ICD-

59. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) xxxi.

60 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) xxx.

61. T Gotsis and H Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local Court*, Research Monograph 31 (Judicial Commission of NSW, 2008) 25.

62. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) 27-37.

63 World Health Organization, *International Classification of Diseases* (2010) 3.

64. World Health Organization, *International Classification of Diseases* (2010). Chapter V of the ICD-10 recognises the following categories of "Mental and Behavioural Disorders": organic, including symptomatic, mental disorders; mental and behavioural disorders due to psychoactive substance use; schizophrenia, schizotypal and delusional disorders; mood disorders; neurotic, stress-related and somatoform disorders; behavioural syndromes associated with physiological disturbances and physical factors; disorders of adult personality and behaviour; mental retardation; disorders of psychological development; behavioural and emotional disorders with onset usually occurring in childhood and adolescence; and unspecified mental disorder.

10 and DSM-IV have worked closely to coordinate their efforts, resulting in much mutual influence" and the two codes are therefore "fully compatible".[65]

5.58 Psychiatrists and other medical and behavioural scientists are often called upon to provide a diagnosis that might, for example, qualify the person for diversion from court, or have an impact on a bail decision, on culpability or sentencing. At these points the definitions and frameworks of understanding used by medical and behavioural scientists must mesh with those used by the law. The fit between the two systems is not always a good one.

5.59 To the psychiatrist, the distinguishing feature of a mental illness or disorder is the presence of symptoms indicating disturbance in mental functioning such as thought, perception, memory or judgement. So, while mental health professionals may be able to agree on the presence or otherwise of particular symptoms, they may not be able to agree whether those symptoms constitute a particular *disorder* for legal purposes. Even if a person has been diagnosed with a particular disorder, there are wide variations in levels of impairment within that disorder. Consequently a diagnosis may not convey the information that the law requires about whether an individual meets a legal standard of impairment.[66] Moreover, a diagnosis "by itself…tells us nothing about the connection between the illness and the crime."[67]

The challenges of defining personality disorder and psychopathy

5.60 One diagnosis that raises particular problems for the criminal justice system is that of personality disorder. Because of the nature of personality disorders, those who have them may be particularly likely to have contact with the criminal justice system. The problems from the perspective of that system are first, the divergences of opinion among behavioural scientists about whether personality disorders are a psychiatric illness or not. Second, there is a problem of circularity in that some personality disorders are defined (at least in part) by the presence of criminal behaviours. It could be argued, therefore, that personality disorders are simply descriptions of bad behaviour. There is a consequent concern that including personality disorders in any definition would open the floodgates, so that everyone in court would have a mental impairment. Third, it can be argued that personality disorders are not treatable, and thus should not be relevant, at least to decisions about diversion.

65. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) xxix.

66. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) xxxiii.

67. P Shea, "M'Naghten Revisited: Back to the Future? (The Mental Illness Defence – A Psychiatric Perspective)" (2001) 12(3) *Current Issues in Criminal Justice* 347, 357-358.

Divergent expert opinion

5.61 Personality disorders comprise an "extremely wide ranging group of disorders thought to be the result of inadequate or improper formation of the personality in childhood".[68] Both ICD-10 and DSM-IV cover personality disorders.

5.62 A personality disorder is described in DSM IV as an "enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment."[69] Given their immutability and entrenched nature, they are sometimes regarded as having more in common with intellectual disability than mental illness and DSM-IV classifies personality disorder, along with "mental retardation" as an Axis II disorder. However personality disorders may be regarded "as risk factors and complicating factors for a wide range of mental disorders".[70] People with personality disorders are more likely to self-harm or commit suicide, and have a reduced life expectancy.[71] They are also more likely to experience depression and anxiety disorders and to misuse alcohol and other drugs.[72]

5.63 The DSM-IV divides personality disorders into three clusters, based on descriptive similarities. Cluster B, which includes antisocial personality disorder, is the most relevant from a criminal justice perspective. Sometimes referred to as "psychopathy, sociopathy, or dissocial personality disorder",[73] antisocial personality disorder has the following diagnostic criteria

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:

(1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest

(2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure

(3) impulsivity or failure to plan ahead

(4) irritability and aggressiveness, as indicated by repeated physical fights or assaults

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68. K Mason, A Ryan and H Bennett *Report of the Committee of Inquiry into Procedures used in Certain Psychiatric Hospitals in Relation to the Admission, Discharge or Release on Leave of Certain Classes of Patient* (1988) 214.

69. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) 685.

70. R E Kendell, "The Distinction Between Personality Disorder and Mental Illness" (2002) 180 *British Journal of Psychiatry* 110, 111.

71. I Kolvin and others, *Continuities of Deprivation? The Newcastle 1000 Family Study* (Avebury, 1991) discussed in IH Treasaden and M Weller, "An Update on Managing Dangerous People with Severe Personality Disorder: 'The Human Time Bombs'" (2004) 72(3) *Medico-Legal Journal* 105, 107. See also B Burdekin, *Report of the National Inquiry into the Human Rights of People with a Mental Illness* (Australian Human Rights and Equal Opportunity Commission, 1993) ch 5.

72. R E Kendell, "The Distinction Between Personality Disorder and Mental Illness" (2002) 180 *British Journal of Psychiatry* 110, 111.

73. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) 702.

(5) reckless disregard for safety of self or others

(6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations

(7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated or stolen from another

B. The individual is at least age 18 years.

C. There is evidence of Conduct Disorder with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.[74]

5.64 Psychopathy is related to antisocial personality disorders but places less emphasis on early-onset delinquency.[75] It is not defined in either of the international classification systems but is diagnosed instead according to Robert Hare's *Psychopathy Checklist – Revised* (PCL-R).[76] It has been described as a

> lifelong persistent condition characterised, in males at least, by aggression beginning in early childhood, impulsivity, resistance to punishment, general lack of emotional attachment or concern for others, dishonesty and selfishness in social interactions, and high levels of promiscuous and uncommitted sexual behaviour. The available evidence suggests that psychopathy is substantially heritable…The evidence indicates that that psychopathy exists in both sexes and in all racial and ethnic groups, though the expression and prevalence vary systematically.[77]

5.65 Despite the association between personality disorder and mental illness, and their presence in diagnostic manuals, there is no consensus that personality disorders in themselves constitute mental illnesses. In 1988, Lewis and Appleby said that "there is, surprisingly, one area of relative agreement; that personality disorder is not a mental illness",[78] and in 2002, R E Kendall, President of the Royal College of Psychiatrists, said that "many – perhaps most – contemporary British psychiatrists seem not to regard personality disorders as illnesses".[79] His review concluded that "it is impossible at present to decide whether personality disorders are mental disorders or not".[80]

5.66 Similarly, Harris, Skilling and Rice considered the question of whether psychopathy (a form of personality disorder) is a mental illness and concluded that while

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74. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) 706.
75. R Hare and others, "Psychopathy and the Predictive Validity of the PCL-R: An International Perspective" (2000) 18 *Behavioural Sciences and Law* 623-645, discussed in A Feeney, "Dangerous Severe Personality Disorder" (2003) 9 *Advances in Psychiatric Treatment* 349, 350.
76. R Hare, *Manual for the Hare Psychopathy Checklist – Revised* (Multi-Health Systems, 1991).
77. G T Harris, T A Skilling and M E Rice, "The Construct of Psychopathy" (2001) 28 *Crime and Justice* 197, 198.
78. G Lewis and L Appleby "Personality Disorder: The Patients Psychiatrists Dislike" (1988) 153 *British Journal of Psychiatry* 44, 44.
79. R E Kendell, "The Distinction Between Personality Disorder and Mental Illness" (2002) 180 *British Journal of Psychiatry* 110, 111.
80. R E Kendell, "The Distinction Between Personality Disorder and Mental Illness" (2002) 180 *British Journal of Psychiatry* 110, 116.

"psychopaths can exhibit subtle neurological, physiological and cognitive differences compared with other people, it is unclear whether these differences constitute defective brain function or the execution of a viable life strategy".[81]

Circularity and opening the floodgates

5.67 There are also concerns that the concept of antisocial personality disorder is circular because mental abnormality is both inferred from and used to explain antisocial conduct.[82] As noted at para 5.67, characteristics of personality disorder include "repeatedly performing acts that are grounds for arrest", "repeated physical fights or assaults" and "impulsivity". These three characteristics would be almost universal among repeat violent offenders. McSherry suggests that that "'antisocial personality disorder' and 'psychopath' are often used as loose labels in order to diagnose an extremely broad range of people who have exhibited behaviour that may be classified as antisocial" and that the DSM-IV has contributed to "an overdiagnosis of the disorder in criminal and forensic settings because it overemphasises overt criminal acts to the neglect of personality traits".[83] She cites Gunn and Taylor as follows:

> The diagnosis of psychopathic disorder has no explanatory, descriptive, prognostic or therapeutic function, it is therefore a "pseudo-diagnosis" used just to get patients "through the customs-barrier of the courts…"[84]

One review of the prevalence of antisocial personality disorder and psychopathy found that "the two diagnoses cover a substantial proportion of the offending population" and that "it is not inconceivable to conclude that a diagnosis of ASPD or psychopathy could be raised in the vast majority, if not all, criminal cases".[85]

5.68 Ambivalence on the part of psychiatrists has obvious repercussions for the criminal justice system. If personality disorders are simply descriptions of bad behaviour, the criminal justice system is caught on the horns of a dilemma. For the purpose of deciding culpability, the criminal justice system cannot escape from the necessity of deciding whether a person should be held fully criminally responsible for their advertent acts, or whether their responsibility should be relieved or mitigated by the presence of a mental illness. Ambivalence about this central issue may be tenable for psychiatry, but is not tenable for law. Further, if bad behaviour by itself can bring an accused within the definition of mental illness the "floodgates" argument arises – it becomes possible for many people charged with offences to claim a mental

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81. G T Harris, T A Skilling and M E Rice, "The Construct of Psychopathy" (2001) 28 *Crime and Justice* 197, 197.
82. B McSherry, "Mental Impairment and Criminal Responsibility: Recent Australian Legislative Reforms" (1999) 23 *Criminal Law Journal* 135, 138.
83 B McSherry, "Mental Impairment and Criminal Responsibility: Recent Australian Legislative Reforms" (1999) 23 *Criminal Law Journal* 135, 138
84. PJ Gunn and J Taylor (ed), *Forensic Psychiatry: Clinical, Legal and Ethical Issues* (Butterworth-Heinemann, 1993) 402 quoted in B McSherry, "Mental Impairment and Criminal Responsibility: Recent Australian Legislative Reforms" (1999) 23 *Criminal Law Journal* 135, 138.
85. J Ruffles, "Diagnosing Evil in Australian Courts: Psychopathy and Antisocial Personality Disorder as Legal Synonyms of Evil" (2004) 11 *Psychiatry, Psychology and Law* 113, 115. On the other hand, Feeney claims that "psychopathy is a relatively rare condition": A Feeney, "Dangerous severe personality disorder" (2003) 9 *Advances in Psychiatric Treatment* 349, 350.

illness. This is perhaps particularly true for psychopathy where criminality is so central to the definition.

Are personality disorders treatable?

5.69 A further concern for law arises out of the generally accepted view that personality disorders are resistant to psychiatric treatment. If an accused person with a personality disorder makes an application for a diversionary order, or for treatment as an element of bail, should that application be granted? Harris, Skilling and Rice's 2001 review of the literature found that "there have been no demonstrations of effective treatment for adult psychopaths".[86]

5.70 A more recent review of eleven psychological interventions for participants with anti-social personality disorder found that "there is insufficient trial evidence to justify using any psychological intervention".[87]

Legal definitions of personality disorder

5.71 The ambivalence of behavioural science is reflected in the law as it applies to personality disorders. Severe personality disorder is expressly included in the definition of "mental impairment" for the defence of mental impairment in Commonwealth and ACT criminal codes.[88] This legislation is based on the recommendations of the Criminal Law Officers Committee, which considered the question of personality disorder:

> too complex to be resolved by a blanket exclusion and that a jury should be allowed to consider whether, for example, a defendant's severe personality disorder prevented him or her from knowing the wrongness of the conduct…The term "severe" was included to emphasise the degree of the disorder.[89]

5.72 The Law Reform Commission of Western Australia recently expressed the view that, unlike intellectual disability, senility and brain damage, personality disorder should not "automatically qualify as a mental impairment" for the purposes of the insanity defence but should also not be specifically excluded.[90]

5.73 Personality disorders have been asserted to be a mental illness relevant to a plea of not guilty by reason of mental illness, substantial impairment and sentencing,

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86. See G T Harris, T A Skilling, M E Rice, "The Construct of Psychopathy" (2001) 28 *Crime and Justice* 197, 233.
87. S Gibbon and others, "Psychological Interventions for Antisocial Personality Disorder" (2010) 6 *Cochrane Database of Systematic Reviews* .
88. See *Criminal Code 1995* (Cth) s 7.3(8); *Criminal Code 2002* (ACT) s 27.
89. See Criminal Law Officers Committee of the Standing Committee of Attorneys-General, *Model Criminal Code Chapters 1 and 2: General Principles of Criminal Responsibility* (Standing Committee of Attorneys-General, 1992), 37. Note discussion of high-risk, "dangerous and severely personality disordered" individuals and preventative detention: A Feeney, "Dangerous Severe Personality Disorder" (2003) 9 *Advances in Psychiatric Treatment* 349, 355. Feeney reports that the Royal College of Psychiatrists considers "that the increasing use of the term "severe personality disorder in the context of offenders reflects a growing reluctance to use the term psychopathy". Feeney notes that there is no way of recording the severity of a personality disorder in either the DSM-IV or the ICD-10.
90. Law Reform Commission of Western Australia, *Review of the Law of Homicide*, Project 97 (2007) 230.

though not always to the advantage of the defendant. Defendants with personality disorders have generally been unsuccessful in establishing the defence of mental illness because of the difficulty of proving that they did not know the nature and quality or the wrongness of their act.[91] The courts have held that a person can know that an act is wrong (and so fail to establish the defence) even though he or she suffers from a personality disorder involving an inability to feel empathy for others and to appreciate the effect of his or her actions on others. It seems that inability to feel empathy is insufficient in itself to ground the defence.[92]

Cognitive impairment

5.74 A number of issues arise in defining cognitive impairment, including:

- widely different definitions of cognitive impairment in law
- diversity in the definitions used by medical and behavioural scientists, and
- imprecision about what is included within the category of cognitive impairment.

5.75 These definitional problems may contribute to:

- a bias on the part of the criminal justice system towards recognising and responding to mental illness and not recognising and responding to cognitive impairment, and
- a tendency in the criminal justice system to confuse cognitive impairment with mental illness.

For example, the MHFPA refers to diversion of people with cognitive and mental health impairments into "treatment".[93] However treatment is not an appropriate response for people with cognitive impairments, who do not have treatable conditions (although they may be assisted by programs of habilitation to avoid offending behaviours, for example). The diversity of legal definitions of cognitive impairment is considered above.[94] Here, medical and behavioural science definitions are considered.

5.76 "Cognitive impairment" refers to impairments in a person's ability to think, concentrate, react to emotions, formulate ideas, and remember and process information. Cognitive impairment can be present at birth or can result from injury, disease or other environmental factors. It is commonly associated with ABI, autism spectrum disorder, Attention Deficit Hyperactivity Disorder, Foetal Alcohol Spectrum Disorder, dementia, learning disorders and substance dependencies. Within this

91. See eg *Willgoss v The Queen* (1960) 105 CLR 295; *Attorney General (South Australia) v Brown* [1960] AC 432; *Attorney General (Northern Ireland) v Gallagher* [1961] 3 All ER 299. Compare *Stapleton v The Queen* (1952) 86 CLR 358, 360-367.

92. See *Willgoss v The Queen* (1960) 105 CLR 295.

93 *Mental Health (Forensic Provisions) Act 1990* (NSW) s 14, s 32, s 33.

94. See 5.29-5.34.

cluster of conditions, some are better defined and more widely understood than others.[95]

Intellectual disability and borderline intellectual functioning

5.77 Intellectual disability is perhaps the most well known form of cognitive impairment. These disabilities affect the way a person learns. A person with an intellectual disability experiences significant deficits in his or her ability to reason, plan, solve problems, think abstractly, understand complex ideas, learn quickly and learn from experience. For example they may:

- take longer to learn things
- have difficulty reading and writing
- have difficulty in communicating
- have difficulty in understanding things and the world around them
- find it difficult to maintain eye contact
- have difficulty understanding abstract concepts
- have difficulty in planning and problem solving and
- have difficulty adapting to new or unfamiliar situations.[96]

5.78 Two commonly used clinical definitions of intellectual disability are those of the ICD-10 and the DSM-IV.[97] DSM-IV uses the term "mental retardation", and defines this as:

> significantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety (Criterion B). The onset must occur before age 18 years (Criterion C).[98]

5.79 Intellectual disability is not delineated according to "type"; it is distinguished according to severity. However, as Jin-Ding Lin reports, different diagnostic authorities provide slightly different measures for the generally accepted streams

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95. L Dowse, E Baldry and P Snoyman, "Disabling Criminology, Conceptualising the Intersections of Critical Disability Studies and Critical Criminology for People with Mental Health and Cognitive Disabilities in the Criminal Justice System" (2009) 15 *Australian Journal of Human Rights* 29, 32.
96. B Fogarty, "Improving Legal Representation for People with Intellectual Disability" (2010) 96 *Precedent* 31, 31.
97. ICD-10: Mental retardation is a condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, which contribute to the overall level of intelligence, ie, cognitive, language, motor and social abilities: World Health Organization, *International Classification of Diseases and Related Health Problems (ICD-10)* (2010) [F70-F79].
98. World Health Organization, *International Classification of Diseases* (2010) F70-F79; American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) 41.

(mild, moderate, severe, profound).[99] All of the measures cited in Jin-Ding Lin's analysis exclude those with IQ over 70. Borderline intellectual disability is defined as IQ in the 70 – 79 range.[100] People with borderline intellectual disability may face particular difficulties in accessing services. Ageing, Disability and Home Care (ADHC) adopts the DSM-IV criteria set out above to define intellectual disability. Services are not available through ADHC for those who fall outside this definition.[101]

5.80 Importantly, measuring intellectual disability is not an exact science. According to DSM-IV:

> *General intellectual functioning* is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests…significantly sub-average intellectual function is defined as an IQ of about 70 or below (approximately 2 standard deviations below the mean). It should be noted that there is a measurement error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument…thus it is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behaviour. Conversely, Mental Retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning …[102]

5.81 Adaptive behaviours are the skills necessary for functioning in everyday life, such as self-care, communication and social skills, concepts of time and money, and work.[103] Individuals with intellectual disabilities usually have contact with medical and support services because of problems with coping with common life demands, rather than because of concerns about a low IQ.[104] People with an intellectual disability are likely to require varying levels of support to communicate effectively, interact socially with others, live independently and develop vocational skills.

5.82 In contrast to mental illness, intellectual disability cannot be "treated". Instead, support programs relevant to a person's functional capacity are required. In his submission to the New Zealand Law Commission, Simpson said that:

> The nature of the care, containment and support that intellectually disabled people require…is very different from that of the mentally ill. While they require psychological and psychiatric understanding and appropriately structured care, to define such processes as treatment is to miss the difference between the onset of an illness which is largely treatable and reversible in the case of major mental illness [and a condition] which is simply managed by training, allowance

99. J Ding Lin, "Intellectual Disability: Definition, Diagnosis and Classification" (2003) 23 *Journal of Medical Science* 83, Table 2.

100. NSW Council for Intellectual Disability, *Submission MH12*, 1; Department of Human Services NSW (Juvenile Justice), *Submission MH28-2*, 2.

101. Para 2.36.

102. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) 41-42.

103. J Ding Lin, "Intellectual Disability: Definition, Diagnosis and Classification" (2003) 23 *Journal of Medical Science* 83, 86.

104. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) 41-42.

> of maturation and caring support in the case of an intellectual deficit. This difference rightly requires different legal mechanisms for each group.[105]

5.83 People with intellectual disability may find that their disability is not recognised in the criminal justice system. Alternatively it may be confused with mental illness. Where courts wish to divert alleged offenders out of the system, services must be available. This may be a particular problem for people with borderline intellectual disability.

Acquired brain injury

5.84 Across the criminal justice system, there is a general lack of knowledge regarding ABI, its symptoms and effects.[106] It is sometimes confused with mental illness or intellectual disability.[107] However, it is quite distinct from both forms of impairment. Because of the nature of ABI it may have criminogenic effects for some people.

5.85 ABI describes all types of non-congenital brain injury that occur after birth. The injury could be a result of trauma, such as stroke, seizure, motor vehicle accident, shaken baby syndrome, and assault or a fall. It could also be from disease (including Parkinson's, Alzheimer's and multiple sclerosis), infection, poisoning or alcohol or drug abuse.[108] The injury results in "an observable abnormality in the structure of the brain".[109] The effects of ABI include:

- difficulty processing information
- shortened attention span
- inability to understand abstract concepts
- impaired decision-making ability
- inability to shift mental tasks or follow multi-step directions
- poor concentration
- memory loss or impairment
- language deficit (difficulty expressing thoughts and understanding others).[110]

5.86 ABI is permanent, and while medication and rehabilitation can be useful, some effects cannot be reversed.[111] One study of 198 clients with severe traumatic brain injury found that after three years, only 10% continued to have significant

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105. New Zealand Law Commission, *Community Safety: Mental Health and Criminal Justice Issues*, Report No 30 (1994) [126].
106. Brain Injury Association of NSW, *Submission MH19*, 9.
107. Brain Injury Association of NSW, *Submission MH19*, 13. For example, a trial recently conducted in the Burwood Local Court and the Parramatta Children's Court revealed a widespread tendency among judicial officers, legal representatives, government and non-government representatives to describe ABI as an "intellectual disability": Department of Human Services NSW (Ageing, Disability and Home Care) *Submission MH28-1*, 11.
108. Brain Injury Association of NSW, *Submission MH19*, 4.
109. Brain Injury Association of NSW, *Submission MH19*, 8.
110. Brain Injury Association of NSW, *Submission MH19*, 6.
111. Brain Injury Association of NSW and Blake Dawson Pro Bono Team, *Submission BA32*, 8.

impairments in the physical domain, a large proportion continued to have clinically significant impairments in the cognitive and behavioural domains: 61% had memory impairment, 52% had problem solving impairment and 20% had impairment in social interaction.[112]

5.87 The Brain Injury Association of NSW report that unlike people born with an intellectual disability, a person with ABI "generally retains his or her level of intellectual functioning, may or may not have acquired his or her disability before the age of 18 and may or may not have deficits in the areas of adaptive behaviour".[113] People with ABI are more likely to experience specific cognitive changes that lead to difficulty in areas such as memory, concentration and communication.[114] Only those who develop an ABI before the age of 18 will be considered to have an intellectual disability. People with ABI tend to experience specific cognitive changes leading to difficulty in the way they think, feel and behave. The nature of ABI means that it is not always easy to identify, leading to its description as a "hidden" disability.[115]

5.88 Some impairments mean that people with ABI are more likely to come into contact with the criminal justice system, where they have problems arising from impulsive behaviour, anger and aggression, increased use of alcohol and other drugs, poor self-monitoring, poor concentration, lack of inhibition, inflexibility, impulsivity, an inability to read social cues and memory loss.[116] Other impairments mean that people with ABI are more likely to struggle to advocate for themselves or to engage fully with complex criminal processes.[117]

5.89 The frontal lobes of the brain are responsible for planning, organising, judgement, problem solving and impulse control. Damage to these areas is particularly likely to lead to cognitive and behavioural impairments that increase the likelihood of offending.[118]

5.90 Where ABI is identified and its criminogenic consequences understood as bringing a person into contact with the criminal justice system, that system may not presently be able to respond appropriately. For example s 32 of the MHFPA refers to developmental disability, mental illness and a mental condition "for which treatment is available in a mental health facility". None of these properly accommodates the peculiarities of ABI (unless the defendant was under 18 when he or she acquired

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112. R Tate and others, *Brain Injury Outcomes Study* (University of Sydney, 2004) 14.
113. Brain Injury Association of NSW, *Submission MH19*, 8.
114. Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28-1*, 10.
115. Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28-1*, 10; Brain Injury Association of NSW, *Submission MH19*, 4.
116. Brain Injury Association of NSW, *Submission MH19*, 10; Brain Injury Association of NSW and Blake Dawson Pro Bono Team *Submission BA32*, 8-9. See also DT Kenny and CJ Lennings *The Relationship Between Head Injury and Violent Offending in Juvenile Detainees*, Crime and Justice Bulletin No 107 (NSW Bureau of Crime Statistics and Research, 2007), 11; N Rushworth, *Out of Sight, Out of Mind: People with an Acquired Brain Injury and the Criminal Justice System* (Brain Injury Australia, 2011) 14-16.
117. Brain Injury Association of NSW and Blake Dawson Pro Bono Team, *Submission BA32*, 9.
118. Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28-1*, 10.

the injury, thereby potentially bringing it within the reach of developmental disability).

5.91 Yet consultations with behavioural scientists and service providers revealed that, in practice, the legislative terminology is often stretched beyond its clear textual meaning. We heard that some judicial officers are open to a pragmatic approach, making decisions not according to the statutory definition but instead according to the needs and circumstances of the case before the court. For example, many experienced practitioners successfully seek diversion for clients with ABI on the basis of developmental disability (even where acquired after the age of 18) or of mental illness.[119] Such practices, while fair and effective in some cases, may in general serve only to confuse further the already blurred lines between different impairments. Where practitioners are less familiar with these provisions and their malleability in certain cases, a person's ABI may not be taken into account at all. It is our view that the law should respond appropriately, rather than being stretched to respond appropriately.

Dementia

5.92 Dementia is "a syndrome associated with a range of diseases which are characterized by the impairment of brain functions, including language, memory, perception, personality and cognitive skills".[120] The impairments may include memory problems, communication difficulties, confusion, personality changes, depression, delusions, apathy and withdrawal.[121] Many illnesses can cause dementia, but the most common are Alzheimer's disease, vascular dementia, dementia with Lewy bodies, frontotemporal dementia and mixed dementia.[122] Less common causes include Parkinson's disease, alcohol-induced dementia, drug-related dementia, head injury dementia and Huntington's disease.[123]

5.93 Dementia presents a number of challenges for the criminal justice system. It may prevent a person understanding the nature of their actions, or impact upon their fitness for trial. It is unlikely to fall within the definition of a "mental illness" for the purposes of s 4 of the MHA. Similarly, given that it does not usually present before the age of 18, and may not involve a loss of intellectual capacity, it is unlikely to qualify as a "developmental disorder" or intellectual disability for the purposes of diversion under the MHFPA.

Alcohol and substance abuse

5.94 For behavioural scientists, substance use disorders refer to the abuse of, and dependence on, drugs, alcohol and/or other substances "to the extent that the

119 Cognitive impairment roundtable, *Consultation MH9.*

120. Australian Institute of Health and Welfare *Dementia in Australia: National Data Analysis and Development* (2007) 25.

121. Australian Institute of Health and Welfare *Dementia in Australia: National Data Analysis and Development* (2007) 25.

122. Australian Institute of Health and Welfare *Dementia in Australia: National Data Analysis and Development* (2007) 25-26.

123. Australian Institute of Health and Welfare *Dementia in Australia: National Data Analysis and Development* (2007) 26.

person's functioning is affected."[124] A substance use disorder is thus to be distinguished from casual substance use or temporary intoxication. It is also to be distinguished from a substance-induced mental disorder, an impairment that is caused by a person's "substance use, abuse, intoxication or withdrawal".[125] Such disorders can be the product of long-term abuse of drugs and alcohol or, in some instances, can be triggered after a single use.

5.95 It is not uncommon for a person who has alcohol and drug abuse problems to also have a range of mental health problems and/or cognitive impairment. There is a high correlation between mental illness and substance use disorder.[126] However, substance induced mental disorders are "distinct from independent co-occurring mental disorders in that all or most of the psychiatric symptoms are the direct result of substance use".[127]

5.96 In some cases, substance use can precipitate or exacerbate cognitive and mental health problems. For example, alcohol dependence may give rise to depression.[128] Similarly, there is evidence that the use of cannabis can trigger psychosis, in some cases schizophrenia, in vulnerable individuals.[129] The severity of symptoms varies according to the level of exposure or the mix of substances taken at the same time. Generally, the symptoms tend to improve very quickly, generally hours or days after a person abstains from the relevant substance. In some cases, the disorder "can persist long after the substance has been eliminated from the body".[130]

5.97 Psychotic symptoms, dementia and ABI caused by heavy and long-term abuse of a substance (such as alcohol, petrol and amphetamines) can become a permanent impairment.[131]

5.98 The law has responded to this complex relationship between mental health impairment and substance abuse. Currently, the MHA provides that a person is not a mentally ill person or a mentally disordered person for the purposes of involuntary

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124. T Butler and S Allnutt, *Mental Illness Among NSW Prisoners* (NSW Corrections Health Service, 2003) 30; American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) 191-199.
125. Center for Substance Abuse Treatment, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Treatment Improvement Protocol Series No 42 (US, Substance Abuse and Mental Health Services Administration, 2005) 249; American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) 209-212.
126. T Butler and S Allnutt, *Mental Illness Among NSW Prisoners* (NSW Corrections Health Service, 2003) 2, 45, 49.
127. Center for Substance Abuse Treatment, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Treatment Improvement Protocol Series No 42 (Substance Abuse and Mental Health Services Administration, 2005) 249.
128. See discussion in National Drug and Alcohol Research Centre, *Comorbid Mental Disorders and Substance Use Disorders: Epidemiology, Prevention and Treatment* (2003) 16.
129. However, research suggests that simple causal hypotheses may not easily explain the association between mental illness and substance abuse and that there is increasing support for the hypothesis that the two share common risk factors and life pathways. See discussion in National Drug and Alcohol Research Centre, *Comorbid Mental Disorders and Substance Use Disorders: Epidemiology, Prevention and Treatment* (2003) 17.
130. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) 209.
131. Center for Substance Abuse Treatment, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Treatment Improvement Protocol Series No 42 (US, Substance Abuse and Mental Health Services Administration, 2005) 250.

treatment merely because he or she "takes or has taken alcohol or any other drug".[132] Similarly at common law, for the purposes of the defence of not guilty by reason of mental illness, the reaction of a healthy mind to external stimuli – including psychoactive substances does not, of itself, constitute a "disease of the mind".[133] However, if there is an "underlying pathological infirmity of the mind" that is *triggered* by intoxication, producing a mental state consistent with the *M'Naghten's* rules, the defence is available.[134]

5.99 Likewise, to make out the partial defence of substantial impairment under s 23A of the *Crimes Act 1900* (NSW), reducing murder to manslaughter, the defendant must demonstrate that he or she was "substantially impaired by an abnormality of mind arising from an underlying condition".[135] While the Act excludes self-induced intoxication for these purposes, defendants who were intoxicated at the time of the killing may be able to rely on the defence if prolonged use of alcohol or drugs led to brain damage that substantially impaired their ability to control their actions. In such cases, the defendant must prove that it was the brain damage (being the underlying condition) that caused the abnormality of mind resulting in the substantial impairment of mental capacity, and not the short-term effects of the intoxication.[136]

5.100 For the purpose of defining cognitive and mental health impairment, it is necessary to emphasise the distinction between:

(a) casual intoxication

(b) substance use disorder or addiction, and

(c) ongoing cognitive and mental impairments *induced* by the use of such substances.

5.101 The first of these is the subject of extensive common law on self-induced intoxication.[137] The second may invoke diversionary, rehabilitative and support programs within the criminal justice system that are designed to respond to

132. *Mental Health Act 2007* (NSW) s 16(1)(k).

133. See, eg, *R v Martin* [2005] VSC 518, 159 A Crim R 314; *Re LIH* [2002] QMHC 14; *R v Falconer* (1990) 171 CLR 30, 53-54, 60, 78, 85; *R v Radford* (1985) 42 SASR 266, 274-275

134. *R v Derbin* [2000] NSWCCA 361; *Stapleton v The Queen* (1952) 86 CLR 358, 360-365; *Sodeman v The King* (1936) 55 CLR 192, 193-194; *R v McMahon* (2006) 3 DCLR (NSW) 398; [2006] NSWDC 81; *Director of Public Prosecutions v Taleski* [2007] VSC 183; *Director of Public Prosecutions v Whelan* [2006] VSC 319; *R v Kucma* [2005] VSCA 58, 11 VR 472; *Re Bromage* [1991] 1 Qd R 1. Compare *Attorney General (Northern Ireland) v Gallagher* [1961] 3 All ER 299, where Gallagher, diagnosed with psychopathy, formed an intention to kill, then consumed alcohol producing a mental state consistent with the *M'Naghten* rules. The House of Lords held that he could not, in those circumstances, rely on the effect of the alcohol on his mental state to support a defence of "insanity" at 310, 313-315.

135. *Crimes Act 1900* (NSW) s 23A(1)(a).

136. *Jones v The Queen* (1986) 22 A Crim R 42, 44; *Ryan v The Queen* (1995) 90 A Crim R 191, 196-197.

137. See discussion in NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences*, Consultation Paper 6 (2010) [3.89]-[3.98].

addiction, for example the Drug Court, the Youth Drug and Alcohol Court, the Magistrates Early Referral Into Treatment (MERIT) program.[138]

5.102 Disorders in the third category, substance induced mental disorders, are said to cause the psychiatric symptoms, whether long or short in duration, and may constitute a mental health impairment.

Complex needs

5.103 During the course of this reference stakeholders repeatedly made the point that there are a number of people who have more than one impairment, or who have a range of other problems co-existing with an impairment. A number of terms are used to describe this group of people. "Dual diagnosis" is often used to describe the situation of a person who has a mental health and/or cognitive impairment as well as a substance abuse problem.[139] Other terms used are "co-occurring disorders" and "comorbidity". In addition to having more than one disability, a person may be dealing with other issues, such as physical illness, or homelessness. People with complex problems have particular difficulty in finding appropriate service provision, are more likely to find themselves involved in the criminal justice system, and to be imprisoned.

5.104 In this report we have adopted the term "people with complex needs" to refer to this group, to acknowledge that the issues that people are dealing with may extend beyond cognitive and mental health impairment. Additionally, if the person has more than one impairment, this terminology acknowledges that their problems are not just doubled but multiplied.

5.105 While the law may make (and need to make) distinctions between cognitive and mental health impairments, there are many individuals who live with both. For example, people with an intellectual disability are at significantly greater risk of developing mental health problems than the general population.[140] Some people have dual diagnosis; some receive different diagnoses over the course of their lives; some will acquire a second impairment over the course of their lives.[141] According to one submission to this reference:

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138. *Drug Court Act* 1998 (NSW); D Weatherburn and others, *The NSW Drug Court: A Re-Evaluation of its Effectiveness*, Crime and Justice Bulletin No 121 (NSW Bureau of Crime Statistics and Research, 2008); Children's Court of NSW, *Practice Note 1: Practice Note for Youth Drug and Alcohol Court* (29 August 2009) 1; NSW Local Court, *Practice Note No 5: Magistrates Early Referral Into Treatment (MERIT) Programme*, 20 August 2002; Magistrates Early Referral Into Treatment Program – Policy Document (April 2002).

139. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 5; P Staiger and others, "Defining Dual Diagnosis: a Qualitative Study of the Views of Health Care Workers" (2008) 1(3) *Mental Health and Substance Use* 194; K Hyrb, R Kirkhardt and R Talbert, "A Call for Standardized Definition of Dual Diagnosis" (2007) 4(9) *Psychiatry* 15, 15.

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

141. E Baldry and L Dowse, *People with Mental Health Disorders and Cognitive Disabilities in the Criminal Justice System in NSW: Policy and Legislative Impacts* (NSW Department of Human Services: Ageing, Disability and Home Care, 2010) 5.

> The situation is more complex, both in terms of the individual diagnoses themselves and in the instances where they co-occur. In particular dual diagnoses or comorbid diagnoses are not simply the presence of two conditions, but rather their combination creates an additional level of complexity that requires attention in its own right.[142]

5.106 People with complex needs may have difficulties in obtaining an accurate diagnosis and receiving effective treatment, care and services. In 2009, Victoria passed the *Human Services (Complex Needs) Act 2009* (Vic), the purpose of which was to

> Facilitate the delivery of welfare services, health services, mental health services, disability services, drug and alcohol treatment services and housing and support services to certain persons with multiple and complex needs by providing for the assessment of such persons and the development and implementation of appropriate care plans.[143]

5.107 Section 7 of this Act defines an eligible person as a person aged 16 years of age or older, who appears to satisfy 2 or more of the following:

> (i) has a mental disorder within the meaning of the Mental Health Act 1986;
>
> (ii) has an acquired brain injury;
>
> (iii) has an intellectual impairment;
>
> (iv) has a severe substance dependence within the meaning of section 5 of the Severe Substance Dependence Treatment Act 2010; and
>
> (c) has exhibited violent or dangerous behaviour that caused serious harm to himself or herself or some other person or is exhibiting behaviour which is reasonably likely to place himself or herself or some other person at risk of serious harm; and
>
> (d) is in need of intensive supervision and support and would derive benefit from receiving co-ordinated services in accordance with a care plan that may include welfare services, health services, mental health services, disability services, drug and alcohol treatment services or housing and support services.[144]

5.108 The Victorian Mental Health Legal Centre has said that:

> Complex and co-morbid conditions and drug and alcohol dependence, affects many of our clients. Like many people with multiple needs this may mean being on the waiting list for a number of different specialist services, though never being a priority for any, each service expecting another "more appropriate" service to act. These clients fall between the gaps between service silos.[145]

This dynamic of agencies refusing or being unable to provide services to clients with complex needs and passing them on to other agencies was noted repeatedly in our consultations. The ability of people with impairments to negotiate satisfactory

142. E Baldry, L Dowse, I Webster and P Snoyman, *Submission MH3*, 1.

143. *Human Services (Complex Needs) Act 2009* (Vic) s 1.

144. *Human Services (Complex Needs) Act 2009* (Vic) s 7.

145. Mental Health Legal Centre (Victoria) submission to the Senate Select Committee on Mental Health (2005) 17.

service delivery is likely to be limited and, as a consequence, they may well not receive the support they require.

5.109 Although there is very little published research on people with complex needs and the criminal justice system in Australia,[146] there is evidence that this group of people is particularly disadvantaged[147] and at high risk of being caught up in the criminal justice system.[148] In 2003, the Department of Human Services in Victoria noted that there are people "whose needs and behaviours challenge health, human services and criminal justice systems".[149] People with complex needs present a challenge to service providers, including disability services, police, ambulance, emergency departments, hospitals and other health services, courts and correctional services.[150] A recent study has found that people with complex cognitive disability are:

> significantly more likely to have earlier contact with police, more police episodes, be more likely to have been clients of juvenile justice, have more police episodes through life and more prison episodes than those with single, or no diagnosis and for this high and ongoing contact with the criminal justice system to lock them into the [criminal justice system] very early rather than assist in rehabilitation.[151]

The Commission's view on definitions

The tension between consistency and purpose

5.110 In CP 5 and in this report we have described the wide range of terminology currently used in the criminal law to define cognitive and mental health impairments. There was broad support in submissions for a review of existing terminology and wide agreement that the interaction of the common law, MHFPA, MHA and other criminal justice legislation makes the issue of cognitive and mental health impairments confusing, inconsistent and difficult to navigate for legal and medical practitioners, community-based service providers, the general public, defendants and victims of

146. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 5.

147. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 5. See also MK Simpson and J Hogg, "Patterns of Offending Among People with Intellectual Disability: A Systematic Review, Part 1: Methodology and Prevalence Data" (2001) 45(5) *Journal of Intellectual Disability Research* 384.

148. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 5. See also NSW Legislative Council Select Committee on Mental Health, *Mental Health Services in NSW*, Final Report, Parliamentary Paper 368 (2002) [11.31].

149. Department of Human Services Victoria, *Responding to People with Multiple and Complex Needs* (2003) 3.

150. J Gardner, "Client Complexity, Compulsory Care and Human Rights" (Paper delivered at the Australian Guardianship and Administration Committee Symposium on Clients with Complex and Exceptional Needs: The Challenge for Policy Makers, Administrators and Service Providers, Adelaide, 30 April 2004) 3.

151. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) <www.app.unsw.edu.au/sites/app.unsw.edu.au/files/mhdcdbackgroundoutlaws_conf1.pdf> 14-15.

crime.[152] The Public Interest Advocacy Centre, for example, considered that a consistent definition would alleviate existing confusion about which conditions meet threshold criteria in various stages of the criminal justice system and would address the complexity caused by the proliferation of terms currently in use.[153]

5.111 While there are undoubted benefits of consistency, it also has limits. NSW law defines cognitive and mental health impairment for different purposes and those purposes often require a broader or a narrower definition. When diverting alleged offenders in Local Courts the definition of mental health impairments and cognitive impairments delineates a category of people who may benefit from programs that will assist them to avoid offending behaviours. However, when deciding whether a person is not guilty by reason of mental illness, the purpose of the definition is to help decide whether the defendants should not be convicted because they did not know what they were doing, or that it was wrong. A different definition may well be appropriate.

5.112 For the purposes of this report we seek to formulate definitions of cognitive impairment and mental health impairment that are appropriate for courts making decisions about the diversion of alleged offenders out of the criminal justice system, and for decisions about bail and sentencing. Stakeholders were generally in favour of a broad construction of cognitive and mental health impairments, incorporating a range of different mental and cognitive conditions. However, we note the concerns raised by the NSW Bar Association concerning the breadth of the definition:

> It is important that conditions qualifying for diversion under the MHFPA should be very clearly set out in the Act, so that they are consistently and correctly applied by magistrates. To create too broad a 'threshold' will result in inconsistent and unequal treatment, as too many discretionary factors would be left to individual magistrates. Clear guidance is what is required on the initial question of which conditions will qualify for diversion.[154]

5.113 In this first report we do not seek to define cognitive and mental health impairment for the purposes of criminal responsibility, or fitness to plead. However we note that, in this context, the broad definition used for the purposes of diversion, bail and sentencing may provide a preliminary "gateway" though which defendants must pass before they reach the narrower portal appropriate to a finding that, for example, their impairment was such that they should not be convicted. We will give further consideration to this approach, and to the best way to define cognitive impairment and mental health impairment in the context of criminal responsibility in our second report.

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152. E Baldry, L Dowse, I Webster and P Snoyman, *Submission MH3*, 1-2*;* NSW Director of Public Prosecutions, *Submission MH5*, 1-2*;* NSW Bar Association, *Submission MH10*, 1-2*;* Law Society of NSW, *Submission MH13*, 1-2*;* Intellectual Disability Rights Service, *Submission MH14*, 2; NSW Trustee and Guardian, *Submission MH16*, 11*;* Corrective Services NSW, *Submission MH17*, 2-5*;* Legal Aid NSW, *Submission MH18*, 4*;* Brain Injury Association of NSW, *Submission MH19*, 18-20*;* Public Interest Advocacy Centre, *Submission MH21*, 12-13*;* NSW, Public Defenders, *Submission MH26*, 12-13*;* NSW Public Guardian, *Submission MH27*, 6-7*;* Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28-1*, 8-11*;* Department of Human Services NSW (Juvenile Justice), *Submission MH28-2*, 6-8*;* NSW Council for Civil Liberties, *Submission MH46*, 2-3*.*
153. Public Interest Advocacy Centre, *Submission MH21*, 12.
154. NSW Bar Association, *Submission MH10*, 1-2.

An umbrella definition of "mental impairment"?

5.114 In CP 5 we asked if there should be a broad umbrella definition of "mental impairment" in the MHFPA, incorporating both mental illness and cognitive impairment. We proposed for discussion the following definition:

> Mental impairment includes a mental illness, cognitive impairment, or personality disorder, however and whenever caused, whether congenital or acquired.[155]

5.115 While there was support for an improved and broad definition of mental and cognitive impairment there was also significant opposition to combining the two in one "umbrella" definition. Stakeholders representing people with cognitive impairments expressed strong concerns that a definition that includes cognitive impairment within the term "mental impairment" could be detrimental for people with cognitive impairment.[156] Mental illness is presently better recognised and provided for by the criminal justice system than is cognitive impairment. If the two are included in one definition, there is a risk that cognitive impairment may again disappear or receive less recognition. The consequence for the criminal justice system is that cognitive impairment may be missed or be dealt with inappropriately.

5.116 According to one submission:

> …the adoption of an umbrella definition runs the risk of returning to conceptualisations abandoned in Australia in the 1920s, when the first distinctions were drawn between mental illness and intellectual disability. Since that time service systems and interventions for disability and mental health have developed along very different trajectories. Returning to an umbrella category is likely to have its most significant practical impact in the area of development and delivery of options for intervention and management.[157]

5.117 The separation of cognitive impairment from mental illness has been described as a "key milestone" in the understanding of cognitive impairment.[158] However, it has been argued that this has not led to an equal understanding of the two types of impairment. The need for support for those with cognitive disability is not always recognised;[159] this under-recognition is even more pronounced for those with multiple impairments.[160]

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155. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: An Overview*, Consultation Paper 5 (2010) Issue 5.2.

156. E Baldry, L Dowse, I Webster and P Snoyman, *Submission MH3*, 1-2; Intellectual Disability Rights Service, *Submission MH14*, 2; NSW Trustee and Guardian, *Submission MH16*, 11; Brain Injury Association of NSW, *Submission MH19*, 18-20; Public Interest Advocacy Centre, *Submission MH21*, 12-13; NSW, Public Defenders, *Submission MH26*, 12-13; NSW Public Guardian, *Submission MH27*, 6-7; Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28-1*, 8-11; Department of Human Services NSW (Juvenile Justice), *Submission MH28-2*, 6-8; NSW Council for Civil Liberties, *Submission MH46*, 2-3.

157. E Baldry, L Dowse, I Webster and P Snoyman, *Submission MH3*, 1-2.

158. L Dowse, E Baldry and P Snoyman, "Disabling Criminology, Conceptualising the Intersections of Critical Disability Studies and Critical Criminology for People with Mental Health and Cognitive Disabilities in the Criminal Justice System" (2009) 15 *Australian Journal of Human Rights* 29, 34.

159. Intellectual Disability Rights Service, *Enabling Justice: A Report on the Problems and Solutions in Relation to Diversion of Alleged Offenders with Intellectual Disability from the New South Wales Local Courts System* (2008) 33; E Baldry, L Dowse and M Clarence, "People with Mental

5.118 ADHC also submitted that an umbrella definition may create further confusion. ADHC submitted that a separation of the two terms is desirable to reassert the distinction between mental illness and cognitive impairment.[161]

5.119 Stakeholders also told the Commission that some lawyers and magistrates do not appreciate the differences between mental health impairment and cognitive impairment and that, because they conflate them, people with cognitive impairments are inappropriately delivered to mental health facilities or are denied any support services altogether.[162] Legal Aid submitted that the problem lies not in the definition, but that the criminal justice system should improve the ways that it accommodates the needs of people with cognitive impairments.[163] The Intellectual Disability Rights Service noted that distinct types of disability affect people very differently and expressed concern about further conflating both intellectual disability and cognitive impairment under the banner of mental health. It advocated instead for a clear delineation in any legislative regime.[164]

5.120 We are persuaded, on the basis of strong submissions and consultations to this effect, that it is appropriate to have separate definitions of cognitive impairment and mental health impairment.

A definition of cognitive impairment

5.121 Stakeholders in consultations emphasised the need for a definition of cognitive impairment that is more inclusive than existing definitions because, as discussed above, our understandings of cognitive impairment have overtaken the law. It was also argued that the definition should be non-exhaustive, so that there remains discretion for the criminal justice system to consider the relevance of conditions as our understanding of them develops further. The definition should also be respectful of people with disabilities and their rights, and be informative and clear, because it will be used by people who are not necessarily knowledgeable or expert about cognitive impairment.[165]

5.122 In CP 5 we suggested a definition of cognitive impairment or disability in the following terms:

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and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 3.

160. L Kavanagh and others, "Neurocognitive Deficits and Psychiatric Disorders in a NSW Prison Population" (2010) 33 *International Journal of Law and Psychiatry* 20, 20.

161. Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28-1*, 8.

162. Corrective Services NSW, *Submission MH17*, 2; Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28-1*, 8; Brain Injury Association, *Submission MH19*, 10*;* Public Interest Advocacy Centre *Submission MH21*, 15*.*

163. Legal Aid NSW, *Submission MH18*, 4.

164. Intellectual Disability Rights Service, *Submission MH14*, 2; see also Intellectual Disability Rights Service, *Enabling Justice: A Report on the Problems and Solutions in Relation to Diversion of Alleged Offenders with Intellectual Disability from the New South Wales Local Courts System* (2008) 30-33.

165. Cognitive impairment roundtable, *Consultation MH9.*

> 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.[166]

This definition is based on the formulation recommended by the Victorian Law Reform Commission as part of its report on a legal framework for the compulsory care of people with intellectual disabilities at risk.[167] It would include people with an intellectual disability, ABI, autism spectrum disorder, brain damage relating to substance abuse (including foetal alcohol syndrome), learning difficulties and neurological disorders. As a result of submissions, consultation with stakeholders and discussion with our Expert Advisory Panel this proposed definition has been modified in a number of ways.

5.123 In the following section, we set out the definition and explain its content.

Recommendation 5.1

The following definition should be used in legislation where appropriate:

(a) Cognitive impairment is an ongoing impairment in comprehension, reason, adaptive functioning, judgement, learning or memory that is the result of any damage to, dysfunction, developmental delay, or deterioration of the brain or mind.

(b) Such cognitive impairment may arise from, but is not limited to, the following:

- (i) intellectual disability
- (ii) borderline intellectual functioning
- (iii) dementias
- (iv) acquired brain injury
- (v) drug or alcohol related brain damage
- (vi) autism spectrum disorders.

5.124 The definition proposed in CP 5 referred to a "significant disability." We intended to convey by this that minor levels of disability, of a type and nature that did not affect a person's functioning in everyday life, would not entitle a person to have their disability taken into account when issues such as diversion, bail, or sentencing are being considered. While stakeholders in consultations were broadly supportive of the proposed definition, they did not support the requirement that the disability be "significant." It was submitted that this term is necessarily imprecise and leaves excessive room for discretion. There was also a concern that it could give rise to unequal treatment across and between different types of cognitive impairment.[168] It is therefore not included.

166. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: An Overview*, Consultation Paper 5 (2010) Issue 5.5.

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

168. Cognitive impairment roundtable, *Consultation MH9.*

5.125 Stakeholders in consultations also preferred the word "impairment" rather than "disability". This suggestion is consistent with the discussion about the meaning of these terms, above, and we have accepted it.

5.126 A requirement that the disability be ongoing has been included in the proposed definition. This acknowledges that cognitive impairments are not, as we noted above, conditions that are transient, or that can be treated, but are conditions that continue throughout the person's life. The addition of the requirement that the disability be ongoing also deals with concerns that the definition of cognitive impairment could otherwise apply to some people who have mental illnesses.

5.127 We have also added "adaptive functioning" to the proposed definition. We discussed above the relevance of adaptive functioning to cognitive impairment, and noted that impairments in adaptive functioning, rather than a low IQ, are usually the presenting symptoms, particularly for people with intellectual disability. Adaptive functioning is tested and is an important part of assessments of intellectual disability, for example by ADHC.

5.128 Given the problems described above in relation to cognitive impairment, especially the lack of familiarity of actors in the criminal justice system with cognitive impairments and their consequent failure to take relevant conditions into account, a non-exhaustive list of cognitive impairments, as suggested in consultations, is also included in the definition. Drug and alcohol related brain damage is included in the list. This would include foetal alcohol syndrome.

A definition of "mental health impairment"

5.129 The discussion in this chapter has demonstrated that the task of defining mental health impairment for the purposes of criminal law is a challenging one. One approach is to provide an indicative definition that leaves decision-making about who has a mental illness to psychiatrists. This is tempting to lawyers who have an imperfect understanding of mental illness and understandably wish to relinquish the decision to experts. It may be a workable approach where psychiatrists are the ones who will put the definition into operation. For example the definition of mental illness in the MHA, discussed above, creates a gateway: when a person is presented at this gate (for admission to a mental health facility), it is a psychiatrist who acts as gatekeeper and decides whether or not the person complies with the definition or not.

5.130 However, such an approach is much less functional when the definition is to be used by a wide range of people, including non-experts. The definition of mental health impairment that is required for our purposes must work in a variety of contexts where it will be used by judicial officers, police officers, lawyers, corrections staff – in other words, by people who cannot reasonably be expected to have DSM-IV at their elbow.

5.131 Many definitions of mental illness in Australia, which might provide a template, are similar to the existing definition in the MHA, discussed above, and apply in the context of compulsory treatment legislation. For example the Northern Territory *Mental Health and Related Services Act* defines mental illness in s 6(1):

> (1) In this Act "mental illness" means a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person in one or more of the areas of thought, mood, volition, perception, orientation or memory and is characterized
>
> (a) by the presence of at least one of the following symptoms:
>
> (i) delusions;
>
> (ii) hallucinations;
>
> (iii) serious disorders of the stream of thought;
>
> (iv) serious disorders of thought form;
>
> (v) serious disturbances of mood; or
>
> (b) by sustained or repeated irrational behaviour that may be taken to indicate the presence of at least one of the symptoms referred to in paragraph (a).

Section 6(2) of the same Act refers directly to the psychiatric diagnostic manuals when it provides

> A determination that a person has a mental illness is only to be made in accordance with internationally accepted clinical standards.

5.132 In both the MHA definition, and the NT definition there is a focus on symptoms of severe illness that are relevant to the question of admission to a mental health facility. However, less acute levels of illness are likely to be relevant to decisions about diversion, bail and sentencing. Second, the reference in the NT definition to clinical standards (such as DSM-IV), makes it suitable for psychiatrists and psychologists, but difficult for non-expert users.

5.133 A similar, but simpler and perhaps broader definition of mental illness is used in some jurisdictions. For example, the *Mental Health Act 1996* (WA) s 4 provides:

> a person has a mental illness if they person suffers from a disturbance of thought, mood, volition, perception, orientation or memory that impairs judgement or behaviour to a significant extent.

5.134 We have drawn from the definitions discussed above, from the advice of our Expert Advisory Panel and from submissions and consultations to arrive at a definition.

Recommendation 5.2

The following definition should be used in legislation where appropriate:

(a) Mental health impairment means a temporary or continuing disturbance of thought, mood, volition, perception, or memory that impairs emotional wellbeing, judgement or behaviour, so as to affect functioning in daily life to a material extent.

(b) Such mental health impairment may arise from but is not limited to the following:

(i) anxiety disorders

(ii) affective disorders

(iii) psychoses

(iv) severe personality disorders

(v) substance induced mental disorders.

(c) "Substance induced mental disorders" should include ongoing mental health impairments such as drug-induced psychoses, but exclude substance abuse disorders (addiction to substances) or the temporary effects of ingesting substances.

5.135 The term "mental health impairment" is used rather than "mental illness". This is consistent with our approach to cognitive impairment. Our proposed term is broader and less clinical in focus, and uses modern understandings of mental health. It is a better term to use in the criminal justice context where compulsory treatment is not in issue. It describes more accurately what is impaired, is less likely to invoke pejorative stereotypes and is therefore more likely to be acceptable to people with mental health impairments. It also has the important advantage of being different from the term "mental illness" used in the MHA. ("Mental illness" as it is defined in the MHA will continue to be relevant to s 33 of the MHFPA).

5.136 We have included a requirement that the mental health impairment "affect the person's functioning in everyday life to a material extent." This narrows the gateway. For example, a person would not have a mental health impairment if their mood was disturbed and their behaviour impaired by grief after the death of a close relative, or as a consequence of anger at conduct that had harmed their property. However where grief had triggered a reactive depression sufficient to affect their functioning in everyday life to a material extent, that person would have a mental health impairment.

5.137 We reviewed above (at para 5.60-5.73) the difficult issues that arise in relation to personality disorders. On balance we have decided that it is appropriate to include severe personality disorders in the definition. However, to qualify as a personality disorder using DSM-IV, criteria the disorder must cause significant functional impairment or subjective distress.[169] This is reflected, in our definition above, in the requirement that a mental health impairment must affect functioning in daily life to a material extent. We recognise the controversies among psychiatrists and psychologists about these disorders. However, we also recognise that these impairments cause a great deal of suffering to some people, and may be relevant to decisions about diversion, bail or sentence. For example, where an accused person has a personality disorder and, as a consequence is suicidal, a judicial officer making a decision about bail or diversion may find this a matter of great relevance. We have dealt with the concerns that the inclusion of personality disorders may open the floodgates, allowing too many people in the criminal justice system to qualify as having mental health impairments, by requiring that the personality disorder must be severe.

5.138 In including severe personality disorders in the definition, we do not consider that people with severe anti-social behaviour disorders, for example, should be

169. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) 686: "Only when personality disorders are inflexible and maladaptive and cause significant functional impairment or subjective distress do they constitute Personality Disorders".

automatically entitled to diversion or bail, or more lenient treatment. In all cases that court must be satisfied that the course of action proposed, whatever it is, must be appropriate in the circumstances. For example in relation to diversion under s 32, while a court may be informed of the defendant's personality disorder it may reach the view that concerns about the ability to treat personality disorders mean that diversion is not likely to succeed in changing the defendant's behaviour and reducing the likelihood of reoffending.

5.139 We have included substance induced mental disorders. We noted the concerns about these disorders above.[170] We therefore include only those people who have ongoing mental health impairments caused by consumption of drugs, alcohol or other substances, such as people with drug induced psychoses. We exclude from the definition of mental health impairment people who have taken a drug or other substance, and who offend when under its influence. We also exclude those people who are addicted to a drug, without more. There are provisions and programs in the criminal justice system for this group and they should be dealt with in that context rather than being defined as having mental health impairments.

Application of our recommended definitions

Application to diversion under the MHFPA

5.140 Diversion under the MHFPA is dealt with comprehensively in Chapters 9 and 10 of this report.

Section 33

5.141 Section 33 of the MHFPA applies to people who appear to be "mentally ill persons" under the MHA.[171] It gives magistrates the power to do a number of things, including to discharge a mentally ill defendant (either unconditionally or conditionally) into the care of a responsible person. It is most frequently used where an accused with a mental illness appears in court and is in crisis, because s 33 allows the court to order that the person be taken to, and detained in, a mental health facility for assessment.[172] A "mentally ill person" is defined in s 14 of the MHA as a person who is suffering from a mental illness, and owing to that illness there are reasonable grounds for believing that the care treatment and control of the person is necessary for the person's own protection or for the protection of others from serious harm. Mental illness is defined in s 4 of the MHA, and that definition is set out and discussed above.

5.142 Because s 33 is used to refer people who are seriously mentally ill to a mental health facility, where they are reviewed by a psychiatrist for admission, the use in s 33 of the definition of "mentally ill person" in the MHA is appropriate and no change is proposed. Section 33 is considered further in Chapter 10.

170. Para 5.95-5.102.

171. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 33(1)(c).

172. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 33(1)(a), s 33(1)(b).

Section 32

5.143 The main diversionary power available in the Local Court is in s 32 of the MHFPA. The core function of this provision is to allow a magistrate to make an order dismissing the charge and discharging the defendant, either into the care of a responsible person, or on the condition that the defendant undertake assessment or treatment. Section 32 is considered in detail in Chapter 10. Our focus here is on the definitions of cognitive impairment and mental impairment that should apply.

5.144 Section 32 (1) permits the magistrate to make diversionary orders if the defendant is "developmentally disabled" or "suffering from mental illness" or "suffering from a mental condition for which treatment is available in a mental health facility" but the person is not a "mentally ill person." Diversion must also be appropriate.

5.145 As will be apparent from the discussion above, these terms are now outdated and, in some cases, unduly restrictive. "Developmentally disabled" excludes cognitive impairments that do not manifest in the developmental stage and may mean that a service provider requires evidence of the presence of a disability before the age of eighteen years. Corrective Services submitted that it is frequently

> difficult and time consuming to seek historical evidence of the onset of the disability in persons who are often living chaotic lifestyles with limited contact with families of origin and whose personal records are often sparse.[173]

5.146 Services from ADHC often rely on such proof. In consultations we were told frequently that ADHC involvement was often crucial, but that the requirement to provide evidence of disability prior to the age of 18 was a barrier to getting services from ADHC. The appeal process to gain exemption from this requirement was described as very time consuming.

5.147 The limitation of mental impairments to mental illnesses and mental conditions for which treatment is available in a mental health facility is also unduly restrictive, in that there are many people who could no doubt benefit from diversion who may not comply with this limited definition.

5.148 There was strong support for the expansion and modernisation of the current definitions for the purposes of s 32. One submission emphasised the need for the legal definitions to reflect "psychological, disability service and policy understandings" and to be open to new categories as they emerge.[174] There was broad agreement that the current definitions in s 32 need to be updated to:

- recognise a broader range of cognitive impairment and complex needs, not limited to conditions acquired before the age of 18, and[175]

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173. Corrective Services NSW, *Submission MH17*, 3.

174. L Steele, *Submission MH9*, 18.

175. E Baldry, L Dowse, I Webster and P Snoyman, *Submission MH3*, 2-3*;* Shopfront Youth Legal Centre, *Submission MH7*, 5; L Steele, *Submission MH9*, 14; NSW Bar Association, *Submission MH10*, 3; Law Society of NSW *Submission MH13*, 1; Intellectual Disability Rights Service, *Submission MH14*, 2*;* IDRS, NSW Health *Submission MH15*, 3, Corrective Services NSW *Submission MH17*, *3;* Legal Aid NSW, *Submission MH18*, 4; Brain Injury Association NSW, *Submission MH19*, 17; Public Interest Advocacy Centre *Submission MH21*,12*;* ADHC *Submission MH28-1*, 9, Public Defender *Submission MH26*, 12.

- provide a definition of "mental illness".[176]

5.149 There was some disagreement as to the benefit of clarifying or further defining the meaning of the term "mental condition". On the one hand it is seen as "not at all helpful"[177] and "ambiguous",[178] and on the other a useful "catch-all" that provides necessary flexibility,[179] particularly where used according to guidance from appropriately qualified mental health practitioners.[180] However there was general agreement that, should "mental condition" be revised, the new definition should remove the current requirement for treatment in a mental health facility.[181] As the Local Court indicated:

> The term "treatment" is understood by members of the Court to refer to an option to assist the person in living in and functioning as a member of the community, rather than a narrower definition of fixing a condition or assuming that the plan will involve medication.[182]

5.150 While it is likely that many magistrates interpret the provisions of s 32 in order to do practical justice, they should not need to bend the law to divert cases where diversion is the best disposition option. Amendment of the categories of people who can qualify for diversion in accordance with the definitions proposed above would materially assist in the operation of s 32.

5.151 In our view, our recommended definitions of cognitive impairment and mental health impairment fit the purpose of s 32 well. The definitions are broad enough to cover the range of people who may be facing significant issues related to their cognitive functions or their mental health and who may benefit from diversionary programs in appropriate cases. However, the definitions do not cover trivial conditions, or transient states of mind. They focus the court on those people who have become entangled in the criminal justice system and need help to address their behaviours and reduce the likelihood of their reoffending.

5.152 In this chapter we recommend the inclusion of our proposed definitions in the MHFPA. We make a recommendation about the coverage of the diversionary powers under a reformed s 32 in Chapter 9 (Recommendation 9.1).

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176. Shopfront Youth Legal Centre, *Submission MH7*, 5; Law Society of NSW *Submission MH13*, 1; NSW Health, *Submission MH15*, 1; Legal Aid, *Submission MH18*, 4; Brain Injury Association, *Submission MH19*, *8;* Public Defender *Submission MH26*, 12.
177. Shopfront Youth Legal Centre, *Submission MH7*, 5.
178. L Steele, *Submission MH9*, 14.
179. NSW Bar Association, *Submission MH10*, 53.
180. NSW Bar Association, *Submission MH10*, 4; Local Court of NSW, *Submission MH4*, *11.*
181. Local Court of NSW, *Submission MH4*, 11; L Steele, *Submission MH9*, 18; Shopfront Youth Legal Centre, *Submission MH7*, 5; NSW Consumer Advisory Group, *Submission MH11.* 47; Law Society of NSW *Submission MH13*, 40-41; Corrective Services NSW, *Submission MH17*, 24; Legal Aid, *Submission* MH18, 29; Brain Injury NSW, *Submission MH19*, *26-27;* Children's Court of NSW, *Submission MH24*, *2-3.*NSW, Public Defenders, *Submission 26*, 13.
182. Local Court of NSW, Submission *MH4*, 11.

Recommendation 5.3

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to include the definitions of "cognitive impairment" and "mental health impairment" set out in Recommendations 5.1 and 5.2.

Application to sentencing law

5.153 Section 21A(3) of the *Crimes (Sentencing Procedure) Act 1999* (NSW) (CSPA) presently lists mitigating factors to be taken into account in determining the appropriate sentence for an offence. These include that "the offender was not fully aware of the consequences of his or her actions because of the offender's age or any disability."[183] "Disability" is not presently defined in that Act (s 3 is the main definition section and it has no particular provision relating to the meaning of disability).

5.154 Disability could be defined to include mental health impairment and cognitive impairment, and the definition of these terms proposed above could be inserted into the CSPA. Such an amendment would also have the effect that courts making sentencing decisions about children would be prompted to consider the relevance of cognitive and mental health impairment to their sentencing,[184] because the CSPA applies to sentencing of children, subject to the provision of Part 2 of the *Children (Criminal Proceedings) Act 1987* (NSW) and the rules of the Children's Court.[185]

5.155 In CP 6 we asked whether s 21A of the CSPA should be amended to include "cognitive and mental health impairment" as a factor in sentencing.[186] Seven submissions responded to this question and all were in agreement that this proposed amendment was desirable.[187]

Reference on Sentencing

5.156 The Commission is presently undertaking a review of the CSPA, with a final report due later in 2012.

5.157 The definitions we have proposed are broad, and encompass the conditions and disorders mentioned in submissions. They also include the conditions and disorders currently encompassed by the *Law Enforcement (Powers and Responsibilities)*

183. *Crimes (Sentencing Procedure) Act 1999* (NSW) s 21A(3)(j).

184. NSW Law Reform Commission, *Young People with Cognitive and Mental Health Impairments in the Criminal Justice System*, Consultation Paper 11 (2010) [6.14].

185. Note that courts sentencing children would need to take into account the principles in s 6 *Children (Criminal Proceedings) Act 1987* (NSW). Those principles may have particular consequences for children and young people with cognitive and mental health impairments, which would be a matter for the exercise of discretion in each case.

186. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences*, Consultation Paper 6 (2010) Issue 6.104.

187. NSW Bar Association, *Submission MH10*, 48; NSW Law Society, *Submission MH13*, 29; Corrective Services NSW, *Submission MH17*, 16; Legal Aid NSW, *Submission MH18*, 23; Brain Injury Association, *Submission MH19*, 23; NSW, Public Defenders, *Submission* MH26, 46; Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28-1*, 16.

Regulation 2005 (NSW) (LEPRR), the *Mental Health Act 2007* (NSW), the *Criminal Procedure Act 1986* (NSW) and the *Crimes Act 1900* (NSW). They are intended to be suitable for a range of uses where special consideration is to be given to people with mental health or cognitive impairments, including diversion and bail.

5.158 However, whether the definitions are equally applicable to sentencing, and the implications of such a broad definition in this context, are questions that we consider best answered in the sentencing review.

Application to bail law

5.159 In our final report on bail (the *Bail Report*),[188] we consider the application of bail law to people with mental health and cognitive impairments. The specific issues in relation to bail for people with cognitive and mental health impairments are dealt with in Chapter 11 of that report.

5.160 The *Bail Report* recommends a new *Bail Act*. The new Act should require a decision-maker take in account:

> (a) the person's ability to understand and comply with conditions or conduct directions,
>
> (b) the person's need to access treatment or support in the community,
>
> (c) the person's need to undergo assessment to determine eligibility for treatment or support,
>
> (d) any additional impact of imprisonment on the person as a result of their cognitive or mental health impairment,
>
> (e) any report tendered on behalf of a defendant in relation to the person's cognitive or mental health impairment,
>
> (f) that the absence of such a report does not raise an inference adverse to the person or a ground for adjourning the proceedings unless on the application of or with the consent of the person.[189]

5.161 Our *Bail Report* recommends that the new *Bail Act* should also require that any special vulnerabilities or need faced by a person with a cognitive or mental health impairment must be taken into account when considering the needs of the person.[190]

5.162 The *Bail Report* recommended provisional adoption of the definitions proposed in this report for use in a new *Bail Act*, in relation to these questions.[191]

5.163 In that report we noted the definition proposed is:

> broad, and encompasses the conditions and disorders mentioned in submissions. It also includes the conditions and disorders currently

188. NSW Law Reform Commission, *Bail*, Report 133 (2012).
189. NSW Law Reform Commission, *Bail*, Report 133 (2012) Recommendation 11.2.
190. NSW Law Reform Commission, *Bail*, Report 133 (2012) Recommendation 10.7(h).
191. NSW Law Reform Commission, *Bail*, Report 133 (2012) [11.34]-[11.39].

> encompassed by the LEPRA Regulation, the *Mental Health Act 2007* (NSW), the *Criminal Procedure Act 1986* (NSW) and the *Crimes Act 1900* (NSW).[192]

5.164 We noted specifically that

> The term 'substance induced mental disorders' is intended to include ongoing mental impairments caused by consumption of drugs, alcohol or other substances (such as drug induced psychoses). It is intended to exclude people with substance abuse disorders (addiction to substances) or people who act when under the temporary effects of such substances.
>
> To be relevant to a decision about bail, a personality disorder must be severe. The diagnosis of personality disorder is not without controversy in this context, for the most part because some personality disorders are diagnosed by reference to criminal behaviour. Used in the context of the criminal justice system, there is the potential for such a diagnosis to be circular (the person is criminal because he or she has a personality disorder, and has a personality disorder because of his or her criminal behaviour.) Nevertheless, a severe personality disorder may, for example, cause self-harming behaviours that need treatment and thus be relevant to a decision about detention or release, and to the conditions of release. In this context, therefore, we have included severe personality disorders in the definition of mental health impairment.[193]

5.165 We remain of the view that the definitions recommended in this report and set out in the *Bail Report* are appropriate to a new *Bail Act.*

Recommendation 5.4
A new *Bail Act* should adopt the definitions of "cognitive impairment" and "mental health impairment" set out in Recommendations 5.1 and 5.2.

The current Bail Act

5.166 As noted above, the *Bail Act 1978* (NSW) currently refers to intellectual disability and mental illness. Section 32(1)(b)(v) requires bail decisions makers to consider, among other things the interest of the person seeking bail including:

> if the person…has an intellectual disability or is mentally ill, any special needs of the person arising from that fact,

There are no definitions for the terms "intellectual disability" or "mentally ill" as used in s 32.

5.167 Section 37(2A) provides that:

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

5.168 Intellectual disability in narrowly defined in s 37(5) as:

192. NSW Law Reform Commission, *Bail*, Report 133 (2012) [11.38].

193. NSW Law Reform Commission, *Bail*, Report 133 (2012) [11.36]-[11.37]

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

This definition only applies to the term "intellectual disability" when used in s 37.[194]

Stakeholder views

5.169 Submissions to our inquiry on bail called for broader and more inclusive definitions that better capture the range of impairments that might impede a defendant's day-to-day functioning and his or her ability to understand and comply with bail conditions.[195] Stakeholders made particular reference to the need for express recognition of ABI,[196] cognitive impairment[197] and mental illness.[198] There was support in submissions for the definitions set out in the MHA,[199] the *Criminal Procedure Act 1986* (NSW)[200] and the *Crimes Act 1900* (NSW),[201] each of which is set out above. In addition, two stakeholders suggested using the definition of "vulnerable person" set out in the regulations to the LEPRR[202] which defines "impaired intellectual functioning" as:

> (a) a total or partial loss of the person's mental functions, or (b) a disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction, or (c) a disorder, illness or disease that affects the person's thought processes, perceptions of reality, emotions or judgement, or that results in disturbed behaviour.[203]

5.170 Submissions to this reference similarly supported a more inclusive definition for the purposes of bail.[204] A broader term, "cognitive impairment", would require courts to advert to a wider range of relevant disabilities that would potentially be relevant to bail decisions.

The Commission's view

5.171 In our view, even if the Government does not proceed with a new *Bail Act*, the current *Bail Act 1978* (NSW) should be amended to adopt our proposed terms and definitions.

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194. *Bail Act 1978* (NSW) s 37(5).
195. Aboriginal Legal Service NSW/ACT Ltd, *Submission BA14*, 44; D Shoebridge, *Submission BA19*, 10.
196. Legal Aid NSW, *Submission BA17*, 24; Public Interest Advocacy Centre, *Submission BA26*, 18-19; Brain Injury Association of NSW and Blake Dawson Pro Bono Team, *Submission BA32*, 3.
197. Public Interest Advocacy Centre, *Submission BA26*, 18-19.
198. Aboriginal Legal Service NSW/ACT Ltd, *Submission BA14*, 44; Public Interest Advocacy Centre, *Submission BA26*, 18-19.
199. Public Interest Law Clearing House, *Submission BA12*, 15.
200. NSW, Office of the Director of Public Prosecutions, *Submission BA21*, 15.
201. Intellectual Disability Rights Service, *Submission MH14*, 8.
202. NSW Young Lawyers, *Submission BA11*, 8; Redfern Legal Centre, *Submission BA18*, *14.*
203. *Law Enforcement (Powers and Responsibilities) Regulation 2005* (NSW) cl 23(1)(a)-(c).
204. NSW Bar Association, *Submission MH10*, *52;* Brain Injury Association of NSW, *Submission MH19*, 25-26*;* Legal Aid NSW, *Submission MH18*, 28; NSW Public Guardian, *Submission MH27*, 21.

5.172 This would make mental health impairments and cognitive impairments relevant in two contexts.

5.173 First, decision-makers would be required to take into account, when considering the interests of the person seeking bail, any special needs arising from the fact the person has a cognitive or mental health impairment. Adoption of our proposed definitions in this context would clarify and broaden the class of people who may seek to have their needs considered. It would be clear that person with dementia and ABI for example, should be considered.

5.174 This is, of course, no guarantee that people with cognitive and/or mental health impairments will get bail. There is a range of countervailing considerations, including any factors relating to the defendants risk of serious reoffending or risks to the safety of others.

5.175 Second, it would require decision makers to consider the capacity of the person seeking bail to understand and comply with bail conditions. Again this is appropriate. At present, this factor is confined to a small group of people with an intellectual disability that is so serious as to require social rehabilitation. This is too narrow a group. Many people with cognitive impairments that are not intellectual disabilities may have difficulty understanding and complying with bail conditions. People with a mental health impairment may also have similar difficulties. For example, defendants with a mental health impairment who are in crisis may need to be admitted to hospital from time to time, and may need reporting requirements that take this into account. Similarly, defendants who have great difficulty in leaving their home because of mental illness may be required to report by telephone.

5.176 If the recommendations in our *Bail Report* are accepted, this issue will be dealt with. If the government does not proceed with a new *Bail Act*, amendments to the current *Bail Act 1978* (NSW) will be required.

Recommendation 5.5

If the Government does not proceed with a new *Bail Act*:

(a) The *Bail Act 1978* (NSW) should be amended to insert definitions of mental health impairment and cognitive impairment set out in Recommendations 5.1 and 5.2.

(b) Section 32(1)(b)(v) of the *Bail Act 1978* (NSW) should be amended to require decision makers to consider any special needs of any person with a cognitive impairment or a mental health impairment.

(c) Section 37 of the *Bail Act 1978* (NSW) should be amended to extend the requirement to consider the capacity to understand and comply with bail conditions to any person with a cognitive impairment or a mental health impairment.

6. Bail

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6.1 In this chapter we provide an overview of the key problems faced by people with cognitive and mental health impairments in relation to bail law and practice. We commence by giving the background to the current *Bail Act 1978* (NSW) (*Bail Act*) and the way it deals with people with cognitive and mental health impairments. We then set out in detail issues raised by stakeholders in this review about the operation of the *Bail Act*, and explain how the recommendations in our recent Report 133 – *Bail* (*Bail Report)*[1] respond to those issues. We deal with the issue of bail support and, finally, we address the question of the relationship between bail and diversion, and in particular the relationship of bail to our recommendations concerning s 32 and s 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW).

Bail law: purpose and current operation

6.2 Bail law provides the framework for decisions to be made about whether a person will be released, with or without conditions or restrictions on their conduct, or detained pending the determination of criminal proceedings. The current Act has been in place since 1978, though subject to frequent amendment.

6.3 In outline, the *Bail Act* works as follows:

(1) Bail decisions can be made by police following arrest, or by the courts once the person has appeared. Bail may be dispensed with, granted (with or without conditions), or refused.

1. NSW Law Reform Commission, *Bail*, Report 133 (2012).

(2) The bail decision is governed by statutory considerations in relation to:

(a) the probability of whether the person will appear in court

(b) the interests of the person

(c) the protection of a particular person at risk, and

(d) the protection and welfare of the community: this includes the likelihood of the person interfering with evidence, witnesses or jurors, and the likelihood of the person committing a serious offence (as defined) while at liberty on bail.

6.4 In some circumstances a person charged with a minor offence has a right to bail.[2] For many offences, there is a presumption in favour of the grant of bail.[3] For other offences, such as certain drug and domestic violence offences, there is no presumption in favour of bail (the so called neutral presumption). For a range of more serious offences, there is a presumption against bail,[4] and for the most serious crimes, murder and violence by repeat offenders, bail is to be granted only in exceptional circumstances.[5] The operation of these presumptions is one of the most contentious aspects of current bail law.

6.5 A court can dispense with bail, or grant bail unconditionally. Alternatively, the court can grant bail subject to conditions which must be satisfied prior to release. The conditions might involve the posting of money or security for bail. Most importantly, these conditions can include a requirement to enter into an agreement to abide by conduct requirements while released on bail (for example, residence, reporting to police, non-association). We will refer to these as "conduct requirements" for accuracy (although they are commonly referred to as "bail conditions").[6]

6.6 A breach of these requirements can result in a person being arrested and returned to the court. Failure to appear in court in answer to the bail undertaking without a reasonable excuse constitutes an offence.[7]

6.7 If bail is refused, the accused person is held in prison. Although it is possible to make multiple applications, the *Bail Act* places significant restrictions on second or subsequent bail applications.[8]

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2. *Bail Act 1978* (NSW) s 8.
3. *Bail Act 1978* (NSW) s 9.
4. *Bail Act 1978* (NSW) s 8A-s 9D.
5. *Bail Act 1978* (NSW) s 9C, s 9D.
6. See NSW Law Reform Commission, *Bail*, Report 133 (2012) [12.4]-[12.5].
7. *Bail Act 1978* (NSW) s 51.
8. *Bail Act 1978* (NSW) s 22A. The operation of s 22A was the subject of some criticism in several submissions to our review, specifically in relation to its impact on young people. These submissions advocated removing young people from the scope of s 22A's application. However, no stakeholder identified any particular concerns in relation to the impact of s 22A on accused people with cognitive and mental health impairments. Consequently, it will not be dealt with any further here. Instead, for a discussion of s 22A and recommendations regarding its amendment see NSW Law Reform Commission, *Bail*, Report 133 (2012) Chapter 18.

6.8 The *Bail Act* recognises people with cognitive and mental health impairment in two specific provisions. First, in considering the interest of the person in making a bail decision, s 32(1)(b)(v) requires the court or police officer to consider:

> if the person is under the age of 18 years, or is an Aboriginal person or a Torres Strait Islander, or **has an intellectual disability or is mentally ill,** any special needs of the person arising from that fact.

Secondly, in relation to the imposition of bail conditions, under s 37 of the *Bail Act,* the court or police officer must observe the following restrictions:

> (2A) Before imposing a bail condition on an accused person who has an **intellectual disability**, the authorised officer or court is to be satisfied that the bail condition is appropriate having regard (as far as can reasonably be ascertained) to the capacity of the accused person to understand or comply with the bail condition.
>
> (5) **intellectual disability** means a significantly below average intellectual functioning (existing concurrently with two or more deficits in adaptive behaviour) that results in the person requiring supervision or social rehabilitation in connection with daily life activities.

6.9 Our comprehensive review of bail law in NSW[9] recommends some significant and substantial reforms to the current operation of the *Bail Act* and the way in which bail applications are dealt with, in order to address a range of concerns with its operation.[10] The recommendations most pertinent to the current review, particularly those most likely to have an impact on the situation of people with cognitive and mental health impairments, are addressed in this chapter.

6.10 In the following section we canvas the issues raised by stakeholders in relation to this inquiry, and the ways in which our *Bail Report* responds to those issues. In our view, the implementation of the recommendations of the *Bail Report* would be the best mechanism to address the issues raised.

The response of the Bail Report in relation to issues for people with cognitive and mental health impairments

6.11 Submissions and consultations have identified several aspects of the current bail regime as disadvantaging certain groups of people, particularly young people and people with cognitive and mental health impairments. This section details those issues and the response of our *Bail Report* to them. We take the view that the *Bail Report* provides an appropriate and balanced response to those issues, and make no further recommendation in this report concerning the general law of bail.

9. NSW Law Reform Commission, *Bail*, Report 133 (2012).
10. See NSW Law Reform Commission, *Bail*, Report 133 (2012) [1.20] for a list of the issues of concern raised by stakeholders.

Barriers to release on bail

6.12 In Consultation Paper 7 (CP 7),[11] we asked whether the provisions of the *Bail Act* setting out the grounds for the grant of bail make it harder for a person with a mental illness or cognitive impairment to be granted bail than other alleged offenders.

6.13 Submissions considered that the current bail regime does make it more difficult for people with cognitive and mental health impairments to be granted bail than other alleged offenders.[12] There is a range of reasons why such defendants may be more likely to be refused bail, including that:

- they may have a history of breaching bail conditions, warrants or failing to appear in court[13]
- they are likely to have a history of prior convictions and potential classification as a repeat offender[14]
- they may have difficulties stating their case in court,[15] and
- the lack of financial resources due to unemployment or reliance on social security benefits may disadvantage them in their ability to raise sufficient funds to meet financial bail conditions.[16]

6.14 Submissions underscored the point that the lack of an appropriate residence, treatment arrangements, provision for care and employment make it more difficult for a person with a cognitive impairment to be granted bail.[17] In particular, the lack of appropriate supports and services may mean that it is difficult to satisfy the court's concern about the protection of the community.[18]

6.15 Stakeholders submitted that the presumptions that currently apply to bail determinations can disadvantage people with cognitive and mental health impairments.[19] For example, the NSW Director of Public Prosecutions argued that

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11. NSW Law Reform Commission, *People With Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010).
12. Public Guardian, *Submission MH27*, 20; NSW Director of Public Prosecutions, *Submission MH5*, 14; Law Society of NSW, *Submission MH13*, 37.
13. NSW, Department of Justice and Attorney General, Criminal Law Review Division, *Review of the Bail Act 1978 (NSW)* (2010) 84.
14. NSW Law Society, *Submission BA05*, 17; See also Criminal Law Review Division, Department of Justice and Attorney General, *Review of the Bail Act 1978 (NSW)* (2010) 84.
15. K Valder, *Submission BA01*, 1. See also Victorian Law Reform Commission, *Review of the Bail* Act, Final Report (2007) 204.
16. M Karras and others, *On the Edge of Justice: The Legal Needs of People with a Mental Illness in NSW* (Law and Justice Foundation of NSW, 2006) 34.
17. Youth Justice Coalition, *Submission MH34*, 22; Shopfront Youth Legal Centre *Submission MH7*, 4. Legal Aid NSW, *Submission MH18*, 28; Law Society of NSW, *Submission BA05*, 17; Office of the Director of Public Prosecutions, *Submission BA21*, 15.
18. NSW Law Society, *Submission BA05*, 17. See also Department of Corrective Services, *Bail Refusal and Homelessness Affecting Remandees in New South Wales* (2010) 4; D Bamford, S King, and R Sarre, *Factors that Influence Remand in Custody: Final Report to the Criminology Research Council*, Research and Public Policy Series 23 (Australian Institute of Criminology Canberra, 2005) 96.
19. Office of the Director of Public Prosecutions, *Submission MH5*, 14; Public Guardian, *Submission MH27*, 20.

the presumptions are "overly prescriptive" and make it "very hard for mentally impaired offenders to get bail".[20]

6.16 The Public Guardian identified specific presumptions as problematic,[21] including the exception to the right to be granted bail if the person has previously failed to comply with a bail undertaking or condition,[22] the presumption against bail for certain repeat property offenders[23] and no presumption in favour of bail if the accused person was serving a sentence but was not in custody or was subject to a good behaviour bond or intervention program order.[24]

6.17 Other stakeholders also submitted that the presumption against bail in cases of allegedly violent offences can make it more difficult for accused people with cognitive and mental health impairments to get bail.[25]

Reforms concerning presumptions

6.18 In the *Bail Report* we recognised that there are extensive problems with the approach of the current Act to presumptions. In particular, we noted a "web of complexity" in the current hierarchy of presumptions applying to the assessment of bail applications.[26] We also noted that some presumptions can disadvantage certain people. Because the presumptions focus on categories of crime or certain aspects of a person's criminal history, they make it impossible to give proper consideration to the appropriateness of a grant of bail based on the actual circumstances of a particular case. [27]

6.19 We recommended the rationalisation of the presumptions relating to grant of bail. In response to overwhelming support from stakeholders, we recommended a uniform presumption in favour of bail.[28]

6.20 By instituting a uniform presumption in favour of bail, the discretion of the police and the discretion of the courts will not be unnecessarily restricted, as they currently are. Rather, decision makers would be able to engage in a balanced assessment of all the considerations which bear rationally on the question of whether to detain or release a person on bail, including any issues arising because the person has a cognitive or mental health impairment.[29]

Reforms concerning considerations

6.21 The considerations in the *Bail Act* establish the framework within which decisions about whether to grant or refuse bail are made. They set out all matters relevant to

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20. Office of the Director of Public Prosecutions, *Submission MH5*, 14. .
21. Public Guardian, *Submission MH27*, 20.
22. *Bail Act 1978* (NSW) s 8(2)(a)(i).
23. *Bail Act 1978* (NSW) s 8C.
24. *Bail Act 1978* (NSW) s 9B(1)(c), s 9B(1)(d).
25. Law Society of NSW, *Submission MH13*, 38; Shopfront Youth Legal Centre, *Submission MH7*, 4.
26. NSW Law Reform Commission, *Bail*, Report 133 (2012) [8.21].
27. NSW Law Reform Commission, *Bail*, Report 133 (2012) [8.65]-[8.66].
28. NSW Law Reform Commission, *Bail*, Report 133 (2012) [8.75], Recommendation 8.1.
29. NSW Law Reform Commission, *Bail*, Report 133 (2012).

this determination. In their current state, these considerations seem to take account inadequately of the circumstances and needs of people with cognitive and mental health impairments.

6.22 We have recommended a list of specific considerations that establish the framework within which decisions to detain or release an accused person on bail would be made. These were:

- the public interest in freedom and securing justice according to law
- the integrity of the criminal justice system having regard to a number of issues including the likelihood of the accused person absconding, the likelihood the person will interfere with the course of justice (evidence, witnesses, jurors, etc), and the fact that a person has committed an indictable offence while subject to "conditional liberty" (bail, parole, home detention, or intensive corrections order, suspended sentence, or good behaviour bond)
- the likelihood that the accused person will harm or threaten harm to any particular person or people
- the protection and welfare of the community having regard to and only to the likelihood the person will commit certain serious offences, and
- the interests of the person and of the person's family and associates.[30]

6.23 These considerations are mandatory and exhaustive.[31] We have specified further detail relevant to the matters that should be taken into account in relation to each of the above considerations.[32]

6.24 Importantly for the purposes of the current reference, Recommendation 10.7, which sets out the matters relevant to the interests of the person, requires the decision maker to consider:

> any special vulnerability or need of any child or young person, of a person with a cognitive or mental health impairment, or an Aboriginal person or Torres Strait Islander, or of any other person.[33]

6.25 This consideration is relevant to the decision to release on bail or detain, and to the imposition of conditions or conduct requirements.

6.26 Recommendation 11.2 of the *Bail Report* contains another general requirement related to people with mental health and cognitive impairments. This recommendation provides more detail in relation to issues that the decision-maker must consider. It provides as follows:

> **Matters to be taken into account when making a determination regarding a person with a cognitive or mental health impairment**

30. NSW Law Reform Commission, *Bail*, Report 133 (2012) Recommendation 10.2.
31. NSW Law Reform Commission, *Bail*, Report 133 (2012) Recommendation 10.2(1).
32. NSW Law Reform Commission, *Bail*, Report 133 (2012) Recommendations 10.3-10.9.
33. NSW Law Reform Commission, *Bail*, Report 133 (2012) Recommendation 10.7(h).

> A new *Bail Act* should provide that, in making a decision in relation to a person with a cognitive or mental health impairment regarding release or a condition or conduct direction, the authority must take into account (in addition to any other requirements):
>
> (a) the person's ability to understand and comply with conditions or conduct directions,
>
> (b) the person's need to access treatment or support in the community,
>
> (c) the person's need to undergo assessment to determine eligibility for treatment or support,
>
> (d) any additional impact of imprisonment on the person as a result of their cognitive or mental health impairment...

6.27 As the recommendation indicates, the specified matters are intended to guide decisions about whether to release or detain a person pending proceedings and decisions relating to the imposition of conditions or conduct directions. It provides a general requirement to consider the special issues facing people with a cognitive or mental health impairment in making decisions about release on bail and as to the conditions and conduct requirements to impose. It is intended to require decision-makers to consider the special position of people with cognitive and mental health impairments and to tailor conditions and conduct requirements to the particular case.

6.28 There is an equivalent recommendation that applies to bail determinations involving young people. It identifies such factors as: the rights of young people; the desirability of not interrupting a young person's education or employment; the desirability of allowing a young person to reside in safe, secure and stable accommodation and to remain in his or her own home; the use of detention as a last resort; the ability of a young person to understand and comply with conditions or conduct directions; and the recognition that young people have an undeveloped capacity for complex decision-making, planning and the inhibition of impulsive behaviours.[34]

6.29 In addition we recommended that certain general rules should apply to bail decisions, including that:

- detention is a last resort, and a person must be released if a reason for detention is sufficiently satisfied by conditions or conduct requirements
- a person must not be detained unless a custodial sentence is likely, and
- a person must not be detained for longer than the likely duration of a custodial sentence.[35]

34. NSW Law Reform Commission, *Bail*, Report 133 (2012) Recommendation 11.1.
35. NSW Law Reform Commission, *Bail*, Report 133 (2012) Recommendation 10.9.

Conditions and conduct requirements

6.30 People with cognitive and mental health impairments may face difficulties in complying with conduct requirements imposed on them in bail decisions.[36] This can lead to arrest for breach of conduct requirements and problems associated with arrest and remand for breach. Stakeholders submitted a range of reasons why people with cognitive impairment might have difficulty in complying with conduct requirements:

- Some people with a cognitive impairment do not want to acknowledge their disability due to stigma, so conduct directions may be imposed not taking into account a person's impairment or its impact on his or her ability to comply.[37]
- People with a cognitive impairment often state that they understand the conditions of bail, but may be unable to read and comprehend the conditions.[38]
- Many people with cognitive impairments have difficulties in complying with conditions that require regular attendance, for example, at a police station at specific times, or which limit a person's movement.[39]
- The imposition of bail conditions that require a particular behaviour to cease immediately can result in anxiety and an escalation of the offending behaviour in some people with a cognitive impairment.[40]
- Offenders with cognitive impairments may have difficulties understanding "what they need to change in order to be able to adhere to the conditions". [41]

6.31 Two factors are primarily responsible for these difficulties. Some are the result of the application of the requirements of the *Bail Act* in a way that does not adequately take into account the needs and abilities of people with cognitive and mental health impairments. In other cases, the problems arise because there is insufficient support available to assist people with cognitive and mental health impairments released on bail to comply with the conduct requirements placed on them. The issue of availability of bail support services is addressed below.[42]

6.32 Ageing, Disability and Home Care (ADHC) reports that in its experience, adults with an intellectual disability are often given more onerous or restrictive bail conditions to comply with "because they have a service provider who is expected to 'enforce'

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36. See, eg, Public Interest Advocacy Centre, *Submission MH21*, 39; Public Guardian, *Submission MH27*, 16.
37. Human Services (Ageing, Disability and Home Care), *Submission MH28-1*, 21.
38. Human Services (Ageing, Disability and Home Care), *Submission MH28-1*, 21.
39. Human Services (Ageing, Disability and Home Care), *Submission MH28-1*, 21; NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) [4.74]. See also 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) 134; Victorian Law Reform Commission *Review of the Bail Act*, Final Report (2007) 124-5.
40. Human Services (Ageing, Disability and Home Care), *Submission MH28-1*, 21.
41. 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) 67.
42. Para 6.54-6.61.

those undertakings".[43] ADHC believes that such conditions would not be imposed if the accused did not receive the service (such as supported accommodation), and in such cases they are effectively disadvantaged by having access to the service.[44]

6.33 Defendants with a mental health impairment may experience a similar difficulty: conduct requirements may conflict with "obligations imposed by Centrelink and job service provider obligations, community treatment orders, drug and alcohol treatment programs, etc". [45]

6.34 The *Bail Report* addressed the extensive problems facing young people in relation to bail, particularly relating to compliance with conditions and conduct requirements. Many of the problems of adults may be heightened for young people with cognitive and mental health impairments, including:

- their ability to comply often depends on being properly informed of the nature of the conditions and consequences of breach in a way that they can understand[46]
- remembering the effect of and applying bail conditions to day to day decision making[47]
- a lack of family or social supports[48]
- the conditions imposed on young people are often numerous and prescriptive as to behaviour and conduct,[49] and
- the conditions imposed may be more onerous than those imposed on adults for similar offences.[50]

6.35 One problem that is particularly pertinent for young people with cognitive and mental health impairments is the lack of appropriate accommodation support. Courts are often unwilling to release young people on bail where they do not have accommodation. This can be particularly difficult for young people with cognitive and mental health impairments as the available accommodation may not be appropriate for their needs, for example staff may not be adequately skilled to manage their

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43. Human Services (Ageing, Disability and Home Care), *Submission MH28-1*, 21.
44. Human Services (Ageing, Disability and Home Care), *Submission MH28-1*, 21
45. Public Interest Advocacy Centre, *Submission MH21*, 40.
46. Human Services (Ageing, Disability and Home Care), *Submission MH35*, 45. See also Noetic Solutions Pty Limited, *A Strategic Review of the New South Wales Juvenile Justice System: Report for the Minister for Juvenile Justice* (2010) [223]. Note, though, that the NSW Police Force submitted that young people are made aware of their rights while in custody: NSW Police Force, *Submission MH42*, 3.
47. Human Services (Juvenile Justice), *Submission MH35*, 7.
48. Illawarra Legal Centre, *Submission MH39*, 3.
49. Youth Justice Coalition, *Kids in Justice, A Blueprint for the 90s: Full Report of the Youth Justice Project* (1990), 2; NSW Law Reform Commission, *Young People with Cognitive and Mental Health Impairments in the Criminal Justice System*, Consultation Paper 11 (2010) [2.35]. See also New South Wales Law Reform Commission, *Young Offenders*, Report 104 (2005) [10.25].
50. New South Wales Law Reform Commission, *Young Offenders*, Report 104 (2005) [10.25]; Noetic Solutions Pty Limited, *A Strategic Review of the New South Wales Juvenile Justice System: Report for the Minister for Juvenile Justice* (2010) [223]. See generally, NSW Law Reform Commission, *Young People with Cognitive and Mental Health Impairments in the Criminal Justice System*, Consultation Paper 11 (2010) [2.35].

behaviour,[51] and it may take time to be find suitable accommodation. Where accommodation options are not available, the likely result is that the young person will remain on remand indefinitely.[52]

6.36 Due to the difficulties young people with cognitive and mental health impairments can have understanding and complying with their bail conduct requirements, they are at greater risk of breaching bail requirements. Stakeholders submitted that the imposition of numerous and prescriptive conduct directions, accompanied by strict policing of compliance, means that many young people with cognitive and mental health impairments are arrested for minor or technical breaches of bail conduct directions.[53] These views are discussed extensively in the *Bail Report*, which comes to the following conclusion:

> [I]t is clear from the submissions and the data that there is a significant problem [in relation to the imposition and monitoring conduct requirement compliance] at the present time. Conduct requirements appear to be imposed routinely and unnecessarily without tailoring to the situation of the individual. Monitoring for compliance by police has become more active and intense in recent times. Arrest for failure to comply has been increasing. We have no statistically significant evidence of a reduction in crime as a result.[54]

Reforms to the imposition of conditions and conduct directions

6.37 In the *Bail Report* we recognised the problems concerning conditions and conduct requirements. In response, we recommended several changes to the current conditions regime and to the provisions relating to arrest for breach of a conduct requirement. In particular we recommended that a condition or conduct requirement should not be imposed unless it is justified.[55] It would be justified where a reason for detaining the person is sufficiently satisfied by setting conditions of release or by giving a conduct direction.[56] Additionally, we recommended that arrest for breach of a conduct requirement should only occur as a last resort, and that a police officer should take into account a person's cognitive or mental health impairment when making the decision whether or not to arrest for breach.[57]

6.38 To determine whether a condition or conduct requirement is justified and should be imposed, we recommended that the same set of considerations applying to decisions whether to detain or release a person should also apply to decisions as to the imposition of conditions or conduct directions, and the nature and substance of any condition or conduct direction imposed.[58] We note in particular that Recommendation 11.2, quoted above at para 6.26, contains requirements that the decision maker must take into account the ability of a person with a cognitive or

51. Shopfront Youth Legal Centre, *Submission MH41*, 6.
52. Yfoundations, *Submission MH31*, 2.
53. Law Society of New South Wales, *Submission MH36*, 1; Legal Aid Commission of New South Wales, *Submission MH38*, 3.
54. NSW Law Reform Commission, *Bail*, Report 133 (2012) [12.73].
55. NSW Law Reform Commission, *Bail*, Report 133 (2012) [14.3] Recommendation 14.1.
56. NSW Law Reform Commission, *Bail*, Report 133 (2012) [14.10].
57. NSW Law Reform Commission, *Bail*, Report 133 (2012) Recommendation 15.2.
58. NSW Law Reform Commission, *Bail*, Report 133 (2012) Recommendation 14.2.

mental health impairment to understand and comply with conditions or conduct requirements.

6.39 We have also recommended the following limitations and prohibitions on the imposition of conditions and conduct directions:

(1) A new *Bail Act* should provide that an authority must:

(a) not impose a condition or conduct direction unless the authority is of the opinion that, without such a condition or conduct direction, the person should be detained pending proceedings having regard to the considerations and rules applicable to a decision whether to release or detain;

(b) consider whether the person has family, community or other support available to assist the person in complying with a condition and conduct direction;

(c) not impose a condition or conduct direction that is more onerous or more restrictive of the person's daily life than is necessary having regard to the considerations and rules applicable to a decision whether to release or detain;

(d) not impose a condition or conduct direction unless the authority is satisfied that compliance is reasonably practicable;

(e) not impose a financial condition concerning the forfeiture of an amount of money, with or without security, in relation to a young person under 18 years, except if charged with a serious indictable offence (as defined in s 4 of the *Crimes Act*);

(f) not impose a financial condition concerning the forfeiture of an amount of money, with or without security, in relation to an adult unless the bail authority is satisfied that:

(i) there would otherwise be a likelihood of the person absconding or being unlikely to appear on a future occasion having regard to the considerations mentioned in Recommendation 10.5(2), and

(ii) payment of the sum involved is or is likely to be within the means of the person or people who may be liable to pay that sum;

(g) not impose a condition or conduct direction for the purpose of promoting the welfare of the person unless it is otherwise justified having regard to the considerations set out in the Act.

(2) In this recommendation ***financial condition*** means a condition requiring a person (who may be the accused person) to enter into an agreement to forfeit a sum of money if the accused person fails to attend court as required.[59]

6.40 This framework is intended to ensure that conditions and conduct requirement are tailored to the circumstances presented by the individual, and that they can be complied with. We note in particular our recommendation that financial conditions

59. NSW Law Reform Commission, *Bail*, Report 133 (2012) Recommendation 14.3.

be restricted in relation to young people, and must be necessary and within the means of a person who may be liable to pay. As noted above, this was raised by stakeholders as a potential barrier to obtaining bail.

6.41 We note also the restriction on welfare conditions in paragraph (g) above. This would prevent the imposition of conditions aimed solely at promoting the accused person's welfare where such conditions could not be justified by reference to the considerations listed above.[60] The intention is to prevent the imposition of excessive conditions that are not required to meet the purposes of bail law, and which may set the person up to fail.[61] As we explained in the *Bail Report*, this would still allow other conduct directions to be imposed which had an incidental effect of promoting the welfare of the accused person, but where the primary purpose was not welfare-related.[62]

6.42 There is a major exception to this prohibition on the imposition of welfare conditions, which is the power of the court to impose a condition referring an accused person to assessment or treatment in a treatment, rehabilitation or intervention program.[63] This would retain the substance of the current s 36A of the *Bail Act*. This provision is discussed further below in relation to the relationship between diversion and bail.[64]

6.43 Restricting welfare conditions should assist to prevent a "proliferation of conduct requirements",[65] including reporting requirements, non-association and place restrictions, curfews and, in the case of young people, requirements to attend school, or obey the instructions of parents and carers.

Reforms to assist homeless young people

6.44 We also made recommendations that attempt to address the issue of bail refusal in cases where there is no suitable accommodation for a young person available at the time of bail determination. Where no suitable accommodation is available the court should be able to impose a condition that the young person not be released until accommodation is available, and impose a conduct direction requiring the young person to reside at such accommodation as may be directed by the relevant agency.[66] The matter must be relisted and reheard every two days until the court is satisfied that suitable accommodation is available.

6.45 While this recommendation will assist to avoid the prolonged detention of young people in instances where there is no suitable accommodation available at the time of initial bail determination, its ultimate effectiveness still relies on the availability of specialist accommodation for young people with cognitive or mental health impairment. [67]

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60. Para 6.22.
61. NSW Law Reform Commission, *Bail*, Report 133 (2012) [14.40]-[14.47].
62. NSW Law Reform Commission, *Bail*, Report 133 (2012) [14.41].
63. NSW Law Reform Commission, *Bail*, Report 133 (2012) Recommendation 13.4.
64. Para 6.68-6.75.
65. NSW Law Reform Commission, *Bail*, Report 133 (2012) [14.40].
66. NSW Law Reform Commission, *Bail*, Report 133 (2012) Recommendation 13.5(1)(b).
67. See NSW Law Reform Commission, *Bail*, Report 133 (2012) [13.40] in relation to this point.

Reforms concerning compliance

6.46 Recommendation 15.2 of the *Bail Report* would give a police officer a clear discretion, in instances of alleged failure to comply with a conduct direction, to take no action, issue a warning, require a person to attend court without arrest, and arrest. In deciding the appropriate response, we recommended consideration of a number of factors: the seriousness of the breach; the fact that arrest is to be a last resort; and the person's age or any cognitive or mental health impairment.[68]

6.47 Consequently, a police officer could, taking into account a person's cognitive or mental health impairment and an apparently trivial breach of a conduct requirement, decide simply to take no further action or issue the person with a warning, rather than arresting the person so that he or she would have to appear before a court.

6.48 In Consultation Paper 11 (CP 11),[69] we asked whether the *Bail Act* should require a court to take account of age, cognitive or mental impairments and/or the nature of the breach in relation to breach proceedings.[70] Every stakeholder who expressed a view on this question, except the NSW Police Force, supported such a move.[71] Although the above recommendation does not explicitly require consideration of age, cognitive impairment or mental health impairment, the broader decision making framework we recommend would effectively require a court to take these matters into account. In particular, where a court determines that a breach is significant enough to exercise its discretion to re-determine whether to release or detain, this redetermination would be subject to the considerations set out earlier in this chapter, including the relevant "special groups" provision.

Definitions and terminology

6.49 As discussed in further detail in Chapter 5, the current *Bail Act* uses a variety of terms. To ensure adequate coverage and terminological consistency, we recommend in that chapter, consistent with the proposals in our *Bail Report*, that the *Bail Act* use the terms "cognitive impairment" and "mental health impairment" and adopt standard definitions.[72]

"Special needs"

6.50 Section 32 of the *Bail Ac*t sets out the considerations including the need to consider the interests of the accused person, which include any "special needs" arising from a person's intellectual disability or mental illness.[73] "Special needs" is not currently

68. NSW Law Reform Commission, *Bail*, Report 133 (2012) Recommendation 15.2.
69. NSW Law Reform Commission, *Young People with Cognitive and Mental Health Impairments in the Criminal Justice System*, Consultation Paper 11 (2010).
70. NSW Law Reform Commission, *Young People with Cognitive and Mental Health Impairments in the Criminal Justice System*, Consultation Paper 11 (2010) Question 11.7.
71. In favour: Youth Justice Coalition, *Submission MH34*, 19; Department of Human Services NSW (Juvenile Justice), *Submission MH35*, 10; Department of Human Services NSW (Community Services), *Submission MH35*, 35-36; Law Society of NSW, *Submission MH36*, 7; Shopfront Youth Legal Centre, *Submission MH41*, 5; Children's Court of NSW, *Submission MH43*, 4. Against: NSW Police Force, *Submission MH42*, 6.
72. Recommendation 5.4.
73. *Bail Act 1978* (NSW) s 32(1)(b)(v).

defined in the *Bail Act*, and it provides no guidance on determining what those special needs might be.[74]

6.51 In CP 11 we asked whether the meaning of "special needs" needed to be clarified.[75] Some stakeholders submitted that it does,[76] while others were opposed to any change on the basis that it would be undesirable to restrict the discretion of any decision maker making a determination under the provision[77] and that any attempt at clarification would be counterproductive.[78]

6.52 As we noted in the *Bail Report*, submissions indicated that, despite of the considerations in s 32 requiring a focus on the interests of a person, including any special needs of members of certain groups, decision makers do not always appropriately take into account these defendants' particular circumstances.[79] A submission to the current review made the same observation.[80]

6.53 Our *Bail Report* takes a mixed approach to this issue. We have left the issue of the special needs of people with cognitive and mental health impairments undefined in Recommendations 10.7 and 15.2. However, Recommendation 11.2 lists particular concerns that would, in part, define the special needs and issues of people with cognitive and mental health impairments.

Bail support services

6.54 Chapter 7 of this report notes that one of the modes of support to people with cognitive and mental health impairments is case management, which can assist accused people to obtain bail and provide ongoing support while an accused person is on bail to help avoid breaches. As noted in Chapter 7, Australian jurisdictions have instituted bail support programs.[81]

6.55 Support services can aid people with cognitive and mental health impairments, assist defendants to secure bail, and also assist defendants to avoid breaching conduct requirements while released.

6.56 There is already extensive bail-related support available for young people. In particular, Juvenile Justice provides a bail supervision program for young offenders, which provides support for "young people who are experiencing difficulty in seeking bail either in the community or in custody".[82] Juvenile Justice also provides a Bail

74. The second reading speech to the *Bail Amendment (Repeat Offenders) Act 2002* (NSW) which introduced the "special needs" provision into s 32, provides no useful guidance on the meaning or scope of the term.
75. NSW Law Reform Commission, *Young People with Cognitive and Mental Health Impairments in the Criminal Justice System*, Consultation Paper 11 (2010) Question 11.4.
76. Department of Human Services NSW (Juvenile Justice) *Submission MH35*, 8; Public Interest Advocacy Centre, *Submission MH40*, 26; Shopfront Youth Legal Centre, *Submission MH41*, 4.
77. Children's Court of NSW, *Submission MH43*, 3; NSW Police Force, *Submission MH42*, 4.
78. NSW Police Force, *Submission MH42*, 4.
79. NSW Law Reform Commission, *Bail*, Report 133 (2012) [11.4].
80. Shopfront Youth Legal Centre, *Submission MH41*, 4.
81. Para 7.45.
82. NSW Department of Attorney General and Justice, *2010/11 Annual Report* (2011) 156.

Assistance Line after hours telephone service, which operates to provide police with support when considering whether to grant bail to a young person. One of the objectives of this service is to "provide services that are appropriate and sensitive to a young person's age, gender, cultural background and disability".[83]

6.57 As we noted in Chapter 2, the problem of homelessness is particularly significant for offenders with cognitive and mental health impairments.[84] Stakeholders identified lack of accommodation as a factor often leading to bail refusal for defendants with cognitive and mental health impairments. That said, we recommended the repeal of provisions in the *Bail Act* allowing bail to be granted on the condition that defendants reside in "accommodation for persons on bail", and requiring the provision of such places by the Minister for Corrective Services.[85] We made this recommendation on the basis that no funding has ever been allocated for the running of bail hostels, and no bail hostels have ever operated in NSW.

6.58 In general, we are of the view that an expansion of the Court Referral of Eligible Defendants into Treatment (CREDIT) service or an equivalent service would have the effect of connecting accused people with a case manager who could effectively provide bail support in many cases. Although such support would not necessarily overcome the problem of bail refusal in cases where the defendant lacked appropriate accommodation, a CREDIT case manager would be in a position to assist in linking a defendant with accommodation services.

6.59 The absence of appropriate accommodation, particularly accommodation requiring specialist staff, is likely to be an on-going problem, and is an area where it would be desirable to ensure adequate funding. As we commented in the *Bail Report:*

> The provision of bail support to assist adults to meet residence requirements or other conduct requirements may be an effective means of avoiding costly and unnecessary detention. This is an area where involvement of the non-government sector could be valuable. It is not appropriate for the legislation to stipulate how or by whom accommodation and other bail support needs are to be met but we do consider further investigation of bail support services would be useful.[86]

6.60 Similarly, although we recommend the expansion of the CREDIT court support service,[87] specifying how accommodation services should be delivered is beyond our Terms of Reference. Nevertheless, we reiterate that we believe that further investigation of bail support services, particularly those directed towards assisting people with cognitive and mental health impairments, would be desirable.

6.61 Finally, in our *Bail Report*, we have recommended trialling a bail reminder service to assist defendants to avoid breaching their bail by forgetting and failing to appear in court. Such a program could help to overcome the problem of inadvertent non-appearance by defendants.[88] It would potentially assist defendants with cognitive or

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83. Juvenile Justice, *Bail Assistance Line* <www.djj.nsw.gov.au/bail_assistance_line.htm>.
84. Para 2.14.
85. *Bail Act 1978* (NSW) s 36(2)(a1), s 36 (2B).
86. NSW Law Reform Commission, *Bail*, Report 133 (2012) [13.12].
87. Recommendation 7.4.
88. NSW Law Reform Commission, *Bail*, Report 133 (2012) Recommendation 10.5.

mental health impairments who are at risk of failing to appear due to difficulties in managing their daily affairs and keeping track of such information.

Bail and diversion

6.62 This section considers the concept of diversion within the context of bail law, and examines practical issues related to the operation of bail diversion alongside other diversionary mechanisms, particularly those in the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA).

6.63 Many of the court intervention programs in Australia operate through the use of bail conditions to regulate the conduct of an accused person and to allow the court to monitor his or her progress in treatment or rehabilitation programs. As noted in Chapter 7, some of these programs specifically target accused offenders with mental health impairments, while some apply more broadly to people with complex needs.[89] These programs use a variety of bail conditions, including conditions requiring reporting to a court liaison service officer, drug and alcohol testing, attendance at rehabilitation programs, drug and alcohol counselling or other appointments, or obeying reasonable directions of a liaison service or bail support officer.[90]

6.64 In considering the relationship between bail and diversion programs as they operate in other jurisdictions, Cunneen and Allison have noted a "common set of characteristics" that represent a shift away from the traditional function of bail as a mechanism to ensure that an alleged offender attends court to answer charges and commits no further offences while released.[91] Instead, these programs "generally seek to assist the offender with underlying factors contributing to offending behaviour and thus to provide an opportunity for rehabilitation during the bail period".[92]

6.65 One key reason for the increase in the use of bail diversion in Australia is a belief that such schemes will assist offenders and prevent reoffending. For example, an evaluation of the Victorian Court Integrated Services Program (CISP) found that Victorian magistrates saw the bail process as a "window of opportunity", in which "defendants with drug problems were highly motivated to deal with their problems".[93] However, the lack of drug treatment services to which magistrates could refer defendants could mean that continuing drug use made them unsuitable to participate in the CISP program. Consequently, such defendants would be more likely to be remanded in custody where "they were unlikely to receive any effective

89. Para 7.17.

90. See, eg, M Hill, "Hobart Magistrates Court's Mental Health Diversion List" (2009) 18 *Journal of Judicial Administration* 178, 180. See also E Newitt and V Stojcevski, *Mental Health Diversion List: Evaluation Report* (Magistrates Court Tasmania, 2009) 89. Also Law Reform Commission of Western Australia, *Court Intervention Programs*, Consultation Paper, Project No 96 (2008) 106.

91. C Cunneen and F Allison, *Indigenous Bail Diversion: Program Options For Indigenous Offenders in Victoria, Report Compiled for the Department of Justice (Victoria)* (2009) 18.

92. C Cunneen and F Allison, *Indigenous Bail Diversion: Program Options for Indigenous Offenders in Victoria, Report Compiled for the Department of Justice (Victoria)* (2009) 18.

93. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (2009) 106.

treatment".[94] Although this point is made in relation to accused persons requiring drug rehabilitation, it has wider relevance. Of particular relevance in relation to defendants with cognitive and mental health impairments, is the importance of utilising the "window of opportunity" that the bail process provides for diverting them into treatment or rehabilitation. If a person is remanded in custody, there is a greater likelihood that he or she will no longer have the ability to access appropriate treatment or rehabilitation options.

Therapeutic/treatment conditions

6.66 In NSW, the *Bail Act* contains provisions which allow the use of bail as a diversionary tool. As noted above, in the *Bail Report* we recommended the retention of an express therapeutic provision, which would allow courts to impose conduct directions relating to participation in treatment and rehabilitation programs where it would be of benefit to an accused person. We indicated that although the capacity to impose such a condition may exist by implication, we included an explicit provision to put the matter beyond doubt.[95] This power currently allows the Magistrates Early Referral Into Treatment (MERIT) drug and alcohol treatment scheme to operate,[96] and we expressed the view that "courts should have the capacity to facilitate participation in treatment and rehabilitation, whenever it appears to the court that this would be of benefit for the charged person or the broader community".[97] These wider benefits justify the inclusion of a provision that would otherwise fall outside the scope of the bail framework we proposed in the *Bail Report.*

6.67 We also recommended that any such conduct direction should only be imposed with the consent of the accused person.[98] An assessment or a treatment or rehabilitation program is unlikely to be successful without the person's consent. Moreover, a person who does not participate voluntarily is unlikely to be accepted into such a program and a court is unlikely to make such a direction without the person's agreement.[99] However, we have noted that in most cases:

> consent would be given due to the benefits at the sentencing stage of successful participation in the program. The issue of consent may therefore be more theoretical than real.[100]

Bail and s 32 diversion in NSW

6.68 The widespread use of bail conditions as a diversionary mechanism in other jurisdictions can perhaps be explained by the fact that none of the other Australian states or territories has an equivalent of the MHFPA diversion provisions. In NSW, magistrates can impose therapeutic bail conditions with a diversionary aim under

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94. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (2009) 107.
95. NSW Law Reform Commission, *Bail*, Report 133 (2012) [13.27].
96. NSW Law Reform Commission, *Bail*, Report 133 (2012) [13.26].
97. NSW Law Reform Commission, *Bail*, Report 133 (2012) [13.27].
98. NSW Law Reform Commission, *Bail*, Report 133 (2012) Recommendation 13.4(2)(c).
99. NSW Law Reform Commission, *Bail*, Report 133 (2012) [13.32].
100. NSW Law Reform Commission, *Bail*, Report 133 (2012) [13.32].

s 36A of the *Bail Act*, or they can make orders under s 32 of the MHFPA. Alternatively, bail orders can be used facilitate or support a s 32 order.

6.69 The principal provision enabling the diversion of people with mental illness and intellectual disabilities in NSW is s 32 of the MHFPA. Section 32 is discussed in detail in Chapter 9 but, in short, it allows a magistrate to take certain actions where an accused person is either "developmentally disabled" or has a mental illness, where it would be "more appropriate" to deal with a person using one of the options below, rather than otherwise in accordance with the law.[101] The options available are to:

- adjourn the proceedings
- grant the defendant bail in accordance with the *Bail Act*, or
- make any other order that the magistrate considers appropriate, including an order dismissing the charge, and discharging the defendant.

An order dismissing the charge can be made unconditionally, or conditionally, including on the condition "that the defendant attend on a person or at a place specified by the Magistrate for assessment of the defendant's mental condition or treatment or both".[102]

6.70 As the law currently operates, there are some situations in which a magistrate would not be able to apply s 32 diversion, but might nevertheless want to refer a person to a diversionary scheme or program for assessment or treatment/rehabilitation. In particular, s 32 restricts eligibility to a person who is either developmentally disabled, or suffering from mental illness, or suffering from a mental condition for which treatment is available in a mental health facility.[103] Consequently, it might exclude an accused person with an ABI or other cognitive impairment that does not fit within the scope of "developmentally disabled". In such a case, it may be necessary to employ the therapeutic provisions of the *Bail Act* to divert a person with a cognitive impairment, such an intellectual disability or acquired brain injury (ABI), to a treatment or rehabilitation program, rather than employing s 32 of the MHFPA. Our recommendations in Chapter 3 would overcome these inconsistencies by ensuring that s 32 has adequate scope to deal with all people with cognitive and mental health impairments and providing there is uniformity in the definitions used in s 32 of the MHFPA and the *Bail Act*.

Bail and diversion under our proposed new diversionary framework

6.71 Our proposed changes to s 32 of the MHFPA are intended to increase the use of the diversionary powers available to magistrates.

6.72 As part of the revised framework we recommend that the court retain its powers to make interlocutory orders, including for the purpose of adjourning in order to enable the defendant to undergo assessment or to develop a diversion plan. We

101. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 32(1)(b).
102. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 32(3)(b).
103. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 32(1)(a).

specifically recommend that the "court's power to make any orders as to bail should be preserved".[104]

6.73 While the case remains in court awaiting finalisation, bail law applies. Bail conditions or conduct requirements may be imposed for reasons set out in the *Bail Act* to deal with issues such as risk of failure to attend, or the commission of serious offences while released. Such bail requirements are not therapeutic and there is no overlap with s 32 of the MHFPA.

6.74 The preservation of bail law under s 32 of the MHFPA, however, also preserves the power to make therapeutic treatment and intervention orders under the current, or a reformed, s 36A of the *Bail Act*. We do not recommend the displacement of s 36A of the *Bail Act* in cases covered by s 32. There may be cases where s 36A might be useful. However, in our view this would be unusual. Section 32 should provide a sufficient framework for diversion to services. This section provides the best framework for diversionary orders for people with cognitive and mental health impairments.

6.75 Moreover, it is generally speaking undesirable to impose compliance with diversion plans as a requirement of bail. Such a conduct requirement invokes the police power of arrest for breach, and the requirement on the court to review bail on breach. This would generally be inconsistent with the purpose of a s 32 diversionary order to keep people out of the criminal justice system. In our view, it should be sufficient to consider compliance with a diversion plan on report back to the court when finalising the charge and considering the possibility of discharge.

Bail and s 33 diversion in NSW

Problems with s 33 and bail orders made in conjunction

6.76 In general, most diversion decisions will occur under s 32 of the MHFPA and the therapeutic conditions provisions of the *Bail Act*. However where, at any time during the course of a hearing, it appears to the magistrate that the accused is a mentally ill person, s 33 of the MHFPA can apply to divert a person to a mental health facility for assessment, or to discharge a person into the care of a responsible person. Section 33(1)(b) also allows a magistrate to make an order that if, following an assessment, the person is found not to be mentally ill, that the person be brought back to court. A mentally ill person is defined in the *Mental Health Act 2007* (NSW).[105]

6.77 Section 33(1) states that a magistrate may make an order in relation to a mentally ill defendant:

> without derogating from any other order the Magistrate may make in relation to the defendant, whether by way of adjournment, the granting of bail in accordance with the *Bail Act 1978* or otherwise.

104. Recommendation 9.3(2).

105. *Mental Health Act 2007* (NSW) s 15. For a full discussion see para 10.4.

6.78 The Local Court submitted that a problem arises from the terms of s 33(1), particularly because that section states that a magistrate can make an order under s 33 "without derogating from any other order the Magistrate may make in relation to…the granting of bail in accordance with the *Bail Act 1978* or otherwise". This might "create the erroneous impression that the magistrate should consider bail at the time of a s 33 application".[106]

6.79 The Local Court Bench Book directs that bail should not be considered in conjunction with a s 33 order for assessment because "police/hospital protocols do not allow admission if bail is refused".[107] However, according to the Local Court submission, bail is "on occasion" considered at the same time as a s 33 order. As the submission explains:

> The result of bail being refused where an accused is to be taken to a mental health facility is that the person is effectively 'in custody' and should be guarded by the police or Corrective Services for the period of time he or she is at the mental health facility (if admitted). The practical effect in such instances is for the accused to be refused admission to the facility, as police/hospital protocols do not allow admission if bail is refused.[108]

The problem is, therefore, that the s 33 order for assessment cannot be effectively carried out in the event that a person is refused bail.

6.80 In 2003 s 33(1D) was inserted to clarify that an order for assessment under s 33 could be made in the context of bail proceedings. The second reading speech to that amendment stated that:

> when a person appears before the court in relation to charges that may be triable summarily and who appears to be mentally ill, the court may order that the person be taken to a hospital for assessment. If, at the hospital, the person is not found to be mentally ill under the Mental Health Act 1990, the person is immediately brought back before the court and a bail determination is then made.[109]

6.81 It appears that the process envisaged here involves the person being taken to hospital *before* any bail determination occurs. It is only after the person is returned to court when they have been assessed not to be mentally ill, that a bail determination is made. It could be assumed that a similar process should be applied to orders made under s 33(1).

Recommendation 6.1

Section 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that if an order is made under that section directing a person be taken to a mental health facility for assessment, a bail determination is not to be made unless the person is brought back to court following assessment.

106. Local Court of NSW, *Submission MH4*, 14.
107. Judicial Commission of NSW, *Local Court Bench Book* (at April 2012) [35-120].
108. Local Court of NSW, *Submission MH4*, 14.
109. NSW, *Parliamentary Debates*, Legislative Council, 25 June 2003, 2042 (John Hatzistergos).

7. Justice system assessment and support services

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7.1 This chapter explores court based services that provide identification, assessment and support for people with cognitive and mental health impairments in the criminal justice system. We consider what needs to be done to identify defendants who have cognitive and mental health impairments that affect their offending behaviour. We further consider what needs to be done, where courts divert offenders, to make that diversion effective. We do this by:

- exploring current approaches to justice system assessment and support in Australia
- considering whether the current approach to assessment and support services in NSW is satisfactory, and
- proposing improvements to the current system of assessment and support services in NSW.

The importance of identification, assessment and support services for NSW courts

7.2 As we discuss in Chapter 4, the evidence indicates that there are high rates of people with cognitive and mental health impairments in the criminal justice system. If the justice system is to respond in a fair and just way to people who have cognitive and mental health impairments, it is necessary that people in this category are first identified. Unless identification occurs, the responses of the criminal justice system outlined in this report are redundant.

7.3 Once a person's cognitive or mental health impairment is identified, assessment of the nature of that impairment and other needs will generally be important in order to deal appropriately with the defendant. While an impairment will not necessarily lead to offending behaviour, in some cases it will have such an effect, either directly or indirectly.[1] Assessment of an impairment may be required to decide whether the defendant is fit for trial in the first instance, as well as in relation to issues of criminal responsibility. These matters will be dealt with in our second report on people with cognitive and mental health impairments in the criminal justice system. Assessment may also be important in order to decide whether diversion is appropriate, how bail should be framed or what sentence should be imposed.

7.4 Where diversion appears to provide the best option for preventing further offending courts need to ensure that the person is directed to the right services, and that connection to services is maintained. If the connection to services is ineffective, the rehabilitative effect of a diversionary order may be lost and the court's order may not address the problem of the "revolving door from street to cell to courtroom".[2]

Identifying people with cognitive and mental health impairments

7.5 Failure to identify an impairment means that a person's eligibility for diversion cannot be raised, and connection or referral to essential supports or services is not arranged.[3] It can also lead to delays in accessing essential community-based services[4] that may be the key to preventing offending. Yet, the burden of identification and management of people with cognitive and mental health impairment in the criminal justice system largely falls on people who do not have the required skills or expertise.[5] Magistrates, lawyers, police officers and others who routinely deal with defendants are unlikely to have the training required to identify

1. The relationship between impairments and offending is addressed in Chapter 2.
2. U Castellano, "Courting Compliance: Case Managers as 'Double Agents' in the Mental Health Court" (2011) 36(2) *Law and Social Inquiry* 484, 485. We discuss s 32 in Chapter 9.
3. M Karras and others, *On the Edge of Justice: The Legal Needs of People with a Mental Illness in NSW* (Law and Justice Foundation of NSW, 2006) 113-114, 124; 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) 60 (*Enabling Justice*).
4. T Exworthy and J Parrot, "Comparative Evaluation of a Diversion from Custody Scheme" (1997) 8(2) *The Journal of Forensic Psychiatry* 406, 407.
5. NSW Health, *Submission MH15*, 6.

cognitive and mental health impairments.[6] Individuals are more likely to be identified when they exhibit clear signs of impairment or have a known history. Quiet or withdrawn defendants without manifest indicators may be less likely to be identified and referred.[7]

7.6 The Law Society of NSW noted that, in practice, it is often the defendant's legal representative that becomes responsible for identifying a cognitive or mental health impairment, but that legal representative may not have the knowledge or skills to do so. As a result, the defendant's trajectory through the criminal justice system may ultimately depend on the expertise of the practitioner or whether they are able to retain legal representation at all.[8] The Shopfront Youth Legal Centre highlighted that some potentially eligible defendants miss out on diversion "due to lack of resources for assessments and treatment plans".[9]

7.7 Even where particular impairments are identified, many people have complex problems with the consequence that coexisting impairments or needs may be overlooked, or potential intervention options may be unclear.[10] The difficulty of identifying particular impairments was addressed in several submissions to this inquiry.[11] For example, the Brain Injury Association of NSW noted that diagnosis of cognitive impairments such as acquired brain injury (ABI) requires specific expertise.[12]

Diversion, complex needs and case management support

7.8 Diversion can facilitate connection with services that deal with the direct and indirect causes of a defendant's offending behaviour. If connection with services does not occur, the defendant may reoffend and be required to return to court.

7.9 Making the connections between defendants and services may be difficult, for a number of reasons. First, the problems presented by some defendants are complex. The Law Reform Commission of Western Australian has noted that people with mental health impairments "commonly present to court with coexisting problems such as homelessness, lack of employment, poor social or interpersonal skills … and social exclusion".[13] These problems can compound, making the person more

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6. M Karras and others, *On the Edge of Justice: The Legal Needs of People with a Mental Illness in NSW* (Law and Justice Foundation of NSW, 2006) 113-114.
7. J Shaw and others, "Prevalence and Detection of Serious Psychiatric Disorder in Defendants Attending Court" (1999) 353 *Lancet* 1053, 1056; Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28-1*, 11.
8. Law Society of NSW, *Submission MH13*, 48.
9. Shopfront Youth Legal Centre, *Submission MH7*, 11.
10. See, eg, S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 101; Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28-1*, 11.
11. Brain Injury Association of NSW, *Submission MH19*, 20; Corrective Services NSW, *Submission MH17*, 5, 27.
12. Brain Injury Association of NSW, *Submission MH19*, 20. See N Rushworth, *Policy Paper: Out of Sight, Out of Mind: People with Acquired Brain Injury and the Criminal Justice System* (Brain Injury Australia, 2011).
13. Law Reform Commission of Western Australia, *Court Intervention Programs: Consultation Paper*, Project No 96 (2008) 96.

likely to come into contact with the criminal justice system,[14] and are likely to present complex challenges in terms of linking those individuals with appropriate rehabilitative services.

7.10 Secondly, those who work in the criminal justice system are not likely to be expert in these complex service systems. For example, one submission noted that "lawyers had extremely limited capacity to negotiate essential services for their clients beyond the legal matters at hand, even though the lack of services such as housing, medical and employment support often adversely impacted upon the outcomes achieved by those clients".[15] Similarly, the *Enabling Justice* report noted that lawyers may encounter difficulties preparing treatment plans and linking clients to services.[16] Legal Aid NSW's review of their Client and Assessment and Support Unit noted that "[m]any solicitors consulted for this review from all practice areas expressed the need for a more accessible referral and support service to assist with clients with a mental illness, developmental disability or brain injury".[17] The review recommended the establishment of an advocate/consultant position for Legal Aid clients suffering from mental illness, developmental disability or brain injury who are in need of support and direct advocacy to link them to services, "which ultimately will assist the client with achieving the legal outcome for which Legal Aid has been granted".[18]

7.11 Some individuals who are diverted do not make connections to services or, if they do, do not maintain them. This may make them vulnerable to a cycle of offending, treatment and relapse, especially if services are not adequate or are not appropriately coordinated. One case worker reported:

> I am aware of a number of offenders with disabilities who become part of a revolving door scenario. They are usually well known to both police and prison staff. They are usually picked up for minor offences … and put back into custody. This typically occurs as a result of inadequate services in the community to manage these individuals.[19]

7.12 If those in the criminal justice system lack expertise in the service system for people with cognitive and mental health impairments, similarly, community service providers may not be familiar with criminal justice system processes:

> A lack of understanding of the criminal justice system among many primary [Ageing, Disability and Home Care] community support staff was identified by stakeholders as a hindrance to the efficiency of the case plan process. Support workers often did not know what was appropriate to include or omit from a report, and what would be in the interests of the client. Moreover, requests by a representative of the client to adjust a plan were often met with reluctance.

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14. Law Reform Commission of Western Australia, *Court Intervention Programs: Consultation Paper*, Project No 96 (2008) 96.
15. Public Interest Advocacy Centre, *Submission MH21*, 3.
16. *Enabling Justice*, 60.
17. Legal Aid NSW, *Client Assessment and Referral (CAR) Review* (2008) 32.
18. Legal Aid NSW, *Client Assessment and Referral (CAR) Review* (2008) 32, Recommendation 10.
19. Personal communication from V Johnson quoted in N Rushworth, *Policy Paper: Out of Sight, Out of Mind: People with Acquired Brain Injury and the Criminal Justice System* (Brain Injury Australia, 2011) 14.

> Delayed court reports or case plans were often said to be a result of poor administration and high turnover of support worker staff.[20]

7.13 An important factor in successful diversion appears to lie in the provision of a "bridge" between the criminal justice system and the service sectors. "Bridges" are often specialist case workers attached to courts, who can translate the needs of the criminal justice system to the service sector, and the needs of the service sector to the court. For example, one report noted "significant positive feedback" where specialist forensic caseworkers provided direct assistance to primary support workers when dealing with people with cognitive impairments in the criminal justice system.[21]

7.14 Stakeholders responding to this inquiry emphasised the importance of good case management support during legal proceedings.[22] One of the identified benefits of case management was the capacity of case managers to provide the court with independent information regarding a defendant's issues or problems in an efficient way. This addressed magistrates' concerns that they were frequently asked to take into account "complex clinical, social or personal issues" without the time or expertise to deal with such issues directly.[23] Support and case management can be a useful way of providing information to magistrates regarding available services. It has been noted that guidance regarding which services are most appropriate "generally improves the court's timeliness and efficiency in [organising] a therapeutic response". It also helps defendants stay "on track" and provides magistrates with feedback regarding their progress.[24]

7.15 One reason for the development of the Statewide Community and Court Liaison Service (SCCLS) in NSW (described in detail below)[25] was the difficulty encountered by magistrates when attempting to divert people from the criminal justice system (for example where mental health facilities refused to admit defendants referred to them by courts). [26]

7.16 Factors central to the successful diversion of people with cognitive and mental health impairments include:

- identification of those persons with impairments
- assessment of their impairments
- case management to connect defendants effectively with appropriate services and to maintain those connections, and
- a "bridge" between the criminal justice system and the service sectors.

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20. *Enabling Justice*, 47.
21. *Enabling Justice*, 47.
22. NSW Public Guardian, *Submission MH26*, 24-25.
23. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 100-101.
24. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 101.
25. Para 7.31-7.42.
26. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 6.

Court assessment and support services: an overview

7.17 Justice system assessment and support schemes perform a variety of functions, but are usually geared towards the provision of services in relation to particular vulnerable groups who may be disproportionately represented in the criminal justice system.[27] There is significant variation in terms of their operational structure and functions.[28] Their ambit is not confined to people with cognitive and mental health impairment, although that is our focus in this chapter.

7.18 Court support can help ensure that "specific resources and expertise" are available to under-serviced groups to assist with the management of complex or serious problems.[29] For example, some assessment and support services were created in direct response to the high number and proportion of people with mental illness encountering the criminal justice system.[30]

7.19 Some services emphasise dealing with a defendant holistically. They emphasise that factors such as accommodation, substance abuse, family, education and employment may appear to be tangential to mental health impairment but "contribute to a person's offending behaviour and addressing these may be more important than mental health treatment in achieving the desired outcome of preventing reoffending".[31]

7.20 The characteristics of assessment and support staff also vary. Many staff are qualified professionals, but others may be volunteers who are trained to become familiar with court processes and terminology, and who "approach people from an essentially non-legal and non-aligned judicial or police perspective".[32]

7.21 One critical function of these services is to know and understand the language, culture, and methods of operation of both systems, and to provide "translation" between systems that may have very different terminology, approaches and understandings. As one court support professional described it:

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27. See, eg, Community Restorative Centre Inc, *Annual Report 2006-2007*, 17; Community Restorative Centre Inc. *Annual Report 2009-2010*, 29.
28. Nacro, *Liaison and Diversion for Mentally Disordered Offenders: A Mental Health Good Practice Guide* (2006) 5; S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (University of Melbourne, 2009) 5; Magistrates Court of Victoria, *Guide to Court Support and Diversion Services* (2011) 2; Community Restorative Centre Inc, *Annual Report 2006-2007*, 17; L Schetzer and J Henderson, *Access to Justice and Legal Needs - A Project to Identify Legal Needs, Pathways and Barriers for Disadvantaged People, Stage 1: Public Consultations* (Law and Justice Foundation of NSW, 2003) [3.103]; Magistrates Court of Victoria, *Guide to Court Support and Diversion Services* (2011) 6, 8.
29. D Greenberg and B Nielsen, "Moving Towards a Statewide Approach to Court Diversion Services in NSW" (2003) 14(11-12) *NSW Public Health Bulletin* 227, 228.
30. K Sly and others, "Court Outcomes for Clients Referred to a Community Mental Health Court Liaison Service" (2009) 32(2) *International Journal of Law and Psychiatry* 92, 93; D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 2.
31. Law Reform Commission of Western Australia, *Court Intervention Programs*, Final Report, Project No 96 (2009) 75; Law Reform Commission of Western Australia, *Court Intervention Programs*, Consultation Paper, Project No 96 (2008) 108.
32. Community Restorative Centre Inc, *Annual Report 2006-2007*, 17.

> We ride the fence. We're in this social work field, but we understand how the criminal justice system works. To ride that fence [means] to have that respect in the clinical field but also have it in criminal justice.[33]

7.22 Justice system assessment and support services for people with cognitive and mental health impairments can:

- identify and assess people with cognitive and mental health impairments to facilitate diversion[34]
- manage people with cognitive and mental health impairments that encounter the criminal justice system and link them with services and treatment in the community, and[35]
- reduce reoffending, where it is closely linked to a cognitive or mental health impairment.[36]

7.23 There is a close relationship between support services and diversion.[37] As noted above, if diversion is to be effective, defendants need to be connected with services that address their offending behaviour, directly or indirectly. Court intervention programs (discussed below),[38] in particular, may involve the development of strong collaboration between support services and judicial officers:

> Court intervention programs are programs that use the authority of the court in partnership with other agencies to address the underlying causes of offending behaviour and encourage rehabilitation.[39]

7.24 However, while support services and diversion are not mutually exclusive, each can exist independently of the other. This means that a person can be provided with

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33. J Evans (treatment supervisor, Boone Municipal Mental Health Court, United States) quoted in U Castellano, "Courting Compliance: Case Managers as 'Double Agents' in the Mental Health Court" (2011) 36(2) *Law and Social Inquiry* 484, 484.
34. K Sly and others, "Court Outcomes for Clients Referred to a Community Mental Health Court Liaison Service" (2009) 32(2) *International Journal of Law and Psychiatry* 92-93; D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 2; Nacro, *Liaison and Diversion for Mentally Disordered Offenders: A Mental Health Good Practice Guide* (2006) 5.
35. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 2; L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 1, 3.
36. K Sly and others, "Court Outcomes for Clients Referred to a Community Mental Health Court Liaison Service" (2009) 32(2) *International Journal of Law and Psychiatry* 92-93; D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 3; Law Reform Commission of Western Australia, *Court Intervention Programs*, Final Report, Project No 96 (2009) 75. See also F Pakes and J Winstone, "Effective Practice in Mental Health Diversion and Liaison" (2009) 48(2) *The Howard Journal of Criminal Justice* 161-162; Nacro, *Liaison and Diversion for Mentally Disordered Offenders: A Mental Health Good Practice Guide* (2006) 53.
37. D Greenberg and B Nielsen, "Moving Towards a Statewide Approach to Court Diversion Services in NSW" (2003) 14(11-12) *NSW Public Health Bulletin* 227, 228.
38. See para 7.26.
39. Law Reform Commission of Western Australia, *Court Intervention Programs*, Final Report, Project No 96 (2009) 5.

various supports without being "diverted", and that diversion can occur in the absence of supports.[40]

Current Australian models of assessment and court support

7.25 As noted above, there are countless variations in approaches to court assessment and support services. Creating a typology of court-based assessment and support services is challenging because of the variety of different approaches. Additionally, some programs are structurally fluid in order to respond to various internal and external pressures.[41]

7.26 In this section we consider different approaches to assessment and court support that are available for defendants with cognitive and mental health impairments within Australia. For the purposes of our analysis, we have grouped these approaches into three categories:

(1) **Assessment and Advice:** Under this model court support personnel (who are generally mental health professionals) undertake clinical assessments in order to determine whether an individual has an impairment. Based on these assessments, support personnel are able to provide feedback to courts to support their ability to make effective and well-informed decisions regarding the best outcome for the individual.[42]

(2) **Case Management:** The case management model is one that addresses complex needs and provides a coordinated, multi-disciplinary team-based approach to assessment and referral of clients to services. This could include linking people to a range of support services such as drug and alcohol treatment, accommodation and health facilities as well as providing ongoing case management and support.[43] Additionally, these programs may help particular vulnerable groups access bail and assist them with bail compliance.[44] Case managers can provide the court with information about the individual. This information can extend to assessment of the individual's impairment or circumstances, as well as their progress or engagement in requisite services. This feedback may assist the court to make appropriate decisions.

(3) **Court Intervention Model:** This model involves the closest collaboration between the criminal justice system and court support staff. Generally, a dedicated court intervention team works with a specialist judicial officer to

40. The benefits and disadvantages of diversion are discussed in Chapter 3.
41. Australian Institute of Criminology, *Court-based Mental Health Diversion Programs*, Research in Practice Tipsheet No 20 (2011) 2.
42. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 2-3, 7-8; Magistrates Court of Victoria, *Guide to Court Support and Diversion Services* (2011) 21.
43. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 3; Magistrates Court of Victoria, *Guide to Court Support and Diversion Services* (2011) 5.
44. Para 6.54-6.61.

connect the defendant with relevant services and to manage the defendant's engagement with those services with the aim of preventing future offending.[45]

7.27 These models have several characteristics in common. All of the models:

- provide services to individuals with cognitive and/or mental health impairments, either primarily or together with other groups
- have multiple referral pathways (accept referrals from a number of sources) such as legal practitioners, magistrates, corrective services staff, police, case workers, court officers, family members and the defendant[46]
- provide a gateway from the criminal justice system into other service sectors, and
- provide advice and information to the court.

Table 7.1 presents an overview of the operation of each of these approaches.

7.28 In Australia, many states offer court support services in these various forms. However, there are no court intervention programs that specifically target people with cognitive and mental health impairments in NSW.[47] We discuss the benefits of this approach in Chapter 11. Australian jurisdictions that do offer a specialist cognitive or mental health court intervention model have only made it available as a trial in one or two locations.[48] It is worthwhile noting, however, that the South Australian Magistrate's Court Diversion Program operates in the Adelaide Magistrates Court on a weekly basis, and at nine further locations on monthly or bi-monthly basis, including regional locations.[49] The NSW Drug Court, discussed in Chapter 13 may also deal with people with cognitive and mental health impairments, where there are coexisting substance abuse issues.[50]

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45. Law Reform Commission of Western Australia, *Court Intervention Programs*, Consultation Paper, Project No 96 (2008) 5.
46. See D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 7; NSW Health Hunter New England, *'Court Liaison' Navigators Guide for Family and Friends* (2008); L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 4; Magistrates Court of Victoria, *Guide to Court Support and Diversion Services* (2011) 2, 7; I Bartkowiak-Thèron and J Flemming, *Integration and Collaboration: Building Capacity and Engagement for the Provision of Criminal Justice Services to Tasmania's Mentally Ill, Final Report* (Tasmanian Institute of Law Enforcement Studies, 2011) 7; SA, Courts Administration Authority, *Magistrates Court, Court Diversion Program* <www.courts.sa.gov.au/courts/magistrates/index.html>.
47. Note that some Drug Court clients may have coexisting substance abuse issues and impairments.
48. See, eg, Magistrates Court of Victoria*, Guide to Court Support and Diversion Services* (2011) 2; I Bartkowiak-Thèron and J Flemming, *Integration and Collaboration: Building Capacity and Engagement for the Provision of Criminal Justice Services to Tasmania's Mentally Ill, Final Report* (Tasmanian Institute of Law Enforcement Studies, 2011) 6.
49. Courts Administration Authority (SA), *Magistrates Court Diversion Program*, <www.courts.sa.gov.au/courts/magistrates/court_diversion.html>.
50. See eg, K Freeman, *New South Wales Drug Court Evaluation: Health, Well-being and Participant Satisfaction* (NSW Bureau of Crime Statistics and Research, 2002) 15.

Table 7.1: Comparison of current models of assessment and support services

	Focus	Feedback/advice to the court	Case management following referral	Conditional	Judicial monitoring	Diversionary
Assessment and Advice	Cognitive or mental health impairments	Yes	No	No	No	Sometimes
Case Management	Complex needs	Yes	Yes	Sometimes	Sometimes	Generally
Court Intervention Model	Cognitive or mental health impairments	Yes	Yes	Yes	Yes	Generally

7.29 Other types of support services are available but are not addressed in detail here, such as, support services or programs that:

- target substance abuse (for example, Magistrates Early Referral Into Treatment, Drug Court)[51]
- support victims of crime (for example, Women's Domestic Violence Court Advocacy Program), and[52]
- assist young people (for example, Adolescent Court and Community Team).[53]

Additionally, non-government organisations provide assistance to and support for people with cognitive and mental health impairments in the criminal justice system. These organisations can play a role in enhancing the prospects of diversion by providing support in a number of areas.[54]

7.30 Furthermore, there are case management and support services that sit outside criminal justice system processes, yet target individuals who have, or are at risk of, encountering the criminal justice system. For example, the Multiple and Complex Needs Initiative in Victoria targets individuals with complex needs who present a serious risk of harm to themselves or others, who are in need of intensive support and supervision and who would benefit from receipt of coordinated services.[55] The program:

51. Attorney General and Justice, *Magistrates Early Referral Into Treatment* (28 July 2011) <www.lawlink.nsw.gov.au/merit>.
52. Legal Aid NSW, *Women's Domestic Violence Court Advocacy Program* (20 February 2012) <www.legalaid.nsw.gov.au/what-we-do/community-partnerships/womens-domestic-violence-court-advocacy-program>.
53. Para 14.65-14.69.
54. D Greenberg and B Nielsen, *Court Liaison and the Role of Non-government Organisations* (Mental Health Coordinating Council, 2003) 3. Services such as the Criminal Justice Support Network provided by the Intellectual Disability Rights Service support people with an intellectual disability in understanding criminal justice processes.
55. Victoria, Department of Human Services, *Multiple and Complex Needs Initiative* (2004) <hwww.dhs.vic.gov.au/__data/assets/pdf_file/0003/611508/macni_information_flier.pdf>.

> arose as a result of a history of concerns raised by a range of stakeholders, including service providers, the Police, Courts, and advocacy groups. It was considered that the government was delivering poor service outcomes for a small but significant group of individuals with complex needs that challenged existing policy and legislative frameworks.[56]

Similarly, in NSW the Integrated Services Program (administered by Ageing, Disability and Home Care, NSW Health and Housing NSW) coordinates cross-agency response for a small group of individuals identified as having complex needs and exhibiting challenging behaviours.[57]

SCCLS: assessment and advice

7.31 In NSW the SCCLS and the Court Liaison Service in Newcastle (Newcastle CLS) provide assessment and advice services to magistrates.[58] However, the Newcastle service has some characteristics of a case management model, since it provides some case management support and there can be judicial monitoring through adjournments and the imposition of bail conditions.[59]

7.32 Although the SCCLS in NSW provides some assistance where it can, there is no dedicated assessment and advice service for people with cognitive impairment in NSW and there are limited examples in other jurisdictions.[60] However, we note that the Queensland Department of Justice and Attorney-General has made a commitment to conduct a trial by 2014 "at selected Magistrates Courts to identify people with intellectual, cognitive or mental health impairments and link these people to any appropriate and available support services".[61]

Objectives

7.33 The SCCLS conducts screening and assessment of individuals with mental illness, generally for the purpose of providing information to the court to assist decision making particularly in relation to diversion from the criminal justice system into

56. Victoria, Department of Human Services, *Development of the Multiple and Complex Needs Initiative* <www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/projects-and-initiatives/cross-departmental-projects-and-initiatives/multiple-and-complex-needs-initiative/development-of-the-multiple-and-complex-needs-initiative>.
57. S McDermott and others, *Evaluation of the Integrated Services Project for Clients with Challenging Behaviours: Final Report* (Social Policy Research Centre, 2010).
58. NSW Health, *Court liaison* (2008) 1. Similar approaches are adopted by many other jurisdictions in Australia: J Ogloff, M Davis, G Rivers, S Ross, *The Identification of Mental Disorders in the Criminal Justice System*, Trends and Issues in Crime and Criminal Justice No 334 (Australian Institute of Criminology, 2007) 3. For example the Mental Health Court Liaison Service (MHCLS) in Victoria.
59. NSW Health, *Court liaison* (2008) 1-2.
60. *Enabling Justice*, 37.
61. Queensland Government, *Disability Service Plan 2011-14*, 4.

appropriate mental health treatment.[62] SSCLS does not generally have an ongoing relationship with the defendant following assessment or referral.[63]

7.34 The benefits of services such as SCCLS can include:[64]

- reducing court delays by providing timely assessments
- providing assessments and reports to facilitate better decision making by the court in situations where mental illness needs to be taken into account
- potentially reducing reoffending by referring defendants to treatment or services, and
- improving links between the criminal justice system and the health and welfare sector.

Target group and eligibility

7.35 In the 2010/11 financial year, the SCCLS screened 12,887 people for a mental illness or a mental health condition. Of this group, 2,066 people received a comprehensive psychiatric assessment. Of those assessed, 1,639 were found to have a mental illness or condition. Of this group:

- 1,229 people were referred to mental health services in the community (237 were dealt with under s 32 of the *Mental Health (Forensic Provision) Act 1990* (NSW) (MHFPA), 278 were dealt with under s 33 of the MHFPA, 714 were linked to community mental health services), and
- 383 people were linked to mental health services in correctional centres.[65]

7.36 In 2007/08, of the 14,746 people screened by SCCLS, 1,990 people were provided with a mental health assessment. Of the group assessed, 1,662 (84%) were identified as suffering from a severe mental illness or disorder and 1,180 (71%) of this group were diverted to treatment facilities in the community.[66]

7.37 The SCCLS is located in 20 court locations; we discuss the issue of coverage below at para 7.78.

7.38 The SCCLS targets people with a mental illness.[67] Mental health assessment may identify other problems as well. For example, 6.6% of people referred to the SCCLS

62. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 2-3, 7-8.
63. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 2, 9.
64. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 3, 7; Magistrates Court of Victoria, *Guide to Court Support and Diversion Services* (2011) 21.
65. Letter to the NSW Law Reform Commission from Executive Director Forensic and Mental Health and Youth Health Services, Justice Health and Forensic Mental Health Network, 29 May 2012. See Table 4.11.
66. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 9.
67. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 2

between February 2003 and March 2004 were identified as having moderate, borderline or mild intellectual disability.[68] It has been reported that while the SCCLS can "flag" or "informally screen" a person for intellectual disability, difficulties arise in relation to referring that person to services. This is discussed further in para 7.83 below.[69]

7.39 The profile of those who have been referred the SCCLS provides an insight into the complexity of the difficulties faced by people with cognitive and mental health impairments dealt with by that service. In the period from February 2003 to March 2004, 55.1% of people were unemployed, 75.8% had past psychiatric problems, 93% had drug and alcohol issues, and 10.8% were homeless.[70]

Program structure

7.40 The SCCLS identifies appropriate individuals using a variety of methods. In addition to accepting referrals from multiple sources, the SCCLS screens all individuals in custody through daily review of police custody management records and Corrective Services NSW documentation and any other relevant information.[71] A referral might occur where the charges or defendant's behaviour suggest the presence of a mental health impairment; where there has been a history of s 32 or s 33 applications under the MHA; or where the defendant is unable to provide instructions. The SCCLS works collaboratively with other organisations including health and legal services.[72]

7.41 The processes undertaken by the SCCLS involve the following components:

(1) identification and screening of defendants who may have a mental illness or mental disorder

(2) immediate mental health assessment involving triage by a mental health professional of defendants identified in the screening phase (this involves obtaining consent, obtaining collaborative background health information and documentation to support clinical findings and discussion of the provisional diagnosis and treatment recommendations with a supervising psychiatrist)

(3) integrating all relevant information into a court report (provision of impartial advice)

(4) potential diversion of the defendant if the court deems it appropriate, and

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68. D Greenberg and C Dixon, "NSW Statewide Community and Court Liaison Service" (Paper presented at NGOs, Mental Health and the Community: Turning the Tide, Novotel Northbeach, 26 March 2004) 18.
69. *Enabling Justice*, 38.
70. D Greenberg and C Dixon, "NSW Statewide Community and Court Liaison Service" (Paper presented at NGOs, Mental Health and the Community: Turning the Tide, Novotel Northbeach, 26 March 2004) 11.
71. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 8.
72. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 7.

(5) linking to treatment and care in the community or in custody, in consultation with treatment providers. [73]

Effectiveness and outcomes

7.42 There is some evidence to suggest that SCCLS intervention has had a positive impact on reducing the frequency of contact with the criminal justice system. The evaluation of the SCCLS noted:

> [T]here was a decline in the mean number of offences per month for SCCLS clients across the 18 months following their index mental health dismissal that was not observed for individuals in the control group …
>
> [F]indings revealed a decreasing trend in monthly offences in the follow-up period relative to the pre-period for both SCCLS clients [with finalised Local Court appearances] and control cases [given supervised bonds]. However, in the month immediately following the index court appearance there was a large decrease in the mean number of offences per month for the SCCLS client group, while a slight increase was shown for the control group. Specifically, after excluding cases that received custodial penalties at the index court appearance, there was an immediate, significant decline in offending frequency following the index date for SCCLS clients that was not observed for the control group of individuals receiving supervised bonds. [74]

Furthermore, stakeholders held generally positive views regarding the impact of the service, and there was strong support for further expansion.[75]

CREDIT: case management

7.43 The Court Referral of Eligible Defendants into Treatment (CREDIT) pilot program is a case management program operating in NSW. The creation of CREDIT was, in part, influenced by the Court Integrated Services Program (CISP), its Victorian equivalent.[76] We refer to CISP in our discussion to enrich our understanding of the approach.

Objectives of CREDIT

7.44 The objectives of CREDIT include:

- reducing offending by targeting the underlying causes of offending, and case managing, for example, by facilitating access to mental health and disability

73. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 8-10. See also Magistrates Court of Victoria, *Guide to Court Support and Diversion Services* (2011) 21.
74. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) viii, 58-59. See para 4.96.
75. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 59.
76. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 1-2.

supports, drug treatment or rehabilitation programs, accommodation and other community based supports[77]

- building partnerships with other agencies, and[78]
- improving the quality of judicial decision making by providing information to the court regarding a defendant's "needs and rehabilitation efforts".[79]

The design of the program has been informed by therapeutic jurisprudence and "problem solving" court approaches.[80]

7.45 CISP has very similar objectives.[81] These are achieved through individualised case management, which entails "therapeutic interactions between clients and workers, in comparison with the predominantly referral and advocacy approach of many pre-trial programs".[82] We also note that the Victorian CREDIT (Court Referral and Evaluation for Drug Intervention and Treatment)/Bail Support program (CBSP)[83] is an example of a case management approach available in rural or regional areas.[84]

Target group and eligibility

7.46 The CREDIT program runs in Burwood and Tamworth Local Courts. Between 24 August 2009 and 23 August 2011 there were 719 referrals to CREDIT; 637 assessments conducted; 483 program entries (counting those who have participated more than once); and 451 CREDIT participants.[85]

7.47 The CREDIT program specifically focuses on the defendant's risk of reoffending:

> The risk principle states that offender recidivism can be reduced if the level of treatment services provided to the offender is proportional to the offender's risk

77. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 3.
78. Crime Prevention Division, *NSW Credit Program: Court Referral of Eligible Defendants into Treatment* (NSW Attorney General's Department, 2009) 5.
79. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 3.
80. Crime Prevention Division, *NSW Credit Program: Court Referral of Eligible Defendants into Treatment* (NSW Attorney General's Department, 2009) 5; L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 1-2.
81. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 21; Magistrates Court of Victoria, *Guide to Court Support and Diversion Services* (2011) 6.
82. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 21.
83. The CBSP program is result of merging of two court support programs.
84. For example it provides support or assistance, facilitates access to treatment and supports as well as attempts to reduce offending behaviours: Magistrates Court of Victoria, *Guide to Court Support and Diversion Services* (2011) 6. See also C Cunneen and F Allison, *Indigenous Bail Diversion: Program Options for Indigenous Offenders in Victoria*, *Report Compiled for the Department of Justice (Victoria)* (2009) 18-19.
85. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 3, 9-10.

> of re-offending. This requires two things: identification of an offender's risk of re-offending and matching the level of treatment to the level of risk.[86]

In determining the level of case management required, the CREDIT program obtains a defendant's Group Risk Assessment Model (GRAM) score. The GRAM scores "are indicative of a defendant's risk of being convicted for an offence committed within two years of the finalisation of their current court matter".[87]

7.48 The inclusion criteria for CREDIT are as follows:[88]

- The defendant must be motivated to address one or more of a range of issues related to their offending.
- The defendant has an "identifiable problem" (for example, substance abuse issue or mental health impairments) that is either directly or indirectly related to their offending behaviour.
- The defendant resides in an area where he or she can participate in treatment and/or other services as agreed in the plan.

However, a defendant will be excluded from participation if he or she is remanded, on a current Corrective Services supervision order or charged with a sexual offence.[89] CREDIT operates both pre-plea and post-plea; however only magistrates may refer a defendant at the post-plea stage.[90]

7.49 Similarly, in Victoria, CISP is available where defendants have an offending history which suggests a likelihood of further offending; intervention is warranted "to reduce risk and address needs"; and the defendant has "physical or mental disabilities or illnesses", substance abuse issues or "inadequate social, family and economic support that contribute to the frequency or severity of their offending".[91]

Program structure

7.50 Important characteristics of CREDIT include:[92]

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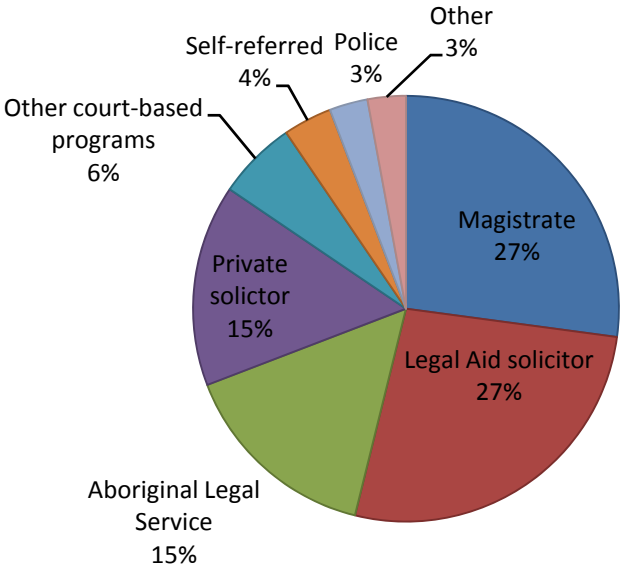
86. Crime Prevention Division, *NSW Credit Program: Court Referral of Eligible Defendants into Treatment* (NSW Attorney General's Department, 2009) 8.
87. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 4.
88. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 4.
89. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 4.
90. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 4.
91. Magistrates Court of Victoria, *Guide to Court Support and Diversion Services* (2011) 5.
92. Crime Prevention Division, *NSW Credit Program: Court Referral of Eligible Defendants into Treatment* (NSW Attorney General's Department, 2009) 6. See also S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 21, 61.

- linking to a range of services, thereby creating the capacity to address a broad range of issues
- variation of intensity of service response dependent on the defendant's needs and risk of reoffending, and
- court involvement, the level of which is dependent on the magistrate's discretion.

Figure 7.1: Sources of referral to CREDIT (total of 483 program entrants)



Source: L Trimboli, NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 9.

7.51 The process commences when a defendant is referred to the program.[93] Once referred, the process generally proceeds as follows:[94]

(1) **A defendant will be assessed/screened for eligibility by a caseworker.** This is an opportunity to provide the defendant with an overview of the program and for CREDIT staff to determine whether or not the defendant meets the eligibility requirements (approximately 30 minutes).

(2) **If a defendant is accepted and agrees to participate, a more detailed assessment will be conducted.** This occurs within one week of the initial assessment for eligibility (and takes 45-60 mins). It assists in identifying key factors which may contribute to offending, the degree to which identified problems can be treated or changed, previous measures to deal with these

93. Crime Prevention Division, *NSW Credit Program: Court Referral of Eligible Defendants into Treatment* (NSW Attorney General's Department, 2009) 4-6. See Figure 7.1.

94. Crime Prevention Division, *NSW Credit Program: Court Referral of Eligible Defendants into Treatment* (NSW Attorney General's Department, 2009) 6-7; L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 4-6.

problems and the capacity and willingness of the defendant to engage with services.

(3) **Either before or after appearance in court the caseworker prepares a draft "intervention plan" to discuss with the defendant.** The plan takes into account the defendant's needs and the availability of services, and crafts the level of intervention accordingly. CREDIT plans generally run for 2-6 months.

(4) **When the defendant appears before a magistrate, he or she will advise the magistrate of involvement in the program and may provide information regarding needs and proposed interventions.** The magistrate may then deal with the matter as considered appropriate. This could include adjourning the matter to allow for the defendant to complete the program or requiring the defendant to appear at regular intervals in order to advise the court of the defendant's progress.

(5) **A case manager will implement the intervention plan by facilitating access to services.** This may involve gathering additional information about the defendant. Referrals can be made to other court-based services.

(6) **When the intervention plan is complete, the case manager will put together a report on compliance and progress for the court.** Under the CREDIT program this report can contain information regarding the participant's background and circumstances, the agreed goals when he or she entered the program, the implementation and outcomes of the intervention plan, the "post-CREDIT" plan and a summary of the participant's participation in the CREDIT program. The court may take into account participation in the program when making its final determination.

(7) **A person may continue to receive services in the community once the legal case is completed**, depending on the individual's needs, and the capacity of servicing agencies.

7.52 Final reports may also be submitted to the court where the relevant period of time for which support can be provided has expired, but where the intervention plan has not yet been completed. In such cases, "the defendant has been actively addressing the agreed-upon goals, but has not completed them".[95] A participant can be terminated from the program if he or she fails to complete the plan or commits an offence and is bail refused.[96] A participant may also choose to withdraw from the program. There are no sanctions if these circumstances arise.[97]

95. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 6-7.

96. Crime Prevention Division, *Operational Manual: Court Referral of Eligible Defendants Into Treatment (CREDIT) Program* (Department of Attorney General and Justice, 2011) 16.

97. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 6-7.

7.53 The level of judicial monitoring will vary according to the circumstances and the magistrate involved. Magistrates may require one or more adjournments in order to be advised of the defendant's progress. [98]

7.54 It is relevant to note that a number of key changes have been made to CREDIT since its creation, including:[99]

(1) widening the use of brokerage funds (one-off payments for particular needs where other recourse is unavailable)

(2) an additional response category called "immediate response" where the defendant is in "crisis" or has immediate needs, and

(3) expansion of CREDIT to the Tamworth court circuit.

7.55 The program structure of CISP is very similar.[100] Magistrates reported two distinct practices with respect to CISP depending on the individual case. The first was described as an "intensive supervision approach" in which magistrates considered the person to be high risk, and as a consequence became "directly and regularly involved in their supervision while on bail", including communicating to the defendant that he or she is accountable to the magistrate for their performance in the program.[101] The second approach involved using CISP as a "referral and support service" where a defendant might not pose a serious risk, but may require support. In these cases the magistrate may not have direct personal involvement.[102]

Effectiveness and outcomes

The BOCSAR evaluation of CREDIT

7.56 The NSW Bureau of Crime Statistics and Research (BOCSAR) has conducted the first of a two stage evaluation of CREDIT. The first stage of the evaluation reviewed key operating characteristics of CREDIT and surveyed the level of satisfaction with the program among stakeholders. The second evaluation report, examining the

98. Crime Prevention Division, *Operational Manual: Court Referral of Eligible Defendants Into Treatment (CREDIT) Program* (Department of Attorney General and Justice, 2011) 16-17; Crime Prevention Division, *NSW Credit Program: Court Referral of Eligible Defendants into Treatment* (NSW Attorney General's Department, 2009) 9.

99. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 7.

100. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 22-23, 25-26. Magistrates Court of Victoria, *Guide to Court Support and Diversion Services* (2011) 6.

101. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 102.

102. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 103.

effectiveness of the program in reducing reoffending is currently being developed, the findings of which will be published by BOCSAR.[103]

7.57 The first evaluation identified that:[104]

- 31% of program entrants had a "psychiatric disability"[105]
- 0.6% of program entrants were identified as having an intellectual disability, and similarly, 0.6% were identified as having an ABI
- 92.7% of program entrants had legal representation (48.9% of this group was represented by Legal Aid), and
- 5% of program entrants had previously had matters dismissed under s 32 or s 33 of the MHFPA.

7.58 An analysis of referrals reveals that 89.9% of 196 program entrants to the Burwood pilot site were referred to services (49% were referred to three or more services), and of these, 96% were accepted into services. Similarly, 95% of 287 program entrants to the Tamworth pilot site were referred to services (38% were referred to three or more services), and of these, 92.7% were accepted into services. Figure 7.3 illustrates the type of services to which CREDIT participants were referred, and accepted, by defendant. Mental health services were the most common service referral type, comprising 30.7% of referrals in Burwood, and 43.6% of referrals in Tamworth.[106]

7.59 The BOCSAR evaluation also found that the majority of CREDIT participants surveyed indicated that they were "satisfied" (18%) or "very satisfied" (82%) with the support provided by CREDIT staff. The vast majority also reported that they were "satisfied" (39.3%) or "very satisfied" (59.8%) with their own progress on CREDIT. 95.9% of surveyed participants "reported that their life had changed being on the CREDIT program". The most common responses to the open-ended question asking what had changed about the participant's life "related to improved physical or mental health, a more positive outlook, improved relationships or increased confidence". The second most common response category "related to achieving positive outcomes or getting treatment and dealing with issues (such as drinking, drug-taking, depression, anger)".[107] When asked about the program's best features, the most frequent comments related to support provided by program staff

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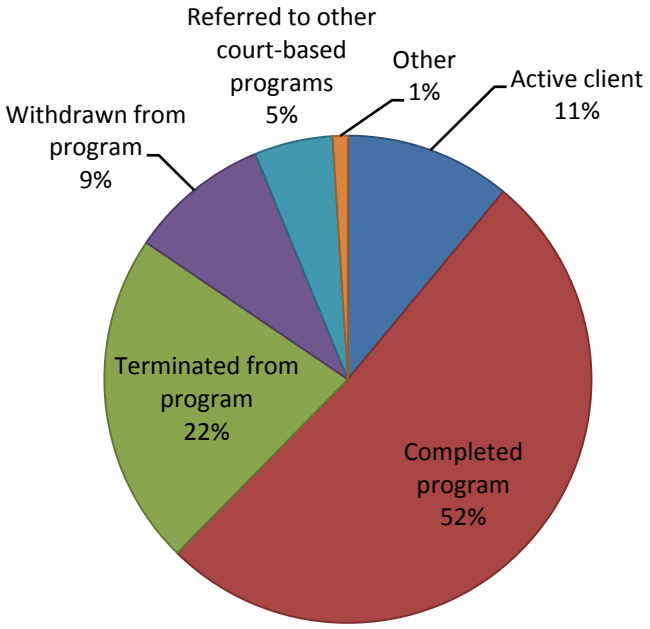
103. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 1.
104. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 9-10.
105. Note that 150 out of 483 program entries were identified as having a psychiatric disability. Program entries include people who have entered the program more than once. The total number of participants was 451. "Psychiatric disability" is not defined.
106. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 11-12. The data is collected from 24 August 2009-23 August 2011.
107. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 15-16.

(encouragement, flexibility, professionalism etc). When asked about the worst features of CREDIT, 62.3% of interviewees replied that "there were none". Of those rare problems reported, most "related to practical difficulties with transport or finding parking when attending appointments".[108]

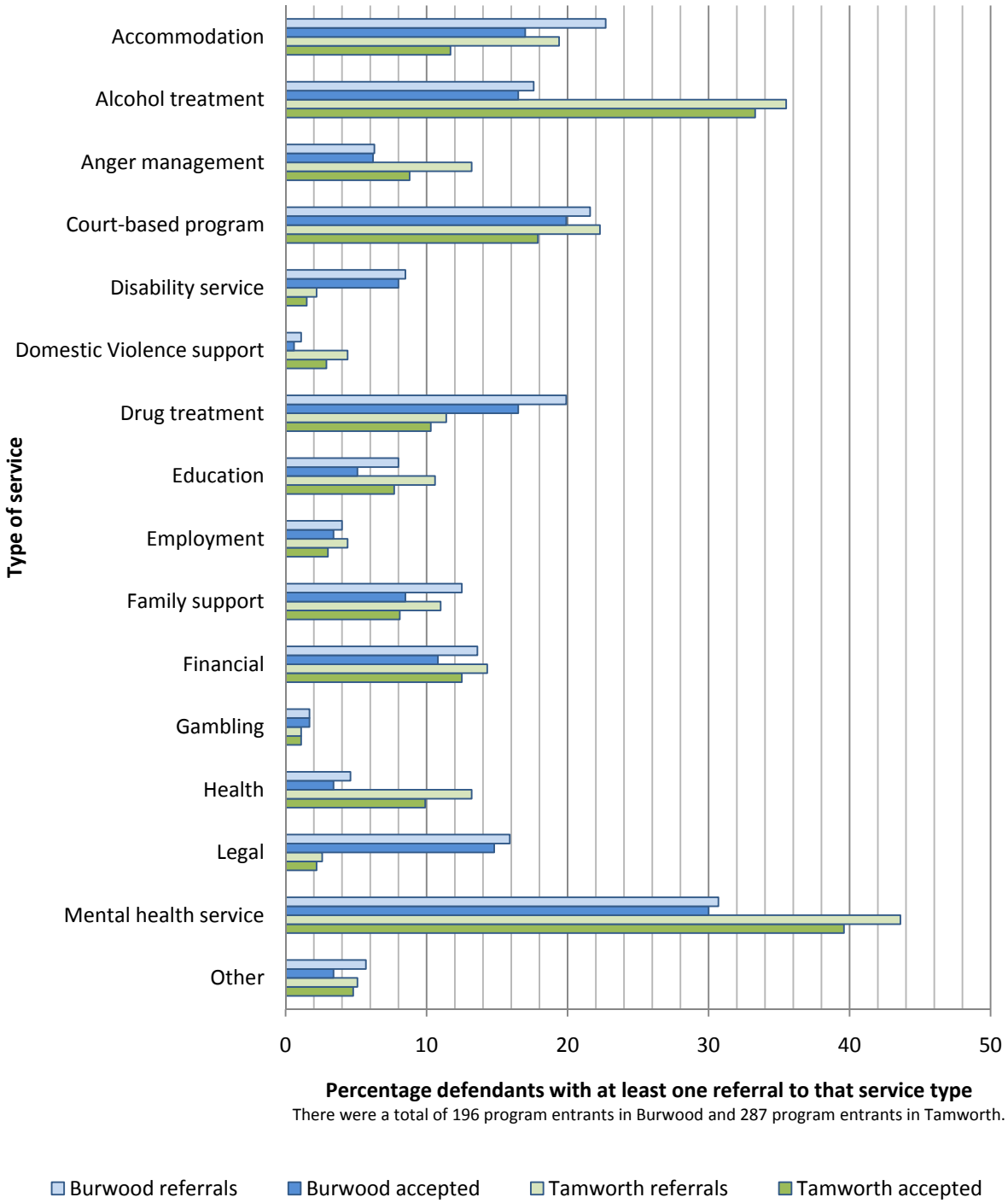
Figure 7.2: CREDIT client program status (total of 483 program entrants)



Source: L Trimboli, NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 9.

108. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 16-17.

Figure 7.3: Defendant referral to services by CREDIT



Source: Developed from data contained in L Trimboli, NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 11-12.

7.60 BOCSAR also conducted surveys of key stakeholders. The majority of court-related stakeholders (magistrates, registrars, solicitors, police prosecutors and program staff) believed that the program was very effective in achieving its objective of contributing to the "quality of decision-making in the local court by helping ensure

that information on defendants' needs and rehabilitation efforts are put before the court".[109] While most respondents believed that no improvements were required, some concerns were raised, including difficulties verifying assertions made by the defendant, and the lack of specificity in some reports. Approximately half of the relevant stakeholders suggested that changes be made to the eligibility criteria, including broadening the criteria (for example, to include a wider range offences) and also more stringent evaluation of the defendant's motivation to address his or her problems. [110]

7.61 Many court related stakeholders believed that participation had an impact on sentencing decisions. For example, their comments included the following observations:

> It has a significant impact. It's highly beneficial when it comes to sentencing if one can demonstrate willingness, or compliance, or that one is trying really hard to change one's behaviour or direction, or that one considers taking up offers and carrying them out.
>
> Rehabilitation is part of the sentencing procedure. It makes logical sense and sentencing sense to take into account a defendant's work to help their own rehabilitation.
>
> One is more likely to leave someone in the community to continue the good work they've commenced.[111]

7.62 Service providers that received referrals from CREDIT believed that such referrals were appropriate. Additionally, all reported positive working relationships with the program staff. Similar comments were made by police prosecutors, solicitors and the probation and parole service. Furthermore, "the majority of providers and solicitors reported that the CREDIT program has eased their workloads", although it has increased the workload of particular service providers responsible for supporting clients with complex needs. The BOCSAR evaluation noted that "[t]his is because the CREDIT participants fit directly into their target groups".[112] Some police prosecutors noted that they are required to attend more court appearances because matters are before the court for longer periods. When service providers were asked about having difficulties with CREDIT clients, the majority reported having difficulties with some clients, such as keeping appointments, not having required

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109. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 16-18.

110. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 18.

111. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 18.

112. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 18-19.

documentation, not paying for services, illiteracy, difficulties sustaining effort, lacking focus and having low self-esteem.[113]

7.63 When asked about what advice should be given to the NSW Government regarding the CREDIT program, the "most common advice was to extend the program, ideally state-wide".[114] The BOCSAR evaluation noted that the "results of the interviews in this study show very clearly that there were high levels of satisfaction among both stakeholders and program participants", concluding that:

> While the over-riding opinion of the program was positive and stakeholders suggested that it be implemented on a state-wide basis, they nonetheless recommended some improvements designed to facilitate beneficial outcomes for both program participants and the broader community. These improvements include the establishment or further enhancement of relevant services, programs and transport options in the catchment areas; clarification of the boundaries of, and intersection with, relevant court-based programs and other government agencies to ensure that defendants are effectively managed; and adequate resourcing of the program.[115]

What can we learn from CISP?

7.64 The findings of the evaluations of CISP in Victoria are also instructive regarding the impact of case management approaches.

7.65 Importantly, the CISP evaluation noted that "offenders who completed CISP showed a significantly lower rate of reoffending in the months after they exited the program" when compared with offenders at other court venues.[116] In particular, the evaluation noted the following:

- 100 days: approximately 20% of both the CISP group and control group had reoffended
- 200 days: approximately 30% of the CISP group and 32.5% of the control group had reoffended
- 400 days: 37% of the CISP group and 43% of the control group had reoffended, the degree of divergence was six percent
- 600 days: 40% of the CISP group and 48% of the control group had reoffended, the degree of divergence was eight percent

113. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 19-20.
114. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 20.
115. L Trimboli, *NSW Court Referral of Eligible Defendants into Treatment (CREDIT) Pilot Program: An Evaluation*, Crime and Justice Bulletin No 159 (NSW Bureau of Crime Statistics and Research, 2012) 20-21.
116. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 5, 115.

- Approximately 700 days: The extent of divergence reaches its maximum of 10%.[117]

7.66 An economic evaluation of CISP was also undertaken. The economic evaluation identified "significant potential benefits associated with CISP", and noted that reduction in reoffending and corresponding reduction in costs (such as costs associated with sentencing) is a key factor.[118] The evaluation also identified other benefits which were not readily quantifiable including reductions in the propensity to offend, and seriousness of offending.[119]

7.67 The CISP evaluation also found that there were 3.3 referrals to services (eg mental health, housing) per engaged client in 2007 and 5.1 referrals to services per engaged client in 2008[120] The evaluation also noted mental health improvements over the course of the program.[121]

7.68 The following personal factors were noted with respect to CISP participants: [122]

- 35% were identified as having a potential mental health problem
- 8.9% were identified as having indications of ABI; however there was variation between program locations
- 16% were recorded as having drug and mental health problems
- 5.7% were recorded as having alcohol and mental health problems, and
- 5.3% were recorded has having drug, alcohol and mental health problems.

7.69 The evaluation of CISP noted that involvement in the program was considered by magistrates as relevant to sentencing, but not determinative of the outcome. It was also noted that the participation was less likely to be a significant consideration in relation to serious offences.[123]

7.70 Several issues were identified with respect to CISP that had an impact on the effectiveness or outcomes of the program including strain on services, duplication of services, difficulty linking defendants to required services, difficulty identifying

117. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 14, 115.
118. PriceWaterhouseCoopers, Department of Justice, *Economic Evaluation of the Court Integrated Services Program (CISP): Final report on economic impacts of CISP* (2009) iv-v, 20.
119. PriceWaterhouseCoopers, Department of Justice, *Economic Evaluation of the Court Integrated Services Program (CISP): Final report on economic impacts of CISP* (2009) 24-25.
120. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 65.
121. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 5.
122. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 54, 84, 88.
123. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 104.

relevant defendants and difficulty maintaining continuity of supervision or management where the defendant appeared before different magistrates.[124]

Improving identification and assessment

7.71 The aims and achievements of criminal justice system support services are evident in the discussion above. In the subsequent sections we explore issues encountered in relation to existing support services in NSW for people with cognitive and mental health impairments, and also consider ways of addressing these issues. In doing so, we draw on our consultations and submissions, reviews, evaluations, and academic materials.[125]

7.72 In Chapter 9 we recommend expansion of diversionary powers available to the Local Court. In order for these powers to be used effectively, it is essential that eligible defendants be identified as early as possible.[126] However, as we have noted, magistrates, court staff, lawyers and other participants in the criminal justice system are unlikely to have the relevant expertise to identify and assess people with cognitive and mental health impairments.

7.73 In order to improve the present arrangements for identification and assessment of cognitive and mental health impairments three key elements are required:

- expansion of assessment and advice services that assist criminal justice stakeholders with identification of mental health impairments
- creation of assessment and advice services to assist criminal justice stakeholders with identification of cognitive impairments, and
- the provision of appropriate information to support referrals from criminal justice system stakeholders as well as targeted training of Legal Aid lawyers.

Service availability

7.74 In Consultation Paper 7 (CP 7) the Commission asked whether there was a need for centralised assessment processes within the Local Court and the NSW Police Force for people with cognitive and mental health impairments at the outset of proceedings.[127] The majority of stakeholders supported this approach,[128] or

124. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 104.

125. In NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Overview*, Consultation Paper 5 (2010) Issue 5.5, we ask whether there should be a general power of the court to order an assessment of an offender at any stage during proceedings. We will address this issue in our next report for this review, however, we have used the responses to help inform this section.

126. Law Society of NSW, *Submission MH13*, 47-48.

127. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) Issue 7.32.

128. Shopfront Youth Legal Service *Submission MH7*, 11; NSW Bar Association, *Submission MH10*, 58; NSW Consumer Advisory Group, *Submission MH11*, 56; Law Society of NSW, *Submission MH13*, 47-48; Legal Aid NSW, *Submission MH18*, 34; Department of Human Services NSW (Ageing Disability and Home Care), *Submission MH28-1*, 23; Children's Court of NSW, *Submission MH24*, 8.

expressed qualified support.[129] NSW Consumer Advisory Group (NSWCAG) noted "for diversion to be an option that is equitably applied in all cases it is imperative that all people with mental health problems are equally able to access an assessment, regardless of their level of legal representation".[130] The Law Society of NSW noted such an approach:

> would ease the burden upon defendants and their legal representatives in having to determine eligibility for s 32. This would be crucial and beneficial for defendants who do not have the resources to do so themselves.[131]

The NSW Local Court highlighted that specially trained support staff should undertake identification instead of general court staff that are already overburdened and under-resourced.[132]

7.75 Stakeholders also raised a number of concerns, including in relation to:

- the limited availability of resource and funding for such services[133]
- difficulties resulting from the geographic distribution of courts and differences in resources and staffing[134]
- the fact that "the operation and success of services is determined, at least to some extent, by the specific individuals in key roles, local relationship dynamics, and also by the differing constraints of the communities in which services are based"[135]
- the limited utility of comprehensive assessment at the outset of proceedings, particularly at the arrest stage, due to factors such as intoxication (noting screening processes would be more appropriate at early stages), and[136]
- the need to ensure that all current court-based programs are well integrated with one another.[137]

Stakeholders also noted that screening through any centralised system should be optional for the defendant.[138]

7.76 We are particularly mindful that people in regional, rural and remote communities may encounter additional barriers in accessing services.[139] For example, stakeholders emphasised that in some regional locations court locations may be

129. Local Court of NSW, *Submission MH4*, 10-11; NSW Health, *Submission MH15*, 16.
130. NSW Consumer Advisory Group, *Submission MH 11*, 56.
131. Law Society of NSW, *Submission MH13*, 48.
132. Local Court of NSW, *Submission MH4* 10-11.
133. NSW Health, *Submission MH15*, 16.
134. Local Court of NSW, *Submission MH4*, 10.
135. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 56.
136. Corrective Services NSW, *Submission MH17*, 27-28.
137. This was noted during consultations.
138. Law Society of NSW, *Submission MH13*, 48; Shopfront Youth Legal Centre, *Submission MH7*, 11.
139. L Schetzer and J Henderson, *Access to Justice and Legal Needs - A Project to Identify Legal Needs, Pathways and Barriers for Disadvantaged People, Stage 1: Public Consultations* (Law and Justice Foundation of NSW, 2003) xviii, 20, 73-78, 165-167, 206-207, 234-236.

remote from key services, there are significant differences in staffing levels and facilities at courts, and travel time to access services may be considerable.[140] Consequently, there are significant challenges, associated with distance and service availability, for support programs in rural, regional and remote areas that rely on accessing existing community resources.[141]

7.77 Currently, the SCCLS is the major provider of assessment and advice services for people in NSW with cognitive and mental health impairments who encounter the criminal justice system. As we note above, the SCCLS presently performs a range of relevant functions including screening, mental health assessment, provision of advice and information to the court, as well as linking defendants to treatment in the community.

7.78 However, the SCCLS only operates in 20 of the 148 Local Courts locations in NSW (13.5%).[142] In 2010, these courts finalised matters for approximately 41% of defendants before the Local Court.[143] Additionally, video conferencing facilities are available in Broken Hill and Griffith to help facilitate contact with a psychiatrist in Sydney.[144] We note that from April 2002 to October 2003, approximately 45% of people accessing the SCCLS lived in rural or regional areas.[145] As we note above, there is an additional assessment and advice service operated by Area Mental Health Services in Newcastle.[146]

7.79 The work of assessment and advice services such as the SCCLS was strongly supported in consultations and submissions.[147] For example, the Local Court submitted that the SCCLS had been of significant assistance to magistrates in identifying defendants with mental illness and providing information about treatment options.[148] Similarly, BOCSAR have noted that one of the "most frequently cited positive aspects" of the SCCLS was the:

> overall assistance that diversion staff provide to the court, including identifying those with mental health problems, advising court staff about mental health

140. Local Court of NSW, *Submission MH4*, 10-11; Children's Court of NSW, *Submission MH24*, 8.
141. M Burvill and others, "The Management of Mentally Impaired Offenders Within the South Australian Criminal Justice System" (2003) 26 *International Journal of Law and Psychiatry* 13, 31.
142. Court locations taken from Local Court of NSW, *Annual Review 2010*, 5. SCCLS locations include Blacktown, Burwood, Campbelltown, Central Sydney, Coffs Harbour, Dubbo, Gosford, Kempsey, Lismore, Liverpool, Manly, Nowra, Parramatta, Penrith, Port Macquarie, Sutherland, Tamworth, Wagga Wagga, Wollongong and Wyong: listed in a letter to NSW Law Reform Commission from the Executive Director Forensic and Mental Health and Youth Health Services, Justice Health and Forensic Mental Health Network, 29 May 2012.
143. NSW Law Reform Commission analysis of data supplied by the NSW Bureau of Crime Statistics and Research (kg11-10065).
144. G Henson, "Diversionary and Other Intervention Programmes within the Local Court of New South Wales" (Paper presented at NSW Bar Association Local Court Diversionary Schemes seminar, NSW Bar Association, 18 March 2010) 10-11.
145. D Greenberg and C Dixon, "NSW Statewide Community and Court Liaison Service" (Paper presented at NGOs Mental Health and the Community: Turning the Tide, Novotel Northbeach, 26 March 2004) 15.
146. NSW Health, *Court liaison* (2008).
147. NSW Bar Association, *Submission MH10*, 58; Legal Aid NSW, *Submission MH18*, 34.
148. Local Court of NSW, *Submission MH4*, 7.

> issues, liaising with other agencies and services and, where appropriate, facilitating diversion into treatment services.[149]

However, as the coverage of the service is limited to approximately 41% of matters proceeding through the Local Court, this disadvantages people with mental health impairments who appear in courts where these services are not available. A number of submissions suggested that SCCLS should be expanded, or could form the "foundation" for expansion of such services.[150] Furthermore, there is support for making the program available to people with cognitive impairment, discussed below.

7.80 Similarly, stakeholders who participated in the BOCSAR review of court liaison services identified "insufficient availability of services at court" as a weakness. This was related to "insufficient coverage of staff absences, the restricted availability of current services in some areas, and in the lack of availability of services at local courts across the state".[151] Furthermore, such services are only generally available for Local Court matters.[152]

7.81 In summary, while there were understandable concerns about fair and effective implementation of expansion of assessment services, there was strong support, both in submissions and in consultations, for extending these services.

7.82 In consideration of the importance of identification and assessment, and the strong support received for the SCCLS, we recommend that this service should be expanded to achieve coverage of all courts in NSW. We note in this context that one court has equivalent services delivered not via SCCLS, but by Area Mental Health Services.[153] Our recommendation is not designed to displace this service: where a local arrangement is providing effective services and is preferred there would appear to be no good reason to alter the existing arrangements.

Identification of cognitive impairment

7.83 Of particular concern is the absence of court-based assessment and advice services in NSW for people with cognitive impairment.[154] The *Enabling Justice* report observed that "[t]his means that alleged offenders with intellectual disability might not be identified and diverted in the same way and to the same degree that offenders with mental illness are".[155] This report also noted that the SCCLS can "informally screen" for intellectual disability but accessing necessary services is challenging due to strict intake processes for disability services and "their physical and organisational separation from the Local Courts".[156]

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149. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 59.
150. Shopfront Youth Legal Service *Submission MH7*, 11; Legal Aid NSW, *Submission MH18*, 34.
151. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 41, 59.
152. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 41.
153. Para 7.31, 7.78.
154. *Enabling Justice*, 37.
155. *Enabling Justice*, 37-38.
156. *Enabling Justice*, 38.

7.84 We have noted throughout this report the particular difficulties faced by people with cognitive impairments in the criminal justice system. While the SCCLS may provide some assistance with respect to cognitive impairment, the primary skill set of SCCLS staff is in mental health rather than cognitive impairment.

7.85 It is clearly a practical problem for the criminal justice system in making appropriate orders, whether for diversion or otherwise, that there are no resources to assist in the identification and assessment of people with cognitive impairments. There is a serious risk that courts will not be able to make orders that might have the appropriate rehabilitative effects and that, in the absence of rehabilitation, some defendants with these impairments will reoffend and some will ultimately be incarcerated. Stakeholders have expressed support for making assessment and advice services available to people with cognitive impairment.[157]

7.86 For these reasons the Commission recommends that the SCCLS be expanded to also provide Local Courts throughout NSW with identification, assessment and advice services for defendants with cognitive impairments, in addition to existing services relating to mental health impairments. We recognise that this expansion of services will present many operational challenges and may require collaboration with other agencies, particularly Ageing, Disability and Home Care. These are best resolved by those with expertise in service delivery.

Recommendation 7.1
Services for identification, assessment and advice concerning defendants with mental health impairments and cognitive impairments should be made available to all Local Court locations, through the expansion of the Statewide Community and Court Liaison Service or, where appropriate, through other local arrangements.

Information to support referral

7.87 The success of assessment and support services, and ultimately of diversion, depends on the SCCLS, or an equivalent service, being alerted to the fact that its services are required. Although the SCCLS can be proactive to some extent, it also relies on police, lawyers, magistrates and other criminal justice stakeholders alerting SCCLS staff to the need for its services in relation to particular defendants.

7.88 It is not realistic to expect those whose expertise is in criminal justice to diagnose or assess people with mental health or cognitive impairments. However, this is not what is suggested or required. What is needed is sufficient understanding to be an effective referral agent; that is to know enough to know when an expert should be brought in. For example, the observation provided by Brain Injury Australia illustrates the importance of the role of legal practitioners:

> Not long ago, I was referred a case because a lawyer was surprised by lack of offence history prior to a certain year and a history of chronic offending following

157. NSW Public Guardian, *Submission MH27*, 24; Local Court of NSW, *Submission MH4*, 8; Shopfront Youth Legal Service *Submission MH7*, 11; NSW Bar Association, *Submission MH10*, 58.

> this whereby the person was imprisoned every six months to a year after this. Since we had worked together previously, he asked the man if he had had a head injury and - sure enough - there was a history of significant head injury a year earlier. We carried out neuropsychological assessment and, yes, we did find deficits.[158]

7.89 The recommendations made above in relation to the expansion of SCCLS, and those we make below in relation to CREDIT, should be supported by providing criminal justice personnel with appropriate information regarding referrals.[159] Key stakeholders such as judicial officers, legal practitioners and police should be provided with resources to understand when it might be appropriate to refer defendants for assessment and the range of services that are available.

Recommendation 7.2

The Department of Attorney General and Justice, in consultation with Justice Health, should develop and distribute information that supports the early identification of people with cognitive and mental health impairments in the criminal justice system and supports appropriate responses, including referral where necessary.

Legal Aid training

7.90 We note that, in a study of the "pathways" of people with mental health and cognitive disabilities in the criminal justice system, approximately 95% of the sample had applied to Legal Aid NSW for assistance at some stage. Approximately 89% of applicants who applied were represented by Legal Aid at some stage.[160] The study further noted that there were significantly higher rates of application to, and receipt of advice from, Legal Aid, in relation to defendants with complex needs in the study.[161] We note Legal Aid is the highest source of referrals to the SCCLS, and to CREDIT.[162]

7.91 The *Enabling Justice* report describes the key role of Legal Aid solicitors in relation to people with cognitive impairment. The report notes that problems may arise due to failure identify or to adapt communication techniques in relation to clients with an intellectual disability. Additional time may be required in dealing with clients in this group. Consistent representation was described as being of "central importance".[163]

7.92 Directing resources to improving the identification and referral skills of Legal Aid lawyers, therefore, is likely to be a very effective way to focus training resources

158. N Rushworth, *Policy Paper: Out of Sight, Out of Mind: People with Acquired Brain Injury and the Criminal Justice System* (Brain Injury Australia, 2011) 14.
159. NSW Bar Association, *Submission MH10*, 58.
160. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) <www.app.unsw.edu.au/sites/app.unsw.edu.au/files/mhdcdbackgroundoutlaws_conf1.pdf> 10.
161. E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) 10.
162. D Greenberg and C Dixon, "NSW Statewide Community and Court Liaison Service" (Paper presented at NGOs Mental Health and the Community: Turning the Tide, Novotel Northbeach, 26 March 2004) 10.
163. *Enabling Justice*, 59-65.

and make effective improvements. However, Legal Aid lawyers often work under pressure, and the ability to spend more time with clients who are suspected of having impairments will be required if they are to be able to put such training into effect.

7.93 We therefore recommend the provision of training and supports for Legal Aid lawyers so that they can identify clients who may have cognitive and mental health impairments and make appropriate referrals. In future, there may be merit in the consideration of extending training to legal practitioners more widely, for example through training provided through the NSW Law Society and NSW Bar Association.

Recommendation 7.3

The Legal Aid Commission of NSW should provide training and support to Legal Aid lawyers to allow them to identify clients with signs of cognitive and mental health impairments and make appropriate referrals for assessment.

Improving case management to support diversion

Service availability

7.94 Once defendants with cognitive or mental health impairment are identified and assessed it is necessary for the court to decide the appropriate way for the criminal justice system to respond. One possible response, the focus of this report, is diversion.

7.95 The conclusion we draw from the discussion above, and from submissions and consultations for this inquiry, is that (in addition to identification and assessment) effective diversion has a number of key qualities. Services to which defendants are diverted should focus on the direct and indirect causes of offending and work to minimise the likelihood of further offences. Appropriate services need to be available, and the defendant needs to be connected with them in an effective fashion. Where problems arise with a diversionary program, defendants with cognitive and mental health impairments need help to navigate changes to that program. If an inappropriate referral is made, or a service cannot be provided, this group of people is unlikely to be able to renegotiate services without assistance. The needs of defendants, and even their diagnoses, may change and require revision of diversionary plans.

7.96 It would appear that, in the present system many defendants do “fall through the cracks”. They do not receive the rehabilitative services that the court ordered, with the consequent risk of reoffending. As we discuss in Chapter 9, when the court makes an order under s 32 there is presently no monitoring of the defendant’s connection with the relevant services. It would seem that some defendants do not connect with services. If they receive services but problems arise, as they reportedly regularly do, there is no case manager to help resolve them. The system for reporting breaches of s 32 orders to court is ineffective, and some magistrates appear to have lost confidence in s 32 orders as a consequence. The end result is that the rehabilitative effect of court orders is lost.

7.97 Services, such as CREDIT in NSW and CISP in Victoria, were designed to deal with these problems. While there is, as yet, no quantitative evaluation of the impact of CREDIT on reoffending, the qualitative evaluation of the service is very positive. As discussed in para 7.64-7.69, CISP has been positively evaluated and a beneficial impact on reoffending has been demonstrated.

7.98 However, CREDIT is only a pilot at this stage, and the availability of CREDIT services is therefore limited to Tamworth and Burwood Local Courts. These courts finalise matters for approximately 5.3% of defendants before the Local Court.[164]

7.99 Consequently we recommend that the CREDIT program in NSW be expanded, with the ultimate aim of achieving state-wide coverage. This should occur within a time frame that will ensure that the expanded service can recruit high quality staff who can work across the relevant service sectors and also with the criminal justice system. We recognise that there may be variation in program delivery in rural, regional and remote areas where, for example, remote provision of services may be required.

7.100 We are aware that this expansion of CREDIT will require considerable resources. However, it seems likely that, if a whole-of-government perspective is taken, any costs involved will be offset by a reduction in offending amongst this group and a consequent reduction in the high costs of dealing with their offending via the criminal justice system. We note that expansion of CREDIT is in line with the NSW Government's goal of preventing and reducing the level reoffending by breaking the cycle of reoffending using specialised treatment and intervention and "diverting people with mental health problems out of the criminal justice system and into services which meet their needs". [165]

Recommendation 7.4
The CREDIT program should be expanded to cover all Local Court locations.

Program length and compliance

7.101 The NSW Public Guardian expressed concern that "[m]any individuals with a mental illness or cognitive impairment are excluded from the current crime prevention programs available", such as CREDIT, because of a perceived inability to participate or rehabilitate.[166] This is an important issue if we envisage a specific role for a service such as CREDIT in relation to people within cognitive and mental health impairments. There may be particular program characteristics that are unsuitable for particular individuals within this cohort. The primary issues appear to relate to the length of program and compliance with program terms or conditions.

164. NSW Law Reform Commission analysis of data supplied by the NSW Bureau of Crime Statistics and Research (kg11-10065).

165. NSW Government, *NSW 2021: A Plan to Make NSW Number One* (2011) 35. See Chapter 1.

166. NSW Public Guardian, *Submission MH27*, 22. See also A Gray, S Forell and S Clarke, "Cognitive impairment, legal need and access to justice", *Justice Issues*, Paper 10 (Law and Justice Foundation of NSW, 2009) 9-10.

Additional concerns may arise in relation to offences that render a defendant ineligible to access those services.

7.102 The length of the program is a particular issue in relation to individuals with cognitive impairment. Stakeholders in consultations reported particular challenges in accessing disability services due to the very strict requirements concerning eligibility and the evidence required by Ageing, Disability and Home Care (ADHC) for the acceptance of a person into a service.[167] It was further noted during consultations that even where an applicant is granted an exemption from eligibility requirements, the process required to obtain it is very time-consuming. This group reportedly faces great difficulty in locating services. Where service location and connection is time-consuming, limited flexibility in relation to the length of CREDIT service delivery will be an issue. As we note in para 7.51, CREDIT generally runs from 2-6 months. Similar concerns were raised in relation to CISP services and clients with ABI due to the time frames required for assessment and service response and the issue that these time frames might be longer than a pre-trial program can accommodate.[168] The CISP evaluation recommended that CISP case managers receive additional advice on the management of ABI while awaiting neuropsychological assessment and that there should be "consideration of the continuing management of these clients as they progress through other stages of the justice system".[169]

7.103 During the Commission's cognitive impairment roundtable discussion it was highlighted that people with cognitive impairment require appropriate support to ensure compliance for the duration of court orders. We were also told that, for some people with a cognitive impairment, making changes to patterns of behaviour may require considerable time and support. Further, it is important that people with cognitive impairments understand the nature of any conditions that are imposed.[170] While this is a general issue that has been raised, rather than an issue specific to CREDIT, the particular needs of defendants with cognitive impairments should be considered when enhancing criminal justice supports.

7.104 In Chapter 9 we discuss the manner in which CREDIT should be used alongside s 32 of the MHFPA to increase the use and effectiveness of this diversionary provision. Much of the functionality required to implement those recommendations is already provided under the current CREDIT model. However, as we note above, some modification of CREDIT will be required as a result of our recommendations. For example, in addition to the issues raised in paragraph 7.102, in Chapter 9 we recommend the extension of s 32 orders to 12 months. Changes will therefore be required to the length of the program. The various ways in which CREDIT could be used, from police referral to CREDIT as described in Chapter 8, to the approaches described in Chapter 9, will also create changes in the approach to service delivery. Furthermore, areas for improvement have, and will be, identified by BOCSAR as

167. See also *Enabling Justice*, 38.

168. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 91.

169. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 91.

170. Cognitive Impairment Roundtable, *Consultation MH9*.

part of its CREDIT evaluation process. These matters will need to be taken into consideration in rolling out the program.

Recommendation 7.5

The Department of Attorney General and Justice should review the CREDIT model in light of the recommendations of this report, and the NSW Bureau of Crime Statistics and Research evaluation.

7.105 We also note that barriers to effective service delivery also include practical difficulties such as high staff turnover. CISP identified this as a particular problem and stated that it prevented the development of stable, productive relationships between team members and had an impact on the quality of services.[171] Continuity in diversionary programs is a key issue because people with complex needs are more likely to require a range of services. Furthermore, "follow up" after participation in programs can be crucial in helping to ensure that ongoing supports are working effectively.[172] These issues will be particularly important if the length of CREDIT is extended.

Service collaboration and coordination

7.106 In this chapter we recommend the expansion of the SCCLS and the CREDIT Program. In Chapter 12 we recommend the development of a specialist list In the Local and District courts for those who have cognitive and mental health impairments and who are at facing a serious prospect of imprisonment. We recommend that those Lists have dedicated court staff linking defendants to services. It is important that these services operate seamlessly, and where they operate together, they should be aligned as far as possible.

7.107 CREDIT and the SCCLS were designed to complement existing services and programs.[173] However, with the recommended expansion of services this issue increases in importance. We would not wish the "silo" effects, that is problems of communication and lack of collaboration that have been identified in the general health and community service sectors, to be replicated in the criminal justice system. Therefore, we recommend that this issue be given specific consideration.

Recommendation 7.6

The Department of Attorney General and Justice and Justice Health should review the relationship between CREDIT and the Statewide Community and Court Liaison Service to ensure that those services operate seamlessly with each other, and in relation to other court based

171. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 8.

172. G Skrzypiec, J Wundersitz and H McRostie, *Magistrates Court Diversion Program: An Analysis of Post-Program Offending* (SA Office of Crime Statistics and Research, 2004) 14, 137.

173. Crime Prevention Division, *NSW Credit Program: Court Referral of Eligible Defendants into Treatment* (NSW Attorney General's Department, 2009) 7; D Greenberg and B Nielsen, "Moving Towards a Statewide Approach to Court Diversion Services in NSW" (2003) 14(11-12) *NSW Public Health Bulletin* 227-228. See also S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 84.

> services, including support staff of the CRISP list proposed in Recommendation 12.1.

7.108 We also note here that effective diversion relies on the availability of services, and the criminal justice system encounters practical challenges in availability of services and resources in the community. In Chapter 2 we discuss the issues that arise in relation to service provision and the impact on people with cognitive and mental health impairments.[174]

7.109 Consequently, access and eligibility issues arise when court based support programs make referrals to services or programs in the community. For example, the BOCSAR evaluation of NSW court liaison services found that while links have been successfully formed between agencies in the health and criminal justice settings, stakeholders reported that a significant barrier to accessing diversion was the "availability of appropriate mental health services and difficulties in accessing existing health services in the community".[175] The evaluation noted that it is important to ensure that "continued efforts are made to develop and maintain effective collaborative links with stakeholder agencies, particularly with potential treatment services in mental health settings".[176] Comparable issues were identified in Victoria in relation to clients of the CISP program and referrals to Area Mental Health services. It was reported that such services were reluctant to accept referrals where the client was not in crisis. In these cases CISP staff had to arrange a psychiatric assessment before acceptance.[177]

7.110 Analogous concerns have been expressed regarding cognitive impairment. BOCSAR noted that:

> Of those respondents who identified obstacles to successful diversion into the community, the most frequently cited challenges included … [d]ifficulties in finding treatment options for some groups including individuals with intellectual disability… Some service staff and Magistrates felt that there are significant gaps in available services for these client groups and that diversion to treatment may not be as successful with these populations as it may be for other client groups.[178]

7.111 Brain Injury Australia noted that access to services and supports in the community is essential, and argued that identification of ABI is only useful if there is capacity to follow through with a plan of action.[179]

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174. Para 2.29-2.52.
175. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 45, 59.
176. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 59.
177. S Ross, *Evaluation of the Court Integrated Services Program: Final Report* (The University of Melbourne, 2009) 87-88.
178. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 45.
179. N Rushworth, *Policy Paper: Out of Sight, Out of Mind: People with an Acquired Brain Injury and the Criminal Justice System* (Brain Injury Australia, 2011) 10.

7.112 Importantly, NSW Legal Aid cautioned that where resources are inadequate, legislative amendment can "only go so far". It noted that prescribing roles for particular agencies in relation to support and supervision for people with cognitive and mental health impairments "cannot fix system difficulties whose root is a lack of resources".[180]

7.113 We note that two major problems identified throughout our report are first, deficits in the understanding of the criminal justice system by the service sector and vice versa, and second, problems in integrating service delivery for defendants with complex needs. CREDIT will respond to the problems of coordinating service delivery in relation to individual clients through case management. It appears likely that, through its objective of building partnerships with other agencies,[181] implementation of the CREDIT program may achieve some broader improvements in relation to both of these problems. The experience of operating under CREDIT may also assist by identifying service gaps, and ideas for improvements in coordinated service delivery, and the CREDIT teams may also be well placed to play a key role in future initiatives to confront these issues at a state and local level.

Data collection and evaluation

7.114 One of the challenges for the development of sound legal policy in this area is the limited evidence base on which evaluations must be made. A common concern is the limited data available to evaluate the impact and outcomes of contemporary initiatives.[182] It is critical that the development of service delivery to support the criminal justice system be accompanied by adequate data collection and evaluation to ensure the programs are meeting their objectives.

7.115 We recommend that the expansion of services, recommended above, should be accompanied by independent evaluations to explore the effectiveness of justice system support services and whether the services are continuing to achieve their desired outcomes. An appropriate evaluation framework should be created, encompassing process, outcomes and economic evaluation.[183]

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180. Legal Aid NSW, *MH18*, 2.

181. Crime Prevention Division, *NSW Credit Program: Court Referral of Eligible Defendants into Treatment* (NSW Attorney General's Department, 2009) 5.

182. E Newitt and V Stojcevski, *Mental Health Diversion List: Evaluation Report* (Magistrates Court of Tasmania, 2009) 68-69; I Bartkowiak-Thèron and J Flemming, *Integration and Collaboration: Building Capacity and Engagement for the Provision of Criminal Justice Services to Tasmania's Mentally Ill, Final Report* (Tasmanian Institute of Law Enforcement Studies, 2011) 21, 29-30; G Skrzypiec, J Wundersitz and H McRostie, *Magistrates Court Diversion Program: An Analysis of Post-Program Offending* (SA Office of Crime Statistics and Research, 2004) 102. See approach adopted in relation to the Assessment and Referral Court List in Victoria: J Lesser, "The Assessment and Referral Court (ARC) List – Victoria's Pilot of a 'Mental Health' Court Model" (Paper presented at Mental Health Diversion List Workshop, Hobart, Tasmania, 8 April 2011).

183. J Lesser, "The Assessment and Referral Court (ARC) List – Victoria's Pilot of a 'Mental Health' Court Model" (Paper presented at Mental Health Diversion List Workshop, Hobart, Tasmania, 8 April 2011) 3, 15.

Recommendation 7.7
Expansion of the Statewide Community and Court Liaison Service and CREDIT should be accompanied by independent process, outcome and economic evaluation which is supported by adequate data collection from the outset of these expanded services.

8. Pre-court diversion

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8.1 The first point of contact with the criminal justice system is typically the police. Police have been described as the "gatekeepers" of the criminal justice system, and to a large extent a person's entry into and journey through that process is determined by the exercise of police discretion.[1]

1. T Calma, *Preventing Crime and Promoting Rights for Indigenous Young People with Cognitive Disabilities and Mental Health Issues*, Report 3 (Australian Human Rights Commission, 2008) 52. See too NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) [4.1]-[4.2]; J Godfredson and others, "Police Discretion and Encounters with People Experiencing Mental Illness: The Significant Factors" (2010) 37 *Criminal Justice and Behavior* 1392,1394; P Snoyman, *Staff in the NSW Criminal Justice System Understanding of People with and without Disability who Offend* (PhD Thesis, University of New South Wales, 2010) 40; E Baldry, L Dowse, I Webster and P Snoyman, *Submission MH3*, 6; NSW Consumer Advisory Group, *Submission MH11*, 43; H Steadman and others, "Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies" (2000) 51 *Psychiatric Services* 645.

8.2 As outlined in Chapter 4, police interaction with people with cognitive and mental health impairment appears to be frequent. There has been an increasing reliance on police in dealing with this group.[2] The Select Committee on Mental Health, noting the concerns of various police organisations, agreed that there is an over-reliance on police resources to deal with mental health, and that this was to the detriment of mentally ill people as well as the community.[3] There are various explanations for the increased reliance on police resources,[4] particularly the lack of community support following the deinstitutionalisation of people with cognitive and mental health impairments.[5]

8.3 People with cognitive and mental health impairments may come into contact with police because they:

- are in crisis and present a risk of harm to themselves or to others
- behave in an irrational manner or a manner which attracts attention[6]
- have undiagnosed or untreated cognitive or mental health impairment, or have difficulty accessing required mental health or disability services
- have greater presence in public spaces which means they are more likely to be charged with particular offences (for example public order offences or possession offences), or
- have difficulty comprehending and managing a stressful situation, which could lead to misunderstanding and escalation in conflict.[7]

8.4 Due to the frequency and nature of police contact with people with cognitive and mental health impairments, it is clear that the law and police operational practice need to deal with these interactions by providing adequate guidance to police officers on their powers, and good policing practice and adequate safeguards for this cohort. To this end, for example the *Law Enforcement (Powers and*

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2. Police Federation of Australia, *Submission to Senate Select Committee on Mental Health* (2005) 3; Australia, *Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health 2009-2014* (2009) 71; P Garling, *Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals*, Vol 2 (2008) [22.18] citing a NSW Health Briefing, 31 March 2008.
3. NSW Legislative Council, Select Committee on Mental Health, *Mental Health Services in NSW*, Final Report, Parliamentary Paper 368 (2002) [14.49]. See also C Henderson "Why People with a Mental Illness are Over-represented in the Criminal Justice System" (Mental Health Coordinating Council, 2006) 4.
4. M Sced, *Mental Illness in the Community: the Role of Police* (Australasian Centre for Policing Research, 2006) 2.
5. Police Federation of Australia, *Submission to Senate Select Committee on Mental Health* (2005) 2; J Wood and others, *Police Interventions with Persons Affected by Mental Illnesses: A Critical Review of Global Thinking and Practice* (Center for Behavioral Health Services and Criminal Justice Research, 2011) 1; M Sced, *Mental Illness in the Community: the Role of Police* (Australasian Centre for Policing Research, 2006) 2-3.
6. People with cognitive or mental health impairments might attract police attention due to higher visibility, especially if they are homeless: Mental Health Coordinating Council, *NSW Mental Health Rights Manual: A Consumer Guide to the Legal and Human Rights of People with Mental Illness in NSW* (3rd ed, 2011) 73.
7. Victoria, Department of Justice, *Justice Mental Health Strategy* (2010) 24; 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) 71.

Responsibilities) Act 2002 (NSW) and associated regulations as well as the *Code of Practice for CRIME (Custody, Rights, Investigation, Management and Evidence)* (CRIME) provide safeguards and guidance including the requirement to contact a support person when conducting an investigative procedure in relation to a person who has "impaired intellectual functioning".[8]

8.5 This report is principally about options for diverting people with cognitive and mental health impairment from the criminal system to avenues that may better deal with their needs, and prevent further offending. In this context this chapter will review:

- the operation of s 22 of the *Mental Health Act 2007* (NSW) (MHA) which allows police to take a person to a mental health facility for assessment and treatment in certain circumstances
- whether there should be a formal statutory or policy framework for pre-court diversion, and
- what supports and training might be needed for assessment and referral if such a diversionary framework where implemented.

Police powers under s 22 of the Mental Health Act

8.6 Section 22 of the MHA provides that:

> (1) A police officer who, in any place, finds a person who appears to be mentally ill or mentally disturbed may apprehend the person and take the person to a declared mental health facility if the officer believes on reasonable grounds that:
>
> (a) the person is committing or has recently committed an offence or that the person has recently attempted to kill himself or herself or that it is probable that the person will attempt to kill himself or herself or any other person or attempt to cause serious physical harm to himself or herself or any other person, and
>
> (b) it would be beneficial to the person's welfare to be dealt with in accordance with this Act, rather than otherwise in accordance with law.

8.7 This will usually involve a "'street level' judgement that clinical intervention is required".[9] The MHA sets out certain procedures which must follow the detention of a person in this situation, and which allow for a person to receive treatment in accordance with the Act.[10]

8. *Law Enforcement (Powers and Responsibilities) Regulation 2005* (NSW) cl 24(1)(b), 25, 27; NSW Police Force, *Code of Practice for CRIME (Custody, Rights, Investigation, Management and Evidence)* (2012) 18, 26-28, 147.

9. N Rees, "The Fusion Proposal: A Next Step?" (Paper presented at the Rethinking Rights-Based Mental Health Laws Workshop, Monash University, Prato campus, Italy, 22 May 2009) 7.

10. These procedures include at least one medical examination and may end in the person's discharge from the facility into the custody of the police officer who brought that person to the facility if the person was apprehended because of a police officer's belief that the person committed an offence, or may result in a mental health inquiry which, depending on its findings,

8.8 It is apparent that police play a significant role in the context of the civil mental health system. In the financial year 2009/10, police referrals of mentally ill persons to mental health facilities under s 22 of the MHA accounted for 23% of requested admissions into a mental health facility, and 18% of accepted admissions. Referral under s 22 is the second largest category of referral for involuntary admission into a mental health facility.[11]

8.9 All jurisdictions in Australia have specific legislative power (by way of mental health legislation), which allows police to intervene in situations involving individuals with mental illness. These powers extend to apprehension and conveyance, for the purpose of mental health assessment, of a person if he or she is believed to have a mental illness and presents a risk to him or herself or others. This is essentially a mental health crisis response role.[12]

Issues that arise in the context of s 22

8.10 In Consultation Paper 7 (CP 7) we asked whether s 22 of the MHA works well in practice. Most submissions noted that s 22 should be used more often or there could be improvements made to the way the provision operates in practice.[13] For example, the Local Court noted that s 22 could be used more effectively. The Court notes that s 22 "provides a significant potential for diverting persons with mental illness away from the criminal justice system into treatment and should be used wherever appropriate".[14]

8.11 Two major concerns have emerged in submissions and consultation:

- the so-called "bounce back" problem and the associated issues of resourcing for mental health services, and
- the challenge of inter-agency collaboration and the question of whether police and health resources are being used appropriately.

8.12 It is critical to note that many stakeholders submitted that one of the primary reasons that s 22 does not work well in practice is the lack of resources in the mental health system.[15] Police have expressed concern that that they are being asked to prop up a "critically under-resourced system" and that the lack of

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may result in the person's involuntary detention in a mental health facility for a specified period or some other less restrictive treatment: *Mental Health Act 2007* (NSW) 27(e), 31, s 32, 35.

11. Mental Health Review Tribunal, *Annual Report 2009-2010*, 36.
12. M Sced, *Mental Illness in the Community: the Role of Police* (Australasian Centre for Policing Research, 2006) 4.
13. Local Court of NSW, *Submission MH4*, 6-8; Shopfront Youth Legal Centre, *Submission MH7*, *3;* Law Society of NSW, *Submission MH13*, *35-36;* Legal Aid NSW, *Submission MH18*, *27;* Public Interest Advocacy Centre, *Submission MH21*, *38;* NSW Public Guardian, *Submission MH27*, *19.* NSW Police Force, *Submission MH42*, *11* noted that s 22 "works adequately in practice".
14. Local Court of NSW, *Submission MH4*, 6.
15. Shopfront Youth Legal Centre, *Submission MH7*, 3; Law Society of NSW, *Submission MH13*, 36; Legal Aid NSW, *Submission MH18*, 27; NSW Public Guardian, *Submission MH27*, 19; Law Society of NSW, *Submission MH36*, 12. See also A Fry, D O'Riordan and R Geanellos, "Social Control Agents or Front-line Carers for People with Mental Health Problems: Police and Mental Health Services in Sydney, Australia" (2002) 10(4) *Health and Social Care in the Community* 277, 283-284.

resources contributes to the revolving door situation.[16] Police and related bodies have argued that some police dealings with mentally ill people can be an inefficient and unjustified use of police time,[17] especially where it is perceived that issues require a health rather than criminal justice intervention.[18]

The "bounce back" problem

8.13 Concerns have been raised about the number of people refused admission to a mental health facility following police diversion under s 22.[19] In the year 2009/10, 26% of people apprehended by police under s 22 were not admitted to a mental health facility.[20] This is the same problem identified in relation to court diversion under s 33 of the *Mental Health Forensic Provisions Act 1990* (NSW) (MHFPA), where a Local Court refers a person who is mentally ill to a mental health facility but he or she is not admitted and is subsequently "bounced back" to the court.

8.14 The reasons for the "bounce back" problem in this case are similar to those expressed in relation to court referral to mental health facilities under s 33 of the MHFPA, discussed in Chapter 10.[21]

8.15 The NSW Legislative Council, Select Committee on Mental Health considered this issue in 2002 and identified the following reasons as to why people brought to a mental health facility by police may not be admitted:

- mental illness as defined in the legislation, is not the primary impairment (for example, the person has a personality disorder)
- it is suspected that they are drug or alcohol affected
- they are violent, or
- there is a limited number of beds and other, possibly more acute, patients are prioritised.[22]

8.16 These were reflected in the Commission's consultations with stakeholders. In particular the issue of a shortage of beds in mental health facilities was mentioned. For example, hospitals may interpret admission criteria based on available beds

16. N Silva, "Stand by Me: Problems with the Mental Health System" (August 2005) *Police News* 20, 21
17. Police Federation of Australia, *Submission to Senate Select Committee on Mental Health* (2005) 6; NSW Legislative Council, Select Committee on Mental Health, *Mental Health Services in NSW*, Final Report, Parliamentary Paper 368 (2002) [14.11]-[14.13] (citing NSW Police and Police Association views).
18. NSW Legislative Council, Select Committee on Mental Health, *Mental Health Services in* NSW, Parliamentary Paper 368 (2002) [14.14].
19. Police Federation of Australia, *Submission to Senate Select Committee on Mental Health* (2005) 6. See also NSW Public Guardian, *Submission MH27*, 19. These issues were also raised during consultations.
20. Mental Health Review Tribunal, *Annual Report 2009-2010*, 36.
21. Para 10.52-10.59.
22. NSW Legislative Council, Select Committee on Mental Health, *Mental Health Services in NSW*, Final Report, Parliamentary Paper 368 (2002) [14.28]-[14.33].

and resources.[23] Police may not know of, or there may not be available, other services to which a person in crisis can be taken. In certain circumstances, police may feel that there is no alternative but to follow the charge route in order to "provide protection to the mentally ill person and the community".[24]

8.17 However, refusal to admit may be because the person does not fit the criteria under the mental health legislation.[25] Emergency psychiatric staff may take the view that police exercise their discretion improperly in apprehending and bringing people to the facility for whom treatment is not a viable option or who do not meet the legal criteria for involuntary admission.[26]

8.18 One submission offered the following case study that demonstrates these problems.

Case study 8.1

Ms X lives with her family in a rural NSW town. She has a history of mental illness. Ms X becomes highly aggressive and agitated, and during one episode, tried to run over her father. The NSW Police were called to take Ms X to the local hospital. The hospital refused to accept Ms X because she had previously assaulted a staff member at the hospital. The closest mental health facility (which is 3 hours away) refused to accept Ms X, despite the fact [that she was] clearly mentally disordered. The result is NSW Police held Ms X for approximately 7 hours in the cells. No alternative options were made available and pressure was put on the family to accept Ms X back for the short term. Ms X returned to the family environment and is at significant risk of committing an offence due to her highly agitated state.[27]

8.19 "Bounce back" remains a significant issue for stakeholders. In Chapter 10 of this report we discuss potential options in the context of s 33 of the MHFPA and recommend that a court be able to refer cases to the Mental Health Review Tribunal for review. We further note in that chapter that this could be supplemented by a second opinion process at the hospital level. In our view a similar process should exist for police under s 22 of the MHA. While this power may not frequently be used by police, it could prove a useful measure of last resort, particularly when dealing with mental health frequent presenters.

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23. Shopfront Youth Legal Centre, *Submission MH7*, 3; NSW Law Society, *Submission MH13*, 36. NSW Legislative Council, Select Committee on Mental Health, *Mental Health Services in NSW*, Final Report, Parliamentary Paper 368 (2002) [14.30].
24. Police Federation of Australia, *Submission to Senate Select Committee on Mental Health* (2005) 7.
25. Police Federation of Australia, *Submission to Senate Select Committee on Mental Health* (2005) 4. See also P Garling, *Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals*, Vol 2 (2008) [22.64].
26. P Kneebone and others, "Characteristics of Police Referrals to a Psychiatric Emergency Unit in Australia" (1995) 46 *Psychiatric Services* 620, 620; A Fry, D O'Riordan and R Geanellos, "Social Control Agents or Front-line Carers for People with Mental Health Problems: Police and Mental Health Services in Sydney, Australia" (2002) 10(4) *Health and Social Care in the Community* 227, 282.
27. NSW Public Guardian, *Submission MH27*, 19.

Recommendation 8.1

When a person is referred to a mental health facility under s 22 of the *Mental Health Act 2007* (NSW) and is not admitted, the police should be able to refer the decision to the Mental Health Review Tribunal for review.

Inter-agency collaboration and use of police resources

8.20 There are divergent views regarding the appropriate role of police in dealing with people with cognitive and mental health impairments who are in crisis. One view sees police playing a minimal role; the other sees police as a part of a broader approach, with police as active participants in the mental health system.[28] In practice, police have a particular operational role with respect to mental illness crises where people pose a risk to themselves or others. However, police do not do this work alone – they work with other services such as mental health facilities, service providers for those with cognitive impairments, providers of crisis accommodation and so on.[29] Challenges may arise around determining the appropriate role and boundaries between police and other services. Additionally, police may experience tension between their law enforcement work and their role with respect to people with mental health impairments.[30]

8.21 Police are often the first line responders to incidents. Where issues arise outside of business hours police may be asked to attend situations because mental health workers are not available.[31]

8.22 As discussed in Chapter 4, the number of "Mental Health Act events" (involving police delivery of a person to a mental health facility under s 22) was 22,234 in 2009. This accounts for 1.05% of all incidents reported on COPS.[32] These "events" can be resource intensive for police, including police time spent:

- at the scene
- in hospital waiting for mental health assessments

28. A Fry, D O'Riordan and R Geanellos, "Social Control Agents or Front-line Carers for People with Mental Health Problems: Police and Mental Health Services in Sydney, Australia" (2002) 10(4) *Health and Social Care in the Community* 277, 277-278.
29. N Silva, "Stand by Me: Problems with the Mental Health System" (August 2005) *Police News* 20-21.
30. A Fry, D O'Riordan and R Geanellos, "Social Control Agents or Front-line Carers for People with Mental Health Problems: Police and Mental Health Services in Sydney, Australia" (2002) 10(4) *Health and Social Care in the Community* 277, 281-282. See also J Wood and others, *Police Interventions with Persons Affected by Mental Illness: A Critical Review of Global Thinking and Practice* (Center for Behavioral Health Services and Criminal Justice Research, 2011) 6.
31. Police Federation of Australia, *Submission to Senate Select Committee on Mental Health* (2005) 12; NSW Legislative Council, Select Committee on Mental Health, *Mental Health Services in NSW*, Final Report, Parliamentary Paper 368 (2002) [14.25]; Parliament of Australia, Senate Select Committee on Mental Health, *A National Approach to Mental Health – from Crisis to Community: First Report* (2006) [13.55]; N Silva, "Stand by Me: Problems with the Mental Health System" (August 2005) *Police News* 22.
32. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report (*Charles Sturt University, 2009) 14.

- dealing with a person who is found not to be mentally ill under mental health legislation
- transporting individuals, and
- responding to repeated use of emergency numbers by people with a cognitive or mental health impairment.[33]

Additionally, s 22 requires police officers to take people to declared mental health facilities. This may prove to be a particular issue in rural or regional areas, where the distance between declared mental health facilities is greater.[34]

8.23 The Police Federation of Australia has argued that once an individual has entered the health system, for example been delivered to a hospital, he or she should cease to be the responsibility of police (unless the person is particularly violent or high risk).[35]

8.24 General concerns have also been raised regarding insufficient information sharing between police and other services.[36] The Mental Health Intervention Team (MHIT) evaluation has noted that:

> In theory, increased information sharing about high-risk individuals increases the likelihood that officers attending calls will be better appraised of what to expect, how a consumer is best approached, and what care management plans are in place to facilitate this; all of which might reduce the likelihood of an event escalating and resulting in injuries.[37]

8.25 There is currently a Memorandum of Understanding (MOU) in place between the NSW Police Force, NSW Health and the Ambulance Service of NSW. Importantly, the MOU defines the roles and responsibilities of the agencies and covers process and operational matters.[38] This would be a useful tool in responding to complex resourcing issues, information exchange and other practical challenges. However, the MOU is now out of date, has not been amended to reflect the current MHA, and has been in need of review for nearly 5 years.[39] The 2009 evaluation of the MHIT

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33. Parliament of Australia, Senate Select Committee on Mental Health, *A National Approach to Mental Health – from Crisis to Community: First Report* (2006) [13.59]. See also Police Federation of Australia, *Submission to Senate Select Committee on Mental Health* (2005) 5, 8-9, 10-11, 13; N Silva, "Stand by Me: Problems with the Mental Health System" (August 2005) *Police News* 22; A Fry, D O'Riordan and R Geanellos, "Social Control Agents or Front-line Carers for People with Mental Health Problems: Police and Mental Health Services in Sydney, Australia" (2002) 10(4) *Health and Social Care in the Community* 277, 281.
34. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report* (Charles Sturt University, 2009) 52-53, 67-68.
35. Police Federation of Australia, *Submission to Senate Select Committee on Mental Health* (2005) 6.
36. Police Federation of Australia, *Submission to Senate Select Committee on Mental Health* (2005) 9; Expert Advisory Committee on Information Sharing in Mental Health Crisis Situations, *Toward a National Approach to Information Sharing in Mental Health Crisis Situations Report* (Commonwealth Department of Health and Aged Care, 2000).
37. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report* (Charles Sturt University, 2009) 37.
38. NSW Health, Ambulance Service of NSW, NSW Police Force, *Memorandum of Understanding: Mental Health Emergency Response* (2007).
39. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report* (Charles Sturt University, 2009) 25.

noted that this has limited the ability of the NSW Police Force to progress its aims of limiting their involvement in mental health related matters.[40] The evaluation recommended that this be addressed as a matter of urgency. NSW Police has reported that the revision is currently underway.[41]

8.26 Ideally, the interface and relationship between police, health and ambulance services should be regulated by agreement. This could be achieved through a revised MOU between police, health and other relevant services which clearly defines responsibilities and boundaries and which aims to support operational efficiencies.

8.27 However, the delay of several years in revising the existing MOU does not provide optimism that agreement will prove an effective way to manage these difficult relationships. For this reason, and the problems raised above, the Commission recommends that the interplay of roles between relevant agencies requires urgent resolution.

8.28 We note that the recent *Mental Health Commission Act 2012* (NSW) established the Mental Health Commission which is intended to operate as of 1 July 2012. The purpose of the Commission is principally to develop a strategic plan for mental health services. One of the principles governing the operation of the MHC is that:

> 11(e) an effective mental health system requires:
>
> (i) a co-ordinated and integrated approach across all levels of government and the non-government sector, including in the areas of health, housing, employment, education and justice, and
>
> (ii) communication and collaboration between people who have a mental illness and their families and carers, providers of mental health services and the whole community.

8.29 In our view the coordination of services and activity by the NSW Police Force and NSW Health is essential to ensuring that people with mental health impairments receive appropriate treatment, and the community as a whole is well served. It is an issue of strategic importance. We therefore recommend that the Mental Health Commission monitor progress toward negotiation of the MOU, and report on its timely completion.

Recommendation 8.2

(1) The renegotiation of the memorandum of understanding between the NSW Police Force, NSW Health and the Ambulance Service of NSW in relation to dealing with people with mental health impairments should be completed within six months.

(2) The NSW Mental Health Commission should monitor and report on the progress of finalising the memorandum of understanding.

40. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team, Final Evaluation Report* (Charles Sturt University 2009) 3, 25.

41. NSW Police Force,"Mental Health Policy update: October 2010 to March 2011" *Mental Health Intervention Team News* (March 2011) 6.

People with cognitive impairment in crisis

8.30 An additional issue relates to police crisis response to people with cognitive impairment. The definitions of "mentally ill" and "mentally disordered" in the MHA do not include cognitive impairment.[42] Indeed s 16 of the MHA prescribes that a person is not a mentally ill or mentally disordered person, merely because of a number of listed matters, including that "the person has developmental disability of mind". Even if the admitting psychiatrist believed that the person could qualify under the Act[43] (for example it is possible that they may be a mentally disordered person) a mental health facility is not an appropriate place for a person with a cognitive impairment if that person does not have a mental illness.

A "crisis" response for cognitive impairment?

8.31 In crisis situations police must inevitably make judgements on the person's behaviour and demeanour. In certain circumstances, for example where a person has co-existing cognitive and mental health impairments, they may be delivered to a mental health facility under s 22. However, if a person with a cognitive impairment does not also fit the relevant admission criteria under the civil mental health system that person should not be admitted.

8.32 In CP 7 we asked whether police should have an express legislative power to take a person to a hospital and/or an appropriate social service if that person appears to have a cognitive impairment. This could be done either by changing the terms used in s 22 to include people with a cognitive impairment, or by formulating a separate provision directed specifically at people with a cognitive impairment.[44]

8.33 There were differing views from stakeholders about the appropriate nature of crisis response for cognitive impairment. Some stakeholders noted that there may be circumstances where it is appropriate for police to take a person with a cognitive impairment to a hospital or service.[45] For example, cases where the impairment is severe and the person poses an immediate risk to him or herself or others:

> Examples might include a person with severe dementia who has absconded from a residential facility, or a person with an intellectual disability and significant behavioural problems who requires full-time care.[46]

The NSW Law Society cautioned that this should not be utilised in borderline cases where this degree of intervention would "constitute a serious abrogation of the civil liberties of such persons".[47]

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42. Law Society of NSW, *Submission MH13*, 35-36.
43. *Mental Health Act 2007* (NSW) s 15 defines a mentally disordered person as a person "(whether or not the person is suffering from mental illness) … [whose] behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care treatment and control of the person is necessary for [that] person's protection from serious physical harm", or "the protection of others from serious physical harm".
44. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) 12, Issue 7.4.
45. Shopfront Youth Legal Centre, *Submission MH7*, 3; NSW Bar Association, *Submission MH10*, 51; Law Society of NSW, *Submission MH13*, 34.
46. Shopfront Youth Legal Centre, *Submission MH7*, 3. See also, Law Society of NSW, *Submission MH13*, 36.

8.34 Conversely, other stakeholders did not see a need for police to have a power to take a person with a cognitive impairment to a hospital or social service against their will.[48] This is because:

- The "nature of community based services for people with cognitive impairment are fundamentally different to mental health facilities".[49]
- It is unclear what circumstances would require urgent transportation of a person with a cognitive impairment to a hospital or social service, and relevant issues that might arise are covered by mental health or guardianship legislation.[50]
- This power would have no practical effect because a person taken to a hospital or service could not lawfully be forced to stay in the facility or forced to receive treatment or services, whereas disability services are generally provided on a voluntary basis[51] – there is no equivalent to the MHA in relation to cognitive impairment.[52]
- The availability of disability services are limited, for example, these services only operate during business hours, they have narrow eligibility criteria, and they do not generally operate on a "crisis" basis.[53]

The Commission's view

8.35 In light of submissions and consultations, we consider that s 22 of the MHA is not the appropriate framework under which to deal with people with cognitive impairments who are in crisis.

8.36 The question remains, however, what police should do with people who have cognitive impairments who are in crisis who pose a threat to themselves or others or who have committed offences. A mental health facility is unlikely to be the right place for them. However police custody or prison are also unsuitable.

8.37 The appropriate legal mechanism for taking decisions about people with cognitive impairments is the guardianship system. The Intellectual Disability Rights Service (IDRS) notes that, where there is a need to restrict movement of a person with a cognitive impairment, the *Guardianship Act 1987* (NSW) is the "appropriate legal mechanism" under which such decisions should be made.[54] This regime focuses on the interests of the individual. Urgent hearings can be conducted if required.[55] In certain circumstances, guardianship orders can authorise, where necessary for a person's wellbeing, the exercise of a power to take that person to place of residence

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47. Law Society of NSW, *Submission MH13*, 37.
48. Public Interest Advocacy Centre, *Submission MH21*, 37.
49. L Steele, *Submission MH9*, 11.
50. L Steele, *Submission MH9*, 12.
51. Public Interest Advocacy Centre, *Submission MH21*, 37; Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28-1*, 20.
52. Intellectual Disability Rights Service, *Submission MH14*, 6.
53. L Steele, *Submission MH9*, 11; Department of Human Services NSW (Ageing, Disability and Home Care) *Submission MH28-1*, 20.
54. Intellectual Disability Rights Service, *Submission MH14*, 6.
55. Intellectual Disability Rights Service, *Submission MH14*, 6.

approved by a guardian.[56] However, the guardianship system provides for decision making. It cannot provide for the identified gap in services.

8.38 We note that there is still a gap in relation to diversionary options for people with cognitive impairments. Our recommendations in relation to a pre-court diversionary power, below, may assist in addressing this gap. Since the problem is primarily related to service provision, it is not a problem that can be resolved by legal reform.

Pre-court diversion

The value of early diversion

8.39 Effective diversion at pre-court stage can help ensure that a person is engaged with requisite services at an early stage.[57] It may be an appropriate response to a significant number of people with cognitive and mental health impairment in the criminal justice system. As the Local Court noted in its submission that pre-court diversion may be "both pragmatic and compassionate".[58]

8.40 Stakeholders suggested that there are many missed opportunities for diversion.[59] They noted that there appear to be many people with cognitive and mental health impairments appearing before the Court for trivial offences.[60] For example, the Local Court noted that many of the Local Court's convictions are for "comparatively minor summary offences" such as offensive language.[61] The precise number of people in this cohort with a cognitive or mental health impairment is not known. However, the Court suggests that, in light of research demonstrating links between impairments and involvement in the criminal justice system, especially for public order offences, and the number of people assessed to be mentally ill by the court liaison service, "it seems reasonable to surmise that there would be a significant number of individuals within this cohort".[62] The Local Court concludes:

> the utilisation of the discretion not to charge an individual with a mental health or cognitive impairment, particularly in instances of lower level offending such as these summary offences, is to be preferred to the practice of charging and leaving the question of mental health or cognitive impairment to the Court to determine.[63]

56. Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28-1*, 20.
57. K Bradley, *The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System* (UK Department of Health, 2009) 34
58. Local Court of NSW, *Submission MH4*, 8.
59. Intellectual Disability Rights Services, *Submission MH14*, 4; NSW Consumer Advisory Group, *Submission MH11*, 45. See also Law Society of NSW, *Submission MH13*, 37.
60. Local Court of NSW, *Submission MH4*, 6; NSW, Office of the Director of Public Prosecutions, *Submission MH5*, 13-14; Legal Aid NSW, *Submission MH18*, 28; Public Interest Advocacy Centre, *Submission MH21*, 38; NSW Public Guardian, *Submission MH27*, 20; Intellectual Disability Rights Service, *Submission MH14*, 4.
61. Local Court of NSW, *Submission MH4*, 6.
62. Local Court of NSW, *Submission MH4*, 7.
63. Local Court of NSW, *Submission MH4*, 7.

8.41 The IDRS observed that it is "neither socially desirable nor useful to see vulnerable community members brought unnecessarily before the courts to be potentially subjected to criminal sanctions".[64] The challenges facing people with multiple forms of vulnerability or complex needs appear to be particularly concerning.[65]

8.42 Furthermore, early diversion has the capacity to alleviate the burden on an overstretched criminal justice system.[66] The Local Court further noted:

> Diversion at the commencement of the Court process requires significant public resources, particularly where an accused needs to be transferred to a mental health facility for assessment.[67]

Effective pre-court diversion can reduce the use of court, prosecution and defence resources.[68]

Current options in NSW

Warnings and cautions

8.43 The basis for the informal power to caution or warn stems from the common law discretion of police.[69] This means that police can exercise discretion in relation to whether a matter should progress through the next stage of the criminal justice system, despite the absence of a legislative framework to do so:[70]

> This discretion allows police some degree of latitude in what action, if any, they take against a person who has committed an offence. There is much debate over the extent of this discretion and its probity.[71]

8.44 Such discretion involves taking unofficial action such as warning an individual or ignoring the offence entirely.[72] Police officers may exercise this discretion for relatively minor offences such as street offences or minor traffic infringements. While such behaviour may technically constitute an offence, it may be more effective to deal with the matter at the time of the event rather than take more formal

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64. Intellectual Disability Rights Services, *Submission MH14*, 2. See also NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) [2.41], [4.5]-[4.7].
65. See Chapter 2, generally.
66. Intellectual Disability Rights Services, *Submission MH14*, 3.
67. Local Court of NSW, *Submission MH4*, 8.
68. Intellectual Disability Rights Services, *Submission MH14*, 4.
69. S Morrison and M Burdon, *The Role of Police in the Diversion of Minor Alcohol and Drug-Related Offenders*, Final Report (Commonwealth Department of Health and Aged Care, 1999) 14; *R v Commissioner of Police; Ex Blackburn* [1968] 2 QB 118, 136, 139. See also C Edwards, *Changing Policing Theories for 21st Century Societies* (The Federation Press, 3rd ed, 2011) 193-194; *Enever v The King* (1906) 3 CLR 969.
70. K Polk and others, *Early Intervention: Diversion and Youth Conferencing, A national profile and review of current approaches to diverting juveniles from the criminal justice system* (Crime Prevention Branch, Australian Government Attorney-General's Department, 2003) 21.
71. A Lewis and C O'Regan, "Police cautioning – Effective Diversion or Expedience?" in L Atkinson and S Gerull (ed), *National Conference on Juvenile Justice: Proceedings of a Conference Held 22-24 September 1992* (Australian Institute of Criminology, 1993) 245.
72. R Wortley, "Measuring Police Attitudes Towards Discretion" (2003) 30 *Criminal Justice and Behavior* 538, 538-539.

action. Informal warnings or cautions are not recorded and can be administered "on the spot".[73]

8.45 The exercise of police discretion is not without controversy. It has been described as an "amorphous beast, intangible, slippery and abused", and may raise issues such as accountability and expose police officers to criticism for being "soft on crime".[74] However, police discretion can also provide police officers with a means of de-escalating potentially dangerous situations, thereby reducing the potential harm associated with arrest and prosecution in cases where that is not warranted, and providing an appropriate response to minor offending.[75] It allows for improved workload management and scope for compassion.[76]

8.46 This discretion is recognised in s 105 of the *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW) (LEPRA), which empowers police to discontinue an arrest where:

- the arrested person is no longer a suspect or the reason for arrest no longer exists for any other reason, or
- it is more appropriate to deal with the matter in some other way, for example by way of warning or caution. [77]

Police are required to make a notebook entry and inform the person of the reason for discontinuance.[78]

The decision to charge or prosecute

8.47 Both the police and the Office of the Director of Public Prosecutions (ODPP) exercise a discretion in deciding whether or not to charge or prosecute. Various factors are taken into account in making this decision. The ODPP has Prosecution Guidelines setting out these factors.[79] The paramount consideration is whether prosecution is in the public interest. This discretion is guided by three factors:

- the availability of evidence that would provide prima facie proof of each element of the offence
- the existence of reasonable prospects of conviction upon weighing the evidence and strength of the case, and

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73. A Lewis and C O'Regan, "Police Cautioning – Effective Diversion or Expedience?" in L Atkinson and S Gerull (ed), *National Conference on Juvenile Justice: Proceedings of a Conference held 22-24 September 1992* (Australian Institute of Criminology, 1993) 245, 247.
74. S Morrison and M Burdon, *The Role of Police in the Diversion of Minor Alcohol and Drug-Related Offenders*, Final Report (Commonwealth Department of Health and Aged Care, 1999) 16.
75. S Morrison and M Burdon, *The Role of Police in the Diversion of Minor Alcohol and Drug-Related Offenders*, Final Report (Commonwealth Department of Health and Aged Care, 1999) 21.
76. S Morrison and M Burdon, *The Role of Police in the Diversion of Minor Alcohol and Drug-Related Offenders*, Final Report (Commonwealth Department of Health and Aged Care, 1999) 16.
77. See also NSW Police Force, *Code of Practice for CRIME (Custody, Rights, Investigation, Management and Evidence)* (2012) 15.
78. NSW Police Force, *Code of Practice for CRIME (Custody, Rights, Investigation, Management and Evidence)* (2012) 15.
79. Office of the Director of Public Prosecutions for NSW, *Prosecution Guidelines* (2007).

- reference to various discretionary factors.[80]

8.48 The Guidelines make brief reference to various personal circumstances of an alleged offender, which may weigh against a decision to prosecute. Among other things, these circumstances require consideration of an alleged offender's mental health, special disability or infirmity.[81] In addition to this, the guidelines stress that "alternatives to prosecution, including diversionary procedures, should always be considered".[82] The ODPP may also advise police as to the "sufficiency of evidence or the appropriateness of charges" and are required to give reasons accordingly.[83]

8.49 The ODPP can exercise discretion to discontinue prosecutions. Discontinuance generally requires consultation with the police officer-in-charge (including in relation to "perceived deficiencies" in the evidence) and the victim. This helps to ensure "that the prosecution is aware of all relevant factors before discontinuing or offering no evidence in a matter".[84] Similarly, where the officer-in-charge receives representations for the withdrawal of matters by police prosecutors, he or she should take into account several considerations including matters raised in correspondence, sufficiency of evidence, the public interest and consultations with victims.[85] If the representation is from a solicitor or defendant to withdraw a matter prosecuted by the police prosecutor, discretionary factors in the ODPPs guidelines apply.[86] NSW Health has observed that it is often a legal representative who will request that a charge be withdrawn.[87]

Are existing powers appropriate and adequate?

Police and ODPP practice and policy

8.50 In CP 7 we asked whether existing practices and policies of the police and the ODPP give enough emphasis to the importance of diverting people with mental illness or cognitive impairment away from the criminal justice system when exercising their discretion to prosecute or charge that person.[88]

8.51 Stakeholders submitted that the current practices and policies of police and ODPP fail to put sufficient emphasis on diversion of people with cognitive and mental

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80. Office of the Director of Public Prosecutions for NSW, *Prosecution Guidelines* (2007) Guideline 4.
81. Office of the Director of Public Prosecutions for NSW, *Prosecution Guidelines* (2007) Guideline 4, [3.17].
82. Office of the Director of Public Prosecutions for NSW, *Prosecution Guidelines* (2007) Guideline 4.
83. Office of the Director of Public Prosecutions for NSW, *Prosecution Guidelines* (2007) Guideline 14.
84. Office of the Director of Public Prosecutions for NSW, *Prosecution Guidelines* (2007) Guideline 7.
85. NSW Police Force, *NSW Police Force Handbook* (version as at October 2011) 87-88. <www.police.nsw.gov.au/about_us/policies__and__procedures >
86. NSW Police Force, *NSW Police Force Handbook* (version as at October 2011) 88. <www.police.nsw.gov.au/about_us/policies__and__procedures >
87. NSW Health, *Submission MH15*, 10.
88. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) 12, Issue 7.5.

health impairments.[89] The NSW Law Society criticised the opaqueness of the current process.[90] Concern has also been expressed regarding inconsistent application of discretion in relation to informal approaches to pre-court diversion.[91] IDRS submitted that current practice and inadequate application of guidelines is problematic.[92] The Public Interest Advocacy Centre (PIAC) submitted that, in relation to cognitive impairment, the problem is primarily related to the fact that existing services are overburdened and inadequate to meet the demand for assistance.[93]

8.52 One stakeholder provided the following case study to illustrate what, from their perspective, was a poor exercise of discretion:

Case Study 8.2

Harry (22) had a disagreement with an acquaintance, Mick, which included a physical fight. He went to the police station to report an assault, and he also told police that Mick had a large cannabis plantation in the hills outside town. The police were very interested and drove him around to look for the plantation. After some time, it transpired that there was no cannabis plantation.

The police charged Harry with "make false accusation with intent to subject another to investigation". Harry was acutely psychotic at the time and was admitted to hospital the following day. The hospital notes recorded that he was experiencing auditory hallucinations and persecutory delusions. It is difficult to see how his symptoms could have escaped the notice of the police just one day before.

We made written representations to the police, requesting them to withdraw the charge because it was most unlikely they would be able to prove each element of the offence.

Although we conceded that Harry made a false accusation, it was unlikely that he possessed sufficient mens rea to form an intention to subject Mick to a police investigation. Further, in his delusional state it was highly likely that Harry actually believed the accusation to be true.

Regrettably, the police refused to withdraw the charge. Harry chose not to go to a defended hearing but instructed us to make a section 32 application, which was ultimately granted.

In our opinion this was a case where the police ought to have exercised their discretion not to prosecute.[94]

89. Law Society of NSW, *Submission MH13*, 37; Public Interest Advocacy Centre, *Submission MH21*, 38; E Baldry, L Dowse, I Webster and P Snoyman, *Submission MH3*, 6-7; NSW Consumer Advisory Group, *Submission MH11*, 44-45; Legal Aid NSW, *Submission MH1*8, 28. NSW Police Force, *Submission MH47*, 12 noted that they have "implemented a number of policies and practices intended to divert people with a mental illness or cognitive impairment away from the criminal justice system".

90. Law Society of NSW, *Submission MH13*, 37.

91. S Morrison and M Burdon, *The Role of Police in the Diversion of Minor Alcohol and Drug-Related Offenders*, Final Report (Commonwealth Department of Health and Aged Care, 1999) 21. See also Intellectual Disability Rights Services, *Submission MH14*, 3.

92. Intellectual Disability Rights Services, *Submission MH14*, 7.

93. Public Interest Advocacy Centre, *Submission MH21*, 38.

94. Shopfront Youth Legal Centre, *Submission MH7*, 4.

8.53 Stakeholders submitted that guidelines should encourage consideration of a person's cognitive and mental health impairment when deciding whether or not to charge or prosecute.[95] However, the ODPP noted that the office primarily deals with serious crime, and many crimes involving people with a cognitive or mental health impairment involve a victim. In these serious cases it is important for the court process to be transparent and consistent with the degree of harm suffered in the context.[96] The ODPP indicated that its office deals with competing factors on a case-by-case basis, as prescribed in their prosecution guidelines,[97] and noted that there may be scope for greater encouragement of diversion by police.[98]

Additional practical concerns regarding cognitive impairment

8.54 Stakeholders highlighted the following practical concerns regarding pre-court diversion of people with cognitive impairments:

- If a person with cognitive impairment is not already linked to a service, police are unlikely to refer that person.[99]
- Limited practical assistance is available to police when determining whether or not to divert a person with a cognitive impairment from the criminal justice system.[100]
- Limited services are available for people with cognitive impairment.[101]
- Referrals to services generally require a detailed assessment.[102]

8.55 As discussed in paragraphs 8.100-8.109, difficulties may arise in relation to identification of cognitive impairment. This could mean that required supports are not provided, support people are not contacted, evidence provided during questioning is not reliable, and diversionary opportunities are not recognised.[103] The following case study illustrates some of the issues:

Case Study 8.3

One recent example is of a young woman with intellectual disability and an ongoing physical disability that causes her considerable pain. To maintain her mobility and to distract her from the pain, she carries and uses craft materials on her daily commute on the train. She also carried a pair of scissors to cut her craft materials. She was search[ed] and charged by police on the railway station while waiting for her train. Her intellectual disability meant that she had difficulties communicating with

95. Law Society of NSW, *Submission MH13*, 37; Public Interest Advocacy Centre, *Submission MH21*, 7, 38.
96. NSW, Office of the Director of Public Prosecutions, *Submission MH5*, 13-14.
97. NSW, Office of the Director of Public Prosecutions, *Submission MH5*, 14.
98. NSW, Office of the Director of Public Prosecutions, *Submission MH5*, 14.
99. NSW Health, *Submission MH15*, *9*.
100. Intellectual Disability Rights Service, *Submission MH14*, 5.
101. NSW Health, *Submission MH15*, 9; Legal Aid NSW, *Submission MH18*, 28.
102. NSW Health, *Submission MH15*, 9.
103. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) [4.5].

> police and was unable to explain her situation. The woman produced a disability support pension card to police when they requested identification.
>
> IDRS assisted her at court and initially proceeded by way of defended hearing. Ultimately the matter was dealt with by way of section 32 with no conditions. IDRS appeared on four occasions for the client before the matter was resolved.[104]

8.56 IDRS notes that in cases where people with cognitive impairments encounter police, what is required is not detention, but rather, support and services.[105] IDRS identifies a "desperate need" for:

- "emergency community based accommodation" for people with cognitive impairments who may require short-term accommodation support[106]
- "specialist disability advice and information" about services, which is made available to police on a 24-hour basis (provided or funded by Ageing, Disability and Home Care [ADHC]), and
- police and ADHC to work on policies and procedures that enable effective diversion of people with cognitive impairment from the criminal justice system.[107]

What is the appropriate role of police?

8.57 An important issue raised by studies, and by stakeholders, concerns whether or not police see it as an appropriate and important part of their role to deal with people with mental and cognitive impairments. Police are "front line" emergency responders, available at all times. In certain circumstances, a police officer can be mediator, referral agent, counsellor, mentor and facilitator of crime prevention.[108] Community expectations of police are high, and police are often asked to reconcile these competing demands. Increasingly, police are contacted to respond to people with a mental illness:

> How law enforcement responds to these individuals can have a tremendous impact on how encounters are resolved and what future these individuals can expect. Law enforcement's actions and perceptions often determine whether the individual will find much-needed treatment, continue in his or her current situation, or enter the criminal justice system.[109]

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104. Intellectual Disability Rights Service, *Submission MH14*, 3.
105. Intellectual Disability Rights Service, *Submission MH14*, 5, 6.
106. One example where the need for short-term accommodation may be required is where challenging behaviours are exhibited in a family home or group home: Intellectual Disability Rights Service, *Submission MH14*, 6.
107. Intellectual Disability Rights Service, *Submission MH14*, 6.
108. M Reuland, M Schwarzfeld and L Draper, *Law Enforcement Responses to People with Mental Illnesses: A Guide to Research-Informed Policy and Practice* (Council of State Governments Justice Center, 2009) 3; J Wood and others, *Police Interventions with Persons Affected by Mental Illnesses: Global Trends and Future Possibilities*, Policy Brief (Center for Behavioral Health Services and Criminal Justice Research, 2010) 1.
109. M Reuland, M Schwarzfeld, L Draper, *Law Enforcement Responses to People with Mental Illnesses: A Guide to Research-Informed Policy and Practice* (Council of State Governments Justice Center, 2009) 3.

8.58 However, despite the importance of their role, and the increasing public attention to the problems for people with cognitive and mental health impairment in the criminal justice system, some studies have suggested that some police officers do not regard dealing with people with a mental illness as "real police work".[110] This can significantly affect diversion, especially in the light of evidence suggesting that police officers who believe their role is primarily one of law enforcement are more likely to resort to arrest.[111] A submission from Professor Eileen Baldry and colleagues argues that the current focus of police practice is on "public safety and equitable treatment for all offenders, and not on the offender or disabilities".[112] This submission suggests that expanding the role of police to encompass, for example, formal cautioning of people with cognitive or mental health impairments would "require a whole new approach to policing". [113]

Other jurisdictions

8.59 The initiatives of other jurisdictions can inform our understanding of potential approaches to pre-court diversion.

8.60 Diversion programs such as the Police Adult Diversion Scheme in New Zealand use a prosecutorial discretion instead of a statutory framework. The program allows offenders who are charged with a criminal offence to agree to complete "diversion activities" in order to avoid prosecution and possible conviction.[114] The program focuses on rehabilitation and reparation and is not limited to offenders with cognitive and mental health impairments.[115]

8.61 The Victorian Police have developed a strategic directions paper titled, *Peace of Mind: providing policing services to people with, or affected by, mental disorders*.[116] The strategy addresses a range of matters including policing roles and responsibilities, information management, and training. Of particular relevance is the trialling of "alternative approaches to responding to people with a mental disorder so that police involvement is appropriate, targeted and well-supported", linking of police to other agencies, and making referral services easier for police to identify and access.[117] The strategy has led to a number of developments such as the "Mental Disorder Transfer Form L42" to facilitate the transfer of people from

110. J Godfredson and others, "Police Discretion and Encounters with People Experiencing Mental Illness: The Significant Factors" (2010) 37 *Criminal Justice and Behavior* 1392,1396; A Fry, D O'Riordan and R Geanellos, "Social Control Agents or Front-line Carers for People with Mental Health Problems: Police and Mental Health Services in Sydney, Australia" (2002) 10(4) *Health and Social Care in the Community* 277, 281.
111. J Godfredson and others, "Police Discretion and Encounters with People Experiencing Mental Illness: The Significant Factors" (2010) 37 *Criminal Justice and Behavior* 1392,1401.
112. E Baldry, L Dowse, I Webster and P Snoyman, *Submission MH3*, 6-7.
113. E Baldry, L Dowse, I Webster and P Snoyman, *Submission MH3*, 6.
114. New Zealand Police, *Adult Diversion Scheme Policy*, Version 17, 2.
115. New Zealand Police, *Adult Diversion Scheme Policy*, Version 17, 2-3.
116. Victoria Police, *Peace of Mind: Providing Policing Services to People with, or Affected by, Mental Disorders*, Strategic Directions Paper (2007).
117. Victoria Police, *Peace of Mind: Providing Policing Services to People with, or Affected by, Mental Disorders*, Strategic Directions Paper (2007) 3.

police to mental health or disability services and the development of a network of police Mental Health and Disability Liaison officers.[118]

Options for improving pre-court diversion

8.62 In CP 7 we asked whether reform should go beyond the existing system by creating legislation that would establish a formalised scheme of warnings and cautions to enhance an arresting officer's discretion in respect of people with a cognitive impairment or mental illness.[119] There was a mixed response to this possibility, which we consider in detail below.

8.63 We have considered two options for a diversionary scheme.

Option 1: improve guidance for use of existing discretion

8.64 A policy and procedure document, either the CRIME code of practice or a separate document, could be developed to include further material on cognitive and mental health impairment, encouraging police to use their existing discretion to divert this group where appropriate. This option could:

- encourage police to look at alternatives to arrest and charge
- encourage police to withdraw charges in appropriate circumstances
- indicate the factors that police should take into account when exercising their discretion to arrest or charge
- focus on diversion for minor offending, particularly public order offences
- encourage police training and education around issues encountered by people with cognitive and mental health impairments, and
- aim to improve networks with services that address the needs of people with cognitive and mental health impairments.

Option 2: a statutory framework

8.65 Specific legislative powers to divert could be provided, for example:

- a specific power to discontinue an arrest, and withdraw charges
- consideration of particular factors governing this decision, and
- clear guidance and procedures to support the exercise of this discretion.

118. Victoria Police, *The Victoria Police Mental Health Strategy: Now, and Then* (2011); Department of Health and Victoria Police, *Protocol for Mental Health* (Victorian Government, Mental Health and Drug Division, 2010) 41.

119. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) 11, Issue 7.2.

Such a scheme could be supported by referral to services in appropriate cases.[120]

Stakeholder views

8.66 The majority of submissions that responded to this issue expressed support for a formalised pre-court diversion scheme.[121] The NSW Police Force indicated their openness to considering a pre-court diversion scheme, although they also submitted that a diversion scheme should operate primarily in the court system.[122] However, the Local Court submitted that the question of cognitive or mental health impairment should not always be left to the court and the exercise of police discretion not to charge an individual with an impairment, particularly in relation to lower level offending, should be used more often.[123] IDRS suggested that, if framed appropriately, such a scheme could help ensure greater consistency in diversion, provide guidance and introduce accountability into diversionary practices (including monitoring of diversionary decisions).[124] A legislative pre-court diversion scheme could also provide an additional 'step' or layer in the options available to police.[125]

8.67 However some key stakeholders expressed concerns about a statutory scheme,[126] arguing that informal exercise of discretion[127] or the use of s 22 apprehensions and assessment[128] were more appropriate mechanisms for diversion. These stakeholders submitted that the police currently have sufficient discretion to warn or caution people with cognitive and mental health impairments,[129] or that improving the exercise of discretion is preferable to the introduction of a formalised scheme.[130] The NSW Bar Association submitted that guidelines and protocols should be complemented with continuing education and training about people with cognitive and mental health impairments in the criminal justice system.[131] Other measures,

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120. 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) 74.
121. NSW, Office of the Director of Public Prosecutions, *Submission MH5*, 13; NSW, Public Defenders, *Submission MH26*, 49; Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28-1*, 18; Shopfront Youth Legal Centre, *Submission MH7*, 2; Legal Aid NSW, *Submission MH1*8, 27; Public Interest Advocacy Centre, *Submission MH21*, 38; Law Society of NSW, *Submission MH13*, *34.*
122. NSW Police Force, *Submission MH47*,11: In response to CP 7 Issue 7.1 NSW Police said "The NSW Police Force is open to the idea of a diversionary scheme for people with a cognitive impairment and/or a mental illness." However, later in the same paragraph they submit that police should retain their power to caution … but the diversion scheme should primarily operate within the court system".
123. Local Court of NSW, *Submission MH4*, 7.
124. Intellectual Disability Rights Service, *Submission MH14*, 4.
125. S Morrison and M Burdon, *The Role of Police in the Diversion of Minor Alcohol and Drug-Related Offenders*, Final Report (Commonwealth Department of Health and Aged Care, 1999) 22.
126. NSW Health, *Submission MH15*, 8.
127. Local Court of NSW, *Submission MH4*, 6; NSW Bar Association, *Submission MH10*, 50*;* L Steele *Submission MH9*, 9.
128. NSW Health, *Submission MH15*, 8; Local Court of NSW, *Submission MH4*, 6.
129. NSW Bar Association, *Submission MH10*, 50.
130. L Steele, *Submission MH9*, 9.
131. NSW Bar Association, *Submission MH10*, 51.

such as expanded support services, could also improve the exercise of informal police discretion.[132]

8.68 Some stakeholders raised matters that require consideration in framing a scheme:

(1) **Training and support.** Stakeholders expressed the view that a formal scheme should be accompanied by effective police training and guidance.[133] Other stakeholders, noted that identification was a practical impediment to equitable operation of a diversion scheme.[134]

(2) **Links to services.** Stakeholders submitted that an effective system of pre-court diversion will require linking or referring people to appropriate services, treatment and support, ideally targeted at reducing reoffending[135] and will require interagency cooperation, communication and systemic changes, for example, more beds from Health and more supports and services from ADHC.[136] The NSW Police Force raised the issue of appropriate resourcing of the scheme of services.[137]

(3) **Net widening.** Stakeholders and commentators expressed concern that the introduction of a formal scheme of cautions and warnings may lead to net widening.[138] For example, formal cautions may be used in response to behaviour which may have otherwise been dealt with on an informal basis.[139] PIAC submitted that cautions should only be used in circumstances where police would have taken action in relation to an alleged offence such as arrest, fine, and issuing a court attendance notice and should not be used where matter would otherwise have been dealt with informally.[140] Similarly, IDRS noted that any formalised scheme should not limit informal police discretion in relation to serious offending.[141] Additionally, stakeholders have noted that a formalised scheme may increase police contact with people with cognitive impairment and thereby increase the possibility of interactions escalating into offences.[142] Any

132. L Steele, *Submission MH9*, 9.

133. L Steele, *Submission MH9*, 10; Legal Aid NSW, *Submission MH1*8, 27; Law Society of NSW, *Submission MH13*, 35. Intellectual Disability Rights Service, *Submission MH14*, 5; NSW Consumer Advisory Group, *Submission MH11*, 44.

134. Shopfront Youth Legal Centre, *Submission MH7*, 3; NSW, Office of the Director of Public Prosecutions, *Submission MH5*, 13; NSW, Public Defenders, *Submission MH26*, 49; Intellectual Disability Rights Service, *Submission MH14*, 5; Department of Human Services NSW (Ageing, Disability and Home Care) *Submission MH28-1*, 18. The Office of the Directory of Public Prosecutions further noted that some people with mental illness may be well known to police.

135. NSW Consumer Advisory Group, *Submission MH11*, 44; Shopfront Youth Legal Centre, *Submission MH7*, 3; Law Society of NSW, *Submission MH13*, 35.

136. E Baldry, L Dowse, I Webster and P Snoyman, *Submission MH3*, 6; Law Society of NSW, *Submission MH13*, 35.

137. NSW Police Force *Submission MH47*, 11.

138. Public Interest Advocacy Centre, *Submission MH21*,42; L Steele, *Submission MH9*, 9; S Morrison and M Burdon, *The Role of Police in the Diversion of Minor Alcohol and Drug-Related Offenders*, Final Report (Commonwealth Department of Health and Aged Care,1999) 22.

139. Public Interest Advocacy Centre, *Submission MH21*, 42.

140. Public Interest Advocacy Centre, *Submission MH21*, 42.

141. Intellectual Disability Rights Service, *Submission MH14*, 4.

142. L Steele, *Submission MH9*, 9-10. 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) 14, 71-72.

net widening effect would be particularly problematic if enforceable conditions were attached to pre-court diversion and exploited to channel people into services who may not have otherwise been within the criminal justice system or who could have engaged in services voluntarily.[143] Conversely, stakeholders also expressed concerns that a formal scheme may not be effective due to under utilisation.[144] The NSW Police Force submitted that police officers would need discretion to decide how to deal with complex cases and recidivist offenders.[145]

(4) **Consent to conditions.** A person with a cognitive or mental health impairment may have difficulty understanding and complying with conditions, if imposed as part of the requirements of a diversionary scheme.[146]

(5) **Legal advice.** A formalised scheme should be accompanied by appropriate safeguards and funding for independent legal advice and access to a support person.[147]

(6) **Admission of guilt.** Some stakeholders argued that admission should not be a prerequisite for pre-court diversion.[148] If admission was required, then pre-court diversion may be less advantageous than court diversion under s 32 of the MHFPA, which requires no admission.[149] Additionally, if admission was required difficulties may arise with respect to capacity or fitness to plead.

(7) **Impairment type.** Stakeholders have argued that cognitive and mental health impairments should be defined broadly for the purposes of pre-court diversion.[150] Legal Aid NSW noted that the impairment types should be consistent with s 32 of the MHFPA.[151] The NSW Police Force had concerns about the difficulty for police if any diversionary scheme asked police to diagnose mental illness and cognitive impairment.[152]

(8) **Offences.** Stakeholders have suggested that a pre-court diversionary scheme could capture more trivial offences that would currently be dealt with under s 32 of the MHFPA.[153] The Public Defenders for example suggested a pre-court diversion system should apply to "relatively minor offences".[154] Some stakeholders submited that pre-court diversion should not be limited to summary offences because this would exclude many minor offences such as petty larceny

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143. L Steele, *Submission MH9*, 9.
144. Shopfront Youth Legal Centre, *Submission MH7*, 3.
145. NSW Police Force *Submission MH47*, 11.
146. Local Court of NSW, *Submission MH4*, 6. See also L Steele, *Submission MH9*, 9-10.
147. Legal Aid NSW, *Submission MH18*, 27; Shopfront Youth Legal Centre, *Submission MH7*, 2; L Steele, *Submission MH9*, 10.
148. Shopfront Youth Legal Centre, *Submission MH7*, 2; L Steele, *Submission MH9*, 10.
149. Shopfront Youth Legal Centre, *Submission MH7*, 2
150. Shopfront Youth Legal Centre, *Submission MH7*, 2; NSW, Public Defenders, *Submission MH26*, 49.
151. Legal Aid NSW, *Submission MH1*8, 27.
152. NSW Police Force *Submission MH47*, 11.
153. NSW, Office of the Director of Public Prosecutions, *Submission MH5*, 13; Legal Aid NSW, *Submission MH18*, 27.
154. NSW, Public Defenders, *Submission MH26*, 49.

and suggest that it should apply to summary offences and indictable offences that are capable of being dealt with summarily.[155]

(9) **Multiple offences.** The ODPP noted the "scheme probably should not be limited by the number of offences on the accused's record".[156]

(10) **Victims.** The NSW Police Force submitted that proper consultations with victims groups should occur to ensure that victims' rights are not compromised by diversion of these offenders.[157]

The Commission's view: a model for NSW

8.69 We support a statutory scheme supported by improved policy and procedural guidance. Increasing pre-court diversion will help to ensure that as many people with cognitive and mental health impairments as possible avoid entering the court system. A statutory scheme would provide the police with a clear and transparent basis for exercising their discretion, and provide safeguards for defendants. It may reduce costs by reducing the number of people who appear before court, particularly the Local Court. By responding to the factors that are causing offending early in an offender's history it could assist in reducing the number of people who repeatedly offend, and who ultimately may end up incarcerated.

8.70 Broadly, the new diversionary provision should have the following characteristics:

- Create a clear power for the police to discontinue proceedings in appropriate circumstances.
- Provide a framework for decisions about whether or not diversion is appropriate.
- Deal with key issues such as consent and admissions.

8.71 The Commission also believes that this power should operate pre and post charge. The power could be exercised through the initiative of police and on the application of the person or someone acting in his or her interests. Where it operates post charge, diversion would essentially amount to a withdrawal of charge. This means that where a person is issued with a Court Attendance Notice (CAN), or where police do not identify an impairment upon arrest and proceed to charge, the person can still apply for consideration to be diverted.

8.72 The criteria for diversion should include:

- **The apparent nature of the person's cognitive or mental health impairment:** We focus here on the *apparent* nature and severity of the impairment, rather than the actual nature or severity. This maximises flexibility and responds to the concern of NSW Police Force that police officers should not be called upon to make diagnoses they are not qualified to make, nor do they have to wait for complex diagnostic reports prior to making a diversion decision.

155. Law Society of NSW, *Submission MH13*, 34; Legal Aid NSW, *Submission MH18*, 27; Shopfront Youth Legal Centre, *Submission MH7*, 2.

156. NSW, Office of the Director of Public Prosecutions, *Submission MH5*, 13.

157. NSW Police Force *Submission MH47*, 11.

- **The nature, seriousness and circumstances of the alleged offence:** This allows the police to take into account various community interests, including that of a victim where applicable.

- **The nature, seriousness and circumstances of the person's history of offending, if any**: We do not recommend that any cap be attached to the number of times that this diversionary option can be used in relation to a particular individual. However, this should be balanced against community interests, which includes the person's history of offending behaviour and whether in the light of this history, pre-court diversion is appropriate.

- **Any information available concerning the availability of treatment, intervention or support in the community:** If police are to divert defendants to services, like courts, they will need assistance and information. It is not reasonable to expect police to develop treatment plans or to engage defendants with services. In some cases the person will already be receiving treatment or services, and the police may consider whether this provides enough support to divert the person. In other cases, police may need to refer the defendant for assessment as to whether there are support services available and the person is suitable and willing to engage. (We recommend police have such referral pathways available to them below, in Recommendation 8.5). On the basis of advice from such a service, police may form the view that diversion is the proper course.

8.73 We believe that the factors relevant to police diversion should be framed in a simple and easy to administer fashion. These factors should be weighed together in the balance. For example, where the offence is relatively minor, the community treatment, intervention or support required to make a person eligible for pre-court diversion may be minimal.

8.74 The factors relevant to decisions made at court stage are, rightly, more complex. This is because the courts may have more time available to them before making a decision, are likely to deal with more serious offences, and have a greater range of powers available to them.

Additional considerations

8.75 As we noted above, stakeholders expressed concern about net widening, consent and coercion and the requirements for an admission of guilt. For these reasons, we believe that:

- The diversion power should only be used where informal discretion, for example an informal warning, is not appropriate.

- The diversion power should not preclude a police officer from exercising their powers under s 22 of the MHA, where appropriate.

- There should not be any ongoing involvement by police after the power is utilised.

- No admission of guilt should be required for the use of this power. Admissions raise capacity issues and could make this power more coercive or punitive than s 32 at court stage.

8.76 Stakeholders warned against placing limitations on the range of impairments, qualifying offences and on the number of times that the power can be exercised. For these reasons, the Commission recommends:

- Adopting the broad definition of cognitive and mental health impairment in Chapter 5. This would ensure consistency with the terminology used in s 32 of the MHFPA and allow for flexibility in making a diversion decision.
- The power should be available for summary offences and indictable offences that are capable of being dealt with summarily. This captures the same range of offences that is currently available in relation to s 32 of the MHFPA.
- A person is not to be precluded from being diverted merely because that person has previously committed offences or been diverted before. This maximises flexibility and means that people who risk being charged and progressing through the criminal justice system can be assessed on a case by case basis. We consider that the imposition of any limit would be arbitrary. However we have listed the defendant's history of offending as a relevant factor to be taken into account.

8.77 The operation of these provisions will require supporting policy and procedure, as well as a range of services to assist police, which we discuss below. Such policies and procedures should provide police officers a clear operational framework for making the diversion decision, including procedures for making referrals to assessment services. We propose that the NSW Police Force develop these procedures in consultation with the Courts, relevant government agencies (such as Health NSW and Department of Attorney General and Justice) and community stakeholders.

Recommendation 8.3

Legislation should provide for a pre-court diversion option as follows:

(a) Where a person appears to have a cognitive impairment or mental health impairment as defined in Recommendation 5.1 and 5.2, a police officer may decline to charge or may withdraw a charge.

(b) In making a decision under (a), the police officer should take into account:

  (i) the apparent nature of the person's cognitive or mental health impairment

  (ii) the nature, seriousness and circumstances of the alleged offence

  (iii) the nature, seriousness and circumstances of the person's history of offending, if any, and

  (iv) any information available concerning the availability of treatment, intervention or support in the community.

(c) This option should:

  (i) be available in relation to summary offences and indictable offences that are capable of being dealt with summarily

  (ii) be available both pre and post charge

  (iii) not require an admission of guilt, and

(iv) not preclude a person from being diverted merely because that person has previously committed offences or been dealt with under this option.

(d) This option should only be used where it is not appropriate to deal informally with the person, such as by warning or caution.

(e) This option does not preclude a police officer from exercising his or her powers under s 22 of the *Mental Health Act 2007* (NSW).

(f) A police officer should make a record where a person has been dealt with under this option.

Recommendation 8.4

The NSW Police Force should develop procedures to support the operation of pre-court diversion of people with cognitive and mental health impairments in consultation with the Courts, relevant government agencies (such as NSW Health and the Department of Attorney General and Justice) and community stakeholders.

Skills and supports for diversion decisions

8.78 In chapter 7 and below, we discuss the challenges encountered by police and other criminal justice stakeholders in relation to identifying and supporting people with cognitive and mental health impairments. Below, we also make recommendations to improve police training to enhance their capacity to identify signs of cognitive and mental health impairment.

8.79 We also highlight the importance of diversion from the criminal justice system by police and prosecutors, and the important role this early intervention in the criminal justice system can play in reducing the likelihood of future contact with police, courts and prison.[158] Increasing the number of diversion pathways can help in removing the barriers to accessing treatment and services as well as to achieving better rehabilitative and integration outcomes.[159] The development of effective, and also cost-effective, interventions for people with cognitive and mental health impairments, and other complex needs, is a challenge for the pre-court diversion system.[160]

How should diversion be supported?

8.80 There was a wide range of views about how police diversion should be supported. PIAC has argued for mental health liaison officers at key police stations.[161] The NSW Law Society submitted that formalised diversion systems should be accompanied by effective referral to support services tailored to each defendant,

158. Victoria, Department of Justice, *Justice Mental Health Strategy* (2010) 15.

159. Victoria, Department of Justice, *Justice Mental Health Strategy* (2010) 15.

160. J Wood and others, *Police Interventions with Persons Affected by Mental Illnesses: A Critical Review of Global Thinking and Practice* (Center for Behavioral Health Services and Criminal Justice Research, 2011) 29-31.

161. Public Interest Advocacy Centre, *Submission MH21*, 39.

which are aimed at reducing reoffending.[162] The Law Society argued that a good diversionary scheme would provide increased and improved opportunities for reduction in future offending.[163] A key factor is strengthening referral pathways at pre-court stage.[164]

8.81 Examples of approaches that go beyond crisis support include policy custody liaison schemes in the UK. One such scheme is the CPN Police Liaison Service in Central London, which is run by Community Psychiatric Nurses (CPNs). Under this scheme, CPNs screen people in custody and respond to referrals from custody managers. The CPN develops a diagnosis, determines the appropriate service (for example, a community organisation or hospital) and makes a referral by contacting mental health professionals. The CPN Liaison scheme has a goal of diverting minor offenders, "who would otherwise receive no service" out of custody and into appropriate services.[165] However such an approach is limited to mental health.

Diversion support – a model for NSW

8.82 In Chapter 7 we recommend that the Statewide Community and Court Liaison Service (SCCLS) and Court Referral of Eligible Defendants into Treatment (CREDIT) services be expanded and developed. These services can assist with identification, assessment, referrals and case management. It would be sensible if police were able to refer people to the same diversion program.

8.83 The SCCLS and CREDIT provide assessment, referral and case management – in other words the skills identified above that are required for successful diversion. Making these services available before a matter proceeds to court can help to facilitate diversion at the earliest possible stages, thereby minimising resource demands and the stress and delay involved in court proceedings.

8.84 Referral to these support services would not be required in all cases. Some decisions could be made on the basis of police knowledge and experience. Other decisions could be made with the support of family members, legal representation, or existing case managers. For example, where a person has a Guardian appointed, the Guardian may be in a position to provide information to the police regarding the nature of that person's impairment as well as advocate and arrange services for that person and provide this information to police (see Case Study 2.2).

8.85 If a police officer suspects that a person with a cognitive and mental health impairment is committing an offence and it would not be appropriate to deal with the person informally he or she could:

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162. Law Society of NSW, *Submission MH13*, 35.

163. Law Society of NSW, *Submission MH13*, 36.

164. Victoria, Department of Justice, *Justice Mental Health Strategy* (2010) 26.

165. D James, "Police Station Diversion Schemes: Role and Efficacy in Central London" (2000) 11 *The Journal of Forensic Psychiatry* 532, 532; J Wood and others, *Police Interventions with Persons Affected by Mental Illnesses: A Critical Review of Global Thinking and Practice* (Center for Behavioral Health Services and Criminal Justice Research, 2011) 29. See D James, "Court Diversion at 10 Years: Can it Work, Does it Work and Has it a Future?" (1999) 10(3) *The Journal of Forensic Psychiatry* 507, 513.

(1) Use his or her training to establish that the person is exhibiting signs of cognitive and mental health impairment.

(2) Confirm identification using one of more of the following:

(a) Deliver that person to a mental health facility (if the person is in crisis) or contact a Mental Health Intervention Team (MHIT) trained police officer (discussed below) to assist with identification and communication.

(b) Talk to the person, family member or legal representative to determine whether that person has previously been identified with an impairment and whether or not that person is connected to services.

(c) Use information drawn from previous encounters with the person, where applicable.

(d) Contact the SCCLS to assist with identification/assessment of a cognitive or mental health impairment.

The approach would depend on the relevant circumstances, including whether or not the person is at the police station. Similarly, where an impairment is not identified by the police officer, or the person is not initially considered for pre-court diversion, a family member or legal representative could make a request for pre-court diversion and provide the police officer with supporting information.

(3) Consider the apparent nature and severity of the impairment (based on available information), the nature, seriousness and circumstances of the alleged offence, and the person's history of offending (if any). The police officer would also consider any information available concerning availability of treatment, intervention and support in the community (this may include advice received from the person or other people regarding this issue). If the police officer is not satisfied with the supports that are currently available the police officer may:

(a) ask SCCLS to arrange an appropriate referral, or

(b) contact CREDIT and ask them to assess the individual, create a plan/report outlining necessary services and whether the person can access them.

(4) The police officer would make a record of the decision to divert the person.

(5) If CREDIT is used as the supporting mechanism a CREDIT case manager can provide short term case management where required (following the diversion decision made by police).

If referral does not lead to diversion, the relevant information could then still be provided to the court to support a s 32 application.

8.86 It is essential that the enhanced diversionary power of police be supported by access to advice and information regarding the nature of an impairment and the availability of services where required to help an individual access a pre-court diversion. Furthermore, making the SCCLS and CREDIT available at pre-court stage provides police with a diversionary option that may be effective in linking people to services and reducing offending.

8.87 We therefore recommend that assessment, advice and referral services be made available to police at the pre-court stage to assist police with identification and diversion decision-making. This recommendation would be supported by increased training of police, as we recommend in Recommendation 8.6 and by the development of guidelines and procedures in accordance with Recommendation 8.4.

Recommendation 8.5

(1) The Statewide Community and Court Liaison Service should be expanded to provide assessment, referral and advice to police officers to assist in making decisions in relation to diversion of people with cognitive and mental health impairments.

(2) The CREDIT program should be extended to provide services and advice to police to assist them in making decisions in relation to the diversion of people with cognitive and mental health impairments.

Police training

8.88 Given the high level of police involvement with people with mental health and cognitive impairment and the special legislative provisions that apply to this group, there is a clear need to ensure that front line police officers, especially those in key roles, such as custody managers, are adequately trained.

8.89 In CP 7 we asked what education and training would assist police in using their powers to divert offenders with a mental illness or cognitive impairment away from the criminal justice system.[166] NSW Police submitted that the current levels of police training are adequate for current needs.[167]

8.90 However, other stakeholders highlighted a need for education and training directed at to improving the way that police deal with people in this group.[168] More specifically they suggested training should encompass:

- the identification of people who may have a cognitive and mental health impairment[169]
- enhancement of police understanding of cognitive impairment, including its effects and required adjustments[170]
- de-escalation of potentially dangerous situations[171]

166. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7, (2010) 15, Issue 7.8.

167. NSW Police Force, Submission MH47, 13.

168. E Baldry, L Dowse, I Webster and P Snoyman, *Submission MH3*, 7; NSW Bar Association, *Submission MH10*, 51; Shopfront Youth Legal Centre, *Submission MH7*, 4; L Steele, *Submission MH9*, 11; NSW Health, *Submission MH15*, 10; Legal Aid NSW, *Submission MH18*, 27, 28. See also Justice Health, Victorian Government Department of Justice and the National Justice Chief Executive Officers' Group, *Diversion and Support of Offenders with a Mental Illness: Guidelines for Best Practice* (2010) 22.

169. Legal Aid NSW, *Submission MH18*, 28; Law Society of NSW, *Submission MH13*, 38.

170. Intellectual Disability Rights Service, *Submission MH14*, 8; L Steele, *Submission MH9*, 11.

- effective communication[172]
- enhancement of police awareness of the difficulties faced by people with cognitive and mental health impairments[173]
- the need for treating people with cognitive and mental health impairments with dignity and respect and being sensitive to their needs[174]
- attitudinal shift, and[175]
- the distinction between mental illness and cognitive impairment. [176]

The current approach to support and training

8.91 The NSW Police have adopted a number of valuable initiatives in order to assist them in their interactions with people with a mental illness or cognitive impairment.

8.92 The Mental Health Intervention Team (MHIT) was established as a pilot program in 2007 to help the police in their interactions with members of the public with mental health issues. This program provides enhanced mental health training to a number of frontline officers (principally constables, senior constables and sergeants).[177] The 4-day training course is designed to engage police with a mix of clinical theory and relevant practical operational skills, which can be used in the field on a day-to-day basis. The program seeks to educate police about identifying behaviours that are indicative of mental illness, communication strategies, risk assessment, de-escalation and crisis intervention techniques.

8.93 The program is also targeted at improving police understanding of the MHA as well as the MOU between police, Ambulance Service and NSW Health.[178]

8.94 The MHIT model was evaluated with positive findings on the basis that it:

- compares favourably with best practice for police training in relation to interaction with people with a mental illness[179]
- has assisted in developing good relationships with police and other relevant stakeholders such as Health, as well as increased information sharing, and[180]

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171. Shopfront Youth Legal Centre, *Submission MH7*, 4; NSW Consumer Advisory Group, *Submission MH11*,46; Law Society of NSW, *Submission MH13*, 38.
172. L Steele, *Submission MH9*, 11; Legal Aid NSW, *Submission MH18*, 28; Parramatta Community Justice Clinic, *Submission MH22*, 4.
173. Legal Aid NSW, *Submission MH18*, 28.
174. L Steele, *Submission MH9*, 11; Legal Aid NSW, *Submission MH18*, 28.
175. E Baldry, L Dowse, I Webster and P Snoyman, *Submission MH3*, 7.
176. Intellectual Disability Rights Service, *Submission MH14*, 8.
177. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report* (Charles Sturt University, 2009) 2.
178. NSW Police Force, "Mental Health Policy update: October 2010 to March 2011" *Mental Health Intervention Team News* (March 2011) 6.
179. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report* (Charles Sturt University, 2009) 18.
180. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report* (Charles Sturt University, 2009) 18.

- has increased use of de-escalation techniques and increased confidence in dealing with people with a mental illness.[181]

8.95 The evaluation made a range of recommendations including increased interaction with non-government organisations (NGOs) at a local and State level, special attention to, and enhanced training of, officers in rural and remote communities as well as revision of key performance indicators to monitor the program.[182]

The evaluation of the MHIT training program also identified training needs, including training police radio dispatchers and linking the use of Tasers to mental illness awareness training.[183] The use of Tasers with respect to people with a mental illness has been reviewed by the NSW Ombudsman.[184] In 2008, the Ombudsman identified that 68% of people subjected to a Taser application were identified as having mental health issues.[185] Tasers may also have a greater physical impact on people with a mental illness, and those who are affected by drug or alcohol use, who may have a different threshold for onset of cardiac arrhythmias.[186] The NSW Ombudsman recommended that all officers authorised to use Tasers should receive training in relation to mental health issues, including training in relation to communication and de-escalation.[187]

8.96 In June 2009, the MHIT program was made a permanent component of the NSW Police Force Policy and Programs Command.[188] A goal of the program is to train 1500 operational police or 10% of front line officers by 2015.[189] By March 2011, over 450 police officers had undertaken the MHIT training.[190]

8.97 A clinical nurse consultant (CNC) is involved with the MHIT. NSW Health funds the position.[191] The CNC delivers training, attends Local Protocol Committee (LPC) meetings (bi-monthly meetings with local mental health, ambulance and Emergency Department staff), provides an on-call number for officers who experience

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181. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report* (Charles Sturt University, 2009) 29.
182. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report* (Charles Sturt University, 2009) 5-6.
183. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report* (Charles Sturt University, 2009) 21-22, 75.
184. NSW Ombudsman, *The Use of Taser Weapons by New South Wales Police Force: A Special Report to Parliament under Section 31 of the Ombudsman Act 1974* (2008).
185. NSW Ombudsman, *The Use of Taser Weapons by New South Wales Police Force: A Special Report to Parliament under Section 31 of the Ombudsman Act 1974* (2008) ii, 59, 78.
186. NSW Ombudsman, *The Use of Taser Weapons by New South Wales Police Force: A Special Report to Parliament under Section 31 of the Ombudsman Act 1974* (2008) 15-16.
187. NSW Ombudsman, *The Use of Taser Weapons by New South Wales Police Force: A Special Report to Parliament under Section 31 of the Ombudsman Act 1974* (2008) 70-71.
188. See NSW Police Force, *Annual Report 2008-2009*, 35; NSW Police Force, "Why MHIT?", *Mental Health Intervention Team News* (March 2011) 1.
189. NSW Police Force, "Why MHIT?",*Mental Health Intervention Team News* (March 2011) 1. NSW Police Force, NSW Police Force, "Mental Health" (last updated 14 October 2011) <www.police.nsw.gov.au/community_issues/mental_health>. NSW Consumer Advisory Group, *Submission MH11*, 44.
190. NSW Police Force, "Why MHIT?", *Mental Health Intervention Team News* (March 2011) 1, 4.
191. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report* (Charles Sturt University, 2009) 17; NSW Police Force, *Mental Health Intervention Team News* (March 2011) 1, 4.

difficulties in the field and enhances communication between the MHIT and LPC about difficulties they encounter.[192]

8.98 The MHIT also assists by providing operation and policy advice to Mental Health Contact Officers in Local Area Commands (LAC) who have to deal with emergency mental health issues in their local areas, for example by assistance with mental health frequent presenters or assisting with interagency disputes.[193] Mental Health Contact Officers are responsible for liaising between Health and police as well as being the LAC representatives on Local Protocol Committees (interagency committees designed to develop and implement interagency protocols and agreements within the bounds of the MOU).[194]

8.99 In addition, all police undergo the Disability Awareness Training Package under the Mandatory Police Continuing Education scheme.[195] The NSW Police Disability Action Plan identifies key areas for police to "minimise barriers to community access, provide information in an accessible way and ensure participation and advice from people with disabilities".[196] The plan highlights areas such as access to services, training and education and agency partnerships.[197]

Identification and response to cognitive and mental health impairments

8.100 Notwithstanding the success of the MHIT program, some stakeholders expressed concerns in submissions that police do not always have the relevant skills to identify a person with a mental illness or cognitive impairment. Identification has been cited as an impediment to effective pre-court diversion of people with cognitive and mental health impairments.[198] In particular, identification may be challenging when dealing with people with cognitive and mental health impairments that are not in crisis. Difficulties with identification may be compounded where a person has complex needs.[199]

8.101 The NSW Consumer Advisory Group (NSWCAG) notes that it is "clear from what NSWCAG hears from consumers that police are inadequately trained to understand and appropriately respond to someone with mental illness".[200] However,

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192. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report* (Charles Sturt University, 2009) 22.
193. NSW Police Force, "Current news" *Mental Health Intervention Team News* (March 2011) 1.
194. NSW Health, Ambulance Service of NSW, NSW Police Force, *Memorandum of Understanding Mental Health Emergency Response* (2007) 4.
195. See NSW Police Force, *Annual Report 2007-2008* 33; NSW Police Force, *Disability Action Plan 2010-2011* (2011) 6.
196. NSW Police Force, *Disability Action Plan 2010-2011* (2011) 3.
197. NSW Police Force, *Disability Action Plan 2010-2011* (2011) 8-11.
198. NSW, Office of the Director of Public Prosecutions, *Submission MH5*, 13; Shopfront Youth Legal Centre, *Submission MH7*, 3; NSW Public Guardian, *Submission MH27*, 24; Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28-1*, 21; Law Society of NSW, *Submission MH13*, *35;* NSW, Public Defenders, *Submission MH26*, 49.
199. See our discussion in para 7.7.
200. NSW Consumer Advisory Group, *Submission MH11*, 43.

stakeholders have also noted that some people with cognitive and mental health impairments may be well known to police.[201]

8.102 The *Framework Report*, a report by the IDRS and NSW Council for Intellectual Disability, highlighted that different disabilities have distinct impacts on communication and support needs. The Report noted that police encounter difficulties distinguishing between different disabilities.[202] While police should not be expected to diagnose disability at initial point of contact it is important that police and support people "broadly recognise the impact of different disabilities on communication and identify strategies to accommodate the person's communication needs".[203] The Report further notes that codes of practice should be complemented with information and training about different disabilities.[204]

8.103 Stakeholders have expressed concern that current levels and coverage of police training in relation to cognitive and mental health impairments is inadequate and that comprehensive coverage would be beneficial.[205] NSWCAG notes that the current aim of training 10% of front line police officers over the next five years is inadequate.[206] Additionally, police have reported feeling unsupported in their work, for example, when dealing with people who are suicidal.[207]

8.104 It was noted during consultations that, outside of the MHIT training, training provided in relation to cognitive and mental health impairments is provided on a more ad hoc basis. For example, while recruit training or specialist training might be available, there is not structured mental health training provided to all police officers. Similarly, stakeholders in consultations noted that more could be done in relation to the type and amount of training in relation to cognitive impairment.

8.105 People with cognitive and mental health impairments have reported a fear of police, feelings of victimisation, as well as undue targeting.[208] Some people with mental health impairments reported that they felt that police were fearful of them and this

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201. Shopfront Youth Legal Centre, *Submission MH7*, 3; NSW, Office of the Director of Public Prosecutions, *Submission MH5*, 13; Public Interest Advocacy Centre, *Submission MH21*, 38.
202. J Simpson, M Martin and J Green, *The Framework Report: Appropriate Community Services in NSW for Offenders with Intellectual Disabilities and those at Risk of Offending* (NSW Council for Intellectual Disability, 2001) 23.
203. J Simpson, M Martin and J Green, *The Framework Report: Appropriate Community Services in NSW for Offenders with Intellectual Disabilities and those at Risk of Offending* (NSW Council for Intellectual Disability, 2001) 26.
204. J Simpson, M Martin and J Green, *The Framework Report: Appropriate Community Services in NSW for Offenders with Intellectual Disabilities and those at Risk of Offending* (NSW Council for Intellectual Disability, 2001) 23.
205. NSW Consumer Advisory Group, *Submission MH11*, 44; Public Interest Advocacy Centre, *Submission MH21*, 39. See also 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) 73.
206. NSW Consumer Advisory Group, *Submission MH11*, 45-46.
207. A Fry, D O'Riordan and R Geanellos, "Social Control Agents or Front-line Carers for People with Mental Health Problems: Police and Mental Health Services in Sydney, Australia" (2002) 10(4) *Health and Social Care in the Community* 277, 280.
208. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report* (Charles Sturt University. 2009) 30; 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) 71.

could lead to an escalation during police encounters.[209] There have been high profile incidents involving fatal use of force by police officers during encounters with people with mental illness.[210] One submission expressed concern regarding police use of force in relation to people with a mental illness.[211] Studies in Victoria have noted the high prevalence of mental health impairments among people who were fatally shot by police.[212]

8.106 Difficulties with identification can also have a significant impact on the ability of police to comply with procedural protections. Stakeholders have expressed concern that the requirements under LEPRA are not always followed. For example, stakeholders noted that police have refused to obtain support people (or do not obtain "adequate" support people for interviews), custody managers are not always present to ensure rights are respected during interview stage and that inappropriate questions are sometimes asked "designed to elicit answers from people who, by reason of a cognitive or mental health impairment, have particular difficulty coping with pressure".[213] We acknowledge that it is difficult to identify cognitive and mental health impairments without expert knowledge and expertise.[214] It is unrealistic to expect police to be able to identify all individuals with such impairments, especially in light of the broad range of functions performed by police. [215]

8.107 Stakeholders also commented that it is desirable for training to be delivered by or alongside external organisations and/or people who have experienced cognitive and mental health impairments.[216] The need for increased utilisation of available support services such as the Criminal Justice Support Network has also been suggested.[217]

8.108 We note that police are frequently asked to make decisions regarding behavioural disturbances and, at times, it can be difficult to distinguish the symptoms of an impairment from, for example, the effects of intoxication:

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209. V Herrington and others, *The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report* (Charles Sturt University, 2009) 30.
210. Expert Advisory Committee on Information Sharing in Mental Health Crisis Situations Report, *Toward a National Approach to Information Sharing in Mental Health Crisis Situations*, (Commonwealth Department of Health and Aged Care, 2000) 7.
211. NSW Consumer Advisory Group, *Submission MH11*, 43.
212. D Kesic, S Thomas and J Ogloff, "Mental Illness among Police Fatalities in Victoria 1982-2007: A Case Linkage Study" (2010) 44 *Australian and New Zealand Journal of Psychiatry* 463, 466-467.
213. Legal Aid NSW, *Submission MH1*8, 27; Law Society of NSW, *Submission MH13*, *3;* 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) 73-74; NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) 81.
214. Local Court of NSW, *Submission MH4*, 7.
215. Stakeholders highlighted that it isn't feasible for police to conduct a comprehensive mental health assessments of everyone they come into contact with: NSW Trustee and Guardian, *Submission MH16*, 4; NSW Health, *Submission MH15*, *8;* M Sced, *Mental Illness in the Community and the Role of Police* (Australasian Centre for Policing Research, 2006) 9.
216. L Steele, *Submission MH9*, 11; NSW Consumer Advisory Group, *Submission MH11*, 46; NSW, Public Defenders, *Submission MH26*, 50; Intellectual Disability Rights Service, *Submission MH14*, 8.
217. L Steele, *Submission MH9*, 9. See also A Fry, D O'Riordan and R Geanellos, "Social Control Agents or Font-line Carers for People with Mental Health Problems: Police and Mental Health Services in Sydney, Australia" (2002) 10 *Health and Social Care in the Community* 277, 280-281.

> Collaboration between the courts, police, mental health services, [alcohol and drug] services and emergency department staff can make a significant difference to the immediate and longer term outcomes for the person involved.[218]

8.109 Stakeholders have also argued that greater coverage of existing support services is required to improve pre-court diversion and support of people with cognitive and mental health impairment. For example, the Criminal Justice Support Network, which provides assistance to people with an intellectual disability who are taken into custody by police, has limited geographic coverage.[219]

Alternative approaches

8.110 An alternative approach to training more police to have expertise in dealing with people with cognitive and mental health impairments is to provide police with expert supports that they can call upon. Some models utilise mobile crisis teams of mental health workers that can act as first responders to crisis situations.[220] Under this model, there are generally collaborative agreements with police, however the organisations remain separate. Other models involve the police employing mental health workers to assist officers when they respond to a mental health crisis.[221]

8.111 The Police, Ambulance and Crisis and Assessment Team Early Response (PACER) is one such example of this approach, and was the subject of a trial in Victoria. PACER partners police officers with clinicians (who are part of a Health-based Crisis and Assessment Team) as a secondary response unit.[222] The trial had aims such as early intervention and assessment for the purposes of *Mental Health Act 1986* (Vic) apprehensions, improved interagency communication and understanding of service systems. Call out criteria included clinical onsite assessment of a person's mental health, onsite or telephone advice of mental health referral options, advice on de-escalation tactics and options, and advice on ways to assist and manage frequent users of emergency services. Clinicians were responsible for the assessment, advice, medical records check and referral, while the police officer received the requests for assistance, checked police databases, and maintained safety. Findings of the trial included:

- In 47% of cases PACER units were able to free up the referrer.
- In 90% of cases the clinicians diagnosed a mental illness or disorder.[223]

8.112 In 2011, the Victorian Department of Health commissioned an evaluation of the effectiveness and efficiency of the pilot and has noted that the evaluation will inform

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218. *Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health 2009-2014* (Australian Government 2009) 68.
219. Department of Human Services NSW (Juvenile Justice), *Submission MH28-2*, 13.
220. J Wood and others, *Police Interventions with Persons affected by Mental Illnesses: Global Trends and Future Possibilities*, Policy Brief (Center for Behavioral Health Services and Criminal Justice Research, 2010) 2.
221. J Wood and others, *Police Interventions with Persons affected by Mental Illnesses: Global Trends and Future Possibilities*, Policy Brief (Center for Behavioral Health Services and Criminal Justice Research, 2010) 2.
222. Victorian Auditor-General, *Responding to Mental Health Crises in the Community* (2009) 19.
223. Victorian Auditor-General, *Responding to Mental Health Crises in the Community* (2009) 19.

future collaboration to improve responses to people in crisis.[224] The evaluation of PACER noted that it resulted in shorter stays in hospital emergency departments as well as fewer referrals to hospital.[225]

8.113 Several submissions to this inquiry noted that there are benefits in having specially trained personnel within police.[226] The NSW Bar Association noted that models, which involve both a specially trained police officer and mental health nurse, have improved and increased links to community services and have assisted with diversion.[227]

The Commission's view

8.114 We note stakeholder concerns about the level and coverage of police training in relation to people with cognitive and mental health impairments.

8.115 We support the scope and approach of the current MHIT training program. The program appears to meet a clearly identified need. We remain concerned, however, about the target level of 10% of front-line officers by 2015. Given the level of interaction between police officers and people with cognitive and mental health impairments, this would seem inadequate. It is impractical to put every officer through this training. However, in our view, the NSW Police force should review the resourcing of the program with a view to ensuring that a critical mass of trained officers is available in each Local Area Command. It is particularly important to target key roles, such as custody managers in this roll-out.

8.116 The scope of the training should also be reviewed, in particular in relation to assessing and managing people with a cognitive impairment as well as those with a mental health impairment. Whether this should be delivered through the MHIT program, or established as a separate program is a matter for the NSW Police Force to consider.

8.117 In light of concerns that some police officers have not received any or adequate training in relation to cognitive and mental health impairments, we recommend that the NSW Police Force review its current approach to training to ensure that all police officers receive an adequate level of training in relation to cognitive and mental health impairments.

8.118 If a formal diversion scheme is established, training will be required on its operation.

8.119 There may be opportunities to partner with community stakeholders, such as IDRS, to assist with training officers.

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224. Victoria, Department of Health, "Police, Ambulance and Clinical Early Response (PACER) Evaluation Report" (last updated 22 May 2012) <http://docs.health.vic.gov.au/docs/doc/Police-Ambulance-and-Clinical-Early-Response-(PACER)-Evaluation-Report>. Allen Consulting Group, Police, *Ambulance and Clinical Early Response (PACER) Evaluation: Final Report* (2012)

225. Allen Consulting Group, Police, *Ambulance and Clinical Early Response (PACER) Evaluation: Final Report* (2012) vi-vii.

226. See Shopfront Youth Legal Centre, *Submission MH7*, 3; Public Interest Advocacy Centre, *Submission MH21*, 39; NSW, Public Defenders, *Submission MH26*, 50.

227. NSW Bar Association, *Submission MH10*, 52-53.

Recommendation 8.6

The NSW Police Force should review its current approach to training front line officers in relation to people with a cognitive and mental health impairment to:

(a) enhance the resourcing of the Mental Health Intervention Team program to enable a critical mass of officers to be trained in each local area command, including key roles such as custody managers

(b) ensure that all police officers have received training that covers

  (i) people with cognitive and mental health impairments, and

  (ii) opportunities for diversion

(c) partner with community stakeholders.

9. Diversion in the Local Court – s 32

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9.1 The vast majority of criminal charges in NSW are heard by the Local Court.[1] Since 1983, the Local Court has had the power to dismiss charges against defendants who are developmentally disabled, or suffering from a mental illness or mental condition, and discharge them into care or treatment.[2] These diversionary provisions were originally enacted in the *Crimes Act 1900* (NSW), but later transferred to mental health legislation.[3] Currently, s 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA) is the most significant of these diversionary powers. It allows the court, in appropriate cases, to dismiss the charge and discharge the defendant unconditionally, or subject to conditions. Such conditions may involve compliance with a plan for treatment or engagement with services.

9.2 The other diversionary power in the MHFPA is the provision in s 33, which allows the court to refer a mentally ill person to a mental health facility for assessment. This provision is discussed in Chapter 10. These powers under s 32 and s 33 are also

1. Bureau of Crime Statistics and Research, *NSW Criminal Courts Statistics 2010* (2011) 3-15.
2. Under *Crimes Act 1900* (NSW) s 428W and s 428X – the predecessors to the existing diversionary provisions of the *Mental Health (Forensic Provisions) Act 1990* (NSW).
3. For a review of the history of the legislative provision see T Gotsis and H Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local Court*, Research Monograph 31 (Judicial Commission of NSW, 2008) 9-10.

available in the Children's Court: diversion of young people is considered in Chapter 14.

9.3 The Local Court has other powers that may be used for diversionary or rehabilitative purposes. For example it can grant bail with conditions that include engagement with services (see Chapter 6). After conviction, sentencing options may also engage defendants with services: for example a bond may include a condition of treatment.[4]

9.4 Alongside these legal powers, some courts have access to criminal justice intervention and rehabilitation programs that provide treatment and/or support to people with special needs. For example, the Magistrates Early Referral Into Treatment (MERIT) is a program based in Local Courts that uses the bail powers of the Local Court, and provides opportunities for adult offenders with substance abuse problems to work on rehabilitative goals.[5] The Court Referral of Eligible Defendants Into Treatment (CREDIT) program, which can be the subject of a referral using the court's powers under s 32 to deal with defendants with multiple problems, is considered in Chapter 7.

9.5 NSW has "mainstreamed" its diversionary powers for people with cognitive and mental health impairments by making provision for all magistrates' courts to divert under s 32. Other Australian jurisdictions use their general powers to adjourn, grant bail with conditions and to sentence, to achieve diversionary ends.[6] In all other Australian states (but not in the ACT or NT) special provision is made for people with mental health impairment (and sometimes also for people with cognitive impairments) by way of a specialist list or specialist court. These developments are reviewed in Chapter 11.

9.6 In this chapter we consider s 32, which is the core of diversionary practice in NSW. We identify the problems that have arisen in relation to this provision and make recommendations to improve the operation of s 32.

Eligibility

9.7 A person is presently eligible for an order under s 32 if they are "developmentally disabled" or are "suffering from mental illness" or from a "mental condition for which treatment is available in a mental health facility". In Chapter 5 we consider the limitations of these terms and propose revised definitions of mental health impairment and cognitive impairment to replace them. These revised definitions update the current definitions, for example to make it clear that impairments such as autism spectrum disorder and dementia are included. They clarify the scope of the definitions and use appropriate and respectful terminology.

9.8 Section 32 is not presently available in relation to a "mentally ill person". A mentally ill person is a person who is suffering from a mental illness as defined in the *Mental*

4. *Crimes (Sentencing Procedure) Act 1999* (NSW) s 95(c).
5. For further information see Department of Attorney General and Justice, *Magistrates Early Referral Into* Treatment, <www.lawlink.nsw.gov.au/merit>.
6 See for example the Mental Health Diversion List in Tasmania, discussed in Chapter 11.

Health Act 2007 (NSW) (MHA)[7] and, because of that illness, there are reasonable grounds for believing that care, treatment or control of that person is necessary for the person's own protection from serious harm, or for the protection of others from serious harm.[8] Thus if a "mentally ill person" appears before the court it is likely that s 33 will be a more appropriate diversionary option.

9.9 However, the exclusion of mentally ill persons from s 32 does not appear to us to perform a useful function, and may sometimes be a barrier to an appropriate order. We can foresee, for example, that a person might appear to be a mentally ill person and be referred to a mental health facility under s 33(b). The mental health facility may decide that the person should not be admitted and the police will return the person to court. At this point (whether or not the magistrate is still of the opinion that the person is a mentally ill person) the most appropriate course of action may be to deal with that person under s 32 by making an order with conditions requiring treatment. However, the exclusion of mentally ill persons from s 32 may preclude, or at least deter, magistrates from taking this course of action. Consequently we recommend that it should be removed from the provision.

Recommendation 9.1

(1) Section 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended so that it applies where it appears to the magistrate that the defendant is, or was at the time of the alleged commission of the offence to which the proceedings relate, suffering from a cognitive impairment or mental health impairment, as set out in Recommendations 5.1 and 5.2.

(2) The existing provision in s 32(1) that excludes a mentally ill person from the application of s 32 should be removed.

When is an order under s 32 "appropriate"?

9.10 Under the present provisions of s 32, a magistrate must decide whether it "would be more appropriate" to deal with the defendant under s 32 than otherwise according to law.[9] Section 32 does not spell out the factors that are relevant to a decision about appropriateness, but relevant case law holds that it is a discretionary decision that involves weighing up two public interests: the public interest in ensuring that those charged with a criminal offence face the full weight of the law; and the public interest

7 The *Mental Health Act 2007* (NSW) s 4(1) provides that mental illness means 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).

8 *Mental Health Act 2007* (NSW) s 14(2). The continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.

9. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 32(1)(b).

in treating those who have a mental health or cognitive impairment with the aim of ensuring that the community is protected from their conduct.[10]

The seriousness of the offence

9.11 A factor that has been held to be relevant to the decision about whether to divert is the seriousness of the offence.[11] One preliminary submission on this issue supported the continued relevance of the seriousness of the offence, but recognised, as did other submissions, that those who have committed serious offences should still sometimes be eligible for diversion, and that the seriousness of the offence should instead be taken into account in crafting the conditions attached to such orders.[12]

9.12 We therefore asked stakeholders whether the seriousness of the offence should be taken into account by a magistrate when deciding whether or not to divert a defendant according to s 32.[13] The majority of submissions supported the continued relevance of the seriousness of the offence.[14]

9.13 Two submissions were opposed. Legal Aid submitted that seriousness is already dealt with by s 31 MHFPA which limits the diversionary provisions to summary offences and indictable offences triable summarily.[15] The Intellectual Disability Rights Service (IDRS) submitted that while particular offences may be objectively serious, they may not be serious for a particular defendant because of his or her intellectual disability and limited capacity to understand. IDRS gave the example of hoax calls to the 000 service. This is an objectively serious offence but the person with the disability may make the calls as a response to anxiety and stress and need for support, and the person may have limited capacity to control his or her behaviour. A treatment plan that, for example, provides alternative sources of support, including telephone support, may be very effective and a better response to offending than dealing with the offender according to law. In effect, therefore, IDRS

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10. See *Confos v Director of Public Prosecutions* [2004] NSWSC 1159 [16]-[18]; *Director of Public Prosecutions v El Mawas* [2006] NSWCA 154; 66 NSWLR 93 [4] (Spigelman CJ) [76] (McColl JA). But see the comments of James J in *El Mawas v Director of Public Prosecutions* [2005] NSWSC 243 [54]: "I do not see that a discretionary judgment, in the strict sense, is made by the Magistrate. To my mind it is rather a value judgment concerning the appropriateness of dealing with the matter under one regime or another".
11. See, for example, *Confos v Director of Public Prosecutions* [2004] NSWSC 1159; *Director of Public Prosecutions v El Mawas* [2006] NSWCA 154; 66 NSWLR 93; *Perry v Forbes* (Unreported, Supreme Court of NSW, Smart J, 21 May 1993); *Mantell v Molyneux* (2006) 165 A Crim R 83; *Khalil v His Honour Magistrate Johnson* [2008] NSWSC 1092. See the discussion in NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) 30-32.
12. Law Society of NSW, *Preliminary Submission PMH11*, 3.
13. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) 30-32, Issue 7.17.
14. NSW, Office of the Director of Public Prosecutions, *Submission MH5*, 15; Shopfront Youth Legal Centre, *Submission MH7*, 6; NSW Bar Association, *Submission MH10*, 54; NSW Consumer Advisory Group, *Submission MH11*, 49; NSW Health, *Submission MH15*, 13; Human Services (Ageing, Disability and Home Care), *Submission MH28-1*, 22; Children's Court of NSW, *Submission MH24*, 4; NSW Police Force, *Submission MH42*, 15; NSW, Public Defenders, *Submission MH26*, 53.
15. Legal Aid NSW, *Submission MH18*, 30.

argued that seriousness is relevant, but may be mitigated by other factors such as the nature of the defendant's disability and the context of offending.[16]

9.14 A number of other submissions also pointed to the importance of considering the seriousness of the offence in the context of other factors such as the nature of the person's disability, the context of the offending behaviour, whether offending is escalating, and the availability of supports and treatment programs.[17] Some submissions also pointed out that, although the offence may be objectively serious, some defendants may not be guilty because their impairment may mean that they were not capable of forming the relevant mental element of the offence, or they may not be able to be tried because they are unfit to plead.[18] It was argued that it is important to bear in mind, in relation to s 32 applications, that the defendant has not pleaded guilty or been convicted of the offence, however serious it may be.

The connection between impairment and offending

9.15 A further question which has arisen in this context is whether a causal connection must be shown between the defendant's impairment and the offending behaviour. The few cases interpreting s 32 have indicated that it is not necessary to show a causal connection.[19] Some preliminary consultations expressed concerns about this issue.[20] Consequently, in Consultation Paper 7 (CP 7) we asked whether or not the decision to divert should depend upon a direct causal connection between the offence and the defendant's impairment.[21]

9.16 Submissions were overwhelmingly opposed to such a requirement.[22] The most frequent reason for rejecting the requirement of a causal connection was that it would be overly simplistic and would deny the broader context of offending. We outline the research on this question in Chapter 2.[23] NSW Health, for example, pointed out that offending behaviour results from a complex interplay of factors, both internal and external.[24] Submissions also argued that identifying a causative factor

16 Intellectual Disability Rights Service, *Submission MH14*, 10-11.

17. L Steele *Submission MH9*, 22; Human Services (Ageing, Disability and Home Care), *Submission MH28-1*, 23; Children's Court of NSW, *Submission MH24*, 5; E Baldry, L Dowse, I Webster and P Snoyman, *Submission MH3*, 8.

18. Shopfront Youth Legal Centre, *Submission MH7*, 7-8; Law Society of NSW, *Submission MH13*, 44.

19. See *Director of Public Prosecutions v El Mawas* [2006] NSWCA 154; 66 NSWLR 93; *Police v Deng* [2008] NSWLC 2.

20. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) 33-4.

21. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) Issue 7.18.

22. E Baldry, L Dowse, I Webster and P Snoyman, *Submission MH3*, 8; Shopfront Youth Legal Centre, *Submission MH7*, *7*; L Steele, *Submission MH9*, 22-24; NSW Bar Association, *Submission MH10*, *54*; NSW Consumer Advisory Group, *Submission MH11*, 49-50; Law Society of NSW, *Submission MH13*, 43; Intellectual Disability Rights Service, *Submission MH14*, 11; NSW Health, *Submission MH15*, 13; Legal Aid NSW, *Submission MH18*, 31; Public Interest Advocacy Centre, *Submission MH21*, 53; Children's Court of NSW, *Submission MH24*, 5; NSW, Public Defenders, *Submission MH26*, 53.

23. Para 2.5-2.15.

24. NSW Health, *Submission MH15*, 13.

would be very difficult.[25] Such a requirement may potentially significantly reduce the number of diversionary orders made.[26]

9.17 The NSW Police Force submitted that requiring a causal connection would be ideal. However, the Police Force recognised at the same time that problems could be caused by such a requirement and concluded that the matter is best left to the discretion of the magistrate.[27]

The likely sentence if convicted

9.18 Although there is little case law to elucidate the meaning of s 32, some cases have indicated that the likely sentence, were the defendant to be convicted, may be relevant to a decision about the appropriateness of diverting under s 32.[28] In CP 7 we therefore asked whether or not this factor should be relevant to a decision about whether or not to divert under s 32.[29] There was some support for such a factor being relevant,[30] especially if it were to be one factor relevant in the context of other factors. However, more than one submission pointed out that when s 32 is used the offence is unproven, and may be incapable of being proven.[31]

Other relevant factors

9.19 Other factors that are taken into account in decisions under s 32 include the availability of a "treatment plan" or case plan detailing the actions that the defendant will take should a diversionary order be granted.[32] The defendant's criminal history has also been taken into account, as has the failure of previous diversion under s 32.[33] However a criminal history does not necessarily weigh against an order under s 32 where it is found that the defendant's criminal history is the result of an impairment and that a diversionary response may prevent further offending.[34]

9.20 Legislation addressing people with limited capacity to make decisions for themselves frequently requires decision makers to consider the desirability of making the order that has the least restrictive effect on the defendant that is appropriate in the circumstances of the case. Such an approach is adopted by the

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25. See NSW Health, *Submission MH15*, 13.
26. See NSW Law Society, *Submission MH13*, 43.
27. NSW Police Force, *Submission MH42*,15.
28. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) 35; *Police v Deng* [2008] NSWLC 2; *Mantell v Molyneux* (2006) 165 A Crim R 83.
29. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) Issue 7.19.
30. Shopfront Youth Legal Centre, *Submission MH7*, 7; L Steel *Submission MH9*, 24; NSW Bar Association, *Submission MH10*, 54-55; NSW Law Society *Submission MH13*, 43; Legal Aid NSW, *Submission MH18*, 31; NSW, Public Defenders, *Submission MH26*, 53.
31. See, for example, NSW Law Society, *Submission MH13*, 43; Shopfront Youth Legal Centre, *Submission MH7*, 7.
32. See *Director of Public Prosecutions v El Mawas* [2006] NSWCA 154; 66 NSWLR 93 [10]; *Khalil v His Honour, Magistrate Johnson* [2008] NSWSC 1092 [85].
33. *Director of Public Prosecutions v El Mawas* [2006] NSWCA 154; 66 NSWLR 93.
34. *Minister for Corrective Services v Harris* (Unreported, Supreme Court of NSW, Brownie J, 10 July 1987).

United Nations *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* in dealing with the treatment of persons with mental illness.[35] Similar provisions are to be found in the *Young Offenders Act 1997* (NSW) and the *Guardianship Act 1987* (NSW).[36] Where an order is made under s 32, the defendant has not been convicted of an offence. Orders under s 32 may place onerous requirements on defendants. It is possible that, with the most benevolent of intentions, requirements may be imposed that are more onerous than is justified, taking into account the nature and seriousness of the alleged offending and other relevant factors. An obligation to consider making the order that has the least restrictive effect on the defendant that is appropriate in the circumstances of the case would remind the court of the need to preserve proportionality in making orders under s 32.

9.21 Additional matters suggested in submissions as relevant to the decision to divert were:

- the likely consequences if the defendant is not dealt with under s 32 but is likely to be found unfit to plead or not guilty by reason of mental impairment[37]
- the defendant's health and history[38] and other environmental and personal factors[39]
- the availability of supports to the defendant[40]
- the nature and seriousness of the defendant's disability and its effect on their capacity[41]
- the defendant's human rights.[42]

9.22 In CP 7 we asked whether s 32 should include a list of relevant factors to be taken into consideration.[43] The responses to this question were mixed. There was some support for such a list. For example NSW Police supported it on the basis that there is currently not enough detail to inform or guide the exercise of the court's

35. Principle 9 provides "[e]very patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others": *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, GA Res 46/119, UN GAOR, 3rd Comm, 46th sess, 75th plen mtg, Agenda Item 98, UN Doc A/RES/46/119 (17 December 1991) 189-192.
36. The *Young Offenders Act 1987* (NSW) provides, at s 7, that one of the principles of the Act is "The principle that the least restrictive form of sanction is to be applied against a child who is alleged to have committed an offence, having regard to matters required to be considered under this Act". The general principles governing decisions under the *Guardianship Act 1987* (NSW), in s 4 of that Act, include the principle that the freedom of decision and freedom of action of such persons should be restricted as little as possible.
37. Shopfront Youth Legal Centre, *Submission MH7*, 8.
38. NSW Consumer Advisory Group, *Submission MH11*, 50, 52.
39. L Steele, *Submission MH9*, 25; NSW Consumer Advisory Group, *Submission MH11*, 51-52.
40. NSW Consumer Advisory Group, *Submission MH11*, *51*.
41. Intellectual Disability Rights Service, *Submission MH14*, 12.
42. L Steele, *Submission MH9*, 25.
43. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) 7.20.

discretion.[44] The NSW Law Society also supported the proposal in order to increase the certainty and transparency of s 32 decisions.[45] The Shopfront Youth Legal Centre supported a list if it were broad and non-exhaustive.[46] However the Local Court opposed such a list, as did other stakeholders, on the basis that a broad and unfettered exercise of discretion is desirable in relation to decisions under s 32.[47]

9.23 Two points are important in this context. First, when discussing factors such as the seriousness of offence and the likely sentence, many submissions supported inclusion if the factor formed part of a list of factors which should be weighed in the balance. Second, the underlying concerns of those who supported a list to guide decision making under s 32 and those who opposed it were broadly similar: there was consensus that these decisions are highly contextual, may be very complex, and require the weighing in the balance of a number of relevant matters. Any limitation of the factors regarded as relevant was seen as undesirable, both by supporters and detractors of a list.

9.24 Suggestions for avoiding any undesirable narrowing of the matters taken into account by magistrates included the use of a statement of principles instead of a list of relevant factors,[48] and the use of a broad, non-exhaustive list. Notably, some of those who were opposed a list nevertheless went on to suggest matters that should be included, were a list to be recommended.

The Commission's view

9.25 The Commission is persuaded that a revised s 32 should include a list of factors that should be taken into account when making diversionary decisions. This list of factors should be broad and should not be exclusive: the court should be able to take into account other factors where they are relevant.

9.26 We recommend below a list of factors that the court should take into account when making diversionary decisions. It is derived from the existing case law, the submissions received in response to CP 7, our consultations, and the advice of our Expert Advisory Panel. In accordance with the advice we received during this inquiry the recommended factors promote a broad contextual approach to decisions under s 32 in which a range of relevant matters are weighed in the balance. Our intention is that magistrates should be prompted to consider relevant matters, but should not be unduly fettered in the exercise of their discretion by this provision.

9.27 So, for example, it is recommended that the seriousness of the offence be a relevant consideration, in the context of the nature and circumstances of the offence. The alleged commission of a serious offence (within the jurisdiction of the Local Court[49]) would not, on its own, preclude diversion under s 32; other factors

44. NSW Police Force, *Submission MH42*, 15.
45. NSW Law Society, *Submission MH13*, 43.
46. Shopfront Youth Legal Centre, *Submission MH7*,8.
47. Local Court of NSW, *Submission MH4*, 12; NSW Bar Association, *Submission MH10*, 55; Intellectual Disability Rights Service, *Submission MH14*, 12; NSW Health, *Submission MH15*, 13-14; Legal Aid NSW, *Submission MH18*, 31.
48. L Steele, *Submission MH9*, 25.
49. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 31.

such as the nature of the defendant's impairment may weigh in the balance towards diversion. A change in the defendant's circumstances, such as an improvement in health resulting from taking medication, might be relevant. The provision of family and community supports to the defendant sufficient to reduce significantly the likelihood of further offending may also weigh in the balance in favour of a diversionary order.

9.28 We recommend that these factors are relevant to decisions about the appropriateness of diversion, the diversion option that is appropriate and in relation to diversion plans. Diversion plans are defined and discussed below.[50]

Recommendation 9.2

(1) Section 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that the court must take into account the factors listed in (2) when making a decision concerning:

- (a) whether diversion is appropriate
- (b) which diversionary option is appropriate for the defendant
- (c) the length and nature of a diversion plan, and the frequency of any reporting requirements associated with that plan.

(2) The court must take into account the following factors, together with any other matter that the court considers relevant:

- (a) the nature of the defendant's cognitive or mental health impairment
- (b) the nature, seriousness and circumstances of the alleged offence
- (c) any relevant change in the circumstances of the defendant since the alleged offence
- (d) the defendant's history of offending, if any
- (e) the defendant's history of diversionary orders, if any, including the nature and quality of the support received during those orders, and the defendant's response to those orders
- (f) the likelihood that proposed orders will reduce the likelihood, frequency and/or seriousness of offending
- (g) whether or not it is appropriate to deal with the defendant according to law in all the circumstances of the case including:
  - (i) the options that are available to the court if the defendant is dealt with according to law, and
  - (ii) any additional impact of the criminal justice system on the defendant as a result of their cognitive or mental health impairment
- (h) the defendant's views about any proposed course of action, taking into account the defendant's degree of understanding
- (i) the availability of services appropriate to the defendant's needs
- (j) the family and community supports available to the defendant

50. See Recommendations 9.6- 9.9.

(k) the benefits of diversion to the defendant and/or the community

(l) the desirability of making the order that has the least restrictive effect on the defendant that is appropriate in the circumstances of the case.

(3) In forming a view about (2)(b), the court may rely on an outline of the facts alleged in the proceedings or such other information as the court may consider relevant.

Powers of the court to make interlocutory orders

9.29 A number of interlocutory orders are presently available under s 32(2). The magistrate may:

- adjourn the proceedings
- grant bail in accordance with the *Bail Act 1978* (NSW), and
- make any other order that the magistrate considers appropriate.

9.30 Since the court has general powers to make interlocutory orders in the course of proceedings, the purpose of s 32(2) is not immediately apparent. Its scope was considered in *Mantell v Molyneux* where Justice Adams commented that if a magistrate has made a decision that it would be more appropriate to deal with the defendant by way of diversion, s 32(2) may allow a magistrate effectively to extend the period of a diversionary order by making an interim order to assess the defendant's response.

9.31 Given the lack of clarity about the scope and purpose of s 32(2), in CP 7 we asked:

(1) whether the powers to make an interim order under s 32(2) give the Local Court additional powers

(2) whether it is necessary or desirable to retain such a separate provision, and

(3) whether the powers in s 32(2) are adequate, or if they should be widened to include additional powers.[51]

9.32 Very few submissions responded to these questions. In summary, those stakeholders who responded submitted that the provisions in s 32(2) did not give magistrates any more powers than they already possess, but that the provision should be retained as a reminder that interlocutory orders may be made.[52]

9.33 In this context the Local Court submitted that, although s 32(2) may be used to extend the period of a s 32 order, it is unsatisfactory to achieve this effect via an interlocutory order.[53] The Court submitted that the period permitted for a diversionary order under s 32 should be sufficient for magistrates to be assured that

51. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) Issues 7.21-7.22.

52. Shopfront Youth Legal Centre, *Submission MH7*, 9; NSW Law Society, *Submission MH13*, 14.

53. Local Court of NSW, *Submission MH4*, 12-13.

the purposes of diversion have been achieved.[54] The issue of the length of orders will be dealt with below.

The Commission's view

9.34 Although it is well recognised that magistrates have general powers to make interlocutory orders, on balance we recommend that interlocutory provisions in s 32 should be retained and amended.

9.35 When a decision is contemplated as to whether or not an order under s 32 is appropriate, an adjournment is generally required for assessment and the engagement of service providers to deliver diversionary services. We were told in consultations that a period of 6 weeks is often requested for the preparation of a treatment plan, including obtaining assessment of the defendant's impairment, and that this period may need to be extended in complex cases. A contextual provision of powers for these purposes may be useful.

9.36 Further, we suggest that there may be some cases of a less complex nature where the magistrate is minded to discharge a defendant unconditionally under s 32. However there may be a residual concern in the mind of the magistrate as to the defendant's commitment to undertakings made to the court. For example, the defendant may submit that he or she has offended as a result of a failure to maintain a regime of medication and may give an undertaking that medication is now being taken regularly and will continue to be taken. Adjournment for a short period so that the defendant can provide evidence of compliance with such an undertaking may be sufficient to allow for unconditional discharge, rather than another order under s 32 which may be more resource intensive and onerous. The availability of adjournment for this purpose should be clarified in s 32.

Recommendation 9.3

(1) Section 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should provide that, without limiting the court's power to make interlocutory orders, the court should have the power to adjourn proceedings, for purposes that include:

(a) assessment of the defendant's cognitive or mental health impairment

(b) the development of a diversion plan

(c) an opportunity for the defendant to demonstrate engagement with relevant services or with treatment, with a view to dismissing the charge and discharging the defendant unconditionally in accordance with Recommendation 9.4(1).

(2) The court's power to make any orders as to bail should be preserved.

54. Local Court of NSW, *Submission MH4*, 13.

Diversionary orders available to the court

9.37 Section 32(3) presently provides that the magistrate may make an order dismissing the charge and discharging the defendant:

(a) into the care of a responsible person, unconditionally or subject to conditions, or

(b) on condition the defendant attend on a person or at a place specified by the magistrate for assessment of the defendant's mental condition or treatment or both, or

(c) unconditionally.[55]

9.38 The section therefore envisages dismissal and discharge at the outset. However s 32(3A) provides that if, within six months of the order being made, a magistrate suspects that a defendant may have failed to comply with a condition, the magistrate may call on the defendant to appear.[56] A warrant may be issued to secure the defendant's appearance.[57] If a defendant discharged under s 32 fails to comply with a condition a magistrate may deal with the charge as if the defendant had not been discharged.[58]

9.39 While s 32 envisages that some defendants will be discharged unconditionally, or discharged into the care of a responsible person unconditionally, in many cases conditions will be imposed on the defendant. The importance of a viable case plan or treatment plan in such cases has been emphasised in two cases, both involving defendants with complex problems and relatively serious offending.[59]

Problems with s 32

9.40 A number of problems have been identified with the provisions of s 32 and its operation in practice. We first consider the scope and nature of those problems and then make proposals to resolve them.

The provision is under-used

9.41 Section 32 appears to be used in a very small percentage of cases. The Judicial Commission's 2008 review of s 32 orders noted that the number of orders made is small: 718 orders were made in 2004, 1020 in 2005 and 973 in April to December 2006.[60] The NSW Bureau of Crime Statistics and Research (BOCSAR) has supplied

55 *Mental Health (Forensic Provisions) Act 1990* (NSW) s 32(3).

56. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 32(3A).

57. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 32(B), s 32(3C).

58. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 32(3D).

59. *Director of Public Prosecutions v Albon* [2000] NSWSC 896; *Perry v Forbes* (Unreported, Supreme Court of NSW, Smart J, 21 May 1993), see further T Gotsis and H Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local Court*, Research Monograph 31 (Judicial Commission of NSW, 2008) 16-17.

60. T Gotsis and H Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local Court*, Research Monograph 31 (Judicial Commission of NSW, 2008) 4.

more recent information to the Commission in relation to orders under s 32. It appears that, since 2005, about 1% of orders made each year in the Local and Children's Court are made under s 32.[61]

9.42 A different perspective on the level of use of s 32 is provided by examining the number of people who were the subject of such orders in each court in NSW.[62] For example, 51 people were dealt with under s 32 in Blacktown Local Court during 2009. This amounts to an average of one order per week under s 32. No criticism of this court is intended – it is in no way unusual. But given the estimates of the prevalence of people with cognitive and mental health impairment in the criminal justice system, discussed in Chapter 4, it seems likely that there would have been more defendants who might have benefited from a s 32 order, had those defendants been identified and applications made to the court.

9.43 It appears to be the case that more s 32 orders are made at courts where there is a court liaison service in operation. The 20 court locations at which the Justice Health Statewide Community and Court Liaison Service operates, together with Newcastle (which has a court liaison service operated by Hunter New England Mental Health), made 53% of all s 32 orders in 2010, despite only dealing with approximately 44% of defendants.[63] This is perhaps not surprising since defendants who have mental health impairments may be more likely to be identified at such courts, and the court liaison service may provide other supports, such as advice about appropriate services, to assist with applications under s 32.

9.44 On the basis of the data available, it seems likely that there is scope for s 32 to be used more extensively. Opportunities for diversion that might effectively prevent or reduce reoffending may be being missed, and defendants who should be dealt with by way of diversion may instead be dealt with according to law. The data discussed in Chapter 4 on the percentage of people in prison with cognitive and mental health impairments would indicate that some of these defendants are ultimately incarcerated for repeat offending.

Non-compliance is not reported to courts

9.45 As noted above, a defendant can be brought back before the court for a breach of a s 32(3) order if the magistrate suspects that the defendant has failed to comply with a condition.[64] The formation of such a suspicion obviously depends upon information about non-compliance being brought to the attention of the magistrate. Section 32A of the MHFPA provides that those who assess or provide treatment in accordance with s 32 may report a failure to comply with a condition of an order to the Probation and Parole Service, and officers of the Department of Human

61. For further discussion of the number of orders made under s 32 see Chapter 4.
62. NSW Bureau of Crime Statistics and Research (LcCc1210500mr).
63. NSW Law Reform Commission analysis of data supplied by the NSW Bureau of Crime Statistics and Research (kg11-10065) This figure takes into account Statewide Community and Court Liaison Service locations (approximately 41% of people finalised in the Local Court in 2010) and the Newcastle court location which deals with approximately 3% of finalisations.
64. *Mental Health (Forensic Provisions) Act 1990* NSW s 32(3A).

Services (now the Department of Family and Community Services).[65] A treatment provider may include any relevant information in such a report.

9.46 The provisions in s 32(3A)-(3D) that provide for defendants to be brought back before the court for non-compliance were introduced in 2004 because s 32 was not being used.[66] As Mary Spiers pointed out:

> This reform was…advocated mainly by magistrates and practitioners who could see that many defendants did not comply with conditions of orders where there were no ramifications for non-compliance. This would lead to their offending behaviour escalating…Ultimately, courts were forced to impose severe criminal penalties, including custodial sentences. As a result, the opportunity for positive, effective, intervention and diversion at the earliest stage was being lost. Many magistrates had become reluctant to make orders under s 32.[67]

However, despite the addition of these call-back provisions, proceedings for breach of s 32 orders are still uncommon.[68] Between 9 and 13 breach applications are brought each year.[69]

9.47 The survey of magistrates conducted by the Judicial Commission in 2008 confirmed that magistrates believe that the six month call-back period in s 32(3A) is inadequate and that there is no real repercussion for failure to comply with an order.

> The surveyed magistrates confirmed that the objectives of making s 32 orders enforceable…and encouraging the reporting of breaches…have not been realised. They reported that call-up proceedings for non-compliance are virtually non-existent.[70]

The Judicial Commission argued in its report:

> If it is shown that breaches are not being brought to the attention of magistrates, the s 32 disposition may become discredited and courts may become reluctant to utilize the statutory scheme.[71]

9.48 The concerns noted by the Judicial Commission were replicated in submissions and consultations during this inquiry. The Local Court submitted that, while in its opinion the range of orders available under s 32 is adequate:

> the provisions for ensuring their effectiveness are poor for several reasons. These include the insufficiency of the six month period for supervision of orders in subsection (3A) and the lack of measures to bring non-compliance to Court's

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65. *Public Sector Employment and Management (Departments) Order 2011* (NSW) cl 34(1).
66. For a more detailed discussion of these amendments see T Gotsis and H Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local Court*, Research Monograph 31 (Judicial Commission of NSW, 2008) 19.
67. M Spiers, "Summary Disposal of Criminal Offences under s 32 Mental Health (Criminal Procedure) Act 1990" (2004) 16(2) *Judicial Officers' Bulletin* 9, 9.
68. T Gotsis and H Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local Court*, Research Monograph 31 (Judicial Commission of NSW, 2008) 20.
69. NSW Bureau of Crime Statistics and Research (lcCc1210500mr). For further discussion see Chapter 4.
70. T Gotsis and H Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local Court*, Research Monograph 31 (Judicial Commission of NSW, 2008) vi.
71. T Gotsis and H Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local Court*, Research Monograph 31 (Judicial Commission of NSW, 2008) v.

> attention … While a treatment provider may report non-compliance to the Probation and Parole Service or the Department of Human Services pursuant to s 32A, there is no structured mechanism for reporting and no formal mechanism for ensuring that such reports are then directed to the attention of the Court. A further issue may be the willingness of health care providers to report breaches, who may consider that this might adversely affect the therapeutic relationship with the defendant. As a result, in the vast majority of instances, the Court never finds out if a treatment plan has been followed or is effective.[72]

9.49 There appears to be a number of reasons why these provisions in s 32 are not working. One reason suggested to us is that lawyers and service providers do not consider reporting non-compliance to the court to be consistent with their relationship with a client.[73] The Public Interest Advocacy Centre asserted that any meaningful relationship with clients would be untenable if a service provider was viewed as "a potential jailer rather [than] as a source of support and guidance".[74] Legal Aid NSW submitted that requiring service providers to be involved in ensuring compliance would result in a drop in the number of providers willing to implement plans under s 32 and a consequent decrease in the availability of s 32 as a diversionary option.[75] In consultations we were told that because s 32A is permissive, providing that assessors and treatment providers "may" report a failure to comply with a condition, lawyers do not report breaches because they see this as inconsistent with their duty to their client.

9.50 Submissions and consultations raised as an important issue the differences in disciplines, cultures and approaches to working with people with cognitive and mental health impairments between the criminal justice system and the service sector. Service providers may be concerned about reporting non-compliance for a number of reasons. The effectiveness of their work with a client may be based on a relationship of trust, which they assert will be compromised if they report non-compliance to a court. While some service providers do successfully manage client relationships in the more coercive context of court programs and orders, the providers of services under s 32 are diverse. They may, for example, be general medical practitioners, psychiatrists, staff of government departments, and non-government organisations (NGOs). Their employees may have little understanding of the criminal justice system, or s 32, or the implications of delivering services prescribed in a treatment plan.

9.51 Service providers may also be concerned about the impact on their limited resources of an obligation to monitor clients and report non-compliance, particularly if they are sole practitioners or small organisations with limited resources. They may be unfamiliar with, and concerned about, working in the context of the criminal justice system. We were also told that the lives of many people subject to s 32 orders are difficult and can be chaotic, especially for those who have complex needs. Precise adherence to an order for treatment may challenge both clients and services. Flexible responses to those clients may be important to retain their

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72. Local Court of NSW, *Submission MH4*, 12, 13.
73. Local Court of NSW, *Submission MH4*, 13; NSW Bar Association, *Submission MH10*,57; Legal Aid NSW, *Submission*, *MH18*, 32; Public Interest Advocacy Centre, *Submission MH21*, 36.
74. Public Interest Advocacy Centre, *Submission MH21*, 36.
75. Legal Aid NSW, *Submission MH18*, 32.

engagement with services, and service providers may not expect courts to understand or to respond in a flexible way.

9.52 Section 32A presently responds to some of these problems by providing a bridge between service providers and courts. Non-compliance is to be reported by service providers to Community Offender Services, Probation and Parole Service, or to the Department of Family and Community Services. However that bridge is not working effectively – certainly the traffic across it is very low indeed.

9.53 At present, therefore, a major reason why s 32 is not working effectively is that there appears, in some respects, to be a stalemate in which service providers (including lawyers) are unwilling to report breaches of s 32, and magistrates are reluctant to make orders under s 32 because those orders are not enforced and may therefore be ineffective.

9.54 One of the aims of our recommendations in Chapter 7, for the roll-out of the CREDIT program, is to resolve some of these problems, by providing a court-located bridge accessible to both the court and service providers, with expertise in managing the relationships between service providers and courts. That service will understand the language, contexts and operational challenges of both the service sector, and the criminal justice system. It will translate between the two systems. It will also provide case management services to ensure that those who have orders under s 32 connect with the services they need, and stay connected with them. It will manage problems as they arise. When diversion plans are not complied with, it may report to the court. We see these functions as essential to the improved operation of s 32 orders.

Difficulty in obtaining assessment and treatment plans

9.55 To make an order under s 32, a court must have before it evidence of a treatment plan.[76] However, putting together such a plan may be challenging.

9.56 As we noted in Chapter 7, the first requirement for effective diversion is that the defendant's impairment be identified. Once identified, an assessment of the defendant's impairment will often be required in order to construct an appropriate treatment plan. In consultation it was reported that there is great variation between magistrates in what they require in terms of such assessment reports. Some insist on a recent assessment, even in relation to conditions that do not change over time, for example where the defendant has an intellectual disability. Other magistrates take a more pragmatic approach. Assessment reports are expensive, and frequently the defendant or Legal Aid NSW must pay for them. More than one report may be required in complex cases.

9.57 As we discussed in Chapter 7, few lawyers have expertise in putting together treatment plans. This task requires engagement with service providers, and lawyers are unlikely to be familiar with the service sector. Even those who are experienced,

76. *Perry v Forbes* (Unreported, Supreme Court of NSW, Smart J, 21 May 1993) 6; *Director of Public Prosecutions v Albon* [2000] NSWSC 896 [26] Dowd J. See further T Gotsis and H Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local Court*, Research Monograph 31 (Judicial Commission of NSW, 2008) 16-17.

and who specialise in this work, assert that it can be a difficult and time consuming job. Legal Aid NSW has a small Client Assessment and Referral Unit that provides non-legal services for Legal Aid lawyers. That unit facilitates assessments and puts together treatment plans for s 32 applications for Legal Aid employed lawyers.[77] Private lawyers, however, may not be funded for the hours of work required to prepare a treatment plan. This is a strong disincentive to s 32 applications.

9.58 Lawyers who do not have specialist skills, or specialist help and support, may decide that a s 32 application is difficult, time consuming, and not remunerative. They may therefore prefer not to explore that avenue, but instead focus their attention on arguments relating to mitigation of sentence in a way that takes into account the defendant's impairment and other issues. This may be an effective short term strategy for both lawyer and client but, because the client's criminogenic issues are not addressed through the provision of services, there may be reoffending.

9.59 It is more difficult to develop treatment plans in some regional, rural or remote areas where services are sparse.[78] Many Aboriginal people and Torres Strait Islanders do not go to a doctor when needed, because of transport and distance, long waiting times and cost.[79] Where there is no history of contact with services, it can be harder to get a s 32 order.

9.60 Problems for people with cognitive impairments were emphasised by stakeholders. The terminology "treatment plan" does not respond to the reality of people with cognitive impairments, who do not have a medical condition that requires treatment. The availability of services for people with cognitive impairment was raised repeatedly.[80] Family and Community Services, Ageing, Disability and Home Care (ADHC) has limited resources which it deploys to those with the greatest need. Stakeholders in consultations reported difficulty therefore in getting support for people with mild or borderline intellectual disability. They also reported that they had difficulties in meeting the criteria of ADHC, in particular providing evidence that a person's disability commenced before the age of 18. Corrective Services noted that it is often difficult and time consuming to seek historical evidence of the onset of the disability in persons who are often living chaotic lifestyles with limited contact with families of origin and whose personal records are often sparse.[81] It was also the experience of the CREDIT program that the requirement to provide evidence of disability prior to the age of 18 caused particular problems. ADHC may accept an argument that this requirement should be dispensed with in a particular case, but in order to be exempted, the client needs to go through the appeal process, which is very time consuming.[82] People with dual diagnoses may find it particularly difficult to access services.

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77. Legal Aid NSW, *Client Assessment and Referral (CAR) Review* (2008) 2077.
78. Kempsey, *Consultation MH19.*
79 Australian Bureau of Statistics, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* (2008) 189.
80. See our discussion in para 2.48.
81. Corrective Services NSW, *Submission MH17*, 3.
82. Court Referral to Integrated Treatment Programs (CREDIT), *Consultation MH21*.

9.61 Compiling assessments and treatment plans under s 32 may be particularly challenging in relation to people who have complex needs. Stakeholders working in Local Courts reported that often mental health and drug and alcohol issues are inter-related, and it is necessary to deal with the alcohol or drug issues first. One stakeholder described the challenges of putting together a treatment plan for a client who has an intellectual disability, abuses alcohol, has an anxiety disorder and is homeless.[83]

Multiple orders under section 32

9.62 An issue raised in the context of s 32 concerns the "revolving door": some stakeholders in consultations expressed concerns that people are receiving multiple orders under s 32, but that the orders are not effective in preventing reoffending and that the defendants return to court.[84] BOCSAR data on reoffending shows that, of 2846 people who were subject to an order under s 32 in 2006-8, 12% were given a further order under s 32, 26% were convicted, 5% had both a further s 32 order and a further conviction and 62% did not return to court.[85]

9.63 One stakeholder told us in consultation about an offender who randomly hits people in the face, is repeatedly discharged under s 32, but then reoffends. It was the impression of some stakeholders that defendants know that they will not get into trouble for breaching a s 32 order. A Sydney lawyer also reported that she had obtained multiple s 32 orders for one of her clients.[86]

9.64 Multiple orders might be expected for some people with cognitive or mental health impairments, especially for people with complex needs. Service providers in consultations reported that, for some people with complex needs, a reduction in offending or the seriousness of offending may be all that can reasonably be expected. Nevertheless, these figures and case studies, together with the other issues raised in relation to s 32, do raise questions about the effectiveness of diversion for some alleged offenders when the present system does not monitor their engagement with services or deal with breaches of orders.

Is the 6 month limit on s 32 orders appropriate?

9.65 The adequacy of the six month period for orders under s 32 is of concern for some magistrates. The Judicial Commission's 2008 survey of magistrates shows that, when asked whether a six-month enforceability period for s 32 orders was adequate, 70% of magistrate respondents stated that it was too short.[87]

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83. Court Referral to Integrated Treatment Programs (CREDIT), *Consultation MH21.*
84. See, eg, NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System: Courts and Sentencing Issues*, Discussion Paper 35 (1994) [5.19].
85. NSW Bureau of Crime Statistics and Research (rod1210501mr).
86. K Weeks, "To Section 32 or Not?" (2010) 48(4) *Law Society Journal* 49, 54.
87. T Gotsis and H Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local Court*, Research Monograph 31 (Judicial Commission of NSW, 2008) 21.

9.66 Reportedly some magistrates deal with this issue by using a combination of adjournments and s 32 orders to extend the time frame of court and service engagement with defendants. However, the Local Court submitted that:

> It would be preferable for magistrates not to need to be creative in the framing of interlocutory orders so as to overcome the time limit in subsection (3A).

The Local Court suggested that a discretionary time limit would be preferable, with a maximum, perhaps of five years in line with the provision relating to good behaviour bonds under s 9 of the *Crimes (Sentencing Procedure) Act 1999* (NSW).[88]

9.67 There may be a dissonance between the expectations of magistrates and the practices of the service sector in this respect. In consultations with representatives from the service sector it was reported that long term engagement with clients is unusual, and programs running for 3 months are found more frequently. However others argued that effective engagement with people with cognitive impairments may require longer term intervention in order to deal with criminogenic behaviours.

Proposals for changes to s 32

9.68 In order to resolve the problems identified above, the Commission proposes two strategies. The first is to provide the court with supports to assist with identification, assessment, case management and reporting in relation to defendants who have cognitive and mental health impairments. This strategy is outlined in Chapter 7. We regard these supports as essential if the diversion under s 32 is to operate effectively.

9.69 The second strategy, outlined below, is to increase the options available to magistrates who are dealing with defendants who have cognitive or mental health impairments.

9.70 We recommend that two of the existing options under s 32, unconditional discharge and discharge to comply with a diversion plan, be retained and improved. In addition two new options are proposed. The first of these will provide magistrates with the power to monitor the progress of the defendant undertaking a diversion plan. The defendant will not be immediately discharged: the case will be adjourned with a view to later discharge, with a requirement that the defendant undertake a diversion plan and report back to the court in relation to that plan. Magistrates will have a broad discretion to adapt the level of court involvement according to the circumstances of the case.

9.71 The second option will apply only where the defendant is at risk of imprisonment, and will allow magistrates to refer defendants with cognitive and mental health impairments to a specialist list, the Court Referral for Integrated Service Provision (CRISP) list. CRISP is considered further in Chapter 12. This option will provide for a specialist and intensive response to defendants with cognitive and mental health impairments who are at risk of imprisonment, aimed at preventing offending by dealing with its causes and, where possible, avoiding imprisonment.

88. Local Court of NSW, *Submission MH4*, 13.

9.72 The recommended orders are first set out, below and subsequently each is explained in more detail.

Recommendation 9.4

Section 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should provide that, taking into account the factors set out in Recommendation 9.2, the court may:

(1) dismiss the charge and discharge the defendant unconditionally

(2) dismiss the charge and discharge the defendant on the basis that a satisfactory diversion plan is in place and the defendant has demonstrated sufficient likelihood of compliance

(3) adjourn the proceedings, with a view to later discharge, on condition that the defendant undertake a diversion plan and report to the court in relation to his or her progress in fulfilling the plan and substantial compliance with that plan, as required by the court, or

(4) if the defendant meets the eligibility criteria in Recommendation 12.2, refer the defendant to the CRISP list proposed in Recommendation 12.1.

The power to dismiss the charge and discharge unconditionally

9.73 Section 32 currently provides magistrates with a power to discharge defendants unconditionally and that power should be retained. There will be many cases where a defendant has a cognitive or mental health impairment but, taking into account the nature of the offending and other relevant factors, the case will not require any further intervention. For example:

- a defendant may have a transient or episodic condition that has resolved by the time of the hearing
- a defendant may have voluntarily engaged in treatment prior to the hearing
- a defendant may have temporarily forgotten to take medication, resulting in irrational behaviour which is unlikely to reoccur
- a defendant may have a severe intellectual disability and is normally in care
- an offence may be so minor that, when taken together with the fact that the defendant has a cognitive or mental health impairment, further action is not warranted.

9.74 We note in this context our recommendation in relation to interlocutory orders. In some cases it may be appropriate for a magistrate to adjourn a simple matter for a few weeks to check that informal undertakings are complied with before discharging under this provision. For example it may be that a minor offence is committed because of a failure to take medication or because of a prescribed change or adjustment to medication. If the defendant asserts that the medication problems are now resolved an adjournment with a view to confirming that this is the case, followed by a discharge under s 32, may be appropriate.

No power to discharge into the care of a responsible person

9.75 Section 32(3)(a) presently provides magistrates with the option of discharging a person into the care of a "responsible person", unconditionally or subject to conditions. However, stakeholders have told us that this provision is very rarely used.[89]

9.76 A number of problems arise. There may be no family members willing to provide support, so identifying a responsible person may be difficult.[90] Potential candidates for this role are deterred because the duties of a responsible person are not defined in the Act.[91] Service providers are reportedly reluctant to be nominated as a responsible person because of this lack of clarity,[92] because they are concerned that they may have to enforce any conditions imposed under this provision, or because the nature and length of their obligation may not be defined.

9.77 Should a situation arise where a magistrate wishes to discharge a person into the care of a responsible person, then there would be nothing to prevent such an order being made under option (2) (discharge on condition that the defendant undertakes a diversion plan) with the role of the responsible person being defined in that plan.

Recommendation 9.5

Section 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to remove the option of discharging the defendant into the care of a responsible person.

Dismiss and discharge for the defendant to undertake a diversion plan.

9.78 Presently s 32 provides that magistrates may discharge a defendant subject to conditions only where they discharge the person into the care of a responsible person, or on condition that they attend for assessment or treatment or both.

9.79 In CP 7 we asked whether the range of orders available under s 32(3) is adequate, and whether it meets the needs and circumstances of defendants with cognitive impairments.[93] While two stakeholders thought the existing range of orders were adequate,[94] the majority of stakeholders that responded to the first question

89. Intellectual Disability Rights Service, *Submission MH14*. 13. The Judicial Commission reported that 55% of person discharged under s 32 during 2004-2006 were discharged under this provision: T Gotsis and H Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local Court*, Research Monograph 31 (Judicial Commission of NSW, 2008) v. However we have confirmed with BOCSAR that this figure is not accurate, as a result of a problem with data collection: for further discussion see Chapter 4.

90. Intellectual Disability Rights Service, *Submission MH14*, 13.

91. Shopfront Youth Legal Centre, *Submission MH7*, 9.

92. Law Society of NSW, *Submission MH13*, 45.

93. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) Issues 7.23-7.24.

94. Legal Aid NSW, *Submission MH18*, 31-32; NSW Police Force, *Submission MH47*, 16. However Legal Aid NSW identified potential areas for improvement in relation to cognitive impairment. See also the NSW Bar Association, *Submission MH10*, 55, that noted the range of orders are adequate, but also noted various improvements.

submitted that the range of orders could be improved.[95] Particular concerns were raised in relation to cognitive impairment.[96] In particular a problem was identified that discharge with conditions is only available where a responsible person is identified.[97] We have noted the problems with identifying a responsible person above. Accordingly it is proposed to provide the power to discharge a defendant to undertake a diversion plan, without the need to identify a responsible person.

9.80 Such an order would not require defendant to return to court, or make reports to the court. The defendant would need to satisfy the court that a satisfactory diversion plan is in place and that there is sufficient likelihood that they will comply with it. There are no enforcement mechanisms. This option is similar in effect to the present s 32 orders. As we have already noted, while such orders are enforceable in theory, enforcement is extremely rare in practice. In cases where magistrates believe that it is important that the defendant demonstrate compliance to the court, they will select option 9.4(3) which does require reporting back to the court. The option of discharge without reporting requirements will be of most use where the court is satisfied that the defendant will comply with the diversion plan.

Diversion plans

9.81 It is envisaged that diversion plans will take the place of the treatment plans presently required under s 32. The term "treatment plan" is problematic and we do not adopt it. The needs of some defendants go beyond, or are different to, treatment. In particular, the term excludes people with cognitive impairments. Corrective Services NSW pointed out that orders that require care and treatment are more appropriate for people with mental health impairments rather than people with cognitive impairments, and suggested that s 32 should provide for situations where what is required is participation in programs or case management.[98] We note that in practice magistrates do not confine their orders according to a medical model and that they respond in ways that give practical effect to s 32, including where the defendant needs other types of services. Nevertheless, it is desirable to use language that is accurate and inclusive.

9.82 We do not envisage that there will be a template for a diversion plan, but that the nature of such a plan will respond to the circumstances of the case, the defendant's impairment and other relevant circumstances.

9.83 The Supreme Court has suggested that a court should be provided with a "clear and effective treatment plan".[99] The Judicial Commission's report on s 32 of the MHFPA confirms the views of stakeholders in this inquiry that the quality of treatment plans

95. Shopfront Youth Legal Centre, *Submission MH7*, 9; L Steel, *Submission MH9*. 26; NSW Law Society, *Submission MH13*, 45; Intellectual Disability Rights Service, *Submission MH14*, 13; Children's Court of NSW, *Submission MH24*, 6.

96. Corrective Services NSW, *Submission MH17*, 25-26; L Steel, *Submission MH9*. 26.

97. Law Society of NSW, *Submission MH13*, 45; Intellectual Disability Rights Service, *Submission MH14*, 13; Shopfront Youth Legal Centre, *Submission MH7*, 9.

98. Corrective Services NSW, *Submission MH17*, 24.

99. *Perry v Forbes* (Unreported, Supreme Court of NSW, Smart J, 21 May 1993) 16.

is sometimes lacking.[100] However, we do not envisage that a high quality diversion plan will always be a lengthy or complex document. The Judicial Commission appear to envisage a very detailed document.[101] While this may be necessary in some cases, it will not be needed in all cases and we are concerned that such onerous requirements will deter applications in suitable cases.

9.84 In some cases, a treatment plan will be brief and simple. Evidence of the defendant's impairment will be included. However we do not envisage that lengthy adjournment to secure new (and expensive) assessments will always be needed. Where the defendant has a long-standing diagnosis, or has a condition that does not change, new assessments are not necessary. Information from service providers and general practitioners will often suffice to establish the impairment. The plan will itemise the actions that the defendant must take. These may not need to be extensive or detailed in all cases. For example, in a case with a long-standing uncontroversial diagnosis of mental illness, a diversion plan may involve a commitment to attend a specified psychiatrist and/or general practitioner and to comply with a regime of medication. In more complex cases, however, the diversion plan will be more detailed and the requirements more onerous. We do not envisage that a diversion plan will be used to authorise detention of a person, for example in a secure facility. Other orders under the MHA or guardianship legislation will be appropriate where detention is contemplated.[102]

9.85 The focus of a diversion plan should be on dealing with those issues that are producing offending behaviour. However, it is apparent from our consultations and submissions that the range of matters that may have an impact on offending behaviour is very diverse. For example, the provision of housing may be a key to avoiding offending for some people. The provision of leisure activities and social supports may be pivotal for others. It is not envisaged, by this recommendation, that specialist rehabilitative programs are necessary to comply with this requirement. On the other hand, s 32 orders are not simply a route to service provision but are designed to have a rehabilitative effect. In constructing a diversion plan under s 32, a focus on the factors that will impact on reoffending is important.

Recommendation 9.6

(1) A diversion plan must:

(a) set out a program of treatment, and/or engagement with services, and/or other activities, appropriate to the circumstances of the case

(b) address those matters that appear to give rise, directly or indirectly, to offending behaviour.

(2) A diversion plan may:

100. T Gotsis and H Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local Court*, Research Monograph 31 (Judicial Commission of NSW, 2008) 4.

101. T Gotsis and H Donnelly, *Diverting Mentally Disordered Offenders in the NSW Local Court*, Research Monograph 31 (Judicial Commission of NSW, 2008) 18.

102. *Darcy v NSW* [2011] NSWCA 413 was a case where a defendant was admitted to a secure facility as a condition of a s 32 order and this decision was later challenged as constituting false imprisonment.

(a) specify the nature, extent and frequency of the treatment, engagement with services or other activities, and who will provide those services and activities

(b) include information relating to the nature and extent of the defendant's cognitive or mental health impairment, such as assessments by psychiatrists, psychologists and other service providers.

Diversion with reporting requirements

9.86 We outlined above the reasons why s 32 is not presently effective. As we note above, in CP 7 we asked if the existing range of orders under s 32 is meeting the aims of the section and the needs and circumstances of defendants with cognitive impairments.[103] Most responses commented on the deficiencies of s 32.[104] The NSW Law Society argued that there is a need for flexibility to tailor orders according to the unique circumstances of each defendant.[105] The Children's Court submitted that the existing range of orders is unduly restrictive.[106]

9.87 The Shopfront Youth Legal Centre proposed that it should be possible to divert defendants with cognitive and mental health impairments to a case management program at an early stage: it envisaged that such a program would run for several weeks or months, followed by a report to court. At this point the court could consider a "final order" under s 32.[107] Similarly the Law Society suggested that a diversion program like MERIT should be considered, followed by report back to the court for a final order.[108]

9.88 We therefore propose that, where there is an application for a s 32 order, magistrates should have an option of adjourning the case with a view to discharge, on condition of substantial compliance with a diversion plan. The diversion plan would be submitted to the court by the defendant. Once the court is satisfied that the plan is appropriate, the court would approve it, and set requirements for the defendant to report back to the court on their compliance with the plan.

Reporting compliance

9.89 It is proposed that the court should have a wide discretion in relation to the requirement to report to the court. In some cases a single report at the end of a diversion plan will suffice. For instance, there could be a requirement that the defendant report to the court after a period of 6 months, bringing a written report from a treating psychiatrist that they have attended appointments and complied with medication. In more complex cases reporting might be required in relation to key milestones in the plan or at regular intervals such as every month or every fortnight.

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103. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) Issue 7.24.

104. See discussion in para 9.40-9.67, above. See also Corrective Services NSW, *Submission MH17*, 25-26.

105. Law Society of NSW, *Submission MH13*, 45.

106. Children's Court of NSW, *Submission MH24*, 6.

107. Shopfront Youth Legal Centre, *Submission MH7*, 12.

108. Law Society of NSW, *Submission MH13*, 49.

9.90 In many cases it will not be appropriate to place the responsibility for reporting to the court on a defendant who has a cognitive or mental health impairment, taking into account also that many defendants for whom these orders are appropriate also have other problems in addition to their impairment. Accordingly we recommend that, when a court makes a diversionary order of this type, the diversion plan should identify a "responsible reporter". The defendant should make proposals as to the identity of the responsible reporter, but the decision should be one for the court.

9.91 The responsible reporter could be a legal representative. However a lawyer is not necessarily the best person to fulfil this role. While lawyers are expert in collecting evidence and presenting it to the court in relation to substantial compliance with a diversion plan, there will be cases where problems arise during the course of the order and the diversion plan needs to be amended. Case management skills, together with knowledge and understanding of the mental health and cognitive impairment service sectors, are required to deal with these problems. However, we note that some lawyers work in conjunction with behavioural scientists in response to challenges such as these. Legal Aid NSW, the Shopfront Youth Legal Centre and some private law firms, for example, have experts from other disciplines working with lawyers. Where a defendant is represented by one of these organisations, that organisation may be willing and able to accept the role of responsible reporter. It is likely that many defendants will be represented by Legal Aid lawyers.

9.92 The ideal person to be a responsible reporter would be a case manager who would assist the defendant to engage with appropriate services, deal with situations where there are problems of compliance (for reasons to do with the service provider or the defendant) and provide support for court appearances. Our recommendations relating to the expansion of the CREDIT program will mean that these services will be available at courts that have CREDIT services. In addition to providing necessary supports to the defendant, CREDIT workers will be known and trusted by the court. High quality reports to the court should support the confidence of the court in orders made under s 32.

9.93 However, where the court does not have a CREDIT service available, it will be necessary to appoint a responsible reporter from elsewhere. Some defendants will have an existing case manager or a long-term service provider who can be appointed. In other cases it will be necessary to locate a responsible reporter. This may present challenges. The difficulties of securing services for some defendants were reported in the discussion above. If the duties of reporting to court are added to the obligations of stakeholders, they may be even more unwilling to take on those who are subject to orders under s 32. It may be necessary for magistrates to make a practical decision about who should be a responsible reporter.

9.94 This fortifies our arguments for the roll-out of the CREDIT program. We anticipate that it may be very difficult for magistrates to make this diversionary provision work in the absence of a CREDIT program. A CREDIT case manager will, for example, ensure that the defendant knows about court dates and that the relevant information is available to the court at those times. In the absence of CREDIT this role will need to be performed by the responsible reporter, or by the defendant's legal representative.

9.95 While recommendations about service delivery are beyond our scope, in the absence of a CREDIT program or another case manager, consideration might be given to provision of case management services by a nominated organisation. In regional areas, for example, there may be an NGO that is well placed to be contracted to provide services, with training and support from CREDIT and Legal Aid NSW.

9.96 One implication of the factors raised above is that the practical operation of our recommendations in relation to s 32 will require discussions between key stakeholders to provide for their effective implementation.

Recommendation 9.7
Where an order is made of the type described in Recommendation 9.4(3) the diversion plan should prescribe a responsible reporter who is the person or organisation responsible for reporting to the court concerning the defendant's progress and outcomes under the diversion plan.

The approach of the court

9.97 Where there is to be ongoing monitoring of diversion involving reporting at key milestones or regular intervals, a different and less adversarial approach by the court is desirable. Consistency in the magistrate who provides that monitoring is highly desirable. A separate listing time for these cases may be adopted in some courts. Judicial education concerning adopting a problem solving approach in the context of s 32 is desirable, and may be resourced from specialist courts that presently adopt this approach.

Amendment and termination of an order

9.98 Diversion plans must necessarily be flexible, and accommodate the changing needs of the defendant, or their rehabilitative purpose may be defeated. A rigid approach to compliance may mean that defendants who could be successfully diverted are instead brought back to court and dealt with according to law. If this happens, the involvement of the defendant with the criminal justice system is increased, as is the cost to the criminal justice system. An appropriate amendment to a plan, for example by substitution of an alternative service or service provider, may resolve the problem.

9.99 A defendant might, for example, agree to undertake a life skills course but become bored with content not relevant to her circumstances. Transfer to a course that targets the defendant's specific needs (such as budgeting and money management) may be entirely appropriate. One stakeholder in consultations provided the example of a defendant with a mental health problem whose diversionary orders provided for mental health treatment. However, after working with the defendant for several weeks, it was discovered that the defendant also had an acquired brain injury which was more directly the cause of his criminal behaviour and the plan was amended.

9.100 Submissions and consultations noted that services under s 32 are often provided by small NGOs with limited resources,[109] and that these services and the programs they offer, may change. In these circumstances defendants may have to find an equivalent replacement service, and may need support to do so.

9.101 On balance we believe that substantial changes to diversion plans should be reviewed by the court. Minor changes would not require review. For example, if the defendant were required to attend a particular psychiatrist and that person retired referring the patient to another psychiatrist, court review of a diversion plan would not be required. If part of a plan involved engaging the defendant with education though a particular course and they wished to transfer to an equivalent and more suitable course, court review would not be required. However if, for example, there were a new diagnosis (such as in the case example provided above of acquired brain injury) resulting in a major revision in services then the matter should go back to court.

9.102 Again, where the court has the advantage of a CREDIT program, managing changes to diversion plans will be simplified. The CREDIT staff and the magistrates will reach practice understandings about which cases require review and which do not. The magistrates would develop trust in the experience and judgement of CREDIT staff over time, and the number of reviews required may be able to be reduced.

9.103 Interim reviews during an order would generally provide the court with updates about the defendant's progress and make any necessary changes to the diversion plan. It is anticipated that the court would provide encouragement and positive feedback to the defendant in appropriate cases, in the manner adopted by problem solving courts.

9.104 In some cases, a review might lead to termination of the plan early. This may occur because the person has made considerable progress, and the court determines that the defendant can be discharged early. On the other hand, it may occur because the plan is not working and the defendant not complying, in such a case, termination and dealing with the defendant according to law may be appropriate. Termination is a major step. Amendment of the plan might also be considered in cases of non-compliance, to change the services to those that might actually work better for the defendant.

9.105 At the end of the period of the plan, the court may decide to extend it up to 12 months. It might do this if compliance or engagement has been insufficient to that point but, given more time, might be successful.

9.106 At the end of plan, whether by expiry or termination, and if it is not extended, the court must finalise the case and deal with the person. The court may:

- discharge the defendant
- deal with the defendant according to law (for example, sentence the person).

109. See Shopfront Youth Legal Centre, *Submission MH7*, 10 NSW Law Society, *Submission MH13*, 46.

9.107 In making this decision, the court should consider a number of factors including:

- whether the defendant has substantially complied with the plan
- the defendant's achievements during the plan
- any significant change in the defendant's circumstances as a result of engagement with the plan
- any other relevant factor.

9.108 We use the term 'substantial compliance', as one factor, to indicate that a diversion plan is not like most court orders where full compliance is required. A diversion plan must be more flexible. The aim of such a plan is that the defendant deals with those issues that are producing the offending behaviour. We have noted throughout this report that many defendants are dealing with complex issues in their lives. It is the experience of problem solving courts that such defendants may have false starts or relapses. It may be appropriate to discharge the defendant in such cases, at the end of the diversion plan, if the defendant has substantially complied with the plan.

Recommendation 9.8

Where an order is made of the type described in Recommendation 9.4(3):

(a) At any time during a diversion plan the court may:

(i) approve an amendment to that plan, or

(ii) terminate that plan

on the application of the defendant, a responsible reporter or of its own motion.

(b) If the court approves an amendment to the diversion plan, it may extend the period of the plan, so long as the total period of the plan does not exceed 12 months.

(c) Upon termination or expiry of the diversion plan, the court must consider how to deal with the defendant in relation to the relevant charges. In making this decision the court must consider:

(i) whether the defendant has substantially complied with the plan

(ii) the defendant's achievements during the plan

(iii) any significant change in the circumstances of the defendant as a result of his/her engagement with the plan

(iv) any other factors the court considers relevant.

(d) Upon termination or expiry of the diversion plan, the court may:

(i) discharge the defendant, or

(ii) deal with the defendant according to law.

(e) When sentencing a defendant who has engaged in a diversion plan, the court must take into account in favour of the defendant, the extent to which the defendant has participated in that plan.

(f) When sentencing a defendant who has engaged in a diversion plan the court must not take into account the defendant's failure to participate in, or complete, a diversion plan.

Duration of orders

9.109 We recommend that the normal period of an order under s 32 should be 6 months. We note the concerns of magistrates, discussed above, that a six month period is not sufficient in some cases. However, we make this recommendation bearing in mind a number of factors.

(1) Stakeholders who provide services in this sector suggested in consultation that the usual period for which they are funded to work with people is 3-6 months

(2) Some diversionary orders are onerous.

(3) Defendants subject to these orders have not been convicted of an offence

(4) If the defendant does not substantially comply with the plan the court may deal with the defendant according to law.

We note also that a s 32 order may establish contact between a defendant and services, and that this relationship will, in some cases, continue after the diversionary order is completed. A person's entitlement to, and engagement with, the services they need should not depend on their involvement with the criminal justice system.

9.110 However, there will undoubtedly be some cases where it is appropriate for an order to extend beyond six months. The Local Court has argued,[110] and we agree, that it is undesirable that "covert" extensions of orders should be achieved via interlocutory orders. Further, some defendants may struggle to complete an order and a court may wish to give them a second chance by way of an extension. For example, some defendants may fail to comply with the requirement of a plan because of a crisis such as becoming homeless, or the death of a relative, but subsequently re-engage and be motivated to continue.

9.111 If the court does not decide to discharge the defendant at the expiry or termination of the plan, the court must deal with the defendant according to law. We note that there are disadvantages to both prosecution and defence if they have to prove a charge or defend it, after a period of more than six months.

9.112 Accordingly we recommend that it should be possible to extend the order up to a maximum of 12 months but do not recommend a longer period.

Recommendation 9.9

A diversion plan under s 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be for a defined period, sufficient for the plan to

110. Para 9.33.

operate, of up to six months. That period may be extended in appropriate cases, up to a total of 12 months.

10. Diversion in the Local Court – s 33

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10.1 This chapter focuses on s 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA). Broadly speaking, this section gives magistrates a number of powers to deal with defendants who appear in court who are acutely mentally ill, including the power to send them to a mental health facility for assessment. The chapter discusses the current confusion about the scope, purpose and operation of this section and makes recommendations for its improvement.

10.2 Section 32 of the MHFPA, which provides the power for magistrates to discharge a defendant to treatment is considered in Chapter 9.

The scope of s 33

10.3 Section 33 of the MHFPA provides that if, at the commencement or at any time during the course of the hearing of proceedings before a magistrate, it appears to the magistrate that the defendant is a mentally ill person, then an order can be made that the defendant be:

- taken to, and detained in, a mental health facility for assessment[1]

1. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 33(1)(a).

- taken to, and detained in, a mental health facility for assessment and if the mental health facility finds that the defendant is not a "mentally ill person" or a "mentally disordered person," the person be brought back to court[2]
- discharged, either conditionally or unconditionally, into the care of a responsible person,[3] or
- placed under a community treatment order (CTO).[4]

Eligibility

10.4 A defendant is eligible for an order under s 33 if it appears to the magistrate that he or she is a "mentally ill person". A "mentally ill person" is defined under s 14 of the *Mental Health Act 2007* (NSW) (MHA) as a person who "is suffering from a mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary" either "for the person's own protection from serious harm" or "for the protection of others from serious harm".[5] A relevant consideration in this regard is "the continuing condition of the person, including any likely deterioration of the person's condition and the likely effects of any such deterioration".[6]

10.5 A "mental illness" is defined in s 4(1) of the MHA as a "condition that seriously impairs, either temporarily or permanently, the mental functioning of a person", and is characterised by delusions, hallucinations, "serious disorder of thought form", "a severe disturbance of mood" or "sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms" just described.

10.6 Section 33 of the MHFPA requires only that it "appears to the magistrate" that the person is a mentally ill person. In other words, the magistrate is not required to be a diagnostician but makes an order on the basis of the appearance of the defendant. Magistrates may be supported in making such assessments by practitioners from the Statewide Community and Court Liaison Service (SCCLS) (see further Chapter 7). The magistrate then refers the person to a mental health facility for assessment by a psychiatrist who will decide if the person should be admitted involuntarily, or provided with some other form of support.

Procedure after referral

10.7 If a defendant is referred to a mental health facility under s 33, the MHA governs the procedure that must be followed.[7] An initial examination must be conducted within 12 hours of admission.[8] The person must not be detained after that examination unless the authorised medical officer certifies that he or she is a "mentally ill

2. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 33(1)(b)
3. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 33(1)(c)
4. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 33(1), s 33(1A).
5. *Mental Health Act 2007* (NSW) s 14(1).
6. *Mental Health Act 2007* (NSW) s 14(2).
7. *Mental Health Act 2007* (NSW) ch 3 pt 1-2.
8. *Mental Health Act 2007* (NSW) s 27(a).

person", or a "mentally disordered person".[9] Section 15 of the MHA defines a mentally disordered person as a person whose behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary for the person's own protection from serious harm or the protection of others from serious harm.

10.8 A mentally ill person can be detained for involuntary treatment, subject to periodic review by the Mental Health Review Tribunal (MHRT).[10] A mentally disordered person must not be detained for a continuous period of more than three days, and up to three times in one month.[11]

10.9 Section 33 of the MHFPA also provides that the magistrate may make a CTO in accordance with the MHA that requires that the defendant accept a regime of treatment provided in the community, rather than in a mental health facility. The magistrate must be satisfied that all the requirements for making a CTO have been met, other than the holding of an inquiry.[12]

10.10 Section 33(2) MHFPA provides that if a person is dealt with under s 33, and is not brought before a magistrate to be dealt with in relation to the charge within 6 months, the charge is taken to have been dismissed.

The use of s 33

10.11 The power to make diversionary orders under s 33 is used very infrequently. Data received from the NSW Bureau of Crime Statistics and Research (BOCSAR) indicates that between January and September 2011, only 0.11% of people brought before the Local Courts, or 94 people, were diverted under a s 33 order.[13]

10.12 The submission from the Children's Court indicates that magistrates are reluctant to make orders under s 33 because of concerns about its meaning and scope.[14] There may also be concerns about its effectiveness. In 1994, we observed that magistrates were unwilling to make orders under s 33 due to the "revolving door" problem, that is, the number of people who would return to court on fresh charges even after they had been the beneficiary of a diversionary order.[15] This concern appears to be well founded: in 2008, of the 197 people diverted under s 33, 66.5% had returned to court for a separate matter within two years.[16]

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9. *Mental Health Act 2007* (NSW) s 27(a).
10. After the expiration of the initial period of detention, the Mental Health Review Tribunal (MHRT) must review the case at least once every three months for the first 12 months that the person is an involuntary patient – *Mental Health Act 2007* (NSW) s 37(1)(b) and at least once every six months while the person is an involuntary patient after the first 12 months of detention – *Mental Health Act 2007* (NSW) s 37(1)(c) but the MHRT may review the case of an involuntary patient at such other times as it sees fit – *Mental Health Act 2007*(NSW) s 37(1A).
11. *Mental Health Act 2007* (NSW) s 31.
12. *Mental Health (Forensic Provisions) Act* 1990 (NSW) s 33(1A).
13. NSW Bureau of Crime Statistics and Research (LcCc1210500mr).
14. Children's Court of NSW, *Submission MH24*, 10.
15 NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System: Courts and Sentencing Issues*, Discussion Paper 35 (1994) [5.19].
16. NSW Bureau of Crime Statistics and Research (rod1210501mr_to2011).

10.13 We anticipate that the recommendations we make in this report concerning s 33, s 32 and improvements to assessment and court support will increase the use of these orders in appropriate cases and will also address problems of recidivism.

Merging s 32 and 33?

10.14 Mentally ill persons[17] are presently excluded from the diversionary powers in s 32 of the MHFPA. In Consultation Paper 7, we asked whether it was preferable to abolish s 33 and broaden the scope of s 32 to include defendants who are mentally ill persons.[18] The balance of opinion was overwhelmingly against such a move, both in submissions[19] and consultations. Stakeholders emphasised that s 32 and s 33 serve different purposes. According to Shopfront Youth Legal Service:

> The two sections serve different purposes and should not be rolled into one…an important purpose of s33 is to enable defendants who are seriously ill to receive appropriate treatment in a hospital rather than a prison.[20]

A number of stakeholders echoed this view,[21] stressing that the central concern of s 33 is to require the magistrate to consider whether accused persons pose a serious risk of harm to themselves or to others and therefore need to be hospitalised.[22]

10.15 Accordingly we make no recommendations to merge these two sections. However, in Chapter 9 we recommend that mentally ill persons should not be excluded from the operation of s 32. In most cases, where a person appears to be a mentally ill person, referral to a mental health facility will be the appropriate course of action and the person will be admitted. However, there will be cases where the defendant is referred under s 33 but found not to be a mentally ill person. The court may then find it appropriate to deal with the case according to law or to make an order under s 32.

Clarifying orders available under s 33

Scope of the referral power under s 33

10.16 Presently there is a dissonance between the basis on which a magistrate may send a matter to a mental health facility and the basis on which that person may be admitted. A magistrate may refer a person under s 33 if they appear to be a

17. As defined by the *Mental Health Act 2007* (NSW) s 14(1). See para 10.4.
18. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) Issue 7.39.
19. Shopfront Youth Legal Centre, *Submission MH7*, 13; NSW Bar Association, *Submission MH10*, 60; Law Society of NSW, *Submission MH13*, 50; NSW Health, *Submission MH15*, 18; Children's Court of NSW, *Submission MH24*, 11; Legal Aid, *Submission MH18*, 35.
20. Shopfront Youth Legal Centre, *Submission MH7*, 13.
21. NSW Bar Association, *Submission MH10*, 60; NSW Law Society, *Submission MH13*, 50; NSW Health, *Submission MH15*, 18; Children's Court of NSW, *Submission MH24*, 11; Legal Aid NSW, *Submission MH18*, 35.
22. Children's Court of NSW, *Submission MH24*, 11; Legal Aid NSW, *Submission MH18*, 35.

mentally ill person. But that person may be admitted involuntarily if they are either a mentally ill person or a mentally disordered person. Thus the "gate" is narrower at the court than it is at the mental health facility.

10.17 Amending s 33 to provide that magistrates may refer a person who appears to be a mentally disordered person to a mental health facility under s 33 would have the advantage that there would be parity between those who may be referred under s 33 and those who may be admitted. It may also assist magistrates who do not have a diagnosis of mental illness in relation to the defendant, but who do have a person before them whose behaviour is so irrational as to justify a conclusion, on reasonable grounds, that that person's temporary care, treatment or control is necessary for their protection, or the protection of others, from serious physical harm.

10.18 A risk associated with such a change would be that magistrates may refer people with cognitive impairments to mental health facilities under s 33. Admission to a mental health facility is unsuitable, and may be harmful, for a person with a cognitive impairment. Magistrates may, however, have to make difficult decisions relating to defendants with cognitive impairments whose behaviour is such that they are concerned that the defendant may do serious harm to themself or others, since it was widely acknowledged in consultations that there is an absence of facilities to which to refer people in this situation.

10.19 However, referral does not mean that the person will be admitted. Further, s 16 of the MHA provides that a person is not a mentally ill or a mentally disordered person "merely because…the person has a developmental disability of the mind". There may also be situations where a person has both a cognitive impairment and is a mentally disordered person. We also note in this regard our recommendations in Chapter 7 for the expansion of the SCCLS, so that magistrates will have expert advice available to assist them with referral decisions.

10.20 Consequently we recommend that s 33(1)(a) and s 33(1)(b) of the MHFPA should be amended to provide that a magistrate may refer a person to a mental health facility for assessment where that person is either a mentally ill person or a mentally disordered person. This recommendation is reflected in Recommendations 10.1 and 10.3

Is an order under s 33 an interlocutory or a final order?

10.21 There is some doubt about the scope of s 33 and whether it authorises a final order (one where there is no expectation that the defendant will return to court) or an interlocutory order (where the defendant is sent to a mental health facility for treatment and, when his or her mental health has improved, is returned to court so that the court can deal with the charge against them). Both of these options appear to be provided for in s 33.

10.22 Section 33(1)(a) provides that the court may order that the defendant be taken to, and detained in, a mental health facility for assessment. Such an order contains no provision for return to the court. Thus s 33 may be a final diversionary order. It may, for example, be used in relation to minor offences where the court takes the view that resolving the defendant's mental health problems is the most appropriate

response to the offence and most effective way to prevent reoffending. Section 33(2) of the MHFPA which provides that charges are taken to be dismissed if a defendant dealt with under s 33 is not brought before the court within 6 months, reinforces this view of s 33(1)(a) as a diversionary order.

10.23 However, s 33(1)(b) empowers the court to order that a defendant may be taken to, and detained in, a mental health facility for assessment and, if he or she is found not to be a mentally ill person or a mentally disordered person, that person is to be brought back before the court. This provision appears to be an order of an interlocutory nature, rather than a diversionary order. Further, s 32 of the MHA provides a procedure for authorised medical officers to release defendants detained under s 33 into the custody of police when they are not to be detained in the facility any further.

Stakeholders' views

10.24 The power to divert a person for assessment and treatment under s 33 is generally seen as prioritising mental health over criminal prosecution and providing for defendants who are seriously mentally ill to receive treatment in a mental health facility rather than being imprisoned. For example, the NSW Law Society noted that "the specific purpose of s 33 is to enable defendants who are seriously ill to receive appropriate treatment in a mental health facility rather than be incarcerated".[23] Similarly, the NSW Bar Association commented:

> It should not be forgotten that S 33 is essentially designed to get persons believed to be mentally ill persons under the MHA to an authorised mental health facility for treatment – that will be the primary concern over [and] above the secondary concern of progressing their case before the court.[24]

10.25 However, opinion is divided as to whether s 33 is intended temporarily to give precedence to mental health concerns or whether it is intended to avoid the application of the criminal justice system altogether. Legal Aid NSW, for example, submitted that once a person has been diverted under s 33, it is inappropriate to return the matter to court at all.[25] Stakeholders in one consultation also referred to this power as "absolute diversion", arguing that conditions should not be imposed on the person and it is not expected that he or she will be brought back to court.

10.26 However, other stakeholders submitted that s 33 is not only about diversion: there will be cases where it is appropriate to return the defendant to court to deal with the substantive charge against him or her. In these circumstances, s 33 is a valuable interlocutory measure. Shopfront Youth Legal Centre said:

> s33 serves a very important purpose as an interlocutory mechanism to obtain appropriate treatment for mentally ill defendants who would otherwise remain in custody on remand. It is often the case that a defendant is acutely unwell at the commencement of proceedings, an interlocutory order is made under s 33 and,

23. NSW Law Society, *Submission MH13*, 50
24. NSW Bar Association, *Submission MH10*, 59.
25. Legal Aid NSW, *Submission MH18*, 35.

> after the defendant's condition has stabilised, the defendant is brought back to court to deal with the substantive proceedings.[26]

10.27 Furthermore, the Children's Court submitted that "most, if not all, persons who are referred to assessment should return to Court", and that call-back procedures in s 33 should be strengthened accordingly.[27] The NSW Police Force submitted:

> It has often been the case that persons dealt with under s.33 have been released once the immediate threat they pose to themselves or the community is no longer in effect due to the treatment they receive in hospital. This, at times, has happened in a short space of time. Such process may not adequately deal with the criminality of the offence charged or adequately deal with the ongoing care and treatment of the person for the purposes of ensuring their criminal behaviour is curtailed.[28]

10.28 In addition to some disagreement amongst stakeholders about the nature and purpose of s 33 there was also criticism about the lack of clarity in the section. NSW Health submitted:

> … the provisions in s 33 do not clearly set out the purpose for which a person is taken to a facility for assessment, and the role of the facility following an assessment, including whether a person should be detained, is also not clear. Consideration should be given to clarifying these provisions to avoid confusion amongst service providers.[29]

10.29 In particular, there is some confusion around the extent of the court's powers to order the return of a person accused of a serious offence who has been diverted for a mental health assessment under s 33(1)(b) and admitted for treatment for a longer period of time. A number of stakeholders agreed that the power could be improved or clarified.[30]

10.30 In his preliminary submission, the Chief Magistrate of the Local Court explained that, where the person has been admitted for treatment, the mental health facility advises the court so that the matter can be adjourned until the hospital considers the person ready to proceed with the matter.[31]

> Occasionally [a] process is required to ensure the defendant returns to court. If they do not the magistrate has the option to deal with the matter in their absence if it is appropriate to do so.[32]

10.31 However, some difficulties remain. As the Public Interest Advocacy Centre explained, "if the client remains an involuntary patient at the time of their next appearance in court, they rely on transport and escort staff being available to take them to court".[33] When hospitals fail to report back to the court about patients'

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26. Shopfront Youth Legal Centre, *Submission MH7*, 13.
27. Children's Court of NSW, *Submission MH24*, 9-10.
28 NSW Police Force, *Submission MH42*, 15.
29 NSW Health, *Submission MH15*, 17.
30. Shopfront Youth Legal Centre, *Submission MH7*, 13; NSW Law Society, *Submission MH13*, 50; Legal Aid NSW, *Submission MH18*, 35; Children's Court of NSW, *Submission MH24*, 9-10.
31. G Henson, *Preliminary Submission*, PMH12, 2.
32. G Henson, *Preliminary Submission*, PMH12, 2.
33 Public Interest Advocacy Centre, *Submission MH21*, 37.

release, the patient can be in breach of the return order "through no fault of their own".[34] The Children's Court also submitted that it is "not uncommon" for the person to be released into the community without being returned to the court.[35] According to the Court, in many cases the mental health facility does not inform police or corrective services about the person's pending release from treatment.

10.32 The Local Court submitted that the clarity of s 33 could be improved. Where s 33 is used as a diversionary provision, the six month time limit in s 33 should be removed from s 33(1)(a) and the magistrate should dismiss the charges against the defendant at the time of making the diversionary order.[36]

The Commission's view

10.33 We concur with the views of stakeholders that there is room to improve the clarity of s 33(1)(a) and (b).

10.34 The section should be amended to provide for two clear options. First, there are the cases involving less serious offences where the defendant is apparently very ill and magistrate considers that the mental health system is the appropriate mechanism to deal with the accused person. In such cases s 33 should provide a clear diversionary option. Accordingly s 33(1)(a) should be amended to confer a power to dismiss the charge and order that the defendant be taken to, and detained in a mental health facility for assessment.

10.35 The provision in s 33(2) for charges to be taken to be dismissed if the defendant is not brought before the court within 6 months should be repealed. We agree with the submission of the Local Court that the provision serves no useful purpose. In view of our recommendation for the amendment of s 33(1)(a) it will have no function because the matter will have been dismissed.

10.36 Second, there will be cases in which a magistrate considers that the matter is sufficiently serious that the ongoing involvement of the criminal justice system is warranted. For these cases a clearly expressed interlocutory order should be made available. The magistrate should be able to order that the defendant be taken to, and detained in, a mental health facility for assessment. If the defendant is found on assessment at the mental health facility not to be a mentally ill person or mentally disordered person, or if the defendant is admitted after assessment but later released, then he or she must be brought back before the court.

10.37 Returning the defendant to court does not preclude diversion. The diversionary provisions of s 32 will be available in relation to persons who are "mentally ill persons", although it is anticipated that defendants who are released from mental health facilities will have a mental illness but will no longer be, or appear to be, "mentally ill persons."

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34. Public Interest Advocacy Centre, *Submission MH21*, 41.
35 . Children's Court of NSW, *Submission MH24*, 10.
36. Local Court of NSW, *Submission MH4*, 15.

Recommendation 10.1

Section 33(1)(a) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that, where it appears to the court that the defendant is a mentally ill person or a mentally disordered person as defined in the *Mental Health Act 2007* (NSW), the court may make an order dismissing the charge against the defendant and requiring that the defendant be taken to, and detained in, a mental health facility for assessment.

Recommendation 10.2

Section 33(2) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be repealed.

Recommendation 10.3

Section 33(1)(b) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that, where it appears to the court that the defendant is a mentally ill person or a mentally disordered person as defined in the *Mental Health Act 2007* (NSW), the court may order that the defendant be taken to, and detained in, a mental health facility for assessment and that, if:

(a) the defendant is found on assessment at the mental health facility not to be a mentally ill person or mentally disordered person, or

(b) if the defendant is released following admission to a mental health facility,

the defendant must be brought back before the court.

Procedures on release from a mental health facility

10.38 As noted at para 10.31, there are difficulties relating to mental health facilities informing the police and/or the court that the person is to be released from a mental health facility. We expect that our recommendations in relation to the provisions of s 33(1)(a) and (b) will assist in clarifying the scope of these orders. However the question of bail on release remains to be addressed.

10.39 In Chapter 6 we recommend amendment of s 33 of the MHFPA to provide that when a person is sent to a mental health facility under s 33, a bail determination should not be made by the court (although bail may be determined when the person returns to court following assessment).[37] When a person is to be released the mental health facility must notify a police officer at the appropriate police station,[38] and may detain the person pending apprehension by the police.[39] The police must attend the mental health facility and apprehend the person as soon as practicable after notification,[40] and may do so without a warrant.[41] Section 32 of the MHA does

37. Recommendation 6.1.
38. *Mental Health Act 2007* (NSW) s 32(3).
39. *Mental Health Act 2007* (NSW) s 32(5).
40. *Mental Health Act 2007* (NSW) s 32(5).
41. *Mental Health Act 2007* (NSW) s 33(6).

not, however, make provision in relation to the actions police are to take once they have apprehended the defendant. In most cases it will be appropriate for the defendant to be taken directly before a court for the court to make an appropriate order, including an order in relation to bail. However, there may also be cases where police bail may be appropriate; for example it may be difficult to get the defendant before a court promptly, or the charge may not be serious and police may be satisfied that the defendant will attend court. One of the functions of s 33 is to keep people who are mentally ill out of prison and instead provide for their treatment in a mental health facility. If they are admitted and treated by that facility, and as soon as they are released are again arrested and placed in custody pending an appearance in court, their mental state may deteriorate. Police bail, in appropriate cases, could prevent such problems from arising, and we recommend that s 32 of the MHA be clarified to ensure that that police bail is available in appropriate cases.

10.40 Further, if s 33(1)(b) is to be used as we recommend, as an interlocutory order, it will be necessary for a court making an order under s 33(1)(b) to adjourn the case for mention at a later date. As the period during which the defendant is to be detained in the mental health facility may not be predictable, further adjournments may be necessary. If detention in the mental health facility is to be of long duration the court may need to take decisions, after hearing submissions, about the proper disposition of the case.

Recommendation 10.4

Section 32 of the *Mental Health Act 2007* (NSW) should provide that if a person has been taken to a mental health facility under s 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW), and is apprehended by a police officer on release from the mental health facility, then that person should either be immediately brought before a court or be granted police bail under the *Bail Act 1978* (NSW).

Discharge into the care of a responsible person

10.41 Under s 33(1)(c), a magistrate may discharge a defendant who is a "mentally ill person", unconditionally or subject to conditions, into the care of a responsible person. Throughout this reference, this power has been subject to criticism, both in submissions and consultations. The main concern expressed by stakeholders is that it is very difficult to find appropriate "responsible persons" to accept the defendant into their care.[42]

10.42 We heard from stakeholders that such an order can place family and support services under enormous pressure: defendants who are "mentally ill persons", as statutorily defined, are people who appear to be so ill that their involuntary admission to hospital is necessary to protect them, or other people, from serious harm. It is therefore likely to be inappropriate to make such an order. Indeed, given the definition of a mentally ill person, such an order may put the safety of the defendant or others at risk. Similarly, the level of responsibility and the uncertainty

42. Shopfront Youth Legal Centre, *Submission MH7*, 9; NSW Law Society, *Submission MH13*, 45; Intellectual Disability Rights Service, *Submission MH14*, 13.

of the role of a responsible person mean that many service providers are reluctant to be nominated as a "responsible person", even if they are otherwise willing to provide appropriate support services.[43]

10.43 While we did not receive many submissions in relation to s 33(1)(c), stakeholders made some relevant comments about the parallel provision in s 32(3). For example, the Intellectual Disability Rights Service (IDRS) argued that the role of a "responsible person" in s 32 is "confusing and ill defined".[44] The Law Society[45] and the NSW Bar Association agreed that the role and duties attaching to a "responsible person" should be clarified but emphasised that retaining a measure of flexibility would be desirable.[46]

10.44 We have also been told that it is the practice of some magistrates, when dealing with a mentally ill person who is subject to a CTO, to discharge the person into the care of a responsible person, that person being the treatment provider under s 33(1)(c).

The Commission's view

10.45 In Chapter 9 we recommend that the provision for discharge into the care of a responsible person in s 32 of the MHFPA be repealed. We concluded that the provision was not necessary in view of our proposed amendments to s 32. Should there be rare cases where a magistrate decides that it is appropriate to discharge the person into the care of a responsible person under s 32, the same effect could be achieved by making an order under s 32 discharging the defendant to undertake a "diversion plan" with appropriate conditions (see further para 9.81-9.85). We have also recommended that mentally ill persons should no longer be excluded from the operation of s 32.

10.46 As to s 33 of the MHFPA, orders to discharge a person who is a mentally ill person into the care of a responsible person will almost always be inappropriate. However there may be exceptional cases, for example where family members or service providers are confident that they can manage the risks. They may, for example, have options immediately available for treatment in the community which will be safe, will avoid involuntary admission and give the person who is ill more choice or more dignity. In such cases, it appears to us that it would be in the interests of all concerned that discharge with a diversion plan under s 32 be used. The treatment that the defendant is to receive, and the role of those who are to support the defendant, would be defined under such a plan, instead of relying upon the undefined role of "responsible person". If an adjournment is necessary to allow the defence to construct a diversion plan, bail conditions could be used in the interim.

10.47 Where the defendant has been discharged from a mental health facility and a CTO is in place, the court could either discharge without conditions under s 32, or discharge subject to a condition of compliance with the CTO.

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43. Shopfront Youth Legal Centre, *Submission MH7*, 9; Intellectual Disability Rights Service, *Submission MH14*, 13.
44. Intellectual Disability Rights Service, *Submission MH14*, 13.
45. NSW Law Society, *Submission MH13*, 45.
46. NSW Bar Association, *Submission MH10*, 55-56.

Recommendation 10.5

Section 33(1)(c) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to remove the option of discharging the defendant into the care of a responsible person.

Community Treatment Orders

10.48 A CTO is implemented by a nominated mental health facility and requires a person to be present, at specified times and places, to receive medication, therapy, rehabilitation and other services.[47] A CTO may only be made if the magistrate is satisfied that the requirements for the making of a CTO under the MHA have been met.[48] In summary, these are:

- the person is a mentally ill person[49]
- no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person[50]
- the person would benefit from the order as the "least restrictive alternative consistent with safe and effective care"[51]
- a mental health facility has developed, and is capable of implementing, an appropriate treatment plan,[52] and
- if the affected person has previously been diagnosed as suffering from a mental illness, that the affected person has a previous history of refusing to accept appropriate treatment[53]

10.49 Section 33(1A) provides a potentially important route into the civil mental health system and treatment in the community. However, in practice, it appears that courts rarely make CTOs. Stakeholders explained that this is largely due to the procedural complexities, "rigorous requirements" and "extensive co-operation" that is required in order for a CTO to be made under s 33(1A).[54] In practice, CTOs require cooperation between the court and the relevant service providers, which can be difficult to coordinate from a court setting.[55]

10.50 However, we heard in consultations that, if appropriate supports are available, courts are more likely to use CTOs. In Chapter 7, we recommend expanding the existing SCCLS and CREDIT programs to improve the supports to courts in relation

47. *Mental Health Act 2007* (NSW) s 56(1).
48. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 33(1A).
49. *Mental Health Act 2007* (NSW) s 53(4).
50. *Mental Health Act 2007*(NSW) s 53(3)(a).
51. *Mental Health Act 2007*(NSW) s 53(3)(a).
52. *Mental Health Act 2007* (NSW) s 53(3)(b).
53. *Mental Health Act 2007* (NSW) s 53(3): previous history of refusing to accept appropriate treatment is defined in s 53 (5).
54. Local Court of NSW,*Submission MH4*,15; NSW Bar Association, *Submission MH10*, 61.
55. Deputy Chief Magistrate of the Local Court of NSW Helen Syme, *Preliminary Consultation*: see NSWLRC, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) 62.

to diversion orders under s 32 and s 33. It is possible that, with such an expansion, courts will also have the support needed to increase the use of CTOs in appropriate cases.

10.51 The provisions for making a CTO in s 33 appear to envisage that such an order is a variant of an order under s 33(1)(c) whereby the defendant is discharged into the care of a responsible person, subject to conditions. Since we recommend above the repeal of s 33(1)(c), s 33(1A) should also be amended to provide that the magistrate may discharge the defendant and make a CTO in accordance with the MHA.

Recommendation 10.6

Section 33(1A) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to remove the words "Without limiting subsection (1)(c)".

The "bounce back" problem

10.52 One of the major difficulties reported to us in relation to s 33 is that a significant number of defendants who present to court manifesting strong symptoms of mental illness are diverted under s 33 only to be assessed as "not mentally ill", refused admission for treatment and "bounced" back to court.

10.53 In 2010, 33% of the 252 defendants taken to a mental health facility under s 33 were not admitted to that facility.[56] As the Local Court explains:

> it is not uncommon to see a reluctance of hospitals to admit accused persons, particularly where an order is made under section 33(1)(b) (enabling the accused to be brought back before the court) or if the accused is violent. When this occurs, but it continues to appear to the court that the accused is a mentally ill person, an accused may be sent back and forth between the court and the hospital on several occasions. This situation may be resolved in one of two ways: the court may make an order under section 33(1)(a), where there is no option for the accused person to be returned to the court, or the accused person may be refused bail despite appearing to be mentally ill, and be detained in prison where treatment will be provided in a secure environment. Neither of these options is desirable.[57]

10.54 The Children's Court submitted that the court can be caught in a double bind in some cases. If the court receives and accepts expert advice that a person is a mentally ill person, but the mental health facility does not agree and does not admit the person, without providing reasons for its contradictory view, the court has no basis on which to depart from its original impression that the defendant is a mentally ill person. As a result of the express exclusion of mentally ill persons from s 32, the court may regard itself as unable to make a diversionary order under s 32. We have addressed this issue in Chapter 9, where we recommend that the exclusion of "mentally ill persons" from s 32 be removed.

56. Mental Health Review Tribunal, *Annual Report 2010-2011*, Appendix 1, 41.

57. Local Court of NSW, *Submission MH4*, 14.

10.55 A number of explanations were offered in relation to the "bounce back" problem. People may be refused admission to mental health facilities because, although they may have a mental illness, they do not meet the requirements in the MHA for a mentally ill or mentally disordered person. These requirements are appropriately set at a high level, because they authorise people to be detained and treated against their will. Thus, although a person may appear to a court to be very unwell, that person nevertheless may not meet the required test in the Act. The person may, for example, have a behavioural disorder, substance abuse disorder or a personality disorder and not qualify as a mentally ill person. Although the person may be behaving irrationally in court, there may be no need for an admission to protect the person, or other persons, from serious harm, as required by s 14 and 15 of the MHA.

10.56 During consultations, it was noted that the problem of defendants being returned to court by mental health facilities sometimes occurs even when a court has made a s 33 order on the basis of a psychiatric report. For example, where a court has the benefit of access to the SCCLS an assessment may have been made by a nurse practitioner at court, and confirmed by an SCCLS psychiatrist, before the defendant is referred under s 33. Stakeholders provided very positive feedback about the role that SCCLS staff can play in finding a solution where a defendant is referred under s 33 and is "bounced back" to court. Nevertheless we were also provided with many examples of defendants who were transferred back and forth from court more than once, in a state of acute ill-health, before finally being admitted.

10.57 Stakeholders in consultation made frequent reference to resource constraints in mental health facilities, suggesting that these impede the operation of s 33. The Local Court's submission recognised that:

> underlying issues, such as the level of resources available to hospitals in order to assess and admit persons for treatment, may similarly need to be addressed to better facilitate assessment and treatment of mentally ill persons pursuant to section 33.[58]

Other stakeholders in consultation emphasised that some mental health facilities must balance difficult admission decisions in relation to limited beds, especially at times of high demand.

10.58 Some stakeholders also argued in consultation that some hospital staff know that defendants referred to a mental health facility under s 33 will not be released into the community if the hospital refuses to admit them, because the court is likely to remand them in custody to a prison or a juvenile detention centre. Prisons were described by clinicians and service providers in consultations as "de facto mental institutions".[59] Some stakeholders argued that staff of some mental health facilities regard prison as the more appropriate place for defendants whose behaviour is violent or threatening because those people present risks to their staff that they are unable to manage.

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58. Local Court of NSW, *Submission MH4*, 14.

59. See also discussion in C Henderson, "Gaols or de facto Mental Institutions? Why Individuals with Mental Illness are Over-Represented in the Criminal Justice System in New South Wales, Australia" (2007) *Journal of Offender Rehabilitation* 4.

10.59 The Public Guardian provided a detailed case study of a client under guardianship who was repeatedly refused admission under s 33 and where there were protracted disputes about whether she was a mentally ill person. The Public Guardian referred to these problems as representing a form of "criminalisation of the mentally ill".[60]

Solutions to the "bounce back" problem

10.60 Two proposals to deal with the bounce back problem received support during the course of this inquiry:

- Legislation could require the mental health facility to provide a report to the court where admission of a person referred under s 33 is refused.
- Legislation could provide for review by the MHRT of involuntary admission refusals by mental health facilities.

Requiring a report

10.61 There was significant support in consultations for a requirement that the mental health facility provide a report to the court where the admission of a person referred under s 33 is refused. The Children's Court submitted that s 33 be amended to enable the court to request the mental health facility to provide information about the defendant's condition. Without such information, it is "very difficult for the Court to dispose of the charge or determine the best way to proceed".[61] The Children's Court submitted:

> On some occasions, a report may be sent with the police when returning the accused to court or the mental health nurse may be able to provide a report, but in many instances the court receives no information about the assessment of the accused or any reasons why he or she was not admitted.
>
> …section 33 should be amended to include a provision to the effect that wherever an assessment of an accused takes place pursuant to an order under that section and the person is not admitted and returned to the court, the hospital must provide the court with a report indicating the outcome of the assessment and reasons for the opinions set out in the assessment. Otherwise, situations in which accused persons may be sent back and forth between the court and the hospital seem likely to continue to arise.[62]

10.62 Other stakeholders also expressed support for this suggestion in consultations as it would have the benefit of informing the magistrate of the determination and the reasons for refusing admission. It would provide a higher degree of accountability and transparency to clinicians' practices, which could be useful where the person is returned to court.

10.63 A related proposal made in consultations was that s 33(1)(c) be amended to require clinicians to report back to court in the form of a treatment plan for people who are returned to court because they are found not to be a "mentally ill person" after a

60 NSW Public Guardian, *Submission MH27*, 25.

61. Children's Court of NSW, *Submission MH24*, 9-10.

62. Local Court of NSW, *Submission MH4*, 14.

s 33 order. Such a reporting obligation could require the clinician to devise a treatment plan, relating to the provision of appropriate services in the community.

10.64 The NSW Ministry of Health did not support a reporting requirement. The Ministry noted that s 33 requires that the admitting clinician assess whether the person is a mentally ill person for the purposes of involuntary admission and treatment. Assessment of the patient in order to make a report for the court that would assist the court in making subsequent orders, or that would recommend an appropriate treatment plan in the community, would involve a different order of assessment.

10.65 The Ministry had serious reservations about the impact of any such requirement, given the number of people in need of acute care who are assessed by mental health facilities, particularly during "peak hours". An increased reporting obligation on clinicians would put a further strain on mental health facilities; time that would otherwise be spent with patients would necessarily need to be devoted to preparing reports for the court. This would have clear resource implications for public mental health services where clinicians must work with large numbers of patients in a high-pressure environment, often with only limited time for individual consultations.[63]

The Commission's view

10.66 We accept the Ministry's view that a requirement for an assessment and report to assist the court in making further orders would be onerous, particularly in peak hours. However it is unsatisfactory for the person to be returned to court with no written confirmation that the defendant has been assessed, and no information as to the outcome of that assessment. We recommend that s 33 should be amended to require the mental health facility to provide a report indicating the time and date of the assessment, the name of the assessing officer, and confirming that the person is assessed as "not a mentally ill person or a mentally disordered person." Such a reporting obligation would make very little imposition on practitioners, while satisfying the court that the person has been appropriately assessed. We note that, if the right to appeal an admission decision to the MHRT is created, as discussed below, the mental health facility will need to maintain a record of admission decisions in the event of appeal. A reporting requirement as described above would therefore not require extra work from pressured mental health facilities.

Review of decisions to refuse admission

10.67 Section 33 is not the only route to admission into a mental health facility. People present themselves for admission, or are brought to the facility by family members, friends, police officers and others. Concerns about refusal to admit mentally ill persons have been raised in relation to all admission decisions, not only those made in relation to people referred under s 33. The government has announced that it is exploring extending MHRT appeal rights to those who are refused access to ensure that mental health services remain open and accessible to consumers.[64]

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63. Ministry of Health, *Consultation MH29*.

64. The Hon Kevin Humphries MP, Media Release, "NSW government response to the release of the report into the evaluation of efficacy and cost of the mental health inquiry system, NSW", 15 March 2012.

Such reviews could be made available in relation to all disputed admission decisions, including where referral is made under s 33.

10.68 If such a proposal is accepted, there will inevitably be practical issues that will need to be resolved. A "second opinion" in the form of internal review would seem desirable before the expense of convening a Tribunal hearing. People do not present to mental health facilities only during office hours, so the Tribunal would need to be able to convene rapidly, perhaps on a 24 hour basis. If a rapid response is not possible, or not desirable because of the need to marshal evidence, the person whose admission is disputed would need to be admitted on a short term basis or other arrangements made. In relation to s 33 referrals, such arrangements may involve remand in custody which fortifies the arguments for rapid response by the tribunal.

The Commission's view

10.69 Review of admission refusals by the MHRT would be a useful response to the "bounce back" problem. It has the advantage of review by an expert judicial body. It would apply across the board to all refusals of admission, rather than making exceptional provision in relation to referrals made under s 33.

10.70 Section 33 referrals are not numerous, and the cases where there is a refusal of admission which cannot be resolved by the intervention of the SCCLS will be small in number. However courts will have recourse to expert decision making in relation to some very difficult cases that presently consume resources and present intractable problems.

Recommendation 10.7

When a defendant is referred under s 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) to a mental health facility and is not admitted:

(a) The mental health facility must provide a report which includes the time and date of the assessment, the name of the assessing officer and a statement that the person has been assessed as "not a mentally ill person or a mentally disordered person."

(b) A court should be able to refer the decision to the Mental Health Review Tribunal for review.

Availability of s 33 in committal proceedings

10.71 Section 31 of the MHFPA provides that the diversionary provisions of that Act apply in respect of summary offences, or indictable offences triable summarily ("being proceedings before a magistrate"), but do not apply to committal proceedings. Committal proceedings may take some time to progress, and some stakeholders

considered that magistrates should be able to make s 33 orders during committal proceedings.[65] As Shopfront Youth Legal Centre pointed out:

> A person may appear before the Local Court charged with a strictly indictable offence. The defendant may be acutely unwell and require treatment. The only options available to the court are to refuse bail or to grant bail, neither of which will necessarily ensure the defendant receives treatment.[66]

10.72 The NSW Law Society supported the extension of interlocutory diversionary options to committal proceedings.[67] The NSW Bar Association was similarly supportive of the extension of s 33 powers to committal proceedings, arguing that:

> it seems somewhat arbitrary that diversion should effectively be unavailable simply because of the level of Court that the charges are pending in. Sometimes even comparatively serious indictable matters will warrant consideration for diversion…[68]

10.73 Where a defendant is charged with an indictable offence triable summarily, the prosecution must make an election in relation to summary trial. Such an election must be made "within the time fixed by the Local Court".[69] It is not uncommon for the Court to adjourn proceedings for 14 days in order for the prosecution to make this procedural election. If, after that time, it is decided that the matter should be dealt with summarily, the Court may then make an order under s 33. Where the defendant is a mentally ill person this presents a significant delay, during which he or she may be remanded in custody. As the Local Court noted in its submission:

> The inability to make an order under section 33 until the election issue is resolved is problematic, given that, although a section 33 application can be made at any time in the proceedings the diversion from the court system and treatment of mentally ill persons should ideally occur as soon as possible.[70]

10.74 Shopfront Youth Legal Centre provided the following case example of a situation where a person with an acute mental illness was remanded in custody, despite the desire of the magistrate to refer her instead to a mental health facility.

Case study 10.1

In the past twelve months, Janelle (19) developed a serious mental illness and her relationship with her parents deteriorated to the point where they kicked her out of home. Janelle was charged with aggravated break, enter and steal (a strictly indictable offence) after she broke into her parents' home and tried to retrieve some of her own belongings.

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65. Shopfront Youth Legal Centre, *Preliminary Submission PMH3*, 2, Shopfront Youth Legal Centre, *Submission MH7*, 14; NSW, Office of the Director of Public Prosecutions, *Preliminary Submission PMH5*, *2*; Intellectual Disability Rights Service, *Preliminary Submission PMH7*, 6; Law Society of NSW, *Preliminary Submission PMH11*, 2, Law Society of NSW, *Submission MH13*, 51; Legal Aid NSW, *Submission MH18*, 35.
66. Shopfront Youth Legal Centre, *Submission MH 7*, 14.
67. NSW Law Society, *Submission MH13*, 51.
68. NSW Bar Association, *Submission MH10*, 61. Emphasis removed.
69. *Criminal Procedure Act 1986* (NSW) s 263.
70. Local Court of NSW, *Submission MH4*, 13-14.

> At the time of her arrest, Janelle was acutely psychotic. Janelle's solicitor asked for bail on the condition that Janelle attend her local community mental health centre immediately upon release. However, the magistrate was understandably concerned about Janelle's ability to comply with such a condition, and about what would happen if she did not attend the mental health centre and receive treatment. Reluctantly, the magistrate said that, while prison was no place for a young woman like Janelle, refusing bail was the only realistic option. The magistrate remarked that she would have sent Janelle to hospital under s 33 had she been empowered to do so.[71]

10.75 The Office of the Director of Public Prosecutions submitted that, if a mentally ill defendant is committed for trial, issues in relation to fitness for trial are likely to arise and noted that it would be desirable to be able to refer the defendant to a mental health facility to ensure that those issues are raised early in proceedings.[72]

10.76 Unsurprisingly, those in support of extending s 33 to committal proceedings noted that, given the potential seriousness of the offence, such matters should not be automatically discharged after six months, but should instead be brought back before the court to allow the magistrate to deal with the charge.[73]

The Commission's view

10.77 Section 33 provides the court with the power to refer people who are acutely ill for treatment in a mental health facility. There appears to be no good reason why such a power should not be available in relation to defendants where there are committal proceedings on foot, or where an election has yet to be made about the appropriate trial court, so long as, in serious cases, the person can be brought back to court when they are released from the mental health facility. Our earlier recommendations are intended to ensure that the defendant will be returned to court. We further recommend that s 33 be amended so that this power is available to court both in relation to committals and in the time prior to the decision regarding the appropriate venue.

Recommendation 10.8

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that where:

(a) a defendant appears before the court in relation to committal proceedings, or

(b) the defendant is charged with an indictable offence triable summarily and an election has not been made,

the court may make an interlocutory order in accordance with Recommendation 10.3.

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71 Shopfront Youth Legal Centre, *Submission MH7*, 14.

72. NSW, Office of the Director of Public Prosecutions, *Submission MH5*, 5.

73. Shopfront Youth Legal Centre, *Preliminary Submission PMH3*, 3; NSW, Office of the Director of Public Prosecutions, *Preliminary Submission PMH5*, 2; Law Society of NSW, *Preliminary Submission PMH*11, 2; Law Society of NSW, *Submission MH13*, 51. See also NSW Police Force, *Submission MH47*, 20.

11. Mental health courts

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11.1 This chapter examines the growing trend to establish specialist courts for people who have mental health impairments and (sometimes) cognitive impairments. Mental health courts were first introduced in the US and there has been evaluation of the success of these courts. This chapter therefore first describes the common features of the US models and synthesises the research about their efficacy. We then examine the criticisms of mental health courts before reviewing mental health courts in Australia. This chapter provides background to our recommendations in Chapter 12 regarding the creation of a specialist list.

A growing trend – mental health courts

11.2 Following in the footsteps of drug courts,[1] mental health courts (MHCs) are a relatively new development. MHCs are "specialty courts with dockets usually

1. Para 3.6.

exclusive to individuals with mental illness",[2] which place greater importance on therapeutic jurisprudence, treatment and ongoing judicial supervision of participants than traditional criminal courts.

11.3 A number of precursors led to the development of the first MHCs in the US, including:

- the difficulties faced by the judiciary in dealing with defendants who do not fit neatly within existing procedures for involuntary detention in a mental health facility, a finding of unfitness, or the defence of mental illness
- critical overcrowding of prisons, and
- the development of drug courts as an alternative means of dealing with a special population of offenders in the community.[3]

11.4 The frustration faced by some members of the judiciary prior to the development of MHCs was described by a judge in Delaware in the following terms:

> [A] colleague came into my office, threw a file on my desk, and asked, "Why do we do this? Why do we expect mentally ill people to be able to comply with regular probation?" … One of the defendants on his calendar was being violated for about the eighth time. The individual was severely bipolar and had been grappling with mental illness for most of his adult life. As a result, he was also grappling with the criminal justice system, and very unsuccessfully. His pattern was clear: he would go off his medication, get into trouble, get convicted, get placed on probation, violate that probation, and end up in prison. It was a vicious cycle.[4]

11.5 Since their inception in 1997, MHCs have grown rapidly to become a major tool in diverting people with mental illness away from the criminal justice system. Today there are over 300 MHCs worldwide.[5]

11.6 The discussion below focuses on mental health impairments and does not discuss cognitive impairments in detail. This is not because the needs of those with cognitive impairments are not regarded as important, but rather because MHCs have developed primarily as a response to issues faced by defendants with mental health impairments. Although some MHCs accept defendants with cognitive impairments, there is ongoing debate about whether these programs are best placed to deal with such individuals.

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2. A Redlich and others, "Patterns of Practice in Mental Health Courts: A National Survey" (2006) 30 *Journal of Law and Human Behaviour* 347, 347.
3. JS Goldkamp and C Irons-Guynn, *Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage* (Bureau of Justice Assistance, 2000) 3-5.
4. J Jurden, *Superior Court Mental Health Court*, Delaware State Courts <courts.delaware.gov/Superior/mental_health2.stm>.
5. L Williams, "Therapeutic Jurisprudence", *Lawyers Weekly* (online), 9 August 2010 <www.lawyersweekly.com.au/blogs/special_reports/archive/2010/08/09/therapeutic-jurisprudence.aspx>.

Defining mental health courts

11.7 The term "mental health court" is used to describe various court and diversionary program models. MHCs in the US usually fall squarely into the category of "problem solving" courts. They typically use a team approach in which the court works with mental health professionals and focus on the treatment of defendants, rather than determining guilt using adversarial processes. In contrast, Queensland's "mental health court" does not act as a problem-solving court, but deals with questions of fitness and criminal responsibility. It is not a diversionary program and does not possess the elements generally associated with the term "mental health court". Toronto's MHC seeks to use both approaches by attempting to deal with issues of fitness expeditiously,[6] while at the same time housing a diversion program, whereby mental health workers at the court link the defendant to treatment and services.[7]

11.8 The US is the home of the majority of the world's MHCs and even in that jurisdiction there is significant variation in how different courts operate. Further, since the first US MHCs commenced operation in the 1990s, the court model has gradually evolved, such that new MHCs can differ substantially from more established courts.[8] For example, initially many MHCs accepted only non-violent misdemeanours, although some also accepted low-level felonies pleaded down to misdemeanours.[9] This approach was criticised for bringing people whose crimes were not serious further within the criminal justice system, rather than immediately diverting them towards more appropriate services.[10] Whether for this or other reasons,[11] the "second generation" of US MHCs is more likely to accept felony cases. As at 2005, 10% of US MHCs *only* accepted people charged with felonies, with 56% of MHCs accepting both felonies and misdemeanours.[12]

11.9 Given that each MHC may operate differently, how can a MHC be defined? Despite their differences, most MHCs have the following common elements:[13]

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6. It does so by having psychiatrists in attendance every day, who conduct an assessment on the day a defendant is referred to the court. Following an opinion from the assessing psychiatrist (provided immediately after the assessment is conducted), the court can go on to make a determination as to fitness and, where the defendant is unfit, hear the Prosecution's application for a treatment order on the same day: Toronto Mental Health Court, *Overview* <www.mentalhealthcourt.ca/pages/2/Overview.htm>; Toronto Mental Health Court, *Partners* <www.mentalhealthcourt.ca/pages/3/Partners.htm>.
7. Toronto Mental Health Court, *Overview* <www.mentalhealthcourt.ca/pages/2/Overview.htm>.
8. A Redlich and others, "The Second Generation of Mental Health Courts" (2005) 11 *Psychology, Public Policy and Law* 527.
9. Australian jurisdictions refer to "summary" and "indictable" offences, rather than adopting the US language of misdemeanours and felonies.
10. See, for example, R Bernstein and T Seltzer, "Criminalization of People with Mental Illnesses: The Role of Mental Health Courts in System Reform" (2003) 7 *District of Columbia Law Review* 143.
11. Redlich and others suggest the funding ramifications of California Proposition 36 may be partly responsible: A Redlich and others, "The Second Generation of Mental Health Courts" (2005) 11 *Psychology, Public Policy and Law* 527, 535.
12. Council of State Governments (US), *Mental Health Courts: A National Snapshot* (2005) 3.
13. Many attempts to define the common elements of MHCs have been made. Most or all of the elements set out here have been repeatedly identified as essential features. See, eg, A Redlich and others, "Patterns of Practice in Mental Health Courts: A National Survey" (2006) 30 *Journal of Law and Human Behaviour* 347, 349; VA Hiday and B Ray, "Arrests Two Years After Exiting a Well-Established Mental Health Court" (2010) 61(5) *Psychiatric Services* 463, 463, 467; D

- A specialised list
- A dedicated court team
- A non-adversarial approach
- Mandated community treatment
- Continuing supervision
- Rewards and sanctions, and
- Voluntary participation.

11.10 These elements are described and discussed below.

A specialised list

11.11 The "core characteristic" of the MHC model[14] is a distinct list or docket, which operates quite separately from the regular criminal court list. Although the court may operate full-time in a physically discrete courthouse, quite often a local or magistrates' court becomes a MHC for one or two afternoons or days per week. On those days, the court will only hear matters from the MHC list and the procedures in the court will be quite different to those in place when the criminal court list is heard.

11.12 In order to be included on the specialised list, defendants must meet the eligibility criteria for the court in question. A mental health expert assesses eligibility once a client is referred to the court. Referrals are commonly made by the public defender's office or by other magistrates,[15] but may come from private lawyers, prosecutors, family members, service providers, court staff, or by defendants themselves.[16]

11.13 Eligibility criteria differ greatly between courts, but more often than not, a diagnosis of a disorder included on the DSM-IV, Axis 1 list is required.[17] Amenability to

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McNiel and R Binder, "Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence" (2007) 164(9) *The American Journal of Psychiatry* 1395, 1395; M Moore and V Hiday, "Mental Health Court Outcomes: A Comparison of Re-Arrest and Re-Arrest Severity Between Mental Health Court and Traditional Court Participants" (2006) 30 *Journal of Law and Human Behaviour*, 659, 660.

14. A Redlich and others, "Patterns of Practice in Mental Health Courts: A National Survey" (2006) 30 *Journal of Law and Human Behaviour* 347, 349.
15. H Steadman and others, "From Referral to Disposition: Case Processing in Seven Mental Health Courts" (2005) 23(2) *Behavioural Sciences and the Law* 215, 218.
16. M Hill, *Tasmania's Magistrates Court Mental Health Diversion List* (18 March 2010) Magistrates Court of Tasmania <www.magistratescourt.tas.gov.au/__data/assets/powerpoint_doc/0019/137143/MHDL_Presentation_-_Launceston_March_2010.pps>.
17. The Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, classifies psychiatric diagnoses into 5 axes. Axis I relates to clinical disorders and includes diagnoses such as depression, schizophrenia, bipolar disorder, anxiety disorders and autism spectrum disorders. It does not include developmental disorders or personality disorders. In 2005, 58% of MHCs would only accept people with a "serious and persistent mental illness" or an Axis I diagnosis: Council of State Governments (US), *Mental Health Courts: A National Snapshot* (2005).

treatment is also a factor considered when assessing eligibility for entry to the court.[18]

11.14 Courts may also have exclusion criteria. For example, people who commit child abuse or sex offences are often not eligible.[19]

A dedicated court team

11.15 A typical feature of a MHC is a dedicated judge, or a very small number of judges on rotation, such that each defendant usually comes before the same judge.[20]

11.16 The judge works together with the MHC team, which may include dedicated defence and prosecution lawyers, mental health workers and court staff.[21]

11.17 MHC defence lawyers have training and experience in dealing with people with mental health impairments.[22] They may be an ongoing part of the team,[23] or may be privately hired for particular cases.[24] Their role is to advocate strongly for their client while acting with the rest of the team in attempting to encourage compliance.[25] A primary role of the defence lawyer is to explain alternatives to MHC to their client, and ensure that the defendant understands the consequences of failing to comply with court requirements.[26] This is one way of minimising the potential for MHC to become coercive (see below at para 11.108 for a discussion of coercion).

11.18 Likewise, the dedicated MHC prosecution lawyer has multiple objectives, for example, to encourage compliance by the defendant, while ensuring that the treatment plan developed for the defendant adequately takes into account

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18. D McNiel and R Binder, "Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence" (2007) 164(9) *The American Journal of Psychiatry* 1395. 1396; G Palermo, "The Nevada Mental Health Courts" (2010) 33 *International Journal of Law and Psychiatry* 214, 216.
19. A Lurigio and J Snowden, "Putting Therapeutic Jurisprudence into Practice: The Growth, Operations and Effectiveness of Mental Health Court" (2009) 30 *Justice System Journal* 196, 206.
20. M Moore and V Hiday, "Mental Health Court Outcomes: A Comparison of Re-Arrest and Re-Arrest Severity Between Mental Health Court and Traditional Court Participants" (2006) *Journal of Law and Human Behaviour* 659, 660.
21. M Moore and V Hiday, "Mental Health Court Outcomes: A Comparison of Re-Arrest and Re-Arrest Severity Between Mental Health Court and Traditional Court Participants" (2006) 30 *Journal of Law and Human Behaviour* 659, 660; K Frailing, "How Mental Health Courts Function: Outcomes and Observations" (2010) 33 *International Journal of Law and Psychiatry* 207, 208.
22. R Bernstein and T Seltzer, "Criminalization of People with Mental Illnesses: The Role of Mental Health Courts in System Reform" (2003) 7 *District of Columbia Law Review* 143, 150.
23. Such as King County in Washington, see eg A Lurigio and J Snowden, "Putting Therapeutic Jurisprudence into Practice: The Growth, Operations and Effectiveness of Mental Health Court" (2009) 30 *Justice System Journal* 196, 203.
24. As with the Mental Health Diversion List in Tasmania: E Newitt and V Stojcevski, *Mental Health Diversion List Evaluation Report* (May 2009) 5.
25. King County Mental Health Court, *FAQ* <www.kingcounty.gov/courts/DistrictCourt/MentalHealthCourt/FAQ.aspx#allcontent>.
26. R Bernstein and T Seltzer, "Criminalization of People with Mental Illnesses: The Role of Mental Health Courts in System Reform" (2003) 7 *District of Columbia Law Review* 143, 152.

considerations about public safety. The prosecutor can also seek sanctions for non-compliance, but takes the interests of the defendant into account when doing so.[27]

11.19 The mental health workers who form part of the team are responsible for clinical assessment of the defendant and providing the expert knowledge necessary to develop individualised treatment plans, discussed below.[28] These members of the team also liaise with community treatment providers and ensure that clients are connected with the services they need. They also inform the decisions of the court, by monitoring the defendant's progress and making recommendations to the court on how to proceed.[29]

11.20 The defendant will be required to attend court on a regular basis, usually between once a week and once a month.[30] At these meetings (and sometimes in pre-hearing reviews conducted by the team without the defendant being present), the MHC team will discuss the defendant's progress and compliance with the treatment plan and determine how to proceed.

11.21 This team approach is regarded as essential in order for a MHC to succeed. A multi-disciplinary team provides a range of services that are seen as necessary in order for long-term positive outcomes to be achieved.[31] A lack of training and awareness amongst staff of issues affecting people with mental illness has been observed to have a negative impact on the daily operation of the court.[32]

A non-adversarial approach

11.22 MHCs focus on how to achieve compliance with court mandates, not on whether defendants are guilty or innocent.

11.23 As a result, prosecution and defence lawyers do not dispute the facts of the case, instead, they work together as part of the MHC team in order to address the underlying causes of each defendant's behaviour in ways which will not diminish

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27. King County Mental Health Court, *FAQ* <www.kingcounty.gov/courts/DistrictCourt/MentalHealthCourt/FAQ.aspx#allcontent>.
28. Para 11.24-11.27.
29. M Hill, *Tasmania's Magistrates Court Mental Health Diversion List* (18 March 2010) Magistrates Court of Tasmania <www.magistratescourt.tas.gov.au/__data/assets/powerpoint_doc/0019/137143/MHDL_Presentation_-_Launceston_March_2010.pps>.
30. A Redlich and others, "Patterns of Practice in Mental Health Courts: A National Survey" (2006) *Journal of Law and Human Behaviour* 347, 357; M Cosden and others, "Efficacy of a Mental Health Treatment Court with Assertive Community Treatment" (2005) 23 *Behavioural Sciences and the Law* 199, 202; CS Leon, K Daly and M Mahoney, University of Delaware, *Delaware Mental Health Courts Process Evaluation: Progressive Treatment and Systematic Obstacles*, Working Paper (State of Delaware Chief Justice's Task Force on Mental Health and Criminal Justice, 2010) 6; GB Palermo, "The Nevada Mental Health Courts" (2010) 33 *International Journal of Law and Psychiatry* 214, 216; HW Wales, VA Hiday and B Ray, "Procedural Justice and the Mental Health Court Judge's Role in Reducing Recidivism" (2010) 33 International *Journal of Law and Psychiatry* 265, 266.
31. RD Schneider, HY Bloom and M Heerema, *Mental Health Courts, Decriminalizing the Mentally Ill* (Irwin Law, 2007) 118.
32. CS Leon, K Daly and M Mahoney, *Delaware Mental Health Courts Process Evaluation: Progressive Treatment and Systematic Obstacles*, Working Paper (State of Delaware Chief Justice's Task Force on Mental Health and Criminal Justice, 2010) 11.

public safety.[33] Lawyers generally play a minimal role in proceedings, being responsible for only 12% of dialogue in the court, according to one study.[34]

Mandated community treatment

11.24 An essential part of the individual plan prepared for each defendant is monitored treatment in the community:

> Mandated treatment supplies the leverage to serve risky clients in the community. MHC participants have typically experienced several failed treatment attempts and incarcerations. Court mandates, and the combined efforts of the MHC team, help engage clients in services and give them an opportunity to complete the program successfully.[35]

11.25 A treatment plan is likely to require regular attendance at community treatment facilities, ongoing appointments with caseworkers and a medication regime. Some courts also incorporate broader therapeutic aims into the treatment plan by requiring participants to undergo vocational training, attend work or school regularly and secure housing before they are eligible for graduation.[36]

11.26 The client's attendance at appointments and status hearings and their compliance with their medication regime are all matters that are discussed by the MHC team at status hearings and pre-hearing case reviews. Because offenders with mental illness often relapse, it is not regarded as necessary to require full and immediate compliance with the treatment plan. As such, MHC team members adjust their expectations of offenders and offer more than one chance to comply.[37] On the other hand, there must come a point where offenders who are not willing to actively participate in the plan are recognised and dealt with by alternative means, as discussed below.[38]

11.27 The proposed length of enrolment in the court (sometimes referred to as the "dose") varies between courts, and participants are likely to be enrolled for longer than initially prescribed, as they are often not compliant with their treatment plan straight away.[39]

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33. VA Hiday and B Ray, "Arrests Two Years After Exiting a Well-Established Mental Health Court" (2010) 61(5) *Psychiatric Services* 463, 463.
34. R Boothroyd and others, "The Broward Mental Health Court: Process, Outcomes, and Service Utilization" (2003) 26 *International Journal of Law and Psychiatry* 55, 57.
35. A Lurigio and J Snowden, "Putting Therapeutic Jurisprudence into Practice: The Growth, Operations and Effectiveness of Mental Health Court" (2009) 30 *Justice System Journal* 198, 207.
36. For examples from North Carolina and Nevada, respectively, see: VA Hiday and B Ray, "Arrests Two Years After Exiting a Well-Established Mental Health Court" (2010) 61(5) *Psychiatric Services* 464, 463-468; and GB Palermo, "The Nevada Mental Health Courts" (2010) 33 *International Journal of Law and Psychiatry* 214, 217.
37. VA Hiday and B Ray, "Arrests Two Years After Exiting a Well-Established Mental Health Court" (2010) 61(5) *Psychiatric Services* 463, 463. .
38. Para 11.30 -11.36.
39. Redlich found that across four courts, graduates were enrolled, on average, for 1.2 years: A D Redlich and others, "The Use of Mental Health Court Appearances in Supervision" (2010) *International Journal of Law and Psychiatry* 272, 274.

Continuing supervision

11.28 As noted, the MHC monitors and discusses the progress of each individual and his or her compliance with treatment requirements throughout the entire duration of enrolment. This is done by regular status hearings at the court. Caseworkers may also have additional meetings with the participant at more frequent intervals.[40]

11.29 Although other diversionary programs operated through the courts aim to connect offenders with treatment and services in the hope of rehabilitation, MHCs go further in taking on the responsibility of supporting the offender through their treatment.

Rewards and sanctions

11.30 Hiday and Ray state that MHCs possess:

> A "carrot" to encourage participation and compliance (the opportunity to have charges dismissed or sentences reduced), [and] a "stick" to enforce compliance with court mandates (the monitoring and sanctions of a judge and court team).[41]

11.31 The manner in which MHCs respond to a defendant's compliance or non-compliance is largely what sets them apart from other diversion programs:

> In a diversion program, the only processes that a court may use [are] the adjournment of the case and the offer of a reduction in sentence for successful compliance. As to whether there is any significant engagement between the judicial officer and the defendant or the use of therapeutic judging techniques such as goal setting, problem-solving and encouragement depends on the individual judicial officer.[42]

11.32 MHCs rely heavily on therapeutic judging techniques, which some researchers hypothesise is a key reason for their success.[43]

11.33 The difference in the judicial approach of MHC judges from judges in traditional proceedings can be observed clearly in studies where researchers have attended and documented court sessions. For example, Kelly Frailing describes a court session in her 2010 study:[44]

> participants were called one by one to stand before the judge. The judge asked how the participant was and how his or her week had been. The participant answered the judge. Often these exchanges were short, but occasionally, a participant wanted to share good news with the judge, such as securing a job or achieving a milestone of sobriety. Following his interaction with the participant, the judge asked the service coordinator supervisor and one of the court services officers (i.e. two MHC staff members) for updates on whether the participant had

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40. CS Leon, K Daly and M Mahoney, *Delaware Mental Health Courts Process Evaluation: Progressive Treatment and Systematic Obstacles*, Working Paper (State of Delaware Chief Justice's Task Force on Mental Health and Criminal Justice 2010) 11.
41. VA Hiday and B Ray, "Arrests Two Years After Exiting a Well-Established Mental Health Court" (2010) 61(5) *Psychiatric Services* 463, 467.
42. The Australian Institute of Judicial Administration, *Court Diversion Programs*, <www.aija.org.au/research/australasian-therapeutic-jurisprudence-clearinghouse/court-diversion-programs.html>.
43. HW Wales, VA Hiday and B Ray, "Procedural Justice and the Mental Health Court Judge's Role in Reducing Recidivism" (2010) 33 *International Journal of Law and Psychiatry* 265, 265.
44. K Frailing, "How Mental Health Courts Function: Outcomes and Observations" (2010) 33 *International Journal of Law and Psychiatry* 207, 211.

> met his or her mental health service and court obligations for the week. When participants had met their obligations, the judge might offer praise. Encouragement was offered to those participants who were struggling. For noncompliance, the judge ordered one of a variety of sanctions, either jail, community service, observing a week's worth of specialty court sessions…[placement on a list] for possible removal from the MHC or [advised that they must]…meet all court and mental health service obligations in the coming week, lest he or she receive a harsher sanction. Those who received jail as a sanction were taken into custody immediately. Participants were not permitted to appeal receipt of a sanction.

11.34 Frailing noted that praise and encouragement were given far more often than sanction, including such comments as "good job", "congratulations on doing great", "you're perfect", "you're making us proud", "you can do it" and "you stick with us and we'll help you". Other team members and courtroom observers also gave expressions of approval, for example, participants were commonly given rounds of applause by the entire court. [45]

11.35 If a participant meets pre-determined criteria of compliance (for example, six months continuous compliance),[46] they will "graduate" from the MHC. Usually, this results in their charges being dismissed.

11.36 If an individual fails to comply with the plan, they may be sanctioned. Sanctions may involve time in prison, but often take the form of expressions of disapproval and increased supervision. Repeated non-compliance generally results in termination from the program.

Voluntary participation

11.37 The US Council of State Governments Justice Centre lists fully informed voluntary participation as an essential element of a MHC[47] and descriptions of MHCs regularly list voluntary participation as a feature.[48] However, voluntariness goes further than agreement by the defendant to enrol in the court. The view that MHCs are coercive in nature remains one of the primary criticisms in response to their proliferation.[49]

11.38 In order for participation to be truly voluntary, defendants must be competent to make a decision to participate;[50] they must be fully informed about the

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45. K Frailing, "How Mental Health Courts Function: Outcomes and Observations" (2010) 33 *International Journal of Law and Psychiatry* 207, 211.
46. As in the North Carolina court studied by Hiday and Ray: VA Hiday and B Ray, "Arrests Two Years After Exiting a Well-Established Mental Health Court" (2010) 61(5) *Psychiatric Services* 463, 464.
47. Council of State Governments Justice Centre *Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court* (2008) 5.
48. See, for example, DE McNiel and R L Binder, "Stakeholder Views of a Mental Health Court" (2010) 33 *International Journal of Law and Psychiatry* 227, 227; VA Hiday and B Ray, "Arrests Two Years After Exiting a Well-Established Mental Health Court" (2010) 61(5) *Psychiatric Services* 463, 463.
49. RD Schneider, HY Bloom and M Heerema, *Mental Health Courts, Decriminalizing the Mentally Ill* (Irwin Law, 2007), 63; AJ Lurigio and J Snowden, "Putting Therapeutic Jurisprudence into Practice: The Growth, Operations and Effectiveness of Mental Health Court" (2009) 30 *Justice System Journal* 196, 202
50. As is required in Broward County, Florida: A J Lurigio and J Snowden, "Putting Therapeutic Jurisprudence into Practice: The Growth, Operations and Effectiveness of Mental Health Court" (2009) 30 *Justice System Journal* 196, 202. See also page 20.

consequences of involvement, so that their decision is not based simply on the prospect of avoiding jail time (particularly if the court in question requires a guilty plea from a defendant in order for them to be accepted into the program);[51] and they must retain the right to withdraw and return to the ordinary criminal court without prejudice.[52]

11.39 A 2010 study of the District of Columbia's MHC found that almost 75% of participants surveyed either agreed or strongly agreed that they had voice and validation in the decision to enter MHC.[53] Similarly, an earlier study by Poythress and others concluded that Broward County MHC participants had very low levels of perceived coercion, particularly those who were made aware that they could opt out of the program at any time.[54]

Evaluating the success of mental health courts

What is "success"?

11.40 Before considering the results of empirical studies of MHCs, it is important to consider what it means for a MHC to be "effective". One commonly measured outcome is recidivism, but this is not the only measure of success for a MHC.

11.41 The US National Center for State Courts has, through a process of research and consultation, developed 14 core performance measures for MHCs, in the hope that MHCs will begin consistently to gather data for each of the measures, enabling robust conclusions to be drawn by researchers regarding the effectiveness of MHCs.[55]

11.42 The measures are as follows:

- In-program reoffending – the percentage of participants who reoffend during their enrolment
- attendance at scheduled judicial status meetings

51. AJ Lurigio and J Snowden, "Putting Therapeutic Jurisprudence into Practice: The Growth, Operations and Effectiveness of Mental Health Court" (2009) 30 *Justice System Journal* 196, 211; T Seltzer, "Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illnesses" (2005) 11 *Psychology, Public Policy and Law* 570, 574.
52. T Seltzer, "Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illnesses" (2005) 11 *Psychology, Public Policy and Law* 570, 575.
53. HW Wales, VA Hiday and B Ray, "Procedural Justice and the Mental Health Court Judge's Role in Reducing Recidivism" (2010) 33 *International Journal of Law and Psychiatry* 265, 267.
54. Participants rated their perceived coercion in the decision to enter the MHC out of 5, with lower scores reflecting a higher level of perceived autonomy. The mean rating by those who were aware that they could opt out (66% of the group) was 0.2 out of 5. For those who were unaware that they could opt out, the mean rating was 1.67 out of 5: N Poythress and others, "Perceived Coercion and Procedural Justice in the Broward Mental Health Court" (2002) 25 *International Journal of Law and Psychiatry* 517, 526.
55. National Center for State Courts *Mental Health Court Performance Measures: Implementation and User's Guide* (2007) 44.

- attendance at scheduled therapeutic sessions
- living arrangements – the percentage of participants who have secured a stable living environment by the time they exit the program
- retention – the percentage of participants who successfully complete the program, or who exit by other means
- time from arrest to referral
- time from referral to admission to the program
- total time in program
- team collaboration – the percentage of time that all relevant information is made available to the MHC team at pre-hearing case reviews
- agency collaboration – timely notification to the MHC of arrests of participants
- needs based treatment and supervision
- participant satisfaction
- participant preparation for transition – participant awareness of sources of assistance in the community, and
- post-program recidivism – the percentage of participants who reoffend within two years of exiting the MHC.

11.43 Widespread implementation of these measurements will hopefully lead to reliable, consistent and global data collection by MHCs, which in turn should enable robust conclusions to be drawn about their effectiveness.

The difficulties of evaluating success

11.44 In 2008, the research institute, RAND, conducted a "synthesis of literature on the effectiveness of community orders".[56] They considered the robustness of a number of studies in relation to a variety of community treatment interventions, including mental health treatment programs.

11.45 One of the primary factors RAND considered was whether the evaluations employed true "experimental design". Experimental studies, which use random design, are the most reliable way of establishing the effectiveness of treatment programs.[57] These studies typically use two groups – a treatment and a non-treatment group – and randomly assign participants to either one or the other. In this way, the individual characteristics of participants are spread randomly amongst both groups, hopefully resulting in comparable groups and thus enabling researchers to determine more reliably whether any positive effects observed in the course of the evaluation are the result of the treatment used, rather than the attributes of group

56. R Davis and others, *A Synthesis of Literature on the Effectiveness of Community Orders* (RAND 2008).
57. R Davis and others, *A Synthesis of Literature on the Effectiveness of Community Orders* (RAND 2008) 3.

members. A further feature of experimental design is that usually, only one variable is changed, and the effect of that variable is able to be measured on its own. However in relation to mental health courts, a number of variables often change for the offender - such as the identification of their impairment, facilitation of access to a range of services, and a sustained relationship with one judicial officer. This makes it difficult to pin-point which particular feature of a mental health court is leading to any changes in the offender, and to compare mental health courts to each other.

11.46 In relation to mental health treatment, RAND was not able to identify any systematic review of diversion program evaluations. RAND identified a small number of studies and evaluated the quality of this research, concluding that there were insufficient studies implementing randomised designs to support a conclusive view that mental health treatment programs (including MHCs) are effective in reducing recidivism. However, amongst the studies considered, there was a strong consensus that non-prison based mental health treatment programs have a positive impact on reoffending rates.[58]

11.47 Although experiments based on random assignment are often referred to as the "gold standard" of research and would assist in providing conclusive evidence of the effectiveness of MHCs, it is intrinsically difficult to utilise such methods in social research.

11.48 Any evaluation of MHCs, or other jail diversion programs, implementing this "gold standard" would present considerable ethical issues because it would require the imposition of sanctions (including the deprivation of liberty through jail time), or the provision of treatment, based solely on random assignment, rather than on established criteria. It is argued that entry to programs such as MHCs, which are thought to provide significant benefits to participants, should be assessed on a case-by-case basis. It is regarded as unfair to deny entry to an eligible defendant and impose detention instead in the interests of robust research.

11.49 As a result, studies in this area do not use experimental design.[59] Typically, evaluations:

(i) track the progress of a group of MHC participants, measuring key outcomes before, during and ideally after participation in the court, and/or

(ii) compare a group of MHC participants to a group of "treatment as usual" defendants who have been sentenced to detention and who are matched to the MHC group on a number of variables, such as age, race, gender, mental health diagnosis, arrest history and seriousness of offence.

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58. R Davis and others, *A Synthesis of Literature on the Effectiveness of Community Orders* (RAND 2008) 26.

59. With the exception of a 2005 study by Cosden and others, which, uniquely, did implement random assignment to evaluate a mental health court. However, the treatment group also received assertive community treatment and, as such, it is not possible to determine whether the positive effects identified through the research are attributable to the mental health court, or the intensive treatment. Further, the researchers identified a change in community practices in the jurisdiction they were evaluating, whereby training of those associated with the mental health court led to provision of higher levels of service to the control group. It was therefore difficult to establish the efficacy of the court: M Cosden and others, "Efficacy of a Mental Health Treatment Court with Assertive Community Treatment" (2005) 23 *Behavioural Sciences and the Law* 199.

11.50 As noted by RAND, these "quasi-experimental" or "non-experimental" designs are not ideal and do not provide categorical proof that MHCs are effective because they cannot singularly assess the impact of MHC enrolment.[60] A particular problem noted by many researchers is the sampling bias which occurs as a result of the willingness or otherwise of individuals to comply with the requirements of MHC. For example, many studies compare the results of MHC graduates with those of participants who withdrew or were terminated from the program, or with prisoners who were eligible for MHC but elected not to participate. The results, on the whole, are better for MHC graduates, but it is possible that participants who persist with the MHC program are those who are most motivated to seek treatment and it is not clear whether their success can be ascribed to the program or whether it is a result of other factors. For this reason, the most persuasive studies are those that compare the MHC group as a whole to the control group, rather than limiting the study to successful graduates.

11.51 A further limitation of the research conducted prior to the RAND evaluation was the fact that many MHCs were relatively new and were still forging inter-agency relationships and developing procedures.[61] Studies also predominantly focussed on a single court, making it difficult to assess globally the effectiveness of MHCs, since there are considerable variations among different courts.

11.52 Notwithstanding the lack of "gold standard" research, early studies identified a crucial point – that, at the very least, offenders diverted away from the criminal justice system were *no more* likely to reoffend than those who are processed through ordinary criminal courts. For example, Christy and co-authors found that the Broward County MHC accomplished its primary goals of moving people from prisons into the mental health system, without compromising public safety.[62]

11.53 This finding is significant, especially when paired with data relating to costs of diversion versus detention, because it raises the question: is it justifiable to detain people who engaged in criminal behaviour as a result of a mental illness if alternative methods for dealing with the behaviour present no increased risk to public safety, and no increase in cost?

Attempts to evaluate success

11.54 A number of studies have attempted to provide empirical support for the effectiveness of MHCs. These are discussed below.

11.55 Although many of these evaluations suffer from some of the shortcomings discussed above, it is important not to entirely disregard data from these studies, simply because they do not utilise the "gold standard" for research. Schneider warns that we must recognise the barriers to research in this area and adjust our

60. R Davis and others, *A Synthesis of Literature on the Effectiveness of Community Orders* (Rand 2008) 3.

61. VA Hiday and B Ray, "Arrests Two Years After Exiting a Well-Established Mental Health Court" (2010) 61(5) *Psychiatric Services* 463, 463.

62. A Christy and others, "Evaluating the Efficiency and Community Safety Goals of the Broward County Mental Health Court" (2005) 23 *Behavioural Sciences and the Law* 227, 241.

expectations for conclusive evidence accordingly.[63] In that light, it is useful to consider the findings of existing evaluations against the 14 measures developed by the US National Center for State Courts.

11.56 The findings summarised below often relate to a single court and may not necessarily be extrapolated to all MHCs. However, they provide useful insights into the potential benefits and problems of MHCs.

11.57 **In-program reoffending:** A number of studies evaluate reoffending rates for a period of time after enrolment in a MHC, for example 12 months. However, defendants may graduate from the court during this period and it is therefore difficult to determine how many of the arrests which occur during the follow-up period occur during participation in the MHC program.

11.58 Moore and Hiday's 2006 study, which considered the reduction in recidivism among defendants from a single MHC in the south-eastern US, did report specifically on in-program reoffending, finding that 11.5% of MHC graduates and 46.7% of defendants who entered the MHC but did not complete the program were arrested at least once during their participation in the court. The researchers considered whether the higher arrest rate for non-completers was inevitable, that is, whether it was a further arrest which resulted in termination from the program, and thus, inclusion in the "non-completers" group. For a number of reasons, the authors considered that this argument was not supported by their research.[64]

11.59 McNeil and Binder measured the number of new charges at various intervals after entry to and graduation from the San Francisco MHC. The median length of enrolment was 8.3 months, so the number of charges six months after enrolment gives a useful insight into in-program reoffending. The authors estimated that the impact of MHC six months after enrolment was a 26.6% reduction in the probability of incurring new charges, with MHC participants having a 23% chance of a new charge having been laid, versus 30% for the comparison group (individuals with a mental disorder who were sent to a county jail, rather than diverted through MHC).[65]

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63. RD Schneider, HY Bloom and M Heerema, *Mental Health Courts, Decriminalizing the Mentally Ill* (Irwin Law, 2007) 203–204.

64. This was because members from both groups were arrested at least once; because there was a significant delay between arrest and termination for non-completers, which suggests that there were intervening events leading to termination; and because each defendant whose participation was terminated had demonstrated an unwillingness to engage and comply with the program. It was this failure, as opposed to the arrest, which led to eventual termination: M Moore and V Hiday, "Mental Health Court Outcomes: A Comparison of Re-Arrest and Re-Arrest Severity Between Mental Health Court and Traditional Court Participants" (2006) 30 *Journal of Law and Human Behaviour* 659, 670.

65. DE McNiel and RL Binder, "Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence" (2007) 164(9) *The American Journal of Psychiatry* 1395, 1400. Note that the observed rate of re-arrest for the comparison group does not appear to have accounted for the reduced period for which this group was at risk of re-offending, so the disparity in the probability of re-offending between MHC participants and the comparison group may be greater than observed.

11.60 Steadman put the annualised arrest rate (which accounts for time at risk of rearrest, that is, time in the community) at 1.04 for those receiving MHC supervision, which is a reduction from the pre-enrolment figure of 2.1 arrests.[66]

11.61 **Attendance at scheduled judicial status meetings and therapeutic sessions:** Delaware's Violation of Probation MHC attempts to prevent violations of probation by offenders with an Axis-I diagnosis.[67]

11.62 Participants in the court must comply with treatment regimes and attend status hearings held bi-weekly in order to have their probation restrictions lessened. For the quarter ending 31 March 2010, the court had a compliance rate of 82.35%.[68]

11.63 Four other US MHCs are the subject of an ongoing multi-site evaluation by Allison Redlich and others. Findings reported in 2010 include an assessment of compliance with:

(i) judicial and court orders

(ii) treatment appointments, and

(iii) medicinal regimes, as rated by MHC coordinators.

Average compliance ratings ranged from 2.88 to 3.75 out of 5 across the four sites.[69]

11.64 **Living arrangements:** The link between housing arrangements and recidivism is complex[70] and the usefulness of this measure is limited because not all MHCs incorporate housing assistance into their programs.

11.65 In a study of the Bronx Mental Health Court (which incorporates service linkage, including to housing and residential treatment facilities), Broner found that 93% of all individuals sampled had moved from unstable accommodation (such as crisis accommodation, incarceration or homelessness) into a treatment or treatment-type setting or into stable housing during the first quarter of treatment.[71] The authors also concluded that homeless individuals did just as well as non-homeless individuals in

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66. H Steadman and others, "Effect of Mental Health Courts on Arrests and Jail Days: a Multisite Study" (2010) *Archives of General Psychiatry* (Published online 4 October 2010), E4.

67. CS Leon, K Daly and M Mahoney, *Delaware Mental Health Courts' Process Evaluation: Progressive Treatment and Systematic Obstacles*, Working Paper (State of Delaware Chief Justice's Task Force on Mental Health and Criminal Justice 2010) 7. See footnote 17 of Chapter 5 for an explanation of Axis I disorders. See also para 5.56.

68. CS Leon, K Daly and M Mahoney, *Delaware Mental Health Courts' Process Evaluation: Progressive Treatment and Systematic Obstacles*, Working Paper (State of Delaware Chief Justice's Task Force on Mental Health and Criminal Justice, 2010) 8.

69. Where 1 = Poor/Not so good and 5 = Excellent/Very good throughout the entire period of enrolment: A D Redlich and others, "The Use of Mental Health Court Appearances in Supervision" (2010) *International Journal of Law and Psychiatry* 272, 274.

70. N Broner, M Lang and S Behler, "The Effect of Homelessness, Housing Type, Functioning, and Community Reintegration Supports on Mental Health Court Completion and Recidivism" (2009) 5 *Journal of Dual Diagnosis* 323, 325.

71. N Broner, M Lang and S Behler, "The Effect of Homelessness, Housing Type, Functioning, and Community Reintegration Supports on Mental Health Court Completion and Recidivism" (2009) 5 *Journal of Dual Diagnosis* 323, 339.

the MHC, with no significant differences in outcomes such as rearrests, days in jail and positive drug tests.[72]

11.66 **Retention**: Compared to many of the performance measures listed here, data on the number of participants who complete MHC programs is relatively easy to obtain and thus readily available.

11.67 Studies show that retention rates vary widely across different courts, for example, the following completion rates have been documented:

Table 11.1: Completion status rates by court

Court	Completed (%)	Terminated (%)	Still enrolled (%)
Clark County, Washington[73]	19	32	21
Washoe County, Nevada[74]	31	13	Unknown
San Francisco County, California[75]	48	9	26
	31	36*	33
Clark County, Nevada[76]	33	31*	36
Santa Clara County, California[77]	39	21*	40
Hennepin County, Minnesota[78]	41	47*	12
Orange County, North Carolina[79]	25	13	54
Bronx, New York[80]	65	33*	0.6

72. N Broner, M Lang and S Behler, "The Effect of Homelessness, Housing Type, Functioning, and Community Reintegration Supports on Mental Health Court Completion and Recidivism" (2009) 5 *Journal of Dual Diagnosis* 323, 346.
73. H Herinckx and others, "Rearrest and Linkage to Mental Health Services Among Clients of the Clark County Mental Health Court Program" (2005) 56(7) *Psychiatric Services* 853, 854.
74. GB Palermo, "The Nevada Mental Health Courts" (2010) 33 *International Journal of Law and Psychiatry* 214, 217.
75. The results of two studies differed: DE McNiel and RL Binder, "Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence" (2007) 164(9) *The American Journal of Psychiatry* 1395, 1399 (first row in table); AD Redlich and others, "The Use of Mental Health Court Appearances in Supervision" (2010) *International Journal of Law and Psychiatry* 272, 273.
76. GB Palermo, "The Nevada Mental Health Courts" (2010) 33 *International Journal of Law and Psychiatry* 214, 217.
77. AD Redlich and others, "The Use of Mental Health Court Appearances in Supervision" (2010) *International Journal of Law and Psychiatry* 272, 273.
78. AD Redlich and others, "The Use of Mental Health Court Appearances in Supervision" (2010) *International Journal of Law and Psychiatry* 272, 273.
79. Figures calculated using a total of 202 participants whose cases were dealt with by the court in 2003: V Hiday and others, "North Carolina's Mental Health Court" (2005) 70 *Popular Government* 24, 29.
80. N Broner, M Lang and S Behler, "The Effect of Homelessness, Housing Type, Functioning, and Community Reintegration Supports on Mental Health Court Completion and Recidivism" (2009) 5 *Journal of Dual Diagnosis* 323, 341.

Marion County, Indiana[81]	80.8	17.2*	2

**Figure includes individuals who voluntarily opted out of the program.*

11.68 What is not necessarily apparent from the research conducted to date is why retention rates vary so much from court to court, and what client characteristics are associated with successful completion of MHC. This information is important as it enables law and policy makers to incorporate the court components that are linked with successful completion into new programs. Further, those programs can be appropriately targeted towards individuals who are likely to succeed.

11.69 Although further research is required, there have been rudimentary attempts to identify predictors of successful completion.

11.70 Redlich and co-authors analysed person-specific characteristics in conjunction with compliance and completion rates. They found that most characteristics, including gender, age, education and diagnosis were not related to completion. Race and seriousness of offence were predictors of compliance, with those committing more serious offences being rated as more compliant.[82]

11.71 **Time from arrest to referral and admission**: Limited data on these outcomes were found. Various studies identify Orange County, North Carolina as successfully undertaking screening and referral very soon after arrest, within 24 hours. However, that court has a relatively small list, with only 25 ongoing and 5 new cases per month in each of two locations.[83]

11.72 **Total time in program**: As noted above,[84] MHCs may have a minimum "dosage" or duration of enrolment before a participant is eligible for graduation, but it is important to measure how long people *actually* spend in the program before their situation has become stable enough for the court to be satisfied that they no longer require supervision.

11.73 Obviously, people who withdraw, or are terminated from the program are likely to spend less time in the court than those who graduate. Various studies put the average length of enrolment for terminated clients at between 5.3 and 9.8 months.[85]

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81. AD Redlich and others, "The Use of Mental Health Court Appearances in Supervision" (2010) *International Journal of Law and Psychiatry* 272, 273.
82. AD Redlich and others, "The Use of Mental Health Court Appearances in Supervision" (2010) *International Journal of Law and Psychiatry* 272, 276.
83. M Moore and V Hiday, "Mental Health Court Outcomes: A Comparison of Re-Arrest and Re-Arrest Severity Between Mental Health Court and Traditional Court Participants" (2006) 30 *Journal of Law and Human Behaviour*, 659; VA Hiday and B Ray, "Arrests Two Years After Exiting a Well-Established Mental Health Court" (2010) 61(5) *Psychiatric Services* 463.
84. Para 11.27.
85. H Herinckx and others, "Rearrest and Linkage to Mental Health Services Among Clients of the Clark County Mental Health Court Program" (2005) 56(7) *Psychiatric Services* 853, 855; V Hiday, and others, "North Carolina's Mental Health Court" (2005) 70 *Popular Government* 24, 29; VA Hiday and B Ray, "Arrests Two Years After Exiting a Well-Established Mental Health Court" (2010) 61(5) *Psychiatric Services* 463, 465; AD Redlich and others, "The Use of Mental Health Court Appearances in Supervision" (2010) *International Journal of Law and Psychiatry* 272, 274.

11.74 On average, those who complete the MHC generally take around a year, or slightly longer, to do so.[86]

11.75 Several studies have also identified a cohort of participants who spend a longer period in the MHC but still do not graduate by the time follow-up research is conducted. For example, 77 of the 368 individuals studied by Herinckx and co-authors had not graduated by the time the researchers measured recidivism, despite having been enrolled for almost 13.5 months.[87] Similarly, 101 individuals had not yet graduated after an average of 21.6 months in the MHCs studied by Redlich and co-authors.[88]

11.76 **Team and agency collaboration**: We have not been able to identify a comprehensive evaluation of these outcomes. The National Center for State Courts developed these outcomes, and instructions on how to measure them, so that MHCs would have a means of gauging how effectively information was shared within the MHC team and between agencies. The outcomes measure:

(i) the percentage of the time that the MHC team has all relevant information before it at pre-hearing reviews; and

(ii) the percentage of the time that police notify the MHC team within 24–48 hours of the arrest of a participant.[89]

Early reports from an Australian MHC, Tasmania's Mental Health Diversion List, indicate high levels of satisfaction with collaboration and communication amongst participants.[90]

11.77 **Need based treatment and supervision**: In 2003, Boothroyd and co-authors conducted a study on the utilisation of treatment services by individuals in Broward County MHC.[91] They found that the use of behavioural health services increased significantly for MHC participants, but stayed virtually the same for traditional criminal court defendants who were matched to the MHC group on demographic variables. Even where members of the control group did make use of services, the volume of services they received was far less than for the MHC group.[92]

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86. VA Hiday and B Ray, "Arrests Two Years After Exiting a Well-Established Mental Health Court" (2010) 61(5) *Psychiatric Services* 463, 465; AD Redlich and others, "The Use of Mental Health Court Appearances in Supervision" (2010) *International Journal of Law and Psychiatry* 272, 274.
87. H Herinckx and others, "Rearrest and Linkage to Mental Health Services Among Clients of the Clark County Mental Health Court Program" (2005) 56(7) *Psychiatric Services* 853, 855.
88. AD Redlich and others, "The Use of Mental Health Court Appearances in Supervision" (2010) *International Journal of Law and Psychiatry* 272, 274.
89. National Center for State Courts, *Mental Health Court Performance Measures: Implementation and User's Guide* (2007) 5.
90. H Graham, *A Foot in the (Revolving) Door? A Preliminary Evaluation of Tasmania's Mental Health Diversion List* (University of Tasmania, 2007) 57–59.
91. R Boothroyd and others, "The Broward Mental Health Court: Process, Outcomes, and Service Utilization" (2003) 26 *International Journal of Law and Psychiatry* 55.
92. The MHC group received almost twice as many units of service: R Boothroyd and others, "The Broward Mental Health Court: process, outcomes, and service utilization" (2003) 26 *International Journal of Law and Psychiatry* 55, 65.

11.78 Two years later, Henrickx and co-authors examined the success of the Clark County MHC in linking clients to treatment services. They found that most clients were linked to treatment services within 10 days of enrolment in the court. Participants also received significantly more hours of case management, medication management and outpatient services; and significantly fewer hours of crisis services and inpatient treatment.[93]

11.79 Broner and co-authors observed the types of services received by homeless and non-homeless MHC participants. They found that homeless individuals were significantly less likely to receive outpatient treatment. They spent a higher proportion of time in treatment or treatment-type settings (such as halfway houses or residential treatment facilities), which was viewed as a positive transition in terms of their housing status.[94]

11.80 **Participant satisfaction**: Wales, Hiday and Ray conducted interviews of MHC participants in order to obtain their perception of procedural justice in the court.[95] Almost 75% of participants either agreed or strongly agreed that they had both voice and validation in the decision to enter MHC.[96] More than 80% of participants had a strong sense of procedural justice in the court proceedings, answering that the judge definitely seemed interested in them as a person; and treated them respectfully and fairly.[97]

11.81 When given an opportunity to express what parts of the MHC they did not like, 50% of the respondents stated that they would change nothing, or that they liked the court as it was. Almost half of the study group named an aspect of the court they would change, although some of these also expressed general satisfaction.[98]

11.82 **Participant preparation for transition**: This outcome is intended to measure the ability of participants to identify sources of assistance to be used after exiting the program.[99]

11.83 Boothroyd and co-authors reviewed transcripts of proceedings in 121 MHC cases. They identified the number of defendants who were linked with mental health services, either through specific referrals or through the provision of information. There were references to linkage methods in over 81% of cases. Although there was no record of service linkage in the remaining transcripts, the authors noted that

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93. H Herinckx and others, "Rearrest and Linkage to Mental Health Services Among Clients of the Clark County Mental Health Court Program" (2005) 56(7) *Psychiatric Services* 853, 855–856.
94. N Broner, M Lang and S Behler, "The Effect of Homelessness, Housing Type, Functioning, and Community Reintegration Supports on Mental Health Court Completion and Recidivism" (2009) 5 *Journal of Dual Diagnosis* 323, 339.
95. HW Wales, VA Hiday and B Ray, "Procedural Justice and the Mental Health Court Judge's Role in Reducing Recidivism" (2010) 33 *International Journal of Law and Psychiatry* 265.
96. HW Wales, VA Hiday and B Ray, "Procedural Justice and the Mental Health Court Judge's Role in Reducing Recidivism" (2010) 33 *International Journal of Law and Psychiatry* 265, 267.
97. HW Wales, VA Hiday and B Ray, "Procedural Justice and the Mental Health Court Judge's Role in Reducing Recidivism" (2010) 33 *International Journal of Law and Psychiatry* 265, 268.
98. HW Wales, VA Hiday and B Ray, "Procedural Justice and the Mental Health Court Judge's Role in Reducing Recidivism" (2010) 33 *International Journal of Law and Psychiatry* 265, 269.
99. National Center for State Courts, *Mental Health Court Performance Measures: Implementation and User's Guide* (2007) [13].

extensive conversations in the court occurred off-the-record and linkage strategies may well have been discussed but not transcribed.[100]

11.84 **Post-program recidivism**: By far the most studied performance measure of MHCs is the impact that MHCs have on the rates of reoffending by participants.

11.85 Given that practices and procedures vary widely across MHCs, it is not unexpected that the outcomes achieved also fluctuate significantly. What is required is further research into why some courts achieve higher reductions in recidivism than others.

11.86 Studies typically use one or more of the measures outlined below, with researchers collecting data at some point/s after a participant's date of entry to or exit from the court. There is empirical data which suggests that:

- MHC participants take longer to reoffend than those who are processed through traditional criminal courts
- the number of MHC participants who reoffend at all is much lower than for comparable offenders processed through traditional criminal courts
- those MHC participants who do reoffend do so less than their counterparts in traditional criminal courts, with fewer arrests per person and
- the severity of the offences committed by MHC participants is much less than the offences committed by comparable defendants in traditional criminal courts.

11.87 **Time to rearrest:** A number of long-term studies show that the initial reduction in arrests, which occurs during enrolment in MHC, subsists for some time after court supervision has ended. Two studies followed participants for two years after their supervision had ended and concurred that completion of MHC had a positive impact on the length of time for which offenders remained non-recidivists.[101]

11.88 Broner and co-authors also found that those who did not succeed in completing MHC (for example, because their participation was terminated) were arrested much sooner than those who graduated, with the median for their first re-arrest falling at 17 months, versus 53 months (over four years) for graduates.

11.89 **Percentage of participants who are rearrested:** Some courts had very low levels of reported short-term reoffending, for example, in New Castle County in Delaware, 85% of participants had no conviction six months after exiting the court.[102]

11.90 As more time passes, rates of recidivism grow, for example, by 12 months after enrolment, Herinckx puts the percentage of MHC offenders who have reoffended at 46%.[103] Hiday and Ray found the figure was 48% two years after exit.[104]

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100. R Boothroyd and others, "The Broward Mental Health Court: Process, Outcomes, and Service Utilization" (2003) 26 *International Journal of Law and Psychiatry* 55, 60.

101. DE McNiel and RL Binder, "Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence" (2007) 164(9) *The American Journal of Psychiatry* 1395, 1401; VA Hiday and B Ray, "Arrests Two Years After Exiting a Well-Established Mental Health Court" (2010) 61(5) *Psychiatric Services* 463, 467.

102. CS Leon, K Daly and M Mahoney, University of Delaware, *Delaware Mental Health Courts* Process Evaluation: Progressive Treatment and Systematic Obstacles Working Paper (State of Delaware Chief Justice's Task Force on Mental Health and Criminal Justice 2010) 7.

11.91 Although the percentage of participants who reoffend grows over time, it does so to a lesser extent than for other groups. Further, the disparity between arrest rates for MHC participants and those who proceed through a traditional criminal court becomes clearer as time goes on. McNiel and Binder studied arrest rates for MHC participants and a control group who progressed through traditional criminal court. They estimated that six months after entering the court, participants had a 23% chance of a new charge versus 30% for the control group. By two years after entry, the figures were 46% and 63%, respectively.[105]

11.92 Steadman's multi-site analysis found that 49% of MHC participants were arrested within 18 months after enrolment, which was significantly less than the percentage of defendants from the control group arrested within the same period (58%), even without adjusting for the reduced time for which the control group was at risk of reoffending.[106]

11.93 Comparisons between MHC graduates and the control group can assist in determining the maximum effect of MHC, because they show what impact a full "dose" of MHC can have on reoffending.[107]

11.94 McNeil and Binder found that 6 months after exiting the court, MHC graduates had a 20% reduced chance of incurring new charges, compared to the control group. By 12 months after exit, graduates had a 34% reduction in the probability of a new charge. At 18 months the reduction was 39% and by 24 months, the figure had grown to 41%.[108]

11.95 Hiday and Ray found that in the two years prior to the arrest that led them to MHC, 97% of participants had also had at least one other arrest (with 59% arrested more than three times). Two years after the program, the percentage of participants re-arrested had fallen to 48%. Only 28% of those who graduated from the program went on to reoffend within two years.[109]

11.96 **Number of re-arrests:** The average number of rearrests for Clark County MHC participants in the year following enrolment in the court was 0.48, down from an

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103. H Herinckx and others, "Rearrest and Linkage to Mental Health Services Among Clients of the Clark County Mental Health Court Program" (2005) 56(7) *Psychiatric Services* 853, 855.
104. VA Hiday and B Ray, "Arrests Two Years After Exiting a Well-Established Mental Health Court" (2010) 61(5) *Psychiatric Services* 463, 465.
105. DE McNiel and RL Binder, "Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence" (2007) 164(9) *The American Journal of Psychiatry* 1395, 1400.
106. H Steadman and others, "Effect of Mental Health Courts on Arrests and Jail Days: A Multisite Study" (2010) *Archives of General Psychiatry* (Published online 4 October 2010) E4 <www.archgenpsychiatry.com>.
107. Such measures should not be used in isolation, because they cannot account for selection bias.
108. DE McNiel and RL Binder, "Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence" (2007) 164(9) *The American Journal of Psychiatry* 1395, 1400.
109. VA Hiday and B Ray, "Arrests Two Years After Exiting a Well-Established Mental Health Court" (2010) 61(5) *Psychiatric Services* 463, 465.

average of 1.99 arrests in the year prior to enrolment.[110] The number of frequent offenders in the group dropped from 26% to 2.8%.[111]

11.97 In Orange County, North Carolina, MHC participants had an average of 1.10 arrests 12 months after entry, versus 2.36 arrests for traditional criminal court participants.[112]

11.98 Steadman identified positive trends in re-arrest rates across all four MHCs included in his multi-site study. Annualised re-arrest rates 18 months after entry were lower for participants than for comparable defendants in traditional criminal courts (TCC), with average rates (TCC v MHC) of: 2.5 v 1.9 in San Francisco County; 2.9 v 2.0 in Santa Clara County; 1.5 v 0.6 in Hennepin County; and 1.5 v 0.6 in Marion County. Arrest rates were also reduced *within* the MHC group, with a drop in the average number of arrests of between 0.5 and 1.2, depending on the court.[113]

11.99 **Jail days**: Data on the number of days spent in detention following participation in MHC is mixed. Cosden and co-authors found a small reduction, but considered the difference between the MHC group and the control group was not significant.[114] Figures from Washoe County MHC show a 95% reduction in the number of jail days for MHC participants in the year following completion of MHC.[115] Steadman's multi-site study showed increases in jail days for both the MHC group and the control group in three of the four courts studied, however, the MHC group had a much smaller increase and thus MHC still had a positive impact on the number of subsequent jail days.[116]

11.100 **Seriousness of subsequent offences:** Moore and Hiday studied the seriousness of crimes committed by MHC participants and a matched control group. They found that the control group was significantly more likely to be re-arrested and to be re-arrested for more serious crimes. Using a 14–level rating system, where 1 is a traffic citation and 14 is the most serious felony, they found that the severity of new

110. This does not include the "index" offence, that is, the offence that resulted in admission to the MHC: H Herinckx and others, "Rearrest and Linkage to Mental Health Services Among Clients of the Clark County Mental Health Court Program" (2005) 56(7) *Psychiatric Services* 853, 855.

111. H Herinckx and others, "Rearrest and Linkage to Mental Health Services Among Clients of the Clark County Mental Health Court Program" (2005) 56(7) *Psychiatric Services* 853, 855.

112. M Moore and V Hiday, "Mental Health Court Outcomes: A Comparison of Re-Arrest and Re-Arrest Severity Between Mental Health Court and Traditional Court Participants" (2006) 30 *Journal of Law and Human Behaviour* 659, 666.

113. H Steadman and others, "Effect of Mental Health Courts on Arrests and Jail Days: A Multisite Study" (2010) *Archives of General Psychiatry* (Published online 4 October 2010) <www.archgenpsychiatry.com> E1, E4.

114. M Cosden and others, "Efficacy of a Mental Health Treatment Court with Assertive Community Treatment" (2005) 23 *Behavioural Sciences and the Law* 199, 205.

115. G Palermo, "The Nevada Mental Health Courts" (2010) 33 *International Journal of Law and Psychiatry* 214, 217.

116. H Steadman and others, "Effect of Mental Health Courts on Arrests and Jail Days: A Multisite Study" (2010) *Archives of General Psychiatry* (Published online 4 October 2010) <www.archgenpsychiatry.com> E1, E5.

arrests was 9.46 for those processed through the ordinary courts, versus 3.9 for MHC participants. Severity of new crimes for MHC graduates was 2.06.[117]

11.101 McNiel and Binder also identified a reduction in violent charges laid against MHC participants, with a 59% reduced chance of incurring a violent charge 24 months after entering the court.[118]

11.102 The studies referred to above provide some support for the following propositions:

- MHC participants have reduced re-arrest rates during the period of participation in the court
- MHCs connect people with the mental health and community services they need and reduce reliance on crisis services
- MHC participants have a strong sense of procedural justice
- MHC participants take longer to reoffend than those who are processed through traditional criminal courts
- the number of MHC participants who reoffend at all is much lower than for comparable offenders processed through traditional criminal courts
- those MHC participants who do reoffend do so less than their counterparts in traditional criminal courts, with fewer arrests per person, and
- the severity of the offences committed by MHC participants is much less than the offences committed by comparable defendants in traditional criminal courts.

Criticisms of mental health courts

11.103 While much of the commentary in relation to MHCs focuses on their therapeutic approach and positive outcomes, the courts are not without their critics. Some of the criticisms levelled at MHCs are discussed below.

A distraction from the problem of inadequate community services

11.104 Tammy Seltzer argues that MHCs are an example of communities addressing the symptoms of a problem, rather than the cause. She argues that the criminal justice system has become the "front door" to access mental health services and that, without simultaneous investment in the public health system, those who do not become involved with the criminal justice system are left without access to the services they need.[119]

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117. M Moore and V Hiday, "Mental Health Court Outcomes: A Comparison of Re-Arrest and Re-Arrest Severity Between Mental Health Court and Traditional Court Participants" (2006) 30 *Journal of Law and Human Behaviour*, 659, 666.
118. DE McNiel and RL Binder, "Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence" (2007) 164(9) *The American Journal of Psychiatry* 1395, 1400.
119. T Seltzer, "Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illnesses" (2005) 11 *Psychology, Public Policy and Law* 570, 578, 583.

11.105 Bernstein and Seltzer noted that few of the MHCs existing at that time were part of a larger plan to address systemic causes of overrepresentation of people with mental health impairments in the criminal justice system.[120]

11.106 Schneider considers this criticism to be misguided, stating that it identifies a problem with state funding of essential services, as opposed to a problem with therapeutic jurisprudence.[121]

11.107 The issue of availability of community services is a significant theme that runs throughout this report and is considered in particular in Chapters 2, 7 and Chapter 14.

Coercion

11.108 Coercion has been identified as a major shortcoming of MHCs.[122] The criticism is based on the principle that people should have the right to decline treatment unless they meet the requirements for involuntary treatment under mental health legislation.[123]

11.109 As indicated above[124] one essential element of a MHC is voluntary participation, however, critics argue that participation cannot be truly voluntary when it is agreed to in circumstances where the threatened alternative is criminal prosecution.[125] A further feature of MHCs is mandated community treatment, with the potential for sanctions or termination from the program if a defendant fails to comply with their treatment plan. Consequently, people may be compelled to undergo treatment in circumstances where the requirements under the civil system for involuntary treatment have not been met, and where the "voluntariness" of participation is doubtful.

11.110 As indicated above, however, perceived levels of coercion by MHC participants are low.[126]

11.111 Schneider and his colleagues, while acknowledging the merit in the criticism, also note that it is "absurd" in the absence of any non-coercive alternatives.[127]

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120. R Bernstein and T Seltzer, "Criminalization of People with Mental Illnesses: The Role of Mental Health Courts in System Reform" (2003) 7 *The University of the District of Columbia Law Review* 143, 147.
121. R Schneider, H Bloom and M Heerema, *Mental Health Courts, Decriminalizing the Mentally Ill* (Irwin Law, 2007) 64.
122. For a detailed discussion about coercion in problem-solving courts, see B Winick, "Therapeutic Jurisprudence and Problem Solving Courts" (2002) 30 *Fordham Urban Law Journal* 1055, 1071–1078.
123. S Haimowitz, "Can Mental Health Courts End the Criminalization of Persons With Mental Illness" (2002) 53(10) *Psychiatric Services* 1226, 1227.
124. Para 11.37- 11.39.
125. Mental Health America, *Position Statement 53: Mental Health Courts* (2009).
126. Para 11.39.
127. R Schneider, H Bloom and M Heerema, *Mental Health Courts, Decriminalizing the Mentally Ill* (Irwin Law, 2007) 65.

11.112 Mental Health America, the leading mental health advocacy organisation in the US, recognises that "even coerced treatment in the community is almost always better than the manner in which persons with mental illnesses are treated in prisons and jails", but advocates for MHCs which use the least coercive models possible. In particular, it considers that MHCs should:

- not require a guilty plea
- provide and explain the terms of a proposed treatment plan to a defendant before requiring the defendant to decide whether to participate
- protect the qualified right of a defendant to refuse a particular treatment, and incorporate a process to review refusal decisions so that only unreasonable refusals result in the reinstatement of charges
- provide advocacy and counselling to enable defendants to make an informed decision about participation, and
- allow participants to opt out and return to the general criminal list, and ensure that all participants are aware of this option.[128]

11.113 Seltzer adds that the right to opt out should be available at any stage of proceedings; and that time served in the MHC program should be credited towards any sentence imposed by a criminal court.[129]

Net-widening

11.114 Some argue that MHCs can have the unintended consequence of bringing people within the criminal justice system, rather than diverting them away from it. MHCs provide an opportunity to connect an individual with treatment and services, where otherwise this may be difficult. For example, police seeking to have someone admitted to hospital may face significant waiting room delays, or may have to invest substantial time in finding a facility that has the resources to deal with the individual.[130] Police may use mercy-arrests in order to get vulnerable people off the streets and into treatment.[131] This approach can result in the criminalisation of people with mental health impairments, because they are arrested in circumstances in which other offenders may be dealt with more leniently.

11.115 Minor "lifestyle offences" are also commonly responsible for bringing people with mental health impairments to the attention of police, but both critics and many

128. Mental Health America, *Position Statement 53: Mental Health Courts* (2009).

129. T Seltzer, "Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illnesses" (2005) 11 *Psychology, Public Policy and Law* 570, 573.

130. These were some of the concerns raised by Victorian Police in a recent survey: J Godfredson and others "Policing People Experiencing Mental Illness: The State of Victoria, Australia" (2011) 44(2) *Australian and New Zealand Journal of Criminology* 180.

131. T Seltzer, "Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illnesses" (2005) 11 *Psychology, Public Policy and Law* 570, 573.

supporters argue that these offences should never end up in court and should be diverted at a much earlier stage.[132]

11.116 For example, the Law Reform Commission of Western Australia refers to a participant in the Tasmanian Mental Health Diversion List who offended by repeatedly making nuisance calls to emergency services.[133] To many, this represents the type of offence that is better dealt with by a police diversion program, in conjunction with an increase in readily accessible mental health services.[134]

11.117 It is difficult to know whether this sort of net-widening effect can be attributed to mental health courts, or it is a result of the criminal justice system being used as a route to accessing services that would be found in the absence of mental health courts.

11.118 Those who consider that MHCs are responsible for net-widening argue that these courts should only be open to serious offences, that is, that they should deal only with indictable offences and summary offences likely to result in a jail sentence.[135] As indicated at paragraph 11.8, US MHCs are increasingly accepting felony cases, with some refusing to deal with low level misdemeanours.

Entrenchment

11.119 There is an argument that some MHCs, rather than achieving their goal of "decriminalising" those with mental health impairments, contribute to the criminalisation of these defendants. A major factor contributing to this phenomenon is net-widening, discussed above.

11.120 A further criticism relates to the requirement of many MHCs that a defendant must enter a guilty plea in order to be eligible for participation. Instability in housing and employment has been identified as a factor contributing to the criminalisation of people,[136] but critics argue that a requirement to plead guilty directly contributes to

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132. Mental Health America, *Position Statement 53: Mental Health Courts* (2009); T Seltzer, "Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illnesses" (2005) 11 *Psychology, Public Policy and Law* 570, 574; S Haimowitz, "Can Mental Health Courts End the Criminalization of Persons With Mental Illness" (2002) 53(10) *Psychiatric Services* 1226, 1226. See also the comments of S Kennedy, Director of Research, Analysis and Development at DC Pretrial Services Agency in R Wolf, "A New Way of Doing Business: A conversation about the Statewide Coordination of Problem-Solving Courts" (2009) 2(1) *Journal of Court Innovation* 191, 194.

133. Law Reform Commission of Western Australia, *Court Intervention* Programs, Final Report, Project No 96 (2009) 75.

134. R Bernstein and T Seltzer, "Criminalization of People with Mental Illnesses: The Role of Mental Health Courts in System Reform" (2003) 7 *The University of the District of Columbia Law Review* 143, 155.

135. T Seltzer, "Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illnesses" (2005) 11 *Psychology, Public Policy and Law* 570, 574.

136. See eg, S Forrell, E McCarron and L Schetzer (2005) *No Home, no Justice? The Legal Needs of Homeless People in NSW* (Law Foundation 2006) Ch 4; E Baldry, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012) <www.app.unsw.edu.au/sites/app.unsw.edu.au/files/mhdcdbackgroundoutlaws_conf1.pdf> 9; D Weatherburn, *What causes crime?*, Crime and Justice Bulletin No 54 (NSW Bureau of Crime Statistics and Research, 2001) 1, 5.

the exacerbation of these social problems, because of the long-term consequences of a criminal record.

11.121 By requiring a defendant to plead guilty at an early stage in proceedings, it is said that MHCs encourage vulnerable participants wanting to avoid prison to plead guilty without fully contemplating the consequences of that decision.[137]

11.122 This is particularly problematic in situations where charges would likely be dismissed if the defendant did not have a mental health impairment and the case was processed in the general criminal court list.[138] In effect, it is argued that MHCs requiring a guilty plea are more punitive, because they impose a "cost" – a criminal record – on obtaining treatment.[139] A suggestion for overcoming this problem is holding charges in abeyance while the defendant participates in treatment, and dismissing them completely upon successful completion.[140]

Diversion of resources

11.123 Whilst in favour of specialised courts, Justice Phylis Skloot Bamberger of the New York Supreme Court notes that courts of general criminal jurisdiction still have the ability to divert offenders from prison and that these courts service large numbers of people who, for one reason or another, are not dealt with by any specialised court. She argues that specialised courts should not be funded to the detriment of general criminal courts, otherwise those defendants who cannot be dealt with by specialised courts may lose the opportunity to access diversionary programs.[141]

Length of supervision

11.124 Some commentators contend that the length of supervised treatment through a MHC should not exceed the maximum length of the sentence the defendant would have received if they had been dealt with through the ordinary criminal courts.[142]

11.125 A counter-argument to this may be that MHCs aim to reduce recidivism and thus increase public safety. It would be futile to allow defendants to "graduate" from the program before their position was sufficiently stable to allow them to carry on without court supervision. An essential element of MHCs is their individualised treatment of defendants and this would be compromised if the "dose" of treatment was based on arbitrary factors such as potential prison sentences.

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137. P Skloot Bamberger, "Specialized Courts: Not a Cure-All" (2003) 30 *Fordham Urban Law Journal* 1091, 1095.
138. T Seltzer, "Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illnesses" (2005) 11 *Psychology, Public Policy and Law* 570, 574.
139. Mental Health America, *Position Statement 53: Mental Health Courts* (2009).
140. Mental Health America, *Position Statement 53: Mental Health Courts* (2009).
141. P Skloot Bamberger, "Specialized Courts: Not a Cure-All" (2003) 30 *Fordham Urban Law Journal* 1091, 1092.
142. For example, see T Seltzer, "Mental Health Courts: A Misguided Attempt to Address the Criminal Justice System's Unfair Treatment of People with Mental Illnesses" (2005) 11 *Psychology, Public Policy and Law* 570, 575.

11.126 When consulting mental health professionals in relation to the establishment of Brooklyn's Mental Health Court, Carol Fisler noted:

> Without exception, the mental health professionals consulted … advised the planning team that there are no quick fixes in the treatment of mental illness and that short treatment mandates were almost certainly not going to yield positive outcomes.[143]

11.127 As with net-widening, this criticism may support the proposition that MHCs should be reserved for more serious offenders, because a lengthy treatment "dose" is likely to be disproportionate to the typical sentence for a minor summary offence.[144]

Victims' rights and the trumping of "justice" by "therapy"

11.128 The criticism that problem-solving courts undermine traditional ideals of the criminal justice system - to deter and punish offenders and protect society - is based on the premise that therapeutic jurisprudence sees therapy as the ultimate goal, to the exclusion of other values.[145] However, proponents of therapeutic jurisprudence do not see the law as serving only therapeutic purposes, and nor do MHCs exist purely to provide therapeutic benefits to offenders. They aim to reduce reoffending and thus increase public safety.[146]

11.129 The view of the community and victims, however, may be that the devotion of resources towards defendants, together with practices such as celebrating positive milestones, places the interests of the offender above those of the victim and the community. The US Council of State Governments Justice Centre stresses the importance of MHC policies that elevate the needs of victims, and of community education about the purpose and goals of the court, in particular the value MHCs place on community and victim safety.[147]

What "problem" should the "problem-solving court" be solving?

11.130 Michael King and his co-authors note that there can be more than one factor underlying criminal activity and that court programs should not presuppose that there is a single "problem" to be solved.[148]

11.131 Some courts have developed "primary diagnosis" criteria, whereby defendants with multiple impairments will be directed towards the most appropriate program based on their primary diagnosis.[149] Others attempt to meet the complex needs of

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143. C Fisler, "Building Trust and Managing Risk: A Look at a Felony Mental Health Court" (2005) 11 *Psychology, Public Policy and Law* 587, 590.
144. C Fisler, "Building Trust and Managing Risk: A Look at a Felony Mental Health Court" (2005) 11 *Psychology, Public Policy and Law* 587, 591–592.
145. R Schneider, H Bloom and M Heerema, *Mental Health Courts, Decriminalizing the Mentally Ill* (Irwin Law, 2007) 65.
146. VA Hiday and B Ray, "Arrests Two Years After Exiting a Well-Established Mental Health Court" (2010) 61(5) *Psychiatric Services* 463, 463.
147. H Glassberg and E Dodd, *A Guide to the Role of Crime Victims in Mental Health Courts* (Council of State Governments Justice Center 2008) 3.
148. M King and others, *Non-Adversarial Justice* (The Federation Press, 2009), 164.
149. See, eg, South Australia's Treatment Intervention Program, para 11.148-11.149.

defendants by incorporating a wide variety of support services into their programs, for example, the Washoe County MHC integrates drug treatment and housing support.[150]

Mental health courts in Australia

11.132 Whilst far more prevalent in the US, the concept of the "problem solving" court has spread around the world, including within Australia. The problem solving court approach has been used in a number of contexts. For example, in NSW it is used in the Drug Court and Youth Drug and Alcohol Court. Other Australian States have implemented MHC models which accord with the US model to varying degrees.

Queensland

11.133 The MHC in Queensland is different to most other mental health court models. The focus of the Court is primarily on issues of criminal responsibility and fitness, rather than rehabilitation, therapeutic jurisprudence or diversion. The court is constituted by a single judge assisted by two psychiatrists.[151] It hears appeals from the Mental Health Review Tribunal and also makes determinations about :

- whether the accused was of unsound mind at the time of the offence
- whether the accused is unfit for trial and, if so, whether the unfitness is permanent, and
- if the offence charged is murder and the court decides the accused was not of unsound mind, whether the accused was suffering from diminished responsibility at the time of the offence.[152]

11.134 Brisbane Magistrates Court also operates the Special Circumstances Court Diversion Program, which is a specialised list open to those with "impaired decision making capacity", including people with a disability attributable to a psychiatric impairment. The purpose of the Special Circumstances Court is to direct participants "to available treatment, rehabilitation and support services with the focus on reduction of their criminal offending behaviour".[153]

11.135 The program is available for defendants charged with offences capable of being tried summarily, except if the charges relate to personal violence, sexual offences or serious offences. Once a defendant is identified as a potential participant, their matter is stood down or adjourned in the ordinary list until an assessment of their eligibility and suitability for the program can be undertaken. If the defendant is eligible, the Magistrate may grant bail and adjourn the matter to the Special

150. HW Wales, V Hiday, B Ray, "Procedural Justice and the Mental Health Court Judge's Role in Reducing Recidivism" (2010) 33 *International Journal of Law and Psychiatry* 265, 268.

151. *Mental Health Act 2000 (*Qld) s 382.

152. Office of the Director of Public Prosecutions (Qld), *The Mental Health Court*, Fact Sheet No C09 (2009) 1.

153. Magistrates Courts (Qld), *Practice Direction No 25 of 2010: Special Circumstances Diversion Court Program* (2010).

Circumstances Court. The program uses conditional bail and sentencing to compel compliance with treatment programs.[154]

11.136 Participation in the program is voluntary, but the defendant must either plead guilty or indicate an intention to plead guilty in order to be accepted. A plea must be entered in order for the defendant to complete the program and the defendant is still sentenced upon successful completion.[155]

11.137 The Special Circumstances Court was originally called the Homeless Persons Court Diversion Program, and was reviewed after it had been in operation for 17 months.[156] The review included no quantitative data on outcomes but, based on interviews with stakeholders and case studies, it concluded that a number of people who had appeared in the court:

- Had been referred to service providers;
- Had complied with referrals;
- Were making some progress with their referral and addressing the causes of their offending behavior;
- Had reduced their re-offending or stopped reoffending.[157]

11.138 A further study of the court was conducted by Walsh,[158] who used court observation over a six-month period to collect data on 185 defendants. Mental illness or intellectual disability was mentioned in court in relation to 53 people in her sample[159] and intellectual impairment in relation to 16.[160] Walsh interviewed 20 defendants, and 12 "professional people" who work at the court.[161] On the basis of this limited data, Walsh concluded that the strengths of the court were:[162]

- The "capacity of the court to contextualise defendants' offending behaviour".
- The "ability of court staff to build supportive relationships with defendants".
- The "court's role in service delivery, including services delivered by the court liaison officers and probation officers, as well as those delivered by external service providers that attend and support the court".

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154. Magistrates Courts (Qld), *Practice Direction No 25 of 2010: Special Circumstances Diversion Court Program* (2010).
155. Magistrates Courts (Qld), *Practice Direction No 25 of 2010: Special Circumstances Diversion Court Program* (2010).
156. Creative Sparks Pty Ltd, *Homeless Persons Court Diversion Program Pilot Evaluation* (2007) 44.
157. Creative Sparks Pty Ltd, *Homeless Persons Court Diversion Program Pilot Evaluation* (2007) 49.
158. T Walsh, *A Special Court for Special Cases* (Australasian Institute of Judicial Administration and TC Beirne School of Law, University of Queensland 2011).
159. T Walsh, *A Special Court for Special Cases* (Australasian Institute of Judicial Administration and TC Beirne School of Law, University of Queensland 2011) 16.
160. T Walsh, *A Special Court for Special Cases* (Australasian Institute of Judicial Administration and TC Beirne School of Law, University of Queensland 2011) 17.
161. T Walsh, *A Special Court for Special Cases* (Australasian Institute of Judicial Administration and TC Beirne School of Law, University of Queensland 2011) 22, 42.
162. T Walsh, *A Special Court for Special Cases* (Australasian Institute of Judicial Administration and TC Beirne School of Law, University of Queensland 2011) 43.

- The "court's capacity to use its authority to encourage and bring about change in defendants' lives".

11.139 She also reported the following issues arising:[163]

- concerns in relation to privacy and confidentiality
- a "lack of resources, both for the community service providers that provide services to the court and defendants, but also within the sector as a whole", and
- the "inadequacy or inappropriateness of existing sentencing alternatives to support the goals of the court".

11.140 From these findings, it appears that the Court's goal of directing defendants to appropriate services is being achieved. However, whether this is resulting in a reduction of offending behaviour is not clear. Although Walsh found that that some defendants reported that the court "had the potential to reduce their chances of reoffending",[164] her study does not attempt to measure recidivism. She notes that longitudinal studies are needed to determine whether the court has an impact on offending behaviour.[165]

South Australia

11.141 The Magistrates' Court Diversion Program (MCDP) has been in operation since 1999 and was Australia's first specialised court for people with mental impairments.[166] The program was established following a review of amendments to the state's mental health legislation, which had resulted in growing numbers of people relying on the costly and resource intensive defence of mental illness for minor charges.[167] The review recommended that a diversion program be created within the Magistrates' Court to provide an alternative avenue for those charged with minor offences.[168]

11.142 The program, which usually runs for six months,[169] is open to people with a mental illness, an intellectual disability, a brain injury, dementia or a personality disorder

163. T Walsh, *A Special Court for Special Cases* (Australasian Institute of Judicial Administration and TC Beirne School of Law, University of Queensland 2011) 44.
164. T Walsh, *A Special Court for Special Cases* (Australasian Institute of Judicial Administration and TC Beirne School of Law, University of Queensland 2011) 40.
165. T Walsh, *A Special Court for Special Cases* (Australasian Institute of Judicial Administration and TC Beirne School of Law, University of Queensland 2011) 64.
166. N Hunter and H McRostie, *Magistrates Court Diversion Program: Overview of Key Data Findings* (SA Office of Crime Statistics and Research, 2001).
167. The defence became more widely relied upon following amendments which broadened the applicability of the defence and introduced a "limiting term", so that offenders found not guilty by reason of mental incompetence could no longer be detained indefinitely: M Burvill and others, "The Management of Mentally Impaired Offenders within the South Australian Criminal Justice System" (2003) 26 *International Journal of Law and Psychiatry* 13, 15.
168. M Burvill and others, "The Management of Mentally Impaired Offenders within the South Australian Criminal Justice System" (2003) 26 *International Journal of Law and Psychiatry* 13, 15.
169. E Richardson and B McSherry, "Diversion Down Under – Programs for Offenders with Mental Illnesses in Australia" (2010) 33 *International Journal of Law and Psychiatry* 249, 250.

who commit summary and certain minor indictable offences.[170] Participation in the program is voluntary and, although defendants are not required to enter a guilty plea, they must indicate that they will not contest the charges against them.[171]

11.143 The MCDP has a dedicated court team, comprising a designated magistrate and a number of court officers – a program manager, four clinical advisors and five clinical liaison officers who develop a personalised treatment plan for each defendant.[172] Regular status meetings are held where the defendant's compliance with their individual intervention plan is assessed. Failure to comply might result in extension, alteration, or termination of the program.[173]

11.144 An evaluation of the program found that fewer participants offended following participation in the program, and that fewer charges were laid against participants in the 12 months following participation, compared with the 12 months before participation.[174]

11.145 Despite these positive results, some concern has been expressed about the program's outcomes. In the first year of operation, approximately two thirds of those who took part in the program left the court with a criminal record.[175] Although legislative amendments were subsequently made to enable magistrates to dismiss charges independently of a decision by the prosecution to withdraw charges,[176] the number of defendants leaving the court with a criminal record has increased. In 2009-2010, only 22.4% of participants were diverted from a traditional sentencing option.[177]

11.146 Schneider argues:

> The … program is, in many respects, similar to the American model. There are, however, different potential outcomes ... Assuming the accused remains with the program, she may nevertheless still be convicted of the original charge or a lesser included offence. Indeed, during the pilot project's first year of operation, two-thirds of the successful enrollees left mental health court with a criminal conviction. This … may be antithetical to the court's primary purpose, which is to decriminalize the mentally disordered population entering the criminal justice system.[178]

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170. N Hunter and H McRostie, *Magistrates Court Diversion Program: Overview of Key Data Findings* (SA Office of Crime Statistics and Research, 2001) 4.
171. N Hunter and H McRostie, *Magistrates Court Diversion Program: Overview of Key Data Findings* (SA Office of Crime Statistics and Research, 2001) 4.
172. Courts Adminstration Authority (SA), *Magistrates Court Diversion Program* <www.courts.sa.gov.au/courts/magistrates/index.html>.
173. N Hunter and H McRostie, *Magistrates Court Diversion Program: Overview of Key Data Findings* (SA Office of Crime Statistics and Research, 2001) 4.
174. G Skrzypiec, J Wundersitz and H McRostie, *Magistrates Court Diversion Program: An Analysis of Post-Program Offending* (SA Office of Crime Statistics and Research 2004) 3.
175. M Burvill and others, "The Management of Mentally Impaired Offenders Within the South Australian Criminal Justice System" (2003) 26 *International Journal of Law and Psychiatry* 13, 29.
176. E Richardson and B McSherry, "Diversion Down Under – Programs for Offenders with Mental Illnesses in Australia" (2010) 33 *International Journal of Law and Psychiatry* 249, 251.
177. Courts Administration Authority (SA), *Annual Report* 2009-10 (2010) 41.
178. RD Schneider, HY Bloom and M Heerema, *Mental Health Courts*, *Decriminalizing the Mentally Ill* (Irwin Law, 2007) 108.

11.147 In urban areas the MCDP is gradually being transitioned into the Treatment Intervention Program (TIP).

11.148 Previously, under the MCDP, defendants who were eligible for both the MCDP and the Drug Court tended to select the MCDP as it was perceived to be the easier or less coercive option. TIP resolves this issue by centralising decision making about the choice of program. TIP recognises the frequently co-occurring nature of mental illness and substance dependence, and integrates rehabilitation for these impairments. TIP consists of three streams, for people with:

- a mental impairment
- substance dependence, and
- both a mental impairment and a substance dependence problem.

All of these streams are based on a health model, and seek to address reoffending and improve mental and physical health.

Tasmania

11.149 Tasmania's Mental Health Diversion List was established in 2007, and now operates within the Hobart and Launceston registries of the Magistrates Court. It uses existing provisions in the *Bail Act 1994* (Tas) and the *Sentencing Act 1997* (Tas) to divert offenders into treatment.[179]

11.150 The list is open to defendants who have impaired intellectual or mental functioning as a result of a mental illness. People with intellectual disabilities will only be accepted if they also have a mental illness. Mental illness is defined as:

> (1) … a mental condition resulting in –
>
> (a) serious distortion of perception or thought; or
>
> (b) serious impairment or disturbance of the capacity for rational thought; or
>
> (c) serious mood disorder; or
>
> (d) involuntary behaviour or serious impairment of the capacity to control behaviour.
>
> (2) A diagnosis of mental illness may not be based solely on –
>
> (a) antisocial behaviour; or
>
> (b) intellectual or behavioural nonconformity; or
>
> (c) intellectual disability; or
>
> (d) intoxication by reason of alcohol or a drug.[180]

179. Magistrates Court of Tasmania, *Mental Health Diversion List Procedural Manual* (2010)
180. *Mental Health Act 1996* (Tas) s 4.

11.151 The list is open to people charged with summary offences, or offences capable of being tried summarily, with the exception of sexual offences and some offences involving bodily harm.[181]

11.152 The list encompasses many of the elements of MHCs set out above. For example, participants must comply with a personalised treatment plan and must attend court on a regular (usually monthly) basis to discuss their progress. Compliance may be met with verbal encouragement, adjustments to the treatment/supervision plan, conferral of other rewards, or graduation. Non-compliance may be met with verbal sanctions, adjustments to the treatment/supervision plan or expulsion from the program.[182]

11.153 Unlike the South Australian program, in the first 12 months of operation, the majority of participants left the program without a conviction.[183]

11.154 Early evaluations provide preliminary support for the conclusion that participation in the program leads to a reduction in reoffending rates in the first six months after participating in the program;[184] and anecdotal evidence is that participants have higher levels of engagement with treatment.[185] One stakeholder made the following observation:

> At the moment, we have got a couple of people on our List that have been coming in and out of this Court for 10 to 15 years, and have never been as good as they are now. We have never been successful at getting them into treatment. We have never been successful at changing their offending patterns. And they are surprising everybody – including us. It is quite exciting to think that we are having an impact on some very difficult people… It is really good. It is clearly what we need to be doing.[186]

Western Australia

11.155 In 2003, following a review of the *Criminal Law (Mentally Impaired Defendants) Act 1996* (WA), Professor Holman recommended the establishment of a taskforce to develop, within 12 months, a plan for the establishment of a mental health court in Western Australia.[187]

11.156 In their 2009 report on court intervention programs, the Law Reform Commission of Western Australia (WALRC) recommended that a mental impairment court

181. Magistrates Court of Tasmania, *Mental Health Diversion List Procedural Manual* (2010) 7.
182. Magistrates Court of Tasmania, *Mental Health Diversion List Procedural Manual* (2010) 17.
183. E Richardson and B McSherry, "Diversion Down Under – Programs for Offenders with Mental Illnesses in Australia" (2010) 33 *International Journal of Law and Psychiatry* 249, 251.
184. E Newitt and V Stojcevski, *Mental Health Diversion List Evaluation Report* (2009).
185. H Graham, *A Foot in the (Revolving) Door? A Preliminary Evaluation of Tasmania's Mental Health Diversion List* (University of Tasmania, 2007) 61.
186. H Graham, *A Foot in the (Revolving) Door? A Preliminary Evaluation of Tasmania's Mental Health Diversion List* (University of Tasmania, 2007) 61.
187. CDJ Holman, *The Way Forward: Recommendations of the Review of The Criminal Law [Mentally Impaired Defendants] Act 1996* (Government of Western Australia, 2003) Recommendation 7.2, 15.

intervention program should be established at the earliest opportunity.[188] The WALRC recommended that the program be voluntary and that it should not include a requirement to plead guilty. In relation to defendants with a cognitive impairment, it was recommended that only those with a primary diagnosis of mental illness or personality disorder should be eligible. In recognition of the different needs of those with cognitive impairments, the WALRC considered that an expanded version of the Intellectual Disability Diversion Program (discussed below) should deal with defendants with a primary diagnosis of intellectual disability or other cognitive impairment.[189] The WALRC's recommendations were subsequently raised in the Legislative Council in September 2010,[190] and debated in May 2011.[191]

11.157 In May of 2012, the Western Australian government announced that it would introduce a Mental Health Court Diversion Program at Perth Magistrates' Court and Children's Court, aimed at diverting people with mental illness facing criminal charges into treatment and services.[192]

11.158 The Mental Health Court Diversion Program will be headed by a full-time magistrate. A team of mental health experts will provide assessments, individualised treatment, and liaison to mental health services in the community.[193] Participation in the program will be voluntary, and suitability for the program and sentencing are determined by a number of factors, including the nature of the offence, the particular mental illness, and potential risks to the community.[194]

11.159 One court diversion program has been available in WA since 2003. The Intellectual Disability Diversion Program (IDDP) is a specialised list located at Perth Magistrate's Court that adopts a problem solving approach for people with an intellectual disability.[195]

11.160 The IDDP is open to people with an intellectual disability who are eligible for particular services from the Disability Service Commission.[196] The matter must be

188. Law Reform Commission of Western Australia, *Court Intervention Programs*, Final Report, Project No 96 (2009) 84. Various court intervention programs, including the Intellectual Disability Diversion Program, were discussed in greater depth in the Commission's consultation paper: Law Reform Commission of Western Australia, *Court Intervention Programs*, Consultation Paper, Project No 96 (2008).

189. Law Reform Commission of Western Australia, *Court Intervention Programs*, Final Report, Project No 96 (2009) 84.

190. Western Australia, *Parliamentary Debates*, Legislative Council, 21 September 2010, 6874d (Alison Xamon).

191. Western Australia, *Parliamentary Debates*, Legislative Council, 18 May 2011, 3516b-3530a (Alison Xamon, Ljiljanna Ravlich.)

192. C Porter and H Morton, "State Budget 2012-13: Supporting our Community – Mental Health Court Diversion Program First for WA" (Media Statement, 19 May 2012) <www.mediastatements.wa.gov.au/Pages/Default.aspx?ItemId=150116>.

193. C Porter and H Morton, "State Budget 2012-13: Supporting our Community – Mental Health Court Diversion Program first for WA" (Media Statement, 19 May 2012) <www.mediastatements.wa.gov.au/Pages/Default.aspx?ItemId=150116>.

194. "Western Australia Introduces Court for Mentally Ill", *ABC News* (Online) 19 May 2012 <www.abc.net.au/news/2012-05-19/western-australia-introduces-court-for-mentallyill/4021238?section=wa>.

195. Law Reform Commission of Western Australia, *Court Intervention Programs*, Consultation Paper, Project No 96 (2008) 105-107.

196. R Zappelli and A Mellor, *Evaluation of the IDDP Project* (TNS Social Research, 2004) 26.

one that can be dealt with in the Magistrate's Court. Further, the defendant must plead guilty, and consent is required.[197]

11.161 Once the defendant is assessed as eligible, the IDDP program coordinator develops a plan that seeks to address the offending behaviour. If the defendant agrees to comply with the directions of the program coordinator, the defendant is then released on bail. The defendant is brought back before the court for monitoring, approximately every two months. At this time, the coordinator provides a report of the defendant's participation to the court.[198]

11.162 The program is usually finalised after approximately six months.[199] Defendants who do not comply with the program may be returned to court for encouragement, or returned to the general list. Compliant defendants "can expect a discount on the sentence they would have received had they not participated in the program".[200]

11.163 The program aims to reduce recidivism and the rate of imprisonment of people with an intellectual disability. It also seeks to improve the justice system's responses to intellectual disability.[201]

11.164 An evaluation of this program was conducted in 2004 by TNS Social Research.[202] The evaluation involved analysis of Department of Justice data on referrals, wait times, sentence outcomes and training evaluation forms, as well as interviews with key stakeholders.[203]

11.165 The evaluation found that although anecdotal evidence appeared positive, it was too early to tell whether the rate of imprisonment of people with an intellectual disability had been reduced,[204] or whether the IDDP reduced recidivism for this group,[205] as the evaluation was conducted one year after the IDDP commenced.

11.166 In relation to other objectives, the evaluation found that stakeholders "unanimously" confirmed that the IDDP program resulted in a more appropriate treatment of people with intellectual disabilities as they are directed to services and assisted to modify their offending behaviour.[206] Further, people with intellectual disabilities and their families or carers were of the view that the IDDP delivered better social welfare outcomes, again due to the provision of services as well as an improved

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197. Law Reform Commission of Western Australia, *Court Intervention Programs*, Consultation Paper, Project No 96 (2008) 106.
198. Law Reform Commission of Western Australia, *Court Intervention Programs*, Consultation Paper, Project No 96 (2008) 106.
199. Law Reform Commission of Western Australia, *Court Intervention Programs*, Consultation Paper, Project No 96 (2008) 107.
200. Law Reform Commission of Western Australia, *Court Intervention Programs*, Consultation Paper, Project No 96 (2008) 107.
201. Magistrates Court of Western Australia, "Intellectual Disability Diversion Program (IDDP)" <www.magistratescourt.wa.gov.au/I/intellectual_disability_diversion_program_iddp.aspx?uid=7942-2328-8603-7948>.
202. R Zappelli and A Mellor, *Evaluation of the IDDP Project* (TNS Social Research, 2004) 14.
203. R Zappelli and A Mellor, *Evaluation of the IDDP Project* (TNS Social Research, 2004) 16.
204. R Zappelli and A Mellor, *Evaluation of the IDDP Project* (TNS Social Research, 2004) 51.
205. R Zappelli and A Mellor, *Evaluation of the IDDP Project* (TNS Social Research, 2004) 52.
206. R Zappelli and A Mellor, *Evaluation of the IDDP Project* (TNS Social Research, 2004) 53.

understanding of the consequences of non-compliance.[207] The economic benefits of the program remain unclear.[208]

11.167 The WALRC noted that the Disability Services Commission eligibility criteria and its association with funding "significantly limits the type of offenders that can be accepted onto the [IDDP] program" such as people with brain injuries acquired in adulthood, or people with borderline range IQ.[209]

Victoria

11.168 In March 2010, Victoria passed legislation to establish the state's first MHC.[210] The Assessment and Referral Court List was originally introduced as the Mental Health List, but was renamed to reflect its role more accurately. The list operates out of the Melbourne Magistrates' Court on two days each week.

11.169 Participation is voluntary,[211] and defendants may withdraw from the list at any time, in which case they will return to the ordinary list.[212] Successful completion may result in discharge without a finding of guilt.[213] However, magistrates retain the full range of sentencing options.[214] Participation in the program to the satisfaction of the court can be taken into account to the benefit of the accused, but unsatisfactory performance cannot be taken into account to their detriment.[215]

11.170 The list is not open to defendants who are charged with serious sexual or violent offences.[216] To be eligible for entry to the list, a defendant must meet eligibility criteria, set out in s 4T of the *Magistrates' Court Act 1989* (Vic). An accused must meet one or more of the following diagnostic criteria:

- A mental illness
- An intellectual disability
- An acquired brain injury
- Autism spectrum disorder, or
- A neurological impairment, including, but not limited to dementia.

Unlike the Tasmanian list, the Victorian list accepts participants with a sole diagnosis of intellectual disability.

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207. R Zappelli and A Mellor, *Evaluation of the IDDP Project* (TNS Social Research, 2004) 58.
208. R Zappelli and A Mellor, *Evaluation of the IDDP Project* (TNS Social Research, 2004) 54-58.
209. Law Reform Commission of Western Australia, *Court Intervention Programs*, Consultation Paper, Project No 96 (2008) 106.
210 *Magistrates' Court Amendment (Assessment and Referral Court List) Act 2010* (Vic).
211. *Magistrates' Court Act 1989* (Vic) s 4S(3)(c).
212. Victoria, *Parliamentary Debates*, Legislative Assembly, 10 December 2009, 4603 (Robb Hulls).
213. *Magistrates' Court Act 1989* (Vic) s 4Y(2).
214. *Magistrates' Court Act 1989* (Vic) s 4Y(9).
215. *Magistrates' Court Act 1989* (Vic) s 4Y(5)-(6).
216. The excluded offences are set out in the *Sentencing Act 1991* (Vic) sch 1, cl 1, 2, 3.

11.171 As a consequence of having one or more of the diagnostic criteria, the accused must meet functional criteria. The accused must have substantially reduced capacity in at least one of the areas of self-care, self-management, social interaction, or communication. The criteria require that there must also be a potential benefit to the accused from receiving coordinated services in accordance with an individual support plan that may include psychological assessment, welfare services; health services; mental health services; disability services; drug treatment services or alcohol treatment services; housing and support services; or other services that aim to reduce the risk of offending or reoffending.

11.172 The Court works with a team of support workers who assess defendants; prepare individual support plans; provide case management; and report to the Court. The police prosecutor and the Legal Aid lawyers who work with the Court are specialists who work consistently with the court. The consistency of the defendant's engagement with the judicial officer, ARC staff and others in court is regarded as very important.[217]

11.173 It is intended that the program will reduce costs of imprisonment and correctional services.[218] Evaluation of the list is in progress.

217. This point was made at the Symposium on mental health courts (see Appendix D) and in consultation with the ARC: ARC List and CISP, *Consultation MH30.*

218. Victoria, *Parliamentary Debates*, Legislative Assembly, 10 December 2009, 4603 (Robb Hulls).

12. Court Referral for Integrated Service Provision list

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12.1 In this chapter we propose the introduction of a specialist list in the Local and District Courts to deal with offenders who have a cognitive or mental health impairment and who face a serious prospect of imprisonment. We propose that the list be called the Court Referral for Integrated Service Provision list (CRISP). The list would take a "problem solving" approach. The judicial officer in each court would work with a team providing assessment, support and case management to the defendant. Defendants would be required to undertake a diversion plan designed to deal with those issues that, directly or indirectly, cause offending behaviour. Diversion plans are defined and discussed in Chapter 9, in relation to s 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA).[1] Diversion plans in the CRISP list and in s 32 would operate in the same way. On completion of the plan, the charges against the defendant would be dealt with. Successful participation in a diversion plan would then be taken into account by the court in this process.

A specialist court for NSW?

12.2 In Chapter 11 we reviewed the key characteristics of "mental health courts". We focussed in particular on the evaluations of these courts to clarify the evidence base for their success or otherwise. We examined the development of mental health courts in Australia and reviewed the limited evaluations of those courts that have been carried out to date.

12.3 As we have seen, there are now specialist courts in Queensland, South Australia, Tasmania, and Victoria. Western Australia has an Intellectual Disability Diversion Program and the establishment of a Mental Health Court Diversion Program was

1. Para 9.81-9.85.

announced in May 2012. The development of mental health courts in recent years, both overseas and in Australia, raises the question as to whether NSW should follow suit and establish such a court.

12.4 To date, NSW has taken a different approach to dealing with defendants who have cognitive and mental health impairments. Rather than establish specialist courts it has chosen to "mainstream" its diversionary efforts. The provisions of s 32 and s 33 of the MHFPA presently allow magistrates in any Local Court to make diversionary orders in relation to defendants who have cognitive and mental health impairments.

12.5 The "mainstreaming" approach to diversion adopted in NSW has the important advantage that it is potentially available to all defendants. It avoids what has been called "post code justice". Specialist courts are rarely available outside metropolitan centres. NSW is a large state, and requiring defendants to travel to a metropolitan specialist court is not realistic for people from rural and remote communities.

12.6 Further, we have made recommendations in this report to improve the operation of the diversionary provisions in s 32. In particular we have recommended the state-wide roll-out of support services for NSW courts[2] and the extension of diversionary powers to higher courts.[3] We have also recommended changes to s 32 that will increase the diversionary options that are available.[4] These options include providing courts with the power to monitor diversionary orders at their discretion. The new powers, together with the recommended roll-out of the Court Referral of Eligible Defendants into Treatment (CREDIT), will allow NSW courts to adopt some of the characteristics of specialist "mental health" courts in appropriate cases.

12.7 On the other hand, our recommendation in relation to s 32 diversionary powers and court support do not go as far as a specialist court. Specialist problem solving courts provide intensive court supervision of defendants undertaking diversion plans. This judicial oversight of defendants is regarded as important to the success of these programs. While NSW courts will have the opportunity to supervise and monitor defendants under our recommendations, doing so will impose a significant burden on them, especially in busy courts. Judicial monitoring also involves developing a relationship over time with defendants, and supporting their rehabilitation. While some judicial officers may find this role satisfying, others may not have aptitude or enthusiasm for it, and may prefer to refer such cases to those with relevant expertise.

Stakeholder views

12.8 The question of whether or not NSW should have a specialist court or list for offenders who have cognitive and mental health impairments was addressed, albeit indirectly, in Consultation Paper 7. We asked whether or not there should be alternative ways of hearing applications under s 32, other than through traditional court procedures. We provided the example of conferencing based procedures as

2. Recommendations 7.1, 7.4.
3. Recommendation 13.2.
4. Recommendation 9.4.

an example of an alternative approach. We also asked, if alternative models were introduced, should they be provided for in legislation or left to administrative arrangements.[5]

12.9 Ten submissions responded to this question and five of these raised the idea of a specialist court or list. The NSW Police Force supported looking at alternative ways of hearing s 32 applications, including through specialist courts. The Police Force mentioned the Queensland Special Circumstances Court as a possible model.[6] The NSW Bar Association also suggested that s 32 cases could be dealt with through a mental health court, and provided examples of such courts in Washington and San Francisco.[7] The NSW Consumer Advisory Group suggested the example of the Queensland Mental Health Court.[8]

12.10 While there was some support in the submissions for methods such as conferencing, there was also opposition to conferencing in this particular context.[9] The Local Court and the Children's Court, for example, argued that there are important advantages of having such cases dealt with by a court.[10]

12.11 In order to develop the arguments in favour of, and against, the introduction of a specialist court in NSW, and to learn first-hand from the experiences of other jurisdictions, we collaborated with the Institute of Criminology in the Faculty of Law at Sydney University, to convene a Symposium on the topic of whether or not NSW should have a mental health court. That Symposium, held on 1 April 2011, was attended by a wide range of stakeholders. It was addressed by judicial officers from mental health courts in Victoria and Tasmania, by a leading academic in this field, by representatives from NSW courts and by a solicitor specialising in intellectual disability work. The Symposium was moderated by journalist Natasha Mitchell and was later the subject of a program in the ABC radio series *All in the Mind.* (For further details see Appendix D.)

12.12 The desirability of a specialist court for people with cognitive and mental health impairments was also canvassed in our consultations with stakeholders. The great majority of stakeholders were in favour of a specialist court.[11] However, that support was not unanimous, and some concerns were expressed.

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5. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) Issue 7.35.
6. NSW Police Force, *Submission MH47*, 19.
7. NSW Bar Association, *Submission MH10*, 59. Other submission mentioning specialist courts were Shopfront Youth Legal Centre, *Submission MH7*, 12; E Baldry, L Dowse, I Webster and P Snoyman, *Submission MH3*, 9.
8. NSW Consumer Advisory Group, *Submission MH11*, 57. But see para 11.7.
9. NSW Bar Association, *Submission MH10*, 64; Law Society of NSW, *Submission MH13*, 49.
10. Local Court of NSW, *Submission MH4*, 16; Children's Court of NSW, *Submission MH24*, 9.
11. Support for a specialist court or list was expressed at the symposium, and during consultations, for instance: Cognitive impairment roundtable, *Consultation MHC9;* Community roundtable, *Consultation MHC11;* Community roundtable, *Consultation MH17;* Kempsey, *Consultation MH19.*

Regional coverage of a specialist court

12.13 Some stakeholders expressed concern that, if a specialist court were established, it would be located in Sydney or in a few metropolitan centres. Regional areas would not have access to it. For example, at a roundtable of stakeholders working in the field of cognitive impairment, it was argued that some rural and remote courts deal with high levels of cognitive impairment, but would not be able to use the specialist court.[12] The same concern was expressed at a roundtable on issues relevant to Aboriginal people and Torres Strait Islanders.[13] It was also argued that, if a specialist court or list were to be introduced, generic training and awareness in the rest of the Local Court should not suffer.[14]

12.14 However, at a community consultation of organisations providing legal and other services to people with cognitive and mental health impairment there was general, though not unanimous, agreement that a specialist court should be established, initially as a pilot program.[15] At another roundtable of community service providers it was agreed that, although mental health and cognitive impairment are "core business" for the Local Court, the particular needs of this group are not being met at present. It was argued by some participants that it would be better to develop a system that goes to the heart of their issues even if only in one location. The service could then be extended to other areas if it were successful. It was argued that geographical limitations should not become a basis for inaction.[16]

12.15 There was also support for a specialist court or list from some regional stakeholders. For example, at a consultation in Kempsey the view was put that a specialist court should be established, and the fact that it could not be available to the whole population should not be a reason to veto a pilot. That pilot could be evaluated and extended if successful. The example of the Drug Court was noted with approval. The Kempsey stakeholders spoke of the frequency with which mental health issues came up at the Local Court and the need to find more effective ways to deal with these defendants.[17]

Responding to complex cases

12.16 The potential for a specialist court or list to provide for people who have complex needs was of particular interest to some stakeholders at the roundtable of experts in cognitive impairment. Participants remarked on the strong educational potential of a specialist list, and its potential to recognise complex needs. There was also some optimism that such a court could overcome the "silo approach" and improve communication between providers of services.[18]

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12. Cognitive impairment roundtable, *Consultation MHC9.*
13. Aboriginal people and Torres Strait Islanders roundtable, *Consultation MH14.*
14. Cognitive impairment roundtable, *Consultation MH9.*
15. Community roundtable, *Consultation MH17.*
16. Community roundtable, *Consultation MH11.*
17. Kempsey, *Consultation MH19.*
18. Cognitive impairment roundtable, *Consultation MH9.*

12.17 One community roundtable considered that a specialist court should have services integrated into it, including housing, mental health, Centrelink, and training and employment, in the manner of the Neighbourhood Justice Centre in Victoria. Participants also supported multiple entry points to such a court, and an exit program at the end of involvement with the court.[19]

12.18 Many stakeholders who supported a specialist court or list recommended that it be based on the Drug Court model. There was a high level of understanding of, and support for the Drug Court and the integrated, problem solving, approach taken by that court.

Serious offenders

12.19 A further issue raised by some stakeholders was that the present provisions of s 32 leave a gap in relation to those who commit more serious offences. For example it was argued at a community roundtable that s 32 deals with minor offending behaviour, but that it may not deal with more serious offences.[20] A list dealing with more serious offences, rather than just minor crimes, would be desirable.[21] Such a list would have particular relevance for people with complex needs who may commit more serious offences or multiple, repeated offences. One stakeholder argued that even if a court dealt with only a few such offenders successfully it would relieve a huge burden on service sectors.

Reservations about a specialist court or list

12.20 A few stakeholders were opposed to a specialist court or list. However, some of this opposition did not arise out of principled objections to such a court but out of a concern that it should not be a priority for NSW at this time. Some stakeholders argued in consultations that it would be preferable to emphasise the extension of court support services, such as the Statewide Community and Court Liaison Service (SCCLS) and CREDIT. They argued that this would be a more important step and should be the priority over establishing a specialist court or list.

12.21 His Honour Justice Blanch, Chief Judge of the NSW District Court, expressed concerns about the impact of a specialist list on the flexibility of listing in the District Court, and thus about its impact on the court's efficiency. Justice Blanch asserted that extra judicial resources would be needed for such a list. He also had concerns about the great difficulties of providing a specialist list outside major metropolitan centres. Justice Blanch pointed out that, as all cases must dealt with by Local Courts (in some cases by way of committal proceedings) it may be more appropriate for a list to operate at that level.[22]

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19. Community roundtable, *Consultation MH11.*
20. While we recommend extension of s 32 to the higher courts, we note that it is not likely to be used often due to the seriousness of offences. See para 13.51.
21. Community roundtable, *Consultation MH17.*
22. Justice Blanch, *Consultation MH31.*

The Commission's view

12.22 The Commission considers that there is a strong case for the introduction of a specialist list in NSW to supplement our recommended enhancements to s 32. There is a great deal of stakeholder support, and there is good evidence that such an approach can provide substantial benefits, including the reduction of reoffending.

12.23 Although our recommendations in relation to s 32 of the MHFPA will provide suitable diversionary options for many cases, there is a group of defendants in relation to whom a specialist list appears to us to be the appropriate response. This group consists of defendants who have cognitive and mental health impairments who are at risk of imprisonment. We describe in Chapter 3 the particular problems associated with imprisonment for people with cognitive and mental health impairment and the high costs of imprisonment, to the state and to the individual.[23] In Chapter 4 we note the very high levels of people with cognitive and mental health impairment in prison.[24] In this context, we note the aims of the *NSW 2021* plan to increase diversion for this group. [25]

12.24 At the point at which a person with a cognitive or mental health impairment faces a serious prospect of imprisonment it appears to us to be worthwhile making a concerted attempt to avoid that imprisonment, if possible, through a specialist list. Using a specialist list at this point means that the resources of the courts and service sector are brought together and deployed at the point at which they are most likely to save the financial and other costs of imprisonment. Such an approach also avoids the criticism of net-widening, discussed in Chapter 11,[26] sometimes levelled at mental health courts. The proposed list would combine a structured and tailored rehabilitative plan, monitored by a dedicated support team, together with regular court monitoring by an expert judicial officer using the approach of a problem-solving court. The proposed model for the list is explained and developed in detail below.

Court Referral for Integrated Service Provision List (CRISP)

12.25 We have sought to give the proposed list a name which describes what it does. This avoids two problems. First, it avoids the stigma associated with names such as "Mental Health Court". Second it avoids the exclusion, or neglect, of people with cognitive impairments that arises with this commonly used terminology.

12.26 It is important that the judicial officer who sits in this list have jurisdiction to deal with all charges against a particular defendant, whether they are indictable offences, summary offences or indictable offences triable summarily. Our observations of the NSW Drug Court and of the Assessment and Referral court list in Melbourne demonstrated the frequency with which fresh charges arise, old charges resurface or additional charges are brought relating to the offence for which the defendant is

23. Para 3.21-3.25.
24. Para 4.109-4.132.
25. Para 1.5-1.10.
26. Para 11.114-11.118.

already before the court. The judicial officer presiding over the CRISP list should be able to decide on the appropriate way to deal with these offences.

12.27 One way to ensure that the List can deal with all offences would be to propose a specialist list at the level of the District Court, in the manner of the NSW Drug Court. However, it appears likely that the very great majority of cases eligible for CRISP will be in the Local Court. While locating CRISP in the Local Court would make sense in terms of the likely workload of the list, it would raise jurisdictional problems, because magistrates are not empowered to dispose of indictable offences. We have therefore proposed two lists, one in each court.

Recommendation 12.1

Legislation should provide for a Court Referral for Integrated Service Provision (CRISP) list to be established in the Local and District Courts at venues to be provided by regulation.

Eligibility

12.28 We recommend that the CRISP list be reserved for those defendants who:

a) have a cognitive or a mental health impairment, and

b) face a serious prospect of imprisonment.

"Faces a serious prospect of of imprisonment" in this context means that the facts alleged in connection with the offence, together with the defendant's history of offending and any other relevant information available to the court, indicate that there is a serious prospect that the defendant will be required to serve a sentence of imprisonment if convicted.

12.29 It would be possible to extend the ambit of the list, either at the outset, or after some experience with the list, by relaxing the criterion somewhat as it relates to the immedicacy of the risk of imprisonment. We heard from stakeholders that it is sometimes possible to identify a trajectory in a history of offending that is ultimately likely to lead to prison. In consultations, experienced police prosecutors appeared to be particularly adept at identifying these cases, as were magistrates and some service providers. Timely intervention in relation to such cases would obviously be desirable.

12.30 Throughout our inquiry, stakeholders have provided us with narratives from their experience that involve people with cognitive and mental health impairments who were imprisoned when their capacity to form the mental element of the offence was in doubt, or for repeated commission of essentially trivial offences, or because they lacked the supports they required from family or services to avoid offending behaviour. Our proposals are designed to provide an alternative to imprisonment for these defendants. Cases eligible for the list are also likely to be those where the defendant has complex needs of the type discussed throughout this report.

12.31 A significant number of cases are likely to arise where a defendant has a mental illness and is also addicted to drugs. Representatives from the CRISP lists, the Drug

Court and CREDIT should make arrangements concerning the best way to manage this issue.

12.32 The requirements placed on defendants by the CRISP list have the potential to be onerous, and will make considerable demands on defendants to address difficult issues. Mental health lists or courts generally require a plea or indication of guilt as a condition of eligibility. We recommend below an alternative formulation that, in order to be eligible, the defendant is "not contesting the facts that form the basis of the alleged offence". This is a response to the situation of defendants who wish to be dealt with via the list, and are otherwise eligible, but in relation to whom there may some doubt about capacity to form the relevant mental element of the alleged offence.

12.33 It is envisaged that referral to the CRISP list from any other court would initially involve assessment of the defendant by the court support team. Assessment of cognitive or mental health impairment would be a preliminary matter, as would assessment of their capacity to benefit from participation in the list. A discussion (in an environment less threatening and time pressured than the court) of the requirements of participation and defendant's acceptance of referral to the list would be desirable. A preliminary assessment of the service needs of the defendant and the likely availability of the services required in a diversion plan would also be made at this stage. Where it is clear that the defendant is not eligible it may be desirable to arrange for early relisting in the referring court in order to avoid a protracted process.

12.34 The defendant would then be referred to the court, where the court would hear from the prosecution, the defence, the CRISP court support team and any other relevant person before deciding whether or not to accept the reference to the list.

Recommendation 12.2

(1) Any court may refer a defendant to a CRISP list if it appears that:

- (a) the defendant has a mental health impairment or cognitive impairment, as set out in Recommendations 5.1 and 5.2
- (b) the facts alleged in connection with the offence, together with the defendant's history of offending and any other information available to the court, indicate that there is a serious prospect that the defendant will be required to serve a sentence of imprisonment if convicted
- (c) the defendant is not contesting the facts that form the basis of the alleged offence, and
- (d) a CRISP list is reasonably accessible by the defendant having regard to the defendant's personal circumstances and the geographical area in which he or she lives.

(2) When a defendant is referred to a CRISP list, the CRISP support team will first assess the defendant as to:

- (a) the nature and extent of the defendant's cognitive or mental health impairment
- (b) the likelihood that the defendant will benefit from the list

(c) the defendant's views about being dealt with in the list

(d) the level of support required by the defendant and the availability of those supports, and

(e) any other relevant matter.

(3) If the CRISP support team assesses that the defendant is eligible and suitable for the list, the defendant will appear before the court administering the CRISP list. The court will hear from the prosecution, defence and support team. Taking into account those submissions, the nature, seriousness and circumstances of the offence, and any other relevant matter, if the the court is satisfied that the defendant:

(a) is eligible, and

(b) is appropriately dealt with by the CRISP list

it may accept the defendant onto the list.

Exclusions

12.35 Most mental health and other problem solving courts have exclusions. Many courts exclude defendants accused of offences involving violence or sexual offences. The Assessment and Referral Court list in Victoria excludes serious violence offences and sexual offences.[27]

12.36 However, sexual offences and offences involving violence may arise frequently for this group, who may nevertheless be suitable for diversion. For example, we were told in consultation about the increasing incidence of offences of indecency committed by persons with dementias who have become disinhibited as a result of their impairment. We were also told of offences of a sexual nature committed by people with intellectual disability who did not understand the wrongness of their behaviour. Further, during consultations we also heard frequently about offences involving violence arising in situations that were serious but where the person's impairment was central to their offending behaviour in ways that changed the assessment of the seriousness of the offence. We are thus unwilling to recommend the exclusion of all sexual offences and offences involving violence from the CRISP list.

12.37 However, there are some offences that are so serious that involvement in a diversionary program would not be appropriate. It is necessary to delineate which offences are excluded and it is highly desirable that this boundary be clear, well understood and practical to operate. We recommend therefore that where the defendant is charged with an offence that it strictly indictable, that the defendant should be excluded from the CRISP list.

12.38 There will also be some cases where the nature and circumstances of the offending behaviour means that an indictable offence triable summarily is properly regarded as so serious as to make it unsuitable for the CRISP list. In these circumstances the judicial officer will have the discretion, in accordance with Recommendation 12.2

27. See s 4S(3) of the *Magistrates' Court Act 1989* (Vic).

above, not to accept the defendant onto the list. However, in circumstances such as those described above, where the nature of the defendant's impairment influences the view that is properly taken about its seriousness, the matter could be dealt with in the CRISP list.

Recommendation 12.3

A court may not refer a defendant to a CRISP list if the proceedings relate to an offence that is strictly indictable.

Judicial officers presiding in the CRISP list

12.39 The suitability of the judicial officer in a list such as the CRISP list is generally regarded as very important. The "problem solving" approach of such a list requires direct and ongoing engagement with offenders and their lives over a significant period of time.[28] It also requires extensive, direct communication with people with cognitive and mental health impairments. The consistency of the presiding judicial officer, so that the defendant regularly sees the same person, is also regarded as very important to the success of such lists.[29]

12.40 Consequently we recommend below that careful consideration be given to the appointment of judicial officers to sit in these lists, and to listing practices. Similar provisions apply to the appointment of judicial officers to sit in other specialist jurisdictions, notably the Family Court of Australia.[30]

Recommendation 12.4

(1) The head of jurisdiction should assign to the CRISP list judicial officers who, by reason of training or experience and aptitude, are suitable to deal with cases in this list.

(2) Listing practices should ensure that, so far as possible, the defendant is listed before the same judicial officer.

Court support and services

12.41 Consistent, specialist staff who work with the court are an important part of the problem solving court approach. In the CRISP list, the CRISP support team would have multiple roles. They would assess the defendant's needs, and provide referral to specialist assessments where required. They would develop diversion plans tailored to the needs of each defendant that focus on the issues that are criminogenic for each individual. These staff would engage the defendant with appropriate services in the community. They would not provide these services themselves: their role should be that of case manager rather than, for example,

28. This point was made at the Symposium on mental health courts, see Appendix D and in consultation with judicial officers in problem solving courts.

29. Para 11.15, 11.172. The importance of consistency in judicial officer was also made in consultation with judicial officers in problem solving courts.

30. *Family Law Act 1975* (Cth) s 22(2)(b).

counsellor or social worker. The CRISP team will be responsible for reporting to the court on the defendant's diversion plan, progress and engagement with services.

12.42 The required set of skills for the CRISP team would therefore be an understanding of cognitive and mental health impairments; wide knowledge of the service sector for these impairments; excellent case management skills and an ability to work in the context of the criminal justice system. These skills are the same as those required for work with CREDIT and we envisage that, while the CRISP list would require dedicated staff to ensure it is properly resourced, the CRISP team and the CREDIT team in the location would work alongside each other, and use the same basic case management approach. However, staff would be assigned to work consistently with the CRISP list so that defendants have consistency in the CRISP staff with whom they work.

12.43 The relationships developed between the CRISP list staff and the service sector are obviously of the greatest importance. In the experience of other diversionary programs, brokerage funds to purchase some services, or facilitate access to services, appear to be highly desirable in some circumstances.[31] The list may also wish to develop memoranda of understanding with key services such as housing. The Memorandum of Understanding of the NSW Drug Court in relation to housing may provide a useful model.[32]

12.44 We note that problem solving courts in other jurisdictions, described in the previous chapter, have specialist dedicated police prosecutors and defence lawyers who are familiar with the approach of the court and also provide consistency of personnel and approach for defendants and the court. We recommend that this approach be employed in relation to the CRISP list.

Recommendation 12.5

(1) Administrative arrangements should be put in place to ensure that the CRISP list is supported by a dedicated support team, with expertise in cognitive and mental health impairment. That team should:

- (a) assess the defendant
- (b) develop diversion plans that:
  - (i) respond to the needs of the defendant, and
  - (ii) focus on reducing or preventing further offending behaviour
- (c) refer the defendant to other agencies and services
- (d) provide case management services to ensure effective engagement of the defendant with relevant services
- (e) monitor the defendant's progress and the suitability of services provided to the defendant, and

31. Reported in Court Referral of Eligible Defendants into Treatment (CREDIT), *Consultation MH21*, and Melbourne: Assessment and Referral Court (ARC) List and Court Integrated Services Program (CISP), *Consultation MH30*.

32. For further information see Drug Court, *Strategic Innovations and News* (11 April 2012) <http://www.drugcourt.lawlink.nsw.gov.au/drgcrt/news.html>.

(f) report to the court.

(2) Specially selected prosecution and defence lawyers should be allocated to the list.

Procedural issues

12.45 We noted in the previous chapter that some specialist courts operate on the basis of practice directions and policies, whereas others have a legislative base. We envisage that the CRISP list will have a legislative base, but acknowledge that this has not been regarded as essential in all jurisdictions.

12.46 While we recommend that the CRISP list will operate in the manner of a problem solving court, the precise nature of proceedings in the list will be developed over time and embodied in Practice Directions and policy documents adapted to the needs and practical circumstances of each court. We have described the characteristics of similar courts and lists in the previous chapter, so that the models employed in other jurisdictions can be used, as appropriate.

12.47 Our recommendations concerning procedural issues are therefore limited and employ the usual legislative formulae supporting informality and providing that the rules of evidence do not apply.[33]

Recommendation 12.6

(1) The CRISP list must exercise its jurisdiction with as little formality and technicality, and with as much expedition, as the proper consideration of the matters before the court permits.

(2) Legislation should provide that, in hearing any proceedings in the CRISP list, the court is not bound by the rules of evidence.

Powers of the court in the CRISP list

12.48 Recommendation 12.7 enumerates the powers of the court in the CRISP list that are typical of those for problem solving courts in other jurisdictions. We have recommended that CRISP be a list in the Local Court and the District Court:[34] some of the listed powers simply reflect powers that the court already has by virtue of other legislation, such as the power to adjourn or grant bail. Others, such as the power to terminate the defendant's participation in the list, are particular to CRISP. For clarity and convenience these powers are collected together, so that the characteristics and limits of the operation of the list are apparent.

12.49 This delineation of the powers that may be exercised in the list do not in themselves provide an indication of the way the list would operate in practice. The detailed practices of the court in the list would be provided for in regulations, practice directions, policies and other documents. We outline some of these practices below.

33. Compare the *Magistrates' Court Act 1989* (Vic) s 4U and *Drug Court Act 1998* (NSW) s 26.

34. Recommendation 12.1.

12.50 We have already described above the procedure for admission to the CRISP list.[35] Once admitted, a diversion plan[36] will be prepared for each defendant by the CRISP support team, and that plan will be approved by the court. The defendant will be required to report back to the court at intervals defined by the court. At these regular appearances the court will review the defendant's progress. Typically the judicial officer presiding over the list will talk informally and directly with the defendant and provide encouragement and support to them in adhering to their diversion plan. This judicial monitoring is a key part of the process.

12.51 Problem solving courts typically use rewards and sanctions. Sanctions may involve, for example:

- more regular court appearances
- changes to the diversion plan
- increasing the length of the plan (within the 12 month limit), and
- where the court assesses that the defendant has not substantially complied with the plan to the satisfaction of the court, termination of the plan, for the defendant to be dealt with according to law.

In recognition of what are likely to be complex and difficult issues, problem solving courts are generally tolerant of a certain level of non-compliance or failure by defendants, especially at the beginning of the plan.

12.52 Rewards may involve:

- positive reinforcement and praise from the court
- relaxation of court attendance and other plan requirements (such as meetings with the case manager), and
- reduction in the length of the plan.

12.53 A time limit for participation in the CRISP list is set at 12 months.[37] It is envisaged that participation in the list would, in most cases, be for less than 12 months, at least initially. However a limit of 12 months is recommended so that the plan may be extended in appropriate cases, for example where the defendant has a "false start" and takes time to engage with a diversion plan. Further, cases in this list will frequently involve complex issues that may require a longer period of time to resolve. We note that defendants may pursue programs and continue to receive services after their involvement with the list has ended.

12.54 In this context we also note that there may be some interaction between criminal proceedings in this list and the civil mental health and guardianship systems. For example, where the defendant has a cognitive impairment and does not have

35. Recommendation 12.2.
36. Diversion plans are discussed further in para 9.81-9.85.
37. The same time limit is provided for in *Magistrates' Court Act 1989* (Vic) s 4V(4).

capacity, a guardianship order will be required if it is proposed to impose some conditions in a diversion plan that have coercive effects.[38]

Recommendation 12.7

(1) When a defendant appears before the court in the CRISP list, the court may:

(a) adjourn the proceedings for assessment of the defendant and preparation of a diversion plan

(b) approve a diversion plan

(c) approve any variation to a diversion plan

(d) order that the defendant report to the court on a specified date or at specified intervals

(e) at any time terminate the defendant's participation in the CRISP list

(f) at any time deal with the defendant according to law

(g) make an order in relation to bail in accordance with the *Bail Act 1978* (NSW)

(h) issue a warrant for the arrest of the defendant, and

(i) make other orders as the case may require, necessary or incidental to the exercise of the court's functions in relation to the CRISP list.

(2) Participation in a diversion plan must not exceed 12 months.

Completion or termination of proceedings in the CRISP list

12.55 At the end of the defined period of participation in CRISP the court must deal with the offence(s) in relation to which the defendant was referred to the list. Discharge is an option that the court has available at its discretion, but successful completion of a diversion plan does not automatically entitle a defendant to discharge. It may be appropriate in some cases: for example the defendant may have been admitted to the list because they were at risk of imprisonment arising from repeated commission of offences that were not individually very serious. In such a case, where the court is satisfied that the diversion plan has assisted the defendant to make sufficient progress with the issues causing the offending behaviour, a discharge may be appropriate.

12.56 In relation to more serious offences, discharge may not be appropriate. However, participation in the list may be sufficient for the defendant to avoid the sentence of full time imprisonment envisaged when they were referred to the CRISP list. An evaluation of the defendant's progress in the list may mean that a bond with conditions is appropriate, or that the sentence of imprisonment is suspended.

38. *Darcy v NSW* [2011] NSWCA 413 was a case where a defendant was admitted to a secure facility as a condition of a s 32 order.

12.57 While the court must take into account the defendant's participation where this is to their credit, it is generally provided in comparable courts and lists that failure to participate in or complete a diversion plan should not be taken into account as an aggravating factor when the court deals with the offence.[39] We agree and our recommendation for NSW is that participation of the defendant in the list cannot put them in a worse position than they were in when they were referred to the list.

Recommendation 12.8

(1) On completion of a diversion plan by a defendant the court must finalise the proceedings.

(2) On termination of a diversion plan the court may hear and determine the proceedings or transfer the proceedings out of the list.

(3) If at any stage the defendant indicates an intention to plead not guilty the court must transfer proceedings out of the list.

(4) On completion of a diversion plan the court may discharge the accused without any finding of guilt, or otherwise impose a sentence or disposition in accordance with the law.

(5) When sentencing the defendant, a court must take into account in favour of the defendant the extent to which the defendant participated in the diversion plan.

(6) When sentencing the defendant a court must not take into account adversely to the defendant, the defendant's failure to participate in, or complete, a diversion plan.

Evaluation of the CRISP list

12.58 We recommend that the success, or otherwise, of the CRISP list should be formally evaluated, and that this evaluation be built into the program from its commencement.

12.59 In the previous chapter we reviewed the criteria against which many programs in the United States are evaluated.[40] It may be that many of these criteria can be utilised in the Australian context. For that evaluation, in addition to qualitative data about the opinions of stakeholders concerning the operation of CRISP, quantitative data should be collected. Some of the benefits of participation will doubtless be outcomes in the mental and general health of defendants, and in improvements to the person's social functioning. Of particular concern to the criminal justice system will be data about the impact of CRISP on reoffending, and the overall economic consequences of any reduction of offending.

Recommendation 12.9

The CRISP list should be subject to an independent process, outcome and economic evaluation which is supported by adequate data collection from the outset.

39. See for example the *Magistrates' Court Act 1989* (Vic) s 4Y(6).

40. Para 11.40-11.43.

13. Diversion in the higher courts

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13.1 In this chapter we consider what diversionary mechanisms should be available in higher courts in NSW. The main diversionary provisions contained in s 32 and s 33 of the *Mental Health (Forensic Provisions) Act 1990* (MHFPA) are available to the Local Court and Children's Court only. The question which arises is whether this limitation is appropriate.

13.2 Enhancing diversionary options might be seen as inappropriate for the District or Supreme Court, which deal with more serious offences. However, there are situations where it is arguable that higher courts should have diversionary powers. These courts deal with some offences that are less serious, and in other cases a person's cognitive or mental health impairment may serve to mitigate the level of moral culpability, even for an ostensibly serious offence.

13.3 In this chapter, we first consider the diversionary mechanisms that are presently available for people with cognitive and mental health impairments in the higher courts. We then consider whether s 32 and s 33 of the MHFPA should be extended to apply to higher courts.

Existing diversionary mechanisms

13.4 The existing powers to divert defendants who have cognitive and mental health impairments are limited. The primary diversionary vehicles are as follows:

- Section 10 of the MHFPA allows for dismissal of a charge in certain circumstances where a question of fitness is raised.
- Provisions of the *Bail Act 1978* (NSW) (*Bail Act*) and the *Crimes (Sentencing Procedure) Act 1990* (NSW) (CSPA) make it possible to require defendants to

access treatment or rehabilitation, which may then be taken into account when sentencing.

- The Drug Court, established under the *Drug Court Act 1998* (NSW), is a specialist court for eligible defendants with substance abuse issues.

Section 10 of the Mental Health (Forensic Provisions) Act

13.5 Section 10(4) of the MHFPA is limited to cases in the Supreme and District Courts[1] where the question of the defendant's fitness to be tried has been raised. It allows the court to dismiss charges against a defendant and order his or her release. The section provides:

> If, in respect of a person charged with an offence, the Court is of the opinion that it is inappropriate, having regard to the trivial nature of the charge or offence, the nature of the person's disability or any other matter which the Court thinks proper to consider, to inflict any punishment, the Court may determine not to conduct an inquiry and may dismiss the charge and order that the person be released.

13.6 This measure is only available to those defendants whose cognitive or mental health impairment raises concerns about their ability to stand trial. As the NSW Court of Criminal Appeal has noted, the "principal purpose" of s 10(4) is to avoid "unnecessary delays, costs and complications" associated with the special procedures that apply when an issue of fitness is raised.[2]

13.7 Furthermore the NSW Court of Criminal Appeal, in considering s 10(4) and, in particular, the broader framework in relation to fitness proceedings in which it is situated, observed:

> The relevant part of the Act is concerned to establish a regime for the determination of criminal guilt or innocence in circumstances where normal criminal procedures could not apply by reason of the mental condition of an accused at the time of trial. It is incorrect to describe the procedures as "diversionary" or as "flexible". They are alternative procedures designed to ensure that justice is done having in mind the possibility of a person's unfitness to be tried. Justice must, however, be done not only to the accused but to the victim, bearing in mind the public interest in resolving allegations of criminal conduct.[3]

13.8 The word "punishment" has been interpreted broadly to include the recording of a conviction without additional penalty.[4] The Court noted that a finding under s 10(4) of the MHFPA is "analogous" to s 10 of the CSPA[5] (a sentencing option that allows the court to dismiss charges after a finding of guilt):

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1. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 10(4) applies, by virtue of s 4, to criminal proceedings in the Supreme Court (including criminal proceedings within the summary jurisdiction of the Supreme Court) and criminal proceedings in the District Court.
2. *Newman v The Queen* (2007) 173 A Crim R 1; [2007] NSWCCA 103 [39].
3. *Newman v The Queen* (2007) 173 A Crim R 1; [2007] NSWCCA 103 [35].
4. *Newman v The Queen* (2007) 173 A Crim R 1; [2007] NSWCCA 103 [41].
5. *Newman v The Queen* (2007) 173 A Crim R 1; [2007] NSWCCA 103 [41]-[46].

> Section 10(4) requires the court to approach an application on the assumption of a finding of guilt, including a finding of qualified guilt, and then to apply a similar range of considerations as now arise under s10 of the *Crimes (Sentencing Procedure) Act 1999*. It permits the court to dismiss a charge without proceeding to a fitness hearing, on the assumption that there would be a finding of guilt if the matter did proceed to either a trial or a special hearing. Where the court would not impose any punishment, including the element of punishment implicit in a conviction, then the proceedings should be dismissed *in limine* without the need for a fitness hearing.[6]

In practice, it will be rare that the circumstances of a case would allow a court to conclude that it is inappropriate to inflict any punishment, except in respect of the most trivial offences.

13.9 If a court decides to deal with a defendant under s 10(4), its options are limited to dismissal of the charge and release of the defendant. There is no power to make a rehabilitative order, for example for treatment or engagement with services.

Does s 10(4) provide higher courts with adequate diversionary powers?

13.10 In Consultation Paper 7 (CP 7) we asked whether s 10(4) of the MHFPA provides the higher courts with an adequate power to divert defendants with a cognitive or mental health impairment.[7] Submissions were overwhelmingly of the view that s 10(4) does not provide adequate powers.[8] The reasons in support of this position include the limited scope of, and options available under, s 10(4) of the MHFPA[9] and the fact that it is only available for trivial offences.[10]

13.11 Conversely, the NSW Police Force noted that s 10(4) provides higher courts with "broad discretion" to discharge and release defendants with mental impairments, where appropriate, and this mechanism provides "ample capacity for diversion".[11]

13.12 The Public Defenders submitted that s 10(4) is "too narrow a gateway for removing an accused from the criminal trial process" where there is a fitness issue. The Public Defenders further noted that dismissal under s 10 of the CSPA is a "rare occurrence" in higher courts, and also observed that common assault, one of the least serious offences coming before the District Court, has attracted very few s 10

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6. *Newman v The Queen* (2007) 173 A Crim R 1; [2007] NSWCCA 103 [46].
7. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion* (2010) Issue 7.40.
8. NSW, Office of the Director of Public Prosecutions, *Submission MH5*, 15; Shopfront Youth Legal Centre, *Submission MH7*, 13; NSW Law Society, *Submission MH13*, 51; Legal Aid NSW, *Submission MH18*, 35; NSW, Public Defenders, *Submission MH26*, 54; NSW Bar Association, Submission MH10, 60-61. See also L Steele, *Submission MH9*, 34. But see NSW Police; *Submission MH47*, 19.
9. NSW, Office of the Director of Public Prosecutions, *Submission MH5*, 15; Shopfront Youth Legal Centre, Submission MH7, 13; NSW Law Society, *Submission MH13*, 5; NSW, Public Defenders, *Submission MH26*, 54. L Steele, *Submission MH9*, 34 notes that "s 10(4) is not a diversionary provision".
10. Shopfront Youth Legal Centre, Submission MH7, 13; NSW Law Society, *Submission MH13*, 51.
11. NSW Police Force, *Submission MH47*, 19.

dismissals.[12] Between July 2004 and June 2011 only two out of 85 common assault matters resulted in a s 10 dismissal.[13]

Extension of s 10(4) MHFPA to cases where nominal punishment is considered

13.13 We address the broad concerns of stakeholders concerning the inadequacy of the diversionary power in s 10 MHFPA below, in the context of proposals relating to the application of s 32 and s 33 of the MHFPA in the higher courts.

13.14 However, the Public Defenders suggested a more modest alternative of extending the powers under s 10(4) of the MHFPA to include cases where the court would otherwise inflict *nominal* punishment by way of a good behaviour bond under s 10 of the CSPA (upon a finding of guilt).[14] Under the current s 10(4) of the MHFPA the order is only available in circumstances where "it is inappropriate … to inflict *any* punishment".[15] This appears to exclude cases where the court is considering the option of not recording a conviction and discharging the person on the condition that he or she enter into a good behaviour bond under s 10(1)(b) of the CSPA. Such an order can be made in cases where it is "inexpedient to inflict any punishment (other than nominal punishment)".[16] The equivalent Commonwealth provision regarding fitness applies where "it is inappropriate to inflict any punishment, or to inflict any punishment other than a nominal punishment".[17]

13.15 We note that s 10(4) of the MHFPA would not allow the imposition of a good behaviour bond in cases where the court would otherwise consider doing so upon a finding a guilt. Nevertheless, the proposed change would ensure some limited flexibility in the operation of s 10(4). We therefore recommend that the section be amended accordingly.

Recommendation 13.1

Section 10(4) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide as follows:

> If, in respect of a person charged with an offence, the Court is of the opinion that it is inappropriate to inflict any punishment, **or to inflict any punishment other than a nominal punishment**, having regard to:
>
> (a) the trivial nature of the charge or offence
>
> (b) the nature of the person's disability, or
>
> (c) any other matter which the Court thinks proper to consider,
>
> the Court may determine not to conduct an inquiry and may dismiss the charge and order that the person be released.

12. See NSW, Public Defenders, *Submission MH26*, 54.
13. Information extracted from the Judicial Commission of NSW, Judicial Information Research System: Higher courts, s 61 of the *Crimes Act 1900* (NSW) at May 2012.
14. NSW, Public Defenders, *Submission MH26*, 54.
15. Emphasis added.
16. *Crimes (Sentencing Procedure) Act 1999* (NSW) s 10(2)(a).
17. *Crimes Act 1914* (Cth) s 20BA(2).

Provisions in the Bail Act and Crimes (Sentencing Procedure) Act

13.16 The *Bail Act*[18] and the CSPA apply to matters before both the Local Court and higher courts. These provisions can divert defendants to some extent, in that they can allow the defendant to enter into an agreement to engage with treatment and services. This engagement may, for example, allow the defendant to access bail in circumstances where he or she may otherwise have been held on remand, or it may have an impact on sentence. The higher courts also have a range of sentencing options at their disposal including fines, bonds, community service orders, intensive correction orders and imprisonment.[19] There is scope in the sentencing process to take into account a defendant's impairment, in various ways.[20] For example, bonds under s 9 of the CSPA can be used to require defendants to connect with services.

13.17 Furthermore, s 11 of the CSPA allows for deferral of sentence for the purpose of rehabilitation or participation in a program and s 10 of the CSPA also allows the court to dismiss charges following a finding of guilt in particular circumstances. These are considered below.

Section 10, Crimes (Sentencing Procedure) Act

13.18 Section 10 of the CSPA allows courts to dismiss charges and conditionally discharge offenders following a finding of guilt:

> (1) Without proceeding to conviction, a court that finds a person guilty of an offence may make any one of the following orders:
>
> (a) an order directing that the relevant charge be dismissed,
>
> (b) an order discharging the person on condition that the person enter into a good behaviour bond for a term not exceeding 2 years,
>
> (c) an order discharging the person on condition that the person enter into an agreement to participate in an intervention program and to comply with any intervention plan arising out of the program.

13.19 As we noted above, an order under s 10(1)(b) can be made if the court is satisfied that it is inexpedient to inflict any punishment (other than nominal punishment) or that it is expedient to release a person on a good behaviour bond.[21] In deciding whether to make an order under s 10(1) the court takes into account a number of factors including "mental condition", the "trivial nature of the offence", "extenuating circumstances" and any "matter that the court thinks proper to consider".[22]

13.20 Intervention programs and plans can be made if the court is satisfied that it would reduce the likelihood of further offending by promoting the treatment or rehabilitation

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18. We discuss bail in Chapter 6.
19. See *Crimes (Sentencing Procedure) Act 1999* (NSW).
20. See NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences*, Consultation Paper 6 (2010) Chapter 8.
21. *Crimes (Sentencing Procedure) Act 1999* (NSW) s10(2); s 9, Pt 8 (dealing with good behaviour bonds).
22. *Crimes (Sentencing Procedure) Act 1999* (NSW) s 10(3).

of the person.[23] However, these terms are precisely defined in the legislation. An intervention plan is a plan, agreement or arrangement arising from participation in an intervention program.[24] Intervention programs are prescribed in regulations and include only circle sentencing, forum sentencing and the traffic offender intervention program.[25] Participation is subject to factors such as the individual's suitability for the relevant program.[26]

13.21 Section 10 of the CSPA may therefore not provide the court with appropriate powers for defendants with cognitive and mental health impairments. The provision only operates following a finding of guilt. A good behaviour bond[27] may also involve conditions relating to treatment, and engagement with services designed to address the defendant's offending behaviour[28] but may also set up a defendant with cognitive and mental health impairments to fail, particularly where appropriate services are not available or the defendant is not supported regarding compliance. Furthermore, intervention programs are limited to those prescribed in regulations. Section 10 of the CSPA does not provide a context and framework directing the attention and effort of the court to issues of cognitive and mental health impairment and the provision of "treatment plans" as does s 32 in the Local Court.

Section 11, *Crimes (Sentencing Procedure) Act*

13.22 Section 11 of the CSPA allows courts to defer sentencing for the purpose of rehabilitation, participation in an intervention program or other purpose:

> (1) A court that finds a person guilty of an offence (whether or not it proceeds to conviction) may make an order adjourning proceedings against the offender to a specified date, and granting bail to the offender in accordance with the *Bail Act 1978*:
>
> (a) for the purpose of assessing the offender's capacity and prospects for rehabilitation, or
>
> (b) for the purpose of allowing the offender to demonstrate that rehabilitation has taken place, or
>
> (b1) for the purpose of assessing the offender's capacity and prospects for participation in an intervention program, or
>
> (b2) for the purpose of allowing the offender to participate in an intervention program, or
>
> (c) for any other purpose the court considers appropriate in the circumstances.

23. *Crimes (Sentencing Procedure) Act 1999* (NSW) s 10(2A).
24. *Criminal Procedure Act 1986* (NSW) s 346(1).
25. *Criminal Procedure Regulation 2010* (NSW).
26. *Crimes (Sentencing Procedure) Act 1999* (NSW) s 10(2B), Part 8C. Intervention programs are only generally available in relation to summary offences and indictable offences that may be dealt with summarily: *Criminal Procedure Act 1986* (NSW) s 348.
27. *Crimes (Sentencing Procedure) Act 1999* (NSW) s 95.
28. See *Crimes (Sentencing Procedure) Act 1999* (NSW) s 95(c); Judicial Commission of NSW, *Sentencing Bench Book* (at June 2012) [4-740]; NSW Sentencing Council, *Good Behaviour Bonds and Non-Conviction Orders* (2011) 6-9.

13.23 As with s 10 of the CSPA, this provision only operates following a finding of guilt. This provision allows a sentencing court to take into account participation in a program, treatment or other intervention. It makes specific reference to rehabilitation, but does not refer to people with cognitive and mental health impairments. It applies in relation to the potential amelioration of sentence, but does not necessarily result in discharge. However, it is possible that demonstrating "capacity and prospects for rehabilitation" or that "rehabilitation has taken place" may incline the court to dismiss the charge(s) under s 10.

Drug Court

13.24 The NSW Drug Court was established under the *Drug Court Act 1998* (NSW). The object of the Act is to reduce drug dependency, re-integrate people into the community and reduce the need for participants to resort to criminal activity.[29] In effect, the Court operates as a diversion scheme by shifting offenders "into programs designed to eliminate, or at least reduce, their dependency on drugs"[30] through compulsory treatment.[31] While the Drug Court primarily deals with people with substance abuse issues, the court may also deal with defendants with coexisting cognitive and mental health impairment.

13.25 The Drug Court is vested with the criminal jurisdiction and functions of the District and Local Courts.[32] The *Drug Court Act 1998* (NSW) deals with:

- acceptance into the program
- the administration of the program
- compulsory drug treatment detention, and
- the constitution, procedures and administration of the Drug Court.

Eligibility

13.26 To be eligible to participate in the Drug Court, a person must:

- be charged with an offence (precluding serious offences such as drug supply, violence and sexual assault)
- be highly likely, if convicted, to be sentenced to imprisonment
- plead guilty (or will plead guilty)
- appear to be dependent on prohibited drugs
- reside within prescribed local government areas
- not be suffering from any mental condition that could prevent or restrict the person's active participation in a program under the *Drug Court Ac 1998* (NSW)

29. *Drug Court Act 1998* (NSW) s 3(1).
30. *Drug Court Act 1998* (NSW) s 3(2).
31. *Drug Court Act 1998* (NSW) s 3(3).
32. *Drug Court Act 1998* (NSW) s 24.

- be above the age of 18 and outside the jurisdiction of the Children's Court, and
- be a willing participant.[33]

Certain convicted offenders are also covered under the *Drug Court Act 1998* (NSW).[34]

13.27 We were told during consultations that a significant proportion of offenders in the program have a mental illness. The mental health of all participants is reviewed. In accordance with the eligibility criteria, people who have a mental illness are excluded where their illness prevents or restricts their participation in the program.[35]

Approach

13.28 The Drug Court adopts a "collaborative approach between all parts of the legal system" and endeavours to improve the health and wellbeing of people who are caught up in a cycle of drugs and crime, as well as to reduce crime.[36] The Drug Court team includes the judge, solicitor from the Office of the Director of Public Prosecutions (ODPP), Police Prosecutor, Clinical Nurse Consultant, Legal Aid solicitors, Community Compliance Monitoring Group Co-ordinator and the court registrar.[37] Participants adopt traditional criminal justice roles but this is complemented by a collaborative team-based dynamic. For example:

> Once the defendant becomes a participant in a Drug Court program the ODPP role, while representing the community's interests at all times, is also to assist and encourage the participant in his or her rehabilitation as part of the team. The ODPP solicitor participates in team meetings and in the discussion of appropriate rewards and sanctions.[38]

Program structure

13.29 The Drug Court uses "the criminal justice process to minimise harm and indirectly prevent further drug use and the criminal offending that accompanies it".[39]

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33. *Drug Court Act 1998* (NSW) s 5; *Drug Court Regulation 2010* (NSW). See Don Weatherburn and others, "The NSW Drug Court: A Re-evaluation of its Effectiveness", Crime and Justice Bulletin 2 (NSW Bureau of Crime Statistics and Research 2008) 2-4.
34. Eligible convicted offenders are defined in the *Drug Court Act 1998* (NSW) s 5A. Compulsory drug treatment orders are available to eligible convicted offenders.
35. Drug Court of NSW, *Who is Eligible?"*(11 April 2012) <www.drugcourt.lawlink.nsw.gov.au/drgcrt/dc_program/dc_eligible.html>.
36. J Hatzistergos (Paper presented at the NSW Drug Court Conference, 6 February 2009) 2.
37. Drug Court of NSW, *Monitoring compliance with the program* (11 April 2012) <www.drugcourt.lawlink.nsw.gov.au/drgcrt/dc_program/dc_monitoring.html>.
38. N Cowdery, "A Prosecutor's Views" (Paper presented at the NSW Drug Court Conference, 6 February 2009) 7.
39. N Cowdery, "A Prosecutor's Views" (Paper presented at the NSW Drug Court Conference, 6 February 2009) 6.

13.30 Program steps involve:[40]

(1) Preliminary screening to determine eligibility before a person is brought to the Drug Court. Where there are more applicants than places in the program, a random selection process occurs. At the defendant's first appearance before the Drug Court, preliminary inquiries occur in relation to eligibility; this includes an evaluation of drug dependency.[41]

(2) Where eligible, a person is remanded in custody (in the Drug Court Unit within the Metropolitan Remand and Reception Centre, separated from other inmates) for detoxification and further assessment. More information about the requirements of the program is provided while the defendant is in custody. This step includes mental health reviews by Justice Health.[42]

(3) The person appears at the Drug Court to enter or confirm a guilty plea. The participant is given a sentence that is suspended (under a "suspension order"), and signs an undertaking to abide by program conditions.[43]

(4) The program then has three "phases", the initiation, consolidation and reintegration phases. During the phases, participants reduce and eventually cease drug use, cease criminal activity and also develop job and life skills in order to eventually gain employment and be financially responsible. As the participant advances through the phases, the frequency of report back to court and drug testing is reduced.[44]

(5) The program generally lasts 12 months unless terminated earlier. When the program concludes, the Drug Court must reconsider its initial sentence. Where appropriate, the Court may set aside the initial sentence and impose a different, sentence (no greater than the initial sentence). In deciding whether to reconsider the initial sentence the Drug Court must take into account participation in the program, sanctions imposed and time spent in custody.[45] Where the Drug Court finds that a participant has substantially complied with the program a non-custodial sentence is generally imposed.[46]

13.31 The Drug Court team meets before court each sitting day in order to discuss the relevant participants appearing in court that day and to receive reports from treatment providers and probation officers. The judge uses this information in

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40. See description at Drug Court of NSW, *Our Program* (11 April 2012) <www.drugcourt.lawlink.nsw.gov.au/drgcrt/dc_program.html>.
41. Drug Court of NSW, *Who is eligible?* (11 April 2012) www.drugcourt.lawlink.nsw.gov.au/drgcrt/dc_program/dc_eligible.html.
42. Drug Court of NSW, *Detoxification in custody* (11 April 2012) <www.drugcourt.lawlink.nsw.gov.au/drgcrt/dc_program/detox.html >; *Drug Court Act 1998* (NSW) s 8A.
43. Drug Court of NSW, *Detoxification in custody* (11 April 2012) <www.drugcourt.lawlink.nsw.gov.au/drgcrt/dc_program/detox.html >; *Drug Court Act 1998* (NSW) s 7A(4)-7A(5).
44. Drug Court of NSW, *For participants* (12 April 2012) <www.drugcourt.lawlink.nsw.gov.au/drgcrt/dc_participants.html>.
45. *Drug Court Act 1998* (NSW) s 12.
46. Drug Court of NSW, *When we terminate a program* (12 April 2012) <www.drugcourt.lawlink.nsw.gov.au/drgcrt/dc_program/dc_terminate.html>.

discussion with the participant later in court.[47] The program offers rewards such as decreased supervision and reduced drug testing, or changes in the frequency of social services the offender is required to attend, as well as sanctions such as increased supervision and drug testing or imprisonment.[48]

13.32 The sentences available to the Drug Court are the same as those available to the District Court and Local Court, and vary depending on whether the Court is dealing with a summary offence or indictable offence.[49]

13.33 A NSW Bureau of Crime Statistics and Research (BOCSAR) evaluation of the Drug Court has shown that "the program is more effective than conventional sanctions in reducing the risk of recidivism among offenders whose crime is drug-related".[50] The evaluation also noted that there is evidence to suggest that outcomes for high-risk offenders are improved when the offender is placed under the supervision of a judicial officer,[51] and that judicial officers can "ensure that Government agencies deliver the services for individual offenders they have undertaken to provide".[52]

13.34 While the Drug Court may provide a diversionary avenue for some defendants with cognitive and mental health impairments, the criteria are limited to a particular targeted group, and the program is focussed on substance abuse issues.

Diversion, fitness to plead and criminal responsibility

13.35 In higher courts issues of fitness to plead may be raised, and issues of cognitive or mental health impairment may be relevant to the criminal responsibility of the defendant, for example in relation to the defence of not guilty by reason of mental illness (NGMI). If enhanced diversionary options are made available, for example by the extension of s 32 and s 33 of the MHFPA to the higher courts, consideration will need to be given to the interaction of these diversionary provisions with issues of fitness and the defence of mental illness.

13.36 Similarly, if the legislative powers governing fitness to be tried and the defence of mental illness are extended to apply to the Local Court, then the interaction of these provisions with s 32 and s 33 will need to be considered in that context.

13.37 One way that the interaction could operate is to allow s 32 or s 33 to be raised, prior to, or alternatively to, a fitness determination or defence of mental illness. Raising issues of fitness and defence of mental illness could be reserved if the s 32 or s 33 applications are not successful.

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47. Drug Court of NSW, *Monitoring compliance with the program* (11 April 2012) <www.drugcourt.lawlink.nsw.gov.au/drgcrt/dc_program/dc_monitoring.html>.
48. *Drug Court Act 1998* (NSW) s 16. Drug Court of NSW, *Monitoring compliance with the program* (11 April 2012). <www.drugcourt.lawlink.nsw.gov.au/drgcrt/dc_program/dc_monitoring.html>.
49. See *Drug Court Act 1998* (NSW) s 15.
50. D Weatherburn and others, *The NSW Drug Court: A Re-evaluation of its Effectiveness*, Crime and Justice Bulletin 121 (Bureau of Crime Statistics and Research, 2008) 12.
51. D Weatherburn and others, *The NSW Drug Court: A Re-evaluation of its Effectiveness*, Crime and Justice Bulletin 121 (Bureau of Crime Statistics and Research, 2008) 14.
52. D Weatherburn and others, *The NSW Drug Court: A Re-evaluation of its Effectiveness*, Crime and Justice Bulletin 121 (Bureau of Crime Statistics and Research, 2008) 14.

13.38 These matters will be discussed in our next report on people with cognitive and mental health impairments in the criminal justice system.

Expanding the diversionary options available to higher courts?

13.39 As we have noted, s 32 and s 33 of the MHFPA currently apply to criminal proceedings in the Local Court and the Children's Court. The Local Court hears proceedings involving less serious criminal offences. As we have seen above, the powers of higher courts to divert a defendant are limited in comparison to the diversion powers of the Local and Children's Court. Higher courts have diversionary options, but they are not specifically tailored to the needs of people with cognitive and mental health impairments. In particular they do not offer the same range of options as those proposed in our recommendations in Chapters 9 and 10. The question which therefore arises is whether the s 32 and s 33 diversionary powers should be available in higher courts.

Stakeholder views

13.40 In CP 7, we asked whether s 32 and s 33 of the MHFPA should apply to proceedings for indictable offences in the Supreme and District Courts as well as proceedings in the Local Court.[53] Submissions in response to this question were generally of the view that extension of s 32 and s 33 of the MHFPA to the higher courts should be seriously considered.[54]

13.41 Stakeholders noted that making additional diversionary options available to the higher courts is desirable because:

- it would be useful for less serious indictable offences[55]
- there are limited options for diversion available in the higher courts[56]
- the procedures applicable to fitness and a verdict of NGMI do not encompass all defendants with a cognitive impairment who might be appropriate for diversion[57]
- the consequences of a finding of unfit but not acquitted or NGMI can result in "significant restrictions on an individual which might be unnecessary", and[58]
- it allows higher courts to avoid the "cumbersome procedures" relating to fitness and the defence of mental illness.[59]

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53. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Consultation Paper 7 (2010) Issue 7.41.
54. NSW, Office of the Director of Public Prosecutions, *Submission MH5*, 15; Shopfront Youth Legal Centre, Submission MH7, 13-14; NSW Bar Association, *Submission MH10*, 61; NSW Law Society, *Submission MH13*, 51; NSW Legal Aid, *Submission MH18*, 35; Brain Injury Association of NSW, *Submission MH19*, 28.
55. Shopfront Youth Legal Centre, Submission MH7, 13-14; NSW Law Society, *Submission MH13*, 51; Mental Health Review Tribunal, *Submission MH48*, 6.
56. L Steele, *Submission MH9*, 40.
57. L Steele, *Submission MH9*, 40; Brain Injury Association of NSW, *Submission MH19*, 28.
58. L Steele, *Submission MH9*, 40.

13.42 Shopfront Youth Legal Centre also expressed concern that:

> some of our clients who have a mental illness or cognitive impairment who are alleged to be involved with others in strictly indictable matters are subject, largely, to the same processes and principles that apply to their co-accused. For example, a young adult with a cognitive impairment charged with robbery in company will still have difficulty obtaining bail and will be housed in a mainstream adult gaol that does not cater for inmates with special needs.[60]

Section 32 and 33 of the MHFPA may be an appropriate alternative for some of these individuals.

13.43 Conversely, NSW Health argued that the current fitness and NGMI regimes "adequately cater for defendants facing indictable offences". NSW Health noted that the interplay between existing provisions dealing with fitness and NGMI and any proposed diversionary scheme should be carefully considered.[61] Furthermore, the NSW Police Force submitted that they do not support extension of s 32 and s 33 to the higher courts, noting that the higher courts deal with more serious offences and:

> therefore a more rigorous regime to deal with accused persons would be more appropriate. It is important to balance the public interest in having persons charged with serious crime appropriately dealt with against an abbreviated and expedient scheme that is oriented towards a therapeutic outcome. The importance of determining significant criminal matters should not be overlooked.[62]

13.44 The NSW Bar Association noted that the challenge in relation to the extension of s 32 is ensuring that adequate supports are available to defendants who are diverted. The Bar Association further noted that a model such as we proposed in Chapter 12 could assist.[63] Such an approach would assist in case management and coordination, as well as supervision and enforcement.[64] In Chapter 7 we make a number of recommendations aimed at expanding the supports available to the court and defendants with cognitive and mental health. In Chapter 12 we recommend the establishment of a specialist list for particular defendants with cognitive and mental health impairments in the Local and District Courts.

The question of seriousness

13.45 The seriousness of the offence is clearly a most important consideration in relation to diversion in higher courts. This was a significant factor in the submission of the NSW Police Force, and weighed strongly in favour of its submission not to extend the diversionary powers of the court.

13.46 Other stakeholders agreed that the issue was important, but nevertheless took a different approach, arguing that the seriousness of the offence could be a matter to be taken into account by the court in deciding whether or not to make diversionary

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59. Shopfront Youth Legal Centre, *Submission MH7*, 13-14.
60. Shopfront Youth Legal Centre, *Submission MH7*, 14.
61. NSW Health, *Submission MH15*, 18.
62. NSW Police Force, *Submission MH47*, 20.
63. NSW Bar Association, *Submission MH10*, 61.
64. NSW Bar Association, *Submission MH10*, 61.

orders. The ODPP argued that the inclusion of criteria that should be taken into account, such as the seriousness of the offence, "would assist in striking the right balance".[65] The Brain Injury Association of NSW noted that since seriousness of the offence has been considered a relevant factor in determining whether it is appropriate to divert under s 32, it is unlikely that the provision will be used with any frequency in the higher courts.[66]

13.47 The NSW Mental Health Review Tribunal pointed out that the District Court does deal with some less serious offences that may be suitable for s 32 diversion:

> With regard to the superior courts, we are increasingly seeing a wider range of offences among those found not guilty by reason of mental illness including relatively low level offences such as send threatening letters and making false accusations against police. In appropriate cases the higher courts should be able to divert the patient, rather than them entering the forensic mental health system which is geared to managing people of a much higher risk of harm to others.
>
> This presents particular problems in light of the current one size fits all forensic mental health system. As these individuals are often not in need of such intensive care and treatment they are not prioritised for placement in the forensic mental health facilities. This absurdly results in them spending longer periods waiting to move through the system.[67]

13.48 The Intellectual Disability Rights Service, in its guide to making a s 32 application, provides examples of situations where the offence was, on the face of it, a serious offence but the defendant's disability shed quite a different light on the assessment of seriousness.[68]

Case Study 13.1

Tim was a great fan of the cops and robbers TV genre and was picked up in a siege-type situation for attempting to hold up a local news agency with a replica pistol. Tim's behaviour was clearly naïve rather than criminal. He was acting out a game based on a favourite TV show rather than acting on any intention to commit an armed robbery. After an interview with Tim's mother and hearing submissions from IDRS about the effects of his disability, the police exercised their discretion and decided not to lay charges. If charges had been laid, the matter may well have ended up in the District Court.[69]

13.49 If Tim's case had indeed been dealt with in the District Court it may have been an appropriate case for diversion, despite the apparent seriousness of the charge.

65. NSW, Office of the Director of Public Prosecutions, *Submission MH5*, 15.
66. Brain Injury Association of NSW, *Submission MH19*, 28.
67. NSW, Mental Health Review Tribunal, *Submission MH48*, 6.
68. Intellectual Disability Rights Service, *Step by Step Guide to Making a Section 32 Application for a Person with Intellectual Disability* (2011) 20 - 21.
69. Intellectual Disability Rights Service, *Step by Step Guide to Making a Section 32 Application for a Person with Intellectual Disability* (2011) 20.

The Commission's view

13.50 We agree with the weight of submissions that the seriousness of the offence is an important factor in relation to the issue of whether the s 32 and s 33 diversionary powers should be available to the higher courts. On balance, however, we are of the view that these powers should be available. Although they may be used infrequently, there will be cases in which diversion is the most appropriate response to even ostensibly serious offending behaviour.

Section 32

13.51 The seriousness of the offence should be a matter that the court takes into account when deciding whether or not to use its diversionary powers. In Chapter 9 we recommend a list of factors that should be weighed in the balance when deciding whether and how a defendant should be diverted under s 32. A relevant consideration is the "nature, seriousness and circumstances of the alleged offence".[70] This test will provide the courts with discretion to weigh the seriousness of the alleged offence alongside other relevant considerations.

13.52 Furthermore, the changes we recommend to s 32 will make that section more amenable to use in the higher courts because the courts would have a range of options, from simple discharge to intensive court monitoring of the defendant's engagement with a diversion program. Furthermore, s 32 could provide an efficient and more appropriate alternative to the complex fitness regime at higher court level in some instances.

13.53 The options available under s 32 are complemented by our recommendation to establish a specialist list in the District Court for people with cognitive and mental health impairments facing a serious prospect of imprisonment.

Section 33

13.54 At any stage of proceedings, before any court, a defendant may appear who is acutely mentally ill. Section 33 allows, amongst other things, for these defendants to be referred to a mental health facility. While many mentally ill persons will be identified when they first appear before Local Courts, this will not always be the case. The health of some defendants may deteriorate during the course of the proceedings, as a result of the stress of court appearances or because of other factors.

13.55 In Chapter 10 we recommend that s 33 should apply in relation to committal proceedings. This will allow courts dealing with defendants suffering from acute mental illness, and who are charged with strictly indictable offences, to have additional options available to them.[71]

13.56 It would be consistent also to provide the higher courts with the full range of options under s 33. Referral to a mental health facility may be a useful tool for higher courts

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70. Recommendation 9.2(2)(b).

71. Shopfront Youth Legal Centre, *Submission MH7*, 14; NSW Law Society, *Submission MH13*, 51; Local Court of NSW, *Submission MH4*, 13-14.

where a defendant requires in-patient treatment before returning to court. Discharge under s 33 may not be utilised very often, taking into account the likely seriousness of offences. However it may be appropriate in some cases and should be available as an option to be used at the court's discretion.

Recommendation 13.2

Sections 32 and 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW), as amended in accordance with Recommendations 9.1-10.8, should be extended to the District and Supreme Courts.

13.57 In Chapter 7 we recommend the expansion of the Statewide Community and Court Liaison Service (SCCLS) and Court Referral of Eligible Defendants Into Treatment (CREDIT) to support the Local Court in the exercise of their powers under s 32 and s 33. Higher courts will encounter similar challenges around identification and management of defendants with cognitive and mental health impairment. An important difference is in the volume of matters proceeding through the courts. For example, there were 120,662 people with matters finalised in the Local Court in 2010, whereas 3,474 people had matters finalised in the higher courts in same year.[72]

13.58 Nevertheless, the Commission is of the view that support should be provided to higher courts where required. We note that the Local Court and District Court sit in the same courthouses in outer Sydney and areas in regional NSW as well as the Downing Centre in Sydney.[73] This may simplify expansion of services in this respect. Furthermore, we note there might be capacity to identify particular defendants at committal stage in the Local Court. The relevant information and advice could be provided to both the Local Court and higher courts at an early stage.

Recommendation 13.3

The Statewide Community and Court Liaison Service and CREDIT services should be made available to the District and Supreme Courts to support those courts in making decisions in relation to defendants with cognitive and mental health impairment.

72. NSW Bureau of Crime Statistics and Research, *NSW Criminal Court Statistics 2010* (2011) 3, 12.

73. See District Court of NSW, *District Court sittings – criminal jurisdiction*, <www.districtcourt.justice.nsw.gov.au/districtcourt/courtlists/sitting_dates_crim.html>.

14. Young people and diversion

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14.1 Young people require a different response to adults when they come into contact with the criminal justice system.[1] In Consultation Paper 11 (CP 11),[2] we provided an overview of the particular considerations that apply to young people with a cognitive or mental health impairment in the criminal justice system.

14.2 Throughout the criminal justice system, both at the time of initial police involvement and at court, there is a focus on diversion of young people. However, there are few options that respond specifically to the needs of young people with cognitive or mental health impairments.

14.3 Diversionary options for young people at the pre-court stage include:

1. See NSW Legislative Council Standing Committee on Social Issues, Parliament of New South Wales, *Juvenile Justice in New South Wales* (1992) 11; Youth Justice Coalition, *Kids in Justice: A Blueprint for the 90s: Full Report of the Youth Justice Project* (1990) 35-36.
2. NSW Law Reform Commission, *Young people with cognitive and mental health impairments in the criminal justice system*, Consultation Paper 11 (2010) (NSWLR CP11).

- informal warnings and cautions under police common law powers
- warnings, cautions and youth conferencing under the *Young Offenders Act 1997* (NSW) (YOA), and
- transfer of the young person to a mental health facility under s 22 of the *Mental Health Act 2007* (NSW) (MHA).

14.4 Diversionary options available to the court include:

- caution or youth conference under the YOA
- diversion under s 32 or s 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA)
- participation in the Youth Drug and Alcohol Court,[3] and
- Youth Conduct Orders.

14.5 The YOA is the main pre-court diversionary route, and it is discussed further below.[4] It provides police with a number of diversionary options for young people. If the case of a young person is heard by a court, it will generally be the Children's Court, a specialist court where judicial officers have an understanding of young people. The Children's Court also has a number of options available to it, including diversion under the MHFPA.

14.6 We note that the Department of Attorney General and Justice is currently reviewing the YOA and the *Children (Criminal Proceedings) Act 1987* (NSW) (CCPA).[5]

14.7 A key question raised in CP 11 was whether the different qualities and needs of young people with cognitive and mental health impairments necessitate a distinct criminal justice response and, if so, what changes are required in light of this.[6]

14.8 This chapter assesses whether the criminal justice system responds to young people with cognitive and mental health impairments in a manner that is effective for their particular needs, which may be multiple and complex. We look at how the criminal justice system could be improved to provide diversionary programs that respond to the causes of offending behaviour, prevent reoffending, and integrate better with the service sector.

The rationale for diversion as it applies to young people

14.9 There is little data on young people with cognitive and mental health impairments in the criminal justice system. What research there is demonstrates significant overrepresentation of this group.[7] We analyse the relevant data in Chapter 4.[8] For

3. If the cognitive or mental health impairment is not severe.
4. Para 14.21-14.45.
5. NSW, Department of Attorney General and Justice, *Review of the Young Offenders Act 1997 and the Children (Criminal Proceedings) Act 1987*, Consultation Paper (2011).
6. NSWLRC CP11 [1.3].
7. D Indig and others, *2009 NSW Young People in Custody Health Survey: Full Report* (Justice Health and Juvenile Justice, 2011) 144.

young people, as for adults, this data provides a much clearer picture of young people who are in custody than elsewhere in the criminal justice system. For example, the 2009 Young People in Custody Health Survey studied 361 young people in custody; 87% were found to "have at least one psychological disorder"; 64% had a form of alcohol or substance disorder.[9] The results of 14% of participants indicated the "possible presence of an intellectual disability".[10] Participants also had many other significant health and social problems.[11]

14.10 As we noted in CP 11,[12] age-related neurological differences may raise particular issues for young people.[13] Adolescence is a period of great biological, psychological and social change.[14] On the one hand these differences and changes present particular challenges for the criminal justice system, because young peoples' brains are "still developing in ways that affect their impulse control and their ability to choose between anti-social behaviour and socially acceptable courses of action".[15] This may be compounded where a young person has a cognitive or mental health impairment, or an emerging impairment. It has been observed that "if the developmental context creates a specific vulnerability in its own right, then the impacts of even moderate mental illness may be magnified".[16]

14.11 On the other hand, age-related neurological differences may lead to a potentially higher capacity for rehabilitation. This capacity for rehabilitation exists because a young person's character is "not yet fully formed", and has been described as a "fundamental tenet of the juvenile justice system".[17] Evidence suggests that the

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8. Para 4.144 –4.158.
9. D Indig and others, *2009 Young People in Custody Health Survey: Full Report* (Justice Health and Juvenile Justice, 2011) 145-146.
10. D Indig and others, *2009 Young People in Custody Health Survey: Full Report* (Justice Health and Juvenile Justice, 2011) 154.
11. D Indig and others, *2009 Young People in Custody Health Survey: Full Report* (Justice Health and Juvenile Justice, 2011) 154.
12. NSWLRC CP11, Chapter 1.
13. Noetic Solutions Pty Ltd, *A Strategic Review of the New South Wales Juvenile Justice System: Report for the Minister for Juvenile Justice* (2010) [15]; NSW Auditor-General, *Addressing the Needs of Young Offenders*, Report (NSW Audit Office, 2007) 14.
14. A Day, K Howells and D Rickwood, *Current Trends in the Rehabilitation of Juvenile Offenders*, Trends and Issues in Crime and Criminal Justice No 284 (Australian Institute of Criminology, 2004) 4.
15. NSW, *Government Response to NSW Juvenile Justice Review* (2010) 3. See also T Grisso, "Juvenile Offenders and Mental Illness" (1999) 6(2) *Psychiatry, Psychology and Law* 143, 145.
16. C Lennings, *Assessment of Mental Health Issues with Young Offenders* (Paper presented at the Juvenile Justice: From Lessons of the Past to a Road for the Future Conference, Sydney, 1-2 December 2003) 4. See also NSW Auditor-General, *Addressing the Needs of Young Offenders,* Report (NSW Audit Office, 2007) 14.
17. L Steinberg and E Cauffman, "A Developmental Perspective on Serious Juvenile Crime: When Should Juveniles be Treated as Adults?" (1999) 63(2) *Federal Probation* 52, 55.

earlier the intervention in relation to mental illness, the better the outcome.[18] The same has been argued with respect to intellectual disability.[19]

14.12 These factors suggest that the arguments in favour of diversion of offenders with cognitive and mental health impairments apply with greater force to young people.[20] The Australian Institute of Criminology (AIC) reports that "rates of offending usually peak in late adolescence and decline in early adulthood" (at the age of 18 or 19 years) and that "while most juveniles grow out of crime, they do so at different rates".[21] However, some young people, who form a "small 'core'", persist with offending and are "responsible for a disproportionate amount of crime".[22] The Commission for Children and Young People has reported that almost 80% of 10-17 year olds who first offended in 1994 reoffended in the following 15 years. However, 40% of these reconvictions occurred in the first year, and the number of young people who reoffended beyond three years showed a downward trend.[23] These findings confirm the AIC's finding that offending in young people tends to peak in late adolescence (the 18-19 years range) and then decline (although some young people will continue to offend).

14.13 The promise of effective diversion is that it will prevent some of the reoffending and that it will have an impact on those young people who go on to commit multiple offences as adults. An Access Economics report on the cost effectiveness of early intervention concluded that:

> preventively oriented interventions targeted to young people aged 12-25 years have the capacity to generate greater personal, social and economic benefits than intervention at any other time in the lifespan.[24]

The evidence of high rates of cognitive and mental health impairment in young people in custody at least suggest that paying attention to effective diversion of young people with cognitive and mental health impairments may have long term benefits for the individual and society.

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18. R Hayes and others "Evidence-Based Mental Health Law: The Case for Legislative Change to Allow Earlier Intervention in Psychotic Illness" (2007) 14(1) *Psychiatry, Psychology and Law* 35, 40. See also R Kessler and others, "Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication" 62(6) *Archives of General Psychiatry* 593.
19. M Guralnic, "Early Intervention for Children with Intellectual Disabilities: Current Knowledge and Furture Prospects" (2005) 18(4) *Journal of Applied Research in Intellectual Disabilities* 313.
20. Public Interest Advocacy Centre, *Submission MH40*, 35.
21. K Richards, *What makes juvenile offenders different from adult offenders?* Trends and Issues in Crime and Criminal Justice No 409, (Australian Institute of Criminology 2011) 2.
22. K Richards, *What makes juvenile offenders different from adult offenders?* Trends and Issues in Crime and Criminal Justice No 409, (Australian Institute of Criminology 2011) 2.
23. Commission for Children and Young People, *A Picture of NSW Children* (2011) <picture.kids.nsw.gov.au/3/7/1/>.
24. Access Economics, *The Economic Impact of Youth Mental Illness and the Cost Effectiveness of Early Intervention*, Report (Orygen Research Centre 2009) iv, 53.

Police diversion

14.14 Here we consider in more detail the diversionary options that are available to police in responding to young people with a cognitive or mental health impairment.

Informal responses

14.15 One response open to police in responding to young people with an impairment is to use the common law discretion to warn or caution. This is discussed in Chapter 8, where we consider the challenges relating to its exercise, including stakeholder concerns that it may be used inconsistently, and that insufficient weight is placed on the diversion of people with impairments.[25] In relation to young people, the Law Society of NSW submitted that police use YOA options when informal warnings and cautions are more appropriate.[26]

Arrest and questioning

14.16 Legislation relating to young people generally discourages their arrest and encourages diversion from formal processes where possible. The *Law Enforcement (Powers and Responsibilities) Act 2002* (LEPRA) provides that nothing in that Act governing arrest requires a police officer to arrest a young person if application of the YOA is the more appropriate option.[27] The CCPA provides that young people should, in most circumstances, be dealt with by way of Court Attendance Notice rather than arrest.[28]

14.17 There are particular protections for young people and for people with cognitive impairments under LEPRA and the *Law Enforcement (Powers and Responsibilities) Regulation 2005* (NSW) (LEPRR).[29] Although not strictly "diversionary", these provisions entitle vulnerable people who are detained, (including people with "impaired intellectual functioning"[30] and young people under the age of 18[31]) to have a support person present when they are interviewed.[32]

14.18 In addition to legislation detailed above, the NSW Police Force has adopted the *NSW Police Force Code of Practice for CRIME (Custody, Rights, Investigation, Management and Evidence)* (CRIME). CRIME provides further guidance in relation to the arrest and questioning of young people. It specifies that a young person should be interviewed at home when possible;[33] provides a list of indicators to assist

25. Para 8.43-8.46, 8.50-8.53.
26. Law Society of NSW, *Submission MH36*, 10.
27. *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW) s 108.
28. *Children (Criminal Proceedings) Act 1987* (NSW) s 8.
29. *Law Enforcement (Powers and Responsibilities) Regulation 2005* (NSW) cl 23, 24.
30. *Law Enforcement (Powers and Responsibilities) Regulation 2005* (NSW) cl 24(1)(b).
31. *Law Enforcement (Powers and Responsibilities) Regulation 2005* (NSW) cl 23, 24.
32. *Law Enforcement (Powers and Responsibilities) Regulation 2005* (NSW) cl 26.
33. NSW Police Force, *Code of Practice for CRIME (Custody, Rights, Investigation, Management and Evidence)* (2010) 85.

in identifying a person with "impaired intellectual functioning";[34] and notes that if police "suspect" that a person is a vulnerable person, they should take "immediate" steps to contact a support person.[35]

Improving procedural protections?

14.19 In CP 11 we asked whether additional protections are required where young people with cognitive or mental health impairments are arrested and/or questioned by police.[36] The NSW Police Force submitted that existing protections for vulnerable people, including young people with cognitive and mental health impairments are "robust",[37] and argued that no additional protections were required.[38] However, other stakeholders indicated that procedural protections are not always followed. For instance a number of stakeholders noted that police sometimes arrest and interview young people prior to using YOA options, although this is not essential for the operation of the YOA.[39] One submission suggested that police should encourage admissions outside of a police station,[40] without the need for a lengthy or formal interview. We note that CRIME already provides guidance on this.[41]

14.20 In Chapter 8, we recommend the further development of police training in relation to the recognition of cognitive and mental health impairments.[42] Identification of impairments is necessary if procedural protections are to be applied. This recommendation will benefit young people as well as adults.

Young Offenders Act

Scope and effectiveness of YOA diversionary options

14.21 The YOA establishes a scheme to divert young people away from the formal court system in certain circumstances.[43] We note that the YOA is currently under review by the Department of Attorney General and Justice.[44] The Act provides police with three diversionary options:[45] warnings, cautions, and conferences.[46] A YOA caution

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34. NSW Police Force, *Code of Practice for CRIME (Custody, Rights, Investigation, Management and Evidence)* (2010) 144.
35. NSW Police Force, *Code of Practice for CRIME (Custody, Rights, Investigation, Management and Evidence)* (2010) 27.
36. NSWLRC CP11, Question 11.14(1).
37. NSW Police Force, *Submission MH42*, 10.
38. NSW Police Force, *Submission MH42*, 10.
39. Shopfront Youth Legal Centre, *Submission MH41*, 10; Law Society of NSW, *Submission MH36*, 11; Young people roundtable, *Consultation MH13.*
40. Shopfront Youth Legal Centre, *Submission MH41*, 10.
41. NSW Police Force, *Code of Practice for CRIME (Custody, Rights, Investigation, Management and Evidence)* (2010) 85.
42. Recommendation 8.6.
43. *Young Offenders Act 1997* (NSW) s 3. See also NSWLRC CP11 [4.3].
44. NSW, Department of Attorney General and Justice, *Review of the Young Offenders Act 1997 and the Children (Criminal Proceedings) Act 1987*, Consultation Paper (2011).
45. *Young Offenders Act 1997* (NSW) s 9.
46. *Young Offenders Act 1997* (NSW) s 9(1).

may only be issued, and a youth justice conference may only be held, after a young person has admitted to an offence.[47]

14.22 An authorised police officer, including a Specialist Youth Officer, may issue a caution.[48] Since 2002, a young person may not be dealt with by way of caution if he or she has already received three cautions.[49] Where a police officer is not satisfied that a young person is eligible to be dealt with by way of warning or caution, the matter is referred to a Specialist Youth Officer who decides whether it should be referred to youth justice conferencing or whether criminal proceedings should be commenced.[50] Cautions are also available as a diversion or sentencing option for the court,[51] and a court may refer a young person to youth justice conferencing.[52]

14.23 The NSW Police Force *Youth Policy Statement* encourages the diversion of young people from court by use of the YOA.[53] A 2010 review of the NSW juvenile justice system reported that 50% of outcomes following police contact with young people involve these diversionary options.[54]

14.24 In CP 11 we asked whether the objects of the YOA are being achieved in relation to young people with cognitive or mental health impairments, and whether any amendments are required.[55] Shopfront Youth Legal Centre (Shopfront) submitted:

> We suspect that *Young Offenders Act* options are being under-utilised for young people with cognitive and mental health impairments. This could be due to a number of factors, including perceived unsuitability and instability, past behaviour which has led to involvement with the juvenile justice system and breaches of bail conditions.[56]

Capacity

14.25 Both cautions[57] and youth justice conferencing[58] require consent. However, if a young person has a cognitive or mental health impairment, the young person's level of understanding of, and ability to participate in, the process may be reduced, and the young person may require more support in making this choice. This is particularly true in relation to conferencing which, although informal, is complex in nature and is a process unlikely to be familiar to most young people.

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47. *Young Offenders Act 1997* (NSW) s 19(b), 36(b).
48. *Young Offenders Act 1997* (NSW) s 27(1).
49. *Young Offenders Act 1997* (NSW) s 20(7).
50. J Chan (ed), *Reshaping Juvenile Justice: The NSW Young Offenders Act 1997* (Sydney Institute of Criminology, 2005) 24; *Young Offenders Act 1997* (NSW) s 9(1), (2).
51. *Young Offenders Act 1997* (NSW) s 31.
52. *Young Offenders Act 1997* (NSW) s 40.
53. NSW Police Force, *Youth Policy Statement*, 9 <www.police.nsw.gov.au/__data/assets/file/0016/4345/Youth_Policy_Statement.pdf>.
54. Noetic Solutions Pty Ltd, *A Strategic Review of the New South Wales Juvenile Justice System: Report for the Minister for Juvenile Justice* (2010) [58].
55. NSW Law Reform Commission, *Young People with Cognitive and Mental Health Impairments in the Criminal Justice System,* Consultation Paper 11 (2010) [Question 11.13].
56. Shopfront Youth Legal Centre, *Submission MH41*, 10.
57. *Young Offenders Act 1997* (NSW) s 19.
58. *Young Offenders Act 1997* (NSW) s 36(c).

14.26 Capacity to participate effectively in a conference is also important. The YOA makes provision for young people with a "communication or cognitive disability" to be assisted during these processes through the provision of an "appropriately skilled person".[59] A conference brings together a young offender with the victim. It may develop an "outcome plan" that requires the offender to deliver an apology, make reparation or participate in a program, including counselling.[60] One of the principles of youth justice conferencing is to "promote acceptance by the child concerned of responsibility for his or her own behaviour".[61] Sanctions applied through a conference should "assist children to accept responsibility for offences".[62]

14.27 It is recognised that the effectiveness of conferencing may be impacted by age and cognitive skills:

> To accept responsibility for offending, a young person has to have an understanding that offending has caused harm or loss to another. The ability to understand is affected by factors such as age, moral development and cognitive skills. The younger a person is, the less likely they may be to understand the impact of their behaviour. Likewise, a young person who has a learning or intellectual disability may experience difficulties in appreciating the wrongdoing and loss involved in offending.[63]

14.28 Conference conveners are assisted by an "Additional Support Needs Checklist" in identifying young people who need additional support.[64] As a response to their impairment and the demands of the caution or conference process, young people with "a communication or cognitive disability" may be provided with the assistance of an "appropriately skilled person." Juvenile Justice, the body that administers youth justice conferences, say that the chief role of the appropriately skilled person in relation to the young person is to:

- help the person understand conference proceedings
- participate in the process to maximum extent of their capacity
- support the person to be understood by others, and
- provide emotional support.[65]

14.29 Juvenile Justice submitted that the phrase "appropriately skilled person" is not legislatively defined, and consequently, "people acting in this role may not have the required skill to appropriately support a conference participant with a communication or cognitive disability".[66] A further submission also noted that "terminology used in the legislation is currently too generic" and pointed to the importance of "extensive training and specialisation".[67] However, Juvenile Justice

59. *Young Offenders Act 1997* (NSW) s 29(2), 47(2)(c).
60. *Young Offenders Act 1997* (NSW) s 52.
61. *Young Offenders Act 1997* (NSW) s 34(1)(a)(i).
62. *Young Offenders Act 1997* (NSW) s 34(1)(b)(iii).
63. Queensland Government, Department of Communities, *Youth Justice Conferencing Queensland: Restorative Justice in Practice* (2010) 98. See NSWLRC CP11 [4.9].
64. Department of Human Services NSW (Juvenile Justice), *Submission MH35,* 16-17.
65. Department of Human Services NSW (Juvenile Justice), *Submission MH35,* 16.
66. Department of Human Services NSW (Juvenile Justice), *Submission MH35,* 18.
67. Alcohol and Other Drugs Council of Australia, *Submission MH32*, 9-10.

told us that the Criminal Justice Support Network assists those with an intellectual disability in relation to youth conferencing.[68] This Network is a service of the Intellectual Disability Rights Service. It provides a network of trained volunteers who assist people with intellectual disabilities at different stages of the criminal justice system.

14.30 We note in comparison the terminology used in LEPRR which provides that a person may be a support person for a vulnerable detained person if that support person "has expertise in dealing with vulnerable persons of the category, or a category, to which the detained person belongs".[69] The LEPRR terminology appears to identify with greater precision the skills required. We recommend adoption in the YOA of terminology based on the LEPRR provision.

Recommendation 14.1

The provisions of the *Young Offenders Act 1997* (NSW) that refer to an "appropriately skilled person" who can provide support to a young person in caution or conference processes (s 28(g), 29(2) and 47(2)(c)) should be amended to refer to "a person with expertise in dealing with young people with the particular disability".

14.31 Although the provision of appropriate supports may assist some young people there will be others who do not have the capacity to participate in YOA processes in a meaningful way, even with this assistance. Other options may be more appropriate for these young people. We discuss a "pre-court diversion mechanism" below.

Admissions

14.32 As noted above, a YOA caution may only be issued, and a youth justice conference may only be held, after a young person has admitted committing the relevant offence.[70] Admission, followed by caution or conference, may be the best option for young people with cognitive or mental health impairments in that it will enable them to avoid potentially stressful court appearances.

14.33 However, submissions raised concerns about young people making admissions and the dilemmas of lawyers who advise them. Shopfront Youth Legal Centre put the point this way:

> There is…a very understandable reluctance on the part of children's lawyers to advise a young person to admit an offence (a pre-condition for a caution or conference) where the lawyer is concerned about the young person's mental state or cognitive ability.
>
> Conversely, there may be young people being inappropriately dealt with under the *Young Offenders Act*, for example, admitting to offences for which they had no [criminal intention] and would not be found guilty by a court.[71]

68. Department of Human Services NSW (Juvenile Justice), *Submission MH35,* 17.
69. *Law Enforcement (Powers and Responsibilities) Regulation 2005* (NSW) cl 26(b)(iii). We note this clause applies to adults. Nonetheless the terminology remains helpful.
70. *Young Offenders Act 1997* (NSW) s 19(b), 36(b).
71. Shopfront Youth Legal Centre, *Submission MH41*,10. See also Law Society of NSW, *Submission MH36,* 10.

14.34 The NSW Police Force noted that the requirement of an admission is "the primary impediment to police initiated diversions".[72]

14.35 Juvenile Justice suggested the use of a "mandatory cooling off period" prior to participating in a police interview, in order to allow the young person to seek advice or assistance.[73] The Young Offender Legal Referral scheme, currently available in Campbelltown and Macquarie Fields,[74] uses this model.[75] Under the Young Offenders Legal Referral (YOLR) protocol police notify a legal representative, such as a representative of the Aboriginal Legal Service, when a young person comes into contact with police in relation to a YOA offence. The young person is then released and usually given between 7–21 days to obtain legal advice before they are required to reappear at a police station.[76]

14.36 In our 2005 *Young Offenders* report, we noted limitations to this protocol, as it was not provided for in legislation. We recommended that an admission should be not considered valid unless "the admission is made, and consent given, after the child has received legal advice or has had a reasonable opportunity to receive legal advice".[77] We made no reference to the application of this protocol to young people with cognitive or mental health impairments.

14.37 The short delay for advice provided by the YOLR protocol could allow an informed decision to be made in favour of police cautions, particularly for young people with cognitive and mental health impairments. It could reduce the number of young people who appear in the Children's Court and receive a caution from the court.[78] If effective, this could relieve court resources. Juvenile Justice submitted that "state-wide application of [the YOLR] scheme would be highly advantageous."[79] The NSW Police Force is currently evaluating the YOLR scheme.[80]

14.38 Adoption of the YOLR scheme will not resolve the need for lawyers to make difficult judgements where there are concerns about a young person's capacity to form the mental element of the alleged offence. A lawyer in this situation may seek to convince police to drop the charges on the basis of lack of criminal intention, or may provide advice on the consequences of admissions or going to court. The pre-court diversion option, discussed below,[81] may be useful in this situation.

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72. NSW Police Force, *Submission MH42*, 9.
73. Department of Human Services NSW (Juvenile Justice), *Submission MH35,* 15.
74. NSW, Juvenile Justice, *Review of the Young Offenders Act 1987 and the Children (Criminal Proceedings) Act 1987: Submission* (2011) <www.lpclrd.lawlink.nsw.gov.au/agdbasev7wr/lpclrd/documents/pdf/djj.pdf>.
75. Department of Human Services NSW (Juvenile Justice), *Submission MH35,* 17.
76. NSW, Department of Attorney General and Justice, *Review of the Young Offenders Act 1997 and the Children (Criminal Proceedings) Act* 1987, Consultation Paper (2011) 27.
77. NSW Law Reform Commission, *Young Offenders*, Report 104 (2005) Recommendation 5.2.
78. NSW Police Force, *Review of the Young Offenders Act 1987 and the Children (Criminal Proceedings) Act 1987: Submission* (2011) 4 <www.lpclrd.lawlink.nsw.gov.au/agdbasev7wr/lpclrd/documents/pdf/nswpf.pdf>.
79. Department of Human Services NSW (Juvenile Justice), *Submission MH35,* 18.
80. NSW Police Force, *Review of the Young Offenders Act 1987 and the Children (Criminal Proceedings) Act 1987: Submission* (2011) 4 <www.lpclrd.lawlink.nsw.gov.au/agdbasev7wr/lpclrd/documents/pdf/nswpf.pdf>.
81. See para 14.46-14.54, Recommendation 14.4.

Recommendation 14.2

The Department of Attorney General and Justice should, as part of its review of the *Young Offenders Act 1997* (NSW), consider options to ensure that young people with cognitive and mental health impairments have adequate support and legal advice before making an admission, including the expansion of the Young Offenders Legal Referral scheme or amendment of the *Young Offenders Act 1997* (NSW).

Limits on cautions

14.39 Since 2002, young people may not be dealt with by way of caution if they have already received three cautions.[82] The reason for this three-caution limit is that: "three cautions are sufficient and a more intensive form of intervention may be needed".[83] As was noted in the second reading speech to the amendment that imposed the limit:

> …there is a perception among some members of the public that juveniles who repeatedly offend are being treated too leniently under the Act. While the Government does not believe there is strong evidence to support this perception, limiting the number of cautions a young offender can receive should address some community concerns in this regard.[84]

14.40 In our 2005 report on *Young Offenders* we expressed concern that:

> fettering the ability to caution conflicts with the aims of the YOA as set out in s 3, especially the aim of providing an efficient and direct response to the commission of certain offences by children. We are also concerned that limiting the number of cautions conflicts with the guiding principles of the YOA as set out in s 7, especially the principle that the least restrictive form of sanction is to be applied against a child who is alleged to have committed an offence.[85]

The 2010 Noetic Review of the juvenile justice system stated that the 2002 changes appeared to have been made without a sound evidentiary base. The Noetic review noted that 58% of young people did not go on to reoffend within 5 years of receiving a caution, suggesting the caution was an effective diversionary mechanism.[86]

14.41 One submission to this reference noted that a "limit on the number of cautions is not appropriate for many with cognitive impairments" and "considerably limits the aims of diversion".[87]

14.42 In some circumstances, repeated cautioning may be appropriate for young people with cognitive and mental health impairments. Their impairment may mean that they have difficulty in understanding that their behavior is wrong or in controlling their offending behavior. They may have made admissions in relation to offences for

82. *Young Offenders Act 1997* (NSW) s 20(7).
83. NSW, *Parliamentary Debates,* Legislative Council, 20 June 2002, 3495 (Eddie Obeid).
84. NSW, *Parliamentary Debates,* Legislative Council, 20 June 2002, 3495 (Eddie Obeid).
85. NSW Law Reform Commission, *Young Offenders*, Report 104 (2005) [6.10].
86. Noetic Solutions Pty Limited, *A Strategic Review of the New South Wales Juvenile Justice System: Report for the Minister for Juvenile Justice* (2010) [180].
87. The Multicultural Disability Advocacy Association of NSW, *Submission MH30*, 7.

which they did not have the necessary criminal intention, and consequently they may have "used up" their three cautions.

14.43 It appears that the three-caution limit may be a problem generally for young people. We believe that it is a particular problem in relation to young people with cognitive and mental health impairments.

14.44 We recommend that s 20(7) of the YOA be amended to permit the three caution limit to be exceeded when it appears to a police officer or court[88] that a young person has a cognitive or mental health impairment.

14.45 It appears preferable in this context to require that a young person "appear" to have a cognitive or mental health impairment (in conformity with s 32 and s 33 of the MHFPA) rather than requiring a formal assessment. Police do not have the skills to make a diagnosis of an impairment.[89] Formal assessment can be expensive and time consuming. However, there will no doubt be many cases where the impairment will be immediately apparent, the defendant will be known to police, or informal methods of establishing an impairment, such as telephone contact with a service provider, will suffice.

Recommendation 14.3

Section 20(7) of the *Young Offenders Act 1997* (NSW) should be amended to allow the three caution limit to be exceeded when it appears to a police officer, or court, that a young person has a cognitive impairment or a mental health impairment.

A further option for pre-court diversion?

14.46 Pre-court diversion has been long recognised as an important feature of the criminal process for young people and is provided for in the YOA.

14.47 In assessing whether the YOA is a sufficient vehicle for diversion of young people with a mental health and cognitive impairment some submissions raised concerns, in particular, that the requirement of an admission may act as a potential barrier to accessing diversion. There may be an issue in some cases of the ability to consent to diversionary measures under the YOA. In addition, the ability of a young person in this situation, even with good support, to participate in the Youth Justice Conference, may be impeded by their impairment. We have discussed these issues above.[90]

14.48 There is a paucity of good data about the prevalence of cognitive and mental health impairment at the police and court stage, but we have data that shows a clear overrepresentation in detention centres and on community orders.[91]

88. Cautions and referral to youth justice conferences are available to the court: *Young Offenders Act 1997* (NSW) s 31, 40.

89. Para 8.58.

90. Para 14.21-14.25.

91. Para 4.144-4.158.

14.49 It is important that effective options are available to divert young people with cognitive and mental health impairments at each stage. Section 32 of the MHFPA provides a vehicle for courts to divert to services that avoids the need for admissions. However, there is no similar option for police, if the YOA options of warnings, cautions and conferences are not suitable or effective for the young person in question, and diversion to services is required.

14.50 In our view there should be a further option for pre-court diversion for young people with a cognitive or mental health impairment, based on the pre-court scheme that we recommend should apply to adults in Chapter 8. It should not require an admission, or participation in a conference.

14.51 Under this option, police would be able to discontinue charges taking into account factors including:

- the apparent nature of the person's cognitive or mental health impairment
- the nature, seriousness and circumstances of the alleged offence
- the person's history of offending, if any, and
- the availability of treatment, intervention or support in the community.[92]

14.52 In relation to the first factor, police may need access to an assessment service. In relation to the last factor, the police should be able to refer the young person to a service that would connect them with programs to address their offending behaviour. In broad terms we consider that police should have access to the same services that are available to courts in this regard.[93]

14.53 Currently, the YOA framework for pre-court diversion is hierarchical – requiring police to consider the options in order of intensity. Our proposed additional option would need to sit outside this hierarchy, and be an alternative for young people with cognitive and mental health impairments. Nonetheless, the relationship with the YOA options would need to be specified in legislation, and clear guidance provided to police on how they interrelate. Further work and consultation will be needed to develop this option and the appropriate relationship between it and the YOA options.

14.54 Currently, we note that the Department of Attorney General and Justice is reviewing the YOA and the CCPA. This could be an appropriate vehicle to consider these issues, since they go to the operation of the YOA. Alternatively a separate process may need to be undertaken.

Recommendation 14.4

(1) Legislation should provide a specific pre-court diversionary option for young people with a cognitive or mental health impairment based on Recommendation 8.3 (applying to adults).

92. Para 8.72-8.77.
93. Para 14.55-14.88.

(2) The Department of Attorney General and Justice should lead further work in consultation with relevant agencies and stakeholders to develop this option and determine the relationship between this option and the pre-court diversionary options under the *Young Offenders Act 1997* (NSW).

(3) Police should have access to assessment and the case management services provided to the Children's Court, as set out in Recommendation 14.5.

Assessment and court support

14.55 In Chapter 7 we outlined the importance of assessment and court support, and recommended the expansion of the Statewide Community and Court Liaison Service (SCCLS) and the Court Referral of Eligible Defendants Into Treatment (CREDIT) case management and court support scheme for adults. Here we consider what approach to assessment and court support is most appropriate for young people, considering their particular needs, and the existing provisions that apply to young offenders.

The Children's Court

14.56 Assessment and court support services for young people operate within the framework of the NSW Children's Court, a specialist court which handles criminal cases involving young people, as well as matters regarding the care and protection of young people. As we discussed in CP 11,[94] the establishment of the Children's Court recognises and responds to, the special needs of young people in the legal system.[95] In general, children's courts assist in keeping young people charged with offences separate from adults and strive to apply speedier, age-appropriate procedures.[96] A person is qualified to be appointed as a children's magistrate if the person is a magistrate with "knowledge, qualifications, skills and experience in the law and the social or behavioural sciences, and in dealing with children and young people and their families".[97]

14.57 The Children's Court is a specialist court that focuses on young people generally. The question that arises here is whether or not it is well equipped to deal with young people who have cognitive and mental health impairments.

The challenges of identification and service delivery

14.58 We have discussed the importance of identifying adults with cognitive and mental health impairments in Chapters 7 and 8. The accurate identification of these impairments can lead to diversion and the provision of services.

94. NSWLRC CP11 [1.46]-[1.49].
95. See, eg, S Vignaendra and G Hazlitt, *The Nexus Between Sentencing and Rehabilitation in the Children's Court of NSW*, Research Monograph 26 (Judicial Commission of NSW 2005) vii.
96. A Borowski and I O'Conner (ed), *Juvenile Crime, Justice and Corrections* (Longman, 1997) 304.
97. *Children's Court Act 1987* (NSW) s 7(2).

14.59 The first challenge is that of identifying which young people have impairments. Data from the Young People in Custody Health Survey report,[98] demonstrates that most young people in custody have an impairment of some type. It is likely that a significant percentage of young people in the criminal justice system will have a cognitive or mental health impairment of some kind. However, it was submitted to us that many young people will have had limited contact with assessment procedures prior to entering the criminal justice system,[99] and there may not be a an available record of previous assessment or treatment. Assessment of a young person's impairments may therefore take place for the first time when they are held on remand. Justice Health conducts a first assessment within the first 24 hours, and a more comprehensive assessment within 10 days. Young people not held on remand may be assessed for the first time by the Adolescent Court and Community Team (ACCT), discussed below.[100] Some of the practical difficulties in creating screening procedures to identify more young people are discussed in an evaluation of the ACCT conducted by the NSW Bureau of Crime Statistics and Research (BOCSAR).[101]

14.60 The second challenge relates to the accurate identification of a cognitive or mental health impairment in a young person, because of the emerging nature of some impairments in young people. One submission pointed out that, because young people are still developing, diagnosis of an impairment is "often varied" and is "never likely to be as precise as a physically mature adult":[102]

> This has consequences in a system where to qualify for diversionary options, the law requires a certain diagnosis and a detailed treatment plan to fit the diagnosis. Law and policy should adjust to take account of this conundrum. Any accused person, particularly a young accused person, should not be disqualified [from] diversionary programs because of perceived imprecise or uncertain diagnoses.[103]

14.61 The third challenge is the availability of services for young people in the community. A number of submissions argued that the criminal justice system is increasingly being used as a route to services for young people because of a lack of community-based services.[104] One mental health expert described youth mental health services as "threadbare and split across multiple levels of government, multiple program areas, and myriad cash-strapped service providers".[105] Submissions stated that

98. Para 14.9. See further para 4.144 –4.158.
99. Illawarra Legal Centre, *Submission MH39*, 1.
100. Para 14.65-14.69.
101. D Bradford and N Smith, *An Evaluation of NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 55.
102. Public Interest Advocacy Centre, *Submission MH40*, 8.
103. Public Interest Advocacy Centre, *Submission MH40*, 8-9.
104. Legal Aid NSW, *Submission MH38*, 2; Children's Court of NSW, *Submission MH43*, 2; Law Society of NSW, *Submission MH36*, 1; Shopfront Legal Centre, *Submission MH41*, 10.
105. P McGorry and others, "Editorial: Investing in Youth Mental Health is a Best Buy" (2007) 187(7) *Medical Journal of Australia* S5, S6.

services for young people with cognitive and mental health impairment should be enhanced.[106] For instance, the Children's Court of NSW submitted:

> [t]he greatest need is for the provision of more and better-targeted services. Changes to the legal provisions will only be a very small part of adequately addressing the needs of young people with mental and cognitive impairments who are involved in the criminal justice system.[107]

14.62 Young people with complex needs face particular problems in accessing services. One community legal centre submitted that a "significant number of young people within the juvenile justice system" are experiencing substance abuse problems, homelessness or loss and grief that "leave them vulnerable to developing mental health problems".[108] The Public Interest Advocacy Centre (PIAC) submitted that problems with diagnosis of impairments and access to diversionary programs is:

> complicated by the prevalence among young people of co-morbidities of early stages of several or more mental illnesses or mental disorders, the most common instance being drug or alcohol addiction or abuse coupled with another disorder.

14.63 PIAC said that this was the case because the "health system usually has different paths of treatment and care for drug and alcohol problems as distinct from the treatment of mental illness".[109] It submitted that this is a particular problem with young people because early treatment is vital.[110]

14.64 It has been argued in Victoria that services, provided at an early stage, and capable of addressing complex needs, are particularly important and effective in reducing offending behaviour and recidivism among young people. These services should take into account the needs of young people, for instance they should involve family where possible, be age appropriate, and provide continuity between adolescence and adulthood.[111]

Current approaches in NSW

14.65 In Chapter 7 we described the SCCLS and the services it provides in relation to people with mental illness in the Local Court.[112] The ACCT provides a similar program for young people including providing assessments and reporting to the Children's Court.[113] It is currently providing a service at nine Children's Court

106. See, eg, Shopfront Youth Legal Centre, *Submission MH41*, 2-3; Public Interest Advocacy Centre, *Submission MH40*, 33-34; Law Society of NSW, *Submission MH36*, 1; Legal Aid NSW, *Submission MH38*, 6; Children's Court of NSW, *Submission MH43*,10.
107. Children's Court of NSW, *Submission MH43*, 14.
108. Illawarra Legal Centre, *Submission MH39*, 1.
109. Public Interest Advocacy Centre, *Submission MH40*, 9.
110. Public Interest Advocacy Centre, *Submission MH40*, 9.
111. Justice Health, Victorian Government Department of Justice and the National Justice Chief Executive Officers' Group, *Diversion and Support of Offenders with a Mental Illness: Guidelines for best practice* (2010) 80.
112. Para 7.15-7.26.
113. D Bradford and N Smith, *An Evaluation of NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) vii.

locations. There are plans for expansion to 12 locations.[114] However, this will still leave a service gap, as the Children's Court sits at 25 locations.[115]

14.66 The ACCT program is available to young people aged 12-18 years who have committed non-indictable offences.[116] The Justice Health Adolescent Health Service runs the service.[117] It accepts referrals from other court-based agencies in order to conduct clinical assessments and provide court liaison services. The ACCT is staffed by a service manager, the clinical director for adolescent mental health and a consulting psychiatrist. In addition, clinical nurse consultants or mental health clinicians are based at the courts on a part-time basis.[118] Similar to the SCCLS, the ACCT does not provide case management.

14.67 The ACCT differs from the SCCLS in that:

- There is no pre-screening component, although assessments are carried out.
- Staff have particular skills in child and adolescent mental health, and risk management.[119]
- The ACCT provides community health and drug and alcohol components in addition to court-based programs.

14.68 The ACCT also refers young people to other services which can develop treatment plans. It does not write these plans itself, but can advise those services on the content of plans.

14.69 In 2009 BOCSAR provided a report on court liaison services including the ACCT.[120] This qualitative analysis found that "the service is generally successful in achieving diversion".[121] Quantitative analysis was not available due to the short time between program implementation and review. Consequently, analysis of the rates of contact with the criminal justice system after receiving services through the ACCT was not possible.[122] It would be useful for an analysis of this kind to be carried out in light of the time that has passed since the introduction of the service.

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114. Justice Health, *Year in Review 2010/11* (2011) 28. At the time of the BOCSAR evaluation, the ACCT was only available in 5 Children's Courts: D Bradford and N Smith, *An Evaluation of NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) vii.
115. Children's Court, *About Us* (14 August 2009) <www.lawlink.nsw.gov.au/lawlink/childrens_court/ll_cc.nsf/pages/CC_about_us>.
116. NSWLRC CP11 [4.25]. See also D Bradford and N Smith, *An Evaluation of NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 11.
117. Justice Health, *Year in Review 2010/2011* (2011) 6.
118. D Bradford and N Smith, *An Evaluation of NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 11.
119. Justice Health, *Year in Review 2010/2011* (2011) 18.
120. D Bradford and N Smith, *An Evaluation of NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 46.
121. D Bradford and N Smith, *An Evaluation of NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 46.
122. D Bradford and N Smith, *An Evaluation of NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 12.

14.70 There is a Children's Court Clinic.[123] However it does not play a part in criminal proceedings. The *Children and Young Persons (Care and Protection) Act 1998* (NSW) provides that the Children's Court may make an order for the "physical, psychological, psychiatric or other medical examination of a child or young person" in relation to care and protection matters.[124]

14.71 Juvenile Justice runs a Bail Supervision Program. The priority group for bail interventions are young people under the age of 14, young people of Aboriginal background and those young people "who are at significant risk of being remanded in custody due to lack of stable accommodation or are in need of other supports in the community".[125] The Bail Supervision Program can assist young people with cognitive and mental health impairments. However, it is not specifically focussed on addressing impairments of this kind. We discussed bail support programs in CP 11[126] and discuss them further in Chapter 6.[127]

14.72 The Intellectual Disability Rights Service runs the Criminal Justice Support Network, a network of trained volunteers who assist people with intellectual disabilities at different stages of the criminal justice system. For instance, they can assist people attending court by meeting them prior to court to explain what will happen.[128] The role of this service is very different from the assessment and advice services outlined above and in Chapter 7. For instance, it does not provide assessment of impairments or reports to the court.

Approaches adopted in other jurisdictions

14.73 There are mental health court support services for young people in some other Australian states. For instance, the Queensland Child and Youth Forensic Outreach Service (a service of the Royal Children's Hospital) has provided a Court Liaison Service since 2006. It is now available across 11 Children's Courts. That service differs from the ACCT in that it provides mental health screening of young people at the Children's Court, and its support is available for families. The service also differs from the ACCT in that it does not provide court reports. Further, it does not assess intellectual disability.[129]

14.74 The Children's Court in Victoria has a clinic attached to it that provides assessments of young people and reports to the court on their psychological and psychiatric wellbeing, and on drug use, in relation to both the Family and Criminal Divisions.

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123. Children's Court Clinic, *Welcome to the Children's Court* Clinic (14 March 2012) <www.lawlink.nsw.gov.au/lawlink/ccc/ll_ccc.nsf/pages/ccc_index>.
124. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 53(1)(a).
125. NSW Department of Juvenile Justice, *Annual Report 2006-2007*, 38.
126. NSWLRC CP11, Chapter 2, especially [2.57]-[2.60].
127. Para 6.54-6.61.
128. Intellectual Disability Rights Service, *CJSN support at court and court related processes* <www.idrs.org.au/_support_cjsn/cjsn_court.html>.
129. Queensland Health, *Child and Youth Forensic Outreach Service (CYFOS) Court Liaison Service* <www.health.qld.gov.au/rch/professionals/Court_Liaison_Info.pdf>.

Only limited treatment is provided.[130] No evaluations of these services in other states are available.

Is the current approach in NSW satisfactory?

14.75 As we note above, BOCSAR positively evaluated the work of the ACCT. Submissions also expressed support for the ACCT. Illawarra Legal Centre reported that the ACCT plays an "invaluable role" at the Port Kembla Children's Court and noted that ACCT expertise "appeared to assist legal practitioners assist their clients and potentially could provide an opportunity for follow up if the child had to return to court".[131]

14.76 However, stakeholders raised concerns in consultations about service provision for young people with impairments. Some of these concerns related to the need for community based services, and problems that arise when trying to locate appropriate services for young people. A lack of case management services to support the diversion of young people with cognitive and mental health impairments from the criminal justice system was identified.[132]

14.77 The Children's Court can divert young people under s 32 of the MHFPA. In Chapter 9, we recommended amending s 32 of the MHFPA to provide that a magistrate may make the following orders:

> (1) dismiss the charge and discharge the defendant unconditionally
>
> (2) dismiss the charge and discharge the defendant on the basis that a satisfactory diversion plan is in place and the defendant has demonstrated sufficient likelihood of compliance
>
> (3) adjourn the proceedings, with a view to later discharge, on condition that the defendant undertake a diversion plan and report to the court in relation to his or her progress in fulfilling the plan and substantial compliance with that plan, as required by the court.[133]

14.78 The Children's Court will therefore have available to it a range of diversionary orders, including an option (option (3) above) that permits the court to engage in judicial monitoring of diversionary orders.

14.79 In Chapter 9 we pointed to the vital role that case management services play in ensuring that s 32 orders operate effectively in relation to adults.[134] The same considerations apply to young people. A court-based case management service will be necessary to ensure that young people with impairments are able to benefit from s 32 in the same manner as adults. However, given the particular needs of young people, and the service sectors that respond particularly to the needs of young people, a case management service specific to young people appears to be desirable to perform this role.

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130. Children's Court of Victoria, *Children's Court Clinic* (2009) <www.childrenscourt.vic.gov.au>.
131. Illawarra Legal Centre, *Submission MH39*, 5.
132. Young people roundtable, *Consultation MH13.*
133. Recommendation 9.4.
134. Para 9.86-9.96.

14.80 In CP 11, we asked whether a supervised treatment or rehabilitation program should be implemented for young people with cognitive or mental health impairments.[135] There was stakeholder support for a case management model for this group, similar to CREDIT or the Magistrates Early Referral Into Treatment (MERIT).[136] Juvenile Justice said that a MERIT style program, "developed within a therapeutic jurisprudence framework" would encourage "the judiciary and associated participants to undertake relevant assessments and develop interventions that assist the young person to receive the services they require".[137] However Juvenile Justice noted that such a program would "have serious implications for agency finances" and that "it would be undesirable for responsibility to rest with Juvenile Justice". [138]

14.81 Shopfront also expressed support for a MERIT or CREDIT style program to "provide appropriate support services to young people who are awaiting the finalisation of their court matters". It proposed that successful completion of a program could lead to either outright dismissal, or a dismissal under s 32.[139]

14.82 The Law Society of NSW suggested that such a program could operate within a legislative scheme whereby an agency with appropriate resources is mandated to provide services, including therapeutic interventions.[140]

Commission's view

14.83 We reviewed the importance of assessment and case management in Chapter 7. The arguments made in that chapter apply with even greater force in relation to young people. Effective diversion of young people with cognitive and mental health impairments to services focussed on dealing with the causes of offending behaviour has greater potential to save both human and financial costs. We also note the stakeholder support for the extension of assessment and court support programs in the Children's Court.

14.84 We support the initiative of the government to extend the availability of the ACCT, and recommend that it should be made available at all locations where the Children's Court sits. Further evaluation of this program may also provide useful data to inform further expansion.

14.85 In line with our recommendations in relation to adults, we recommend the establishment of a case management and support service that will be available to the Children's Court. It is apparent that such a service is essential to the successful diversion of young people with cognitive and mental health impairments from the criminal justice system. If our recommendations in relation to s 32 of the MHFPA are to work successfully, case management and court support services are needed.

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135. NSWLRC CP11, Question 11.21.
136. Illawarra Legal Centre, *Submission MH39*, 6; Shopfront Legal Centre, *Submission MH41*, 3; Law Society of NSW, *Submission MH36*, 3; Department of Human Services NSW (Juvenile Justice), *Submission MH35*, 22.
137. Department of Human Services NSW (Juvenile Justice), *Submission MH35*, 22.
138. Department of Human Services NSW (Juvenile Justice), *Submission MH35*, 22.
139. Shopfront Legal Centre, *Submission MH41*, 3.
140. Law Society of NSW, *Submission MH36*, 3.

14.86 The development of the service should draw from the model provided by CREDIT and MERIT, and from the experience of the ACCT, Juvenile Justice, other agencies and non-government stakeholders. However, in the absence of an existing model for young people in NSW, we make no more precise recommendations concerning the model that should be adopted or which agency should lead the development and implementation of the service. These matters require further consultation and are more appropriately determined by stakeholders with knowledge of service delivery to young people. The capacity to work collaboratively with other services associated with the court, and planning to avoid duplication will be important.

14.87 In Chapter 7 we discussed the importance of making assessment and advice services available to adults with cognitive impairments, as well as to those with mental health impairments. That point is also relevant in relation to young people. Justice system assessment and support services provided to young people should provide support both for young people with mental health impairments, and those with cognitive impairments.

14.88 We recognise that implementation of these recommendations will have significant resource implications. We also recognise that challenges may arise in rural or regional areas where courts may sit less regularly and where appropriate outreach arrangements for service delivery may need to be made to respond to local conditions.

Recommendation 14.5

(1) The Adolescent Court and Community Team should be expanded to provide assessment and support services at all locations where the Children's Court sits.

(2) A service for case management and court support for young people with cognitive and mental health impairments should be made available to the Children's Court at all its locations in NSW.

(3) The government should allocate a lead agency to develop the service recommended in (2). The Department of Attorney General and Justice, Juvenile Justice NSW, the Children's Court, the NSW Police Force, the Department of Family and Community Services, the Department of Education and Communities, Justice Health and relevant non-government stakeholders should be involved in its development.

Youth Conduct Orders

14.89 The Children's Court can impose Youth Conduct Orders (YCOs).[141] YCOs aim at diverting a young person from the "mainstream criminal justice system through participation in a diversionary program that will focus on addressing the reasons for their antisocial behaviour".[142] They target young people aged between 14 and 17 years[143] in certain Police Local Area Commands,[144] who have been charged with

141. *Children (Criminal Proceedings) Act 1987* (NSW) s 48L.

142. NSW, *Parliamentary Debates*, Legislative Council, 23 October 2008, 10489 (J Hatzistergos).

143. *Children (Criminal Proceedings) Regulation 2011* (NSW) cl 5(1)(a).

offences covered by the YOA, but for whom diversionary options under that Act are not appropriate.[145] The CCPA makes it clear that, if the YOA applies to the young person, it is generally preferred to a YCO.[146]

14.90 The scheme encourages positive conduct, such as meeting with health professionals;[147] and restricts certain forms of conduct, for instance "associating with specified persons".[148] Compliance with a YCO may result in the Children's Court dismissing the charges, or dealing with the child in the light of his or her compliance.[149] The penalty imposed by a court after revocation of a YCO should not be more severe than if the young person had never undertaken a YCO.[150]

14.91 Juvenile Justice reports that YCOs are based on a "case coordination model" of a number of agencies, and young people may access services "that assist them to address the causes of their behaviour" through YCOs. However it also reports that the purpose of YCOs is to "impose restrictions" on those who commit less serious offences, while recognising that "this group of young people clearly lacks the capacity to abide by onerous and restrictive conditions".[151]

14.92 An interim evaluation of YCOs by the Nous Group in 2010 cited concerns that young people do not have any certainty that they will receive a better outcome through participation in a YCO, and this may have a negative impact on participation rates.[152] The evaluation found that too few YCOs had been finalised to evaluate their effectiveness (there had been five at time of publication of the Nous Report), and there was no indication that the number of YCOs would increase in the near future.[153]

14.93 We asked the following questions regarding YCOs in CP 11:

(1) Are youth conduct orders an appropriate way of dealing with young people with cognitive and mental health impairments?

(2) How are youth conduct orders currently applied to young people with cognitive and mental health impairments?

(3) How can the conditions of youth conduct orders be adapted to the needs of young people with cognitive and mental health impairments?[154]

14.94 Stakeholders referred to the paucity of data available on YCOs.[155] Some submissions[156] expressed concerns about YCOs, particularly in relation to the

144. *Children (Criminal Proceedings) Regulation 2011* (NSW) cl 4, cl 5(1)(c).
145. *Children (Criminal Proceedings) Act 1987* (NSW) s 48A.
146. *Children (Criminal Proceedings) Act 1987* (NSW) s 48G(4).
147. *Children (Criminal Proceedings) Act 1987* (NSW) s 48C(1)(a)(ii).
148. *Children (Criminal Proceedings) Act 1987* (NSW) s 48C(2)(a).
149. *Children (Criminal Proceedings) Act 1987* (NSW) s 48R(2), (3).
150. *Children (Criminal Proceedings) Act 1987* (NSW) s 48Q(5).
151. Department of Human Services NSW (Juvenile Justice), *Submission MH35*, 19-20.
152. The Nous Group, *Youth Conduct Order and Anti-Social Behaviour Pilot Project: Interim Evaluation Report* (2010) 13.
153. The Nous Group, *Youth Conduct Order and Anti-Social Behaviour Pilot Project: Interim Evaluation Report* (2010) 6.
154. NSWLRC CP11, Question 11.15.

capacity of young people with a cognitive or mental health impairment to provide consent,[157] and in relation to the overall suitability of YCOs for this group.[158] For instance, Juvenile Justice submitted that the YCO scheme is not a diversionary program at all. It said that YCOs are a "court-based criminal justice response".[159]

14.95 Juvenile Justice recommended the Anti Social Behaviour Pilot Project (as it then was) as an alternative to YCOs for young people with a cognitive or mental health impairment, as this project does not require court attendance and provides support to young people and their families in accessing services.[160] The Nous Group reviewed this program alongside YCOs in their Interim Evaluation Report. It reported satisfaction resulting from increased inter-agency coordination, but noted that a more detailed evaluation of this program is to follow.[161]

14.96 A final report is due from the Nous Group in 2012. However if, as expected, there has been no significant increase in the number of YCOs, then it may be that the task of connecting young people with services and monitoring their engagement with services is better carried out through expansion of the court support program recommended. However, given the lack of data available, it is not appropriate that we make recommendations regarding YCOs at this time.

Section 32 and 33 of the MHFPA

14.97 We have already described our recommendations in relation to the expansion of s 32 of the MHFPA and provided an outline of the options that would be available if they are implemented.[162]

14.98 Here we examine some of the considerations that arise in relation to young people in the application of s 32 and s 33 of the MHFPA. We note at the outset that the NSW Police Force saw "no need for s 32 or s 33 to contain particular provisions directed at young people".[163] The Children's Court was also of the view that these sections are "appropriately drafted to deal with young people in the criminal justice system".[164]

155. Shopfront Youth Legal Centre, *Submission MH41,* 11; Children's Court of NSW, *Submission MH 43,* 8.
156. Department of Human Services NSW (Juvenile Justice), *Submission MH35*, 19; Alcohol and Other Drugs Council of Australia*, Submission MH32*, 11; Public Interest Advocacy Centre, *Submission MH40*, 33.
157. *Children (Criminal Proceedings) Act 1987* (NSW) s 48G(1)(a)(ii).
158. Alcohol and Other Drugs Council of Australia*, Submission MH32,* 11; Public Interest Advocacy Centre, *Submission MH21,* 33; Law Society of NSW, *Submission MH36,* 11; Legal Aid NSW, *Submission MH38,* 9; Shopfront Youth Legal Centre, *Submission MH41,* 11.
159. Department of Human Services NSW (Juvenile Justice), *Submission MH35*, 19.
160. Department of Human Services NSW (Juvenile Justice), *Submission MH35*, 20.
161. The Nous Group, *Youth Conduct Order and Anti-Social Behaviour Pilot Project: Interim Evaluation Report* (2010) 18.
162. Para 14.77.
163. NSW Police Force*, Submission MH42*, 12.
164. Children's Court of NSW, *Submission MH43*, 9.

14.99 Some stakeholders noted that the current diversionary provisions may be too narrowly framed for young people who do not have a clear diagnosis of their cognitive or mental health impairment, and suggested:

- adoption of a new diversionary measure that can be used for those who present with early signs of impairment, until a s 32 order is appropriate,[165] and
- application of s 32 to young people with substance abuse disorders, personality/conduct disorders, and young people who show symptoms but who lack a clear diagnosis.[166]

14.100 We believe that our recommendations in Chapter 5 address these concerns. We recommended new definitions of cognitive and mental health impairments that are wider than those currently in place. The recommended definition of a mental health impairment states:[167]

> Mental health impairment means a temporary or continuing disturbance of thought, mood, volition, perception, or memory that impairs emotional wellbeing, judgement or behaviour, so as to affect functioning in daily life to a material extent.
>
> Such a mental health impairment may comprise, but is not limited to, the following:
>
> - Anxiety disorders
> - Affective disorders
> - Psychoses
> - Severe personality disorders
> - Substance induced mental disorders.

14.101 The recommended definition of a cognitive impairment states:[168]

> Cognitive impairment is an ongoing impairment in comprehension, reason, adaptive functioning, judgement, learning or memory that is the result of any damage to, dysfunction, developmental delay, or deterioration of the brain or mind
>
> Such cognitive impairment may arise from, but is not limited to, the following:
>
> - Intellectual disability
> - Borderline intellectual functioning
> - Dementias
> - Acquired brain injury

165. Legal Aid NSW, *Submission MH38,* 8.
166. Shopfront Youth Legal Centre, *Submission MH41*, 12.
167. Recommendation 5.2.
168. Recommendation 5.1.

- Drug or alcohol related brain damage
- Autism spectrum disorders

14.102 We note that the proposed definitions are inclusive, rather than exhaustive. We also note the inclusion of substance induced disorders in the definition. There are some disorders or impairments that are specific to young people, such as conduct disorder.[169] The definitions we propose are sufficiently inclusive for clinicians to determine whether or not a child qualifies.

14.103 The CCPA provides that the Children's Court has the jurisdiction to hear proceedings in relation to any offence, other than a serious children's indictable offence; and to hear committal proceedings in relation to any offence, including a serious children's indictable offence.[170] Section 31 of the MHFPA excludes committal proceedings from the operation of s 32 and s 33.[171]

14.104 This means that currently, the Children's Court cannot use s 32 or s 33 to divert young people charged with some serious offences at the committal stage. This is unlikely to create a difficulty in relation to s 32 orders, given the serious nature of the offences concerned, but may be problematic in relation to young people who are acutely mentally ill and would benefit from an interlocutory s 33 order. This problem is resolved by a recommendation in Chapter 10 to extend the reach of s 33 to committal proceedings.

14.105 Further, we have recommended in Chapter 13 that the s 32 and s 33 powers be made available in the higher courts. That is, s 32 and s 33 may be used in appropriate cases once young people move beyond the committal stage.

A specialist list

14.106 The question arises in relation to young people, as it does in relation to adults, as to whether our recommendations in relation to diversion are sufficient, or whether a specialist court or list is desirable to provide for case management together with judicial monitoring of defendants.

14.107 The Children's Court currently administers one specialist "court", the Youth Drug and Alcohol Court (YDAC). YDAC recognises that some young people have particular needs that require more intensive supervision and case management than is available in the mainstream Children's Court.

169. Conduct disorder may be particularly difficult to diagnose as many of the diagnostic criteria relate to criminal behaviour: "the essential feature of Conduct Disorder is a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated." See American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) 99.

170. *Children (Criminal Proceedings) Act 1987* (NSW) s 28(1)(a),(b).

171. *Mental Health (Forensic Provision) Act 1990* (NSW) s 31.

Youth Drug and Alcohol Court

14.108 YDAC is a program administered under a practice note by the Children's Court[172] which aims to reduce drug and alcohol related crime by young people under the age of 18 years. It commenced in 2000,[173] and is available in the Parramatta, Bidura (Glebe) and Campbelltown Children's Courts.[174]

14.109 The purpose of YDAC is to:

> rehabilitate young offenders with alcohol and or drug problems. It seeks to address not only the legal factors, but the holistic and systemic health and welfare issues which have affected the young person's ongoing substance misuse and associated offending. The YDAC program is an integrated and collaborative initiative, which brings together the elements of the juvenile criminal justice system with various government and non-government adolescent service providers.[175]

14.110 YDAC applies if a young person is ineligible for diversion under the YOA.[176] It is a pre-sentence program.[177] Once a young person has been accepted into the YDAC, the matter is adjourned and the young person is placed on bail.[178] Participation is taken into account in sentencing.[179] YDAC provides intensive case management as part of its program.[180]

14.111 According to BOCSAR, in 2010, of the 18 864 charges in finalised Children's Court appearances, 248 charges were adjourned to YDAC, while 490 charges were dismissed under the MHFPA.[181]

14.112 Although YDAC does not keep records relating to the number of young people with cognitive or mental health impairments who pass through its programs, it reports that there have been "many participants with reoccurring psychosis, brain injury, mental health and cognitive issues".[182] Currently, however, although young people

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172. Children's Court of NSW, *Practice Note 1: Practice Note for Youth Drug and Alcohol Court,* 29 August 2009 1.
173. T Eardley and others, *Evaluation of the New South Wales Youth Drug Court Pilot Program: Final Report for the NSW Attorney-General's Department* (Social Policy Research Centre, 2003/2004) 1.
174. NSW, Youth Drug and Alcohol Court, *Contact us* (22 December 2009) <www.lawlink.nsw.gov.au/lawlink/drug_court/ll_drugcourt.nsf/pages/ydrgcrt_contactus>.
175. NSW, Youth Drug and Alcohol Court, *About us* (4 March 2010) <www.lawlink.nsw.gov.au/lawlink/drug_court/ll_drugcourt.nsf/pages/ydrgcrt_aboutus>.
176. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 35(5A)(a).
177. T Eardley and others, *Evaluation of the New South Wales Youth Drug Court Pilot Program: Final Report for the NSW Attorney-General's Department* (Social Policy Research Centre, 2003/2004) 2.
178. Children's Court of NSW, *Practice Note 1: Practice Note for Youth Drug and Alcohol Court,* 29 August 2009 [9].
179. Children's Court of NSW, *Practice Note 1: Practice Note for Youth Drug and Alcohol Court,* 29 August 2009 [18.1]-[18.2].
180. T Eardley and others, *Evaluation of the New South Wales Youth Drug Court Pilot Program: Final Report for the NSW Attorney-General's Department* (Social Policy Research Centre, 2003/2004) ii.
181. NSW Bureau of Crime Statistics and Research (kg12-10515).
182. Email from S Fitzjohn, Acting Registrar Youth Drug and Alcohol Court, 4 May 2012.

with impairments may participate in YDAC, those who have a severe mental illness or intellectual disability may not be suitable for participation.[183]

14.113 Between July 2000 and March 2012, 1,115 young people have been referred to YDAC, of whom:

- 161 failed to meet eligibility criteria
- 210 declined to participate
- 133 were found unsuitable after initial/comprehensive assessment, and
- 525 were placed on the program.[184]

A comparable approach?

14.114 Although it does not target young people with cognitive or mental health impairments, many of the YDAC's characteristics coincide with those of the court intervention model described in depth in Chapter 11. These characteristics are:

- **A specialised list:** YDAC is administered by the Children's Court and operates within the existing framework of the CCPA, supplemented by Practice Directions.[185]
- **A dedicated court team:** A Joint Assessment and Referral Team,[186] consisting of representatives from NSW Health, Community Services, Education and Juvenile Justice conducts assessments and interventions, and provides monitoring and review of programs.[187]
- **A non-adversarial approach:** Report back sessions occur with "little formality".[188]
- **Mandated community treatment:** Program plans can require a young person to reside as directed; participate in counselling, educational programs, health assessments or intervention and recreational programs; submit to urinalysis and attend YDAC report back sessions.[189]
- **Continuing supervision:** Report back sessions with the YDAC Court Team occur regularly and "provide an intensive monitoring process and continuing supervision of the child's progress and general compliance with the Program

183. NSW, Youth Drug and Alcohol Court, "Policy and Programs", <www.lawlink.nsw.gov.au/lawlink/drug_court/ll_drugcourt.nsf/pages/ydrgcrt_policy>.
184. Email from S Fitzjohn, Acting Registrar, Youth Drug and Alcohol Court, 4 May 2012.
185. NSW, Youth Drug and Alcohol Court, "About us", <www.lawlink.nsw.gov.au/lawlink/drug_court/ll_drugcourt.nsf/pages/ydrgcrt_aboutus>.
186. Children's Court of NSW, *Practice Note 1: Practice Note for Youth Drug and Alcohol Court,* 29 August 2009 [7.1].
187. NSW, Youth Drug and Alcohol Court, *Policy and Programs*, (4 March 2010) <www.lawlink.nsw.gov.au/lawlink/ drug_court/ll_drugcourt.nsf/pages/ydrgcrt_policy>.
188. Children's Court of NSW, *Practice Note 1: Practice Note for Youth Drug and Alcohol Court,* 29 August 2009 [10.5].
189. NSW, Youth Drug and Alcohol Court, *Policy and Programs*, (4 March 2010) <www.lawlink.nsw.gov.au/lawlink/drug_court/ll_drugcourt.nsf/pages/ydrgcrt_policy>.

Plan". Program Plans are normally completed within 6 months but may be extended.[190]

- **Rewards and sanctions:** Participation in YDAC is taken into account in sentencing, although a sentence may be no more punitive than if the young person did not participate.[191] Serious breaches may lead to arrest and/or discharge from the program.[192]

- **Voluntary participation:** Referral to the YDAC may be made with or without the child's consent.[193] However, the young person may withdraw his or her consent at anytime, resulting in the matter being adjourned for sentence.[194]

Effectiveness and outcomes

14.115 A 2003 evaluation of YDAC (then the Youth Drug Court) noted that 164 young people were referred to the Youth Drug Court in its first two years. 75% of these young people were deemed eligible, and 29% of these went on to "graduate".[195] While data problems made it difficult to assess the levels of reoffending, the evaluators found that overall, "the program is having an important, positive impact on the lives of many of those participating".[196]

14.116 The number of young people engaged with YDAC with a cognitive or mental health impairment was not reported. However the evaluation noted that young people participating in the evaluation had poorer mental health than young people in the population as a whole.[197] The evaluation identified positive outcomes such as decreased drug use and improved mental health.[198] It also reported that some stakeholders saw the exclusion of some young people with a mental as problematic because:

> it is hard for drug-dependent young people with a mental illness to access services generally. This can be because mental health services require the drug

190. Children's Court of NSW, *Practice Note 1: Practice Note for Youth Drug and Alcohol Court,* 29 August 2009 [8.1]-[10.8].
191. Children's Court of NSW, *Practice Note 1: Practice Note for Youth Drug and Alcohol Court,* 29 August 2009 [18.1]-[18.2].
192. Children's Court of NSW, *Practice Note 1: Practice Note for Youth Drug and Alcohol Court,* 29 August 2009 [12.1]-[13.3].
193. Children's Court of NSW, *Practice Note 1: Practice Note for Youth Drug and Alcohol Court,* 29 August 2009 [4].
194. Children's Court of NSW, *Practice Note 1: Practice Note for Youth Drug and Alcohol Court,* 29 August 2009 [17].
195. T Eardley and others, *Evaluation of the New South Wales Youth Drug Court Pilot Program: Final Report for the NSW Attorney-General's Department* (Social Policy Research Centre, 2003/2004) iii.
196. T Eardley and others, *Evaluation of the New South Wales Youth Drug Court Pilot Program: Final Report for the NSW Attorney-General's Department* (Social Policy Research Centre, 2003/2004) v, 182.
197. YDAC participants were compared to young people 18-24 years of age in the general population. No comparable data was available in relation to young people under the age of 18. T Eardley and others, *Evaluation of the New South Wales Youth Drug Court Pilot Program: Final Report for the NSW Attorney-General's Department* (Social Policy Research Centre, 2003/2004) 89.
198. T Eardley and others, *Evaluation of the New South Wales Youth Drug Court Pilot Program: Final Report for the NSW Attorney-General's Department* (Social Policy Research Centre, 2003/2004) iii-iv.

problem to be resolved first, or because drug rehabilitation services require the mental illness issue to be overcome.[199]

Other jurisdictions

14.117 There is a range of specialist mental health courts for young people in operation overseas, many in North America. Frequently these courts take a mental health focus, and do not include people with cognitive impairments. In some ways, these youth mental health courts resemble mental health courts for adults. For instance, a serious offence may exclude a young person from eligibility;[200] multi-disciplinary teams work together to assist the young person;[201] and the young person regularly appears before the court for a progress report.[202]

14.118 Key characteristics of these youth-focused courts, which differ from adult mental health courts, include:

- different eligibility criteria, for instance in respect of conduct disorder or oppositional defiant disorder[203]
- participation of the family in treatment,[204] and
- participation of school representatives.[205]

Benefits and disadvantages of youth mental health courts

14.119 In Chapter 12 we recommend the establishment of a specialist list for people over the age of 18 with cognitive and mental health impairments who are at risk of imprisonment. We explore the advantages and disadvantages of a mental health court or specialist list, derived from the experiences in other jurisdictions. Youth

199. T Eardley and others, *Evaluation of the New South Wales Youth Drug Court Pilot Program: Final Report for the NSW Attorney-General's Department* (Social Policy Research Centre, 2003/2004) 151-152, 155.

200. DE Arredondo, "Juvenile Mental Health Court: Rationale and Protocols" [2001] Fall *Juvenile and Family Court Journal* 1, 6.

201. DE Arredondo, "Juvenile Mental Health Court: Rationale and Protocols" [2001] Fall *Juvenile and Family Court Journal* 1, 8.

202. DE Arredondo, "Juvenile Mental Health Court: Rationale and Protocols" [2001] Fall *Juvenile and Family Court Journal* 1, 16.

203. The Court for the Individualized Treatment of Adolescents in Santa Clara Country, California accepts young people with severe mental illnesses, and excludes young people with oppositional defiant disorders and conduct disorder unless this is complicated by another condition: DE Arredondo, "Juvenile Mental Health Court: Rationale and Protocols" [2001] Fall *Juvenile and Family Court Journal* 1, 6. Conversely, the Los Angeles County Juvenile Mental Health Court accepts young people with more treatable mental disorders as well as personality disorders: A DiGiovanni, "The Los Angeles County Juvenile Mental Health Court: An Innovative Approach to Crime, Violence and Delinquency Among Our Youth" (2002-2003) 23 *The Journal of Juvenile Law* 1, 12-13.

204. DE Arredondo, "Juvenile Mental Health Court: Rationale and Protocols" [2001] Fall *Juvenile and Family Court Journal* 1, 16; A DiGiovanni, "The Los Angeles County Juvenile Mental Health Court: An Innovative Approach to Crime, Violence and Delinquency Among Our Youth" (2002-2003) 23 *The Journal of Juvenile Law* 1, 6, 8.

205. A DiGiovanni, "The Los Angeles County Juvenile Mental Health Court: An Innovative Approach to Crime, Violence and Delinquency Among Our Youth" (2002-2003) 23 *The Journal of Juvenile Law* 1, 8

mental health courts are a relatively new phenomenon. As such, one report has noted that:

> While there has been no large scale examination of how these courts are developing, the kinds of services that are offered, and how successful they are in addressing psychiatric needs and reducing recidivism, there is significant interest in these courts as a way to provide effective mental health and other services to youth.[206]

14.120 Although the available data is limited, some studies have indicated similar positive effects to those outlined in Chapter 11 such as lower rates of reoffending;[207] fewer offences committed by those who do reoffend;[208] and a reduction in the violence used in the offences that are committed.[209]

14.121 A mental health court for young people could also assist young people in accessing services, which, as we have identified earlier, young people can find particularly difficult.[210]

14.122 Some of the criticisms of mental health courts generally[211] have been made in relation to youth mental health courts, for instance, that resources would be more efficiently directed at prevention and services:

> Even if rigorous studies ultimately show that mental health courts improve mental health intervention and reduce recidivism for youth, they may not be the best vehicle for making such gains. If provided the appropriate services *prior to* their involvement with the court, these young people may demonstrate similar or better outcomes.[212]

14.123 Youth mental health courts can give rise to a risk of net widening, with young people being drawn into the juvenile justice system, the "gateway" to services, when they may otherwise have faced a much lower sanction or dismissal of their case.[213]

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206. National Centre for Mental Health and Juvenile Justice, *Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System* (2007) 55.
207. MP Beknken, DE Arredondo and WL Packham, "Reduction in Recidivism in a Juvenile Mental Health Court: A Pre- and Post-Treatment Outcome Study" (2009) 60(3) *Juvenile and Family Court Journal* 23, 37. This study focused upon the Court for the Individualized Treatment of Adolescents in Santa Clara, California. The authors noted limitations to the study similar to those we note in Chapter 11, for instance the lack of a randomised control group: at 40.
208. MP Beknken, DE Arredondo and WL Packham, "Reduction in Recidivism in a Juvenile Mental Health Court: A Pre- and Post-Treatment Outcome Study" (2009) 60(3) *Juvenile and Family Court Journal* 23, 39.
209. MP Beknken, DE Arredondo and WL Packham, "Reduction in Recidivism in a Juvenile Mental Health Court: A Pre- and Post-Treatment Outcome Study" (2009) 60(3) *Juvenile and Family Court Journal* 23, 35.
210. Para 14.62.
211. Para 11.104-11.131.
212. E Harris and T Seltzer, "The Role of Specialty Mental Health Courts in Meeting the Needs of Juvenile Offenders" (2004) September *Bazelon Center for Mental Health Law* 1, 5.
213. E Harris and T Seltzer, "The Role of Specialty Mental Health Courts in Meeting the Needs of Juvenile Offenders" (2004) September *Bazelon Center for Mental Health Law* 1, 5-6; JJ Cocozza and JL Shufelt, "Juvenile Mental Health Courts: An Emerging Strategy" Research and Program Brief (National Center for Mental Health and Juvenile Justice, 2006) 5; MP Behnken, DE Arredondo and WL Packham, "Reduction in Recidivism in a Juvenile Mental Health Court: A Pre- and Post-Treatment Outcome Study" (2009) 60(3) *Juvenile and Family Court Journal* 23, 41.

14.124 There is also a risk that young people with cognitive or mental health impairments are particularly susceptible to coercion, raising concerns "about a youth's ability to make informed, independent decisions about whether to participate and whether participation is truly voluntary".[214]

A Youth Diversion List for NSW?

14.125 In responding to the question of whether a specialist list is needed for young offenders with cognitive and mental health impairments, we note first that young people with cognitive or mental health impairments who appear in the Children's Court already have the advantage of a specialist court for children and young people. However its expertise is not in the field of cognitive and mental health impairment, and it does not have a specialist team that responds to the particular needs of defendants, as the YDAC does.

14.126 In this chapter, we recommend the extension of the ACCT and the provision of case management services to provide the Children's Court with the services it needs for effective identification and diversion of young people with cognitive and mental health impairments. The improved range of orders under s 32 will also provide the Children's Court with more options in relation to young people with impairments, including case management of diversion plans and judicial supervision.

14.127 We did not ask a question in CP 11 about the establishment of a specialist list within the Children's Court. However, some submissions touched upon this point. The Alcohol and Other Drugs Council of Australia suggested that extension of the Mental Health Diversion List to young offenders is an option that is "at least worth exploring".[215] However, other stakeholders were more equivocal about whether they supported a specialist list or improved case management services associated with the Children's Court. For instance, the Illawarra Legal Centre noted that "there has been extensive discussion and lobbying" for the establishment of a YDAC in the Illawarra. They said "there should be an investigation into the establishment of YDAC, MERIT or CREDIT type programs for young people with cognitive and mental health impairments".[216] Shopfront also envisaged a program such as the YDAC team that can supervise treatment or rehabilitation programs.[217] Shopfront suggested that a practice note may be the most desirable method of regulating this program.[218]

14.128 If a specialist list for young people with cognitive and mental health impairments were to be created in NSW, there would appear to be two options:

- Creation of a new specialist list in the Children's Court, achieved by way of legislation or by a practice note.

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214. JJ Cocozza and JL Shufelt, "Juvenile Mental Health Courts: An Emerging Strategy" Research and Program Brief (National Center for Mental Health and Juvenile Justice, 2006) 5.
215. Alchohol and other Drugs Council of Australia*, Submission MH32,* 9
216. Illawarra Legal Centre, *Submission MH39,* 6.
217. Shopfront Youth Legal Centre, *Submission MH41*, 12-13.
218. Shopfront Youth Legal Centre, *Submission MH41,* 13.

- Expansion of YDAC expressly to include young people with cognitive and mental health impairments.

14.129 As we have discussed elsewhere, cognitive and mental health impairments often co-exist with substance abuse. Addressing these complex needs side by side, and providing staff capable of addressing both sets of needs may assist in overcoming the difficulties that commonly faces people with multiple needs when accessing services.[219] Further, having two specialist lists within an already specialist court is difficult to justify when there is significant overlap between defendants with substance abuse problems and with cognitive and mental health impairments. Expansion of YDAC may be a more efficient use of resources than creation of a new list, which could create extra administrative burdens.

14.130 However, we note that such an expansion of the YDAC would require significant changes to that court, as well changes to the programs and expansion of its staff. Some of YDAC's current procedures are specific to alcohol and drug addiction. For instance, urinalysis is central in drug programs but not required for young people with impairments who do not have a co-existing alcohol or drug addiction. However, other aspects of the YDAC program, such as case management and assessment, participation in programs in relation to work and leisure, and court monitoring would apply equally to young people with cognitive or mental health impairments.

The Commission's view

14.131 While the proposal to establish a specialist list within the Children's Court has some strengths, on balance we do not recommend it at this stage. It is difficult to justify a further specialisation within an already specialist court. There is little evidence to date about the effectiveness of combining mental health and cognitive impairment and drug courts. We did not consult extensively on this issue, and we do not have the views of many important stakeholders. However, as we discuss elsewhere, cognitive and mental health impairments often co-exist with substance abuse.[220] Addressing these complex needs explicitly and side by side may assist in overcoming issues in relation to accessing services that currently face young people with multiple needs.

14.132 We have recommended the extension of assessment and case management services in the Children's Court, and this would appear to be the most appropriate next step. Further consideration may be given to providing a specialist list when evaluations of the effectiveness of assessment and court support services have been carried out and evidence in relation to the CRISP list is available.

14.133 In conclusion, we recommend that the Department of Attorney General and Justice monitor and evaluate the performance of both assessment and court support services provided to the Children's Court, and the CRISP model. In the light of these evaluations, further consideration may be given to the development of a specialist list within the Children's Court.

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219. Para 2.11-2.15.

220. Para 2.11-2.15.

Recommendation 14.6

(1) The Department of Attorney General and Justice should monitor and evaluate the performance of assessment and court support services provided to the Children's Court, as set out in Recommendation 14.5.

(2) In light of this evaluation, and the evaluation recommended in Recommendation 12.9, consideration should be given to the desirability of developing a specialist list within the Children's Court.

Appendix A
Submissions

MH1 Magistrate Jim Coombs, 1 April 2010

MH2 Mr Dallas McLoon, 22 May 2010

MH3 Prof Eileen Baldry, Ms Leanne Dowse, Prof Ian Webster and Mr Philip Snoyman, 25 May 2010

MH4 Local Court of NSW, 25 June 2010

MH5 NSW, Office of the Director of Public Prosecutions, 28 June 2010

MH6 Ms Susan Pulman and Ms Amanda White, 30 June 2010

MH7 Shopfront Youth Legal Centre, 30 June 2010

MH8 Mr Allan Vaughn and Ms Elaine Vaughn, 16 July 2010

MH9 Ms Linda Steele, 28 July 2010

MH10 NSW Bar Association, 29 July 2010

MH11 NSW Consumer Advisory Group, 30 July 2010

MH12 NSW Council for Intellectual Disability, 30 July 2010

MH13 Law Society of NSW, 30 July 2010

MH14 Intellectual Disability Rights Service, 2 August 2010

MH15 NSW Health, 26 July 2010

MH16 NSW Trustee and Guardian, 30 July 2010

MH17 Corrective Services NSW, 4 August 2010

MH18 Legal Aid NSW, 3 August 2010

MH19 Brain Injury Association of NSW, 12 August 2010

MH20 Homicide Victims' Support Group, 10 August 2010

MH21 Public Interest Advocacy Centre, 10 August 2010

MH22 Parramatta Community Justice Clinic, 16 August 2010

MH23 Aboriginal Legal Service (NSW/ACT), undated

MH24 Children's Court of NSW, 20 August 2010

MH25 Ms Satish Dayalan, 13 September 2010

MH26 NSW, Public Defenders, 23 September 2010

MH27 NSW Public Guardian, 28 September 2010

MH28 Department of Human Services NSW, 17 August 2010 (now the Department of Family and Community Services)

MH29 NSW Bar Association, 2 February 2011

MH30 Multicultural Disability Advocacy Association of NSW, 4 February 2011

MH31 Yfoundations, 9 February 2011

MH32 Alcohol and other Drugs Council of Australia (ADCA), 10 February 2011

MH33 UnitingCare Children, Young People and Families, 11 January 2011

MH34 Youth Justice Coalition, 18 February 2011

MH35 Department of Human Services NSW, 17 February 2011 (now the Department of Family and Community Services)

MH36 The Law Society of NSW, 23 February 2011

MH37 NSW, Office of the Director of Public Prosecutions, 28 February 2011

MH38 Legal Aid NSW, 7 March 2011
MH39 Illawarra Legal Centre, 7 March 2011
MH40 Public Interest Advocacy Centre, 18 March 2011
MH41 Shopfront Youth Legal Centre, 18 March 2011
MH42 NSW Police Force, 23 March 2011
MH43 Children's Court of NSW, 4 April 2011
MH44 Mr Robert Barco, 8 April 2011
MH45 Ms Linda Steele, 8 April 2011
MH46 NSW Council for Civil Liberties, 6 April 2011
MH47 NSW Police Force, 27 October 2011
MH48 NSW, Mental Health Review Tribunal, 21 March 2012
CMH1 Confidential Submission, 30 June 2010
CMH2 Confidential Submission, 3 March 2011

Appendix B
Preliminary submissions

PMH1	Mr Steven Yannoulidis, undated
PMH2	Mr Ian Bond, 10 May 2007
PMH3	The Shopfront Youth Legal Centre, 15 May 2007
PMH4	Mr John Haigh, 16 May 2007
PMH5	NSW, Office of the Director of Public Prosecutions, 16 May 2007
PMH6	NSW Crown Advocate, 18 May 2007
PMH7	Intellectual Rights Disability Service, 21 May 2007
PMH8	Dr Andrew Walker, 25 May 2007
PMH9	NSW Mental Health Review Tribunal , 24 May 2007
PMH10	NSW Legal Aid, 22 May 2007
PMH11	Law Society of NSW, 18 May 2007
PMH12	His Honour Graeme Henson, Chief Magistrate of the Local Court of NSW, 23 May 2007
PMH13	NSW, Public Defenders, 25 May 2007
PMH14	Justice Peter McClellan, Chief Judge at Common Law, Supreme Court of NSW, 28 May 2007
PMH15	NSW, Department of Ageing, Disability and Home Care, 23 May 2007 (now Ageing, Disability and Home Care within the Department of Family and Community Services)
PMH16	Redfern Legal Centre, 28 May 2007
PMH17	NSW Bar Association, 28 May 2007
PMH18	Anti-Discrimination Board of NSW, 8 June 2007
PMH19	Corrective Services NSW, 21 June 2007
PMH20	Mr Peter Shea, 4 July 2007
PMH22	Mr John Ellard, 13 November 2007
PMH23	Ms Rebecca McMahon, 2 November 2008
PMH24	Judicial Commission of NSW, 25 March 2008
PMH25	Ms Bernadette McSherry, 10 April 2008
PMH26	Victim's Advisory Board, 18 April 2008

Appendix C
Consultations

A White and S Pulman (MH1)

31 June 2010

Dr Susan Pulman, Clinical Neuropsychologist and Forensic Psychologist
Ms Amanda White, Forensic Psychologist

Brain Injury Australia (MH2)

1 February 2011

Mr Nick Rushworth, Executive Officer

Legal Aid NSW (MH3)

17 February 2011

Ms Danielle Castles, Manager, Client Assessment and Referrals Unit
Mr Todd Davis, Solicitor in Charge, Mental Health Advocacy Service
Ms Erin Gough, Legal Policy Branch
Mr Alan Kirkland, CEO
Ms Debra Maher, Solicitor in Charge, Children's Legal Service
Mr Richard Mendon, Solicitor, Mental Health Advocacy Service
Ms Siobhan Mullany, Solicitor, Criminal Law Indictable Offences Section
Mr Geoff Tremelling, Solicitor, Prisoners Legal Service
Mr Tristan Webb, Lay Advocate, Mental Health Advocacy Service
Mr Rob Wheeler, former Solicitor in Charge, Mental Health Advocacy Service

Public Interest Advocacy Centre (MH4)

21 February 2011

Mr Jamie Alford, Social Worker, Shopfront Youth Legal Centre
Ms Brenda Bailey, Senior Policy Officer
Mr Peter Dodd, Solicitor, Health Policy and Advocacy
Mr Gary O'Brien
Mr Jeremy Rea, Homeless Persons' Legal Service

Aboriginal Legal Service (NSW/ACT) (MH5)

22 February 2011

Ms Rebecca McMahon, Managing Lawyer, Redfern, Aboriginal Legal Service

NSW, Justice Health (MH6)

25 February 2011

Dr Stephen Allnutt, Clinical Director, Community Forensic Mental Health Service

Associate Professor John Basson, Statewide Clinical Director, Forensic Mental Health

Ms Michelle Eason, Nurse Manager, Mental Health

Mr Adrian Keller, Director of Civil Patients

Mr Colman O'Driscoll, Service Director Mental Health, Statewide Forensic Mental Health

Mr Trevor Perry, Manager, Service Development and Quality, Mental Health

Morisset FLAMES (MH7)

4 March 2011

Morisset FLAMES group

Mr Peter Dodd, Solicitor, Health Policy and Advocacy, Public Interest Advocacy Centre

Mr Chris Hartley, Senior Policy Officer, NSW Consumer Advisory Group

Sentencing Council of NSW (MH8)

16 March 2011

Mr Howard Brown, Deputy President, Victims of Crime Assistance League

Assistant Commissioner Luke Grant, Offender Services and Programs, Corrective Services

Assistant Commissioner David Hudson APM, Commander of State Crime Command, NSW Police Force

Ms Martha Jabour, Executive Director, Homicide Victims Support Group

Ms Viviane Mouait, Policy and Research Officer, Sentencing Council

Ms Penny Musgrave, Director Criminal Law Review, Department of Attorney General and Justice)

Prof David Tait, University of Western Sydney

Ms Sarah Waladan, Executive Officer, Sentencing Council

Mr Paul Winch, Public Defender

The Hon James Wood AO QC, Deputy Chairperson, Sentencing Council

Cognitive impairment roundtable (MH9)

17 March 2011

Mr Adam Bannon, Policy Officer, Disability Council of NSW

Mr Matthew Bowden, Executive Director, Leadership Team, People with Disability Australia

Ms Samantha Chung, Policy Officer, Multicultural Disability Advocacy Association of NSW

Ms Janene Cootes, Executive Officer, Intellectual Disability Rights Service

Ms Ali Craig, Solicitor, Intellectual Disability Rights Service

Dr Leanne Dowse, University of NSW

Ms Judy Harper, Board Member, NSW Council for Intellectual Disability

Professor Susan Hayes, University of Sydney

Ms Rachel Merton, CEO, Brain Injury Association of NSW

Ms Melinda Smith, A/Director Policy and Practice, Ageing, Disability and Home Care

Ms Karen Wells, Principal Solicitor, Intellectual Disability Rights Service

Corrective Services NSW and Juvenile Justice NSW (MH10)

21 March 2011

Ms Cathy Bracken, Director Operations, Juvenile Justice NSW.

Assistant Commissioner Rosemary Caruana, Community Offender Management, Corrective Services NSW

Assistant Commissioner Luke Grant, Offender Services and Programs, Corrective Services NSW

Mr Terry Halloran, Executive Director, Inmate Classification and Case Management, Corrective Services NSW

Ms Natalie Mamone, Chief Psychologist, Juvenile Justice NSW

Mr Phillip Snoyman, Acting Principal Officer, Statewide Disability Services, Corrective Services NSW

Mr Jayson Ware, Acting Executive Director, Offender Services and Programs, Corrective Services NSW

Community roundtable 1 (MH11)

29 March 2011

Mr Laurie Bassett, Housing and Accommodation Support Initiative, Mission Australia

Ms Heidi Becker, Project Manager, Network of Alcohol and Drug Agencies

Ms Katherine Boyle, Solicitor, Homeless Persons' Legal Service

Ms Samantha Chung, Policy Officer, Multicultural Disability Advocacy Association of NSW

Ms Tara Dias, Policy Officer, NSW Consumer Advisory Group

Mr Chris Hartley, Senior Policy Officer, NSW Consumer Advisory Group

Mr Richard Mendon, Mental Health Advocacy Service, Legal Aid

Mr Geoff Odgers, Edward Eagar Lodge, Wesley Mission

Ms Christine Regan, Senior Policy Officer, Council of Social Services of NSW

Mr Lou Schetzer, Policy Officer, Homeless Persons' Legal Service

Ms Helen Seares, Mental Health Advocacy Service, Legal Aid

Mr Will Temple, Chief Executive Officer, Watershed

Apprehended Violence Legal Issues Coordinating Committee (MH12)

5 April 2011

Ms Marianne Carey, Assistant Managing Lawyer, Office of the Director of Public Prosecutions

Ms Pip Davis, Community Legal Centres NSW

Ms Ann Lambino, Chief Magistrates Office

Ms Bev Lazarou, Project Officer, Women's Domestic Violence Court Advocacy Program, Legal Aid NSW

Ms Rachael Martin, Principal Solicitor, Wirringa Baiya

Ms Karen Mifsud, Supervising Solicitor, Domestic Violence Legal Service, Women's Legal Service

Ms Amy Mouafi, Senior Project Officer, Domestic Violence Intervention Court Model, NSW Police Force

Ms Kylie Nicholls, Manager of Business Innovation, Courts Services, Department of Attorney General and Justice

Ms Susan Smith, Coordinator, Sydney Women's Domestic Violence Court Advocacy Service

Ms Sally Steele, NSW Women's Refuge Movement

Ms Carolyn Thompson, Manager Domestic Violence, Crime Prevention Division Department of Attorney General and Justice

Senior Sergeant Wayne Thurlow, NSW Police Force

Ms Vanessa Viaggio, Criminal Law Review, Department of Attorney General and Justice

Ms Helen Wodak, Criminal Law Review, Department of Attorney General and Justice

Young people roundtable (MH13)

5 April 2011

Associate Professor John Basson, Statewide Clinical Director, Forensic Mental Health

Mr Jamie Alford, Social Worker, Shopfront Youth Legal Centre

Ms Jenny Bargen

Ms Jane Irwin, Solicitor, Shopfront Youth Legal Centre

Ms Claire Gaskin, Clinical Director, Adolescent Mental Health, Justice Health

Ms Jo-Anne Hewitt, Director Disability, UnitingCare Children, Young People and Families

Ms Katherine Higgins, Adolescent Health, Drug and Alcohol Mental Health, Justice Health

Professor Dianna Kenny, Behavioural and Community Health Sciences, University of Sydney

Mr Steve LaSpina, Senior Project Officer, Operations, Juvenile Justice

Ms Debra Maher, Solicitor in Charge, Children's Legal Service

His Honour Judge Mark Marion, President, Children's Court

Ms Megan Mitchell, Commissioner, Commission for Children and Young People

His Honour Magistrate Paul Mulroney, Children's Court

Ms Jane Sanders, Principal Solicitor, Shopfront Youth Legal Centre

Ms Sumitra Vignaendra, Senior Researcher, Commission for Children and Young People

Aboriginal people and Torres Strait Islanders roundtable (MH14)

7 April 2011

Associate Professor John Basson, Statewide Clinical Director, Forensic Mental Health

Rodney Beilby, Professional Development Officer, Programs, Juvenile Justice NSW

Dr Ilse Blignault, Maru Marri Aboriginal Health Unit, University of NSW

Ms Dianne Brooks, Indigenous Disability Advocacy Service

Associate Professor Ngiare Brown, Co-director, Poche Centre for Aboriginal Health, University of Sydney

Ms Alison Churchill, CEO, Community Restorative Centre

Ms Janelle Clarke, Senior Aboriginal Project Officer, Aboriginal Services, Legal Aid NSW

Ms Jo Courtney, Coordinator, Social and Cultural Resilience and Emotional Well-being of Aboriginal Mothers in Prison

Mr Chris Horgan, Senior Project Officer, Support and Planning Unit, Corrective Services

Maree Jennings, Manager Policy and Performance, Aboriginal Services Division, Department of Attorney General and Justice

Mr Ken Jurotte, A/Director, Aboriginal Support and Planning Unit, Corrective Services

Ms Jenny Lovric, Program Manager, Legal Aid NSW

Ms Elizabeth McEntyre, Area Manager, Aboriginal Health, Justice Health

Ms Rebecca McMahon, Managing Lawyer, Redfern Aboriginal Legal Service

Ms Vickie Roach, Researcher, Social and Cultural Resilience and Emotional Well-being of Aboriginal Mothers in Prison

Ms Juanita Sherwood, Chief Investigator, Social and Cultural Resilience and Emotional Well-being of Aboriginal Mothers in Prison

Ms Kylie Wilson, Manager Aboriginal Programs, Juvenile Justice NSW

Victims of crime roundtable (MH15)

11 April 2011

Ms Clare Blanch, Homicide Victims Support Group

Mr Howard Brown, Deputy President, Victims of Crime Assistance League

Ms Mirella Fisicaro, Homicide Victims Support Group

Ms Cecilia Fuentes, Victims of Crime Bureau

Ms Rachelle Johnston, Project Officer, Legal Aid NSW

Ms Bev Lazarou, Project Officer, Legal Aid NSW

Ms Rachael Martin, Principal Solicitor, Wirringa Baiya

Ms Lynne Mitchell, Victims of Crime Bureau

Ms Susan Smith, Coordinator, Sydney Women's Domestic Violence Court Advocacy Service

Ms Karen Willis, Executive Officer, NSW Rape Crisis Centre

Academic roundtable (MH16)

14 April 2011

Associate Professor John Basson, Statewide Clinical Director, Forensic Mental Health

Professor David Greenberg, Clinical Director, Statewide Community and Court Liaison Service

Professor Susan Hayes, University of Sydney

Professor Ian Hickie, Brain and Mind Research Institute, University of Sydney

Associate Professor Dan Howard, School of Psychiatry, University of NSW

Dr Arlie Loughnan, University of Sydney Law School

Associate Professor Alex Steel, Faculty of Law, University of NSW

Ms Amanda White, Forensic Psychologist

Community roundtable 2 (MH17)

20 April 2011

Ms Kat Armstrong, Director, Women in Prison Advocacy Network

Ms Fleur Beaupert, Committee Member, NSW Council for Civil Liberties

Mr Peter Dodd, Solicitor, Health Policy and Advocacy, Public Interest Advocacy Centre

Ms Giselle Goy, Case Manager, The Haymarket Foundation

Mr Jonathan Harms, Mental Health Carers, Association of Relative and Friends of the Mentally Ill

Ms Corinne Henderson, Senior Policy Officer, Mental Health Coordinating Council

Ms Maria Karras, Senior Researcher, Law and Justice Foundation

Mr Gary Lazarus, Community Support Worker, Housing and Accommodation Support Initiative, Mission Australia

Ms Elizabeth Priestley, CEO, Mental Health Association of NSW Inc

Mr John Rafferty, Principal Solicitor, Macquarie Legal Centre

Ms Mindy Sotiri, Member, Beyond Bars

Ms Linda Steele, Postgraduate Fellow, Sydney Law School, University of Sydney

Mr Daniel Stubbs, Coordinator, Inner City Legal Centre

Ms Felicia Tungi, Team Leader, The Haymarket Foundation

Ageing, Disability and Home Care (MH18)

29 April 2011

Mr Peter Goslett, Acting Executive Director, Office of the Senior Practitioner, Ageing, Disability and Home Care

Ms Natalie Mamone, A/Director, Criminal Justice Program, Ageing, Disability and Home Care

Mr Vince Ponzio, Director, Integrated Services Project, Ageing, Disability and Home Care

Ms Melinda Smith, A/Director Policy and Practice, Ageing, Disability and Home Care

Mr Rodney Spitzer, Senior Legal Officer, Ageing, Disability and Home Care

Associate Professor Julian Trollor, School of Psychiatry, University of NSW

Kempsey (MH19)

10 May 2011

Mr Wally Ball, Police Prosecutor

Mr Greg Brown, Aboriginal Community Liaison Officer, NSW Police Force

Mr Victor Darcy, Circle Sentencing

His Honour Magistrate Wayne Evans

Mr Mark Smith, Court Clinician, Statewide Community and Court Liaison Service

Community Justice Group:

Mr Vincent Cook

Ms Madeline Donovan, Goorie Galbans

Mr Gerald Hoskins, CEO, Durri Aboriginal Corporation Medical Service

Ms Debra Morris, Coordinator, Dunghutti Community Justice Group

Mr Deal Roberts, CEO, Thungutti Local Aboriginal Land Council

Mr Malcolm Webster, Chairperson, Macleay Valley Local Aboriginal Education Consultative Group

Public Guardian and Trustee and Guardian (MH20)

11 May 2011

Ms Meredith Coote, Assistant Director, NSW Trustee and Guardian

Ms Angela Kazonis, Senior Client Service Officer, NSW Trustee and Guardian

Ms Wendy Kemp, NSW Public Guardian

Ms Alison Perry, Senior Guardian, NSW Public Guardian

Mr Graeme Smith, NSW Public Guardian

Mr Michael Tyrrell, Senior Guardian, NSW Public Guardian

Court Referral of Eligible Defendants into Treatment (CREDIT) (MH21)

13 May 2011

Ms Sandra Crawford, Assistant Director, Criminal Justice Interventions, Crime Prevention Division

Ms Kylie Gersbach, Coordinator, Court Referral of Eligible Defendants into Treatment (Burwood)

Ms Mandy Loundar, Coordinator, Court Referral of Eligible Defendants into Treatment (Tamworth)

Ms Geetha Varughese, Manager, Court Referral of Eligible Defendants into Treatment

Mental Health Review Tribunal (MH22)

3 June 2011

Mr John Feneley, Deputy President, Mental Health Review Tribunal
Ms Sarah Hanson, Forensic Team Leader, Mental Health Review Tribunal

Disability Advisory Council of NSW (MH23)

8 June 2011

Mr Geoffrey Beatson, representing people with an intellectual disability
Mr Richard Brading, representing people who have hearing impairments
Ms Elizabeth Buchanan, representing people with acquired brain injuries
Mr Laurie Glanfield, Director General, Department of Attorney General and Justice
Mr Phillip French, cross disability representation
Ms Julie Haraksin, Manager, Diversity Services, Department of Attorney General and Justice
Ms Helen Laverty, Policy Officer, Disability Advisory Council of NSW
Mr Stepan Kerkyasharian, President of the Anti-Discrimination Board

Statewide Community and Court Liaison Service (SCCLS) (MH24)

9 June 2011

Ms Carolynn Dixon, Operations Manager
Professor David Greenberg, Clinical Director

Local Court of NSW (MH25)

28 June 2011

Her Honour Deputy Chief Magistrate Jane Culver
His Honour Judge Graeme Henson, Chief Magistrate of the Local Court of NSW
Her Honour Deputy Chief Magistrate Jane Mottley

NSW Police Force (MH26)

9 September 2011

Assistant Commissioner Dennis Clifford
Ms Yasmine Hunter, Senior Policy Officer, Operational Programs

NSW Police Force (MH27)

20 September 2011

Ms Gina Andrews, Senior Policy Officer, Mental Health
Superintendent David Donohue, Corporate Spokesperson - Mental Health

Drug Court of NSW (MH28)

19 March 2012

His Honour Judge Roger Dive, Senior Judge, Drug Court of New South Wales

Ms Filiz Eminov, Drug Court Registrar

Ms Sue Jeffries, Clinical Nurse Consultant

Ministry of Health (MH29)

18 April 2012

Mr John Allan, Chief Psychiatrist

Ms Antoinette Aloi, Manager Clinical Governance

Mr David McGrath, Director, Mental Health and Drug and Alcohol Office

Ms Karen Price, Associate Director, Mental Health and Drug and Alcohol Office

Mr Marc Reynolds, Manager, Mental Health Clinical Services Development Team, Mental Health and Drug and Alcohol Office

Melbourne: Assessment and Referral Court (ARC) List and Court Integrated Services Program (CISP) (MH30)

2 May 2012

Ms Elizabeth Adams, Case Advisor Assessment and Referral Court List, Magistrates' Court of Victoria

Ms Stephanie Ash, Case Advisor Assessment and Referral Court List, Magistrates' Court of Victoria

Mr Glen Hardy, Program Analyst Assessment and Referral Court List, Magistrates' Court of Victoria

Mr Peter Lamb, Manager Therapeutic Justice, Courts and Tribunals Unit, Department of Justice, Victoria

His Honour Magistrate John Lesser

Ms Nareeda Lewers, Victoria Legal Aid

Mr Simon McDonald, Manager Specialist Courts and Court Support Services, Magistrates' Court of Victoria

Ms Rebecca McParland, Senior Policy Officer, Courts and Tribunals Unit, Department of Justice, Victoria

Ms Liliana Melone, Case Advisor Assessment and Referral Court List, Magistrates' Court of Victoria

Mr Rudy Monteleone, Acting CEO, Magistrates' Court of Victoria

Ms Viv Mortell, Program Manager Assessment and Referral Court List, Magistrates' Court of Victoria

Ms Carrie O'Shea, Victoria Legal Aid

Her Honour Deputy Chief Magistrate Jelena Popovic

Ms Kristy Rowe, Team Leader Court Integrated Services Program, Magistrates' Court of Victoria

Mr Glenn Rutter, Manager Court Support and Diversion Services, Magistrates' Court of Victoria

Ms Shirralee Sisson, Case Advisor Assessment and Referral Court List, Magistrates' Court of Victoria

Sergeant Mark Stephens, Prosecutions Division, Victoria Police

Leading Senior Constable Jackie Urquhart, Prosecutions Division, Victoria Police

District Court of NSW (MH31)

11 May 2012

The Hon Justice Reginald Blanch, Chief Judge of the District Court of NSW

Local Court of NSW (MH32)

18 May 2012

Her Honour Deputy Chief Magistrate Jane Mottley

Appendix D
Mental health courts symposium

THE UNIVERSITY OF SYDNEY

SHOULD NSW HAVE A MENTAL HEALTH COURT?

1 APRIL 2011

FOYER, LEVEL 2, NEW LAW SCHOOL, UNIVERSITY OF SYDNEY, CAMPERDOWN CAMPUS

NSW GOVERNMENT | NSW Law Reform Commission
Justice & Attorney General

In partnership with the NSW Law Reform Commission

A symposium to discuss the potential of a mental health 'court' or a specialist list to address issues of diversion in relation to people with cognitive and mental health impairments in the criminal justice system and how such a court or list might be implemented in NSW.

The symposium forms a part of the Commission's consultation process in relation to its review of People with cognitive and mental health impairments in the criminal justice system. Further information about the review is available at:

http://www.lawlink.nsw.gov.au/lrc

8:30-9:00 AM
REGISTRATION

9:00 AM
OPENING ADDRESS

The Hon James Wood
Review of People with Cognitive and Mental Health Impairments in the Criminal Justice System

9:10 AM
EXISTING MENTAL HEALTH COURTS

CHAIR –
Emeritus Professor Hilary Astor

Chief Magistrate Michael Hill
The Tasmanian Mental Health Diversion List - our experience

Magistrate John Lesser
The Assessment and Referral Court (ARC) List - Piloting Victoria's 'Mental Health' Court Model

Elizabeth Richardson
The Difficulties and Downsides of Mental Health Courts: Time to pause and reflect

10:30 AM
MORNING TEA

11:00 AM
EXPERT PANEL AND AUDIENCE DISCUSSION

PANEL MODERATOR –
Natasha Mitchell
Science journalist and host of ABC Radio National's 'All in the Mind' program

PANEL MEMBERS –
Chief Magistrate Michael Hill
Chair of the Steering Committee overseeing the development of the Magistrates Court of Tasmania's Mental Health Diversion List Program

Magistrate John Lesser
Supervising Magistrate for the Assessment and Referral Court List at Melbourne Magistrates' Court

Elizabeth Richardson
PhD Candidate at the Faculty of Law, Monash University, researching the operation of mental health courts and diversionary programs in Australia and overseas

Deputy Chief Magistrate Jane Mottley
Deputy Chief Magistrate, Local Court of NSW

Sue Jefferies
Clinical Nurse Consultant, Drug Court of NSW

Karen Wells
Principal Solicitor, Intellectual Disability Rights Service

1:00 PM
CLOSE

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Baldry, E, L Dowse and M Clarence, "People with Mental and Cognitive Disabilities: Pathways into Prison" (Background Paper for Outlaws to Inclusion Conference, 2012)

Baldry, E and L Dowse, *People with Mental Health Disorders and Cognitive Disabilities in the Criminal Justice System in NSW: Policy and Legislative Impacts* (NSW Department of Human Services: Ageing, Disability and Home Care, 2010)

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