NSW GOVERNMENT

New South Wales
Law Reform Commission

Report
138

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

Criminal responsibility and consequences

May 2013
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Law Reform Commission
Attorney General & Justice

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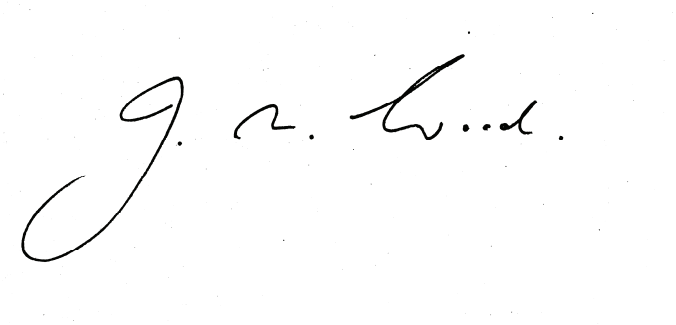
Dear Attorney

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

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



The Hon James Wood AO QC
Chairperson
May 2013

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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

ACAT	ACT Civil and Administrative Tribunal
ADHC	Ageing, Disability and Home Care
ADT	Administrative Decisions Tribunal
ADVOs	apprehended domestic violence orders
APVOs	apprehended personal violence orders
ASU	Additional Support Units
AVO	apprehended violence orders
BOCSAR	NSW Bureau of Crime Statistics and Research
CAA	*Criminal Appeal Act 1912* (NSW)
CCA	Court of Criminal Appeal
CDPVA	*Crimes (Domestic and Personal Violence) Act 2007* (NSW)
CFPA	*Crimes (Forensic Procedures) Act 2000* (NSW)
CHROA	*Crimes (High Risk Offenders) Act 2006* (NSW)
CJSN	Criminal Justice Support Network
CP	Consultation Paper
CREDIT	Court Referral of Eligible Defendants into Treatment
CSNSW	Corrective Services NSW
CSPA	*Crimes (Sentencing Procedure) Act 1999* (NSW)
CTO	community treatment order
DAGJ	NSW Department of Attorney General and Justice
DFACS	NSW Department of Family and Community Services
DPP	Director of Public Prosecutions
DSA	*Disability Services Act 1993* (NSW)
GAL	Guardian *ad litem*
HVSG	Homicide Victims' Support Group
ICCPR	International Covenant on Civil and Political Rights
LRCWA	Law Reform Commission of Western Australia

MAPPA	Multi-Agency Public Protection Arrangements
MCCOC	Model Criminal Code Officers Committee
MHA	*Mental Health Act 2007* (NSW)
MHC	Mental Health Commission
MHFPA	*Mental Health (Forensic Provisions) Act 1990* (NSW)
MHRT	Mental Health Review Tribunal
MRRC	Silverwater Metropolitan Remand and Reception Centre
NCIDD	National Criminal Investigation DNA Database
NGMI	not guilty by reason of mental illness/the defence of mental illness
NGO	non-government organisation
NSWCAG	NSW Consumer Advisory Group
ODPP	NSW Office of the Director of Public Prosecutions
PIAC	Public Interest Advocacy Centre
PBDU	Personality and Behaviour Disorder Unit
QP	Question Paper
SCCLS	Statewide Community and Court Liaison Service
SDS	Statewide Disability Services
SMAP	Special Management Assessment for Placement
SYLC	Shopfront Youth Legal Centre
UNA	unfit and not acquitted (following a special hearing)
VLRC	Victorian Law Reform Commission
WDVCAS	Women's Domestic Violence Court Advocacy Services
YOA	*Young Offenders Act 1997* (NSW)

Executive Summary

Chapter 1: Introduction

0.1 This is the second and final report addressing people with cognitive and mental impairments and the criminal justice system. The first report (Report 135) was issued in June 2012. It dealt with the diversion of people with cognitive and mental health impairments from the criminal justice system, as well as related matters such as definitions of cognitive impairment and mental health impairment. The Government has established a committee to prepare a whole-of-government response to that report.

0.2 The focus of this report, broadly speaking, is on the law relating to people with mental health and/or cognitive impairments who have committed serious offences. We consider fitness to plead, the defence of mental illness, substantial impairment, and infanticide. We also examine the procedures that follow a finding of unfitness or not guilty by reason of mental illness (NGMI), and the management of people who become forensic patients. Further, we consider issues relating to apprehended violence orders against people who have cognitive and/or mental health impairments. We also deal with the retention and destruction of forensic samples taken from people who are diverted, who are found NGMI, or who are unfit and not acquitted at a special hearing (UNA).

0.3 In September 2011, the Attorney General asked the Commission to conduct a review of sentencing and a report is in preparation. Sentencing of people with cognitive and mental health impairments will be dealt with in that report.

0.4 Consultation with stakeholders has been extensive. We produced five consultation papers. We also issued two question papers to collect further information from stakeholders on particular issues requiring additional input. We received 70 submissions and conducted 39 consultations involving more than 200 stakeholders.

0.5 A consistent finding of our review is that people with cognitive impairments face particular difficulties in the forensic system. We recommend that a Forensic Working Group be established and that one of its tasks be to develop an action plan for additional and improved options for the detention, care and community support of forensic patients with cognitive impairments (Recommendation 1.1).

0.6 We also recommend that the principal legislation, the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA), should be renamed to include people with cognitive impairments (Recommendation 1.2). We recommend a review of the MHFPA to ensure it is clear and comprehensible (Recommendation 1.3).

Chapter 2: Fitness to be tried

0.7 The minimum standards that the defendant must meet before he or she is considered fit to stand trial were set in 1958, and are commonly referred to as the *Presser* test. From our review of cases and feedback from stakeholders, the

standards appear to work well and we do not recommend any fundamental change of direction.

0.8 However, in response to stakeholder concerns, we recommend that the standards be updated and incorporated into statute, as in most other Australian jurisdictions (Recommendation 2.1). Codification will improve clarity and accessibility and will deal with some limitations of the present test.

0.9 On balance we think it desirable to include in the test reference to the overarching principle that the defendant must be able to have a fair trial. This is the "touchstone" for making the judgement about whether or not the defendant's degree of incapacity is, or is not, sufficient to do those things required by the *Presser* test.

0.10 Modifications to trial processes are sometimes made in some cases where unfitness is an issue in order to make it possible for the defendant to have a normal trial. It is desirable, on the basis of fairness and public interest, for the defendant to have a normal trial if this can be achieved. We therefore recommend that the statutory provisions relating to the test for fitness should also provide that the court consider whether modifications to the trial process can be made, or assistance be provided, to make it possible for the defendant to participate effectively in the trial (Recommendation 2.2).

Chapter 3: The defence of mental illness

0.11 Stakeholders identified difficulties with the current *M'Naghten* test for the defence of mental illness. A number of alternative formulations were proposed and considered in an extensive process of consultation. On the basis of the responses, we recommend that the *M'Naghten* test be revised and updated and incorporated into the MHFPA (Recommendation 3.1). This approach had the support of stakeholders and is consistent with developments in Australian and other cognate jurisdictions.

0.12 The *M'Naghten* test has two elements: the definition of the qualifying mental state and the nexus between that mental state and the defendant's acts. We recommend that the definition of the mental state required for the defence should be updated, and should be based on the definitions of mental health and cognitive impairment developed in Report 135 (Recommendation 3.2). There was very strong stakeholder support for the explicit inclusion of cognitive impairment in the definition. However, we note significant concerns relating to personality disorders and we recommend that they be excluded. We review the relationship between substance induced mental states and the *M'Naghten* test and recommend excluding addiction and the temporary effects of ingesting substances from the definition. Our recommended definition does, however, include those people who have complex needs.

0.13 So far as the nexus between mental state and act is concerned, we recommend adding to the *M'Naghten* test a third "limb", that the defence is made out if the person was unable to control their conduct. We recognise genuine concerns that this element of the test may act to exculpate defendants who were able to, but did not, resist the urge to offend and that it may pose evidentiary challenges, and create some difficult decisions for the tribunal of fact. However, this element of the test is

included in most other Australian jurisdictions and was supported by the majority of stakeholders (Recommendation 3.2).

0.14 We also consider a number of procedural issues relevant to the defence of mental illness. We recommend that the MHFPA provide that the defence of mental illness may be raised by the defence or, if the interests of justice require it, by the court or by the prosecution with permission by the court (Recommendation 3.3).

0.15 We also recommend that if the prosecution and defence agree that the proposed evidence in a case establishes the defence of mental illness, the judge may review the relevant evidence. If satisfied that the evidence establishes the defence of mental illness, the judge must enter a verdict of NGMI. This approach is consistent with other jurisdictions and may save resources in some cases by obviating the need for a trial (Recommendation 3.4).

0.16 Finally, we recommend that the name of the defence should include cognitive impairment (Recommendation 3.5) and that the verdict should be one of "not criminally responsible by reason of mental health or cognitive impairment" Recommendation 3.6).

Chapter 4: Substantial impairment

0.17 In this chapter we review the arguments for and against retention of the partial defence of substantial impairment and recommend in favour of retention because:

- the balance of opinion of stakeholders weighed strongly in favour of retention
- the complexity of cognitive and mental health impairments, and their nature and effects, requires an appropriate range of legal responses
- it is inappropriate to apply the label "murderer" to a person whose capacity to understand, make judgments or control her or himself was substantially impaired
- flexibility of responses in sentencing and post sentencing apply in cases of manslaughter which do not apply for murder
- changes following our 1997 recommendations appear to have appropriately reduced the number of cases in which substantial impairment is raised, and
- the jury should have the role of making decisions about community standards in determining culpability.

0.18 We recommend amendments to deal with some deficiencies identified in the formulation of this defence (Recommendation 4.1). For reasons of consistency and clarity, we propose that the same definition of cognitive and mental health impairments as we recommend in relation to the defence of mental illness in Chapter 3 should replace the current requirement that a person be affected by an "abnormality of the mind arising from an underlying condition".

Chapter 5: Infanticide

0.19 We review the arguments for and against abolition of the offence and partial defence of infanticide. Although the arguments are finely balanced we conclude in favour of retention. In the very few cases where the defence is used:

- infanticide affords an appropriate and compassionate criminal law response to the complex and tragic circumstances that may result in a mother killing her infant
- stakeholder opinion was strongly in favour of retention, and
- infanticide provisions respond appropriately to a particular set of circumstances that may not, in all cases, be adequately dealt with by the partial defence of substantial impairment.

The identified deficiencies in the present infanticide provisions are best dealt with by way of amendment.

0.20 Section 22A of the *Crimes Act 1900* (NSW), which deals with infanticide, relevantly provides that "at the time of the act or omission the balance of her [the mother's] mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent on the birth of the child". We recommend amending this formulation to require that, at the time of the conduct causing the death of the child, the defendant had a "mental health impairment consequent on or exacerbated by her having given birth to that child" (Recommendation 5.1). This formulation:

- retains the nexus between the birth of the child and the mental illness that is central to infanticide
- requires that there be a temporal connection, and that the mental illness is a consequence of the birth or exacerbated by it, but does not require that it be shown that the illness was *caused* by the effect of giving birth
- replaces the outdated and anachronistic term "wilful act or omission" in favour of "carries out conduct"
- removes the reference to lactation because of the lack of evidence of any causal relationship between lactation and mental illness, and
- adopts the updated definition of mental health impairment recommended in previous chapters.

Chapter 6: Procedure following a finding of unfitness

0.21 The current procedures that are followed after a person has been found unfit to be tried are complex and cumbersome, can cause lengthy delays and uncertainty, are not appropriate for defendants with cognitive impairments, and were criticised by stakeholders. In consultation we proposed a procedure to streamline these procedures and our proposal received universal stakeholder support.

0.22 We recommend that when the court makes a finding in relation to the defendant's fitness it also makes a finding as to the likelihood that the defendant will become fit. Those people that the court finds unlikely to become fit will proceed directly to a special hearing. Only those people who are likely to become fit will be referred to the Mental Health Review Tribunal (MHRT) for a maximum of 12 months, so that the MHRT can review their fitness periodically. If the MHRT finds the person fit, the presumption of fitness will be restored and the ordinary trial process may continue. If the person remains unfit, the matter will be referred to the court for a special hearing (Recommendation 6.1).

0.23 In relation to the special hearing of a case where the defendant is unfit, we recommend that the MHFPA be amended so that the court may permit the non-appearance of the defendant, or exclude the defendant from the special hearing (Recommendation 6.2). In some cases the benefits of the defendant's attendance at the special hearing cannot be realised. There are sometimes strong countervailing reasons in favour of non attendance, for example, if attendance is demonstrably producing deterioration in the defendant's health, or where the defendant is unable to control his or her behaviour so that he or she persistently disrupts proceedings. We anticipate that this discretion will be exercised rarely.

0.24 It is the present practice of courts to consider modifications of the trial process to facilitate the defendant's participation in special hearings. We recommend that a provision in the MHFPA formalise this practice (Recommendation 6.3).

0.25 Two issues relating to the conduct of special hearings require further attention. These are the appropriate role of lawyers who represent unfit defendants, and the possible role of a support person to assist the defendant to participate in the special hearing process. We recommend that the Department of Attorney General and Justice convene a working group to give further consideration to these matters (Recommendation 6.4).

Chapter 7: Powers of the court and MHRT following a finding of UNA or NGMI

0.26 People who are found UNA or NGMI have much in common. In both cases the legal system goes as far as possible in the circumstances to provide a fair trial or to establish that the person committed the acts constituting the offence. The MHRT manages both groups in substantially the same way. However, there are significant differences in court powers in relation to these two groups. We recommend that the court powers should be consistent following a finding of both UNA and NGMI (Recommendation 7.1).

0.27 We recommend that, in relation to both groups, the court first determine if the person would have been sentenced to imprisonment if found guilty at a normal trial. If he or she would have been imprisoned, the court must nominate a limiting term, being the best estimate of the sentence that would have been imposed at a normal trial. When setting the limiting term the court must take into account that the person's cognitive or mental situation may mean that he or she cannot demonstrate mitigating or discounting factors available to other defendants. A person ceases to be a forensic patient at the end of the limiting term (Recommendation 7.2).

0.28 A significant consequence of this recommendation is that those found NGMI will no longer be at risk of being detained indefinitely. Because of the potential risk factors associated with this recommendation we consulted on this issue extensively. We concluded that a time limit should apply because it:

- provides an important protection for forensic patients
- is fair, and does not provide for forensic patients to be detained or managed within the forensic system for longer than they would have been detained following conviction, and
- supports the raising of NGMI in appropriate cases: we were told repeatedly by stakeholders that indeterminate outcomes deter people from raising NGMI, so that people who should be in the forensic system are instead in the correctional system.

0.29 Issues of community safety upon release will be dealt with through:

- ongoing treatment and support in the community
- transfer to the civil mental health system or the guardianship system, and
- provisions for continuing detention in cases of continuing risk, as recommended in Chapter 11.

0.30 After a court has determined that imprisonment would be appropriate and has set a limiting term it should refer the defendant to the MHRT. The present procedures governing referral and the powers of the MHRT are confusing and inconsistent and we make recommendations to improve them. In particular we recommend that the initial determination about the detention and treatment of forensic patients should be made by the MHRT, which has the relevant expertise (Recommendation 7.3). The court should make only an interim order pending MHRT review, which should occur within two months after referral (Recommendations 7.3 and 7.5.)

0.31 There may be a few cases where a person found UNA or NGMI would not have been sentenced to imprisonment at a normal trial. We recommend that such people should be made forensic patients for a two year period (unless unconditionally released earlier), and that the MHRT supervise them with a presumption that they will be treated in the community (Recommendation 7.4).

0.32 We recommend that people found NGMI should be able to appeal against this finding regardless of whether they set up the defence. The current position in NSW, which limits appeals if the defendant sets up the defence, is inconsistent with many other Australian jurisdictions. Given the likely mental state of the defendant when making such decisions, and the inherent difficulty in ascertaining this if an appeal is raised, we are of the view that an appeal against a finding of NGMI or a limiting term should not be restricted (Recommendation 7.6). We make an alternative recommendation to similar effect which will apply in the event that our recommendations (7.3-7.5) revising procedures after a finding of UNA and NGMI are not adopted.

Chapter 8: Factors to guide decision making

0.33 This chapter deals with the considerations to which the court and the MHRT should have regard when deciding what orders to make about a person who has been found UNA or NGMI.

0.34 One of the most important decisions concerns the circumstances in which the person should be granted leave or should be released into the community. The existing test is inconsistent both with the test for involuntary detention in the civil mental health system and contemporary understandings of risk assessment. We recommend that the test be changed so that the MHRT should only make an order for leave or release if it is satisfied that the person's release would not pose a significant risk of serious physical or psychological harm to others (Recommendation 8.1).

0.35 We also recommend amendments to the MHFPA to the effect that the MHRT may order leave or release in the rare circumstances where a forensic patient poses a risk of harm solely to themselves, and not to others (Recommendation 8.2). In these circumstances the patient should be managed in the civil mental health system or the guardianship system.

0.36 The present relevant provisions of the MHFPA contain a presumption of detention when deciding whether to release a person into the community. We have concluded that this presumption should continue to apply.

0.37 The principle of least restriction, namely that a person with a cognitive or mental health impairment should be entitled to treatment in the least restrictive environment possible, is presently relevant to decisions about forensic patients under the MHFPA, but only indirectly. We recommend that the principle receive more prominence. When making decisions the MHRT should apply the principle that a forensic patient should be provided with the least restrictive environment necessary to protect against serious harm to the forensic patient or to others (Recommendation 8.3). This principle means that a more restrictive environment should only be imposed on a patient to the extent that it is necessary to protect against a risk of harm to the person or to others. If there is a less restrictive alternative that would achieve the same aim, then that alternative should be applied.

0.38 We recommend that the provisions for the making of a victim impact statement to the court should be extended to apply in circumstances where the defendant has been found UNA or NGMI (Recommendation 8.4). We do so for two reasons. First, such a statement can play an important role in the grieving process for victims of crime. It may also assist in alleviating the problem identified by stakeholders, that victims seek to put their views before the MHRT as the only avenue through which they may be heard. Secondly, we have recommended that the court set a limiting term for people found UNA and NGMI by reference to sentencing principles. Given that a court can take into account victim impact statements in the ordinary course of sentencing a convicted offender for certain specified offences, it is appropriate for victim impact statements to be taken into account similarly in setting a limiting term.

0.39 We also consider the appropriate role of victims and carers in review proceedings before the MHRT. We make no recommendations for change to the provisions

applying to victims, this being best left to the MHRT to manage. We recommend that regulations be made to require that carers be notified of upcoming MHRT reviews, and that they be given the opportunity to make submissions to the MHRT on relevant matters pertaining to the care, treatment, control or release of the forensic patient (Recommendation 8.5).

Chapter 9: Management of forensic patients

0.40 In this chapter, we consider the management of forensic patients after the court process has ended, focusing on the decision making functions, powers and procedures of the MHRT.

0.41 We identified a number of problems relating to the relationship between the MHRT and other agencies and individuals in the forensic system, including problems with:

- provision of information to the MHRT
- failure to comply with requests or orders of the MHRT
- information sharing about forensic patients, especially difficulties relating to privacy issues
- availability of services for the support of forensic patients to allow them to progress through the forensic system, and
- arrangements for continuing care when a person ceases to be a forensic patient, especially for people with cognitive impairments and complex needs.

We have concluded that these problems are best resolved by agreement and collaboration between the relevant agencies, rather than by law reform. We recommend that a Forensic Working Group of key stakeholders be established to consider these issues and to develop proposals to deal with them (Recommendations 9.6, 9.7 and 9.13).

0.42 The MHFPA makes provision for arrangements to be made for the care of forensic patients who are given leave or release from a mental health facility. However, no agency appears to be responsible for such arrangements when a forensic patient is given leave or released from another place – usually a prison or detention centre. We therefore recommend that the Commissioner of Corrective Services and the Chief Executive of Juvenile Justice develop processes to support planning and arrangements for leave or release of forensic patients, including their subsequent treatment (Recommendation 9.8).

0.43 If the MHRT is considering the release of a forensic patient who is UNA, under the MHFPA it must currently have regard to “whether or not the patient has spent sufficient time in custody”. The MHFPA provides no guidance as to the meaning of “sufficient” in this context but it has been interpreted as implicitly punitive in intent. A punitive approach is inconsistent with the legislated objects of the forensic system, and with the MHRT’s central role of overseeing the provision of treatment to forensic patients with a view to promoting patient recovery and protecting the community from harm. Stakeholders agreed that the requirement of sufficient time

in custody should be abrogated. We recommend the removal of this consideration from the framework of MHRT decision making (Recommendation 9.12).

0.44 The MHRT must inform the Minister for Police, the Minister for Health and the Attorney General of any order it makes for the release of a forensic patient. The provision appears to be a relic from the days when the executive government could instigate the return to custody of forensic patients who were conditionally released into the community. Previous reviews have recommended that the requirement to notify the Minister for Police should be removed and we also make this recommendation. The Minister for Health and the Attorney General have appeal rights against release, and we recommend that the requirement that they be notified be moved, for clarity, to the section of the MHFPA dealing with appeals (Recommendation 9.5). Arrangements concerning any notification of the NSW Police Force about release of forensic patients should be dealt with by information sharing arrangements arrived at by agreement between agencies.

0.45 We also make a number of procedural recommendations to respond to identified problems with the MHFPA. These recommendations:

- clarify when a person becomes, and ceases to be, an interim forensic patient and a forensic patient (Recommendation 9.1)
- permit reviews to be adjourned by a President or Deputy President of the MHRT sitting alone (Recommendation 9.2)
- clarify some of the terminology used in the MHFPA to describe people with mental health and cognitive impairments (Recommendation 9.3)
- suggest that the content of reports to the MHRT be dealt with by regulation (Recommendation 9.4)
- suggest that the MHRT provide information about ways in which breaches of orders relating to leave and release may be reported (Recommendation 9.9)
- clarify certain provisions relating to detention and treatment of forensic patients in the civil mental health system (Recommendations 9.10 and 9.11)
- clarify certain provisions relating to release (Recommendation 9.14), and
- provide for suspension of reviews and limiting terms where a forensic patient leaves NSW without the MHRT's approval (Recommendation 9.15).

Chapter 10: Forensic patients detained in correctional centres

0.46 The aims of the forensic system are to protect the community, and to provide treatment and services for forensic patients to resolve the issues that caused their offending behaviour. However, in NSW, as in many other jurisdictions, there are insufficient facilities able to provide both the required level of security and also the treatment and services needed by some forensic patients. Consequently, some forensic patients are held in correctional centres.

0.47 A number of problems have been identified with detaining forensic patients in correctional centres, including:

- providing appropriate therapeutic treatment and services in a correctional environment
- the potentially detrimental effect of that environment on the health and psychological wellbeing of people with cognitive and mental health impairments, and
- providing programs involving monitored reintegration into the community.

The problems appear to be particularly acute for forensic patients with cognitive impairments.

0.48 We conclude that the MHFPA should provide that forensic patients should only be detained in correctional centres when there is no other practical alternative (Recommendation 10.1). Although the detrimental effects of holding forensic patients in correctional institutions are well recognised, it would not be desirable to recommend prohibition of such detention in NSW until alternative facilities are available.

0.49 Resolution of the practical and resource issues that arise in this context, particularly in relation to forensic patients who have cognitive impairments, is a complex task. Consequently we recommend that the Forensic Working Group (Recommendation 9.6) develop a strategy and implementation plan for the provision of facilities outside correctional centres for forensic patients who have cognitive impairments, and for management of forensic patients in correctional centres in ways that facilitate leave and release during their limiting term (Recommendation 10.2).

Chapter 11: Forensic patients who present a risk of harm at the end of their limiting term

0.50 We recommend that all people found UNA or NGMI should have a limiting term imposed (Recommendation 7.2). However, there may be some forensic patients who reach the end of a limiting term and still present a serious risk of harm to others if released into the community without the continued oversight of the MHRT. Many forensic patients who present a continuing risk of harm are dealt with by admission to the civil mental health system, by appointment of a guardian with appropriate powers, or through the Community Justice Program. There are likely to be very few patients who cannot be provided for in these ways and in relation to whom continued detention or supervision remains an issue. However, their number is likely to increase as a consequence of our recommendation introducing limiting terms for those found NGMI.

0.51 In this chapter we recommend that it should be possible for forensic patients to be detained or to be subject to continuing supervision in the community beyond the expiry of their limiting term in certain carefully defined circumstances. To be consistent with principles of domestic and international law, such a scheme for preventative detention should contain clear grounds and procedures established in advance, reasons for the detention should be required and court control of the decision should be available.

0.52 We review several options for legal regulation of continuing detention. In particular we consider the existing provisions in NSW relating to continued detention of high risk sex offenders and violent offenders and recommend that these provisions be adapted to apply to forensic patients who present an unacceptable risk of causing serious physical or psychological harm to others if they were to cease to be a forensic patient. An application to extend a person's forensic status should be made to the Supreme Court. There should be an obligation to consider managing risk using less restrictive means, and orders should be limited to a maximum period of five years. If the Supreme Court makes an order, the MHRT will continue to manage the forensic patient, including holding regular reviews, and will be able to make any order it can presently make except an order for unconditional release. The Supreme Court should be able to revoke an extension order if circumstances change significantly so that the order is no longer necessary (Recommendation 11.1).

Chapter 12: Fitness and NGMI in the Local and Children's Courts

0.53 In this chapter we consider the current application and operation of fitness procedures, and the defence of mental illness in the Local and Children's Courts. Currently the provisions in the MHFPA relating to fitness and the defence of mental illness do not apply in the Local and Children's Courts. Significant problems with the current regime are identified. We recommend that these courts should be able to apply the provisions relating to fitness and the defence of mental illness in the MHFPA. The Local Court and Children's Court may divert defendants who have cognitive or mental health impairments under s 32 and s 33 of the MHFPA. Consistent with a proportional response to offending we recommend that, where questions of fitness or the defence of mental illness are raised in the Local or Children's Courts, the court must first consider whether an order under s 32 or s 33 of the MHFPA should be made. (Recommendations 12.1, 12.3, 12.4 and 12.6).

0.54 Deficiencies in the current law are also identified relating to committal proceedings in both the Local Court and Children's Court where a defendant is unfit. We recommend that the MHFPA be amended to provide that, if an issue of fitness is raised, the Local Court and the Children's Court should continue with committal proceedings and reserve the question of fitness for determination by the District or Supreme Court if the defendant is committed (Recommendations 12.2 and 12.5). This has the consequence that a committal hearing will be conducted when the defendant is unfit and unable to participate effectively in the proceedings. However, it appears to be a better solution than the alternative, that there be no committal proceedings because of the defendant's unfitness, in which case the defendant would lose the possibility of early discharge and the advantage of screening and testing the evidence.

Chapter 13: Apprehended violence orders

0.55 Stakeholders frequently raised issues relating to apprehended violence orders (AVOs) and, as a result, we issued Question Paper 1 to seek further information. We have summarised the information and case studies submitted by stakeholders to provide a resource for future work on this issue. Because of the nature of our inquiry our focus is on people with cognitive and mental health impairments as

defendants in AVO applications. Other issues arise which are not addressed in this report, for instance relating to people with impairments as victims, witnesses and family members.

0.56 Stakeholders reported that AVOs are commonly being taken out against people with cognitive and mental health impairments, and that they regularly breach these orders. Applications are made by family members, paid carers, and others. People with cognitive and mental health impairments have problems in understanding and complying with AVOs, particularly in the absence of legal representation. For these reasons, orders may not provide the required protection for the victims of violence, and extra-legal supports may be required to ensure compliance.

0.57 We recommend that the court take into account the defendant's cognitive or mental health impairment in considering whether or not to make an AVO, where the defendant's capacity to understand and comply with an order is significantly affected. We also recommend that the defendant's capacity to understand and comply with the order be taken into account when framing the terms of an order. While the protections provided by an order should not be compromised, the effectiveness of an order may be improved if the person can understand what is required of them (Recommendation 13.1).

0.58 The terms of AVOs are difficult to understand for many defendants, and we recommend that the Apprehended Violence Legal Issues Coordinating Committee convene a working group to revise the standard and common additional conditions of AVOs and redraft them in plain English (Recommendation 13.1).

0.59 Magistrates may be under-resourced and ill-equipped to make an assessment as to the extent and effect of a defendant's cognitive or mental health impairment in a busy court list. We recommend that they be provided with support and advice by the Statewide Community and Court Liaison Service and that Legal Aid NSW extend provision of legal representation to AVO defendants who have impairments (Recommendation 13.1).

0.60 Although an AVO is a civil order, breach is an offence. We recommend that, when responding to breach of an AVO by a person with a cognitive or mental health impairment, the court should consider whether or not it should make an order under s 32 of the MHFPA, so that the defendant is connected with services that will deal with the causes of the breach (Recommendation 13.1).

0.61 We note that the requirement for police to apply for an AVO where a domestic violence offence is suspected can have particularly detrimental effects for a defendant with a cognitive or mental health impairment, especially where the AVO is applied for on behalf of a family member or paid carer. We recommend that guidelines be developed for police who are dealing with AVOs where the defendant has an impairment, especially in relation to the exercise of their discretion as to whether that impairment constitutes a good reason not to make an application for an AVO (Recommendation 13.2).

0.62 Finally, the Department of Attorney General and Justice is carrying out a statutory review of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW), with particular focus on the definition of "domestic relationship" in that Act. If the review recommends retention of the current definition of "domestic relationship", then we

recommend that further consideration be given to clarifying that that a paid carer and client relationship will only qualify as a "domestic relationship" where the client is seeking an apprehended violence order against a paid carer (Recommendation 13.3).

Chapter 14: Forensic materials

0.63 The NSW Police Force can retain fingerprints, DNA samples and other forensic material of some offenders to assist in the investigation of crime. The legislation regulating the retention and destruction of forensic material, the *Crimes (Forensic Procedures) Act 2000* (NSW) (CFPA), is intended to strike a balance between promoting the efficient investigation of crime and protecting privacy rights. Although the CFPA contains provisions detailing what should happen to forensic material collected from people who are subsequently convicted or acquitted of an offence, the Act does not specify what should happen to forensic material collected from people who are:

- subject to a diversionary order under s 32 or s 33 of the MHFPA
- found NGMI, or
- found UNA.

0.64 We recommend that forensic material relating to people subject to a diversionary order under s 32 or s 33 of the MHFPA should be destroyed if the person is discharged without conditions. If conditions are applied, as they will be in most cases, the material should be retained only for the period during which it is possible for the court to deal with the original charge. However, the Police Force or the Director of Public Prosecutions may apply to the court for the forensic material to be retained. When considering such an application the court should take into account the gravity of the alleged offence, the circumstances of the offence and the person's impairment (Recommendation 14.1).

0.65 We recommend that a finding of NGMI and a finding of UNA should be treated as equivalent to a conviction for the purposes of the CFPA (Recommendations 14.2 and 14.3). The general effect of these recommendations is that forensic material will be retained in such cases.

Recommendations

	Chapter 1: Introduction	page
1.1	The Forensic Working Group, the formation of which is recommended in Recommendation 9.6, should be required to develop an action plan to provide for additional and improved options for the detention, care, and community support of forensic patients with a cognitive impairment.	10
1.2	The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be renamed the Mental Health and Cognitive Impairment (Forensic Provisions) Act.	12
1.3	The Attorney General, the Minister for Health and the Minister for Mental Health should review the *Mental Health (Forensic Provisions) Act 1990* (NSW) with a view to improving its comprehensibility and clarity.	14
	Chapter 2: Fitness to be tried	**page**
2.1	The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to include a statutory fitness test, as follows: A person is unfit to stand trial if the person cannot be afforded a fair trial because it is established on the balance of probabilities that the person is unable to do any one or more of the following: (a) understand the offence with which the person is charged (b) understand generally the nature of the proceeding as an inquiry into whether it has been proved that the person committed the offence charged (c) follow the course of proceedings and understand what is going on in a general sense (d) understand the substantial effect of any evidence that may be given against the person (e) understand the information relevant to the decisions that the person will have to make before and during the trial, and use that information as part of a rational decision making process (f) communicate effectively with, and understand advice given by, legal representatives, and (g) provide the person's version of the facts to the court, if necessary.	31
2.2	In determining whether a person is unfit for trial, the matters that a court must consider include: (a) whether modifications to the trial process can be made or assistance provided to facilitate the person's understanding and effective participation (b) the likely length and complexity of the trial, and (c) whether the person is legally represented.	35
	Chapter 3: The defence of mental illness	**page**
3.1	The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to include a statutory test for the defence of mental health or cognitive impairment as follows: A person is not criminally responsible for an offence if, when carrying out the conduct required for the offence, the person was suffering from a mental health impairment or a cognitive impairment that had the effect that the person: (a) did not know the nature and quality of the conduct (b) did not know that the conduct was wrong, that is, the person could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong, or (c) was unable to control the conduct.	50
3.2	The *Mental Health (Forensic Provisions) Act 1990* (NSW) should include definitions of "mental health impairment" and "cognitive impairment" for use in the defence of mental health or cognitive impairment as follows: (1) Mental health impairment:	61

(a) Mental health impairment means a temporary or continuing disturbance of thought, mood, volition, perception, or memory that impairs emotional wellbeing, judgment 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) substance induced mental disorders.

"Substance induced mental disorders" include ongoing mental health impairments such as drug-induced psychoses, but do not include substance abuse disorders (addiction to substances) or the temporary effects of ingesting substances.

For the purposes of this section "mental health impairment" does not include a personality disorder.

(2) Cognitive impairment:

(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.

3.3	The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that the defence of mental health or cognitive impairment may be raised at any time during a trial by the defence or, if the interests of justice require it, by: (a) the court of its own motion, or (b) the prosecution with the leave of the court.	76
3.4	The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that if the prosecution and defence agree that the evidence in a case establishes the defence of mental health or cognitive impairment, then: (a) the court must enter a verdict of not criminally responsible by reason of mental health or cognitive impairment if satisfied that the defence is established on the evidence, or (b) if the court is not satisfied that the defence is established, then the case should proceed.	78
3.5	The *Mental Health (Forensic Provisions) Act 1990* (NSW) should refer to the defence of mental health or cognitive impairment.	78
3.6	A verdict of "not guilty by reason of mental illness" should be replaced with a verdict of "not criminally responsible by reason of mental health or cognitive impairment".	80
	Chapter 4: Substantial impairment	**page**
4.1	(1) Section 23A(1)(a) of the *Crimes Act 1900* (NSW) should be amended by substituting "mental health or cognitive impairment" as the specified mental state, instead of "abnormality of the mind arising from an underlying condition". (2) For the purposes of s 23A(1)(a) "mental health impairment" and "cognitive impairment" should be defined as in Recommendation 3.2.	101

	Chapter 5: Infanticide	page
5.1	(1) Section 22A(1) of the *Crimes Act 1900* (NSW) should provide: If a women carries out conduct that causes the death of her child in circumstances that would constitute murder, and at the time she had a mental health impairment consequent on or exacerbated by her having given birth to that child within the preceding 12 months, she is guilty of infanticide, and not of murder. (2) Section 22A(2) of the *Crimes Act 1900* (NSW) should provide: If a women carries out conduct that causes the death of her child in circumstances that would constitute murder, and at the time she had a mental health impairment consequent on or exacerbated by her having given birth to that child within the preceding 12 months, the jury should find that she is guilty of infanticide, and not of murder. (3) For the purposes of s 22A "mental health impairment" should be defined as in Recommendation 3.2. (4) The maximum penalty for infanticide should continue to be the same as for manslaughter.	124

	Chapter 6: Procedures following a finding of unfitness	page
6.1	The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide: (1) If the court finds a person unfit to be tried and unlikely to become fit, the court may hold a special hearing. (2) If the court finds a person unfit to be tried and likely to become fit and it would be in the interests of justice to delay resolution pending that likelihood: (a) The court: (i) may adjourn the proceedings for a specified period of time, not exceeding 12 months (ii) may grant bail, remand in custody, and make any other order (iii) must refer the person to the Mental Health Review Tribunal. (b) Until the end of the specified period of time, the Mental Health Review Tribunal must review the person's case periodically to determine whether or not the person has become fit to be tried: (i) If the Mental Health Review Tribunal finds that the person has become fit to be tried, the Mental Health Review Tribunal should be required to notify the court and the Director of Public Prosecutions of its finding. This finding would operate to restore the presumption that the person is fit to be tried. The ordinary trial process should then continue. (ii) If the person is still unfit to be tried at the end of the specified period of time, or, if on review, the Mental Health Review Tribunal finds that the person will not become fit to be tried during the specified period of time, the Mental Health Review Tribunal should be required to notify the court and Director of Public Prosecutions of its finding. The matter should then return to court and the special hearing procedure should be followed. (3) Unless released on bail, a person found unfit to be tried becomes an interim forensic patient.	139
6.2	The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that the court may permit the non-appearance of the defendant at a special hearing, or exclude the defendant from a special hearing.	146
6.3	The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to the effect that, prior to or at a special hearing, the court must consider whether modifications to court processes can be made or assistance provided to facilitate the defendant's effective participation in the special hearing.	150
6.4	The Department of Attorney General and Justice should convene a working group of key stakeholders to give consideration to: (a) defining the appropriate role of legal representatives and support people at special hearings (b) consequential amendments to law and professional ethics rules, and (c) the most appropriate organisation to provide support people.	152

	Chapter 7: Powers of the court and MHRT following a finding of UNA or NGMI	page
7.1	The powers available to a court following a finding of not guilty by reason of mental illness and the powers	166

available to a court following a finding at a special hearing that a person has, on the limited evidence available, committed an offence ("a finding of unfit and not acquitted") should be consistent with each other.

7.2 The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to the effect that: 180

(a) Where a person has been found unfit and not acquitted at a special hearing or not guilty by reason of mental illness at a special hearing or at a normal trial, the court must determine whether or not that person would have been sentenced to imprisonment if found guilty at a normal trial.

(b) Where the court determines that a sentence of imprisonment would have been imposed under Recommendation 7.2(a) the court must nominate a limiting term.

(c) The limiting term should be the court's best estimate of the length of the sentence of imprisonment that would have been imposed had that person been found guilty at a normal trial.

(d) When setting the limiting term, the court should be required to take into account that, because the person is unfit to stand trial or not guilty by reason of mental illness (or both), it may not be possible to demonstrate particular mitigating or discounting factors (for example, a guilty plea or expression of remorse).

(e) A person must cease to be a forensic patient at the expiry of his or her limiting term (if not released earlier by order of the Mental Health Review Tribunal).

7.3 The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to the effect that: 187

(a) Where the court has nominated a limiting term, as described in Recommendation 7.2, the court must refer the person to the Mental Health Review Tribunal.

(b) The person should then become a forensic patient.

(c) The Mental Health Review Tribunal should be required to conduct an initial review as soon as practicable, or in any case within two months, and make decisions regarding:

(i) the person's detention, care or treatment in a mental health facility or other place, or

(ii) the person's release (either unconditionally or subject to conditions).

7.4 The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to the effect that where the court determines that a person found unfit and not acquitted or not guilty by reason of mental illness would not have been sentenced to imprisonment if found guilty at a normal trial: 192

(a) The court should be required to refer the person to the Mental Health Review Tribunal.

(b) The person should become a forensic patient for a period of two years (if not unconditionally released earlier by order of the Mental Health Review Tribunal).

(c) The Mental Health Review Tribunal should be required to conduct an initial review as soon as practicable, or in any case within two months.

(d) The Mental Health Review Tribunal must not order that the person be detained at an initial review, or at further reviews, unless the person poses a significant risk of serious physical or psychological harm to others.

(e) The Mental Health Review Tribunal may transfer the person to the civil mental health system in accordance with Recommendation 8.2.

7.5 The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to the effect that: 194

(a) When the court refers a matter to the Mental Health Review Tribunal as described in Recommendations 7.3 or 7.4, the court may:

(i) order that the person be released subject to conditions or unconditionally

(ii) order that the person be detained in a mental health facility or other place, or

(iii) make such other orders as the court considers appropriate.

(b) Every such order should specify that it is an interim order pending further order by the Mental Health Review Tribunal.

7.6 The *Mental Health (Forensic Provisions) Act 1990* (NSW) and the *Criminal Appeal Act 1912* (NSW) should be amended to the effect that: 201

(1) A person found not guilty by reason of mental illness may appeal against:

(a) a verdict of not guilty by reason of mental illness, and

(b) the duration of a limiting term,

whether or not he or she set up the defence.

(2) The prosecution may appeal against the duration of a limiting term imposed by the court.

7.7 If Recommendations 7.3-7.5 are not adopted, the *Criminal Appeal Act 1912* (NSW) should be amended to clarify that: 202

(a) The defendant may appeal a verdict of not guilty by reason of mental illness whether or not the defendant set up the defence.

(b) The defendant and prosecution may appeal an order following a finding of not guilty by reason of mental illness whether or not the defendant set up the defence.

(c) Before making an order for release of a person found not guilty by reason of mental illness, the Court of Criminal Appeal must be satisfied that the person's release would not pose a significant risk of serious physical or psychological harm to others.

Chapter 8: Factors to guide decision making **page**

8.1 (1) Section 43 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that in making a decision about release, including conditional release, the Mental Health Review Tribunal: 218

(a) may make such an order only if it is satisfied that the person's release would not pose a significant risk of serious physical or psychological harm to others

(b) must consider:

(i) the matters contained in s 74 of the *Mental Health (Forensic Provisions) Act 1990* (NSW)

(ii) the principles contained in s 68 of the *Mental Health Act 2007* (NSW), and

(iii) whether the person requires further support, supervision or treatment, and if so, whether effective and appropriate support, supervision or treatment would be available to the person in the community upon release.

(2) Section 49(3) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that the Mental Health Review Tribunal may make an order allowing a forensic patient to be absent from a mental health facility, correctional centre or other place only if it is satisfied that the person's leave of absence would not constitute a significant risk of serious physical or psychological harm to others.

(3) Section 74(d) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to adopt the same terminology proposed for s 43(a) in Recommendation 8.1(1).

(4) If Recommendations 7.3-7.5 are not adopted and the court retains the power to order the release of a defendant following a finding of not guilty by reason of mental illness or a finding of unfit and not acquitted, then the legislation should provide that the court may make an order for release only if it is satisfied that the person's release would not pose a significant risk of serious physical or psychological harm to others.

8.2 (1) The reference to the safety of the patient in s 43(a) and s 49(3) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be removed. 221

(2) Where a person:

(a) presents a risk of harm solely to himself or herself, as opposed to a risk of harm to others, and

(b) meets the criteria for admission as an involuntary patient under the *Mental Health Act 2007* (NSW),

then the Mental Health Review Tribunal should have the power to transfer that person into the civil mental health system, in addition to anything else it can do under the *Mental Health (Forensic Provisions) Act 1990* (NSW).

8.3 Section 74 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to include, as a consideration to which the Mental Health Review Tribunal must have regard, that a forensic patient should be provided with the least restrictive environment necessary to protect against serious harm to the forensic patient or to others. 229

8.4 (1) The provisions relating to the making of a victim impact statement to the court under Part 3, Division 2 of the *Crimes (Sentencing Procedure) Act 1999* (NSW) should be extended to apply to circumstances where the defendant is found unfit and not acquitted or not guilty by reason of mental illness under the *Mental Health (Forensic Provisions) Act 1990* (NSW). 233

(2) If Recommendations 7.3-7.5 are not adopted and the court retains the power to order the release of a defendant following a finding of not guilty by reason of mental illness or a finding of unfit and not acquitted, the court should be permitted to invite representations from victims and carers of the defendant regarding:

(a) the risk, if any, that the defendant's release may pose to a victim or carer

(b) the conditions, if any, that should be imposed on the defendant's release, and

(c) any other matter which may impact on the court's decision to order release.

8.5 (1) A regulation should be made under s 160 of the *Mental Health Act 2007* (NSW) to: 240

(a) require a primary carer of a forensic patient to be notified about forthcoming review hearings by the Mental Health Review Tribunal concerning the forensic patient, and

(b) permit the primary carer, with the leave of the Tribunal, to make representations in relation to matters relevant to its deliberations.

(2) "Primary carer" should have the meaning given to it under s 71 and s 72 of the *Mental Health Act 2007* (NSW).

	Chapter 9: Management of forensic patients	**page**

9.1 The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that: 248

(a) Where a person has been found unfit to be tried by the court, that person should be an "interim forensic patient".

(b) A person ceases to be an "interim forensic patient" when:

(i) the person is released on bail

(ii) the person is found to have become fit

(iii) the Director of Public Prosecutions advises that no further proceedings will be taken

(iv) the charges are dismissed

(v) he or she is acquitted, or

(vi) he or she is found unfit and not acquitted or not guilty by reason of mental illness (in which case the person becomes a forensic patient).

(c) Where a person is found unfit and not acquitted or not guilty by reason of mental illness that person should be a "forensic patient".

(d) A person ceases to be a "forensic patient" when:

(i) the Mental Health Review Tribunal releases the person unconditionally

(ii) the Mental Health Review Tribunal reclassifies the person as a civil involuntary patient

(iii) the person's limiting term expires, or

(iv) the person, having been found unfit, is found to have become fit.

(e) Provisions in the *Mental Health (Forensic Provisions) Act 1990* (NSW) should refer to "interim forensic patients", "forensic patients" or both, as relevant.

9.2 A regulation should specify that, for the purposes of the function of adjourning a review under the *Mental Health (Forensic Provisions) Act 1990* (NSW), the Forensic Division of the Mental Health Review Tribunal may be constituted by the President or a Deputy President of the Tribunal sitting alone. 255

9.3 (1) Section 40(b) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be replaced with "to provide for the care, treatment and control of persons subject to criminal proceedings who have a cognitive or mental health impairment". 258

(2) Section 74(a) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be replaced with "the nature of the person's cognitive or mental health impairment".

9.4 The *Mental Health (Forensic Provisions) Act 1990* (NSW) should allow regulations to provide for the types of information that may be included in a report under s 74(d) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) including, where such information is available: 259

(a) the nature and circumstances of the index event

(b) the patient's condition at the time of the index event, and

(c) the patient's treatment history before and after the index event.

9.5 (1) The requirement in s 76A(6) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) that the Mental Health Review Tribunal must inform the Minister for Police of any order it makes for the release of a person and the date of the person's release should be removed. 262

(2) The requirement in s 76A(6) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) that the Mental Health Review Tribunal must inform the Attorney General and Minister for Health of any order it makes for the release of a person and the date of the person's release should be moved to s 77A.

9.6 (1) A Forensic Working Group should be established, comprised of representatives from the Mental Health Review Tribunal and senior officers from Corrective Services NSW, Juvenile Justice NSW, Ministry of Health, Justice and Forensic Mental Health Network, Ageing, Disability and Home Care, NSW Police Force, Mental Health Commission of NSW and other agencies involved in supervising and caring for forensic patients. 268

(2) The Forensic Working Group should develop a framework for cross-agency supervision and support of forensic patients including:

(a) agency responsibilities regarding forensic patients, including funding and arrangement of particular assessments and services

(b) agency response arrangements and expected response time to Mental Health Review Tribunal requests, and

(c) strategies to deal with people with cognitive impairments and complex needs.

(3) The Forensic Working Group should identify barriers to effective management and supervision of forensic patients and develop priority actions to deal with these barriers.

9.7 (1) The Forensic Working Group recommended in Recommendation 9.6 should work with the NSW Privacy Commissioner to review information sharing arrangements in relation to forensic patients to determine: 275

(a) the nature and extent of existing problems

(b) the avenues that already exist to deal with the identified problems

(c) how those avenues may be efficiently used, and

(d) whether any change to legislation is required.

(2) The Forensic Working Group should provide a report to the Minister for Health addressing any actions required to improve information sharing arrangements.

9.8 (1) The Commissioner of Corrective Services NSW and the Chief Executive of Juvenile Justice NSW should develop processes to support planning and arrangements for leave or release of forensic patients, including subsequent treatment or other action required. 276

(2) Section 76G of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that the Commissioner of Corrective Services NSW and the Chief Executive of Juvenile Justice NSW should take all reasonably practicable steps to ensure that the forensic patient, any primary carer, dependents, and agencies involved in providing services to that person are consulted when making arrangements for leave or release of a forensic patient.

9.9 The Mental Health Review Tribunal should make information publicly available regarding how breaches under s 68 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) can be reported. 278

9.10 A provision should be included in either the *Mental Health (Forensic Provisions) Act 1990* (NSW) or *Mental Health Act 2007* (NSW) to clarify that where a forensic patient is in the community, he or she can still be detained under the civil provisions of the *Mental Health Act 2007* (NSW). 279

9.11 Section 68 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should allow the Mental Health Review Tribunal, when making an order for apprehension, to specify that, pending review of a breach by the Tribunal: 281

(a) the forensic patient may continue to be given treatment in accordance with the terms of conditional release imposed by the Tribunal

(b) a medical practitioner must assess the forensic patient's mental state, and

(c) the forensic patient may be detained in a mental health facility for the purposes of assessment and treatment.

9.12 The provision in s 74(e) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) requiring the Mental Health Review Tribunal to consider whether the forensic patient has spent "sufficient time in custody" should be removed. 286

9.13 The Forensic Working Group recommended in Recommendation 9.6 should develop arrangements for continuing care when a person ceases to be a forensic patient, including in particular arrangements for people who have cognitive impairments or complex needs. 288

9.14 (1) Section 53(2) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that the Tribunal **must** order that a patient classified as an involuntary patient under this section be transferred from a correctional centre to a mental health facility. 290

(2) A forensic patient who is detained in a mental health facility, correctional centre, or other place, should be discharged from that place of detention when he or she ceases to be a forensic patient, unless there is another lawful basis upon which to detain that person.

9.15 The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that, where a forensic patient has left NSW without the Mental Health Review Tribunal's approval, during that period of absence: 293

(a) the Tribunal may suspend reviews,

(b) the operation of the limiting term should be suspended.

Chapter 10: Forensic patients detained in correctional centres **page**

10.1 The *Mental Health (Forensic Provisions) Act 1990* (NSW) should provide that forensic patients should only be detained in correctional centres where there is no other practical alternative. 314

10.2 The Forensic Working Group recommended in Recommendation 9.6 should develop a strategy and an implementation plan relating to: 314

(a) as a priority, the provision of facilities outside correctional centres for forensic patients who have cognitive impairments, and

(b) management of forensic patients within correctional centres that facilitates leave and release during the limiting term.

Chapter 11: Forensic patients who present a risk of harm at the end of their limiting term **page**

11.1 (1) A provision should be included in the *Crimes (High Risk Offenders) Act 2006* (NSW) or the *Mental Health (Forensic Provisions) Act 1990* (NSW) to allow for a person's forensic patient status to be extended beyond the expiry of the person's limiting term in defined circumstances. 337

(2) The Supreme Court should make the decision to extend a person's forensic patient status, broadly following the process for the making of an extended supervision order or continuing detention order under the *Crimes (High Risk Offenders) Act 2006* (NSW). The scheme should include the following features:

(a) Six months prior to the expiry of the forensic patient's limiting term, a Minister responsible for the administration of the *Mental Health (Forensic Provisions) Act 1990* (NSW), acting on behalf of the State, may apply to the Supreme Court for extension of a person's forensic patient status (an "extension order") if there are reasonable grounds to believe that the person poses an unacceptable risk of causing serious physical or psychological harm to others if the person were to cease to be a forensic patient.

(b) The provisions in the *Crimes (High Risk Offenders) Act 2006* (NSW) relating to pre-trial procedures and the making of interim orders should be followed, including provision for a pre-trial hearing and the commissioning of two independent expert reports.

(c) The Supreme Court should be able to make an extension order for a forensic patient if the court is satisfied to a high degree of probability that:

(i) the person poses an unacceptable risk of causing serious physical or psychological harm to others if the person were to cease to be a forensic patient, and

(ii) that risk cannot be adequately managed by other less restrictive means (such as reclassification as an involuntary patient under the civil mental health system or through the making of a guardianship order).

(d) In making the order the Supreme Court should have regard to the following considerations:

(i) the safety of the community

(ii) the reports prepared by the independent experts appointed by the court, and any other expert reports submitted by the parties

(iii) any orders or decisions of the Mental Health Review Tribunal

(iv) the person's level of compliance with any obligations imposed while a forensic patient including while on leave or conditional release

(v) the views of the court at the time the limiting term was imposed

(vi) a report from the forensic patient's treating team as to the need for ongoing management of the person as a forensic patient and the reasons why alternative arrangements are not suitable.

(e) The Supreme Court should be able to make an extension order for up to five years, although subsequent applications may be made. In determining the length of the order, the court should have regard to whether the person's level of risk is likely to change significantly.

(f) If an order is made, the person should be referred back to the Mental Health Review Tribunal for ongoing management as a forensic patient.

(g) The Mental Health Review Tribunal should review the person every six months and may make any order in relation to that person that it can make for a forensic patient, except an order for unconditional release.

(4) The Supreme Court should be able to make an order at any time revoking an extension order on the application of the State or the forensic patient, including on the ground that circumstances have changed significantly so as to render the extension order unnecessary.

(5) The scheme should include the provisions of Part 4 of the *Crimes (High Risk Offenders) Act 2006* (NSW).

	Chapter 12: Fitness and NGMI in the Local and Children's Court	**page**
12.1	(1) The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended so that Part 2 of the Act, dealing with fitness to be tried, applies in the Local Court. (2) The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that, if the question of fitness is raised in the Local Court under Part 2 of the Act, the court must first consider whether it should make an order under s 32 or s 33 of the Act.	352
12.2	The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to the effect that, if the question of fitness is raised at a committal hearing in the Local Court: (a) the committal hearing must be completed (b) the defendant must not be discharged only because the question has been raised, and (c) if the defendant is committed for trial, the trial court must consider the question of fitness.	356
12.3	(1) The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended so that Part 4 of the Act, dealing with the defence of mental illness, applies in the Local Court. (2) The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that, if the defence of mental illness is proposed to be raised in the Local Court under Part 4 of the Act, the court must first consider whether it should make an order under s 32 or s 33 of the Act.	362
12.4	(1) The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended so that Part 2 of the Act, dealing with fitness to be tried, applies in the Children's Court. (2) The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that, if the question of fitness is raised in the Children's Court under Part 2 of the Act, the court must first consider whether it should make an order under s 32 or s 33 of the Act.	368
12.5	The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to the effect that, if the question of fitness is raised at a committal hearing in the Children's Court: (a) the committal hearing must be completed (b) the defendant must not be discharged only because the question has been raised, and (c) if the defendant is committed for trial, the trial court must consider the question of fitness.	369

12.6 (1) The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended so that Part 4 of the Act, dealing with the defence of mental illness, applies in the Children's Court. 372

(2) The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that, if the defence of mental illness is proposed to be raised in the Children's Court, under Part 4 of the Act, the Court must first consider whether it should make an order under s 32 or s 33 of the Act.

Chapter 13: Apprehended violence orders **page**

13.1 (1) Section 17 and s 20 of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) should be amended to provide that an additional relevant matter to be considered by the court when deciding whether or not to make an apprehended violence order is the defendant's capacity to understand and comply with the terms of an order, where that capacity is significantly affected by a cognitive or mental health impairment. 404

(2) The *Crimes (Domestic and Personal Violence) Act 2007* (NSW) should be amended to provide that, in making an apprehended violence order against a defendant whose capacity to understand and comply with the terms of an order is significantly affected by a cognitive or mental health impairment, the court must consider:

(a) whether the order can be drafted using language that the defendant can understand, and

(b) whether the conditions contained in the order can be modified, without compromising the protections afforded to the protected person, to enable the defendant to understand and comply with those conditions.

(3) The Apprehended Violence Legal Issues Coordinating Committee should convene a working group to revise the standard and common additional conditions for an apprehended violence order and redraft them in plain English.

(4) The expansion of the Statewide Community and Court Liaison Service (SCCLS) recommended in Recommendation 7.1 of Report 135 should include provision for identification and assessment services for defendants to apprehended violence order applications.

(5) Where an apprehended violence order application is made and the defendant appears to the court to have a cognitive or mental health impairment:

(a) the court may refer the defendant to the SCCLS for assessment, and adjourn the proceedings pending the outcome of the assessment

(b) the SCCLS should provide a report to the court which addresses:

(i) the nature and extent of the defendant's cognitive or mental health impairment (if any), and

(ii) as far as can be ascertained, the consequences of that impairment for the application before the court.

(6) Recommendations 13.1(4)-(5) should also apply where the defendant consents to the making of the apprehended violence order.

(7) Where a defendant with a cognitive or mental health impairment is charged under s 14 of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW), the court should be required to consider whether it should make an order under s 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) for diversion of the defendant to services that will deal the causes of the offending.

(8) The *Crimes (Domestic and Personal Violence) Act 2007* (NSW) should include the definitions of "cognitive impairment" and "mental health impairment" set out in Recommendations 5.1 and 5.2 of Report 135.

(9) Legal Aid NSW should extend provision of legal representation to defendants to apprehended violence order applications who have a cognitive or mental health impairment.

13.2 (1) The NSW Police Force should develop guidelines for determining the circumstances in which a defendant's cognitive or mental health impairment will constitute "good reason" for a police officer not to make an apprehended violence order application, within the meaning of s 27(4)(b) and s 49(4)(b) of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW). 409

(2) Relevant considerations in the exercise of the discretion could include:

(a) the circumstances in which the police officer was called to attend the scene

(b) the likelihood that an apprehended violence order will provide effective protection for the person in need of protection

(c) the defendant's capacity to understand and comply with the terms of an apprehended violence

order (as far as it can be ascertained by the police officer)

(d) the wishes of the person in need of protection, and

(e) the availability of other resources to protect the person in need of protection.

13.3 If the statutory review of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) recommends that paid care be retained within the definition of "domestic relationship" in s 5(f) of the Act, the NSW Department of Attorney General and Justice should give further consideration to whether s 5(f) should be amended to clarify that a paid carer and client relationship will only qualify as a "domestic relationship" where the client is seeking an apprehended violence order against a paid carer. 411

	Chapter 14: Forensic material	**page**
14.1	(1) Section 88(4) of the *Crimes (Forensic Procedures) Act 2000* (NSW) should be amended to the following effect: (a) If forensic material has been taken from a person who is a suspect and the charge against the person is dismissed under s 32 or s 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW): (i) if the person is discharged unconditionally (whether into the care of a responsible person or not), then the forensic material relating to the charge must be destroyed as soon as practicable, (ii) if the person is discharged subject to conditions, then the forensic material relating to the charge must be destroyed as soon as practicable after the expiry of the six month period referred to in s 32(3)(A) or s 33(2), unless further proceedings are brought in relation to the charge. (b) Notwithstanding the above, the court may make an order for retention of forensic material on the application of a police officer or the Director of Public Prosecutions if such an order is justified in all the circumstances of the case, having regard to: (i) the gravity of the alleged offence (ii) the circumstances in which the offence is alleged to have been committed, and (iii) the person's cognitive and mental health impairment. (2) Alternatively, if Recommendations 9.4-9.9 of Report 135 are adopted, s 88(4) of the *Crimes (Forensic Procedures) Act 2000* (NSW) should be amended to the following effect: (a) If forensic material has been taken from a person who is a suspect, the material relating to the charge must be destroyed as soon as practicable in the following circumstances: (i) the charge against the person is dismissed under s 32 or s 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) and the person is discharged unconditionally (ii) the charge is dismissed under s 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) and the person is discharged on the basis that a satisfactory diversion plan is in place, or (iii) the charge is dismissed under s 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) after the defendant has undertaken a diversion plan. (b) Notwithstanding the above, the court may make an order for retention of forensic material on the application of a police officer or the Director of Public Prosecutions if such an order is justified in all the circumstances of the case, having regard to: (i) the gravity of the alleged offence (ii) the circumstances in which the offence is alleged to have been committed, and (iii) the person's cognitive and mental health impairment.	426
14.2	The *Crimes (Forensic Procedures) Act 2000* (NSW) should be amended to provide that for the purposes of s 88, a finding that a person is not guilty by reason of mental illness is equivalent to a conviction.	430
14.3	The *Crimes (Forensic Procedures) Act 2000* (NSW) should be amended to provide that for the purposes of s 88, a finding at a special hearing that a person has, on the limited evidence available, committed an offence is equivalent to a conviction.	433

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 resulted 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* (NSW) (now the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA)) and sentencing of people with cognitive and mental health impairments.

1.3 In June 2012, we issued the first report in this reference (Report 135), which responds to the first specific term of reference concerning s 32 and s 33 of the MHFPA. It deals with the diversion of people with cognitive and mental health

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

impairments from the criminal justice system, as well as related matters such as definitions of cognitive impairment and mental health impairment. The Government has indicated that it will establish a committee to prepare a whole-of-government response to the report, comprising senior officers from mental health, disability and criminal justice agencies.[2]

1.4 This is the second and final report addressing these terms of reference. Its focus, broadly speaking, is on defendants who have mental health and cognitive impairments who have committed more serious offences. We consider: fitness to be tried; the defence of mental illness; substantial impairment; and infanticide. We also examine the procedures that follow a finding of unfitness or not guilty by reason of mental illness (NGMI), and the management of defendants who become forensic patients. We examine the use and impact of apprehended violence orders against people who have cognitive and mental health impairments, as well as the retention and destruction of forensic samples in relation to people who are diverted or found unfit and not acquitted at a special hearing (UNA) or NGMI.

1.5 In September 2011, the Attorney General asked the Commission to conduct a review of sentencing. The report is in preparation. For this reason, we have not dealt with sentencing of people with cognitive and mental health impairments in this report; it will be considered in our report on sentencing.

This report in context

1.6 This report should be read together with Report 135.

1.7 In Report 135 we outline the relationship between this review and:

- the NSW Government's *NSW 2021* plan
- the establishment of the Mental Health Commission of NSW (MHC) and the National Mental Health Commission, and
- relevant concurrent and previous reviews, including a chronology of key reviews.[3]

Here we consider how this report relates to the *NSW 2021* plan, and to reviews specifically relevant to this report.

NSW 2021 plan

1.8 The NSW Government's *NSW 2021* plan, a 10 year plan to guide policy and budget decision making in NSW, identifies several goals important to this review. In

2. G Smith, "Mental Illness and the Criminal Justice System" (Media Release, 23 August 2012).
3. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) [1.5]-[1.17].

Report 135 we identify a range of goals, targets and priority actions relevant to diversion.[4] Many goals are also relevant to this report, including:

- **Goal 11:** Keep people healthy and out of hospital.
- **Goal 13:** Better protect the most vulnerable members of the community and break the cycle of disadvantage.
- **Goal 14:** Increase opportunities for people with a disability by providing supports that meet their individual needs and realise their potential.
- **Goal 17:** Prevent and reduce the level of reoffending.

1.9 Our recommended changes to the tests for fitness and the defence of mental illness, together with proposals for significant procedural improvements to the forensic system, are likely to increase the number of people willing to raise unfitness or the defence of mental illness before or during trial. Changed definitions of impairment and updating of the law relating to criminal responsibility to accord with contemporary knowledge will assist in ensuring that the right people are found UNA or NGMI. Those whose offending is affected by significant cognitive or mental health impairments are better dealt with through a forensic system focused on care, treatment and community safety. Our recommendations will assist in keeping people with serious impairments out of prisons and detention centres.

1.10 Interventions focussed on treatment, as well as on community safety, will help keep people healthy, and reduce reoffending by linking people to services. These interventions will better protect vulnerable members of the community and provide additional supports for people with a disability. Our recommendations relating to those people who pose a serious risk at the end of a term of detention will prevent reoffending and promote community safety.

1.11 Our recommended changes to apprehended violence order legislation will assist courts to make orders that defendants with cognitive and mental health impairments can understand and comply with, thereby providing more effective protection for applicants.

1.12 The recommendations in this report aim to make the current system fairer and more responsive to the needs of people with cognitive and mental health impairments, with due regard to the safety and other interests of the community.

Other reviews

1.13 In Report 135 we provide a comprehensive overview of recent relevant reports.[5]

1.14 A number of concurrent reviews are directly relevant to this report:

- The review of the *Mental Health Act 2007* (NSW) by NSW Health.[6]

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4. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) [1.5]-[1.10].
5. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) [1.13]-[1.17].

- The statutory review of the *Crimes (Domestic and Personal) Violence Act 2007* (NSW) by the NSW Department of Attorney General and Justice is relevant to Chapter 13, apprehended violence orders.[7]
- A review of forensic procedures, including the *Crimes (Forensic Procedures) Act 2000* (NSW), by a working group headed by Acting Justice Graham Barr, is relevant to Chapter 14, forensic material.[8]

1.15 The NSW government established the MHC in 2012. The MHC is developing a whole-of-government plan to support people who experience mental illness, their families and their carers to live full and rewarding lives. The MHC will be monitoring and reporting on the implementation of its plan.

1.16 The Government has also announced its response to our Report 133 *Bail*. In relation to recommendations to ensure that bail legislation takes into account the needs of vulnerable groups, including people with a cognitive and mental health impairment, the Government has stated that it:

> acknowledges that some members of particular groups may have special needs and be vulnerable, particularly in the context of the criminal justice system. The new Act will require the bail authority to consider the special vulnerability or needs of the accused when determining bail, including because of … cognitive or mental health impairment. This ensures the special vulnerabilities and needs of these groups of people are adequately addressed in the bail decision making process.[9]

Our process

Submissions and consultations

1.17 After receiving our terms of reference, the Commission received 25 preliminary submissions.[10] Five Consultation Papers (CPs) on people with cognitive and mental health impairments in the criminal justice system were published in 2010:

- An overview (CP 5).
- Criminal responsibility and consequences (CP 6).
- Diversion (CP 7).
- Forensic samples (CP 8).
- Young people (CP 11).

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6. NSW Health, "Review of the NSW Mental Health Act 2007" <www.health.nsw.gov.au/mhdao/Pages/Review-of-the-NSW-Mental-Health-Act-2007.aspx>.
7. NSW Department of Attorney General and Justice, *Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007,* Discussion Paper (2011).
8. K Keneally, "Major Review of State's DNA Forensics Procedures" (News Release, 6 April 2010); NSW, *Parliamentary Debates*, Legislative Assembly, 20 April 2010, 21 825 (J Hatzistergos).
9. NSW Government, *NSW Government Response to the NSW Law Reform Commission Report on Bail* (2012) 11-12.
10. See NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) Appendix B.

1.18 In 2012 we circulated two Question Papers (QPs) to address particular issues that required additional information:

- Apprehended violence orders (QP 1).
- Fitness to plead guilty (QP 2).

1.19 We received 70 submissions in response to these CPs and QPs. 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 also conducted 39 consultations involving more than 200 people. The consultations took a number of forms, ranging from meetings with individuals, roundtables, court observations and a symposium. The consultations informed all aspects of our review, including Report 135 on diversion. These consultations are listed in Appendix B of this report. We also worked particularly closely with the Mental Health Review Tribunal (MHRT), given its central role and experience in this field.

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. Good policy-making in this area must also go beyond law, to its intersection with behavioural sciences. Ongoing legal expertise is provided by the members of our Division. To secure ongoing advice and assistance about behavioural sciences and the operation of the service sectors, we continued to work with our Expert Advisory Panel in developing this report.[11]

1.22 We thank our experts, all those who made submissions, and all who contributed to our consultations. Their contributions are part of the fabric of Report 135 and this report, and inform and enrich every aspect of them. 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: criminal responsibility and consequences

1.23 This report will focus upon issues raised in CPs 6 and 8.

1.24 There are 14 chapters in this report:

- **Chapter 2** examines the *Presser* criteria, the current test for fitness to stand trial.
- **Chapter 3** examines the *M'Naghten* rule, the current standard for the defence of mental illness.
- **Chapter 4** considers the partial defence of substantial impairment.

11. See page xi.

- **Chapter 5** explores the offence and partial defence of infanticide.
- **Chapter 6** deals with the procedures following a finding that the defendant is unfit to be tried, including special hearing processes.
- **Chapter 7** deals with court processes following a finding of UNA or a verdict of NGMI, including the question of limiting terms.
- **Chapter 8** addresses the key factors that guide decision making regarding forensic patients, including the principle of least restriction and risk of harm.
- **Chapter 9** deals with the management of forensic patients by the MHRT, including the MHFPA provisions regarding review, release and conditions.
- **Chapter 10** deals with the issue of forensic patients detained in correctional centres.
- **Chapter 11** proposes a scheme for dealing with forensic patients who are at risk of harm at the end of their limiting term, and whose harm cannot be managed within the civil systems.
- **Chapter 12** examines the processes of the Local Court and Children's Court associated with fitness and NGMI, and recommends extension of the current system to address gaps in the current legislation relating to those courts.
- **Chapter 13** explores apprehended violence orders and their application to people with cognitive and mental health impairments.
- **Chapter 14** deals with the retention and destruction of forensic samples in relation to people who are diverted or found UNA or NGMI.

1.25 The scope of this review is limited to the law relating to people with cognitive and mental health impairments as alleged offenders. However, people with cognitive and mental health impairments are also involved in the criminal justice system as victims, witnesses or family members. We recognise in particular the overrepresentation of this cohort as victims of crime,[12] but consideration of these issues is beyond the scope of this report.

1.26 In this report, when we refer to people with cognitive and mental health impairments we mean people with cognitive impairments, mental health impairments or both.

Key issues

Incidence

1.27 There is strong evidence (reviewed in Report 135) that people with cognitive and mental health impairments are overrepresented throughout the criminal justice

12. See, eg, 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>.

system.[13] However, the majority of people with cognitive and mental health impairments do not offend. The higher representation does not arise from a simple relationship between impairment and crime, but rather it is frequently the product of impairment together with other factors, such as disrupted family backgrounds, family violence, abuse, misuse of drugs and alcohol, and unstable housing.

1.28 Most offending by people with cognitive and mental health impairment involves minor offences dealt with in the Local Court. Diversion is frequently the most appropriate way to deal with these offenders.

1.29 Fitness for trial and the defence of mental illness are a significant focus of this report. They are usually raised only in relation to serious offences and the total number of cases is very small. For example, the verdict of NGMI has been found in only 23 to 31 cases each year.[14] People found NGMI represent the significant majority of forensic patients – approximately 85%.[15] A finding that the defendant is unfit and not acquitted has occurred in only 5 to 11 cases each year.[16]

1.30 The partial defence of infanticide is rarely used in practice, with only four cases in NSW between 2001 and 2011.[17] There would appear to be about six cases a year in NSW in which the partial defence of substantial impairment is raised.[18]

The criminal justice system in context

1.31 Providing effective responses to people with cognitive and mental health impairments who offend requires that the criminal justice system work alongside and in cooperation with government and non-government service providers. In Report 135, we deal with diversion of offenders and demonstrate the importance of communication, coordination and collaboration between courts and the service sector to prevent reoffending.

1.32 In this report the focus is, broadly speaking, on more serious offences allegedly committed by people with cognitive and mental health impairments. Here the criminal justice system works closely with the forensic system. The management of forensic patients is monitored and supervised by a specialist tribunal, the MHRT. The MHRT relies on information from, and makes orders that affect, the work of mental health personnel and those who provide services for people with cognitive impairments.

1.33 When forensic patients are given leave or released from detention and the process of reintegration into the community occurs, a wide range of services are needed to provide health care, housing, employment, and social supports. These are provided

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13. This is discussed in detail in NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) Ch 4.
14. NSW Bureau of Crime Statistics and Research (ref: Hc12/10999dg).
15. As of June 2012: Mental Health Review Tribunal, *Annual Report 2011-2012*, 36.
16. As recorded from June 2008 - July 2012: NSW Bureau of Crime Statistics and Research (ref: mai12/11000hc revised).
17. See further para 5.2.
18. For a discussion of incidence see Chapter 4.

by government agencies and by non-government organisations (NGOs), as well as by families.

1.34 We noted above that impairment is generally not the only criminogenic factor when offending behaviour results in a person being made a forensic patient. If the goals of community protection, support for vulnerable people, and preventing and reducing reoffending are to be realised, it is vital that the forensic system attends to all criminogenic factors. Interventions that are effective in preventing further offending require attention to factors such as abuse of substances, lack of housing, lack of employment and social supports. Consequently it is necessary for services to be delivered by more than one agency and for delivery to be integrated or, at least, collaborative. To be effective the relationship between the criminal justice system and health and other services must be one of mutual understanding and effective collaboration.

1.35 As mentioned above, the MHC is currently working on a whole-of-government plan for mental health. Its ambit extends to include the criminal justice system. It is obvious from this inquiry that a whole-of-government approach is required.

1.36 In relation to mental health, but perhaps more particularly in relation to cognitive impairment, the operation and response of the criminal justice system is also affected by resource constraints in the justice, health and community service sectors. These difficulties are mentioned throughout this report, and cannot be resolved by changing the law. Rather, the resolution of these difficulties relies on the ability of government to resource and deliver effective programs and services that successfully support people with cognitive and mental health impairments, and enables them to avoid entering and reentering the criminal justice system. Although it is beyond our brief to make recommendations to government on these matters, we have noted throughout this report the resource issues that were reported to us.

Cognitive impairment

1.37 An issue that has arisen repeatedly during this review is that the criminal justice and forensic systems do not deal effectively with people with cognitive impairment. While the MHRT reports that over 90% of forensic patients have a primary diagnosis of mental illness, some also have, for example, co-morbid brain injury, cognitive difficulties due to long-standing mental illness, intellectual disability and dementia.[19] Only 10 out of 387 forensic patients in NSW in mid 2012 (2.6%) had an intellectual disability alone.[20]

1.38 Problems relating to people with cognitive impairments have been noted repeatedly in past reviews. Our 1996 review concerning people with intellectual disability and the criminal justice system highlighted the lack of coordination between government agencies in providing services to people with intellectual disability[21] and noted the

19. Mental Health Review Tribunal, *Submission MH67*, 5.
20. Mental Health Review Tribunal, *Submission MH67*, 5. Intellectual disability is defined more narrowly than cognitive impairment.
21. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) Ch 10.

consequence that people with cognitive impairment fall into "grey areas of departmental responsibility and often do not get the services they need".[22]

1.39 The 2001 *Framework Report* also highlighted issues regarding people with cognitive impairments in the criminal justice system, noting the need for improved systems to assess and meet the needs of this cohort.[23]

1.40 The 2007 review of the forensic system (2007 Forensic Review) noted that many of our 1996 recommendations had not been implemented, and "generally remain appropriate".[24] The views of stakeholders expressed to us during this review indicate that many problems still remain.

1.41 Briefly, the continuing problems appear to be that:

- cognitive impairment may not be perceived, diagnosed or responded to, especially where it co-exists with mental health impairment, drug and alcohol abuse and other factors
- cognitive impairment is frequently confused with mental illness
- people with cognitive impairment are dealt with, inappropriately, in the mental health system, and
- services responding to the needs of people with cognitive impairment may be absent, hard to locate or not coordinated with each other.

1.42 The forensic system has been developed to deal with people with a mental illness, and it is ill suited to dealing with people with a cognitive impairment. For example, where people are found unfit to be tried, they are referred to the MHRT to determine whether they will become fit within 12 months. While mental illnesses may improve with appropriate treatment and the person may become fit, cognitive impairments do not improve over time with treatment, and so reference to the MHRT for such people is inappropriate.

1.43 While the mental health system has gaps, services for people with cognitive impairment in the community are even more limited. For example, there is very little secure accommodation available that is suitable for forensic patients with cognitive impairments. Mental health facilities are not suitable, and may be even be harmful for people with cognitive impairments. Forensic patients with cognitive impairments may thus spend all of their time as a forensic patient in a prison or detention centre.[25]

1.44 Another example of a gap is that the MHFPA imposes particular requirements on service providers where a person is discharged from a mental health facility,[26] but there are no equivalent provisions relating to people leaving other places, such as

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22. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) [10.2].
23. 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* (2001) 28-35.
24. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [3.19].
25. See the discussion in Chapter 10.
26. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 53, s 76G, s 76H.

prison. The provisions in the Act support planning for release and leave and transfer into the civil mental health system where ongoing hospital care is needed. There are no equivalent provisions for people with a cognitive impairment.

1.45 Although Ageing, Disability and Home Care (ADHC) may assist when a person has an intellectual disability, there may be no obvious service provider where a person has, for example, an acquired brain injury or borderline intellectual functioning. This has many practical consequences. For instance, the MHRT may have difficulty locating a service to provide an assessment or care in the community. There may be no-one available to make arrangements for a forensic patient's release into the community or to make arrangements for continuing care when the person's forensic status ceases.[27] While there have been some positive improvements, such as the expansion of the Community Justice Program,[28] significant issues with resources and services still arise.

Working group to address issues relating to cognitive impairment

1.46 In Chapter 9, we recommend creating a Forensic Working Group of representatives from a range of agencies involved in supervising and supporting forensic patients. This working group would be charged with developing a framework for cross agency supervision and support of forensic patients, exploring impediments to information sharing, and dealing with issues such as arrangements for continuing care of forensic patients when they cease to be a forensic patient.

1.47 As with many of the issues outlined in Chapter 9, problems with the management of forensic patients with cognitive impairment are primarily operational rather than legal. There is a particular need for a coordinated cross agency solution to deal with issues that arise in relation to cognitive impairment. We therefore recommend that the Forensic Working Group proposed in Recommendation 9.6 should develop an action plan to deal with detention, care and community support of forensic patients with a cognitive impairment.

Recommendation 1.1

The Forensic Working Group, the formation of which is recommended in Recommendation 9.6, should be required to develop an action plan to provide for additional and improved options for the detention, care, and community support of forensic patients with a cognitive impairment.

What's in a name? Acknowledging cognitive impairment in law

1.48 Many of the matters relevant to cognitive impairment raised above are service related, and would not be cured by legislative change alone. However, we believe that it is important that legislation that applies to people with cognitive impairment should make explicit, accurate and up-to-date reference to them. To that end, we make a number of recommendations in this report relating to terminology and definitions.

27. See Chapter 9.
28. See para 11.11-11.12.

1.49 In Report 135, we deal with definitions of cognitive and mental health impairment. We recommend definitions of cognitive impairment and mental health impairment that reflect contemporary knowledge about those impairments and can be used widely and consistently. We have adopted these definitions in this report, with some amendment where required.[29] Cognitive impairment is defined separately from mental health impairment. The definition provides examples of some of the wide range of different cognitive impairments.

1.50 An additional issue is that key legal instruments and institutions in the forensic system are named in ways that neglect cognitive impairment. For example:

- The relevant legislation is the ***Mental Health*** *(Forensic Provisions) Act 1990* (NSW).
- The name of the Tribunal responsible for management of forensic patients is the **Mental Health** Review Tribunal (MHRT).
- People managed by the MHRT are called "forensic **patients**". The word "patient" is a term associated with illness, whereas cognitive impairment is not an illness.
- The "defence of **mental illness**" might suggest that it excludes cognitive impairment.

1.51 Related legislation, such as the *Criminal Appeal Act 1912* (NSW), refers to "mentally ill persons", even though the related provisions may also apply to people with cognitive impairment.[30]

1.52 We have identified three major areas requiring attention to terminology: the title of the principal legislation; the name of the Forensic Division of the MHRT; and the client group that is managed by the MHRT. Elsewhere in this report we make recommendations that other relevant provisions include explicit reference to cognitive impairment.[31]

"Mental Health (Forensic Provisions) Act"

1.53 Provisions dealing with the management of forensic patients were previously located in the *Mental Health Act 1990* (NSW), with procedures relating to fitness and NGMI located in the *Mental Health (Criminal Proceedings) Act 1990* (NSW). However, provisions dealing with court processes relating to unfitness, NGMI and related processes associated with the management of forensic patients are now located in the MHFPA. While these provisions apply to people with mental health impairments and cognitive impairments, this is not recognised in the title of the legislation.

1.54 The MHFPA does not apply only to those with mental health impairments. While the majority of forensic patients may have a mental illness, not all do. Some forensic patients have only a cognitive impairment and others have both types of

29. See Recommendations 3.2, 4.1(2), 5.1(3).
30. *Criminal Appeal Act 1912* (NSW) s 6A.
31. See Recommendations 3.2, 4.1, 9.3.

impairments. The name of the legislation should be amended to describe accurately its true scope.

1.55 Two options present themselves. One is simply to include cognitive impairment in the name of the Act and to call it the "Mental Health and Cognitive Impairment (Forensic Provisions) Act". An alternative to this lengthy title would be to remove the reference to mental health and entitle the Act the "Forensic Provisions Act". This has the merit of brevity, but it may be misunderstood by those not familiar with it to cover matters relating to the collection and disposition of forensic materials. It also does not act as a reminder of the inclusion of cognitive impairment in the legislation. On balance therefore we recommend the MHFPA should be renamed the "Mental Health and Cognitive Impairment (Forensic Provisions) Act".

Recommendation 1.2

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be renamed the Mental Health and Cognitive Impairment (Forensic Provisions) Act.

"Mental Health Review Tribunal"

1.56 The vast majority of the MHRT's work relates to mental illness and the jurisdiction of the MHRT is conferred through mental health legislation. For this reason the MHRT itself is of the view that its current name remains appropriate.[32]

1.57 However, the role of the MHRT with respect to forensic patients extends beyond mental illness. Forensic Patients are dealt with by the Forensic Division of the Tribunal. This Division deals with those forensic patients who have cognitive impairments and, in that context, it engages with agencies such as Corrective Services NSW; Juvenile Justice; ADHC; Housing NSW; NGOs and private health professionals.

1.58 We do not recommend that the name of the MHRT be changed. While the name does not include cognitive impairment, it appropriately reflects the mental health focus of the whole Tribunal. Forensic patients are dealt with by a separate Division of the MHRT, the name of which is appropriate to its function and does not have any bias or exclude people with cognitive impairments.

1.59 More importantly, the MHRT has members with expertise in cognitive impairment. Section 73(2) of the MHFPA allows the MHRT to convene a panel which can include a "registered psychologist or other suitable expert in relation to a mental condition" and "a member who has other suitable qualifications or expertise". This allows the MHRT to access expertise regarding cognitive impairment. The MHRT has noted that it is:

> considering constituting panels with two experts in cognitive impairment, particularly if the Tribunal is considering an application for conditional release for

32. Mental Health Review Tribunal, *Submission MH67*, 6.

> a patient to enter a [Community Justice Program] and whose only diagnosis is intellectual disability.[33]

We support these developments in enhancing the MHRT's expertise concerning cognitive impairment.

"Forensic patients"

1.60 The characterisation "patient" is inappropriate for people with cognitive impairment. Their impairments are not responsive to treatment, and do not change over time in response to treatment. Other interventions are important in overcoming criminal behaviour for this group.

1.61 However, we have been unable to find an alternative and better term to describe people with cognitive impairments who are subject to the jurisdiction of the Forensic Division of the MHRT. Alternatives such as forensic clients or forensic consumers imply a level of freedom and choice which is not available to forensic patients. Accordingly we make no recommendation for change at this time.

Review of the Mental Health (Forensic Provisions) Act 1990 (NSW)

1.62 This report reviews a range of issues concerning the MHFPA. For example, we have noted confusion or uncertainty regarding the:

- processes following a finding of unfitness by the court (Chapter 6)
- processes following a finding of UNA and NGMI (Chapter 7), and
- definition of forensic patient (para 9.15).

We recommend changes to simplify processes and improve clarity.

1.63 We also note that the provisions are difficult to navigate. For example, it is currently the case that:

- Considerations relating to leave and release are located in s 43, s 49, s 74 and s 76 – with preconditions for release contained in multiple sections.
- Processes relating to cessation of forensic status are outlined in s 51, s 52, s 54, s 65 and s 76H – with some important provisions (for example, the effect of expiry of a limiting term) not given the prominence they appear to deserve.

1.64 Some provisions are unclear, for example:

- "Detention" and "custody" are used interchangeably, and it is not always clear whether custody is limited to a prison environment.[34]

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33. Mental Health Review Tribunal, *Submission MH67*, 6.
34. See, eg, *Mental Health (Forensic Provisions) Act 1990* (NSW) s 74(e), which requires that particular forensic patients spend sufficient time in "custody".

- It is not made explicitly clear whether the verdict of NGMI is available in the lower courts – the reference to the jury may infer that the verdict is only available in superior courts.[35]

- An initial review of individuals found NGMI involves review of care, treatment and detention, whereas initial review of individuals found UNA only involves consideration of fitness issues (and does not refer to care, treatment and detention). There is no clear basis for this distinction. We are told that, in practice, the MHRT will generally conduct an initial review together with a subsequent review where a person has been found UNA.[36]

- The MHFPA refers to both recommendations and determinations of the MHRT in relation to a person becoming fit following a finding of UNA – use of consistent language would improve clarity.[37]

- Further to our discussion above concerning the inclusion of cognitive impairment in the MHFPA, we note that there are a number of provisions in the Act and in related legislation that apply to people who have a cognitive impairment, but where this is not reflected in the language used.

1.65 In light of the recommendations in this report, we believe that there is significant scope to revise, simplify and consolidate the MHFPA.

1.66 Presently, the Attorney General is responsible for administration of the MHFPA, except for Part 3, pertaining to management of forensic patients. The Minister for Health and the Minister for Mental Health are jointly responsible for those provisions.[38]

1.67 We recommend that the Attorney General, the Minister for Health and the Minister for Mental Health conduct a review of the MHFPA with a view to improving comprehensibility and clarity of the provisions.

Recommendation 1.3

The Attorney General, the Minister for Health and the Minister for Mental Health should review the *Mental Health (Forensic Provisions) Act 1990* (NSW) with a view to improving its comprehensibility and clarity.

35. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 38.
36. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 44-46; Information supplied by the Mental Health Review Tribunal, 5 February 2013, 3.
37. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 45, s 47.
38. *Allocation of the Administration of Acts* (NSW) (21 December 2012) 24, 28-29.

2. Fitness to be tried

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2.1 A person cannot be tried for a criminal offence unless that person is "in a mental condition to defend himself".[1] Lord Chief Justice Lord Kenyon said in 1790 that the rule was based on "common humanity [which] has prescribed, that no man shall be called upon to make his defence at a time when his mind is in that situation as not to appear capable of so doing".[2] At this time, the consequence of being unfit to stand trial was indefinite detention at the Sovereign's pleasure.[3]

2.2 Contemporary courts have indicated that fitness requirements are based on the right to a fair trial: they are intended to ensure that a trial is not held when the defendant's abilities are so limited that the trial would be unfair or unjust.[4] An unfit defendant is now subject to the procedures set out in Part 2 of the *Mental Health*

1. *R v Dashwood* [1943] KB 1, 4.
2. *Frith for High Treason* (1790) Howell's State Trials Vol 22 (1783-1794) 318, cited in *R v Mailes* [2001] NSWCCA 155, 53 NSWLR 251 [119] (Wood CJ at CL).
3. 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) [6.6].
4. *R v Presser* [1958] VR 45, 48; *Eastman v The Queen* [2000] HCA 29; 203 CLR 1 [64].

(Forensic Provisions) Act 1990 (NSW) (MHFPA). These procedures are considered in detail in Chapter 6. A special hearing may be held, which is conducted as nearly as possible as if it were a normal trial.[5] If the defendant is found to have committed an offence, the court may nominate a limiting term[6] and the defendant may be detained in a mental health facility or elsewhere.[7]

2.3 From the perspective of the unfit defendant, the procedures set out in the MHFPA are a significant improvement on indefinite detention. However, from this perspective the limiting term is still in some ways an unfair outcome compared to a sentence imposed after a normal trial. There is no provision in the MHFPA for a non-parole period, and limiting terms can be longer than terms imposed for an equivalent offence on a fit offender, as the unfit defendant cannot take advantage of a discount for an early guilty plea.[8] We consider these issues in detail in Chapter 7. For the purposes of this chapter these factors, as well as broader considerations of fairness and justice, make it desirable for a defendant with a cognitive or mental health impairment to have a trial if it is possible, or can be made possible, for a fair trial to be conducted. We will examine the fitness requirements, and associated procedural matters, with this principle in mind.

The *Presser* test

2.4 The MHFPA governs the procedure for raising fitness and making a determination, and also makes provision for the consequence of a finding of unfitness. However the common law continues to govern the test of fitness to stand trial.

2.5 At common law, a person is fit to plead if he or she is sufficiently able to comprehend the nature of the trial so as to make a proper defence to the charge, to challenge jurors and to comprehend the evidence.[9] In *R v Presser*, Justice Smith developed the common law test by identifying minimum standards that the accused must meet before he or she was considered to be fit to stand trial.[10]

2.6 The *Presser* standards require that the accused be able to:

(1) understand the offence with which he or she is charged

(2) plead to the charge

(3) exercise the right to challenge jurors

(4) understand generally the nature of the proceeding as an inquiry into whether he or she committed the offences charged

5. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 21.
6. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 23. For a full discussion see Chapters 6 and 7.
7. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 27. See further Chapters 7 and 10.
8. C Bruce "Ethics and the Mentally Impaired" (Paper presented at the Public Defenders Criminal Law Conference 2011, Taronga Centre, 27 February 2011), citing *R v Mitchell* [1999] NSWCCA 120; 108 A Crim R 85.
9. See *R v Pritchard* (1836) 7 Car & P 304; 173 ER 135; *Ngatayi v The Queen* (1980) 147 CLR 1, 6-7; *Kesavarajah v The Queen* (1994) 181 CLR 230, 245.
10. *R v Presser* [1958] VR 45, 48.

(5) follow the course of proceedings so as to understand what is going on in a general sense

(6) understand the substantial effect of any evidence that may be given against him or her

(7) make a defence or answer to the charge

(8) where the accused is represented, give necessary instructions to counsel regarding the defence, and provide his or her version of the facts to counsel and, if necessary, the court, and

(9) have sufficient mental capacity to decide what defence he or she will rely on and to make that known to counsel and the court.[11]

2.7 The *Presser* standards have been approved by the High Court.[12] They have been substantially incorporated into statute in all Australian jurisdictions except Queensland and NSW.[13]

2.8 Failure to meet any of these standards renders the accused unfit to stand trial. The determination is made by reference to evidence of experts including psychiatrists and psychologists. These experts address the standards and may also express an opinion about the overall fitness of the accused to stand trial.

2.9 The minimum standards set out in *Presser* do not require that the accused be conversant with court procedure or understand the law governing the case.[14] Nor do they require that the accused have sufficient capacity to make an *able* defence or to act wisely in his or her best interests.[15]

2.10 The courts have stressed that *Presser* sets out minimum standards, and once the defendant has met them, the court will not hear an argument that the defendant could have conducted a better defence, for example if he or she had different medical treatment.[16]

2.11 It has been held that a person can be fit for trial even if the person:

- suffers from a delusion relating to the subject matter of the trial
- has a mental disorder that may cause the person to conduct a defence that is not in his or her best interests
- has a mental disorder that produces behaviour that disrupts the trial, or

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11. *R v Presser* [1958] VR 45, 48.
12. *Ngatayi v The Queen* (1980) 147 CLR 1, 8; *Kesavarajah v The Queen* (1994) 181 CLR 230.
13. *Crimes Act 1900* (ACT) s 311; *Criminal Code* (NT) s 43J; *Criminal Law Consolidation Act 1935* (SA) s 269H; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 8; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 6(1); *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 9.
14. *Ngatayi v The Queen* (1980) 147 CLR 1, 8-9; *R v Mailes* [2001] NSWCCA 115; 53 NSWLR 251 [148].
15. *Ngatayi v The Queen* (1980) 147 CLR 1, 8-9; *R v Presser* [1958] VR 45, 48.
16. *R v Walker* [2008] NSWSC 462 [24], citing *R v Rivkin* [2004] NSWCCA 7; 59 NSWLR 284.

- has a mental disorder that prevents a trusting relationship with counsel.[17]

Procedure

2.12 A defendant is presumed to be fit to be tried unless and until a question as to his or her fitness is raised.[18] That question may be raised by any party to the proceedings, or by the court.[19] At common law, the court has a duty to consider the question of the defendant's fitness if there is material before it that raises the issue, even if neither the defence nor the prosecution asserts that the defendant is unfit.[20] Additionally, a legal practitioner may have an ethical obligation to raise the issue of fitness, even contrary to the client's instructions, as part of the overriding duty to the court.[21]

2.13 While it is preferable to raise the question before arraignment, it may be raised at any time during the proceedings,[22] including at sentencing,[23] or retrospectively on appeal.[24] If a question of fitness is raised, the court must hold an inquiry into the defendant's fitness,[25] unless the question is not raised in good faith,[26] or the court discharges the defendant.[27] A question is raised in good faith unless "no reasonable jury, properly instructed, could find that the accused was not fit to be tried".[28] The court may decide not to conduct a fitness inquiry and instead discharge the defendant if the trivial nature of the charge or offence, the "nature of the person's disability" or any other matters render it inappropriate to inflict any punishment.[29]

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17. *Eastman v The Queen* [2000] HCA 29; 203 CLR 1 [26], citing *R v Taylor* (1992) 77 CCC (3d) 551, 564-565.
18. *Eastman v The Queen* [2000] HCA 29; 203 CLR 1 [86].
19. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 5.
20. *Eastman v The Queen* [2000] HCA 29; 203 CLR 1 [84]-[87] (Gaudron J), [172], [177]-[179] (Gummow J), [282] (Kirby J), [294]-[296], [300]-[301] (Hayne J), [333] (Callinan J). Gleeson CJ and McHugh J dissented on this point: [41], [46]-[48], [102], [166]-[167]. See also *Kesavarajah v The Queen* (1994) 181 CLR 230.
21. *Eastman v The Queen* [2000] HCA 29; 203 CLR 1 [297] (Hayne J), but contrast [373]-[374] (Callinan J); M Ierace, "Fitness To Be Tried" (Paper presented at the University of NSW Law Faculty CLE/CPD day, 5 November 2010); C Bruce, "Ethics and the Mentally Impaired" (Paper presented at the Public Defenders Criminal Law Conference 2011, Taronga Centre, 27 February 2011).
22. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 7(1).
23. *Wills v The Queen* [2007] NSWCCA 160; 173 A Crim R 208 [51]-[81].
24. The appellate court must quash the conviction unless it is satisfied that, had the question been raised at trial, the trial court would have found that the accused was fit to stand trial: see *Eastman v The Queen* [2000] HCA 29, 203 CLR 1; *R v RTI* [2003] NSWCCA 283; 58 NSWLR 438; *R v Rivkin* [2004] NSWCCA 7; 59 NSWLR 284 [297]-[301]; *R v Henley* [2005] NSWCCA 126 [4], [13]-[15]; *Kirkwood v The Queen* [2006] NSWCCA 181 [7]-[15]; *Wills v The Queen* [2007] NSWCCA 160; 173 A Crim R 208; *Robinson v The Queen* [2008] NSWCCA 64; *R v Zhang* [2000] NSWCCA 344.
25. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 10(1).
26. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 10(2). The threshold is also referred to as a "real", "genuine" or "real and substantial" question as to fitness: see *Ngatayi v The Queen* (1980) 147 CLR 1, 9; *Eastman v The Queen* [2000] HCA 29; 203 CLR 1 [296], [319]; *R v Tier* [2001] NSWCCA 53; 121 A Crim R 509 [1]-[6], [69]-[72]; *R v Mailes* [2001] NSWCCA 155; 53 NSWLR 251 [173]-[181], [224].
27. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 10(4).
28. *Kesavarajah v The Queen* (1994) 181 CLR 230, 245.
29. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 10(4).

2.14 A judge sitting alone[30] determines the question of the defendant's fitness on the balance of probabilities.[31] The judge must give reasons for his or her decision.[32] While the defendant must be represented by a legal practitioner unless the court otherwise allows, the inquiry is not conducted in an adversarial manner and no party bears the burden of proof.[33]

2.15 The question of fitness is not determined once and for all: the fact that a question of fitness has been raised in the proceedings does not preclude the question of the defendant's fitness being raised again later in the same proceedings.[34]

2.16 The provisions of the MHFPA only apply to proceedings in the District and Supreme Courts.[35] The common law regarding fitness is still relevant in the Local Court. Normally, people who are unfit in the Local Court will be dealt with under Part 3 of the MHFPA which provides for the diversion of people with mental illnesses or developmental disabilities.[36] However, there are some matters that cannot be dealt with under Part 3 and in these cases fitness must be considered in the Local Court.[37]

Survey of cases

2.17 We have surveyed the decisions on fitness published in NSW in the last four years, in order to provide background information and to understand the type of cases that come before the courts. Using the NSW Caselaw database a search was conducted for fitness hearings since 1 January 2008. We identified 30 decisions on fitness concerning 27 different defendants (three defendants were the subject of two fitness hearings). There were 20 in the Supreme Court, eight in the District Court and one each in the Local Court and the Land and Environment Court.

2.18 These 30 decisions represent only a fraction of the number of fitness hearings held, as not all decisions are published.[38] We do not know how many are held, but we do know that around 40 people each year are referred to the Mental Health Review Tribunal (MHRT) after having been found unfit in the District or Supreme Court.[39]

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30. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 11(1). At common law, a jury had to be empanelled for the purpose of determining whether or not the defendant was fit to plead or fit to be tried: see discussion in *R v Mailes* [2001] NSWCCA 155; 53 NSWLR 251 [112]-[132].
31. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 6.
32. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 11(2).
33. See *Mental Health (Forensic Provisions) Act 1990* (NSW) s 12; *Eastman v The Queen* [2000] HCA 29; 203 CLR 1 [294].
34. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 7(2).
35. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 4.
36. See NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) Ch 9, 10.
37. *Mantell v Molyneux* [2006] NSWSC 955; 165 A Crim R 83. For a full discussion of fitness in the Local Court see Chapter 12.
38. The database contains all decisions from the Supreme Court and Land and Environment Court, but the collection from the Local Court and District Court is incomplete. Only selected decisions from these courts are published.
39. Mental Health Review Tribunal, *Annual Report 2009-10*, 32; Mental Health Review Tribunal, *Annual Report 2010-11*, 37; Mental Health Review Tribunal, *Annual Report 2011-12*, 34. Defendants found

2.19 Of the 17 defendants in our survey who had fitness hearings in the Supreme Court, all were charged with murder except one who was charged with acts in preparation for a terrorist act. In the District and Local Courts, four defendants were charged with sex offences, while others were charged with drug offences, obtain money by deception, armed robbery, and giving false evidence before the Police Integrity Commission. The defendant in the Land and Environment Court was charged with clearing native vegetation.

2.20 Of the 27 defendants, seven were ultimately found to be fit (including three of the eight defendants in the District Court and the one defendant in the Local Court). There were 22 who were at some stage found to be unfit, 12 because of mental illness, eight because of cognitive impairment and two because of both mental illness and cognitive impairment.

2.21 A list of the cases included in our survey is at Appendix C.

Law and practice relating to fitness in NSW: the need for change?

2.22 All Australian jurisdictions except NSW and Queensland have set out in legislation the standard required to be fit for trial.

2.23 Evidence of difficulties with the *Presser* criteria is not apparent from our review of recent cases. The criteria are routinely referred to in NSW fitness hearings. Our survey did not identify any judicial commentary indicating that the criteria are unclear or unsatisfactory. Nevertheless, stakeholders identified some inconsistencies in fitness decisions by courts, and these are discussed below.

2.24 Codification of the common law standards in the MHFPA offers an opportunity to update the criteria and to express them in a more succinct way. Evidence of practical difficulties with the *Presser* criteria was provided in submissions to this inquiry. In Consultation Paper 6 (CP 6) we asked whether the *Presser* standards remain relevant and sufficient criteria for determining a defendant's fitness for trial or whether considerations distinct from or additional to the *Presser* standards should augment or replace them.[40] Submissions from the NSW Bar Association and NSW Police Force indicate that the *Presser* standards are satisfactory in their present form.[41] Both refer to the flexibility inherent in the standards, and the Bar Association noted that "cases where there is a genuine risk of a trial being unfair will be identified".[42]

2.25 However, a number of other stakeholders suggested that changes to *Presser* are necessary.

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unfit in the Local Court and Land and Environment Court are not referred to the Mental Health Review Tribunal.

40. 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 6.2, 6.3.

41. NSW Police Force, *Submission MH47*, 3; NSW Bar Association, *Submission MH10*, 9.

42. NSW Bar Association, *Submission MH10*, 9.

2.26 The NSW Consumer Advisory Group (NSWCAG) submitted that a statutory test would help clarify the purpose and elements of the test and make it easier to understand and access for people who are not legally trained, including consumers, carers and advocates.[43] The Office of the Director of Public Prosecutions submitted that it is too easy for an accused to be found unfit, and suggested that the number of criteria should be cut down substantially.[44] Legal Aid NSW and the Law Society of NSW suggested that the test could be made more robust by incorporating an "effective participation" standard (discussed further below), but supported the current criteria in other respects.[45] The Homicide Victims' Support Group (HVSG) submitted that the *Presser* criteria are difficult for victims to understand, and that legislative codification would be useful.[46]

2.27 The Public Defenders submitted that there is a problem with the way in which the test deals with decision making capacity. They suggested that the test should continue to be defined at common law, but that the statute should require the court to be satisfied, where the defendant has a mental impairment, that the defendant has the capacity "to make sensible decisions affecting the trial; decisions that are, from an objective standpoint, reasonably in his or her best interests".[47]

2.28 We have therefore given careful consideration to codifying the *Presser* criteria in the MHFPA, in particular to the questions of whether it is desirable to:

(1) update the criteria

(2) simplify the test

(3) improve the test, especially in relation to:

  (a) its approach to the defendant's decision making capacity, and

  (b) an "effective participation" standard.

Decision making capacity

Limited standard required by Presser

2.29 The *Presser* standards focus on the defendant's general understanding of the nature of the proceedings and his or her ability to follow the course of proceedings as well as on functional skills such as the ability to instruct advisers and provide his or her version of the facts to the court. However, only the ninth standard refers explicitly to the defendant's decision making capacity, and only in a limited way: the defendant must "have sufficient mental capacity to decide what defence he or she will rely on".[48] Many other decisions are made during criminal proceedings, and

43. NSW Consumer Advisory Group, *Submission MH11;* Information supplied by NSW Consumer Advisory Group, 4 October 2012, 4.
44. NSW Office of the Director of Public Prosecutions, *Submission MH5, 3.*
45. Law Society of NSW, *Submission MH13*, 4-5; Legal Aid NSW, *Submission MH18*, 6.
46. Homicide Victims' Support Group, *Submission MH20,* 5.
47. NSW, Public Defenders, *Submission MH26*, 16.
48. See para 2.6 for a list of the criteria.

there is no explicit requirement that the defendant be able to make those decisions rationally. There is some decision making capacity implied in the second (plead to the charge) and seventh (make a defence or answer to the charge) standards, but it is unclear what level of decision making capacity is necessary.

2.30 A common feature of certain mental illnesses is that people are not aware of their own mental illness. They may have a thought disorder such as delusions, hallucinations, paranoid or grandiose thinking, or severe depression which lead them to make decisions that are not in their own best interests. The Public Defenders reports that:

> it does occasionally happen that a Public Defender is confronted in a murder case with a mentally ill accused who is otherwise fit, but who gives instructions not to run obvious defences such as the insanity defence or substantial impairment, or, in one recent instance, an accused with a personality disorder who insisted that no mitigatory material be put before the Court on a murder conviction, and that no non-parole period be sought.[49]

The submission notes that the consequence of such a decision can be as catastrophic as the inability of an accused to satisfy other elements of the fitness test.[50]

2.31 The Law Commission of England and Wales reported similar problems, noting three recent cases where the defendants (two of whom had paranoid schizophrenia) refused to plead guilty to manslaughter on the grounds of diminished responsibility, despite that defence being clearly available.[51]

The law in NSW

2.32 In CP 6 we noted that the *Presser* standards are articulated in terms that are capable of allowing courts to take into account, in determining the defendant's understanding or capacity, his or her ability to make rational decisions in relation to participation in the trial proceedings.[52] Recent Supreme Court decisions on fitness have referred to the ability to "exercise an informed and rational decision"[53] and placed weight on the defendant's inability to make rational decisions.[54]

2.33 On the other hand, the submission of the Public Defenders argued that a requirement of rationality is "either not presently part of the *Presser* test, or if it is, its presence is not beyond reasonable argument to the contrary".[55] This submission noted that in *Presser*, Justice Smith said the defendant "need not have the mental capacity to make an able defence", and pointed to High Court cases where the

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49. NSW, Public Defenders, *Submission MH26*, 18.
50. NSW, Public Defenders, *Submission MH26,* 19.
51. England and Wales, Law Commission, *Unfitness to Plead,* Consultation Paper 197 (2010) [2.80]-[2.87].
52. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences,* Consultation Paper 6 (2010) [1.16].
53. *R v Chong* [2011] NSWSC 914 [5].
54. *R v Waszczuk* [2011] NSWSC 212 [35]. See also *PFC v The Queen* [2011] NSWCCA 275 [298] where the court rejected a claim that the appellant was either unfit for trial or suffering from a mental illness, saying that there was no evidence that "the appellant laboured under a mental state during the course of the trial which compromised his ability to give rational instructions".
55. NSW, Public Defenders, *Submission MH26*, 16.

court confirmed that a person may be fit even where the person's mental illness means he or she is unable to act in his or her own best interests.

2.34 It is not clear that the common law requires defendants to be found unfit if they are unaware of their own illness and make decisions based on delusions, particularly in light of *Eastman*.[56] In some cases in our survey, the court concluded that the defendant in this situation was unable to make a defence, and was therefore unfit for trial.[57] However in the case of *Holt*, the court relied on the statement of Justice Wood in *Mailes*: "fitness was concerned with comprehension of proceedings and the ability to communicate with legal advisors rather than the ability to conduct a defence wisely or even rationally".[58] The court found that it could not be assumed that the accused was acting irrationally in refusing to consider a plea of not guilty on the grounds of mental illness,[59] but even if this was so, it would not necessarily result in a trial which was unfair to the accused.[60]

The ability to make rational decisions

2.35 One option to resolve the problems identified above is to introduce into the test a requirement that the defendant be able to make rational decisions, that is, decisions based on reason. In SA, the relevant statute contains two references to rationality: the ability to respond rationally to the charge or the allegations,[61] and the ability to give rational instructions about the exercise of procedural rights.[62]

2.36 These provisions do not appear to have caused any difficulties for the SA courts.[63] As noted above, NSW courts already refer to the ability to make rational decisions when making decisions about fitness.[64]

2.37 In CP 6 we asked "[s]hould the test for fitness to stand trial be amended by legislation to incorporate an assessment of the ability of the accused to make rational decisions concerning the proceedings?"[65] This approach was supported by the Public Defenders.[66] It was also supported by the submission from neuropsychologists Susan Pulman and Amanda White, who noted that expert witnesses already assess defendants with this criterion in mind.[67]

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56. *Eastman v The Queen* [2000] HCA 29; 203 CLR 1.
57. *Wills v The Queen* [2007] NSWCCA 160; 173 A Crim R 208 [80]; *R v JH* [2009] NSWSC 551 [36], [41]; *R v Waszczuk* [2012] NSWSC 380 [24], [26]; *R v Chanthasaeng* [2008] NSWDC 122; 7 DCLR (NSW) 158 [66]-[67].
58. *R v Holt* [2009] NSWDC 147; 9 DCLR (NSW) 87 [20], relying on *R v Mailes* [2001] NSWCCA 155; 53 NSWLR 251 [143] per Wood CJ at CL.
59. *R v Holt* [2009] NSWDC 147; 9 DCLR (NSW) 87 [31]-[32].
60. *R v Holt* [2009] NSWDC 147; 9 DCLR (NSW) 87 [24]-[30].
61. *Criminal Law Consolidation Act 1935* (SA) s 269H(a).
62. *Criminal Law Consolidation Act 1935* (SA) s 269H(b).
63. See, eg, *R v Larizza* [2004] SASC 360; *R v Gillard* [2006] SASC 46.
64. *R v Chong* [2011] NSWSC 914 [5]; *R v Waszczuk* [2011] NSWSC 212 [35]; *PFC v The Queen* [2011] NSWCCA 275 [293], [298].
65. 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 6.3.
66. NSW, Public Defenders, *Submission MH26,* 16.
67. S Pulman and A White, *Submission MH6*, 3.

2.38 However several other submissions opposed the amendment of the fitness test in this way. The HVSG argued that it is not necessary for a defendant to be able to formulate rational decisions in order to have a fair trial, and such a requirement would needlessly exclude people from being tried.[68]

2.39 The submission of the NSW Bar Association also rejected the addition of a rational decision making requirement. It said that a test that focuses on rational understanding is over-inclusive, "rubbery and difficult to pin down", and "would lead to uneven application of standards".[69]

2.40 Even those submissions supporting the introduction of a rational decision making standard noted that it can be difficult to distinguish between the person who is unable to make rational decisions and the person who makes poor decisions, or decisions against self-interest.[70] The Law Commission of England and Wales recently considered the question of what decision making capacity is necessary for a fair trial, and in particular whether the ability to form a rational judgment should be a factor in a revised test of capacity. It noted that the term "rationality" does not have a settled meaning.[71] It was also concerned that a test requiring an ability to form rational decisions would lead to an undue focus on the content of the decision, and would interfere with the right to make unwise or ill advised decisions.[72]

Understanding and using relevant information

2.41 The Law Commission of England and Wales proposed that the test should focus on "the process of understanding and reasoning" and made a provisional recommendation for a fitness test based on the civil capacity test in the *Mental Capacity Act 2005* (UK). An accused would be found to lack capacity if he or she were unable:

(1) to understand the information relevant to the decisions that he or she will have to make in the course of his or her trial,

(2) to retain that information,

(3) to use or weigh that information as part of decision making process, or

(4) to communicate his or her decisions.[73]

2.42 The Law Commission's proposal would result in significant change to the law in the UK presently contained in the case of *Pritchard*[74] which propounds a test similar to, but less detailed than, *Presser*.

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68. Homicide Victims' Support Group, *Submission MH20*, 5-6.
69. NSW Bar Association, *Submission MH10*, 9.
70. S Pulman and A White, *Submission MH6*, 3; NSW, Public Defenders, *Submission MH26,* 18.
71. England and Wales, Law Commission, *Unfitness to Plead,* Consultation Paper 197 (2010) [3.48].
72 . England and Wales, Law Commission, *Unfitness to Plead,* Consultation Paper 197 (2010) [3.50]-[3.54].
73. England and Wales, Law Commission, *Unfitness to Plead,* Consultation Paper 197 (2010) [3.12]-[3.13], [3.50]-[3.51].
74. *R v Pritchard* (1836) 7 Car & P 304; 173 ER 135.

2.43 One option for reform in NSW would be to utilise the approach of the Law Commission as part of the fitness criteria. A person would be unfit if he or she was unable to understand the information relevant to the decisions that he or she will have to make before and during the trial, and to use that information as part of a decision making process.

2.44 The advantage of this approach is that it avoids the lack of clarity that some stakeholders identified with the use of the word "rational". By requiring decisions to be based on "relevant information", it may exclude defendants who base their decisions on their delusions, paranoias or other thought disorders. However, absent a specific reference to rationality, such a change may not achieve this end. For example, in consultation we were provided with an example of a person who, because of a mental illness, believed that she was an evil person who should be locked up forever. She understood advice, could retain information, and use it as part of a decision making process and could communicate with her lawyer – but despite this, she rejected that advice and insisted on a course of action that was caused by her mental illness and directly contrary to her own interests.

A statutory requirement of a fair trial?

2.45 The principle underlying the inquiry into the fitness of the defendant is the right to a fair trial.[75] Thus, when Justice Smith detailed the standards required to be fit for trial, he explained that "the question … is whether the accused, because of mental defect, fails to come up to certain minimum standards which he needs to equal before he can be tried without unfairness or injustice to him".[76]

2.46 A fair trial cannot be held unless the defendant is in a fit state to participate in the proceedings and defend him or herself.[77] Unless the defendant is able to understand the proceedings and participate in them, the trial is a "nullity",[78] or as Justice Gaudron put it, "there is a fundamental failure in the trial process".[79]

2.47 If the fitness test is to be codified in NSW in the MHFPA, one option would be for the requirement of a fair trial to be prescribed as the overarching principle, with the *Presser* standards as relevant considerations. Alternatively, a second option would be for the *Presser* standards to be set out, and the common law regarding fitness and a fair trial to continue to underpin the statutory test.[80] These two options are explored further below.

2.48 In relation to the first option, we note that in other Australian jurisdictions where the fitness test is contained in legislation, the principle of a fair trial is not mentioned. Instead, the statutes provide that a person is unfit to stand trial if the person is unable to do certain things.[81] The capacities required are based on the *Presser*

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75. *R v Presser* [1958] VR 45, 48; *Kesavarajah v The Queen* (1994) 181 CLR 230, 245.
76. *R v Presser* [1958] VR 45, 48.
77. *R v Presser* [1958] VR 45, 48; *Eastman v The Queen* [2000] HCA 29; 203 CLR 1 [399].
78. *R v Begum* (1985) 93 Cr App R 96, 100 (Watkins LJ).
79. *Eastman v The Queen* [2000] HCA 29; 203 CLR 1 [62].
80. *R v WRC* [2003] NSWCCA 394; 59 NSWLR 273 [49].
81. *Crimes Act 1900* (ACT) s 311; *Criminal Code* (NT) s 43J; *Criminal Law Consolidation Act 1935* (SA) s 269H; *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 9; *Criminal Justice (Mental*

criteria. All of the statutes refer to the first five of the *Presser* criteria (understand the nature of the charge, enter a plea, challenge jurors, understand the nature of proceedings, follow the course of proceedings) and some of the statutes include one or more of the sixth, seventh and eighth criteria (understand the substantial effect of evidence, make a defence, give necessary instructions and provide his or her version of facts).

2.49 Should NSW adopt the approach of the first option, it would be consistent with the approach taken in most other Australian jurisdictions. It is also consistent with the common law approach, and is therefore familiar to courts and practitioners. It would continue to require the defendant to meet all of the listed standards before being tried. It has the advantage of being clear and easy to apply, because the specific capacities required are set out in some detail and in concrete terms. It would function in the context of the common law tradition which has as its underlying theme effective participation[82] and the right to a fair trial.

2.50 In relation to the second option it could be provided that "a defendant is unfit for trial if the defendant cannot be afforded a fair trial". The statute could include a non-exhaustive list of relevant considerations, resembling the *Presser* standards. This approach captures the underlying rationale for fitness procedures. It also helps to establish the level of capacity required. Decisions as to the defendant's capacity necessarily involve questions of degree. Under this option, the question of whether the defendant has sufficient capacity is answered by considering the over-arching test of whether the defendant can be afforded a fair trial.

2.51 This approach could be a significant step away from the common law. Unless the statute so prescribes, the defendant would not necessarily be required to be able to perform *all* of the listed tasks. If the defendant was unable, for example, to give evidence effectively, he or she might still be fit for trial if it is possible for a fair trial to be held. Conversely, the list of considerations need not be comprehensive. If the court considers that the defendant lacks an essential capacity that is not listed in the statutory considerations, and cannot be afforded a fair trial, then the defendant can be found unfit.

A requirement of effective participation?

2.52 In CP 6 we canvassed a slightly different option. We asked if the test should be whether the defendant can "participate effectively" in a trial, with the *Presser* standards forming a non-exhaustive list of considerations.[83] A number of stakeholders agreed with the concerns expressed in CP 6 that this test is likely to be over-inclusive or there is the potential for over-inclusiveness.[84] It is possible that defendants might be thought to be unable to participate effectively if they are young

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Impairment) Act 1999 (Tas) s 8, *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 6(1).

82. *Eastman v The Queen* [2000] HCA 29; 203 CLR 1 [399]; *Kesavarajah v The Queen* (1994) 181 CLR 230, 247, *R v Mailes* [2001] NSWCCA 155; 53 NSWLR 251 [215].

83. 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 6.4.

84. NSW, Public Defenders, *Submission MH26*, 20; NSW Bar Association, *Submission MH10*, 9; Homicide Victims' Support Group, *Submission MH20*, 6-7.

and intimidated by the court process, have poor educational attainment or a disadvantaged social background. Such a test might be uncertain in its application, even if the *Presser* criteria were incorporated as considerations.

2.53 The Law Society of NSW and Legal Aid NSW supported this option in their submissions, suggesting that the effective participation standard would provide "greater protection to vulnerable defendants".[85] However, at a roundtable of stakeholders to discuss fitness many stakeholders preferred a test based on capacities, largely for reasons of consistency with the common law and other jurisdictions.[86]

Should the scope of fitness provisions be limited to cognitive and mental health impairment?

2.54 At common law, fitness is concerned with the capacity to participate in proceedings, regardless of the source of the incapacity. The most common source of incapacity is conditions affecting understanding and communication (for example, mental illness, cognitive impairment, hearing or speech impairments).[87] The *Presser* test was developed to address defendants experiencing these conditions, and the MHFPA contains procedures designed to accommodate defendants who are unfit for these reasons.

2.55 Incapacity may also stem from the inability to withstand the stress of a trial, for example, because of heart disease.[88] The regime established by the MHFPA to provide for unfit defendants includes six monthly reviews of the defendant's capacity and, potentially, a special hearing, which may be very similar in form to a trial. This regime is not suitable for some people, including those with disorders that could be exacerbated by the stress of trial. The remedy used by the courts in these cases has been a permanent stay of proceedings.[89]

2.56 For example, there have been a number of cases where a defendant is charged with child sex offences alleged to have occurred many years previously, and where the defendant has age-related impairments that affect his or her *Presser* capacities.[90] In these cases the court must decide whether to continue with a trial, stay proceedings as an abuse of process, or deal with the matter by way of unfitness.[91] The power to stay proceedings should be exercised only in exceptional circumstances,[92] and not where *Presser* capacities are the primary concern.[93]

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85. Law Society of NSW, *Submission MH13*, 4-5; Legal Aid NSW, *Submission MH18*, 6.
86. Test for fitness and NGMI roundtable, *Consultation MH34*.
87. See, eg, *R v Mailes* [2001] NSWCCA 155; 53 NSWLR 251; *Ebatarinja v Deland* [1998] HCA 62; 194 CLR 444 (defendant was illiterate and speech and hearing impaired); *R v Abdulla* [2005] SASC 399 (defendant was speech and hearing impaired).
88. *R v Sexton* [2000] SASC 276; 116 A Crim R 173; *R v Hakim* (1989) 41 A Crim R 372.
89. *R v Hakim* (1989) 41 A Crim R 372; *R v Sexton* [2000] SASC 276; 116 A Crim R 173.
90. *R v Littler* [2001] NSWCCA 173; 120 A Crim R 512; *R v WRC* [2003] NSWCCA 394; 59 NSWLR 273; *R v W* [2009] NSWDC 124.
91. *R v WRC* [2003] NSWCCA 394; 59 NSWLR 273 [50].
92. *R v WRC* [2003] NSWCCA 394; 59 NSWLR 273 [55].
93. *R v WRC* [2003] NSWCCA 394; 59 NSWLR 273 [57]-[64].

2.57 Other jurisdictions that have codified the fitness test have specified the source of the incapacity – for example, the ACT, SA and Victorian statutes include the phrase "if the person's mental processes are disordered or impaired".[94] However it has sometimes been necessary to interpret these words rather widely, as when the South Australian courts found that a deaf and mute defendant fell within the meaning of this phrase.[95]

Two options

2.58 Consideration of the matters discussed above led us to develop two options for a statutory fitness test for NSW, and to consult further on these options. We presented the options to a roundtable of legal and medical experts, and discussed them with our expert advisers.

2.59 The first option requires the defendant to meet all of a set of standards, which are recognisably based on *Presser*. The most significant difference is that the option incorporates a standard of decision making capacity that is based on the Law Commission of England and Wales' approach discussed above. It does not include any reference to the reason for the incapacity. It does include some additional considerations that the court may take into account. Four of the *Presser* standards have been removed on the basis that they are encompassed by the decision making capacity test – the ability to plead to the charge (2), make a defence or answer to the charge (7) and decide what defence he or she will rely on (9), and exercise the right to challenge jurors (3).

Option 1

(1) A person is unfit to stand trial if it is established on the balance of probabilities that the person is unable to:

(a) understand the offence with which the person is charged

(b) understand generally the nature of the proceeding as an inquiry into whether the defendant committed the offence charged

(c) follow the course of proceedings and to understand what is going on in a general sense

(d) understand the substantial effect of any evidence that may be given against the defendant

(e) understand the information relevant to the decisions that he or she will have to make before and during the trial, and to use that information as part of a decision making process

(f) communicate effectively with legal representatives, or

94. *Crimes Act 1900* (ACT) s 311(1); *Criminal Law Consolidation Act 1935* (SA) s 269H; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 6(1).

95. *R v Abdulla* [2005] SASC 399 [77] (Besanko J), [28] (Duggan J), but see [49]-[50] (Debelle J).

(g) provide his or her version of the facts to the court, if necessary.

(2) In determining whether a person is unfit for trial, the court must consider:

(a) whether modifications to the trial process can be made to facilitate the person's effective participation

(b) the likely length and complexity of the trial

(c) whether the person is legally represented, and

(d) any other relevant matter.

2.60 The second option brings the principle of a fair trial to the centre of the test. The decision making capacity required is the ability to make rational decisions. Option 2 contains a much more succinct list of relevant considerations, but these considerations are not exhaustive – that is, any matter relevant to whether a fair trial can be held may be considered. This test is limited to defendants whose unfitness is due to mental health or cognitive impairments.[96]

Option 2

(1) A defendant is unfit for trial if the defendant cannot be afforded a fair trial by reason of mental health impairment or cognitive impairment or both.

(2) In deciding whether a defendant cannot be afforded a fair trial, the court must have regard to all relevant considerations including the defendant's capacity to:

(a) understand the charge, the trial process and the evidence

(b) understand advice given by the defendant's legal representatives concerning the trial

(c) communicate effectively with defendant's legal representatives concerning the trial

(d) make rational decisions in relation to the trial, and

(e) give evidence effectively, if necessary.

Response of expert group

2.61 The roundtable of experts largely preferred Option 1. The reasons given were that the *Presser* standards are well understood in both legal and psychiatric fields. The modifications proposed in Option 1 were generally supported. It was thought that Option 2 does not provide sufficiently specific criteria for medical experts to report against, and would generate divergent opinion.

2.62 The group considered that the "ability to provide his or her facts to the court" was a more appropriate standard than "ability to give evidence effectively" as the latter

96. The significance of this limitation is discussed in para 2.54-2.57.

expression implies a higher standard that many defendants without an impairment are not able to reach.

2.63 Following the roundtable further correspondence was received from the NSWCAG. It also supported Option 1 because it establishes clear criteria for determining effective participation that are not based on medical diagnosis and it is straight forward. The NSWCAG suggested, however, that the test should clarify whether a person must be able to fulfil all of the criteria to be unfit, or only some of them.[97]

The Commission's view

2.64 We recommend a statutory fitness test for NSW. We are persuaded of the need to codify the test in the MHFPA because it is timely to update the test, to improve its clarity, and to deal with some limitations of the present test. We also seek to make the test more accessible by including it in the MHFPA, noting that the test is important to, and is used by, non-lawyers.

2.65 Nevertheless, the approach and much of the content of the common law test works well and we do not propose any significant change of direction. The test should continue to prescribe the minimum capacities that are necessary for a person to be afforded a fair trial. This option is consistent with the approach taken in the common law, and is familiar to both medical and legal practitioners.

2.66 On balance we think it desirable to include in the test the over-arching principle that the defendant must be able to have a fair trial. This is the 'touchstone' for making the judgment about whether or not the defendant's degree of incapacity is, or is not sufficient to do those things required by the *Presser* factors. It is desirable that it be included, especially so that expert witnesses who do not have legal expertise understand its significance.

2.67 We note that the MHFPA provides that the question of a person's unfitness is to be determined by a judge alone.[98] Expert witnesses will generally provide evidence of the defendant's capacity to do those things required by the test. That evidence will be assessed by the judge in deciding whether or not the defendant's capacities are sufficient to enable a fair trial to be afforded. A question arises as to whether the evidence of experts should be confined to providing an opinion concerning the nature and extent of the person's capacity to do the things required by the test, and if they should be precluded from providing an opinion on whether a fair trial can be afforded. However we have not consulted on this issue and make no recommendation in this respect.

2.68 The *Presser* standards regarding understanding the proceedings, following the course of the proceedings, understanding the substantial effect of evidence, and making his or her version of the facts known to the court are all working satisfactorily and should be included in the statutory test. We would merely clarify

97. Information supplied by NSW Consumer Advisory Group, 4 October 2012, 4.

98. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 11.

that a trial is in fact an inquiry into whether the defendant has been proved to have committed the offence charged.

2.69 We also recommend that the *Presser* standard regarding communications with counsel should be clarified to ensure that the person has the capacity not only to communicate with counsel but to understand the advice given.

2.70 We recommend that the test should include a requirement for decision making capacity which will ensure that a person is only tried if he or she is able to understand the information relevant to the decisions that he or she will have to make before and during the trial, and to use that information as part of a rational decision making process.

2.71 While the criminal justice system rightly places weight on the right of defendants to make their own decisions (even if those decisions might appear misguided to an impartial observer) it cannot be said that defendants are effectively participating in a trial if they are unable to make rational decisions, for example because they cannot distinguish between delusion and reality.

2.72 This change responds to a problem with the *Presser* test identified by stakeholders. It also means that it is not necessary to include in the revised test separate standards regarding capacity to challenge jurors,[99] plead to the charge, make a defence, or decide what defence he or she will rely on. All of these standards are subsumed within the requirement of decision making capacity.

2.73 We do not consider it necessary for the proposed test to specify the source of the defendant's incapacity. If the source were limited to cognitive and mental health impairment, it is possible that some defendants who would appropriately be subject to the MHFPA regime will be excluded.

2.74 For the avoidance of doubt, we have specified that the defendant must be able to do all of the specified elements of the test if they are to be fit to be tried.

Recommendation 2.1

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to include a statutory fitness test, as follows:

> A person is unfit to stand trial if the person cannot be afforded a fair trial because it is established on the balance of probabilities that the person is unable to do any one or more of the following:
>
> (a) understand the offence with which the person is charged
>
> (b) understand generally the nature of the proceeding as an inquiry into whether it has been proved that the person committed the offence charged
>
> (c) follow the course of proceedings and understand what is going on in a general sense

99. The capacity to challenge jurors would anyway appear to be a relic of the time when juries had a somewhat different role in trials and the right to challenge them was an important part of a much more constrained role for defendants in criminal trials.

(d) understand the substantial effect of any evidence that may be given against the person

(e) understand the information relevant to the decisions that the person will have to make before and during the trial, and use that information as part of a rational decision making process

(f) communicate effectively with, and understand advice given by, legal representatives, and

(g) provide the person's version of the facts to the court, if necessary.

Steps to secure a fair trial

Accommodations to trial arrangements

2.75 The courts have indicated their willingness to modify proceedings in order to accommodate defendants with cognitive and mental health impairments. For example, in *R v KF*, Magistrate Heilpern said:

> In my view, this case is typical of where a person's memory is fading as a result of Alzheimer's disease. That is a tragedy, however it does not make for an unfair trial. The trial may need to have more time allocated than normal, there may need to be breaks to allow counsel to work through evidence and obtain instructions more slowly and cross-examination will need to be more cautious and perhaps more gentle than usual. Allowances such as this can easily be made.[100]

2.76 Such steps have not always been taken. In *Tuigamala*, a medical expert gave evidence on appeal that the defendant was in fact unfit at trial, as he was incapable of understanding or answering many of the questions he was asked. However she gave evidence that "that incapacity could have been overcome if Mr Tuigamala's intellectual disability, communication deficits and English as a second language had been taken into account during the trial, by those who posed questions to him."[101] The NSW Court of Criminal Appeal ordered a new trial and indicated that at that trial the question of his fitness would be investigated. The Court went on to note:

> If he is found fit to be tried but on condition that his intellectual impairment is recognised during the course of the trial, it would be a matter for the trial judge to protect the process at any retrial to ensure that it is fair.[102]

2.77 The *Evidence Act 1995* (NSW) allows a court to make orders in relation to the way in which witnesses are to be questioned.[103] In some cases, it might be useful for a court to hear evidence from an expert as to what arrangements are necessary for a particular person to have a fair trial.[104] The person could be given the opportunity to

100. *R v KF* [2011] NSWLC 14 [45].
101. *Tuigamala v The Queen* [2006] NSWCCA 380 [22].
102. *Tuigamala v The Queen* [2006] NSWCCA 380 [34].
103. *Evidence Act 1995* (NSW) s 26, s 29.
104. Information supplied by the Mental Health Review Tribunal, D Howard, President, 18 October 2012.

become familiar with the courtroom, a support person could be of assistance and the formality of proceedings could be reduced as much as possible.[105]

2.78 The Equality Before the Law Bench Book sets out some examples of adjustments that can be made. For example, for people with cognitive impairments, it suggests using slow, simple and direct speech, using short sentences, and avoiding double negatives, hypothetical questions, abstract concepts and legal jargon.[106] The Bench Book also provides advice on working with people who are delusional, anxious, paranoid or aggressive because of mental health impairments.[107] Taking breaks in the proceedings can be helpful.[108]

2.79 We consider that such procedural modifications should be encouraged. The defendant has a right to a fair trial if it is possible for one to be held, and it is in the public interest for the defendant to have a fair trial if this can be achieved. The recommended statutory provisions relating to the test for fitness should include provision that the court should consider whether modifications to the trial process can be made, or assistance be provided, to make possible the defendant's effective participation in the trial.

Relevance of the nature and circumstances of the trial

2.80 There is some debate as to whether there is an absolute minimum standard required to be fit for a trial, or whether this standard varies depending on the supports available to the defendant (such as legal representation) and the complexity of the trial that the defendant will face.[109] Birgden and Thomson argue (in the Victorian context) that fitness is a sliding scale, and a defendant may be able to effectively participate in a short trial with simple issues, but be unfit to participate in a long and complex trial.[110] In the US, there is evidence that clinicians take the seriousness of the charge into account in assessing competence – that is, they require a higher standard of competence for defendants facing more serious charges.[111] Commentators argue that it is proper to require a higher level of competence for more serious charges,[112] or when the defendant is waiving rights (for example, pleading guilty against legal advice).[113] Also in the US, the courts have acknowledged that legal representation is relevant to the assessment of

105. Information supplied by the Mental Health Review Tribunal, D Howard, President, 18 October 2012.
106. Judicial Commission of NSW, *Equality Before the Law Bench Book* [5.4.3.5].
107. Judicial Commission of NSW, *Equality Before the Law Bench Book* [5.4.3.7].
108. Judicial Commission of NSW, *Equality Before the Law Bench Book* [5.4.3.7]; Information supplied by the Mental Health Review Tribunal, D Howard, President, 18 October 2012.
109. See S Rubenzer, *Competency to Stand Trial: Legal Issues and Developments in Assessment* (2002) <http://www.steverubenzerphd.com/Competency-to-Stand-Trial-Defender.php>.
110. A Birgden and D Thomson, "The Assessment of Fitness to Stand Trial for Defendants with an Intellectual Disability: A Proposed Assessment Procedure Involving Mental Health Professionals and Lawyers" (1999) 6 *Psychiatry, Psychology and Law* 207, 211.
111. B Rosenfeld and K Ritchie, "Competence to Stand Trial: Clinician Reliability and the Role of Offense Severity" (1998) 43 *Journal of Forensic Sciences* 151.
112. A Buchanan, "Competency to Stand Trial and the Seriousness of the Charge" (2006) 34 *Journal of the American Academy of Psychiatry and the Law* 458, 459.
113. See S Rubenzer, *Competency to Stand Trial: Legal Issues and Developments in Assessment* (2002) <http://www.steverubenzerphd.com/Competency-to-Stand-Trial-Defender.php>.

fitness: "[o]ne might not be insane in the sense of being incapable of standing trial and yet lack the capacity to stand trial without benefit of counsel".[114]

2.81 The Law Commission of England and Wales considered this issue in its review of the fitness test. It chose not to include "proportionality", or the complexity of the proceedings, in its provisional proposal for a new test for fitness. The Commission was concerned that proportionality could produce a lack of certainty, as complexity is difficult to predict. It could result in appeals on the basis that the defendant was assessed as fit for straight forward proceedings, but the proceedings unexpectedly became more challenging.[115]

2.82 The Law Commission of England and Wales does not canvass the alternatives. One approach would be to require the court to ignore any information available to it about the likely complexity of the trial and instead assess fitness on the basis of an average or typical trial. Another would be to require the courts, in each case, to assess fitness on the basis that the trial would be long and complex. This would result in many defendants being found to be unfit, when in fact they have the capacity necessary for the trial they are likely to face.

2.83 The NSW courts currently take into account the likely complexity of the trial. For example:

> I also had regard to the fact that there was consensus between [the expert witnesses] as to the availability of the defence of mental illness, which meant that the complexity of the trial would be substantially reduced. Further, I took into account the fact that the estimated length of the trial was only one day: cf *Kesavarajah* at 246. In the circumstances, I was satisfied on the balance of probabilities that the accused was fit to be tried.[116]

2.84 NSW courts have heard expert evidence that takes into account the fact that the defendant was likely to be unrepresented,[117] or indicates that fitness "would be conditional on him receiving legal advice with simple explanations from his legal counsel".[118]

2.85 We therefore recommend that courts should take into account the likely length and complexity of a trial, and whether the defendant is legally represented, in making its decisions. This is consistent with current practice and no difficulties appear to have arisen with this approach.

2.86 There may be an occasional case when a person is found to be fit on the basis that the demands of the trial will be low, and the trial is unexpectedly complex. Such a case would be dealt with by raising fitness again, whether at trial or on appeal. This would result in some expense and inconvenience, but is a reasonable response to the uncertainties of litigation.

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114. *Massey v Moore* 348 US 105, 108; 75 S Ct 145, cited in A Buchanan, "Competency to Stand Trial and the Seriousness of the Charge" (2006) 34 *Journal of the American Academy of Psychiatry and the Law* 458, 460.

115. England and Wales, Law Commission, *Unfitness to Plead*, Consultation Paper 197 (2010) [3.91].

116. *R v Aliwijaya* [2012] NSWSC 503 [16] (McCallum J).

117. *R v Waszczuk* [2012] NSWSC 380 [26]-[27], [31]-[32]. The court accepted the opinions of the experts without making any comments about this particular issue: [35].

118. *R v Walker* [2008] NSWSC 462 [16].

Recommendation 2.2

In determining whether a person is unfit for trial, the matters that a court must consider include:

(a) whether modifications to the trial process can be made or assistance provided to facilitate the person's understanding and effective participation

(b) the likely length and complexity of the trial, and

(c) whether the person is legally represented.

Fitness to plead guilty

2.87 The English 19th century authority of *Pritchard* makes a distinction between the ability to plead and the ability to stand trial:

> There are three points to be inquired into: - First, whether the prisoner is mute of malice or not; secondly, whether he can plead to the indictment or not; thirdly, whether he is of sufficient intellect to comprehend the course of proceedings on the trial, so as to make a proper defence - to know that he might challenge any of you to whom he may object - and to comprehend the details of the evidence.[119]

2.88 However, in Australia, the distinction between fitness to plead and fitness to stand trial appears to have blurred. The Australian authority of *Presser* includes the ability to plead to the charge as one of the capacities that are necessary to be able to stand trial, and in Australian courts the terms "fit to plead" and "fit to stand trial" are often used interchangeably.[120] Chris Bruce SC has argued that in fact the minimum standards required to plead guilty are "vastly less onerous" than those required to stand trial.[121]

2.89 The question of fitness to plead may arise for lawyers considering the appropriate course of action for a client with cognitive or mental health impairments. It may also arise where a defendant has been referred to the MHRT to determine if the defendant will become fit.[122] The MHRT has experienced cases where the defendant wished to plead guilty and the Tribunal concluded that they were fit to plead guilty, but not fit to be tried. In consultation, the President of the MHRT noted that the MHRT has reviewed cases where the defendant lacked the concentration span to follow a trial but would have been fit to enter a guilty plea.[123] However, the MHRT may only make a determination as to whether a person is fit to be tried,[124] so the person cannot be referred back to the court to plead guilty, but must be referred

119. *R v Pritchard* (1836) 7 Car & P 304; 173 ER 135, 135.

120. See, eg, *R v Mailes* [2001] NSWCCA 155; 53 NSWLR 251 [146], *Eastman v The Queen* [2000] HCA 29; 203 CLR 1 [62]. See also *Mental Health (Forensic Provisions) Act 1990* (NSW) s 17(1) where the heading of the section says "fit to plead" but the section itself says "fit to be tried".

121. C Bruce, "Ethics and the Mentally Impaired" (Paper presented at the Public Defenders Criminal Law Conference 2011, Taronga Centre, 27 February 2011) 3.

122. For a review of the current process see Chapter 6.

123. Information supplied by the Mental Health Review Tribunal, D Howard, President, 18 October 2012.

124. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 16.

for a special hearing.[125] The MHRT submitted that a person who had previously been found to be unfit should be able to make an application to the MHRT for a finding of fitness to plead guilty. If the MHRT determines that the person is fit to plead guilty, the person should be able to enter their plea in court and be dealt with accordingly.[126]

2.90 It appears likely that the courts do in practice accept pleas of guilty from people who are unfit for trial but fit to plead guilty. Their legal representatives may be satisfied of their capacity to plead and to participate in a sentencing hearing, and consider it unnecessary to raise the issue of fitness for trial. The defendant's impairment may not be evident to the prosecution or the court. However once a fitness inquiry has been held, the options open to the defendant decrease. If found unfit for trial, the defendant can no longer plead guilty, but must have a special hearing, with the disadvantages associated with that process.[127]

2.91 Our consultations therefore raised the question of whether or not there should be a separate test for fitness to plead guilty. This was not an issue canvassed in CP 6. Consequently we issued Question Paper 2 (QP 2) in which we asked stakeholders whether a separate test of fitness to plead guilty should be promulgated, what any such test should be, and the situations in which such a test should be used.[128]

2.92 We received seven submissions in response to QP 2.[129] Six of these submissions were opposed to a separate test of fitness to plead guilty.[130] Only the MHRT was in favour of a separate test.[131]

2.93 The reasons for the opposition to a separate test for fitness to plead guilty were that the concerns about the defendant's capacity are the same when considering fitness to plead guilty and fitness to be tried, and therefore the test should be the same.[132] It was argued that a separate test would be an unnecessary complication,[133] confusing and burdensome.[134] It was also submitted that the central issue in

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125. If found unfit to be tried and not likely to become fit by the Mental Health Review Tribunal: *Mental Health (Forensic Provisions) Act 1990* (NSW) s 16, s 19. Procedures following a finding of unfitness, including special hearings, are discussed in Chapter 6.

126. Mental Health Review Tribunal, *Submission MH65*, 1.

127. See Chapter 7, where we discuss the issues that surround the nomination of a limiting term including no non-parole period and no discount for a guilty plea.

128. NSW Law Reform Commission, *Fitness to Plead Guilty*, People with Cognitive and Mental Health Impairments in the Criminal Justice System: Question Paper 2 (2012).

129. M Ierace, Senior Public Defender, *Submission MH61*; NSW Director of Public Prosecutions, *Submission MH62*; Law Society of NSW, *Submission MH63*; NSW Bar Association, *Submission MH64*; Mental Health Review Tribunal, *Submission MH65*; NSW Police Force, *Submission MH66*, 1; Legal Aid NSW, *Submission MH68*.

130. M Ierace, Senior Public Defender, *Submission MH61*, 1; NSW Director of Public Prosecutions, *Submission MH62*, 1; Law Society of NSW, *Submission MH63,* 1; NSW Bar Association, *Submission MH64*, 1; NSW Police Force, *Submission MH66*, 1; Legal Aid NSW, *Submission MH68*, 2.

131. Mental Health Review Tribunal, *Submission MH65*, 1.

132. M Ierace, Senior Public Defender, *Submission MH61,* 1. The Senior Public Defender circulated his response to QP 2 to other stakeholders, and the response of the Law Society of NSW, the NSW Bar Association and the Director of Public Prosecutions was to endorse his submission. Because the NSW Police Force does not prosecute cases in the District and Supreme Courts, the Police Force deferred to the opinion of the Director of Public Prosecutions on this issue. Legal Aid NSW, *Submission MH68*, 2 noted that separate tests assume a clear division that is not evident in the law of fitness.

133. M Ierace, Senior Public Defender, *Submission MH61,* 1; Legal Aid NSW, *Submission MH68*, 2.

134. NSW Director of Public Prosecutions, *Submission MH62*; Law Society of NSW, *Submission MH63*, 1.

unfitness is the capacity of the accused,[135] and expert assessments of capacity can take into account whether the defendant is facing a sentencing hearing or a trial, and the likely length or complexity of any trial.[136]

2.94 In view of the strength of the opposition from key stakeholders to the idea of a separate test for fitness to plead guilty we make no recommendation in this regard.

Procedures ancillary to the determination of fitness

An express requirement to consider fitness

2.95 In CP 6 we asked if the MHFPA should expressly require the court to consider the issue of fitness whenever it appears that the accused person may be unfit to be tried.[137] Responses were mixed on this issue. Some submissions indicated that the current provisions are sufficient, and that the court would consider the issue of fitness when asked to do so.[138] Other submissions emphasised that trial of an unfit person is an abuse of court process[139] and preferred an express requirement to consider fitness.[140]

2.96 We agree that the trial of an unfit person is an abuse of process. However, the court may already consider the issue of fitness of its own motion.[141] In the absence of any indication that the courts have been reluctant to consider the issue of fitness, we do not recommend a mandatory requirement.

Power to order assessment reports

2.97 There is no general statutory power for a court to order an assessment of a defendant's mental state. Under the MHFPA if the court determines that an inquiry into fitness should be conducted, or if a question of fitness is raised in the District or Supreme Courts, the court may "request", but not order, that a defendant undergo a psychiatric or other examination, or that a psychiatric or other report be obtained, as directed by the court.[142]

2.98 In SA and Victoria, the court may order the defendant to be examined by a psychiatrist or other appropriate expert and order the report to be produced to the

135. Legal Aid NSW, *Submission MH68*, 2; Law Society of NSW, *Submission MH63*, 1.
136. Law Society of NSW, *Submission MH63*, 1.
137. 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 6.1.
138. NSW Bar Association, *Submission MH10*, 7; Homicide Victims' Support Group, *Submission MH20*, 4; NSW, Public Defenders, *Submission MH26*, 14-15.
139. Law Society of NSW, *Submission MH13*, 4; Legal Aid NSW, *Submission MH18*, 6.
140. NSW Office of the Director of Public Prosecutions, *Submission MH5*, 3; NSW Consumer Advisory Group, *Submission MH11*, 15; Law Society of NSW, *Submission MH13*, 4; Legal Aid NSW, *Submission MH18*, 6; Brain Injury Association of NSW, *Submission MH19*, 21; Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28,* 14.
141. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 5.
142. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 10(1), s 10(3)(d)-(e).

court.[143] In other jurisdictions, the court may "require" the defendant to be examined.[144]

2.99 In our survey of cases, the courts appeared to have adequate access to expert reports and there did not appear to be a need for a power to order an assessment of the defendant's fitness. If a court raises fitness of its own motion, conducts an inquiry, and requests the accused person to undergo a psychiatric examination, it would be unusual for the accused person to refuse. If the person did refuse, it is not clear that a statutory power would be of assistance, as it is not possible to force a person to be psychiatrically examined.[145]

2.100 For this reason, we consider that in the context of a fitness hearing, the power to request a person undergo assessment is sufficient.

Consent to finding of unfitness

2.101 In SA, the NT and Tasmania, legislation provides that if the defence and prosecution agree that the defendant is unfit, the court may enter a finding to that effect.[146] In cases where the defendant's unfitness is not in dispute, those jurisdictions are able to avoid the delays and expense of conducting a fitness inquiry. However, in NSW, it is necessary to hold a hearing.[147]

2.102 In CP 6, we asked if the MHFPA should allow for the defence and prosecution to consent to a finding of unfitness.[148] Several stakeholders agreed with this proposal, without providing reasons. However other stakeholders urged caution. The NSW Bar Association submitted that "the final determination of such an important issue ought to be the subject of proper scrutiny by the court, given the potentially very significant consequences of a finding of unfitness".[149] It suggested that some experts are "in effect, 'hired guns'" – that is, they will provide an opinion that is tailored to the needs of the person requesting and paying for it - and because of this, the court should continue to scrutinise the process.[150]

2.103 The Public Defenders also submitted that a provision for consent orders should not be included. This submission noted that fitness hearings where the parties agree are normally brief and are not resource-intensive.[151] It also argued that in the interests of justice and for the benefit of victims' families, court proceedings should

143. *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 10(1)(d); *Criminal Law Consolidation Act 1935* (SA) s 269J(1), s 269K(1).

144. *Crimes Act 1900* (ACT) s 315A(1)(b); *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 11(1)(c), s 39(1B)(b); *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 12(2)(a); *Criminal Code* (NT) s 43N.

145. See, eg, *R v Rush* [2009] NSWDC 325 [37].

146. *Criminal Code* (NT) s 43T(1); *Criminal Law Consolidation Act 1935* (SA) s 269M(A)(5); *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 19.

147. See, eg, *R v Wilson* [2000] NSWSC 1104, where the defendant and the Crown agreed that the defendant was unfit.

148. 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 6.9.

149. NSW Bar Association, *Submission MH10*, 13.

150. NSW Bar Association, *Submission MH10*, 13-14.

151. NSW, Public Defenders, *Submission MH26*, 21.

be open and transparent.[152] The HVSG agreed that making a provision for a consent orders creates a risk of leaving the victim's family confused. It supported the use of consent orders only if the victim's family is informed in advance.[153]

2.104 We consider that where highly vulnerable defendants are concerned, such an important decision should not be left to a consent agreement between the prosecution and the defence, and the court should continue to make an independent decision on fitness. There is a public interest in the conviction and punishment of offenders according to law. If an exception is to be made in the case of a person found unfit to be tried, an independent public authority should decide that the case is appropriate for such exceptional treatment. We also consider that such an important decision should be made in open court, with reasons given and the evidence relied upon identified. We therefore make no recommendation on this issue.

Substitute qualified finding of guilt

2.105 A person who is convicted of an offence may appeal on the ground that he or she was, or may have been, unfit at the time of the trial. The appeal court must allow the appeal unless it reaches the view that had the question of fitness been raised at trial, the court below, acting reasonably, *must* have found the appellant fit to stand trial.[154] The conviction must be quashed and a new trial ordered, at which time the question of fitness may be raised.[155]

2.106 If the person is subsequently found unfit by a court, and the MHRT considers that the he or she will not become fit within 12 months, a special hearing will be held. At the special hearing, the verdicts available are:

- not guilty
- not guilty by reason of mental illness
- that on the limited evidence available, the accused person committed the offence charged, or
- that on the limited evidence available, the accused person committed an offence available as an alternative to the offence charged.[156]

2.107 In CP 6 we asked if the Court of Criminal Appeal (CCA) should have the power to quash the conviction and substitute a finding that on the limited evidence available, the accused person committed the offence charged, or an alternative offence, if satisfied that there is no reasonable possibility of any other finding if a special hearing were to be held, and/or that the parties consent to the order.[157] Such an

152. NSW, Public Defenders, *Submission MH26*, 21-22.

153. Homicide Victims' Support Group, *Submission MH20*, 7.

154. *Eastman v The Queen* [2000] HCA 29; 203 CLR 1 [99]-[100]; *R v RTI* [2003] NSWCCA 283; 58 NSWLR 438; *R v Rivkin* [2004] NSWCCA 7; 59 NSWLR 284, 296; *R v Henley* [2005] NSWCCA 126; *Kirkwood v The Queen* [2006] NSWCCA 181.

155. See, eg, *Robinson v The Queen* [2008] NSWCCA 64.

156. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22.

157. 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 6.10.

approach might be suitable where the defendant was unfit at trial (but the unfitness was not raised at that time), remains unfit at the time of the appeal and is not likely to become fit within 12 months. It would avoid the expense and trauma of a further fitness hearing, followed by a special hearing.[158]

2.108 There are difficulties with this approach. First, the CCA must allow an appeal if the defendant *may* have been unfit at trial. If the CCA is to substitute a qualified finding of guilt, it must establish that the defendant *is* unfit, either by holding a fitness enquiry or by the consent of the parties. We have given our views on a finding of unfitness by consent above. It is not the usual function of the CCA to hold a fitness inquiry.

2.109 Second, for the CCA to conclude that there is no possibility of acquittal, it would have to rely either on evidence led at the trial, or it would have to hear further evidence. Relying on the evidence led at trial is problematic because that trial was fundamentally flawed by the unfitness of the defendant.[159] The Public Defenders' submission points out that if a retrial is held, the evidence led may be substantially different when the parties are aware of the defendant's impairments.[160]

2.110 Alternatively, the CCA would have to hear further evidence, but again, this is not its usual function.[161]

2.111 Appeals on the basis that the accused person may have been unfit at trial are rare. We are aware of four since 2007,[162] and two of these appeals were allowed. It is distressing for victims, their families and the unfit defendant to endure a trial, an appeal, a fitness hearing and a special hearing. We have made recommendations in Chapter 6 which will streamline the processes that take place after a finding of unfitness. However, we do not recommend extending the powers of the CCA as proposed in CP 6, as we consider it would impose burdens on that court that it is not designed to bear, and it would erode the protections for the unfit defendant.

158. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 4; Homicide Victims' Support Group, *Submission MH20*, 7.

159. *Eastman v The Queen* [2000] HCA 29; 203 CLR 1 [63].

160. NSW, Public Defenders, *Submission MH26*, 22.

161. NSW Bar Association, *Submission MH10*, 14.

162. *Clarkson v The Queen* [2007] NSWCCA 70 (dismissed); *Philopos v The Queen* [2008] NSWCCA 66 (dismissed); *Wills v The Queen* [2007] NSWCCA 160; 170 A Crim R 208 (allowed); *Robinson v The Queen* [2008] NSWCCA 64 (allowed).

3. The defence of mental illness

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3.1 This chapter first outlines the current law relating to the defence of mental illness in NSW and provides a snapshot of the use of the defence in NSW. We then consider the problems that arise, outline options for changing the law, and explain the extensive process of consultation with stakeholders we undertook in relation to those options. We outline our recommendations for change and explain in detail the reasons for our recommendations. Finally, we consider some procedural issues relating to the defence and the name that should be used to describe the defence.

The defence of mental illness: the current law

3.2 The current provisions relating to the defence of mental illness are dealt with in Part 4 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA). The preconditions for the special verdict of not guilty by reason of mental illness (NGMI)[1] are contained in s 38 of the MHFPA, which provides:

> If, in an indictment or information, an act or omission is charged against a person as an offence and it is given in evidence on the trial of the person for the offence that the person was mentally ill, so as not to be responsible, according to law, for his or her action at the time when the act was done or omission made, then, if it appears to the jury before which the person is tried that the person did the act or made the omission charged, but was mentally ill at the time when the person did or made the same, the jury must return a special verdict that the accused person is not guilty by reason of mental illness.

3.3 The phrase "so as not to be responsible, according to law" refers to the common law, the basis of which is the so-called *M'Naghten* rules. *M'Naghten*[2] was an English case of 1843. The defendant shot Edward Drummond, the Private Secretary to Sir Robert Peel, apparently thinking he was shooting Peel, because he was acting under a paranoid delusion that he was being persecuted by the Tories. The *M'Naghten* rules were developed, not in the judgment in the case, but in response to a series of questions put to the judges as a result of the case. They defined the defence of mental illness in the following way:

> The defendant was labouring under a defect of reason caused by disease of the mind and, because of the disease the defendant either
>
> - did not know the nature and quality of the act, or
> - did not know that the act was wrong.

3.4 In a defence of mental illness (as the common law "insanity defence" is now known), there are two elements. The first is a qualifying mental state, which in the present law requires a defect of reason caused by disease of the mind. The second is a qualifying nexus between that mental state and the act or omission; here that the person did not know the nature and quality of the act or did not know that it was wrong. Unsurprisingly, case law has elaborated the meaning of both elements of the

1. While NGMI is an acronym for the verdict of not guilty by reason of mental illness, for convenience we have sometimes used it to refer also to the defence of mental illness.
2. *M'Naghten's Case* (1843) 10 Cl & F 200; 8 ER 718.

defence. That case law was reviewed extensively in Consultation Paper 6 (CP 6)[3] and is considered below.

3.5 If a person is found to be "mentally ill, so as not to be responsible, according to law, for his or her action" a special verdict of NGMI must be returned.[4] The consequence of a finding of NGMI is usually that the person becomes a forensic patient.[5] Forensic patients who are ordered by the court to be detained are reviewed by the Mental Health Review Tribunal (MHRT) every six months. They may be released by an order of the MHRT, but only if it is satisfied, on the balance of probabilities, that the safety of the person or any member of the public will not be seriously endangered by the person's release.[6]

3.6 The provisions of the MHFPA that provide for the defence of NGMI do not apply in the Local Court.[7] In theory, however, the *M'Naghten* rules apply and could be used.[8]

The defence of mental illness: its use in NSW

3.7 The annual number of cases in which a person is found NGMI is relatively small.[9] According to the NSW Bureau of Crime Statistics and Research (BOCSAR), in 2009-10 there were 31 cases; in 2010-11 there were 23 cases; and in 2011-12 there were 29 cases.[10] The number of cases in which the defence of mental illness was raised is not available.

3.8 The Annual Reports of the MHRT provide information about the number of forensic patients reviewed by the MHRT following a finding of NGMI. Because the court can make an order for the unconditional release of a person found NGMI, and those people do not become forensic patients,[11] the MHRT's figures do not necessarily reflect the precise number of cases where a finding of NGMI is made. However, since orders for unconditional release are thought to be made infrequently, the forensic patient numbers should provide a reasonably accurate guide.

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3. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences*, Consultation Paper 6 (2010) [3.23]-[3.48].
4. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 38.
5. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 39, s 42. For consideration of the procedures that apply after a finding of not guilty by reason of mental illness see Chapter 7.
6. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 43.
7. *Mental Health (Forensic Provisions) Act 1990* (NSW) pt 4, s 37-39 refers to trials by jury. This limitation almost certainly contributes to the low incidence of findings of NGMI. The availability of the defence in the Local Court is considered further in Chapter 12.
8. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences*, Consultation Paper 6 (2010) [3.114]-[3.116]. See also Chapter 12.
9. No information is available about the number of times the defence is raised in the Local Court.
10. NSW Bureau of Crime Statistics and Research (ref: Hc12/10726dg). BOCSAR data is provided by calendar year. In order to compare this data with the information provided by the Mental Health Review Tribunal on the basis of financial year, BOCSAR provided monthly data: NSW Bureau of Crime Statistics and Research (ref: Hc1210999dg). Cases where there is a finding of NGMI after a special hearing are recorded separately and were added to these figures: NSW Bureau of Crime Statistics and Research (ref: mai12/11000hc).
11. See Chapter 7, para 7.12- 7.13 and subsequent discussion.

3.9 From 2003 to 2008 the MHRT estimated that less than 20 referrals were made each year following a finding of NGMI.[12] In each of 2008-9 and 2009-10, 39 cases were referred.[13] In 2010-11 there were 24 referrals.[14] In 2011-12 there were 32 referrals.[15] Thus the MHRT's figures appear to be slightly inconsistent with the BOCSAR figures, but not in the predicted direction. The difference may be a function of the time lag between a court finding and the MHRT review. Nevertheless, these two data sources provide an indication of the number of cases annually in NSW where a finding of NGMI is made.

3.10 A different perspective is provided by a review by Hayes of forensic patients who received an NGMI verdict over an 11 year period from 1 January 1990 to 31 December 2010.[16] This study was based on MHRT files and showed a total of 364 patients found NGMI over that period. Of those, 85 were unconditionally released and 112 conditionally released during that period.[17]

3.11 Although in theory the defence can be used in relation to any offence, it is used most frequently in relation to homicide or other offences involving serious violence, which carry heavy penalties. It has also been used in relation to driving offences involving serious injury. For example, in *R v Sandoval*[18] the defence was used successfully in relation to charges of dangerous driving. The defendant, who was suffering from a psychosis, believed that there were demons and evil voices in the car with him, when in fact he was being pursued by police because of his erratic driving.

3.12 The reason that the defence is only used in relation to a limited number of serious offences is that the consequence of a finding of NGMI is very likely to be that the person becomes a forensic patient. Although forensic patients are regularly reviewed by the MHRT, no limiting term is set in cases where there is a finding of NGMI and there is no certainty about a release date.[19] Thus, as a practical matter, a defendant may prefer the certainty of a criminal sentence to the uncertainty of a period as a forensic patient.

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12. Mental Health Review Tribunal, *Annual Report 2009-10*, 7.
13. Mental Health Review Tribunal, *Annual Report 2009-10*, 7.
14. Mental Health Review Tribunal, *Annual Report 2010-11*, 34.
15. Mental Health Review Tribunal, *Annual Report 2011-12*, 31.
16. H Hayes, *Not Guilty by Reason of Mental Illness: A 21 Year Retrospective Study of Released Forensic Patients in NSW* (Masters in Psychology Thesis, University of NSW, 2011).
17. H Hayes, *Not Guilty by Reason of Mental Illness: A 21 Year Retrospective Study of Released Forensic Patients in NSW* (Masters in Psychology Thesis, University of NSW, 2011) 17, 20. Note that the data collected in the study did not include clients who had been detained, but died during the period of the study. The corrected total figure therefore appears to be 364 forensic patients: Information supplied by H Hayes, 17 October 2012.
18. *R v Sandoval* [2010] NSWDC 255.
19. For discussion of the powers of the court after a finding of NGMI see Chapter 7. In that chapter we recommend that limiting terms be introduced for people found NGMI: see Recommendation 7.2.

A new direction for the defence of mental illness?

3.13 The *M'Naghten* rules were developed at a time when our knowledge of human psychology was far less developed. However, the rules have persisted, and have been widely adopted across the common law world. In many Australian and overseas jurisdictions the rules have been codified and updated over time.

Are there problems with the current law?

3.14 In CP 6 we asked whether stakeholders in NSW think that the current law fulfils its purposes of:

- recognising impairment of mental functioning as an excuse from criminal responsibility, and
- the protection of the community through detention of those who, because of their mental impairment, pose a threat to themselves or others.[20]

3.15 To this end we asked a general question concerning the effectiveness or otherwise of the present law. Although the test is dated, we wished to know if stakeholders considered that a sufficient body of law had developed to allow it to be applied with certainty, consistency and ease. We also asked if the test works well in practice, and if its scope is appropriate.[21]

3.16 The main focus of the seven submissions that dealt with this question was the need to change the way the defendant's mental state is defined. The terms "disease of the mind" and "defect of reason" were criticised,[22] and it was argued that these terms needed to be replaced with contemporary definitions of mental illness and cognitive impairment.[23]

3.17 Legal Aid NSW submitted that the current defence is too narrow and excludes many defendants with impairments who should not be held criminally responsible for their actions.[24] The Law Society of NSW expressed concern about the phrase "disease of the mind'" and submitted that the test includes some categories of people who should be excluded and excludes some who should be covered by the defence.[25] The Public Defenders, however, was in favour of retention of the "disease of the

20. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences*, Consultation Paper 6 (2010) [3.3]-[3.5], [3.49].
21. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences*, Consultation Paper 6 (2010) [3.49].
22. NSW Bar Association, *Submission MH10,* 25; Law Society of NSW, *Submission MH13,* 10; Legal Aid NSW, *Submission MH18,* 11; Brain Injury Association of NSW, *Submission MH19,* 22; NSW Council for Civil Liberties, *Submission MH46,* 7.
23. NSW Bar Association, *Submission MH10,* 25; Brain Injury Association of NSW, *Submission MH19,* 22; NSW Council for Civil Liberties, *Submission MH46,* 7.
24. Legal Aid NSW, *Submission MH18*, 10.
25. Law Society of NSW, *Submission MH13*, 9.

mind" test because of the common law developed around it which remains relevant.[26]

3.18 Apart from the definition of the person's mental state, the other elements of the *M'Naghten* rules were generally supported. The NSW Bar Association and the NSW Police Force submitted that the current rules work well and do not require change.[27] The Office of the Director of Public Prosecutions (ODPP) argued that no basis for changing the *M'Naghten* rules has been established, and that they should be formulated in legislation.[28] The Public Defenders submitted that the rules should be imported into legislation in contemporary language.[29]

3.19 In summary, modifications to the *M'Naghten* rules were suggested, but the predominant theme of submissions and of consultation meetings was that, broadly speaking, the defence of mental illness works in practice without significant difficulty and that the right results are achieved.

Alternatives to *M'Naghten*

3.20 Despite this support from stakeholders, the *M'Naghten* rules have been subjected to extensive criticism and numerous suggestions for change have been made. In CP 6 we outlined several alternatives to the rules[30] and asked whether they should be replaced with a different formulation.[31]

3.21 Only four submissions responded to this question. The NSW Bar Association and the Public Defenders both rejected the idea of replacing the *M'Naghten* rules.[32] The Law Society of NSW pointed out that the defence has been "remarkably resistant to reform". Both the Law Society and Legal Aid NSW preferred an approach based on cognitive competency.[33] No submissions expressed support for any other of the approaches mentioned in CP 6.

3.22 Taking into account these responses, and in light of further consultations with stakeholders, we developed two proposals for reform and engaged in further consultation with stakeholders concerning the best way forward.

3.23 We first outline these two alternatives, their nature and qualities. We then set out the responses of stakeholders to the two proposals and our decision as to which option we recommend. We then explore the chosen option in more detail.

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26. NSW, Public Defenders, *Submission MH26*, 31.
27. NSW Bar Association, *Submission MH10,* 26; NSW Police Force, *Submission MH47,* 6.
28. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 5.
29. NSW, Public Defenders, *Submission MH26*, 31.
30. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences*, Consultation Paper 6 (2010) [3.64]-[3.88].
31. 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 6.29.
32. NSW Bar Association, *Submission MH10,* 25-26; NSW, Public Defenders, *Submission MH26,* 31.
33. Law Society of NSW, *Submission MH13*, 11; Legal Aid NSW, *Submission MH18,* 11.

The revised M'Naghten test

3.24 The first of the two alternatives was a revised and codified test based on the *M'Naghten* rules. This option was distilled from the comments of stakeholders, the codification of the *M'Naghten* rules in comparable jurisdictions, and scholarly commentary. We refer to it below as the "revised *M'Naghten* test".

Revised *M'Naghten* test

A person is not criminally responsible for an offence if, when carrying out the conduct required for the offence, the person was suffering from a mental health impairment or a cognitive impairment that had the effect that the person:

(a) did not know the nature and quality of the conduct

(b) did not know that the conduct was wrong, that is, the person could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong, or

(c) was unable to control the conduct.

3.25 This test adapts the *M'Naghten* rules in the following ways. First, the qualifying mental state is changed. The terms cognitive and mental health impairment are adopted in the place of the much criticised and now outdated terms "defect of reason" and "disease of the mind". In Report 135 we recommend the use of these terms in relation to diversion, and we defined them to incorporate contemporary understandings of those impairments.[34]

3.26 Second, the qualifying nexus between the person's mental state and his or her acts or omissions is revised. Paragraph (a) replicates the *M'Naghten* rules. Paragraph (b) replicates and also elaborates the meaning of "did not know that the conduct was wrong" in line with the case law[35] and provisions in other Australian jurisdictions.[36] Paragraph (c) adds to the test the inability of the individual to control his or her conduct. This element is not part of the original *M'Naghten* test, but has been widely adopted elsewhere in Australia.[37]

The Allnutt O'Driscoll test

3.27 The second proposal on which we consulted we refer to as the "Allnutt O'Driscoll test". It was developed during the course of consultations for this reference by Stephen Allnutt and Colman O'Driscoll, in consultation with Harold Sperling.[38] It

34. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion,* Report 135 (2012) Recommendations 5.1, 5.2, 5.3.

35. See especially *R v Porter* (1933) 55 CLR 182, 189-90.

36. *Criminal Code* (Cth) s 7.3(1)(b); *Criminal Code* (ACT) s 28(2); *Criminal Code* (NT) s 43C(1)(b); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 20(1)(b).

37. *Criminal Code* (Cth) s 7.3; *Criminal Code* (ACT) s 27, s 28; *Criminal Code* (NT) s 43A, s 43C; *Criminal Law Consolidation Act 1935* (SA) s 269C.

38. Dr Stephen Allnutt is Clinical Director of the NSW Community Forensic Mental Health Services. Colman O'Driscoll was Service Director for the Statewide Forensic Mental Health Service and is presently Chief of Staff to the Minister for Mental Health. The Hon Harold Sperling QC is a part-time Commissioner of the NSW Law Reform Commission and a part-time Deputy President of the Forensic Division of the Mental Health Review Tribunal.

updates the law, avoids some of the problems identified with the existing *M'Naghten* rules and creates a test that is understandable both to lawyers and also to the experts who provide reports to the court in cases involving a plea of NGMI.

The Allnutt O'Driscoll test

(1) If it is found that the defendant carried out the conduct required for the offence charged or for an alternative offence, and it is further found–

(a) that at the time of carrying out the conduct the defendant had a qualifying mental state

(b) that, as a result of the qualifying mental state, the defendant made an irrational decision to carry out the conduct, and

(c) that the defendant carried out the conduct in consequence of that irrational decision,

the court must not find the defendant guilty of the offence and must find that the defendant carried out the conduct but is not responsible in law.

(2) The burden of proving the matters in subsection (1)(a), (b) and (c) is on the defendant and the standard of proof is proof on a balance of probabilities.

(3) For the purposes of this section and subject to subsection (4), the following and only the following are qualifying mental states: delusions, hallucinations, severely disordered thought process, severe disturbance of mood (including severe depression, mania or anxiety), cognitive impairment, and inability to control conduct.

(4) A mental state is not a qualifying mental state for the purposes of this section unless it is either continuous or prone to recur. Intoxication and transitory emotions such as anger, jealousy and hatred are not, of themselves, qualifying mental states.

(5) Without limiting the generality of the phrase, "irrational decision", the decision may result from a false perception of reality, an irrational justification for action or an inability to perceive available options.

3.28 This test has many advantages. First, it defines mental illness, at paragraph 3, according to symptoms. Defining mental illness by diagnosis may create difficulties for experts, since expert witnesses often see the person only once and for a comparatively short period of time. They may disagree on a diagnosis, while observing the same symptoms.

3.29 Second, in defining the nexus between the person's mental state and the acts or omissions, the test focuses on the rationality of the person's decision to carry out the conduct that constitutes the offence. Arguably it is the issue of irrationality that should be at the centre of a defence of NGMI. Irrational conduct underlies what is presently the most frequently used element of the *M'Naghten* test – that "the person could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong".[39] Further, the Allnutt

39. *R v Porter* (1933) 55 CLR 182, 189-90.

O'Driscoll test makes sense to those experts whose evidence is crucial to a decision as to whether or not the defendant is NGMI, since psychiatrists are accustomed to evaluating rationality.

3.30 Below we first describe the response of stakeholders to these two options, set out our recommended test and then consider the elements of that test in more detail.

Stakeholders' views

3.31 These two tests were discussed at a roundtable of key stakeholders.[40] They were also considered at a consultation with the NSW Supreme Court[41] and by our panel of experts.

3.32 The outcome of these consultations was clearly in favour of the revised *M'Naghten* test. In summary, stakeholders considered that the *M'Naghten* rules worked well; that they are familiar; and that they do not cause particular problems in practice. Some stakeholders argued that the *M'Naghten* test is clear and is well understood by juries. Consistency between NSW, federal law and other states and territories was also supported as an important advantage of the *M'Naghten* test.[42]

3.33 The one element of the *M'Naghten* rules that again attracted consistent criticism was the way in which it defines the person's mental state. The terms "disease of the mind" and "defect of reason" were rejected as outdated and offensive.

3.34 There was very little support from stakeholders at the roundtable for the Allnutt O'Driscoll test. However, after that meeting the NSW Consumer Advisory Group (NSWCAG), the state peak organisation for consumers, provided written feedback expressing support for the Allnutt O'Driscoll model. The NSWCAG preferred the emphasis of that test on symptoms rather than diagnoses and on the rationality of the person's decision.[43]

3.35 We therefore concluded that, despite the technical strengths of the Allnutt O'Driscoll test, there is presently no appetite amongst stakeholders for a change of that nature, but rather a preference for revising and updating the longstanding *M'Naghten* test.

The Commission's view

3.36 We recommend that the revised *M'Naghten* test be incorporated into NSW law, for the following reasons.

3.37 First, we conducted extensive consultation with stakeholders on this issue and the response of those stakeholders was clearly in favour of retention and updating of the *M'Naghten* rules.

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40. Test for fitness and NGMI roundtable, *Consultation MH34*.
41. Supreme Court of NSW, *Consultation MH36*.
42. Supreme Court of NSW, *Consultation MH36*; NSW, Public Defenders, *Submission MH26,* 32.
43. Information supplied by NSW Consumer Advisory Group, 4 October 2012, 5-6.

3.38 Second, retention would be consistent with other Australian jurisdictions and cognate jurisdictions:

- Most Australian states and territories, and the Commonwealth, have a version of the *M'Naghten* rules.[44] Harmonisation of criminal laws in Australia is important and has been promoted for some time.
- For practitioners in NSW, consistency between NSW and Commonwealth legislation is important because they commonly work across both jurisdictions.[45]
- Psychiatrists who are called upon to give evidence in NGMI cases noted in consultation the problems caused when the same issues are dealt with in different ways in different jurisdictions.[46]
- Cognate jurisdictions such as NZ, the UK, Canada, the US (federal code) and the Statute of the International Criminal Court also have a version of the *M'Naghten* rules.[47]

3.39 Third, the *M'Naghten* rules have the advantage of longevity. *M'Naghten's* case was decided in 1843. There have been many opportunities for NSW to move to a different test since that time, and none of these opportunities have been taken. Although there are some strong arguments for substantial modification of the *M'Naghten* rules, most cognate jurisdictions have not taken a fundamentally different route in dealing with this legal issue. For example, the New Zealand Law Commission examined this issue in December 2010 and recommended no change from a *M'Naghten* based definition.[48]

3.40 There is a substantial amount of existing case law that elaborates and interprets the *M'Naghten* rules. This case law was cited at length and with approval in submissions. Although the proposed changes would render some of the case law irrelevant, much of it would be retained.

3.41 Accordingly, we recommend that s 38 of the MHFPA be amended to insert the following test for NGMI.[49]

Recommendation 3.1

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to include a statutory test for the defence of mental health or cognitive impairment as follows:

> A person is not criminally responsible for an offence if, when carrying out the conduct required for the offence, the person was suffering

44. See Appendix D.
45. NSW, Public Defenders, *Submission MH26*, 32.
46. NSW, Justice Health, *Consultation MH7*.
47. See Appendix D.
48. New Zealand, Law Commission, *Mental Impairment Decision-Making and the Insanity Defence*, Report 120 (2010) Recommendation R1, [6.11].
49. In this Recommendation 3.1 we refer to the defence of mental health or cognitive impairment. Note that Recommendation 3.5 below recommends that the *Mental Health (Forensic Provisions) Act 1990* (NSW) explicitly includes cognitive impairment by referring to "the defence of mental health or cognitive impairment".

> from a mental health impairment or a cognitive impairment that had the effect that the person:
>
> (a) did not know the nature and quality of the conduct
>
> (b) did not know that the conduct was wrong, that is, the person could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong, or
>
> (c) was unable to control the conduct.

3.42 This test contains two key elements. The first is the required mental state – that the person had a mental health or cognitive impairment. The second describes the nexus between that mental state and the person's actions, in paragraphs (a) to (c). We now examine these elements of the proposed defence in detail, explaining and supporting our recommendation.

The qualifying mental state: defining mental health and cognitive impairment

Criticisms of the current definition

3.43 In summary, the *M'Naghten* rules refer to the person labouring under a "defect of reason caused by a disease of the mind". These terms are generally regarded as limited, outdated and offensive.[50] They were strongly criticised by stakeholders.[51] In CP 6 we asked the opinion of stakeholders about this formulation. If they were in favour of redefinition we asked how the relevant mental state should be defined.[52] There was no support in submissions for retention of the term "defect of reason".[53] The term "disease of the mind" was also regarded as problematic and in need of reformulation in any codification of the law.[54]

3.44 Those jurisdictions that have codified the *M'Naghten* rules have chosen to define the required mental state using more contemporary terminology.[55] For example the Criminal Code (Cth) uses the term "mental impairment" and defines it to include "senility, intellectual disability, mental illness, brain damage and severe personality disorder".[56]

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50. New Zealand, Law Commission, *Mental Impairment Decision-Making and the Insanity Defence,* Report 120 (2010) [2.8].
51. See para 3.16-3.17, 3.33.
52. 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 6.26, [3.51]-[3.55].
53. NSW Bar Association, *Submission MH10,* 25; Law Society of NSW, *Submission MH13,* 10.
54. NSW Bar Association, *Submission MH10,* 25; Law Society of NSW, *Submission MH13,* 10; Legal Aid NSW, *Submission MH18,* 11; Brain Injury Association of NSW, *Submission MH19,* 22; NSW, Public Defenders, *Submission MH26,* 29, 32; NSW Council for Civil Liberties, *Submission MH46,* 7.
55. See Appendix D.
56. *Criminal Code* (Cth) s 7.3, especially subsection (8).

The proposed definition

3.45 In Recommendation 3.1 we use the term "mental health or cognitive impairment." In Report 135, after extensive consultation, we developed definitions of mental health impairment and cognitive impairment.[57] These definitions were crafted for the purpose of diversion from the criminal justice system, although we envisaged at the time that they may have wider application. Here we consider their utility for the defence of mental illness and adapt them for use in defining the qualifying mental state for this defence. The definitions recommended in Report 135 are as follows.

Definitions provided in Report 135

(1) Mental health impairment:

(a) Mental health impairment means a temporary or continuing disturbance of thought, mood, volition, perception, or memory that impairs emotional wellbeing, judgment 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

(iv) 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.[58]

(2) Cognitive impairment:

(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

57. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) Recommendations 5.1, 5.2.

58. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) [5.134].

(vi) autism spectrum disorders.[59]

Are these definitions appropriate for the defence of mental illness?

3.46 These definitions, while developed in relation to diversion, have qualities that are also advantageous in the context of the defence of mental illness, since they:

- capture the appropriate people
- are consistent with the definitions recommended for diversion and bail[60]
- reflect contemporary psychological and psychiatric understandings
- are respectful of people with such impairments, and
- are tighter and more precise than the current outdated terminology.

3.47 However, definitions must primarily be appropriate for their purpose. Report 135 focuses on diversion, and in that context we recommend definitions that are broad and inclusive in order to provide courts with discretion to divert people to rehabilitative services where they are accused of less serious offences. NGMI is generally raised only in relation to serious offences. It may be argued that a broad definition is less appropriate for a defence which, if successful, exculpates the person.

3.48 However, the function of the definition of the person's mental state in the defence is to provide a preliminary "gate" through which a defendant must pass. In order to succeed in the defence of NGMI, defendants must also pass through a second, and much narrower, "gate" by demonstrating the required nexus between their impairment and the offence. They must show that their impairment is so serious that when they offended they did not know what they were doing, did not know it was wrong, or that they were unable to control their conduct. It is the second part of this test, rather than the definition, which operates to limit the defence to those people who are so affected by their impairment that they should not be held criminally responsible.

3.49 The term employed in the current test, "defect of reason caused by disease of the mind" is broad and, despite its problems, its inclusive terms appear to function adequately in conjunction with the other elements of the test. The definition of mental health impairment employed in the definition in Report 135 is arguably tighter, in that it requires that a person demonstrate that their mental health impairs their emotional wellbeing, judgment or behaviour, so as to affect their functioning in daily life to a material extent.

3.50 However, a number of questions arise as to whether the scope of the definition proposed in Report 135 is appropriate for the purpose of a defence of mental illness and cognitive impairment:

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59. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) [5.123].

60. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) Recommendations 5.3-5.5.

- Should cognitive impairment be included in the definition?
- Should personality disorder be included?
- Are substance induced disorders dealt with appropriately?
- Does the proposed definition and test respond to people who have complex needs?

These questions are dealt with below.

People with cognitive impairments

3.51 Presently, people with cognitive impairments may be found to have a "disease of the mind" and so may be able to avail themselves of the defence.[61] However, the fit between cognitive impairments and the terminology that presently describes the mental state of the person for the purposes of NGMI is not a good one.

3.52 In contrast to the legislation in many other Australian jurisdictions,[62] the current law in NSW does not make specific provision for people with cognitive impairments: they must argue their inclusion within a definition of mental illness generated in 1843 if they wish to avail themselves of this defence.[63]

3.53 In CP 6 we asked whether legislation should expressly recognise cognitive impairment as a basis for acquitting a defendant in criminal proceedings. If this question was answered affirmatively, we asked if cognitive impairment should be included with mental illness in the NGMI defence or whether a separate defence should be formulated.[64]

3.54 There was strong and almost unanimous support for making provision for people with cognitive impairments.[65] Opposition came only from the NSW Police Force, which commented that it "does not support the expansion of categories that might be relied upon by defendants to avoid liability for their crimes".[66]

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61. See the 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) [3.32]-[3.34].
62. See Appendix D for provisions in cognate jurisdictions.
63. See NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System,* Report 80 (1996) [6.5]-[6.6]; Public Interest Advocacy Centre, *Time for Change: Response to the Consultation Paper: Review of the Forensic Provisions of the Mental Health Act 1990 and the Mental Health (Criminal Procedure) Act 1990* (2007) 19.
64. 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 6.21.
65. NSW Office of the Director of Public Prosecutions, *Submission MH5*, 6; NSW Bar Association, *Submission MH10*, 18; Law Society of NSW, *Submission MH13*, 8; NSW Health, *Submission MH15*, 3-5; Corrective Services NSW, *Submission MH17*, 6-7; Legal Aid NSW, *Submission MH18*, 10; Brain Injury Association of NSW, *Submission MH19,* 21; Public Interest Advocacy Centre, *Submission MH21*, 17; NSW, Public Defenders, *Submission MH26*, 29-30; NSW Public Guardian, *Submission MH27*, 8; Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28-1*, 15; NSW Council for Civil Liberties, *Submission MH46*, 5.
66. NSW Police Force, *Submission MH42*, 6.

3.55 There was some support for including cognitive impairment in the existing defence. For example the NSW Bar Association submitted that cognitive impairment should qualify under the *M'Naghten* rules "provided it is still established that the person did not know the nature [and] quality of their act, or that it was wrong".[67]

3.56 There was also some support for a separate defence[68] with some stakeholders submitting that cognitive impairment is often neglected by the law, and that cognitive and mental health impairments are often confused or conflated. For example, Corrective Services NSW submitted that the defence should be separate from mental illness in recognition of the differences between psychiatric disorders and cognitive impairments.[69] In Report 135 we recognise the problems caused by failure to provide for cognitive impairment, and its confusion with mental illness.[70]

3.57 A further, related concern expressed by stakeholders was that if cognitive impairment and mental illness are combined in the same provision, the consequences of a finding of NGMI could be the same for both groups, and people with cognitive impairments would be dealt with as forensic patients and committed to institutions for mentally ill persons.[71]

3.58 In Report 135, we recognise that mental health facilities are not appropriate for people with cognitive impairments and that separate provision should be made for them.[72] We repeat our conclusion that appropriate provision should be made for offenders who have a cognitive impairment who are dealt with through the forensic system as a consequence of a finding of NGMI. These issues are dealt with further in Chapters 9 and 10.

3.59 However, our recommendations here are not concerned with the provision of services, or with decisions about where forensic patients with cognitive impairments should be held. They are confined to the preliminary question of whether the defence of NGMI should explicitly include people with cognitive impairments, or alternatively whether separate provision should be made for a defence that would apply only to people with cognitive impairments.

3.60 We note in this context that defendants who have a cognitive impairment sufficiently severe to be found NGMI may have great difficulty doing those things that are

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67. NSW Bar Association, *Submission MH10*, 18. See also NSW Office of the Director of Public Prosecutions, *Submission MH5*, 6; Legal Aid NSW, *Submission MH18*, 10; NSW, Public Defenders, *Submission MH26*, 29; NSW Public Guardian, *Submission MH27*, 7-8.
68. NSW Health, *Submission MH15*, 4; Corrective Services NSW, *Submission MH17*, 6-7; Public Interest Advocacy Centre, *Submission MH21*, 17; Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28-1*, 15.
69. Corrective Services NSW, *Submission MH17*, 6-7.
70. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) [5.75], [10.18].
71. NSW Health, *Submission MH15*, 4; Public Interest Advocacy Centre, *Submission MH21*, 18; Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH28-1*, 15.
72. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) [5.119].

required by the *Presser* test and therefore may often may be found unfit to stand trial.[73] However, a finding of NGMI is available to a court after a special hearing.[74]

The Commission's view

3.61 We conclude that cognitive impairment and mental health impairment should be separately defined, and both should be included in the defence of NGMI. This would be consistent with other jurisdictions,[75] would make the law of NSW consistent with current behavioural science understandings and would be more respectful of the individuals concerned.

3.62 We do not recommend a separate defence for people with cognitive impairments. The concerns of stakeholders are dealt with by providing a separate definition of cognitive impairment and creating a separate defence would serve no useful purpose.

3.63 We have referred in Recommendation 3.1, and elsewhere, to the defence of mental health or cognitive impairment so that it is plain that only one of these must be satisfied for the defence to be made out. However we recognise that there will be many people who have both a cognitive and a mental health impairment.

Personality disorder

3.64 A condition that has been the subject of much debate in the context of NGMI is personality disorder. In Report 135 we examine at length the difficulties that personality disorders present for the criminal justice system.[76] In CP 6 we raised issues relating to offenders with personality disorders who seek to use the defence of NGMI.[77]

Summary of arguments against the inclusion of personality disorders in the definition of impairment

3.65 It is argued that including personality disorders would open the floodgates, because many people who commit crimes have personality disorders. Juvenile Justice submitted that conduct disorder in juveniles and personality disorder in adults are present in the majority of those who commit crime: thus the inclusion of personality disorders would enormously broaden the application of the MHFPA.[78] The NSW Bar Association cited with approval the concerns expressed by Professors Bronitt and McSherry[79] about the inclusion of severe personality disorders in federal legislation,

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73. For the capacities required by the *Presser* test, see Chapter 2.
74. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 25.
75. See Appendix D.
76. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) [5.60]-[5.73], [5.137]-[5.138].
77. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences*, Consultation Paper 6 (2010) [3.35]-[3.40].
78. Department of Human Services NSW (Juvenile Justice), *Submission MH28-2*, 12-13.
79. Citing S Bronitt and B McSherry, *Principles of Criminal Law* (Thomson, 2nd ed, 2005) 217. See now S Bronitt and B McSherry, *Principles of Criminal Law* (Thomson, 3rd ed, 2010) [4.45].

namely that inclusion of personality disorders goes against the weight of psychiatric opinion and that people with personality disorders have no problem in understanding the nature or wrongness of their acts.[80] The Law Society of NSW was also opposed to the inclusion of those with personality disorders within the defence.[81]

3.66 Two personality disorders raise particular difficulties. Anti-social personality disorder is defined substantially by engagement in criminal behaviours.[82] Hence there is a circularity problem: the defendant commits crimes because of a personality disorder, and is exculpated because of that personality disorder.

3.67 Psychopathy has also raised concerns. In some cases it has been alleged that people with psychopathy know, as a matter of intellect, that what they have done is wrong but that they have no (or limited) capacity for empathy and are unable to appreciate the effect of their actions on other people. In CP 6 we reviewed the case law on the application of the defence of NGMI to people with personality disorders, and noted the lack of clarity in this area of law, in particular the uncertainty about the application of the defence to those with psychopathy.[83] We also noted the argument that a failure of empathy should not be sufficient to exculpate a defendant and that the defence of NGMI should not be available to people with psychopathy. No support was expressed in submissions for extending the defence to exculpate those who engage in criminal activity but have an inability to experience empathy.

3.68 We note also that personality disorders are not included in the definitions of mental illness or mental impairment in most Australian jurisdictions.[84]

Summary of arguments in favour of inclusion

3.69 There are also a number of arguments that support the inclusion of personality disorders in the proposed definition. First, the gate is narrowed by the requirement that the personality disorder be severe. Any assertion that the person has a personality disorder will be tested, and expert evidence provided on this issue. The proposed definition also requires that personality disorder must affect functioning in everyday life to a material extent. This requirement also narrows the gateway and may exclude many people with personality disorders.

3.70 Further, to succeed in a defence of NGMI, the person must also pass through the second, and narrower, gate and show that the personality disorder had the effect that he or she did not know what they were doing, or know that it was wrong, or that he or she was unable to control their actions.

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80. NSW Bar Association, *Submission MH10*, 20.
81. Law Society of NSW, *Submission MH13*, 8. No reasons were given for this answer.
82. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) [5.63], [5.67].
83. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences*, Consultation Paper 6 (2010) [3.35]-[3.40].
84 The exceptions are the ACT and the Commonwealth: see *Criminal Code* (ACT) s 27(1); *Criminal Code* (Cth) s 7.3(8).

3.71 Legal Aid NSW supported the inclusion of personality disorder in the definition, recognising that the second part of the *M'Naghten* test requires that the effect of the personality disorder must be sufficient to negate criminal responsibility.[85] Corrective Services NSW noted the great range in severity and manifestation of personality disorders, and expressed concerns about the inclusion of anti-social personality disorders in particular. However, it supported the inclusion of personality disorder as a threshold issue, subject to the testing of its extent.[86]

3.72 In other jurisdictions where severe personality disorder has been included in legislation or via case law, there appears to be no evidence of a floodgates effect.[87] In its recent review, *Mental Impairment Decision-Making and the Insanity Defence*, the New Zealand Law Commission noted the controversies arising over the inclusion or exclusion of personality disorders.[88] It referred to the case of *R v MacMillan*[89] where the New Zealand Court of Appeal held that the defence would apply if the person knew that his or her act was morally wrong in the eyes of the community although not morally wrong in the eyes of the person. The Commission noted that, while this decision had the potential to increase significantly the number of people availing themselves of the defence, in practice, this has not happened in the 40 years since this decision.[90]

3.73 However the proverbial floods may have been held back by the fact that if NGMI is found, the person becomes a forensic patient and the term of their incarceration is indeterminate. The option of indeterminate detention in a forensic unit may have little appeal to defendants with personality disorders, who may strategically decide that other options are preferable to NGMI.

3.74 Expertise concerning personality disorders is developing. The Model Criminal Code Officers Committee (MCCOC) argued that this may be a reason to favour a broad definition of mental impairment which allows the tribunal of fact to hear psychiatric testimony based on the latest expertise while leaving the ultimate question of responsibility to the relevant decision maker.[91] Both the MCCOC and the Law Reform Commission of Western Australia (LRCWA) concluded that the question of personality disorder was too complex to be determined by a blanket exclusion.[92]

3.75 There was some stakeholder support for the inclusion of severe personality disorder on this basis. The ODPP and the Public Defenders supported the inclusion of

85. Legal Aid NSW, *Submission MH18*, 10.
86. Corrective Services NSW, *Submission MH17,* 7.
87. Severe personality disorders are included in the Commonwealth and ACT Criminal Codes. See the discussion of this issue by the New Zealand, Law Commission, *Mental Impairment Decision-Making and the Insanity Defence,* Report 120 (2010) [4.17]-[4.20].
88. New Zealand, Law Commission, *Mental Impairment Decision-Making and the Insanity Defence,* Report 120 (2010) [4.17]-[4.20].
89. *R v MacMillan* [1966] NZLR 616.
90. New Zealand, Law Commission, *Mental Impairment Decision-Making and the Insanity Defence,* Report 120 (2010) [4.19].
91. Criminal Law Officers Committee of the Standing Committee of Attorneys-General, *Model Criminal Code Chapter 2: General Principles of Criminal Responsibility*, Final Report (1992) 41.
92. Criminal Law Officers Committee of the Standing Committee of Attorneys-General, *Model Criminal Code Chapter 2: General Principles of Criminal Responsibility*, Final Report (1992) 41; Law Reform Commission of Western Australia, *Review of the Law of Homicide,* Final Report (2007) 230.

severe, or extreme, personality disorders in NGMI. The Public Defenders argued that our psychiatric and psychological understanding of personality disorder has not developed at the same pace as our understanding of mental illness, and that there should be some "legislative latitude" to accommodate the dynamic nature of our knowledge in this area.[93]

3.76 Uncertainty of diagnosis may also provide an argument in favour of inclusion of personality disorder. It would appear that there are cases where psychiatrists disagree about whether or not the person has a personality disorder or a psychosis. An example of such a case is provided by *R v Heatley*[94] in which the defendant committed an armed robbery and later killed his cell mate under the influence of what he called "homicidal urges". He had been found NGMI in relation to two previous alleged offences, although he argued substantial impairment in the instant case. He had been seen over an extended period of time by several different psychiatrists and psychologists and there was considerable disagreement about whether he had a severe personality disorder or a psychosis, or both.[95] The picture was complicated (as it often is) by substance abuse and also in this case by the unreliability of the defendant in describing his symptoms and the events surrounding his offending. It was clear, however, that Mr Heatley was very unwell and a danger to other people and that his detention as a forensic patient was a necessary outcome. It is not unusual for defendants to have complex presentations of the type that arose in *Heatley's* case. If severe personality disorders are excluded from the definition of mental illness, it may be that proceedings will be protracted by arguments about the precise nature of the defendant's illness.

The Commission's view

3.77 The analysis above demonstrates that the inclusion of personality disorder as a qualifying impairment for NGMI poses difficult challenges. On balance, we conclude that personality disorder should not be included in the definition of mental health impairment for the purposes of NGMI at this time. We arrive at this conclusion for the following reasons.

3.78 First, including personality disorder throws the net too wide. In particular we do not believe that it is appropriate for those with anti-social personality disorder or psychopathy to be exculpated substantially because of their criminal behaviour.

3.79 Second, the weight of community opinion would appear to favour exclusion. In this respect we note the response of our stakeholders, the legislation in the majority of Australian jurisdictions and the opinions of academic experts.

3.80 Third, the psychiatric understandings of personality disorders, and the precision with which they are defined, is not sufficient to allow their inclusion with any degree of confidence at this present time. We note that psychiatric expertise is developing, and that both the MCCOC and the LRCWA were concerned about the state of our

93. NSW Office of the Director of Public Prosecutions, *Submission MH5*, 6-7; NSW, Public Defenders, *Submission MH26*, 30.

94. *R v Heatley* [2006] NSWSC 1199.

95. *R v Heatley* [2006] NSWSC 1199 [46]-[62].

knowledge about personality disorders. They concluded in favour of inclusion.[96] We have concluded in favour of exclusion, preferring to review the issue further as knowledge develops and there is a better evidence base for policy development.

3.81 Because our proposed definition is structured to provide a broad definition of mental health impairment first, followed by a non-exhaustive list of such impairments, it is necessary to expressly exclude personality disorders. Were they simply omitted from the list of impairments it would be possible to argue that personality disorders are included.

Substance induced mental disorders

3.82 The proposed definition of mental health impairment, set out above, also includes "substance induced mental disorders". It defines this term to include ongoing mental health impairments such as drug-induced psychoses, but excludes substance abuse disorders (addiction to substances) or the temporary effects of ingesting substances. Consequently a person who has a psychiatric disorder at the time of the offence, albeit one brought on by abusing substances, will fall within the definition. For example, a person with a drug induced psychosis will be included, as will a person who has a long term drug induced psychiatric disorder such as Korsakoff's Syndrome.

3.83 However, a person who is only addicted to substances without such complications falls outside the definitions, as does a person who has ingested a substance and is temporarily affected by it.

3.84 This definition is consistent with the existing common law on NGMI. A "disease of the mind" is presently required by *M'Naghten*[97] and the reaction of a healthy mind to extraordinary external stimuli, including psychoactive substances, is not sufficient.[98]

3.85 The proposed definition performs the same function as the provisions in the Commonwealth, NT and ACT Codes. The Criminal Code (Cth) defines mental illness as:

> an underlying pathological infirmity of the mind, whether of long or short duration and whether permanent or temporary, but does not include a condition that results from the reaction of a healthy mind to extraordinary external stimuli. However, such a condition may be evidence of a mental illness if it involves some abnormality and is prone to recur.[99]

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96. Criminal Law Officers Committee of the Standing Committee of Attorneys-General, *Model Criminal Code Chapter 2: General Principles of Criminal Responsibility*, Final Report (1992) 41; Law Reform Commission of Western Australia, *Review of the Law of Homicide,* Final Report (2007) 230.
97. See the 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) [3.25]-[3.26].
98. *R v Radford* (1985) 42 SASR 266, 274, cited with approval in *R v Falconer* (1990) 171 CLR 30, 53-54, 78, 85.
99. *Criminal Code* (Cth) s 7.3(9). See also *Criminal Code* (ACT) s 27; *Criminal Code* (NT) s 43A.

Complex needs

3.86 In Report 135 we note the particularly difficult issues that arise for people who have complex needs.[100] We will not repeat here the points we make in that report. We note however that it is not uncommon for a person who pleads NGMI to have both mental health and cognitive impairments. This combination of impairments creates an additional level of complexity that cannot be understood by simply taking into account each impairment separately.[101] Expert evidence about the effect of such impairments in combination may be necessary to assist the court to decide whether or not the impairments in combination had the result that the person did not know the nature and quality of his or her conduct, or know it was wrong, or was unable to control it.

3.87 In the case of a person with both a cognitive and mental health impairment, both impairments will usually be relevant in determining whether the person meets the test for NGMI. However, difficult issues will continue to arise where a person has an included impairment such as a psychosis, and an excluded impairment such as the effects of ingesting substances.

The Commission's view

3.88 Taking into account the matters discussed above, we recommend that the definitions of cognitive impairment and mental health impairment recommended in Report 135 should be adapted for the purposes of the defence of NGMI in the following way.

Recommendation 3.2

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should include definitions of "mental health impairment" and "cognitive impairment" for use in the defence of mental health or cognitive impairment as follows:

(1) Mental health impairment:

(a) Mental health impairment means a temporary or continuing disturbance of thought, mood, volition, perception, or memory that impairs emotional wellbeing, judgment 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) substance induced mental disorders.

"Substance induced mental disorders" include ongoing mental health impairments such as drug-induced psychoses, but do not include

100. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) [5.103]-[5.109].

101. E Baldry, L Dowse, I Webster and P Snoyman, *Submission MH3,* 1.

substance abuse disorders (addiction to substances) or the temporary effects of ingesting substances.

For the purposes of this section "mental health impairment" does not include a personality disorder.

(2) Cognitive impairment:

(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.

The nexus between impairment and act

3.89 The proposed test for NGMI, set out at Recommendation 3.1, requires not only a qualifying mental state, but also a nexus between that mental state and the person's act or omission. There are three possible ways in which this nexus may be established under the proposed formulation:

(a) the person did not know the nature and quality of the conduct

(b) the person did not know that the conduct was wrong; that is, the person could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong, or

(c) the person was unable to control the conduct.

Here we examine these three limbs of the test in turn.

Did not know the nature and quality of the conduct

3.90 This element of the test is rarely used because it has been interpreted in a very limited way. Not knowing the nature and quality of the act means that the person does not know the physical quality of the act, rather than its moral character.[102] In the case of *R v Porter* it was said that the defendant must have "so little capacity for

102. See *R v Codere* (1917) 12 Cr App R 21, 26-27. There is some support for the idea that knowledge of the nature and quality of the act includes understanding the significance of what was done: see *Wilgoss v The Queen* (1960) 105 CLR 295.

understanding" that killing another means "no more than breaking a twig or destroying an inanimate object".[103]

3.91 Consequently there are very few cases in practice where this limb of the test may be relied upon.[104] For example, those who kill while acting under a delusion frequently appear to know that they are killing, but believe that the killing is necessary or justified. Behavioural scientists Allnutt, Samuels and O'Driscoll say:

> There are few cases where a person was so unwell that he or she did not know or understand the 'nature and quality' of their actions. As a consequence, the finding of insanity is rarely a result of this type of incapacity.[105]

3.92 The difficulty of fulfilling this test has also been noted by legal commentators[106] and there have been attempts to improve its utility. Professor Stanley Yeo has argued that the test could be improved by a requirement that the defendant *appreciate* the nature of the conduct. Yeo argues that "'appreciate' connotes a deeper level of cognition which includes not only knowledge of the surface features of one's conduct but also the effect of such conduct".[107] He points in illustration to the Statute of the International Criminal Court which provides:

> a person shall not be criminally responsible if, at the time of that person's conduct:
>
> (a) The person suffers from a mental disease or defect that destroys the person's capacity to appreciate the unlawfulness or nature of his or her conduct, or capacity to control his or her conduct to conform to the requirements of law.[108]

3.93 The implication of Yeo's argument in NSW would be that the word "appreciate" could be utilised instead of "know" in a new codified version of the test (that is, the person did not appreciate the nature of the conduct). If NSW courts then interpreted this term in the way Professor Yeo intends, this first part of the test may become more functional and apply to more cases. However, the moral content of the term "appreciate" (as opposed to "know") is arguable but not immediately apparent. It is possible that NSW courts may not take the same view.

3.94 A number of other Australian jurisdictions have retained this limb of the test.[109] Tasmania has avoided using the term "nature and quality"' and instead refers to an impairment that renders the defendant "incapable of … understanding the physical

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103. *R v Porter* (1933) 55 CLR 182, 188.
104. S Bronitt and B McSherry, *Principles of Criminal Law* (Thomson, 3rd ed, 2010) [4.55].
105. S Allnutt, A Samuels and C O'Driscoll, "The Insanity Defence: From Wild Beasts to M'Naghten" (2007) 15 *Australasian Psychiatry* 292, 296.
106. S Yeo, "Commonwealth and International Perspectives on the Insanity Defence" (2008) 32 *Criminal Law Journal* 7, 12; S Bronitt and B McSherry, *Principles of Criminal Law* (Thomson, 3rd ed, 2010) [4.55].
107. S Yeo, "Commonwealth and International Perspectives on the Insanity Defence" (2008) 32 *Criminal Law Journal* 7, 12.
108. *Rome Statute of the International Criminal Court,* opened for signature 17 July 1998, 2187 UNTS 90 (entered into force 1 July 2002) art 31(1)(a).
109. *Criminal Code* (Cth) s 7.3(1)(a); *Criminal Code* (ACT) s 28(1)(a); *Criminal Code* (NT) s 43C(1)(a); *Criminal Law Consolidation Act 1935* (SA) s 269C(a); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 20(1)(a).

character of such act or omission."[110] However, the inclusion of the term "physical character" appears to align this provision with the decision in *Porter* and does not appear to improve the utility of this limb of the test.[111]

3.95 WA and Queensland use the test of whether the person is deprived of the capacity to understand what the person is doing.[112] Capacity tests may pose difficulties, in particular because a person with a mental illness may have capacity at one time, but not another, or may have capacity to understand some things but not others. Our stakeholders in consultations were divided in their response to tests of capacity.

3.96 A further alternative would be to amend the first limb of the test to provide that the person "did not understand what he or she was doing".

Submissions and consultations

3.97 In CP 6 we asked if the *M'Naghten* rules were reformulated in legislation, whether that legislation should recognise a lack of knowledge of the nature and quality of the act as a way of satisfying the defence.[113] We also asked if the legislation should provide for lack of knowledge or lack of capacity to know. We received only four responses to this question.[114] All were in favour of retaining this element of the defence.

3.98 However, there was no consistent approach concerning the form in which it should be retained. For example, the NSW Bar Association submitted that "'capacity to know' would unnecessarily restrict the defence",[115] whereas Legal Aid NSW thought that this change was desirable and would appropriately expand the test.[116]

The Commission's view

3.99 On balance, we are in favour of retaining this element of the defence without change. It appears that this limb of the test will be rarely used. However, amendment would introduce inconsistency with other Australian jurisdictions; and removal is not supported by other reviews of the *M'Naghten* rules, by stakeholders or in scholarly writing.

Did not know that the act was wrong

3.100 The second limb of the *M'Naghten* test requires that the person did not know that the act was wrong. In *Porter* Justice Dixon said that, in this limb of the test, "wrong"

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110. *Criminal Code* (Tas) s 16(1)(a).
111. See also *R v Codere* (1917) 12 Cr App R 21; S Bronitt and B McSherry, *Principles of Criminal Law* (Thomson, 3rd ed, 2010) [4.55].
112. *Criminal Code* (WA) s 27; *Criminal Code* (Qld) s 27.
113. 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 6.27.
114. NSW Bar Association, *Submission MH10*, 25-26; Law Society of NSW, *Submission MH13,* 10; Legal Aid NSW, *Submission MH18*, 11; NSW, Public Defenders, *Submission MH26*, 32.
115. NSW Bar Association, *Submission MH10,* 26.
116. Legal Aid NSW, *Submission MH18*, 11.

is to be judged according to the everyday standards of reasonable people and the question to be asked is whether the person "was disabled from considering with some degree of composure and reason what he [or she] was doing and its wrongness".[117]

3.101 This approach has been widely accepted and adopted. A version of it is found in the Criminal Code (Cth), and in the relevant provisions in the ACT, NT and Victoria.[118]

3.102 This limb of the test, as interpreted in *Porter*, appears from our consultations to be the most frequently used element of the test and to be relied on particularly in those cases where the person is suffering from delusions.[119] Cases in which the defendant acts under a delusion have traditionally presented difficulties. For example, a person who kills believing that the victim is a danger to the safety of his or her family may not qualify under the first limb of the defence, because they know the nature and quality of their act (that they are killing a person) even though they believe that killing to be necessary. There may also be difficulty in bringing cases of delusional actions within the second limb of the test, because such people may also know that killing is wrong. However, the *Porter* approach enables proof that the person did not know the act to be wrong by inference from an inability to reason with sense and composure about whether the conduct was wrong.

Submissions and consultations

3.103 In CP 6 we asked whether a revised test for NGMI should refer explicitly to delusional belief as a condition that can be brought within the test.[120] While stakeholders thought that people suffering from delusions should be included in the test, support for a separate provision was equivocal.[121] The NSW Bar Association, for example, submitted that there was no need for a separate provision concerning delusions, and the ODPP submitted that the *M'Naghten* rules are sufficient and that there is no need to widen the test.[122]

3.104 We also asked in CP 6 whether, if the *M'Naghten* rules were to be reformulated in legislation, that legislation should recognise a lack of knowledge that the conduct was wrong as one way of satisfying the defence. Further, we asked if any guidance should be provided about the meaning of this element of the rules: in particular we asked if it should require that the defendant could not have reasoned with a moderate degree of sense and composure about whether the conduct, as perceived

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117. *R v Porter* (1933) 55 CLR 182, 190.
118. See Appendix D.
119. See *R v Gomaa* (Unreported, NSW Supreme Court, Badgery-Parker J, 27 April 1994)*; R v Issa* (Unreported, NSW Supreme Court, Sperling J, 25 October 1995); *R v Darmadji* (Unreported, NSW Supreme Court, Hidden J, 9 December 2008).
120. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences*, Consultation Paper 6 (2010) [3.48], Issue 6.24.
121. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 7; NSW Bar Association, *Submission MH10,* 23; Law Society of NSW, *Submission MH13,* 9; Legal Aid NSW, *Submission MH18,* 10; NSW, Public Defenders, *Submission MH26,* 30-31; NSW Council for Civil Liberties, *Submission MH46,* 6.
122. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 7; NSW Bar Association, *Submission MH10,* 23.

by reasonable people, was wrong. Finally, we asked if the legislation should require a lack of capacity to know, rather than a lack of actual knowledge.[123]

3.105 We received responses from five stakeholders to these questions.[124] All supported the continued inclusion of the second limb of the *M'Naghten* rules, that the person did not know the act was wrong. The NSW Public Guardian pointed to the potential utility of this provision for people with cognitive impairments who may behave in certain ways because it produces a consequence that they desire, but without knowing that they are doing wrong. They may be charged with an offence when they are aggressive towards others, but their actions may be motivated by a wish to gain attention, or to reduce anxiety.[125]

3.106 The NSW Bar Association submitted that any codification of the rules should include the *Porter* exposition of this limb of the test.[126] In a roundtable consultation it was argued that this formulation contained ideas that juries can understand, and therefore it should be included.[127]

3.107 Two submissions commented on the inclusion of a test of capacity. The Law Society of NSW welcomed the idea of a reference to capacity to know; whereas the Public Defenders expressed a preference for actual knowledge, rather than capacity.[128]

The Commission's view

3.108 The inclusion of this element of the test was strongly supported as a practically functional part of the test that is understood by juries and by the behavioural scientists who provide expert evidence in these cases. Accordingly we recommend that the test include an element that the person did not know that the act was wrong, together with the addition "that is, the person could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong".

3.109 We do not recommend moving to a test defined in terms of capacity to know. There was very little support for this approach in the submissions.

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123. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences*, Consultation Paper 6 (2010) [3.61], Issue 6.28.
124. NSW Bar Association, *Submission MH10,* 26; Law Society of NSW, *Submission MH13,* 10-11; Legal Aid NSW, *Submission MH18,* 11; NSW, Public Defenders, *Submission MH26,* 33; NSW Public Guardian, *Submission MH27,* 11-12.
125. NSW Public Guardian, *Submission MH27*, 11-12.
126. NSW Bar Association, *Submission MH10,* 26.
127. Test for fitness and NGMI roundtable, *Consultation MH34.*
128. Law Society of NSW, *Submission MH13,* 10-11; NSW, Public Defenders, *Submission MH26,* 33.

Was unable to control the conduct

3.110 Inability to control conduct is not a part of the *M'Naghten* defence. It has, however, been included in the defence in the Commonwealth Criminal Code, and in the ACT, NT, SA, Queensland and WA.[129]

3.111 Only Victoria and NSW fail to include this element. The Victorian Law Reform Commission (VLRC) reviewed the test in 2004 and concluded then that a "volitional element" should not be inserted into the legislation. The VLRC concluded that the second limb of the defence is sufficiently flexible to include some defendants who cannot control their actions, where they also fulfil the requirement of not being able to reason with a moderate degree of sense and composure about whether their conduct was wrong.[130]

3.112 One difficulty with the ground of inability to control conduct is that it may be hard to judge if the person was unable to control the conduct, or simply did not control it. While expert evidence may be presented in such cases, the issue is ultimately to be decided by the judge or jury. In *R v Byrne* Lord Parker said:

> In a case where the abnormality of mind is one which affects the accused's self-control the step between "he did not resist his impulse" and "he could not resist his impulse" is … one which is incapable of scientific proof … These problems … the jury can only approach in a broad, common-sense way.[131]

3.113 An illustration of the difficulties that may arise in practice where it is alleged that the accused could not control his actions is provided by *R v Cox.*[132] This was a South Australian case in which the accused was charged with the murder of his partner whom he beat to death. There was a long history of domestic violence. The accused argued that he suffered from "morbid jealousy with delusions of infidelity". One of the expert witnesses in this case testified that the accused's capacity to control his actions was impaired. Section 269C of the *Criminal Law Consolidation Act 1935* (SA) includes, as part of the defence, a provision that the person was unable to control his conduct.[133] Justice White held that this amounted to:

> an inability to refrain from a willed action. Such an inability would exist if the accused had an uncontrollable impulse to carry out the actions which caused

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129. *Criminal Code* (Cth) s 7.3(1)(c); *Criminal Code* (ACT) s 28(1)(c); *Criminal Code* (NT) s 43C(1)(c); *Criminal Law Consolidation Act 1935* (SA) s 269C(c); *Criminal Code* (Qld) s 27(1); *Criminal Code* (WA) s 27(1).

130. Victorian Law Reform Commission, *Defences to Homicide,* Final Report (2004) [5.31]. However, on 24 August 2012 the Victorian Attorney-General gave the Victorian Law Reform Commission terms of reference to review the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic): see Victorian Law Reform Commission, "Crimes (Mental Impairment): Terms of Reference" (24 August 2012) <http://www.lawreform.vic.gov.au/projects/crimes-mental-impairment/crimes-mental-impairment-terms-reference>.

131. *R v Byrne* [1960] 2 QB 396, 404. *Byrne* was an English case involving an accused who successfully appealed a conviction for the murder and mutilation of a young girl, on the basis of diminished responsibility. He alleged that he was acting under an abnormal sexual impulse or urge which was so strong that he found it difficult or impossible to resist. He was convicted of murder and appealed. A verdict of manslaughter on the basis of diminished responsibility was substituted on appeal because the question of the irresistibility of the defendant's impulses had not been left to the jury. The appeal court thought that there was no question that the defendant was "partially insane." The sentence of life imprisonment was left undisturbed.

132. *R v Cox* [2006] SASC 188.

133. See Appendix D.

> the fatal injuries … or if, although the relevant actions were willed, the mind of the accused was not able to control them. Put slightly differently, the question is whether the accused lacked the capacity to exercise willpower to control his physical acts.[134]

3.114 Justice White (in the absence of a jury) was not satisfied that the accused was unable to control his conduct and found the accused guilty of murder.

3.115 Bronnitt and McSherry argue that this limb of the test is problematic.[135] First, they point to the problem of devising an objectively verifiable test to determine when a person can control their actions and when they cannot. Second, they argue that this limb of the test requires a separation between cognition and action in the mind of the person. The person has the ability to understand what he or she is doing but cannot control the impulse to commit a serious offence. This separation runs counter to modern understandings of human psychology. In common with the VLRC these authors are of the opinion that an incapacity to control conduct should not form a ground on its own. However, the VLRC argued that inability to control conduct may be evidence that the person could not reason with a moderate degree of sense and composure that the act was wrong; that is, it could be relevant to the second limb of the test.[136]

Submissions and consultations

3.116 In CP 6 we asked if the defence of mental illness should be available to defendants who lack the capacity to control their actions.[137] We received seven responses to this question: five were in favour of the inclusion of such a provision[138] and two were opposed.[139]

3.117 Those who favoured inclusion submitted that it is appropriate to leave to the jury the issue of whether the person could not or would not control his or her actions.[140] The Brain Injury Association of NSW pointed out that impairment of volition and difficulty with self-monitoring and self control are common effects of an acquired brain injury.[141]

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134. *R v Cox* [2006] SASC 188 [25].
135. S Bronitt and B McSherry, *Principles of Criminal Law* (Thomson, 3rd ed, 2010) [4.65].
136. Victorian Law Reform Commission, *Defences to Homicide,* Final Report (2004) [5.31]; see also *Sodeman v The King* (1936) 55 CLR 192.
137. 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 6.23.
138. NSW Consumer Advisory Group, *Submission MH11,* 18; Law Society of NSW, *Submission MH13,* 9; Legal Aid NSW, *Submission MH18,* 10; Brain Injury Association of NSW, *Submission MH19,* 22; NSW, Public Defenders, *Submission MH26,* 30.
139. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 7; NSW Bar Association, *Submission MH10,* 20-22.
140. Law Society of NSW, *Submission MH13,* 9; Legal Aid NSW, *Submission MH18,* 10.
141. Brain Injury Association of NSW, *Submission MH19,* 22.

3.118 Both the ODPP and the NSW Bar Association were opposed to the inclusion of this ground, and were concerned that it is difficult to distinguish between impulses that could not be resisted and those that were not resisted.[142]

The Commission's view

3.119 On balance we recommend the inclusion of this limb of the test. We recognise the genuine concerns that it may act to exculpate defendants who were able to, but did not, resist the urge to offend. It may also pose evidentiary challenges, and create some difficult decisions for the tribunal of fact (whether judge or jury).

3.120 However, despite these challenges, we believe it to be appropriate to include this limb of the defence. Consistency with other Australian jurisdictions supports inclusion. It is appropriate to provide for the exculpation of those defendants who, because of cognitive or mental health impairments, genuinely could not control their actions. Further, we note that in jurisdictions where this provision is available, the "floodgates" have not opened and it would appear that this element of the defence is very rarely used.[143]

Procedural issues relating to the defence of mental illness

Who should be able to raise the defence of mental illness?

The legal policy issue

3.121 The defence of mental illness is somewhat unusual in that, in certain circumstances reviewed below, it may be raised by the court or by the prosecution, as well as by the defendant. The law on this topic is complex. In CP 6 we sought the opinion of stakeholders about whether the law should be simplified and clarified by amending the MHFPA to provide that either the prosecution or the court may raise the defence of mental illness, with or without the defendant's consent.[144]

3.122 One obvious question is why the court or prosecution should be responsible for raising a defence. The answer is that there may be public interest issues that weigh in favour of this course of action. If the defendant has committed a serious offence by reason of a cognitive or mental health impairment, then it is arguably in the interests of both fairness and community safety that the person be found NGMI and become a forensic patient, in which case he or she will not only be detained but will receive treatment.

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142. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 7; NSW Bar Association, *Submission MH10,* 21.

143. S Bronitt and B McSherry, *Principles of Criminal Law* (Thomson, 3rd ed, 2010) [4.65]; Law Reform Commission of Western Australia, *Review of the Law of Homicide,* Final Report (2007) 231, especially fn 61.

144. 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 6.32.

3.123 That there are such public interest concerns is reflected in the judgment of Justices Deane and Dawson in *R v Falconer*:

> Indeed, nowadays it is often in the interests of the prosecution (or, at all events, the community) to raise the question of insanity, rather than in the interests of the accused. It used to be said that it was for the defence to raise a plea of insanity and not for the prosecution. That is probably still the case, but we think that the position has now been reached where it is only realistic to recognize that, if there is evidence of insanity, the prosecution is entitled to rely upon it even if it is resisted by the defence … It may be anomalous for the prosecution to raise the matter initially because the prosecution should not commence proceedings if it is seeking an acquittal, even on the grounds of insanity. The responsibility for the protection of the community in those circumstances lies elsewhere than in the criminal law. But we can see no reason why, if there is evidence which would support a verdict on the grounds of insanity, the prosecution should not be able to rely upon it in asking for a qualified acquittal as an alternative to conviction.[145]

3.124 Some defendants resist raising the defence of mental illness because of the consequence that they are likely to become a forensic patient and be subject to indeterminate detention.[146] In consultation with forensic patients, we were told how unpalatable these consequences are believed to be, despite the benefits of regular reviews of forensic patients by the MHRT.[147] Submissions from, and consultations with, legal practitioners confirmed that the prospect of indeterminate detention as a forensic patient has a significant effect on the willingness of a defendant to raise NGMI.[148] Reported cases also indicate resistance from defendants to the proposal that the prosecution or court raise NGMI. It may be, in such cases, that the defendant will respond by pleading guilty.[149]

3.125 The resistance of defendants to the defence of mental illness may be largely ameliorated by our recommendation in Chapter 7 for the introduction of a limiting term for those found NGMI.[150] Some resistance may remain, however, unless limiting terms are brought into line with the length of ordinary sentences,[151] where defendants do not wish to enter the forensic system at all, or where the defendant denies or has no insight into his or her illness.

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145. *R v Falconer* (1990) 171 CLR 30, 62-3. However, the defendant had raised a defence of automatism, so these dicta, however persuasive and sensible, do not resolve the question of whether legal change is required.
146. See NSW Consumer Advisory Group, *Submission MH11,* 23; G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [5.31]; NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) [6.29]; Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness*, Report of the National Inquiry into the Human Rights of People with Mental Illness (1993) 801-802.
147. Morrisett FLAMES, *Consultation MH6*.
148. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 8; Forensic process roundtable, *Consultation MH35*.
149. *R v Alford (No 2)* [2005] VSC 405; *R v Alford* [2005] VSC 419 [48].
150. See Recommendation 7.2.
151. Which we recommend: see Recommendation 7.2.

Statutory provisions in NSW and other jurisdictions

3.126 The ability of the judge and prosecution to raise NGMI is dealt with by statute in most Australian jurisdictions,[152] and many provide that the defence of mental illness may be raised by the court, or by the prosecution with the permission of the court. For example in Victoria, the defence may be raised at any time during the trial by the defence or, with leave of the trial judge, it may be raised by the prosecution.[153] Victoria also codifies the common law and provides that, if there is admissible evidence that raises the question of mental impairment, the judge must direct the jury to consider the question.[154] The Criminal Code (Cth) provides that the prosecution may raise the defence if the court gives leave.[155]

3.127 In NSW s 38(1) of the MHFPA provides that a verdict of NGMI can be returned "if it is given in evidence on the trial of the person for the offence that the person was mentally ill" and "if it appears to the jury" that the person was mentally ill. The section does not specify who may raise the defence. The common law therefore applies. In the following sections we discuss how this issue is dealt with by the common law.

When can the court raise the defence of mental illness?

3.128 At common law, a trial judge should put to the jury any defence available on the evidence, even if the defendant does not raise it or objects to it being raised.[156] This applies to the defence of mental illness.[157] Further, a trial judge may raise the defence of mental illness and may put the defence to the jury of her or his own motion.[158]

3.129 The court has the power not only to raise the defence of mental illness, but to call evidence of it in an appropriate case. In *R v Damic*[159] the trial judge became concerned about the defendant's mental state at the time of the offence and directed that a psychiatrist (who had seen the defendant in previous proceedings related to the defendant's fitness) be called to give evidence. The defendant did not object to the witness being called or to the judge asking questions of the witness

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152. See *Criminal Code* (Cth) s 7.3(4) (prosecution may raise if court gives leave); *Criminal Code* (ACT) s 28(6) (prosecution may raise if court gives leave); *Criminal Code* (NT) s 43F(1) (may be raised by court, on application by prosecution, or on own initiative); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 22(1) (may be raised by prosecution if court gives leave), s 22(2) (if admissible evidence raises the issue, judge must direct the jury to consider); *Criminal Law Consolidation Act 1935* (SA) s 269E(1)(b) (may be raised by prosecution, or by court of own initiative "in the interests of the proper administration of justice"). See also *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 20(4) (judge, on own initiative, may require jury to consider the defence if raised on the evidence); *Criminal Code*, RSC 1985 (Can) s 16(2)-(3) (party that raises the issue of mental disorder bears the burden of establishing the defence).
153. *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 22(1).
154. *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 22(2).
155. *Criminal Code* (Cth) s 7.3(4). A person cannot rely on a mental impairment to deny voluntariness or the existence of a fault element, but may rely on it to deny criminal responsibility: s 7.3(6).
156. *Pemble v The Queen* (1971) 124 CLR 107.
157. *R v Damic* [1982] 2 NSWLR 750.
158. *R v Issa* (Unreported, NSW Supreme Court, Sperling J, 16 October 1995); *R v Damic* [1982] 2 NSWLR 750.
159. *R v Damic* [1982] 2 NSWLR 750.

about the mental health of the defendant. The prosecution asked questions of the witness as amicus curiae. The witness gave evidence that the defendant was mentally ill at the time of the offence.

3.130 On appeal, the NSW Court of Criminal Appeal held that a judge in a criminal trial does have the power, of his or her own motion and regardless of the attitude of the parties, to call a witness when the interests of justice make that course necessary. However, the power should be exercised carefully in the context of the adversarial system. When a judge calls a witness, the judge may either elicit evidence in chief or invite one or other of the parties to assist by eliciting evidence in chief. Both the Crown and the defendant should be offered an unrestricted right of cross-examination.[160] The decision in *Damic* has been followed in NSW in another NGMI case, *R v Issa,* where Justice Sperling called a witness on the question of whether or not the person was mentally ill.[161]

3.131 There are dicta in other cases to the effect that the judge should only exercise the power to call a witness with the greatest care. For example the High Court held in *R v Apostilides* that the court should only call a witness in the most exceptional circumstances.[162] There are also dicta to the effect that judges must take very great care not to adopt an inquisitorial role and that there are dangers in judges calling witnesses when the nature of the evidence the witness will give is unknown and may take the trial in an unanticipated direction.[163] However, these authorities do not exclude the possibility of the judge taking such a course in an appropriate case where the interests of justice require it.[164]

When can the prosecution raise the defence of mental illness?

3.132 The common law position in NSW is that the prosecution cannot commence by raising NGMI. However, if the defendant puts their mental state in issue by raising substantial impairment or automatism then the prosecution may raise the defence of mental illness.[165]

3.133 While *R v Damic* did not explore in any detail the power or obligation of the prosecution to raise mental illness, Chief Justice Street said in that case that it was not the province of the prosecution to call evidence of the defendant's mental

160. *R v Damic* [1982] 2 NSWLR 750, 762.

161. *R v Issa* (Unreported, NSW Supreme Court, Sperling J, 16 October 1995.) The Hon Harold Sperling QC is now a member of this Commission. See also *R v Waszczuk* [2012] NSWSC 1080, where Adamson J arranged for Mr James QC to act as amicus curiae, rather than taking the step of calling witnesses relating to the mental state of the defendant.

162. *R v Apostilides* (1984) 154 CLR 563, 575.

163. *Whitehorn v The Queen* (1983) 152 CLR 657, 682-3 (Dawson J).

164. See *Whitehorn v The Queen* (1983) 152 CLR 657 (Dawson J) and the cases reviewed therein.

165. See *Crimes Act 1900* (NSW) s 23A(7) (substantial impairment); *R v Meddings* [1966] VR 302 (automatism); *R v Ayoub* [1984] 2 NSWLR 511 (diminished responsibility).

illness.[166] Justice Sperling in *R v Issa* also ruled that the Crown could not adduce evidence going to the question of mental illness.[167]

3.134 In the Victorian case of *R v Starecki*[168] Justice Sholl considered the question of whether, when the defence does not wish to raise the issue of mental health impairment and does not wish to take advantage of evidence of such impairment, the prosecution nevertheless can do so. Justice Sholl decided, having reviewed the authorities, that the prosecution cannot do so. He also expressed the view that this issue should be dealt with by legislative amendment if, as a matter of public policy, it is thought that the prosecution should be able to introduce such evidence.

3.135 In *R v Jeffrey* the Full Court of the Supreme Court of Victoria held that the established rule is that it is for the defence, and not the prosecution, to raise insanity.[169] In that case the defendant appeared to have instructed her counsel not to raise the issue of insanity and to resist the introduction of evidence relating to her mental illness. In those circumstances, the court held that it was not for the prosecution to introduce such evidence, nor was there sufficient evidence before the court for the judge to put the issue of insanity to the jury.

3.136 In the South Australian case of *R v Joyce*[170] the Full Court of the Supreme Court also held that the Crown cannot give evidence of the defendant's insanity when the question of the defendant's state of mind is not raised by the defence.

3.137 It is apparent therefore that there may be some cases where the defence wishes to avoid raising the issue of the defendant's mental state at the time of the offence, but where the prosecution believes it to be in the public interest to raise the defence of mental illness. The ODPP described such cases as not uncommon.[171]

Submissions and consultations

3.138 In CP 6 we asked whether the MHFPA should be amended to allow the prosecution or the court to raise the defence of mental illness, with or without the defendant's consent.[172] This question prompted strongly divergent views from stakeholders.

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166. *R v Damic* [1982] 2 NSWLR 750, 753 (Street CJ): "It was plain that the appellant himself had no intention of calling Dr Barclay or setting up mental illness as a defence, and it was not, of course, the province of the Crown to take an initiative in this regard".
167. *R v Issa* (Unreported, NSW Supreme Court, Sperling J, 16 October 1995).
168. *R v Starecki* [1960] VR 141, 143.
169. *R v Jeffrey* [1967] VR 467, 473.
170. *R v Joyce* [1970] SASR 184.
171. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 8. Note also that the *Criminal Appeal Act 1912* (NSW) s 5(2) makes special provision to permit appeals by a person who is found NGMI where mental illness was not set up as a defence by the person. The person is deemed to have been convicted and any order to keep the person in custody is deemed to be a sentence. However this provision does not answer the question of whether or not NGMI may be raised by the prosecution if the defendant's mental state has not been put in issue. On the issue of appeals, see Chapter 7.
172. 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 6.32.

3.139 One factor that weighed heavily with stakeholders is that, despite regular review by the MHRT, a finding of NGMI still carries with it an indeterminate period of forensic detention. It was argued that the defendant's consent should be a pre-requisite for the defence, given the consequences of a finding of NGMI.[173] The NSW Council for Civil Liberties argued that the present law is both satisfactory and consistent with international obligations to respect the dignity, autonomy and freedom to make decisions of people with disabilities.[174]

3.140 However, the NSW Bar Association submitted that a provision allowing the prosecution or the court to raise NGMI may be consistent with a more therapeutic approach to mental illness, especially in the context of the introduction of the powers of the MHRT to monitor forensic patients. The Bar Association hoped that this approach:

> will lead to a more enlightened attitude toward mental illness within the community and the legal profession, where the present practice remains not to raise the issue except as a last resort in the most serious cases.[175]

3.141 Other stakeholders argued that the prosecution and court should be able to raise mental illness. The ODPP submitted that it is not uncommon for an obviously mentally ill person not to rely on the defence because of the indeterminate detention that follows a finding of NGMI.[176] The Law Society of NSW and the Public Defenders supported permitting mental illness to be raised by the prosecution or the court, although both the Public Defenders and the Bar Association submitted that the leave of the court should be required where it is sought to be raised by the prosecution.[177] The Bar Association also submitted that there should be guidelines governing the granting of such leave to the prosecution.[178]

3.142 In CP 6 we asked if the court should have the power to call evidence of mental illness on its own motion.[179] We received nine submissions. Two were opposed to the court having such a power.[180] The NSW Police Force submitted that it is not the role of the court to take over the conduct of the case.[181] The NSWCAG was also opposed to the court having such a power, and argued that the defendant should have the freedom to raise this plea, or not, "like all other citizens".[182]

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173. NSW Consumer Advisory Group, *Submission MH11,* 18; Legal Aid NSW, *Submission MH18,* 12.
174. NSW Council for Civil Liberties, *Submission MH46,* 7 cited *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) art 3(a), art 17.
175. NSW Bar Association, *Submission MH10*, 29.
176. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 8.
177. Law Society of NSW, *Submission MH13,* 12; NSW, Public Defenders, *Submission MH26,* 33-34; NSW Bar Association, *Submission MH10,* 28.
178. NSW Bar Association, *Submission MH10,* 28.
179. 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 6.34.
180. NSW Police Force, *Submission MH47,* 8; NSW Consumer Advisory Group, *Submission MH11,* 19-20.
181. NSW Police Force, *Submission MH47,* 8.
182. NSW Consumer Advisory Group, *Submission MH11,* 19-20.

3.143 Seven stakeholders were in favour,[183] although some of these submissions were qualified. Legal Aid NSW agreed that the court should have such a power, with the consent of the parties,[184] and the Public Defenders agreed that the court should have this power if it raised NGMI of its own volition.[185]

The Commission's view

3.144 There appear to be few cases where the absence of a prosecution power to raise NGMI arises as a practical problem. Frequently the defendant's mental state will be in issue anyway, or there will be sufficient evidence before the court to ensure that the defence is put to the jury. Nevertheless there may be a few cases in which this is not so but the defence would be made out if the matter were fully ventilated in evidence. A statutory provision on the matter would remove that doubt.

3.145 Most Australian jurisdictions deal with this issue by way of statute. The common law that applies in NSW is complex and difficult to ascertain. Arguments of clarity and accessibility support a statutory provision.

3.146 Prescribing the content of any statutory provision involves balancing competing interests. On the one hand there is the interest of the defendant in retaining control of his or her defence. This is of particular importance in relation to the defence of mental illness because a finding of NGMI is not a normal acquittal, and usually involves the defendant becoming a forensic patient. We note, however, that many of the concerns of stakeholders in this respect will be considerably ameliorated by our recommendation that limiting terms apply where there is a verdict of NGMI.[186]

3.147 On the other hand there is a public interest in the protection of the community that militates in favour of the defence of mental illness being raised in appropriate cases, so that the defendant is detained and receives treatment through the forensic system, with the MHRT determining when the person is fit to be released into the community. This would suggest the need for clear provision in favour of both the court and the prosecution being able to raise the defence of mental illness. This public interest is recognised by the common law, and we find it to be persuasive.

3.148 Accordingly we recommend that the MHFPA clarify the question of who may raise the defence of mental illness. These amendments should be to the effect that the defence of mental illness may be raised by the defence or, if the interests of justice require it, by the court or, with the permission of the court, by the prosecution.

3.149 There does not presently appear to be a problem with the law in NSW in relation to the power of the court to call evidence of mental illness. Any further development of the law relating to the role of the judge in calling witnesses, in NGMI or in other

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183. E Baldry, L Dowse, I Webster and P Snoyman, *Submission MH3,* 3-4; NSW Office of the Director of Public Prosecutions, *Submission MH5,* 9; NSW Bar Association, *Submission MH10,* 29; Law Society of NSW, *Submission MH13,* 12; Legal Aid NSW, *Submission MH18,* 12; NSW, Public Defenders, *Submission MH26,* 34; NSW Council for Civil Liberties, *Submission MH46,* 8.
184. Legal Aid NSW, *Submission MH18,* 12.
185. NSW, Public Defenders, *Submission MH26,* 34.
186. See Recommendation 7.2.

types of cases, is best left to further development by the common law or by court rules. Accordingly we make no recommendation in this respect.

Recommendation 3.3

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that the defence of mental health or cognitive impairment may be raised at any time during a trial by the defence or, if the interests of justice require it, by:

(a) the court of its own motion, or

(b) the prosecution with the leave of the court.

Should a finding of NGMI "by consent" be possible?

3.150 A number of jurisdictions provide for the defence of mental illness to be dealt with "by consent".[187] Cases arise where it is apparent in the early stages of a case to both the defence and prosecution that the defendant was mentally ill at the time of the offence and a finding of NGMI is appropriate. There are clear advantages, in appropriate cases, in avoiding a trial and so reducing the costs, the stress on the defendant (who may still be ill at the time of the trial), witnesses including victims, and family members.

3.151 Cases of infanticide are dealt with by consent in this way.[188] Substantial impairment may also be dealt with by consent, in the sense that where a defendant charged with murder pleads guilty to manslaughter on the basis of substantial impairment, the ODPP may evaluate the case and accept that plea.[189] Cases involving NGMI may be very similar in their nature to cases of substantial impairment: both are likely to involve a very serious charge and a defendant whose mental illness has affected their offending. In both types of case, the prosecution and defence may take the same view of a case. However, NGMI does not involve a plea to a lesser offence, but is a defence which exculpates the defendant (although with the likely consequence of detention as a forensic patient).

3.152 We were informed by stakeholders in consultation that the trial will be brief in those cases where the prosecution and defence are in agreement about the defence being made out.

3.153 One response to these issues adopted in other jurisdictions is a legislative requirement that the judge hear evidence and, if satisfied that the defence is made out, direct a verdict of NGMI. If the judge is not satisfied, the case proceeds to trial.[190]

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187. *Crimes Act 1900* (ACT) s 321(2)(b); *Criminal Law Consolidation Act 1935* (SA) s 269F(A)(5), s 269G(B)(5); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 21(4); *Criminal Procedure Act 2004* (WA) s 93(1); *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 20(2).

188. See Chapter 5, para 5.18.

189. Chapter 4, para 4.10.

190. See, eg, *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 21(4); *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 20(2).

3.154 We note that evidence relating to the defence of mental illness, if not found pre-trial, may be raised at any time during the trial.[191]

Submissions and consultations

3.155 In CP 6 we asked if the MHFPA should be amended to allow for a finding of NGMI to be entered by the consent of both parties.[192] We received seven submissions on this question which were almost equally divided.

3.156 The NSW Bar Association, the Public Defenders and the NSW Council for Civil Liberties were opposed.[193] The Bar Association argued that this is not an appropriate area for consent orders and that court scrutiny is an important safeguard.

3.157 The Law Society of NSW and Legal Aid NSW were in favour, although without providing reasons.[194] The ODPP also supported NGMI by consent in this context, arguing that:

> It is not uncommon for experts to all agree on this result but the hearing has to formally proceed nonetheless, even though the result is inevitable. There should be no need for this to have to occur.[195]

3.158 The NSW Police Force submitted that there is practical utility in allowing the prosecution and defence to agree that NGMI is appropriate, but that the court should still be satisfied that such a finding is appropriate.[196]

The Commission's view

3.159 We agree with the submission of the NSW Police Force that, while there are advantages in allowing the prosecution and defence to agree on a finding of NGMI, court scrutiny is important. This approach is consistent with provisions in jurisdictions that permit a "consent" approach to NGMI. Although presently there may be agreement that a brief approach to the evidence be taken, nevertheless a trial must take place. We agree with the ODPP that it is important to save resources where possible by obviating the need for a trial, however brief.

3.160 Accordingly we recommend that the MHFPA be amended to provide that, if the prosecution and defence agree that the proposed evidence in a case establishes the defence of mental illness, the trial judge may review the relevant evidence. If satisfied that the evidence establishes the defence of mental illness the judge must enter a verdict of NGMI. If the trial judge is not satisfied, then the case must be dealt with in the usual way.

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191. *R v Damic* [1982] 2 NSWLR 750, 762.
192. 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 6.33.
193. NSW Bar Association, *Submission MH10,* 13-14, 29; NSW, Public Defenders, *Submission MH26,* 21-22, 34; NSW Council for Civil Liberties, *Submission MH46,* 8.
194. Law Society of NSW, *Submission MH13,* 12; Legal Aid NSW, *Submission MH18,* 12.
195. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 8-9.
196. NSW Police Force, *Submission MH47,* 8.

Recommendation 3.4

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that if the prosecution and defence agree that the evidence in a case establishes the defence of mental health or cognitive impairment, then:

(a) the court must enter a verdict of not criminally responsible by reason of mental health or cognitive impairment if satisfied that the defence is established on the evidence, or

(b) if the court is not satisfied that the defence is established, then the case should proceed.

Nomenclature

3.161 Two issues relating to the name of this defence were raised during the course of consultations and in submissions:

(1) Should the name of this defence include cognitive impairment as well as mental health impairment?

(2) Should the description of the offence and the verdict include the term "not guilty"?

Should cognitive impairment be included in the name of this defence?

3.162 As we have noted throughout this inquiry, cognitive impairment too frequently goes unnoticed or becomes subsumed within mental health. People who are found NGMI may have cognitive impairments, or may have both cognitive and mental health impairments. We have clearly and expressly included both mental health and cognitive impairments in the definition. We can find no good reason to omit cognitive impairment from the name of this defence. We therefore recommend that Part 4 of the MHFPA refer to the defence of mental health or cognitive impairment, and that that name be used to refer to the defence throughout the legislation.

Recommendation 3.5

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should refer to the defence of mental health or cognitive impairment.

Should the verdict be one of "not guilty"?

3.163 A successful defence of NGMI exculpates the defendant from criminal responsibility even though the consequence of a finding of NGMI is that the person becomes a forensic patient. Consequently the verdict is "not guilty by reason of mental illness".

3.164 It is of interest to note that the verdict has not always been one of "not guilty". The *Trial of Lunatics Act 1883* (UK) provided for a special verdict where a person did the act but was insane so as not to be responsible according to law. In such a case the

jury was required to return a special verdict to the effect that the person was guilty of the act or omission charged but was insane at the time.[197]

3.165 The Homicide Victims' Support Group submitted to this inquiry that the verdict of "not guilty" is inappropriate.[198] The ODPP also submitted:

> It is our experience that victims of crime, especially, find it confusing and unpalatable for the verdict, as presently expressed, to have the words "not guilty" feature prominently at the beginning of the phrase. We suggest that, to convey a proper sense that the accused has been found objectively guilty (as is the case) the verdict could be … known as a verdict of objective guilt, which the community generally may find more accurately expresses the situation.[199]

3.166 A submission from Alan and Elaine Vaughan expressed the same concern:

> This verdict has a defined meaning understood by the legal fraternity but to the community at large it sounds like "not guilty" and no conviction is recorded. It is profoundly unsatisfying to relatives of homicide victims as it implies no-one was responsible for the death of their loved one.[200]

3.167 There is some dissonance between the way the defence and the verdict of NGMI are understood by lawyers, and the way in which these terms are understood by the general community, in particular by victims and their families.

3.168 Other jurisdictions describe the defence of NGMI by providing that a person is "not criminally responsible".[201] In our recommendation for a revised test for NGMI for NSW we have recommended that the same terminology be adopted. Nevertheless, these jurisdictions describe the *verdict* in cases of NGMI in various ways that include the term "not guilty", as does NSW. For example the Criminal Code (Cth) provides that a person is not criminally responsible for an offence if, at the time of the offence, they were suffering from a mental impairment that had prescribed effects.[202] However, the Code then goes on to prescribe that:

> The tribunal of fact must return a special verdict that a person is not guilty of an offence because of mental impairment if and only if it is satisfied that the person is not criminally responsible for the offence only because of a mental impairment.[203]

The Commission's view

3.169 For convenience, and because it is the acronym with which stakeholders are familiar, we have referred throughout this report to NGMI. However, we have already recommended that the way in which the defence of NGMI is defined be changed to provide that a person is "not criminally responsible", rather than "not

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197. Cited in D Howard and B Westmore, *Crime and Mental Health Law in New South Wales* (LexisNexis Butterworths, 2nd ed, 2010) 271.
198. Homicide Victims' Support Group, *Submission MH20,* 10.
199. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 7.
200. A Vaughan and E Vaughan, *Submission MH8,* 1.
201. See, eg, *Criminal Code* (Cth) s 7.3; *Criminal Code* (ACT) s 28(1); *Criminal Code* (Qld) s 27(1); *Criminal Code* (Tas) s 16(1).
202. *Criminal Code* (Cth) s 7.3(1).
203. *Criminal Code* (Cth) s 7.3(5).

guilty". On balance we recommend that this wording also be reflected in the verdict, which should be "not criminally responsible by reason of mental health or cognitive impairment". No change of substance is proposed – simply a change of the name by which the defence is formulated and the way the verdict is described. It is our intention by this recommendation to ensure that this law is more readily understood in the community, and to remove the offence to victims, family members and others who find the present law confusing and unpalatable. A simplified version of this verdict, such as "not criminally responsible", may be a suitable form of words for use by the jury in court when the verdict is announced.

Recommendation 3.6

A verdict of "not guilty by reason of mental illness" should be replaced with a verdict of "not criminally responsible by reason of mental health or cognitive impairment".

3.170 Consequential changes to other issues canvassed in this report will be required if our recommendations in relation to nomenclature are accepted.

3.171 At a roundtable of victims groups we were told that there are practical consequences to the fact that the verdict is one of "not guilty".[204] First, it means that no victim impact statement is admitted at the trial. Victims thus feel that their perspective is not acknowledged. In Recommendation 8.4 we recommend that victim impact statements should be permitted where there is a finding of NGMI.

3.172 Secondly, because of a finding of "not guilty", people found NGMI may benefit from the will of the deceased in cases where they were in fact responsible for their death. The forfeiture rule is an unwritten rule of public policy that, in certain circumstances, precludes a person who has unlawfully killed another person from acquiring a benefit in consequence of the killing.[205] In the case of people found NGMI, often the defendant and the victim were family members. Therefore in some cases it may be that the defendant is a beneficiary in the victim's will. However, where the defendant is found NGMI the verdict is one of "not guilty" and the forfeiture rule does not apply.

3.173 The *Forfeiture Act 1995* (NSW) makes specific provision for this situation, so that where a defendant found NGMI would benefit from the deceased's estate, an application may be made to the court to have the forfeiture rule applied.[206] Victims' groups informed us that the requirement to make an application to the court to have the forfeiture rule applied adds to the stress and cost for victims' families, and submitted that the law should be changed so that the rule applies automatically.[207]

3.174 When the *Forfeiture Act* was introduced in 1995 the government considered that it was important that judicial discretion be exercised in relation to the application of the rule, there being some situations where it is appropriate for the rule to apply, and some cases where to do so would produce injustice.[208] The provisions relating

204. Victims of crime roundtable, *Consultation MH15*.
205. Now incorporated into legislation: see *Forfeiture Act 1995* (NSW) s 3.
206. *Forfeiture Act 1995* (NSW) s 11.
207. Victims of crime roundtable, *Consultation MH15*.
208. NSW, *Parliamentary Debates*, Legislative Council, 25 October 1995, 2257 (J W Shaw).

to cases of NGMI were introduced into the *Forfeiture Act* in 2005, when the Act was reviewed.[209]

3.175 The approach of providing for judicial discretion in the application of the rule, rather than codification of the circumstances in which an order should be made, has been the subject of scholarly criticism.[210] However, we are of the view that any change to the *Forfeiture Act* in relation to NGMI cases should properly be considered in the context of a further review of that legislation, which is outside the scope of this inquiry. Accordingly we make no recommendations on this issue.

209. *Confiscation of Proceeds of Crime Amendment Act 2005* (NSW) sch 4.

210. See A Hemming, "Killing the Goose and Keeping the Golden Nest Egg" (2008) 8 *Queensland University of Technology Law and Justice Journal* 342.

4. Substantial impairment

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4.1 In NSW, substantial impairment is a statutory partial defence that operates to reduce a charge of murder to manslaughter where the culpability of an offender was diminished by mental illness or cognitive impairment. The defence was introduced in 1974, when a murder conviction attracted a mandatory life sentence, and a successful insanity defence resulted in indefinite detention.

4.2 With the introduction of discretionary sentencing for murder, and review of forensic patients by the Mental Health Review Tribunal, some of the objectives are no longer current and there have been calls to abolish the defence.

4.3 In this chapter we trace the origins and use of substantial impairment in NSW, and review the objectives of legislative amendments made in 1997, which gave the defence it current form. We examine the arguments for and against abolition, and conclude that the partial defence of substantial impairment in homicide cases is an appropriate response to diminished criminal liability. Amendments to update and improve consistency in terminology are recommended.

Background to the current provisions

The history and development of the current provisions

4.4 The partial defence of substantial impairment (originally known as "diminished responsibility") was developed in the nineteenth century in Scotland, with the purpose of allowing defendants with impaired mental states who did not fulfil the *M'Naghten* criteria to avoid a murder conviction. It was later codified by the *Homicide Act 1957* (UK)[1] and introduced into NSW law in 1974.[2]

4.5 At that time the mandatory punishment for murder in NSW was life imprisonment.[3] Defendants with a mental illness who committed homicide might have had available to them a plea of "insanity" under the *M'Naghten* criteria (now the defence of mental illness)[4] but, if successful, this resulted in indefinite detention in a mental health facility or prison.[5] A 1973 Report of the NSW Criminal Law Committee cited the "continuation of the mandatory life sentence for murder and the comparative inflexibility of the *M'Naghten* approach" as the key reasons to introduce the defence of diminished responsibility in NSW. [6]

4.6 Section 23A of the *Crimes Act 1900* (NSW) was originally formulated as follows:

> Where, on the trial of a person for murder, it appears that at the time of the acts or omissions causing the death charged the person was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for the acts or omissions, he shall not be convicted of murder.

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1. *Homicide Act 1957,* 5 & 6 Eliz 2, c11, s 2; United Kingdom, *Parliamentary Debates,* House of Commons, 15 November 1956, vol 560, col 1153-1154 (G Lloyd George).
2. By the *Crimes and Other Acts (Amendment) Act 1974* (NSW) s 5(b), which inserted the original s 23A into the *Crimes Act 1900* (NSW). See NSW, *Parliamentary Debates*, Legislative Assembly, 13 March 1974, 1356 (J Maddison).
3. The *Crimes Act 1900* (NSW) s 19 was amended by the *Crimes (Amendment) Act 1955* (NSW) to change the death penalty for murder to "penal servitude for life". Until 1982 a mandatory life sentence was imposed for murder. The *Crimes Act 1900* (NSW) s 19A currently provides that a person who commits murder is liable to life imprisonment; meaning "for the term of the person's natural life". The *Crimes (Sentencing Procedure) Act 1999* (NSW) s 61(1) provides that life imprisonment is to be imposed upon a person convicted of murder if "the court is satisfied that the level of culpability in the commission of the offence is so extreme that the community interest in retribution, punishment, community protection and deterrence can only be met through the imposition of that sentence". The *Crimes Act 1900* (NSW) s 19A(3) and the *Crimes (Sentencing Procedure) Act 1999 (NSW)* s 21 authorise a lesser sentence being imposed. Note: the *Crimes Act 1900* (NSW) s 19B prescribes a mandatory life sentence for the murder of a police officer.
4. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 38.
5. Offenders who plead the defence of mental illness still receive an indeterminate term, but they are no longer held at the Governor's pleasure. Instead they have periodic reviews by the Mental Health Review Tribunal, which is empowered to order conditional or unconditional release. See Chapter 9.
6. NSW Criminal Law Committee, *Report of the NSW Criminal Law Committee on Proposed Amendments to the Criminal Law and Procedure* (1973) 6.

Rationale for the current legislative framework

4.7 In 1997, we reviewed the 1974 formulation of the defence of diminished responsibility in *Partial Defences to Murder: Diminished Responsibility* (Report 82).[7] At that time, we found it fundamental to our system of criminal justice that culpability for serious offences be measured according to the defendant's mental state at the time the offence was committed. The partial defence of diminished responsibility recognised that factors may exist which significantly affect a person's mental state, and when these factors are taken into account they can evince a lesser degree of culpability. Decreased culpability is represented in a finding of manslaughter and, as murder carries a stigma of full criminal liability, the murder/manslaughter distinction remained relevant.[8]

4.8 To "enhance community acceptance of the due administration of justice", including acceptance of any lesser sentence imposed for diminished responsibility, we recommended that the jury needed to determine the degree of culpability.[9] Accordingly, we considered it necessary to retain a modified version of diminished responsibility, and argued that the public would understand and accept lesser sentences for manslaughter where the jury found the defendant had a diminished level of criminal responsibility.[10]

The current provision

4.9 Following legislative amendments in 1997, s 23A of the *Crimes Act 1900* (NSW) currently provides for the partial defence of substantial impairment:

> (1) A person who would otherwise be guilty of murder is not to be convicted of murder if:
>
> (a) at the time of the acts or omissions causing the death concerned, the person's capacity to understand events, or to judge whether the person's actions were right or wrong, or to control himself or herself, was substantially impaired by an abnormality of mind arising from an underlying condition, and
>
> (b) the impairment was so substantial as to warrant liability for murder being reduced to manslaughter.
>
> (2) For the purposes of subsection (1)(b), evidence of an opinion that an impairment was so substantial as to warrant liability for murder being reduced to manslaughter is not admissible.
>
> (3) If a person was intoxicated at the time of the acts or omissions causing the death concerned, and the intoxication was self-induced intoxication (within the meaning of s 428A), the effects of that self-induced intoxication

7. NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility,* Report 82 (1997).
8. NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility,* Report 82 (1997) [3.18].
9. NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility,* Report 82 (1997) [3.11].
10. NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility,* Report 82 (1997) [2.24]-[3.18].

are to be disregarded for the purpose of determining whether the person is not liable to be convicted of murder by virtue of this section.

(4) The onus is on the person accused to prove that he or she is not liable to be convicted of murder by virtue of this section.

(5) A person who but for this section would be liable, whether as principal or accessory, to be convicted of murder is to be convicted of manslaughter instead.

(6) The fact that a person is not liable to be convicted of murder in respect of a death by virtue of this section does not affect the question of whether any other person is liable to be convicted of murder in respect of that death.

(7) If, on the trial of a person for murder, the person contends:

(a) that the person is entitled to be acquitted on the ground that the person was mentally ill at the time of the acts or omissions causing the death concerned, or

(b) that the person is not liable to be convicted of murder by virtue of this section,

evidence may be offered by the prosecution tending to prove the other of those contentions, and the Court may give directions as to the stage of the proceedings at which that evidence may be offered.

(8) In this section:

'underlying condition' means a pre-existing mental or physiological condition, other than a condition of a transitory kind.

4.10 The provision prescribes a partial defence that operates to reduce a finding of murder to manslaughter.[11] The partial defence of substantial impairment may be raised when a defendant charged with murder pleads guilty to a reduced charge of manslaughter as a result of his or her substantial impairment. If that plea is accepted by the prosecution, the defendant is then sentenced by a judge in relation to the offence of manslaughter. Alternatively, the defendant may raise substantial impairment as a defence at trial for murder. If this defence is accepted by the jury,[12] the defendant is then sentenced for manslaughter.

4.11 Section 23A(2) provides that experts cannot present an opinion about whether they consider the offender's impairment to be substantial enough to warrant the liability of murder being reduced to manslaughter. This is a matter of fact for the jury to consider and forms the "community standards" aspect of the provision.

11. *Crimes Act 1900* (NSW) s 23A(5).

12. Or a judge sitting alone as permitted under the *Criminal Procedures Act 1986* (NSW) s 132, although this is discouraged in cases of substantial impairment. See NSW Office of the Director of Public Prosecutions, *Prosecution Guidelines* (2007) [24].

4.12 Substantial impairment or a cognate provision is available in NSW, the ACT, NT, Queensland, and the UK.[13]

Incidence

Sources of data

4.13 In 2005, the Judicial Commission of NSW released a study intended to present a "comprehensive empirical picture of partial defences in NSW".[14] In this study, 126 cases of diminished responsibility/substantial impairment were reviewed from January 1990 to September 2004.[15] We utilised this extensive study to determine the incidence of diminished responsibility from 1990 to 1997, and to collect information on the use of substantial impairment from 1998 to 2004. We conducted our own review of cases from 2005 to 2011.[16] A case list is at Appendix E. The results from the three study periods were analysed and comparisons are outlined below.

Findings

4.14 The Judicial Commission studied cases from 1990 to 2004. From 1990 to 1997 the statutory partial defence of diminished responsibility existed. During this time the defence was raised in 11% of murder cases (a total of 95 cases raised diminished responsibility).[17] Of these, 67% were successful and resulted in a manslaughter finding. Forty-three trials were conducted with a jury, which returned a finding of manslaughter in 39% of cases.

4.15 From 1998 the partial defence of substantial impairment replaced diminished responsibility. From 1998 – 2011, the defence was raised in a total of 82 cases, amounting to 6.5% of murder cases.[18] Of these, 48 (58%) were successful and received a manslaughter finding. Thirty-six trials were conducted with a jury, which returned a finding of manslaughter in 25% of cases.

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13. *Crimes Act 1900* (ACT) s 14; *Criminal Code* (NT) s 159; *Criminal Code* (Qld) s 304A; *Homicide Act 1957,* 5 & 6 Eliz 2, c11, s 2.
14. Judicial Commission of NSW, *Partial Defences to Murder in NSW 1990-2004,* Research Monograph 28 (2006) 2.
15. The Judicial Commission reviewed data via the Commission's Judicial Information Research System (JIRS). Information on diminished responsibility/substantial impairment was extracted from remarks on sentence and appeal judgments: Judicial Commission of NSW, *Partial Defences to Murder in NSW 1990-2004*, Research Monograph 28 (2006) 5.
16. We conducted a search of NSW case law via JIRS, LexisNexisAU, Austlii and Caselaw NSW for "substantial impairment", "diminished responsibility" and "Crimes Act 1900 s 23A". Information on substantial impairment was extracted from remarks on sentence and appeal judgments released during the study period. Each case was reviewed, and notations on case name, facts, gender of defendant, type of "abnormality of the mind", jury involvement, success of s 23A claim and sentence type were documented. We applied all care when searching for cases that raised substantial impairment in the study period. There is, however, the possibility that some cases where substantial impairment was unsuccessfully raised may not have been captured (this may especially apply to defendants who raised multiple defences).
17. NSW Bureau of Crime Statistics and Research, *NSW Recorded Crime Statistics* 1990–2004: Figure derived from number of victims, all data as reported or detected by NSW Police.
18. NSW Bureau of Crime Statistics and Research, *NSW Recorded Crime Statistics* 2005–2011: Figure derived from number of victims, all data as reported or detected by NSW Police.

Table 4.1: Diminished responsibility and substantial impairment in NSW from 1990-2011, incidence and outcomes

Description	Diminished Responsibility 1990 – 1997	Substantial Impairment 1998 - 2011
Defence raised	95	82
Average per year	**12**	**6**
Defence unsuccessful	31	34
Average per year	**4**	**2**
Defence accepted	64	48
Average per year	**8**	**3**
Number of custodial sentences for manslaughter	59	39
Average per year	**7**	**3**
Number of jury trials (JT)	43	36
Average per year	**5**	**3**
JT where defence unsuccessful	26	27
Average per year	**3**	**2**
JT where defence accepted	17	9
Average per year	**2**	**1**

Source: Judicial Commission of NSW, Partial Defences to Murder in NSW 1990-2004, *Research Monograph 28 (2006); JIRS, Lexis NexisAU, Austlii and Caselaw NSW*

Conclusions

4.16 Since the 1997 amendment that introduced substantial impairment, there have been fewer cases where this partial defence is raised. Once raised, the defence is less likely to be successful, and this is particularly so when the trial is conducted before a jury.

Should substantial impairment be retained as a defence?

4.17 In Consultation Paper 6 (CP 6) we asked whether s 23A should be abolished or retained.[19] We pointed out numerous controversies attached to substantial impairment, including the perception that a finding of substantial impairment is a "soft option" that allows offenders to escape a murder conviction[20] and the evidentiary issues that can occur due to the ambiguous and unscientific drafting of the provision.[21]

4.18 In this section we review the principal arguments raised by stakeholders, jurists and academics for and against the abolition of substantial impairment.

The viewpoint of law reform commissions

4.19 In 2004, the Victorian Law Reform Commission (VLRC) recommended against introducing diminished responsibility into Victorian statute. The VLRC argued that degrees of mental responsibility are better assessed during the sentencing process by a judge, who must give reasons for a decision which can be scrutinised.[22] This approach was also adopted by the Law Reform Commission of WA (LRCWA) in 2007.[23] The LRCWA considered the sentencing process to be sufficiently flexible to allow for all relevant factors, including the culpability and dangerousness of the defendant, and the seriousness of the offence. The LRCWA cautioned that the verdict of manslaughter in diminished responsibility cases risked "inappropriate sentencing outcomes" and the "premature release of violent offenders",[24] as exemplified by the High Court cases of *Veen* and *Veen (No 2).*[25]

4.20 The Law Commission of England and Wales recommended the retention of the defence in 2006, but did so only "for as long as the law of murder remains as it is, and conviction carries a mandatory sentence of life imprisonment".[26] An earlier UK report also found that the only justification for retaining this defence was the

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19. 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 6.40.
20. On this point, also see the discussion in NSW, *Parliamentary Debate*s, Legislative Council, 12 November 1997, 1547 (JP Hannaford); NSW, *Parliamentary Debates*, Legislative Assembly, 26 November 1997, 2653 (P Whelan) (The Hon P Whelan MP reads a letter from a victim's family stating: "We believe that the Law of Diminished Responsibility is a loophole in the legal system that allows killers to receive a reduction in charges ..."); A Hemming, "It's Time to Abolish Diminished Responsibility, the Coach and Horses' Defence through Criminal Responsibility for Murder" (2008) 10 *University of Notre Dame Australia Law Review* 1, 35.
21. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences,* Consultation Paper 6 (2010) [4.11]-[4.13].
22. Victorian Law Reform Commission, *Defences to Homicide,* Final Report (2004) [5.127].
23. Law Reform Commission of Western Australia, *Review of the Law of Homicide,* Final Report (2007) Recommendation 39.
24. Law Reform Commission of Western Australia, *Review of the Law of Homicide,* Final Report (2007) 259.
25. *Veen v The Queen (No 1)* (1979) 143 CLR 458; *Veen v The Queen* (*No 2)* (1988) 164 CLR 456.
26. England and Wales, Law Commission, *Partial Defences to Murder,* Final Report (2004) [5.92].

mandatory life sentence imposed for murder.[27] Criminal law authors Card, Cross and Jones (writing in the UK) supported this view and noted that "a defence of diminished responsibility is not required for other offences because they do not carry a fixed penalty, so that the judge has discretion as to the punishment imposed".[28]

Submissions

4.21 We received six written submissions on whether substantial impairment should be retained or abolished. Five recommended retention of the defence[29] and the Office of the Director of Public Prosecutions (ODPP) recommended abolition. The ODPP argued that the current legislative regime related to homicide renders the provision obsolete, and agreed with the VLRC that its continuance confuses issues that are more appropriately dealt with in sentencing.[30] The ODPP's submission canvassed arguments raised in the Law Commission of England and Wales' report on *Partial Defences to Murder* to conclude that matters related to substantial impairment are "very much matters of degree on which minds will differ" and are "much more relevant to sentencing".[31]

4.22 The ODPP was also concerned about abuse of process, and raised the "real risk" that a defendant could seek opinions from multiple psychiatrists until he or she located a psychiatrist who would support that defendant's view.[32] Further, it was the opinion of the ODPP that substantial impairment is a defence of last resort that is overrepresented in court and in pleas.[33]

4.23 Supporters of substantial impairment pointed out that the criminal justice system needs to deal with the spectrum of cognitive and mental health impairments, and to label and treat people according to their criminal liability. The NSW Consumer Advisory Group (NSWCAG) and the Public Defenders joined the NSW Bar Association in attaching importance to the argument that offenders should not be labelled murderers if they are not fully criminally responsible for their actions.[34] Legal Aid NSW supported the continuation of the defence because, among other things, the law needs to maintain a range of responses to offending that "reflects the continuum of mental illness". [35]

4.24 The Public Defenders submitted that an additional advantage of this defence is that life imprisonment is not an option; rather the defendant receives the benefit of more

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27. Committee on Mentally Abnormal Offenders, *Report of the Committee of Mentally Abnormal Offenders* (1975) [19.27].
28. R Card, *Card, Cross & Jones Criminal Law* (Oxford University Press, 18th ed, 2008) [15.53].
29. NSW Bar Association, *Submission MH10,* 31; NSW Consumer Advisory Group, *Submission MH11,* 23; Law Society of NSW, *Submission MH13,* 13; Legal Aid NSW, *Submission MH18,* 13; NSW, Public Defenders, *Submission MH26,* 38.
30. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 9-10.
31. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 10.
32. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 10-11.
33. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 11.
34. NSW Bar Association, *Submission MH10,* 32; NSW Consumer Advisory Group, *Submission MH11,* 23; NSW, Public Defenders, *Submission MH26,* 38.
35. Legal Aid NSW, *Submission MH18,* 13.

flexible sentences.[36] However, the Public Defenders also noted that to some extent a "general mental impairment sentencing model" could serve equally well in providing the advantages currently available under substantial impairment.[37] The NSW Bar Association did not support dealing with substantial impairment by way of sentencing, arguing that the fact finding process at trial is more rigorous than it is in sentencing.[38]

4.25 A majority of submissions emphasised the importance of a continued role for the jury in determining which conditions should reduce murder to manslaughter,[39] and the importance of demarcating the role of the jury and experts.[40] For instance, the NSW Bar Association noted that cases claiming substantial impairment are:

> among the most serious in the criminal calendar, and the variety of conditions that can be put forward in support of substantial impairment are of many shades and degrees, and many (such as personality disorders and psychopathy) will be highly controversial. Cases may…warrant input from representatives of the community as arbiters of what conditions and circumstances might be worthy of consideration of reduced moral culpability.[41]

The issues

4.26 Below we review the arguments related to retaining or abolishing substantial impairment. These include:

- the ongoing significance of the murder/manslaughter distinction in relation to homicide convictions
- the flexibility of the current sentencing regime for homicide
- dealing with offenders with a cognitive or mental health impairment at sentencing
- the decreasing role of the jury
- the potential for improper use of the provision
- the increased risk to the community from the operation of substantial impairment
- the terms of the statute, and
- whether the provision is achieving the goals set by Parliament.

The murder/manslaughter distinction

4.27 The key point of departure in arguments for and against substantial impairment is the extent to which the distinction between murder and manslaughter is significant

36. NSW, Public Defenders, *Submission MH26,* 38.
37. NSW, Public Defenders, *Submission MH26,* 38. An outline of this model is provided in the submission: NSW, Public Defenders, *Submission MH26,* 2.
38. NSW Bar Association, *Submission MH10,* 32.
39. NSW Bar Association, *Submission MH10,* 32; Legal Aid NSW, *Submission MH18,* 13.
40. Law Society of NSW, *Submission MH13,* 13-14.
41. NSW Bar Association, *Submission MH10,* 32.

to homicide convictions in cases where the offender's responsibility was diminished by a cognitive or mental health impairment. Supporters consider a manslaughter finding to be imperative to the recognition of lower culpability, while detractors hold that a murder conviction does not impede a fair and responsive sentencing regime.

4.28 Supporters of substantial impairment contend that the murder/manslaughter distinction is important because it reflects moral understandings of blameworthiness. The stigma that a murder conviction attracts is not appropriate for people who kill when their judgment was significantly affected by a cognitive or mental health impairment. Murder is stigmatised because it is the "most severe offence in the criminal calendar, attracting the longest sentences and the greatest community outrage".[42] That stigma is suitably lessened in a finding of manslaughter, which reflects a diminished level of moral and criminal responsibility.[43]

4.29 The application of "fair and just labelling" to homicide convictions informed the Law Commission of England and Wales' view that substantially impaired people should not be labelled "murderers".[44] Even the VLRC noted that it may be "unjust to assign the label of murderer to a person who was affected by mental illness, because in such cases the law ought to recognise that they were not criminally responsible".[45] In Report 82, we emphasised the murder/manslaughter distinction and noted that "people who kill while in a state of substantially impaired responsibility should not be treated as 'murderers'".[46] In submissions to this inquiry the NSW Bar Association and Public Defenders raised fair and just labelling, and the stigma attached to a murder conviction, as arguments in favour of retaining substantial impairment.[47]

4.30 There are different legal consequences resulting from a finding of murder as opposed to manslaughter. Murder is legally defined as an act or omission that causes death and was done or omitted with "reckless indifference to human life or with the intent to kill or inflict grievous bodily harm upon some person".[48] Punishment for a murder conviction in NSW can include imprisonment for the term of the offender's natural life,[49] or a sentence of imprisonment for a specified term.[50] The *Crimes (Sentencing Procedure) Act 1999* (NSW) provides a standard non-parole period of between 20 and 25 years for murder, but provides no such constraint on sentencing for manslaughter.[51] In appropriate cases, the sentence for manslaughter will reflect the lesser culpability, and imprisonment may be for a short period or a suspended sentence may be imposed. A person who successfully raises the defence of substantial impairment should receive a sentence proportionate to

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42. Judicial Commission of NSW, *Partial Defences to Murder in NSW 1990-2004,* Research Monograph 28 (2006) 1.
43. G Cumes, "Reform of Diminished Responsibility in New South Wales" (1999) 6(2) *Psychiatry, Psychology and Law* 175, 177.
44. England and Wales, Law Commission, *Partial Defences to Murder,* Final Report (2004) [5.18].
45. Victorian Law Reform Commission, *Defences to Homicide,* Final Report (2004) [5.110].
46. NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility,* Report 82 (1997) [3.18].
47. NSW Bar Association, *Submission MH10*, 32; NSW, Public Defenders, *Submission MH26,* 38.
48. *Crimes Act 1900* (NSW) s 18.
49. *Crimes Act 1900* (NSW) s 19A(1), s 19B, s 61(1).
50. *Crimes (Sentencing Procedure) Act 1999* (NSW) s 21.
51. *Crimes (Sentencing Procedure) Act 1999* (NSW) pt 4 div 1A.

their culpability.[52] In 1997, we argued that such sentences may be more likely to be accepted and understood by the public because they are attached to a conviction for manslaughter, not murder.[53]

4.31 Supporters of substantial impairment also contend that the manslaughter finding attached to substantial impairment provides a jury with options. The Law Commission of England and Wales noted the possibility that in the absence of a defence of substantial impairment, juries may be reluctant to find offenders with substantial impairments guilty of murder, acquitting them instead.[54] The NSW Bar Association agreed with this concern in its submission to this inquiry.[55] Legal Aid NSW noted that:

> if the defence were to be abolished, it would give both the jury and the defendant less options for verdict and pleas, and could lead to perverse outcomes that are not reflective of what actually happened.[56]

4.32 There are also custodial consequences attached to the murder/manslaughter distinction. A person convicted of murder is automatically classified as a serious offender.[57] This impacts on the offender's prison classification and case plan,[58] and may have implications for future applications for change of status or parole.[59] There is no such assumption for offenders charged with manslaughter. Here the classification depends on the length of sentence, and case plans are drawn up with reference to the sentencing court's comments, the offender's criminal and/or correctional history and physical and mental health.[60]

Murder no longer attracts a mandatory life sentence

4.33 A significant reason for the introduction of substantial impairment was to ameliorate the effects of mandatory life sentences where homicide was committed by a person with a cognitive or mental health impairment.[61] As we noted above, mandatory sentences for murder no longer exist in NSW. The ACT and NSW are now the only

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52. JIRS sentencing statistics indicate that 24% of people convicted of manslaughter under the *Crimes Act 1900* (NSW) s 24 from 2004 to 2011 received a sentence of six years, whereas the majority of people sentenced for murder under the *Crimes Act 1900* (NSW) s 19A received 25 years or 18 years with a standard non-parole period. For example, from 2005, orders following the successful raising of substantial impairment ranged from a suspended sentence of two years and a good behaviour bond to an eight year non-parole period. For an overview of methodology used by the Law Reform Commission see fn 16; NSW, Public Defenders, *Submission MH26,* 38.
53. NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility,* Report 82 (1997) [2.24].
54. England and Wales, Law Commission, *Partial Defences to Murder,* Final Report (2004) [5.22].
55. NSW Bar Association, *Submission MH10*, 31-32.
56. NSW Legal Aid, *Submission MH18,* 13.
57. *Crimes (Administration of Sentences) Act 1999* (NSW) s 3.
58. *Crimes (Administration of Sentences) Regulation 2008* (NSW) cl 13-21.
59. *Crimes (Administration of Sentences) Act 1999* (NSW) s 142-154.
60. *Crimes (Administration of Sentences) Regulation 2008* (NSW) cl 13-14.
61. NSW Criminal Law Committee, *Report of the NSW Criminal Law Committee on Proposed Amendments to the Criminal Law and Procedure* (1973) 6.

jurisdictions that have both a discretionary sentencing option for murder and the defence of substantial impairment.[62]

4.34 That there is no longer a mandatory life sentence for murder in NSW underpins arguments for the repeal of s 23A.[63] As previously noted, the Law Commission of England and Wales' recommendation to retain the defence was contingent upon murder carrying a mandatory sentence of life imprisonment.[64] The ODPP submitted that the partial defence should be abolished because the rationale for its creation no longer exists in NSW, making it a "historical anomaly".[65] It is obsolete because the only current function of a substantial impairment plea is to reduce the term of a sentence, which can appropriately be done at sentencing.

Sentencing is the more appropriate forum

4.35 Proponents for abolition argue that if the fundamental elements of murder are made out then murder is the appropriate charge. If a person with a substantial impairment is convicted, that impairment should be taken into account in sentencing.[66]

4.36 Section 21A(3)(j) of the *Crimes (Sentencing Procedure) Act 1999* (NSW) provides that it is a mitigating factor to be taken into account when determining a sentence if the offender "was not fully aware of the consequences of his or her actions because of the offender's age or any disability".[67] The ODPP submitted that by operation of this provision any consideration of substantial impairment arising from an underlying condition at the time of an offence should be dealt with as a mitigating factor at the sentencing stage.[68]

4.37 It is also argued that sentencing is the appropriate forum to consider cognitive and mental health impairments because psychiatric evidence can be presented in a more informal way than at trial. On this point, the Law Commission of England and Wales reported:

> [W]here the law does not attempt to construct 'discrete' defined 'mental condition constructs', within an adversarial legal process, but allows for a 'graded' approach to justice within sentencing, there is far less mismatch between law and psychiatry. That is, abandonment of 'trials of mental responsibility', and substitution of judicial consideration of medical evidence expressed in its own terms, is likely not only to all but abolish the 'mismatch' but

62. See *Crimes Act 1900* (ACT) s 14. This partial defence is also available in Queensland: *Criminal Code* (Qld) s 304A and the Northern Territory: *Criminal Code* (NT) s 159, however in each of those jurisdictions a mandatory life sentence for murder applies: *Criminal Code* (Qld) s 305(1) and *Criminal Code* (NT) s 157.
63. NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility,* Report 82 (1997) [2.11]-[2.13], [3.14].
64. England and Wales, Law Commission, *Partial Defences to Murder,* Final Report (2004) [5.92].
65. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 11.
66. Victorian Law Reform Commission, *Defences to Homicide,* Final Report (2004) Recommendation 45; Law Reform Commission of Western Australia, *Review of the Law of Homicide,* Final Report (2007) Recommendation 39; Model Criminal Code Officers Committee of the Standing Committee of Attorneys-General, *Model Criminal Code: Chapter 5 Fatal Offences Against the Person,* Discussion Paper (1998) 129.
67. *Crimes (Sentencing Procedure) Act 1999* (NSW) s 21A(3)(j).
68. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 9-10.

> also to enhance justice, so far as it depends upon the application of medical evidence.[69]

4.38 Supporters of the retention of the substantial impairment defence argue that mitigation of cognitive or mental health impairments in sentencing is an inadequate legal response. Cognitive and mental health impairments are complex and have a range of impacts on criminal behaviour, and it is therefore appropriate for the criminal justice system to have a corresponding range of responses. Abolition of substantial impairment would limit the defence available for people with cognitive and mental health impairments who kill to "not guilty by reason of mental illness" (NGMI).

4.39 There are strong similarities between the elements of substantial impairment and the grounds for a plea of NGMI, but they are not the same. The test for NGMI is more stringent, presently requiring a person to either not know the nature and quality of their act, or to not know that the act was wrong.[70] Substantial impairment instead requires a substantial impairment of the capacity to understand events, differentiate between right or wrong, or to control oneself sufficient to warrant liability for murder being reduced to manslaughter.

4.40 As we commented in Report 82:

> Diminished responsibility is an intermediate defence for those offenders whose mental impairment is not so extreme as to warrant an acquittal and consequent indefinite detention in 'strict custody' in a prison or psychiatric hospital, but whose mental state is nevertheless such that they should not be convicted of murder.[71]

4.41 We also gave weight to the need for "flexibility to determine responsibility according to degrees of mental impairment, rather than according to a strict contrast between sanity and 'insanity'".[72] The same argument was made by the Royal Commission on Capital Punishment, which originally considered the introduction of a diminished responsibility offence in England:

> It must be accepted that there is no sharp dividing line between sanity and insanity, but that the two extremes of 'sanity' and 'insanity' shade into one another by imperceptible gradations. The degree of individual responsibility varies equally widely; no clear boundary can be drawn between responsibility and irresponsibility.[73]

4.42 The then Model Criminal Code Officers Committee of the Standing Committee of Attorneys-General has criticised diminished responsibility on the grounds that the difference between this partial defence and the defence of mental illness is "purely

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69. England and Wales, Law Commission, *Murder, Manslaughter and Infanticide,* Report 304 (2006) [5.89].
70. For a detailed examination of NGMI and our proposed amended legal test see Chapter 3.
71. NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility,* Report 82 (1997) [3.19].
72. NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility,* Report 82 (1997) [3.19].
73. Great Britain, *Royal Commission on Capital Punishment 1949-1953*, Cmd 8932 (1953) [411], cited in Committee on Mentally Abnormal Offenders, *Report of the Committee of Mentally Abnormal Offenders* (1975) [19.8].

one of degree".[74] However, supporters of substantial impairment consider this "matter of degree" to be important as it appropriately reflects the circumstances of the offender and the offence. The NSWCAG submission to this inquiry supported the retention of this defence on these grounds.[75]

Community participation and the role of the jury

4.43 Section 23A(1)(b) of the *Crimes Act 1900* (NSW) provides that a jury must determine whether an impairment "was so substantial as to warrant liability for murder being reduced to manslaughter". This is strengthened by s 23A(2), which states that for the "purposes of s 23A(1)(b), evidence of an opinion that an impairment was so substantial as to warrant liability for murder being reduced to manslaughter is not admissible." This means that expert opinion is confined to evidence of the defendant's underlying condition and how the condition affected his or her capacity to understand events, judge right from wrong or control him or herself.[76] The jury makes the ultimate judgment of culpability on whether the impairment was so substantial to warrant a reduction to manslaughter without the expert's direct opinion.[77] Clearly stating that the determination of the ultimate issue is a matter for the jury was regarded as the "centrepiece" of substantial impairment when it was introduced to parliament,[78] and was the "principal and fundamental reason" for our recommendation to retain and amend the defence of diminished responsibility in Report 82.[79]

4.44 Proponents of abolition point out that this objective has been weakened by the reduced use of juries in substantial impairment cases. Since 2005, 43% of substantial impairment cases have been heard before a jury, 39% were negotiated on a plea with the ODPP and 18% were heard by a judge alone.[80] Accordingly, in a significant number of cases, the issue of whether or not substantial impairment was satisfied was determined not by a jury but by the prosecutor, in negotiation with the defendant's legal representative. The ODPP has issued strict guidelines that prescribe that the prosecution must consider community values inherent in the requirement of s 23A when negotiating a plea in cases of substantial impairment.[81] However, an assessment of community values by the prosecutor relies on expertise and experience but lacks the legitimising force of a jury decision.

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74. Model Criminal Code Officers Committee of the Standing Committee of Attorneys-General, *Model Criminal Code: Chapter 5 Fatal Offences Against the Person,* Discussion Paper (1998) 125.
75. NSW Consumer Advisory Group, *Submission MH11,* 23.
76. *Crimes Act 1900* (NSW) s 23A(1)(a).
77. NSW, *Parliamentary Debates*, Legislative Council, 25 June 1997, 11 065 (J W Shaw): The Hon J W Shaw MP, then Attorney General and Minister for Industrial Relations, stated that "the centrepiece of the legislation is the emphasis on the moral assessment to be made by the jury ... the jury as the appropriate body to assess guilt or innocence when the defence is raised".
78. NSW, *Parliamentary Debates,* Legislative Council, 25 June 1997, 11 066 (J W Shaw).
79. NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility,* Report 82 (1997) [3.11].
80. See para 4.13-4.16.
81. NSW Office of the Director of Public Prosecutions, *Prosecution Guidelines* (2007) Guideline 20, 24.

4.45 Supporters of substantial impairment point to three key areas where community involvement continues to impact upon decision making. First, a majority of cases that go to trial are still heard by a jury and rely upon the jury's assessment of community standards. Secondly, the ODPP's Prosecution Guidelines provide that the community values inherent in s 23A(1)(b) are to be taken into consideration when a prosecutor is considering whether to accept a plea of guilty to manslaughter based on the defence of substantial impairment.[82] Thirdly, some of the mental illnesses put forward by defendants in support of substantial impairment are controversial. The NSW Bar Association argued that this warrants input from community members as "arbiters of what conditions and circumstances might be worthy of considerations of reduced moral culpability".[83] Howard and Westmore also argue:

> To remove the touchstone of the jury would inappropriately diminish the input that the community ought to have in such matters and would tend also to diminish respect from the criminal justice process and its outcomes, which will, inevitably, from time to time be controversial.[84]

Potential for improper use

4.46 A further argument adopted by proponents of abolition is that, because the elements of substantial impairment are so unclear and open to interpretation, it is open to abuse. Of concern is the possibility that the defendant may seek opinions from multiple psychiatrists until he or she finds one that supports the defence.[85]

4.47 Concern has also been expressed that substantial impairment may inappropriately be relied upon in the context of family violence.[86] Some have argued that the defence allows a just outcome in cases where women kill their abusive partners.[87] However others, including the VLRC and NZ Law Commission, argue that, by representing the actions of "battered women" as the result of a psychological disturbance rather than a defensive reaction to violence, the defence entrenches misleading stereotypes of women.[88] It has also been asserted that substantial impairment may be available to depressed men who kill their female partners when that partner ends the relationship, such that the defence operates to excuse male violence against women.[89]

4.48 Supporters of substantial impairment point out that there is little evidence of misuse of the defence. Defendants do not appear to shop for psychiatrists to support an unfounded claim of substantial impairment.

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82. NSW Office of the Director of Public Prosecutions, *Prosecution Guidelines* (2007) Guideline 20.
83. NSW Bar Association, *Submission MH10*, 32.
84. D Howard and B Westmore, *Crime and Mental Health Law in New South Wales* (LexisNexis Butterworths, 2nd ed, 2010) [8.23].
85. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 9-10, citing England and Wales, Law Commission, *Partial Defences to Murder,* Final Report (2004) [5.43].
86. Victorian Law Reform Commission, *Defences to Homicide,* Final Report (2004) [5.115]-[5.121].
87. England and Wales, Law Commission, *Partial Defences to Murder,* Final Report (2004) [5.22].
88. Victorian Law Reform Commission, *Defences to Homicide,* Final Report (2004) [5.116]; New Zealand, Law Commission, *Battered Defendants: Victims of Domestic Violence Who Offend,* Preliminary Paper 41 (2000) [135].
89. Victorian Law Reform Commission, *Defences to Homicide,* Final Report (2004) [5.117]-[5.118].

4.49 In addition, statistics published by the Judicial Commission and our research demonstrate that the defence does not appear to be used inappropriately by perpetrators of domestic violence.

4.50 Between 1998 and 2004, there were six cases in which an offender successfully raised substantial impairment after killing an intimate partner. Two of these cases involved women who killed abusive partners; the remaining four male defendants involved what the Judicial Commission referred to as "unusual subjective features"[90] and were not connected with a history of abuse. Between 2005 and 2011, the partial defence of substantial impairment was raised in 51 cases. It was successful in 28 cases, of which only two cases show a history of domestic violence.[91] There are a further two cases in which an intimate female partner was killed in circumstances where it is difficult to discern domestic violence.[92] In six cases where an intimate female partner was killed the defence of substantial impairment was rejected.[93]

4.51 As we noted in *Family Violence - A National Legal Response* (a joint report with the Australian Law Reform Commission) provocation, self-defence and excessive self-defence appear to be more relevant defences in the context of family violence.[94]

Risk to the community

4.52 The *Veen* case is often cited to demonstrate the high risk to the community offenders of this category can pose.[95] Veen, who suffered from brain damage caused by alcohol abuse, was convicted of manslaughter on the basis of diminished responsibility in 1975. Released on parole after having served eight years, he killed again nine months later.[96] A further example from NSW is that of Malcolm Potts,[97] who was diagnosed with paranoid schizophrenia and killed his father by stabbing him thirty times in 2000. Potts successfully raised substantial impairment and was convicted of manslaughter, and sentenced to seven years imprisonment. Released in 2007,[98] he killed a female sex worker the following year and was convicted of her murder, the jury rejecting a further claim of substantial impairment.

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90. Judicial Commission, *Partial Defences to Murder in New South Wales 1990-2004,* Research Monograph 28 (2006) 25-27.
91. *R v Zeilaa* [2009] NSWSC 532; *R v Paddock* [2009] NSWSC 369. In *Zeilaa* the defendant, who had dementia, killed his wife after a history of abuse when she expressed a desire to leave him. The defendant successfully raised substantial impairment and was sentenced to a non-parole period of two years and six months. A similar fact scenario occurred in *Paddock.*
92. *R v Massei* [2005] NSWSC 549*; R v Dowley* [2009] NSWSC 369. The facts are drawn from sentencing comments, which do not always elucidate the full set of circumstances.
93. *R v Biddle* [2011] NSWSC 1262; *R v Borg* [2010] NSWSC 951; *R v Lechmana* [2010] NSWSC 849; *R v Naa* [2009] NSWSC 1077; *R v Valiukas* [2009] NSWSC 808; *R v Christov* [2006] NSWSC 972.
94. Australian Law Reform Commission and NSW Law Reform Commission, *Family Violence – A National Legal Response,* ALRC Report 114 and NSWLRC Report 128 (2010) [14.3].
95. *Veen v The Queen (No 1)* (1979) 143 CLR 458; *Veen v The Queen (No 2)* (1988) 164 CLR 465.
96. *Veen v The Queen (No 2)* (1988) 164 CLR 465, 466.
97. *R v Potts* [2010] NSWSC 731.
98. Mr Potts was first released in 2004 but was rearrested in that same year on a charge of intimidation, leaving him to serve the balance of his term: *R v Potts* [2010] NSWSC 731 [37].

4.53 These cases throw into relief the argument that because offenders receive substantially shorter prison terms than people found guilty of murder, and are not necessarily treated for their impairment in prison, people with substantial impairments are a potential risk to the community.[99] Unlike a person found NGMI,[100] a person whose criminal liability is reduced to manslaughter due to substantial impairment does not become a forensic patient, and is not treated in the forensic system, which has community safety and the provision of treatment at its centre.[101] This gives rise to the concern that substantially impaired offenders may pose a particular risk to the community upon their release.[102]

4.54 Supporters of substantial impairment argue that this concern will not be resolved by abolishing substantial impairment and that the range of sentencing options for manslaughter is sufficiently wide to respond to offenders who present a risk to the safety of others. Additionally, post-custody management schemes introduced for high risk violent offenders may apply to detainees convicted of murder or manslaughter.[103] Further, if substantial impairment is abolished, and defendants are instead convicted of murder, this would not alter their chances of receiving treatment for their impairment. People with impairments who are imprisoned as a result of a conviction for either murder or manslaughter will be detained in a correctional facility and may be treated within that facility, or they may be transferred to a mental health facility as a "correctional patient".[104] They do not become forensic patients.[105]

Insuperable definitional problems

4.55 The problems involved in precisely defining this defence have been referred to by various law reform bodies as "overwhelming",[106] "disastrous", "beyond redemption"[107] and so serious that they cannot be overcome by reformulation.[108]

4.56 The majority of criticism has been directed towards the term "abnormality of mind", which has been described as "largely…meaningless" because it lacks legal or

99. A Hemming, "It's Time to Abolish Diminished Responsibility, the Coach and Horses' Defence through Criminal Responsibility for Murder" (2008) 10 *University of Notre Dame Australia Law Review* 1. Hemming contends that it is the "unstable people", partial to raising the defence of substantial impairment, who are the offenders who should be held in custody for longer in order to protect the community.
100. See *Mental Health (Forensic Provisions) Act 1990* (NSW) s 38. This also applies where a person unfit for trial underwent a special hearing and was found unfit and not acquitted: see *Mental Health (Forensic Provisions) Act 1990* (NSW) s 19-22.
101. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 40.
102. J Carne, "The Unimportance of M'Naghten's" (2003) 15 *Judicial Officers' Bulletin* 91, 91.
103. See *Crimes (High Risk Offenders) Act 2006* (NSW) s 5A.
104. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 41, s 55.
105. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 42.
106. Law Reform Commission of Western Australia, *Review of the Law of Homicide,* Final Report (2007) 253.
107. England and Wales, Law Commission, *Partial Defences to Murder,* Final Report (2004) [5.43].
108. Victorian Law Reform Commission, *Defences to Homicide,* Final Report (2004) [5.132].

medical basis.[109] Further, disagreement between experts[110] means that "abnormality of the mind" risks inconsistent application[111] and too wide an interpretation.[112]

4.57 Because of such problems the then Model Criminal Code Officers Committee of the Standing Committee of Attorneys-General rejected the inclusion of a defence of diminished responsibility in a national model criminal code. The Committee found that "the practical problems with the partial defence…will not be remedied by further changes to the test. This is because the concept of this partial defence is fundamentally confused". The Committee also noted that this partial defence is "inherently vague" and that "all three elements of the defence are immersed in uncertainty".[113]

4.58 The criticisms and concerns regarding the terms of the provision are addressed below.[114]

The objectives set by Parliament

4.59 The legislature amended the statutory test of diminished responsibility in 1997 in response to expressions of concern about the breadth of the defence. One of the objectives of the amendment to substantial impairment was to provide a "new and stricter" defence that excluded "trivial impairments".[115]

4.60 The Judicial Commission reported that since the 1997 reforms, offenders who claimed the defence generally displayed "severe mental health conditions".[116] The 1997 reforms provided a stricter test, with fewer offenders raising the defence, and fewer raising it successfully. This claim was also supported by our review of cases from 2005 to 2011. Accordingly, the amended statutory test of substantial impairment is meeting the objective of narrowing the field of cases where it can be raised, and in doing so, restricting the application of the substantial impairment defence to serious cognitive and mental health conditions.

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109. NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility,* Report 82 (1997) [3.34].
110. In the *Chayna* case, seven psychiatrists offered different opinions as to the defendant's mental state at the time of the killings: *R v Chayna* (1993) 66 A Crim R 178. See also NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences,* Consultation Paper 6 (2010) [4.13].
111. Victorian Law Reform Commission, *Defences to Homicide,* Final Report (2004) [5.113]; New Zealand, Law Commission, *Battered Defendants: Victims of Domestic Violence Who Offend,* Preliminary Paper 41 (2000) [132].
112. NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility,* Report 82 (1997) [3.34]; Law Reform Commission of Western Australia, *Review of the Law of Homicide,* Final Report (2007) 251.
113. Model Criminal Code Officers Committee of the Standing Committee of Attorneys-General, *Model Criminal Code: Chapter 5 Fatal Offences Against the Person,* Discussion Paper (1998) 123.
114. See para 4.74-4.81.
115. NSW, *Parliamentary Debates,* Legislative Council, 25 June 1997, 11 065-6 (J W Shaw).
116. Judicial Commission of NSW, *Partial Defences to Murder in NSW 1990-2004,* Research Monograph 28 (2006) 9.

4.61 Further, supporters of substantial impairment point out that defendants may be more inclined to plead guilty to manslaughter on the basis of substantial impairment than to murder, which avoids the time and expense of a trial.[117]

The Commission's view

4.62 The arguments in favour of abolition have merit, particularly given the changes in the sentencing options for those charged with murder. However, on balance we recommend that the partial defence of substantial impairment be retained.

4.63 In favour of retention we find the following factors persuasive. First, the balance of opinion of stakeholders weighed strongly in favour of retention. Second, as we argue in Report 135, cognitive and mental health impairments are complex and varied in their nature and effects. That complexity requires an appropriate range of legal responses. Third, we agree with the argument that it is inappropriate to apply the label "murderer" to a person whose capacity to understand, make judgments or control her or himself was substantially impaired. Finally, there is the added flexibility of responses in sentencing and post sentencing that apply to manslaughter.

4.64 The changes to s 23A following our 1997 recommendations appear to have appropriately reduced the number of cases in which substantial impairment is raised. We are still of the view, as were many stakeholders, that the jury should have the role of making decisions about community standards in determining culpability.

4.65 There are some deficiencies in the formulation of this defence that we believe are best dealt with by way of amendment, rather than abolition. Below we first set out our proposed amendments, and subsequently explain the reasons for these in detail.

Recommendation 4.1

(1) Section 23A(1)(a) of the *Crimes Act 1900* (NSW) should be amended by substituting "mental health or cognitive impairment" as the specified mental state, instead of "abnormality of the mind arising from an underlying condition".

(2) For the purposes of s 23A(1)(a) "mental health impairment" and "cognitive impairment" should be defined as in Recommendation 3.2.

A new definition

4.66 We recommend amending s 23A of the *Crimes Act 1900* (NSW) to clarify the language of the provision in line with contemporary understandings of cognitive and mental health impairments and mental health law.

117. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences,* Consultation Paper 6 (2010) [4.56], citing New Zealand, Law Commission, *Battered Defendants: Victims of Domestic Violence Who Offend*, Preliminary Paper 41 (2000) [130].

Our proposed definition – what is it and where does it come from?

4.67 For reasons of consistency and clarity, we propose that our definition of cognitive and mental health impairments replace the current requirement that a person be affected by an "abnormality of the mind arising from an underlying condition". The proposed definition was developed for Report 135 to apply in the context of diversion, and as a standard definition for consideration in other areas of law. We have adopted it in our report on Bail[118] and earlier in this report in a modified form for NGMI, and envisaged that it will also have application in the context of other areas of law such as sentencing.[119]

4.68 For the purposes of substantial impairment and NGMI we propose that the definition should exclude personality disorders. The reasons for this exclusion are reviewed in Chapter 3.

4.69 It is proposed that the threshold test for substantial impairment be whether the defendant has a cognitive impairment or a mental health impairment or both. Once the threshold test is established, the defendant must then show that his or her impairment substantially diminished his or her capacity to understand events, judge whether actions were right or wrong, or control him or herself. A cognitive or mental health impairment alone is not enough. The impairment must be demonstrated to have had the required impact at the time of the relevant events. The jury then decides if the impairment is substantial enough to warrant murder being reduced to manslaughter.[120] The onus is on the defendant to establish the defence of substantial impairment on the balance of probabilities. [121] This is consistent with the position in relation to NGMI.

Submissions

4.70 In CP 6 we asked if the term "abnormality of mind arising from an underlying condition" should be replaced.[122] The NSW Police Force expressed concern about narrowing court discretion and opposed the amendment.[123] The NSW Bar Association, the Law Society of NSW, Corrective Services NSW, Legal Aid NSW, the Brain Injury Association of NSW and the Public Defenders all supported a new definition.[124]

4.71 In CP 6, we also sought views on whether the community standard requirement in s 23A of the *Crimes Act 1900* (NSW), which states juries must determine whether

118. NSW Law Reform Commission, *Bail*, Report 133 (2012) [11.30]-[11.39].
119. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) Ch 5.
120. *Crimes Act 1900* (NSW) s 23A(1)(b).
121. *Crimes Act 1990* (NSW) s 23A(4).
122. 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 6.37.
123. NSW Police Force, *Submission MH47,* 9.
124. NSW Bar Association, *Submission MH10*, 30; Brain Injury Association of NSW, *Submission MH19*, 23; Corrective Services NSW, *Submission MH17,* 7; Law Society of NSW, *Submission MH13*, 13; Legal Aid NSW, *Submission MH18*, 12; NSW, Public Defenders, *Submission MH26,* 35.

the impairment was "so substantial as to warrant liability for murder being reduced to manslaughter", is sufficiently clear or whether it should be modified.[125]

4.72 Of the four submissions that addressed this issue, three favoured retention of s 23A(1)(b) in its current form or with slight modification.[126] Submissions noted that the current formulation is clear and appropriately divides the role of the jury in making an ultimate decision in relation to community standards from expert evidence.[127]

4.73 Only the Public Defenders argued for the removal of this requirement. On this point, the Public Defenders agreed with proponents of abolition that the exercise the jury must carry out, in weighing the impact of the impairment against the defendant's degree of criminal culpability and the nature of the offence, was more suited to sentencing.[128]

An overview of the proposed amendments

Replace abnormality of mind

4.74 The quintessential legal definition of "abnormality of mind" was articulated by Lord Parker CJ in *Byrne*, as follows:

> a state of mind so different from that of ordinary human beings that the reasonable man would term it abnormal. It appears to us to be wide enough to cover the mind's activities in all its aspects, not only the perception of physical acts and matters, and the ability to form a rational judgment as to whether an act is right or wrong, but also the ability to exercise will power to control physical acts in accordance with that rational judgment.[129]

4.75 As previously noted, the requirement that a person must be substantially impaired "by an abnormality of mind arising from an underlying condition" has been subject to sustained criticism. In our view, the term "abnormality of the mind" is an antiquated phrase attached to outmoded understandings of mental illness that are both medically and legally vague. The Law Commission of England and Wales commented that this terminology had "not been drafted with the needs and practices of medical experts in mind", although evidence from such experts is crucial to the defence.[130] In Report 82 and CP 6, we expressed concerns about the

125. 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 6.39.

126. NSW Bar Association, *Submission MH10*, 31; Law Society of NSW, *Submission MH13,* 13; Legal Aid NSW, *Submission MH18*, 12.

127. NSW Bar Association, *Submission MH10*, 31; Legal Aid NSW, *Submission MH18*, 12.

128. NSW, Public Defenders, *Submission MH26*, 37.

129. *R v Byrne* [1960] 2 QB 396, 403. This definition has been cited with approval: see *Rose v The Queen* [1961] AC 496, 507; *R v Tumanako* (1992) 64 A Crim R 149, 159; *R v Chayna* (1993) 66 A Crim R 176, 190-191.

130. England and Wales, Law Commission, *Murder, Manslaughter and Infanticide,* Report 304 (2006) [5.111].

lack of clarity in this description of impairment,[131] which has created disagreement amongst experts,[132] and has been inconsistently applied.[133]

4.76 The types of conditions found by the courts to amount to an abnormality of mind include personality disorders,[134] post-traumatic stress disorders,[135] severe depression,[136] paranoia,[137] schizophrenia,[138] epilepsy,[139] adjustment disorder[140] and intellectual disability/cognitive impairment.[141] The Judicial Commission notes that the 1997 amendments applied a stricter filter to the types of conditions successfully raised as defences and reports a significant fall in the number of defendants with personality disorders able to persuade the court of the existence of an abnormality of mind in the relevant sense.[142] From 2005 to 2011 we were unable to find any cases that had successfully raised substantial impairment where the defendant had relied upon a personality disorder. The Judicial Commission has attributed this to the common incidence of personality disorders in the general population, possibly leading to a community perception that such disorders are not sufficiently "abnormal".[143]

4.77 We recommend replacing the term "abnormality of the mind arising from an underlying condition" with "cognitive impairment or mental health impairment" based on our standard definition, with the exclusion of personality disorders. This would align with the cases to explicitly exclude personality disorders and using a structured medical definition would also provide experts with tighter guidelines on the threshold question.

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131. NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility,* Report 82 (1997) [3.34]; NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences,* Consultation Paper 6 (2010) [4.25]-[4.28].
132. *R v Chayna* (1993) 66 A Crim R 178. See further NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility,* Report 82 (1997) [3.64]-[3.66]; NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences,* Consultation Paper 6 (2010) [4.13].
133. Victorian Law Reform Commission, *Defences to Homicide,* Final Report (2004) [5.113]; New Zealand, Law Commission, *Battered Defendants: Victims of Domestic Violence Who Offend*, Preliminary Paper 41 (2000) [132].
134. *R v Whitworth* [1989] 1 Qd R 437; *R v McGarvie* (1986) 5 NSWLR 270; *R v Turnbull* (1977) 65 Cr App R 242; *R v Heatley* [2006] NSWSC 1199.
135. *R v Mawson* [2007] NSWSC 1473; *R v Neilsen* [1990] 2 Qd R 578.
136. *R v Chen* [2012] NSWSC 1000; *R v Chayna* (1993) 66 A Crim R 178; *R v Neilsen* [1990] 2 Qd R 578.
137. *R v Chayna* (1993) 66 A Crim R 178; *R v Fenton* (1975) 61 Crim App R 261.
138. *R v LTN* [2011] NSWSC 614.
139. *R v Dick* [1966] Qd R 301.
140. *R v DR* [2012] NSWSC 922 (case name changed to protect the name of the child victim).
141. For examples of cognitively impaired defendants who raised substantial impairment or diminished responsibility see: *R v Glanville* [2010] NSWSC 364; *R v Fisher* [2009] NSWSC 348; *R v Leach* [2007] NSWSC 429; *Walton v The Queen* [1978] AC 788.
142. Judicial Commission, *Partial Defences to Murder in New South Wales 1990-2004,* Research Monograph 28 (2006) 21-22. See also *R v Maxwell* [1999] NSWSC 1085; *R v Matheson* [2001] NSWSC 332.
143. Judicial Commission, *Partial Defences to Murder in New South Wales 1990-2004,* Research Monograph 28 (2006) 21.

Remove definition of an "underlying condition"

4.78 Section 23A(1) presently provides that the "abnormality of mind" must arise from an underlying condition. Subsection (8) defines underlying condition as a "pre-existing mental or physiological condition, other than a condition of a transitory kind". That provision was inserted to ensure that an impairment was "of a more permanent nature than simply a transient state of heightened emotions".[144] It operates to exclude defendants from claiming the partial defence on the basis, for example, that they were temporarily overcome by anger, rage or jealousy.

4.79 The requirement in the proposed definition of cognitive and mental health impairment that an impairment "affect functioning in daily life to a material extent" is intended to serve a similar role. This criterion aims to "narrow the gateway"[145] and exclude people experiencing such transient emotions. In Report 135, we said that:

> A person would not have a mental health impairment if their mood was disturbed and their behavior 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.[146]

4.80 The same concern does not arise in relation to cognitive impairment, which must be an "ongoing impairment." Accordingly, if our proposed definition is adopted, s 23A(8) would be obsolete, and should be repealed.

Recognise cognitive impairment

4.81 People with cognitive impairments have not been excluded from using the defence of substantial impairment. Since 2005, four people with cognitive impairment have successfully raised the defence.[147] These have included defendants with brain damage, dementia and intellectual disability. It would appear, therefore, that cognitive impairments are being identified and that the partial defence is used in such cases where it is appropriate. However, as we point out in Report 135, it is easy for cognitive impairments to be neglected or confused with mental illness.[148] We therefore recommend that the definition explicitly recognise these impairments.

No change to the role of the jury concerning community standards

4.82 Section 23A(1)(b) currently requires that a person's impairment be so substantial as to "warrant liability for murder being reduced to manslaughter". This phrase was

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144. NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility,* Report 82 (1997) [3.51].
145. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) [5.136].
146. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) [5.136].
147. *R v Leach* [2007] NSWSC 429 (intellectual disability); *R v Fisher* [2009] NSWSC 348 (brain injury); *R v Zeilaa* [2009] NSWSC 532 (dementia); *R v Glanville* [2010] NSWSC 364 (brain damage).
148. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012).

adopted as a result of recommendations made in Report 82.[149] Its purpose was to create a "tighter" defence which emphasised the role of the jury,[150] and to make clear:

> the distinction between the respective roles of the expert and the jury, with the jury left to decide the ultimate issue of whether the accused should be convicted of manslaughter.[151]

4.83 We noted in CP 6 that there are two key issues relating to this provision. First, the provision offers no criteria on which the judgment is to be exercised, and this imprecision is open to criticism.[152] Secondly, as discussed above, a significant number of cases in which substantial impairment is raised are decided without the involvement of a jury, weakening arguments about the jury providing an important touchstone of community values.[153]

4.84 The provision has, however, received support in academic writing. For example, Professor Stanley Yeo has noted that it assists in clarifying the roles of the expert and jury, and argues that it would have been beneficial for the UK to incorporate a similar provision into its substantial impairment provision.[154] NSW forensic mental health specialists Howard and Westmore have described the community standard provision as the "most important component of the defence", which will "act as a kind of 'safety brake' against a floodgate of mental states" such as psychopathy.[155] Under this provision a jury must be satisfied that the impairment is serious enough to warrant a reduction in criminal responsibility and may not let through some controversial impairments.

4.85 We consider that the role of the jury concerning community standards is a key element of the defence and recommend retaining it.

No change to the exclusion of self-induced intoxication

4.86 Section 23A(3) provides that the effects of self-induced intoxication are to be disregarded in assessing whether or not the defence of substantial impairment is applicable. This provision adopted the common law position that the effects of self-induced intoxication do not amount to an abnormality of mind in the relevant sense.[156]

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149. NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility,* Report 82 (1997) Recommendation 4.
150. NSW, *Parliamentary Debates,* Legislative Council, 25 June 1997, 11 065 (J W Shaw).
151. NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility,* Report 82 (1997) [3.57].
152. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences,* Consultation Paper 6 (2010) [4.38] and [4.57].
153. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences,* Consultation Paper 6 (2010).
154. S Yeo, "English Reform of Partial Defences to Murder: Lessons for New South Wales" (2010) 22 *Current Issues in Criminal Justice* 1, 6.
155. D Howard and B Westmore, *Crime and Mental Health Law in New South Wales* (LexisNexis Butterworths, 2nd ed, 2010) [8.15].
156. See *R v Jones* (1986) 22 A Crim R 42; *R v De Souza* (1997) 41 NSWLR 656.

4.87 However, a defendant who was intoxicated at the time of the killing may be able to rely on the defence if prolonged use of alcohol or drugs has led to brain damage or disease that substantially impairs the defendant's ability to control his or her actions. In such cases, the defendant must prove that it is 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.[157]

4.88 Our proposed definition of mental health impairment includes "substance induced mental disorders". These are defined in the following way:

> "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.[158]

4.89 A substance induced mental disorder does not include self-induced intoxication, or indeed any type of intoxication.[159] This definition also excludes addiction to substances, but includes recognised ongoing cognitive and mental health impairments caused by abuse of substances. So, for example, brain damage due to alcohol abuse, such as Korsakoff's syndrome and drug induced psychoses, would be included. Our recommendation is therefore consistent with the existing law.

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157. *R v Jones* (1986) 22 A Crim R 42, 44; *R v Ryan* (1995) 90 A Crim R 191, 197.
158. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) Recommendation 5.2.
159. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) [5.96].

5. Infanticide

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5.1 In legal terms, infanticide involves the killing of a child under twelve months old by its birth mother in circumstances where the mother's mental state has been disturbed by childbirth or lactation. Under s 22A of the *Crimes Act 1900* (NSW), a mother may be charged with the substantive offence of infanticide, or may be charged with murder and raise infanticide as a partial defence to reduce liability to manslaughter.

5.2 Infanticide is rarely used. In NSW there have been four recorded cases between 2001 and 2011.[1] In all cases, infanticide was accepted by the prosecution as the appropriate charge. The offence/defence of infanticide has come under sustained criticism for gendered medical assumptions, which suggest that this type of offending by women is biologically determined. It has also been argued that the introduction of the potentially overlapping partial defence of substantial impairment has rendered the defence irrelevant.

5.3 Despite its limited application, and the criticisms that have been made of it, supporters of the provision argue that infanticide provides an appropriate legal response to a very specific crime. The offence/defence of infanticide receives

1. To protect the names of the child victims, all cases and case citations referred to in this and corresponding chapters have been changed to include only the initials of the offender. *R v TS* (Unreported, NSW District Court, Toner J, 27 February 2008); *R v T* (Unreported, NSW District Court, Finnane J, 11 September 2003) (Transcripts for *R v T* have been destroyed, and the case and sentencing remarks have not been cited by the NSW Law Reform Commission); *R v KP* [2002] NSWSC 397; *R v MC* [2001] NSWSC 769.

support from some jurists, academics and feminists who view it as an important defence, distinct from substantial impairment or a finding of not guilty by reason of mental illness (NGMI).

5.4 In this chapter, we first review the historical context and use of the NSW provision. Arguments that favour abolition and retention are presented. We conclude that while s 22A is flawed, the defects of the provision are able to be resolved, and so we propose retention and amendment.

Background

5.5 Infanticide provisions were originally introduced in NSW in 1951.[2] They were legislated so that women who killed their babies while "temporarily deranged" from the after-effects of childbirth could avoid a conviction for murder and the consequent mandatory punishment of death.[3] The provisions were modelled on UK legislation developed in the early 20th century, when infant mortality rates were high, illegitimacy attracted a social stigma, and child killing was not infrequent. Offenders at that time were typically young sexual assault victims or unmarried or deserted mothers experiencing chronic hardship. Public sentiment tended towards leniency in such circumstances, with juries refusing to convict the women of murder given the social and economic context of their actions. In the rare event of a guilty finding, pleas for clemency generally resulted in the mandatory death penalty being commuted.[4]

5.6 The *Infanticide Act 1922* (UK) aimed to align law with the public sentiment that such crimes should be treated with greater leniency.[5] The Act enabled a woman who killed her newborn child to be tried for manslaughter rather than murder, where she suffered from "puerperal psychosis", being a severe form of mental disorder associated with childbirth.[6] As such, the 1922 Act provided a psycho-medical rationale for what was essentially a crime contextualised by social and economic factors. Put another way, the mother's state of mind was "convenient shorthand for

2. By the *Crimes (Amendment) Act 1951* (NSW) s 2(d).
3. NSW, *Parliamentary Debates,* Legislative Assembly, 25 September 1951, 3225 (CE Martin).
4. See NSW Law Reform Commission, *Partial Defences to Murder: Provocation and Infanticide*, Report 83 (1997) [3.2]-[3.3]. For a more detailed account of the origin of the infanticide provisions, see N Walker, *Crime and Insanity in England* (University Press, 1968) Ch 7; R Lansdowne, "Infanticide: Psychiatrists in the Plea Bargaining Process" (1990) 16 *Monash University Law Review* 41, 43-47; P Bergin, *The Crime of Infanticide: A Case for its Abolition in New South Wales* (Paper submitted for the Research Paper Unit, Faculty of Law, Australian National University, 2004); A Wilczynski, *Child Homicide* (Greenwich Medical Media, 1997) Ch 6.
5. It has been argued in the literature that complex contributing factors, such as an implicit recognition of poverty as a crime causing agent, also contributed to the development of the UK provision. Examination of these broader factors are outside the scope of this chapter, but can be reviewed at: KJ Kramer, *Unwilling Mothers Unwanted Babies* (University of British Columbia Print, 2006); R Lansdowne, "Infanticide: Psychiatrists in the Plea Bargaining Process" (1990) 16 *Monash University Law Review* 41, 45; J Osborne, "The Crime of Infanticide: Throwing the Baby out with the Bathwater" (1987) 6 *Canadian Journal of Family Law* 47.
6. NSW Law Reform Commission, *Partial Defences to Murder: Provocation and Infanticide,* Report 83 (1997) [3.6].

the whole range of distressing circumstances surrounding a concealed illegitimate pregnancy and birth".[7]

5.7 The 1922 Act was revised and replaced with the *Infanticide Act 1938* (UK), which applied to the death of children up to 12 months old at the hands of their mother, and extended the qualifying mental disorder to disturbances associated with lactation.[8] The current formulation of the NSW provision draws directly from the 1938 UK legislation, and has not been amended since its introduction more than half a century ago.

The legislative framework: NSW

5.8 Section 22A provides as follows:

> (1) Where a woman by any wilful act or omission causes the death of her child, being a child under the age of twelve months, but at the time of the act or omission the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent upon the birth of the child, then, notwithstanding that the circumstances were such that but for this section the offence would have amounted to murder, she shall be guilty of infanticide, and may for such offence be dealt with and punished as if she had been guilty of the offence of manslaughter of such child.
>
> (2) Where upon the trial of a woman for the murder of her child, being a child under the age of twelve months, the jury are of opinion that she by any wilful act or omission caused its death, but that at the time of the act or omission the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to such child or by reason of the effect of lactation consequent upon the birth of the child, then the jury may, notwithstanding that the circumstances were such that but for the provisions of this section they might have returned a verdict of murder, return in lieu thereof a verdict of infanticide, and the woman may be dealt with and punished as if she had been guilty of the offence of manslaughter of the said child.
>
> (3) Nothing in this section shall affect the power of the jury upon an indictment for the murder of a child to return a verdict of manslaughter or a verdict of not guilty on the ground of insanity,[9] or a verdict of concealment of birth.[10]

5.9 Section 22A of the *Crimes Act 1900* (NSW) therefore provides for the offence and partial defence of infanticide. The provision allows a conviction for infanticide rather than murder where a mother kills her child, aged less than 12 months, while suffering from a mental disturbance resulting from the birth of that child, or from the effects of lactation. The accused is sentenced as if she had been found guilty of manslaughter, the maximum penalty for this offence being imprisonment for

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7. R Lansdowne, "Infanticide: Psychiatrists in the Plea Bargaining Process" (1990) 16 *Monash University Law Review* 41, 47.
8. Presumably to justify increasing the ambit of the provisions beyond newborn babies: NSW Law Reform Commission, *Partial Defences to Murder: Provocation and Infanticide,* Report 83 (1997) [3.6].
9. This refers to the special verdict of not guilty by reason of mental illness (NGMI): *Mental Health (Forensic Provisions) Act 1990* (NSW) s 38. See Chapter 3 for a discussion of the defence and options for reform.
10. See *Crimes Act 1900* (NSW) s 85.

25 years.[11] The infanticide provisions do not prevent the court finding an accused NGMI, provided the requirements for that defence are satisfied.[12]

The legislative framework: cognate jurisdictions

5.10 NSW, Victoria and Tasmania are the only Australian jurisdictions that have infanticide provisions.[13] WA repealed its infanticide provision in 2008.[14] NSW is the only Australian jurisdiction that has both infanticide and substantial impairment[15] as partial defences to murder.

5.11 Except that it does not refer to lactation as a possible cause of mental disorder, the Tasmanian provision[16] is in similar terms to s 22A. In 2005, the Victorian infanticide provision was reformulated to modernise the terms of the statute.[17] The current Victorian law[18] departs from the NSW provision in the following ways: lactation is not included; the maximum age of the infant victim is two years rather than one year; the maximum sentence of imprisonment is five years; and the balance of the accused's mind may be disturbed by a disorder consequent upon her giving birth.[19]

5.12 The UK legislation has been the foundation for infanticide provisions in NZ and Canada. However, the NZ provision is markedly wider than any other. The child victim can be up to 10 years of age, and the mental disorder may be consequent on the birth of the victim or another child. The balance of the mother's mind can have been disturbed by giving birth, lactation, or by reason of any disorder consequent upon birth or lactation. The maximum term of imprisonment is three years.[20]

Infanticide in NSW: incidence and use

5.13 There are two broad types of case that are dealt with as infanticide. The first is when a (usually young) mother kills her newborn baby at birth,[21] and the second is the killing of an infant by the mother that occurs after months of parenthood. In the cases we have reviewed since 2001, only the latter category has been prosecuted in NSW. Below we describe both types of cases, and briefly examine how these proceed through the courts.

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11. *Crimes Act 1900* (NSW) s 24.
12. See *Crimes Act 1900* (NSW) s 22A(3). See also Chapter 3.
13. See, eg, *Crimes Act 1958* (Vic) s 6; *Criminal Code* (Tas) s 165A, s 333.
14. The infanticide provisions in the *Criminal Code Compilation Act 1913* (WA) s 281A, s 287A were repealed by the *Criminal Law Amendment (Homicide) Act 2008* (WA) s 13.
15. See *Crimes Act 1900* (NSW) s 23A.
16. *Criminal Code* (Tas) s 133, s 165A.
17. On recommendation from the Victorian Law Reform Commission: Victorian Law Reform Commission, *Defences to Homicide,* Final Report (2004) Ch 6.
18. *Crimes Act 1958* (Vic) s 6.
19. See Explanatory Memorandum, Crimes (Homicide) Bill 2005 (Vic) cl 5.
20. *Crimes Act 1961* (NZ) s 178(1).
21. A Wills, "Neonaticide: The Necessity of Syndrome Evidence When Safe Haven Legislation Falls Short" (2004) 77 *Temple Law Review* 1001.

Infanticide and neonaticide

5.14 Infanticide law developed in the UK as a legal response to neonaticide;[22] that is, mothers who killed their newborn infant at birth to evade social censure, ostracism and further poverty.[23] Mothers who commit neonaticide are reported to deny their pregnancies to themselves and others; hide their physical signs of pregnancy; and give birth alone.[24] Offenders are generally teenagers, and their circumstances appear to generate a compassionate legal response from law enforcement and the courts.[25] The maternal killing of a newborn remains a prevalent category of conviction under the infanticide laws of the UK and Canada.[26] This is not the case in NSW.

5.15 Over the past 10 years there were only four cases of infanticide in NSW, of which no convictions of neonaticide occurred. It would appear from the limited number of cases that women who are dealt with in NSW under s 22A generally have a mental health impairment and their victims are over three months old.

5.16 This does not mean that neonaticide does not happen in NSW.[27] It can be inferred by the rare discovery of an abandoned deceased newborn,[28] and was relevant to a recent Coroner's inquiry into the death and subsequent concealment of a newborn by the infant's young mother.[29] In that inquest, the law enforcement officer's decision that it was not in the "interests of justice"[30] to pursue criminal charges

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22. See PJ Resnick, "Murder of the Newborn: A Psychiatric Review of Neonaticide" (1970) 126 *American Journal of Psychiatry* 1414.
23. R Lansdowne, "Infanticide: Psychiatrists in the Plea Bargaining Process" (1990) 16 *Monash University Law Review* 41, 46-47.
24. A Wills, "Neonaticide: The Necessity of Syndrome Evidence When Safe Haven Legislation Falls Short" (2004) 77 *Temple Law Review* 1001; *Inquest into the death of Ella Anne Moore* (Unreported, NSW Coroner's Court, Deputy State Coroner Magistrate Freund, 28 August 2012).
25. See *R v Hutty* [1953] VLR 338; A Wills, "Neonaticide: The Necessity of Syndrome Evidence When Safe Haven Legislation Falls Short" (2004) 77 *Temple Law Review* 1001; R Lansdowne, "Infanticide: Psychiatrists in the Plea Bargaining Process" (1990) 16 *Monash University Law Review* 41, 46-47.
26. T Porter and H Gavin, "Infanticide and Neonaticide: A Review of 40 Years of Research Literature on Incidence and Causes" (2010) 11 *Trauma, Violence and Abuse* 99, 100; KJ Kramer, *Unwilling Mothers Unwanted Babies* (University of British Columbia Print, 2006); England and Wales, Law Commission, *Murder, Manslaughter and Infanticide,* Report 304 (2006) Appendix D, 196.
27. Lansdowne observes that the "classic type of neonaticide still occurs despite advances in contraception, sex education and the lessening of the stigma of illegitimacy although few cases proceed to trial": R Lansdowne, "Infanticide: Psychiatrists in the Plea Bargaining Process" (1990) 16 *Monash University Law Review* 41, 47.
28. Bartels notes that the discovery of a dead newborn infant in a public place is "far from an unheard of occurrence": L Bartels, "Safe Haven Laws, Baby Hatches and Anonymous Hospital Birth: Examining Infant Abandonment, Neonaticide and Infanticide in Australia" (2012) 36 *Criminal Law Journal* 19, 20; see also J Elder, "Sins of the Mother: The Tragedy Of Neonaticide" (19 December 2010) *Sydney Morning Herald* <www.smh.com.au/national/sins-of-the-mother-the-tragedy-of-neonaticide-20101218-191ee.html>.
29. *Inquest into the death of Ella Anne Moore* (Unreported, NSW Coroner's Court, Deputy State Coroner Magistrate Freund, 28 August 2012).
30. R Olding, "Inquest into Baby's Death Told Teen Was in a 'State Of Denial' Over Pregnancy" (28 August 2012) *Sydney Morning Herald* <www.smh.com.au/nsw/inquest-into-babys-death-told-teen-was-in-state-of-denial-over-pregnancy-20120827-24wn9.html>.

against the mother was upheld by the Coroner, who described the birth as a "terrifying and very lonely experience".[31]

5.17 The exact incidence of neonaticide in NSW is unknown. Unless a deceased infant is found, the birth and death of a newborn can go unnoticed. If the child is found and the mother also located, prosecutorial discretion may be exercised in such a way that neonaticide does not appear in criminal statistics.[32]

Infanticide in the courts

5.18 Since 2001, there have been four cases of infanticide prosecuted in NSW. All convictions were reached via a plea agreement with the prosecution. We have been able to access the sentencing remarks of three of these cases: *MC*,[33] *KP*[34] and *TS*.[35] The transcripts for *T*[36] have been destroyed. There are some commonalities between the reviewed cases. All of the offenders had a mental illness, such as schizophrenia, post-natal psychosis[37] and post natal depression.[38] In two cases, the mental illness had been exacerbated by circumstances of new parenthood, including geographic and social isolation, and abandonment by the biological father.[39] There were also indications that the offenders had a cognitive impairment and limited education.[40] In all cases, the women displayed "deep contrition" to the court and received a good behaviour bond at sentence.[41] *TS,* where the qualifying mental illness was less apparent, was the only case in which the Crown submitted that imprisonment was appropriate, and a suspended sentence was imposed.[42]

5.19 Over the same period of time, there have been six cases where a mother killed her child and pleaded[43] or was found guilty[44] of manslaughter due to substantial impairment. In four of these cases, the child was over one year old,[45] making the

31. *Inquest into the death of Ella Anne Moore* (Unreported, NSW Coroner's Court, Deputy State Coroner Magistrate Freund, 28 August 2012).
32. Judicial Commission of NSW, *Sentenced Homicides in New South Wales 1994-2001*, Research Monograph 23 (2004) 33; L De Bortoli, J Coles and M Dolan, "Maternal Infanticide in Australia: Mental Disturbance during the Postpartum Period" (2012) *Psychiatry, Psychology and Law* 1, 3.
33. *R v MC* [2001] NSWSC 769.
34. *R v KP* [2002] NSWSC 397.
35. *R v TS* (Unreported, NSW District Court, Toner J, 27 February 2008).
36. *R v T* (Unreported, NSW District Court, Finnane J, 11 September 2003).
37. *R v MC* [2001] NSWSC 769; *R v KP* [2002] NSWSC 397.
38. *R v TS* (Unreported, NSW District Court, Toner J, 27 February 2008).
39. *R v MC* [2001] NSWSC 769; *R v TS* (Unreported, NSW District Court, Toner J, 27 February 2008).
40. *R v MC* [2001] NSWSC 769; *R v TS* (Unreported, NSW District Court, Toner J, 27 February 2008).
41. Pursuant to *Crimes (Sentencing Procedure) Act 1999* (NSW) s 9. *R v MC* [2001] NSWSC 769 (four year good behaviour bond); *R v KP* [2002] NSWSC 397 (three year good behaviour bond); *R v TS* (Unreported, NSW District Court, Toner J, 27 February 2008) (suspended two year sentence and good behaviour bond); *R v T* (Unreported, NSW District Court, Finnane J, 11 September 2003) (five year good behaviour bond with supervision).
42. *R v TS* (Unreported, NSW District Court, Toner J, 27 February 2008) 9.
43. *R v LTN* [2011] NSWSC 614; *R v JS* [2007] NSWSC 809; *R v RG* [2006] NSWSC 21; *R v RR* [2002] NSWSC 415.
44. *R v DR* [2012] NSWSC 922 (jury trial); *R v TN* [2009] NSWSC 918 (judge trial).
45. *R v DR* [2012] NSWSC 922; *R v LTN* [2011] NSWSC 614; *R v TN* [2009] NSWSC 918; *R v RR* [2002] NSWSC 415.

defence of infanticide inapplicable. In the two cases where the child was under one year old, the sentencing remarks indicate that one of the accused had a drug dependency and prior history of abusing the infant,[46] and the other had an episode of severe psychosis not attributable to the birth of the child.[47] The facts outlined in the sentencing remarks for these two cases do not elucidate the characteristics of infanticide, where circumstances related to the birth of an infant precipitate mental illness. Four of the six women received a sentence that resulted in imprisonment.[48]

Table 5.1: Cases where mothers had killed their infants resulting in a finding of manslaughter (2001 – 2012)

Year	Case Name	Qualifying Mental Illness	Jury	Judge	Plea	Sentence
Infanticide						
2008	*TS*	Post-natal depression.				2 yr suspended sentence with good behaviour bond.
2003	*T*	UNKNOWN.				5 yr good behaviour bond.
2002	*KP*	Post-natal condition and pre-existing psychiatric illness.				3 yr good behaviour bond.
2001	*MC*	Cognitive impairment. History of mental illness. Severe auditory delusions after birth.				4 yr good behaviour bond.
Substantial Impairment						
2012	*DR*	An adjustment disorder of severe intensity.				Imprisonment for 5 yrs. NPP 3 yrs and 2 mnths.
2011	*LTN*	Schizophrenia.				Imprisonment for 4 yrs. NPP 2 yrs.
2009	*TN*	Severe depression.				Imprisonment for 6 yrs. NPP 4 yrs.
2007	*JS*	History of mental illness and drug dependency.				Imprisonment for 7 yrs. NPP 3.5 yrs.
2006	*RG*	Severe psychotic episode.				Imprisonment for 3 yrs. NPP 15 mnths. Released on parole on day of sentencing.
2002	*RR*	Delusional disorder.				Three offences: Fixed term of imprisonment for 18 mnths (for two counts of attempted murder). For manslaughter, released on day of sentencing with 5 yr bond.

46. *R v JS* [2007] NSWSC 809.
47. *R v RG* [2006] NSWSC 21.
48. *R v DR* [2012] NSWSC 922; *R v LTN* [2011] NSWSC 614; *R v JS* [2007] NSWSC 809.

Report 83 and Consultation Paper 6

5.20 In 1997, the Commission's report *Partial Defences to Murder: Provocation and Infanticide* (Report 83)[49] recommended abolishing s 22A. At that time, we argued that the infanticide provision was based on unsound and outmoded notions of mental disturbance, reflected an anachronistic view of women, and was arbitrarily restrictive. Infanticide was no longer necessary as a means of mitigating culpability due to the availability of diminished responsibility (now substantial impairment).[50] We concluded that the benefit to women afforded by a gender-specific provision capable of recognising the physical, social and economic circumstances experienced by women who have recently given birth was outweighed by the discriminatory basis of the provision and its misplaced assumptions.[51]

5.21 In Consultation Paper 6 (CP 6), we again canvassed the statutory offence/defence of infanticide. The paper was released in 2010, and we asked stakeholders whether, in the current legal and cultural climate, there was a continuing need for infanticide to operate.[52]

Submissions

5.22 Four submissions, from the NSW Bar Association, Law Society of NSW, Legal Aid NSW and Public Defenders, argued that there was a continuing need for the offence/defence of infanticide in NSW.[53] These submissions reasoned that infanticide cases are "special" in that the circumstances that surround infanticide are both "tragic and unique",[54] and so require "specific provisions".[55] Legal Aid submitted that it is:

> inappropriate for women who kill their infant children in particular circumstances to be prosecuted for murder. Infanticide as an offence also enables the woman charged to avoid the burden of proving that, at the time of the killing, her mental state was so diminished as to rob her of the capacity to control her actions, or to know that they were wrong.[56]

5.23 Submissions from the Bar Association and Law Society referred to the recent review of homicide by the Law Commission of England and Wales. The Bar Association adverted to that Commission's arguments, including: that there is sufficient medical evidence to justify a separate defence; the need for a lower burden of proof for women who commit infanticide; the low number of cases arising;

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49. NSW Law Reform Commission, *Partial Defences to Murder: Provocation and Infanticide,* Report 83 (1997).
50. NSW Law Reform Commission, *Partial Defences to Murder: Provocation and Infanticide,* Report 83 (1997) [3.16].
51. NSW Law Reform Commission, *Partial Defences to Murder: Provocation and Infanticide,* Report 83 (1997) [3.31]-[3.33].
52. 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 6.41-6.43.
53. NSW Bar Association, *Submission MH10,* 33-34; Law Society of NSW, *Submission MH13,* 14-15; Legal Aid NSW, *Submission MH18,* 13; NSW, Public Defenders, *Submission MH26,* 39.
54. Legal Aid NSW, *Submission MH18,* 13.
55. NSW Bar Association, *Submission MH10,* 33.
56. Legal Aid NSW, *Submission MH18,* 13.

and that infanticide provides for "substantive justice" for women and does not discriminate against mothers.[57]

5.24 The current practice of lenient sentences in cases of infanticide was paramount for some stakeholders. The Public Defenders supported the retention of infanticide as an offence/defence on the basis that the current sentencing patterns are desirable.[58] It suggested that if infanticide were abolished, the second reading speech to any Act introducing its abolition should make clear that there is no intention to change the sentencing pattern that currently applies.[59]

5.25 Only one submission, from the Office of the Director of Public Prosecutions, supported abolition of the offence.[60]

Arguments for abolishing infanticide

5.26 Those who favour abolition argue that s 22A is obsolete and a historical anomaly. The many uncertainties and inconsistencies of the medico-legal foundation, the contemporary social and economic situation of women, and the availability of alternative partial defences are considered key reasons to repeal the NSW provision.

The medical foundation is uncertain

5.27 Section 22A requires that a mental disturbance be caused by a woman having "not fully recovered" from either childbirth or the effects of lactation. In other words the cause of the mental disturbance is linked to the physical effects of the birth or of lactation. This requirement raises three problems that support the case for abolition.

5.28 First, there is disagreement amongst psychiatric and medical experts as to the causes of post-partum mental disorder.[61] While post-natal depression has increasingly been recognised, there is insufficient evidence to suggest that it can be attributed solely to the after-effects of childbirth.[62] Further, there is little support for the notion that lactation can cause a significant mental disturbance.[63] Women may experience symptoms of depression, stress and anxiety for a number of reasons

57. NSW Bar Association, *Submission MH10,* 33-34.
58. NSW, Public Defenders, *Submission MH26,* 38.
59. NSW, Public Defenders, *Submission MH26,* 38-39.
60. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 11. No reasons were given.
61. B McSherry, "The Return of the Raging Hormones Theory: Premenstrual Syndrome, Postpartum Disorders and Criminal Responsibility" (1993) 15 *Sydney Law Review* 292; NSW Law Reform Commission, *Partial Defences to Murder: Provocation and Infanticide,* Report 83 (1997) [3.27]-[3.30]; Victorian Law Reform Commission, *Defences to Homicide,* Final Report (2004) [6.32].
62. Model Criminal Code Officers Committee of the Standing Committee of Attorneys-General, *Model Criminal Code: Chapter 5 Fatal Offences Against the Person,* Discussion Paper (1998) 135; NSW Law Reform Commission, *Partial Defences to Murder: Provocation and Infanticide,* Report 83 (1997) [3.27]-[3.30]; Victorian Law Reform Commission, *Defences to Homicide,* Final Report (2004) [6.32]. See table of post-partum mental illnesses in Appendix F.
63. As a result, references to lactation were removed from the Victorian legislation: see *Crimes Act 1958* (Vic) s 6. Cf the findings of England and Wales, Law Commission, *Murder, Manslaughter and Infanticide,* Report 304 (2006).

following the birth of a child, including physical, social, cultural, emotional and economic factors.[64]

5.29 Secondly, infanticide is the only offence/defence that requires an inquiry into the *cause* of an offender's mental illness. In practice, medical experts may distort their diagnoses to point to a causal link between childbirth and mental disturbance to fit the legal requirements.[65]

5.30 Thirdly, it is argued that the provision reflects outmoded understandings of female behaviour. In the Victorian era, women were considered predisposed to insanity by their biology.[66] Mental health specialists considered rebellious, aggressive or promiscuous behaviour as manifestations of insanity in females and believed, amongst other things, that it was natural for female reproductive organs to produce madness after childbirth.[67] Such ideas have long since been discredited; nevertheless the implication in s 22A that disturbance of the mind is produced by childbirth or lactation continues to perpetuate this fiction.[68] The Law Reform Commission of Western Australia considered the required biological link between childbirth and mental impairment a key reason to recommend repeal of the WA infanticide provision.[69]

Statutory infanticide provisions are obsolete and other defences cover the field

5.31 It may be argued that the offence/defence of infanticide was developed to address a specific set of legal and cultural circumstances that no longer exist. The introduction of other partial defences, and changed circumstances for unmarried women with children, have rendered the NSW provision unnecessary.

5.32 The infanticide provision was introduced in NSW in 1951 to recognise the particular social context in which single mothers were greatly stigmatised and mothers that killed their babies were often poor, abandoned and undereducated. In contemporary NSW, most sections of the community do not stigmatise illegitimacy in the same way that it did in the 1950s. Birth control is readily available, and extreme poverty has been somewhat alleviated by state support.[70]

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64 . NSW Law Reform Commission, *Partial Defences to Murder: Provocation and Infanticide,* Report 83 (1997) [3.29]; Victorian Law Reform Commission, *Defences to Homicide,* Final Report (2004) [6.33]-[6.34].

65. NSW Law Reform Commission, *Partial Defences to Murder: Provocation and Infanticide,* Report 83 (1997) [3.30].

66. A Loughnan, "The 'Strange' Case of the Infanticide Doctrine" (2012) *Oxford Journal of Legal Studies* 1, 21.

67. R Lansdowne, "Infanticide: Psychiatrists in the Plea Bargaining Process" (1990) 16 *Monash University Law Review* 41, 46.

68. B McSherry, "The Return of the Raging Hormones Theory: Premenstrual Syndrome, Postpartum Disorders and Criminal Responsibility" (1993) 15 *Sydney Law Review* 292, 297; A Loughnan, "The 'Strange' Case of the Infanticide Doctrine" (2012) *Oxford Journal of Legal Studies* 1, 21.

69. Law Reform Commission of Western Australia, *A Review of the Law of Homicide,* Report 97 (2007) 117.

70. R Lansdowne, "Infanticide: Psychiatrists in the Plea Bargaining Process" (1990) 16 *Monash University Law Review* 41, 60-61.

5.33 The three NSW cases of infanticide where we have sentencing remarks involved women who killed their infants while experiencing a post-partum mental illness. Arguably those women can access the defences of substantial impairment or mental illness and infanticide is not needed to allow the courts to take their circumstances into account.

5.34 Substantial impairment is argued to be an appropriate substitute for infanticide, and it has been used as a defence in circumstances which, apart from the age of the child, closely resemble those that would satisfy the infanticide test.[71] In some recent cases, women who raised substantial impairment received a similar non-custodial penalty to that received by offenders who relied on s 22A.[72]

Arguments for retaining infanticide

5.35 Supporters of the provision are generally in accord with the Victorian Law Reform Commission's (VLRC) observation that infanticide is "a distinctive kind of human tragedy which requires a distinctive response".[73] Although a woman charged with infanticide must demonstrate that the balance of her mind was disturbed, it appears that in practice (whatever s 22A might provide) courts also take into account stresses on the mother that exacerbate and make it more difficult to cope with her mental illness. Infanticide requires a lower threshold of impairment; and – though there are no directly comparable cases in our survey above – appears to incur appropriately lower sentences than cases of substantial impairment.

Infanticide is a practical legal solution to a particular set of circumstances

5.36 Arguments in support of infanticide recognise that some of the considerations that led to the introduction of the infanticide provision are still relevant today. Women are still likely to be the primary carers of an infant. In June 2011, the Australian Bureau of Statistics reported that 90% of fathers in an opposite-sex relationship had full time employment. Sixty-seven percent of mothers worked full time, but only 18% of mothers whose children were between 0-4 years had full time employment.[74] A 2005 study by the Social Policy Research Centre identified that, following the birth of a first child, three-quarters of all child care and domestic work is conducted by women.[75] Thus even where women are partnered (and many of those who kill their infants are not), the burdens and responsibility of caring for infants still falls primarily on mothers.

5.37 Post-natal mental illnesses do occur. Seventy percent of women will experience mild post-partum depression, referred to as "baby blues". Eight to nine percent of women will experience post-partum depression, and less than 1% will have a post-

71. *R v DR* [2012] NSWSC 922; *R v LTN* [2011] NSWSC 614.
72. See *R v BL* [2000] NSWSC 1088; *R v MS* [2000] NSWSC 648; *R v RR* [2002] NSWSC 415.
73. Victorian Law Reform Commission, *Defences to Homicide,* Final Report (2004) [6.19]-[6.22].
74. Australian Bureau of Statistics, *Labour Force, Australia: Labour Force Status and Other Characteristics of Families* (2011).
75. See L Craig and M Bittman, "The Effects of Children on Adults' Time-Use: Analysis of the Incremental Time Costs Of Children in Australia", *Social Policy Research Centre Discussion Paper No 143* (2005) 17.

partum psychosis.[76] We now recognise the causes of post-natal mental illnesses as being complex and including the stresses of providing primary care and the social, economic and other issues that face women after childbirth.[77]

5.38 These factors are also recognised by courts in cases of infanticide. Lansdowne, who surveyed infanticide cases in NSW from 1976 to 1980, argues that the availability of infanticide has allowed the courts to take into account the total circumstances in which mothers became mentally ill.[78] More recently, in sentencing remarks of the NSW case *MC,* Justice Simpson observed that the infanticide had occurred because the defendant "lacked the resources – mainly emotional, but also intellectual and probably financial – to manage the family for whom she was responsible". [79]

5.39 In addition to the conclusion of the VLRC cited above, the Law Commission of England and Wales also found infanticide to be a "practicable legal solution to a particular set of circumstances" and observed:

> we do not believe that the offence/defence of infanticide pathologizes women or motherhood ... rather it recognises that some women do suffer from psychiatric disorders triggered by childbirth (and very possibly lactation) and as a result may kill their infants ... In this unique situation there is only the surface appearance of discrimination; the substantive offence ensures substantive justice.[80]

Infanticide is a better response than substantial impairment to these special cases

5.40 It is argued by commentators and stakeholders that infanticide is a better response than substantial impairment to these special cases. This is because infanticide has, in practice, allowed courts to appropriately consider the wider social and economic stressors in the woman's life in which her mental illness has arisen. In contrast, substantial impairment focuses on the mental illness and its effect on conduct.

5.41 A special and broader response is required in all cases, on this argument. However, it is arguably particularly important in neonaticide cases, where the mother may be able to establish that the balance of her mind was disturbed by the immediate physical and emotional consequences of giving birth after a long period of denial, and most likely while unattended.[81]

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76. See table at Appendix F for an overview of symptoms and references.
77. NSW Law Reform Commission, *Partial Defences to Murder: Provocation and Infanticide,* Report 83 (1997) [3.38]-[3.41], [3.29], [3.39]; LL Shwartz and NK Isser, *Child Homicide: Parents Who Kill* (CRC Press, 2007) 118; Victorian Law Reform Commission, *Defences to Homicide,* Final Report (2004) [6.33]-[6.34]; A Wilczynski, *Child Homicide* (Greenwich Medical Media, 1997) 157.
78. R Lansdowne, "Infanticide: Psychiatrists in the Plea Bargaining Process" (1990) 16 *Monash University Law Review* 41.
79. *R v MC* [2001] NSWSC 769 [24].
80. England and Wales, Law Commission, *Murder, Manslaughter and Infanticide,* Report 304 (2006) [8.39].
81. A Wills, "Neonaticide: The Necessity of Syndrome Evidence When Safe Haven Legislation Falls Short" (2004) 77 *Temple Law Review* 1001.

5.42 This broader approach of infanticide is reflected in the fact that:

- The requirements of s 22A are less rigorous than substantial impairment. There is no need to show the disturbance of the mind be causally related to the killing, only that it is temporally related.
- Sentences for infanticide appear – on our limited survey – to be generally lower than in substantial impairment cases.[82]

5.43 Lansdowne has argued that:

> The leniency in the infanticide cases cannot be entirely explained by reliance on evidence of mental disturbance. It is something about infanticide in particular that consistently attracts a compassionate response.[83]

5.44 The courts have also recognised this approach, as Justice Simpson observed:

> I am conscious that s 22A was inserted into the Act as long ago as 1951 in order to recognise a perceived phenomenon relating to the effects ... of childbirth. The legislature then identified infanticide as a form of homicide having particular characteristics and a particular genesis which therefore justifies, in an appropriate case, a different approach to sentencing.[84]

Support for reformulation of the partial defence

5.45 In CP 6 we asked whether infanticide should be recast, and how best to do so.[85] A majority of stakeholder submissions supported retaining and amending the current provision. The Law Society of NSW cited the proposal of the Law Commission of England and Wales' in favour of removing the reference to lactation, raising the age limit of the child to two years, and extending the infanticide provision so that it considers both the effects of giving birth and circumstances consequent upon that birth.[86]

5.46 In 2005, Victoria removed the reference to lactation and amended the law to provide that the balance of the defendant's mind could be disturbed by "a disorder consequent upon her giving birth".[87] The England and Wales Criminal Law Review Committee recommended that the UK infanticide provisions be amended to explicitly provide that "at the time of the act or omission the balance of the woman's mind was disturbed by reason of the effect of giving birth *or circumstances consequent upon that birth*".[88] In the opinion of the Committee this formulation more

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82. We note that the size of the sample of cases over the past ten years is so small that no firm conclusion can be drawn.
83. R Lansdowne, "Infanticide: Psychiatrists in the Plea Bargaining Process" (1990) 16 *Monash University Law Review* 41, 59.
84. *R v MC* [2001] NSWSC 769 [6].
85. 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 6.43.
86. Law Society of NSW, *Submission MH13,* 14-15.
87. *Crimes Act 1958* (Vic) s 6. Victoria also raised the age limit of the child to two years and reduced the maximum level of imprisonment to five years.
88. England and Wales, Criminal Law Review Committee, *Offences against the Person,* Fourteenth Report (1980) [114] (our emphasis).

accurately reflected the existing approach of the courts. The Law Society of NSW and Legal Aid NSW have suggested that this option should be implemented in NSW.[89]

The Commission's view

5.47 We acknowledge the force of the arguments for abolition of infanticide. Indeed, we found those arguments persuasive in 1997 when we recommended the abolition of s 22A.[90] Of particular concern then and now is that the requirement of a biological connection between the effects of childbirth and lactation with mental impairment is not supported by the scientific evidence and relies on discredited ideas in behavioural science.

5.48 The arguments for and against retention of this partial defence are finely balanced. However, ultimately we are persuaded in favour of retention and reform to update infanticide.

5.49 Like the VLRC, we acknowledge infanticide to be a "distinctive kind of human tragedy".[91] The statutory offence/defence of infanticide affords an appropriate and compassionate criminal law response to the complex and tragic set of circumstances that may result in a mother killing her infant. Key stakeholders recognised this argument and stakeholder opinion was strongly in favour of retention. Further, the infanticide provisions respond appropriately to a particular set of circumstances that may not, in all cases, be adequately dealt with by the partial defence of substantial impairment.

5.50 While there are deficiencies in the terms of s 22A, we find that these are best dealt with by way of amendment.

Reformulating s 22A

5.51 The primary difficulty identified with s 22A is that it requires the disturbance to the balance of the defendant's mind to be caused by the effects of childbirth or lactation. Our proposed reformulation of s 22A aims to address this shortcoming as well as to update other aspects of the provision.

Remove the biological nexus between childbirth and mental illness

5.52 Section 22A currently provides that "at the time of the act or omission the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent on the birth of the child". We recommend that this formulation be amended to require that,

89. Law Society of NSW, *Submission MH13,* 15-16; Legal Aid NSW, *Submission MH18,* 13; S Dayalan, *Submission MH25,* 9.

90. NSW Law Reform Commission, *Partial Defences to Murder: Provocation and Infanticide,* Report 83 (1997) Recommendation 3.

91. Victorian Law Reform Commission, *Defences to Homicide,* Final Report (2004) [6.22].

at the time of the conduct causing the death of the child, the defendant had "a mental health impairment consequent on or exacerbated by her having given birth to that child". This formulation retains a relationship between the birth of a child and mental illness that is central to infanticide. There must be a temporal connection, and the mental illness must be a consequence of the birth or exacerbated by it. However, it should not be necessary to show that the illness was caused by the effect of giving birth.

5.53 This reformulation follows the provision in the Victorian statute, and received strong stakeholder support.[92] It is also compatible with the decided cases which, as we demonstrate above, acknowledge consequences of childbirth beyond the physical act of giving birth.

Remove the reference to lactation

5.54 "Lactational insanity" is unproven, and is not referred to in the Victorian or Tasmanian infanticide provisions. Only the UK, upon recommendation from the Law Commission of England and Wales, retained the reference to lactation after a review of infanticide provisions. The recommendation of the Law Commission was based on one "inconclusive" study that connected lactation to dopamine sensitivity and psychosis.[93] We are unaware of any other study confirming a causal connection between lactation and mental illness. We consider it unnecessary to include lactation within a reformulated infanticide provision. That lactation is causally connected to childbirth is uncontroversial. In the unlikely event that an evidence base emerges that indicates lactation causes mental impairment leading to infanticide, this would in any event be covered by our proposed provision as a "mental health impairment consequent on ... giving birth."

Wilful act or omission

5.55 The term "wilful act or omission" is outdated and does not appear in any provision in the *Crimes Act 1900* (NSW) other than infanticide. In the Victorian infanticide provision, the term "wilful act or omission' was replaced by "carries out conduct".[94] The term "carries out conduct" currently appears with the same meaning in the self defence provision of the *Crimes Act 1900* (NSW).[95]

Defining mental health impairment

5.56 The term used to define the relevant mental health impairment in s 22A is "the balance of her mind was disturbed". This term is unique to infanticide and was introduced in 1932.[96] The term has not caused any difficulties in practice and

92. See Law Society of NSW, *Submission MH13,* 14-15; Legal Aid NSW, *Submission MH18,* 13.
93. England and Wales, Law Commission, *Murder, Manslaughter and Infanticide,* Report 304 (2006) [8.26].
94. *Crimes Act 1958* (Vic) s 6.
95. *Crimes Act 1900* (NSW) s 418.
96. See England and Wales, Law Commission, *Murder, Manslaughter and Infanticide,* Report 304 (2006) [8.11]-[8.13]. The then Lord Chancellor (Viscount Birkenhead) who introduced the amendment to include this phrase in the Bill stated that "they are new words. They are not terms

appears to cover the mental health impairments that present themselves to the courts in this context. For example, it includes women who experience a post-natal psychosis who have an underlying mental health impairment exacerbated by the circumstances of caring for an infant.[97] It has included cases where the psychosis is an isolated event, apparently caused by severe post-natal depression.[98] In a recent UK study, the majority of women who carried out neonaticide had a dissociative disorder at the time of the act, and these cases came within the same definition in the UK provision.[99]

5.57 While the term "balance of her mind was disturbed" has generated little comment or controversy, we nevertheless propose to replace it with our definition of mental health impairment for three reasons. First, the definition of mental health impairment was developed to be broadly and consistently applied.[100] Adopting the definition for infanticide would ensure consistency, especially within the defences and partial defences explored in this reference.[101] Secondly, our definition was developed in consultation with medical and forensic experts, and should be easily and consistently applied by experts called to give evidence. The proposed definition of mental health impairment explicitly includes affective disorders and psychoses, which will ensure that the post-natal mental health impairments that arise in cases of infanticide remain captured by the infanticide provision.

5.58 Finally, the definition "mental health impairment" is a contemporary term, which aligns the provision with modern understandings of mental illnesses.

5.59 We consider that the adoption of this term will not affect the ability of the courts to consider the context in which the mental health impairment arises, including the social and economic stresses in a woman's life that may exacerbate her illness or make it more difficult to cope with.

5.60 Consistent with our approach in the relation to verdict of NGMI and substantial impairment, we do not propose to include severe personality disorder in the definition in this context.[102]

Recommendation 5.1

(1) Section 22A(1) of the *Crimes Act 1900* (NSW) should provide:

> If a women carries out conduct that causes the death of her child in circumstances that would constitute murder, and at the time she had a mental health impairment consequent on or exacerbated by her having given birth to that child within the

of art". These new words were designed to avoid misunderstanding and "to give effect to the intention" of the framers of the Bill: United Kingdom, *Parliamentary Debates,* House of Lords, 25 May 1922, col 761-762 (Viscount Birkenhead).

97. See *R v KP* [2002] NSWSC 397; *R v MC* [2001] NSWSC 769.
98. See the Victorian case of *R v Azzopardi* [2004] VSC 509.
99. England and Wales, Law Commission, *Murder, Manslaughter and Infanticide,* Report 304 (2006) Appendix D, 207.
100. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) Ch 5.
101. This includes the partial defence of substantial impairment and the defence of mental illness.
102. See Chapters 3 and 4.

preceding 12 months, she is guilty of infanticide, and not of murder.

(2) Section 22A(2) of the *Crimes Act 1900* (NSW) should provide:

> If a women carries out conduct that causes the death of her child in circumstances that would constitute murder, and at the time she had a mental health impairment consequent on or exacerbated by her having given birth to that child within the preceding 12 months, the jury should find that she is guilty of infanticide, and not of murder.

(3) For the purposes of s 22A "mental health impairment" should be defined as in Recommendation 3.2.

(4) The maximum penalty for infanticide should continue to be the same as for manslaughter.

6. Procedures following a finding of unfitness

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6.1 This chapter examines the procedures that are followed after a finding of unfitness in the Supreme or District Courts of NSW. In part one, we review the complex interplay between the courts and the Mental Health Review Tribunal (MHRT) prior to a special hearing for an unfit defendant, and propose a streamlined alternative.

6.2 In part two, we trace the policy objectives and prevalence of special hearings in NSW. Several areas for procedural reform are identified.

Part one: the legal framework after a court finding of unfitness

Step 1: the current court process following a finding of unfitness

6.3 In NSW, the procedures following a finding of unfitness to be tried in the Supreme and District Courts are prescribed by the *Mental Health (Forensic Provisions) Act 1990* (MHFPA).[1] The legislative pathways following a finding of unfitness are outlined in Figure 6.1 and summarised below.

6.4 Under the MHFPA, fitness can be raised at any point in the relevant proceedings and by any party.[2] Once raised, the court holds an inquiry to determine if the defendant is unfit to stand trial.[3] Fitness is determined by the judge alone[4] and, while the defendant is to have legal representation, the inquiry is of a non-adversarial nature.[5] If the court finds the defendant fit to stand trial criminal proceedings recommence and continue in the ordinary way.[6]

6.5 If the court finds the defendant unfit to stand trial three procedural events occur. The court pauses proceedings, the court refers the unfit person to the MHRT and, if remanded in custody,[7] the unfit person is classified a "forensic patient".[8]

6.6 When the court pauses proceedings relevant to the offence it may immediately discharge any jury constituted for initial proceedings.[9] The unfit person must be referred to the MHRT for review.[10] The court must make a direction regarding the person while he or she awaits a MHRT review.[11] Directions can include granting bail, remanding in custody or any other order that the court considers appropriate.[12] Unless the unfit person is released on bail,[13] he or she is classified as a "forensic patient" and the MHRT has jurisdiction in relation to his or her care and treatment.[14]

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1. *Mental Health (Forensic Provisions) Act 1990* (NSW) pt 2. For an examination of the procedures relating to fitness to be tried in the Local Court see Chapter 12.
2. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 5, s 7(1), s 7(2).
3. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 10. Fitness is determined by reference to the common law. For an examination of the *Presser* test see Chapter 2.
4. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 11.
5. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 12.
6. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 13.
7. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 14.
8. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 42; G James, J Feneley and S Hanson, "The Mental Health Legislation Amendment (Forensic Provisions) Act" (2009) 21 *Judicial Officers' Bulletin* 19, 21.
9. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 14(b).
10. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 14(a).
11. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 14.
12. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 14(b)(i)-(iv).
13. See *Khoury v Mental Health Review Tribunal* [2012] NSWSC 703.
14. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 14(a), s 42, div 7.

Step 2: the current role of the Mental Health Review Tribunal

6.7 The MHRT is a quasi-judicial body constituted under the *Mental Health Act 2007* (NSW).[15] Broadly speaking, the MHRT's Forensic Division reviews and oversees the management of forensic patients. It can recommend placement for care, treatment, and make appropriate orders for release.[16] For a detailed discussion on the role and principles employed in decision making by the MHRT see Chapters 8 and 9.

The defendant will *become fit within 12 months*

6.8 When the MHRT reviews an unfit person referred by a court, it is required to determine, on the balance of probabilities, if he or she will become fit within 12 months.[17] If the MHRT determines that the person *will* become fit within 12 months, it advises the court on the nature of the impairment and whether the person can be treated in a mental health facility until well enough to stand trial.[18] Upon notification from the MHRT, the court can grant the unfit person bail or detain him or her in a mental health or prison facility.[19]

6.9 The MHRT must review an unfit person deemed likely to become fit as soon as practicable after the court orders detention,[20] and then conduct a review at least every six months.[21] If the MHRT determines that the person has become fit,[22] the MHRT must inform the court and DPP.[23] If the DPP decides to proceed with the charges, the person is directed back to the court for another inquiry into their fitness before a normal criminal trial proceeds.[24] If found fit by the court, the person ceases to be a forensic patient.[25]

6.10 On further inquiry, the court may disagree with the MHRT and find the person still unfit.[26] If the person has been a forensic patient for more than 12 months, they must then proceed directly to a special hearing.[27] Otherwise the court may conduct a special hearing or order the person to be returned to custody or a mental health facility[28] and undergo further reviews by the MHRT.[29]

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15. *Mental Health Act 2007* (NSW) ch 6.
16. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 46, s 47(2): There are limits to the Mental Health Review Tribunal (MHRT) powers in regards to release. The MHRT cannot release a forensic patient from detention in a mental health facility or prison who is awaiting court, but can recommend release to the court.
17. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 16.
18. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 16(2).
19. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 17.
20. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 17(3), s 45(1).
21. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 46.
22. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 45(3)(a).
23. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 45(3).
24. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 30(1).
25. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 52(3).
26. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 29, s 30; see *R v Waszczuk* [2012] NSWSC 380.
27. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 30(2)(a).
28. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 30(2)(b) or s 46-47.
29. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 46, 47.

The defendant will not *become fit within 12 months*

6.11 The MHRT can also determine that an unfit person *will not* become fit for trial[30] or that an unfit person previously thought likely to become fit has not or will not do so within the 12 month period.[31] Here the MHRT notifies the DPP who then decides whether to proceed to a special hearing.[32] If the DPP decides not to proceed, it advises the court and then the person is released[33] and ceases to be a forensic patient.[34] Otherwise the unfit person attends a special hearing.[35]

Statistics

6.12 In the 2011/12 financial year period the MHRT determined 45 cases of fitness.[36] Of these:

- Nine people found to be unfit to stand trial by the court were found by the MHRT likely to become fit within a 12 month period.
- 32 people would not become fit.[37]
- Four hearings were adjourned.[38]

6.13 Out of 45 individual cases referred to the MHRT from the courts, a minority of people were determined to be unfit and likely to become fit within 12 months. Thirty two cases were found unlikely to become fit within 12 months, of which 20 proceeded to a special hearing.[39]

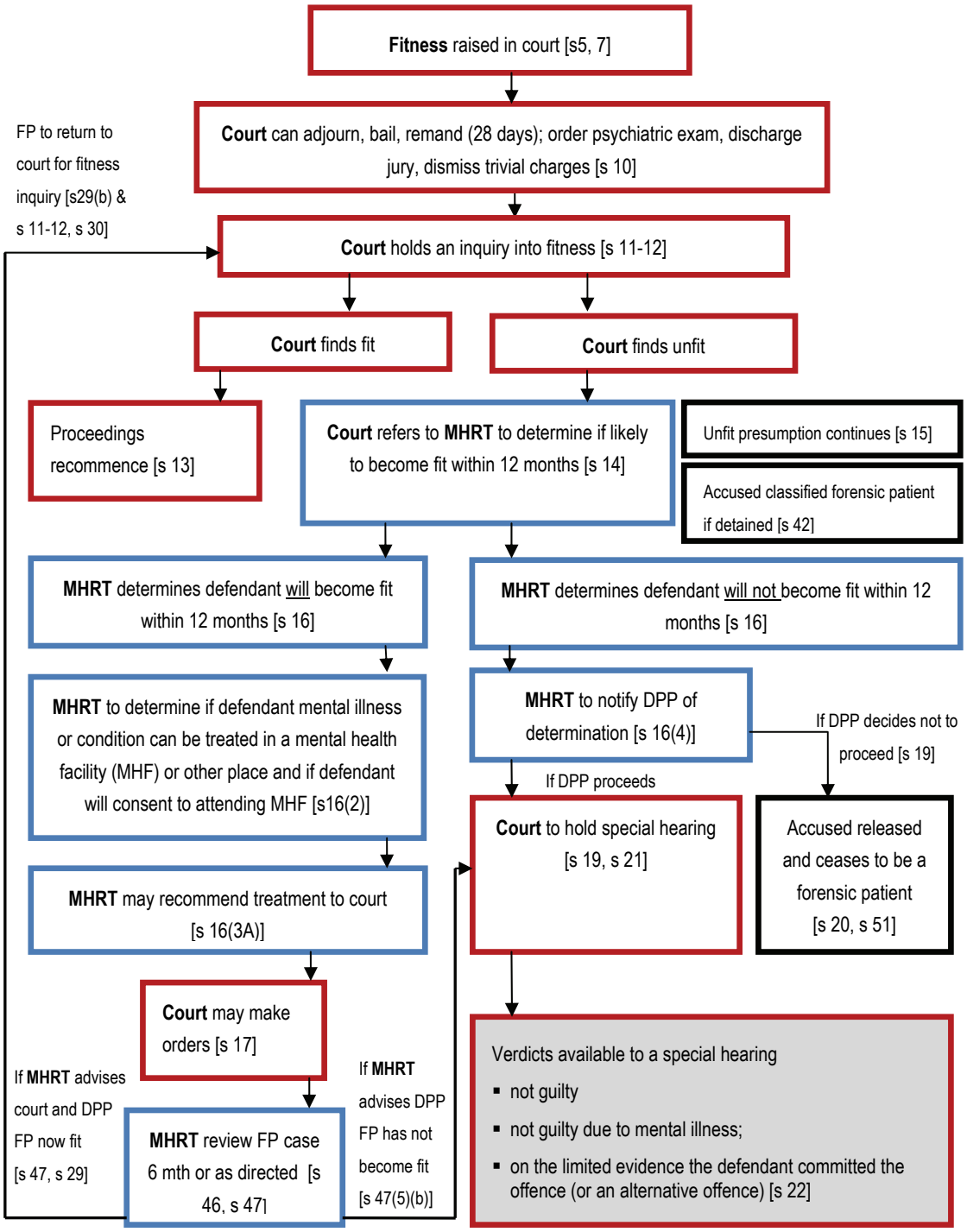
Table 6.1 MHRT determinations on fitness 2007/8 – 2011/12

		Date by financial year				
MHFPA	**FITNESS**	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**
s 16	Cases of unfitness referred to MHRT	49	38	29	40	45
s 16	WILL become fit to stand trial	1	4	5	4	9
s 16	WILL NOT become fit for trial	24	24	17	31	32
s 19	Special hearings conducted	N/a	11	18	7	20

Source: Mental Health Review Tribunal, Annual Reports 2007-2011; NSW Bureau of Crime Statistics and Research (ref: mai12/11000hc)

30. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 16(1).
31. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 45, s 47.
32. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 16, s 19.
33. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 20.
34. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 52.
35. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 19.
36. Mental Health Review Tribunal, *Annual Report 2011-12*, 31.
37. Mental Health Review Tribunal, *Annual Report 2011-12*, 34.
38. Mental Health Review Tribunal, *Consultation MH38.*
39. NSW Bureau of Crime Statistics and Research (ref: mai12/11000hc). Information supplied on 5 April 2013 has not been incorporated into this chapter due to time constraints: NSW Bureau of Crime Statistics and Research (ref: mai13/11186hc).

Figure 6.1: Current regime for procedures following a finding of unfitness



Jurisdictional comparison of legal frameworks following a finding of unfitness

6.14 NSW is the only Australian jurisdiction where any determination in relation to fitness is made by a court in collaboration with a tribunal. In other jurisdictions, the court alone makes such determinations, and tribunals oversee the case management of forensic patients who have been found unfit.

6.15 In WA, fitness is decided by the presiding judicial officer.[40] If found unfit, the court determines if the defendant is likely to become fit within six months,[41] and holds a further inquiry on the matter at the end of the six month period.[42] There is no special hearing procedure. The court can order the release[43] or detention[44] of an unfit person, and the role of the Mentally Impaired Accused Review Board is limited to determining the type of detention[45] and reporting on request from the Minister on the possibility of any release.[46]

6.16 Queensland has established a Mental Health Court which investigates issues of fitness.[47] The Queensland Mental Health Review Tribunal reviews unfit defendants considered by the court as likely to become fit within 12 months,[48] and conducts periodic reviews of forensic patients in custody.[49] In SA, fitness is a question of fact for the court as is any "prognosis of condition".[50] There is no special hearing process; instead a finding of unfitness can result in a trial on the objective elements of the offence.[51]

6.17 In Victoria,[52] Tasmania,[53] ACT[54] and the NT,[55] the courts determine fitness, and an unfit person proceeds directly to a special trial. If found likely to become fit, the court will re-investigate after a set time period.[56] In the ACT, Mental Health Tribunal oversight occurs only after a court finding at a special hearing for an indictable offence.[57]

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40. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 12.
41. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 19.
42. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 13. Or earlier as advised by the Mentally Impaired Accused Review Board.
43. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 19(4)(a).
44. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 19(4)(b), s 19(5).
45. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 25.
46. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 33.
47. *Mental Health Act 2000* (Qld) s 383.
48. *Mental Health Act 2000* (Qld) s 437(d)(i).
49. *Mental Health Act 2000* (Qld) s 209.
50. *Criminal Law Consolidation Act 1935* (SA) s 269K(2).
51. *Criminal Law Consolidation Act 1935* (SA) s 269MB.
52. *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 11.
53. *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 12-14.
54. *Crimes Act 1900* (ACT) s 315, s 315D, s 316: Temporary unfitness results in the defendant being put into remand or given bail, and the court *can* refer to ACT Civil and Administrative Tribunal for a mental health review.
55. *Criminal Code* (NT) s 43R(1): Fitness is a matter of fact to be determined by a jury, and then the judge alone decides if an unfit defendant is likely to become fit.
56. *Crimes Act 1900* (ACT) s 315D(4); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 11(4)(b); *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 15; *Criminal Code* (NT) s 43R(7), s 43R(9)(b).
57. For example *Mental Health (Treatment and Care) Act 1994* (ACT) s 68.

Issues with the current process

6.18 The procedures that follow a finding of unfitness in NSW courts are particular to the NSW legislative regime, and are cumbersome and complex. A person whom the court has found unfit to be tried must go through a similar process at an MHRT review where the tribunal determines whether the person will, during the period of 12 months, become fit to be tried.[58] The court reviews and establishes unfitness, and then the MHRT reviews the scope and extent of the unfitness. These are two different inquiries, yet the court and the MHRT traverse similar ground, and the MHRT is likely to review the evidence from the court.

6.19 This duplication can cause lengthy delays and uncertainty, which can place undue stress on the defendant.[59] When people are unfit to be tried because of cognitive or mental health impairments, that stress can compromise their rehabilitation. Distress has been described as having "anti-therapeutic implications"[60] for the defendant, and delay can also cause major inconvenience and further suffering for victims, family members and others involved in the proceedings.[61]

Issue 1: delay

6.20 Delay is an intrinsic and often functional element of the forensic process in NSW. Currently, the MHRT must determine, on the balance of probabilities, if an unfit person referred from the court will become fit within 12 months. A delay between the court's initial finding of unfitness and the MHRT fitness review is necessary to give the person time to be treated. It is only after an unfit person has undergone treatment that the MHRT can make an accurate assessment of their ongoing mental health.

6.21 Where the MHRT determines that a person is presently unfit but will become fit within 12 months, the legislation is designed to postpone proceedings for up to one year. This period of time is allocated to give the unfit person the best chance to recover and plead in an ordinary criminal trial; it also ensures that a special hearing does not occur prematurely, with the result being that the defendant may potentially be subjected to an ordinary criminal trial once fit.

6.22 Adjournments that assist diagnosis or procedural fairness may be unavoidable. However, when the courts and the MHRT do not agree on a finding of unfitness, an unfit person can be held on remand in a prison or mental health facility for extended periods of time. This is illustrated by the procedures that occurred in *R v Waszczuk* [2012].[62] In this case, the Supreme Court found a defendant charged with murder unfit on initial inquiry. On review, the MHRT found the defendant fit,[63] so the defendant was sent back to court for another inquiry.[64] An adjournment was required to evaluate material recently introduced. During the adjournment, the

58. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 16.
59. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [6.9].
60. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [6.11].
61. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [6.9].
62. *R v Waszczuk* [2012] NSWSC 380.
63. On review pursuant to *Mental Health (Forensic Provisions) Act 1990* (NSW) s 45, s 46.
64. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 29.

MHRT undertook a further periodic review,[65] and again found that the defendant had become fit to be tried. The adjourned enquiry was resumed by the court when the additional material had been evaluated. The court again found that the defendant was unfit, with the consequence that the case had again to be referred to the MHRT with the possibility of repetition of the same circular process. The court urged the MHRT to take into account the expert opinions relied upon by the court so as to prevent the matter "bouncing backwards and forwards".[66] The initial court finding of unfitness occurred in March 2011. At the time of the last mentioned decision by the court, in April 2012, the issue had still not been resolved.

Issue 2: duplication

6.23 Both the court and MHRT's inquiries into fitness necessitate acquiring and considering evidence about the defendant's mental health. The court receives reports from cognitive and mental health professionals, who may also testify as to the defendant's current ability to stand trial. The objective of the court inquiry is to determine a person's fitness to stand trial.[67] Once the court has found the person unfit, the inquiry process is then repeated at the MHRT, whose key objective is to determine the extent and longevity of the unfitness. The MHRT can examine the evidence submitted to the court and may make its own inquiries.[68]

6.24 The court and the MHRT are seeking to fulfil somewhat different objectives, yet the evidence tendered is comparable in each inquiry. Duplicating the process can negatively affect participants, and appears to be an unnecessary and inefficient use of resources.[69]

Issue 3: cognitive impairment

6.25 In Report 135, we recommend that cognitive impairment be understood as an "ongoing impairment in comprehension, reason, adaptive functioning, judgement, learning or memory" that is a result of damage, dysfunction, developmental delay or deterioration of the brain. That was for the purpose of our recommendations in relation to diversion but we said that the definition could be useful in relation to other aspects of this reference. Cognitive impairment, so understood, may arise from, among other things, an intellectual disability, dementias, acquired brain injuries, drug or alcohol related brain damage, or autism spectrum disorders.[70]

6.26 The current regime may be unsuitable for unfit people who have a cognitive impairment. All people deemed by the court unfit to be tried must be transferred to the MHRT, where the processes are designed to accommodate mental conditions which may improve or fluctuate significantly over time, either spontaneously or with

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65. Pursuant to *Mental Health (Forensic Provisions) Act 1990* (NSW) s 46.
66. *R v Waszczuk* [2012] NSWSC 380 [40].
67. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences,* Consultation Paper 6 (2010) [1.36].
68. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 16, s 76A(1).
69. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) Ch 6; Mental Health Review Tribunal, *Submission MH57*, 9-10.
70. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion,* Report 135 (2012) 135-137.

treatment. In contrast, cognitive impairment generally does not change over time.[71] The MHRT submitted to this inquiry that, in cases of cognitive impairment, the "utility of being referred to the Tribunal for a determination as to whether forensic patients are likely to become fit within 12 months is questionable".[72]

Submissions and consultations

6.27 Delay and duplication featured heavily in responses to questions on fitness procedures posed in Consultation Paper 6 (CP 6).[73] Submissions from the NSW Bar Association,[74] the Law Society of NSW,[75] Legal Aid NSW[76] and the MHRT[77] drew attention to "unnecessary duplication and consequent delay"[78] between the role of the court and the role of the MHRT. Stakeholders observed that any significant delay - even if deliberate - can cause uncertainty and distress for the defendant,[79] and asserted that long periods of remand are unduly punitive.[80] The Office of the Director of Public Prosecutions (ODPP) maintained that long periods of postponement and delay were deeply unsatisfactory in many instances, and pointed to cases of child sexual assault where delay can compromise the Crown case and place an "unacceptable burden on child witnesses".[81]

6.28 Legal Aid NSW suggested that the courts closely monitor matters relevant to delay, such as time required for reporting, and supply more stringent timelines to participants.[82] The ODPP agreed that courts should set clear expectations and establish dates for key milestones in the process at the initial finding of unfitness. This included a suggestion that courts set a date for a special hearing or trial one year from the initial fitness inquiry.[83]

Summary

6.29 On the issue of fitness, the MHRT review is an unnecessary step. The current system is particularly inappropriate for people who are unlikely to become fit, including most cases of cognitive impairment, for which delay and duplication are a significant problem. Accordingly, we propose that the power to find on all issues relevant to an initial finding of unfitness be vested in the court.

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71. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [6.9].
72. Mental Health Review Tribunal, *Submission MH57,* 9.
73. 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 6.7-6.8.
74. NSW Bar Association, *Submission MH10*, 13.
75. Law Society of NSW, *Submission MH36*, 5.
76. Legal Aid NSW, *Submission MH18*, 7.
77. Mental Health Review Tribunal, *Submission MH57*, 9.
78. Mental Health Review Tribunal, *Submission MH57*, 9.
79. NSW Office of the Director of Public Prosecutions, *Submission MH5*, 5.
80. Legal Aid NSW, *Submission MH18,* 8.
81. NSW Office of the Director of Public Prosecutions, *Submission MH5*, 4.
82. Legal Aid NSW, *Submission MH18*, 7.
83. NSW Office of the Director of Public Prosecutions, *Submission MH5*, 4.

Proposed reform

6.30 In CP 6, we proposed to address these issues of duplication and delay by transferring to the court the current responsibilities of the MHRT in regards to fitness prognoses. We suggested the procedure replicated below. The proposed changes are also set out in Figure 6.2 below.

> (1) A defendant is presumed fit to be tried unless a question of fitness is raised in good faith by the defence, prosecution or the court.
>
> (2) If a question of fitness is raised, the court is to hold an inquiry. Unfitness is to be established on the balance of probabilities, but no party is to bear the onus of proving it, and fitness hearings are to be conducted in a non-adversarial way.
>
> (3) If the person is found to be fit, the trial is to continue in the ordinary way.
>
> (4) If the person is found unfit then:
>
> (a) the court may adjourn the proceedings for a specified period of time and make an order as to custody if the court considers that the person is likely to become fit during that period, and it would be in the interests of justice to delay resolution pending that possibility; or
>
> (b) the court may hold a special hearing.
>
> (c) In either case the person becomes a forensic patient.[84] The MHRT is to periodically review the person's case, including a determination as to whether or not the person has become fit to be tried.
>
> (5) If the MHRT finds that the person has become fit to be tried, the MHRT is to notify the court and the Director of Public Prosecutions of its finding. This finding would operate to restore the presumption that the person is fit to be tried. The ordinary trial process is then to continue.
>
> (6) If the person is still unfit to be tried at the end of the adjournment period, or, if on review, the MHRT finds that the person will not become fit to be tried during the adjournment period, the MHRT is to notify the court and Director of Public Prosecutions of its finding. The matter is to then return to court and the special hearing procedure is to be followed.[85]

6.31 There are two main differences between this proposed procedure and the existing procedure. First the court would decide whether the defendant is fit and is likely to become fit within a set period. Only when the court determines that the person is unfit but likely to become fit would the court refer the defendant to the MHRT for periodic review. If not likely to become fit within the maximum postponement period, the court would proceed to a special hearing. In both instances, unless released on bail, the defendant would become a forensic patient. We propose that this category of forensic patient be termed "interim forensic patient" in Chapter 7.

6.32 If an unfit person becomes fit within the set period, the presumption of fitness would be restored and the trial would recommence. The second difference is therefore that

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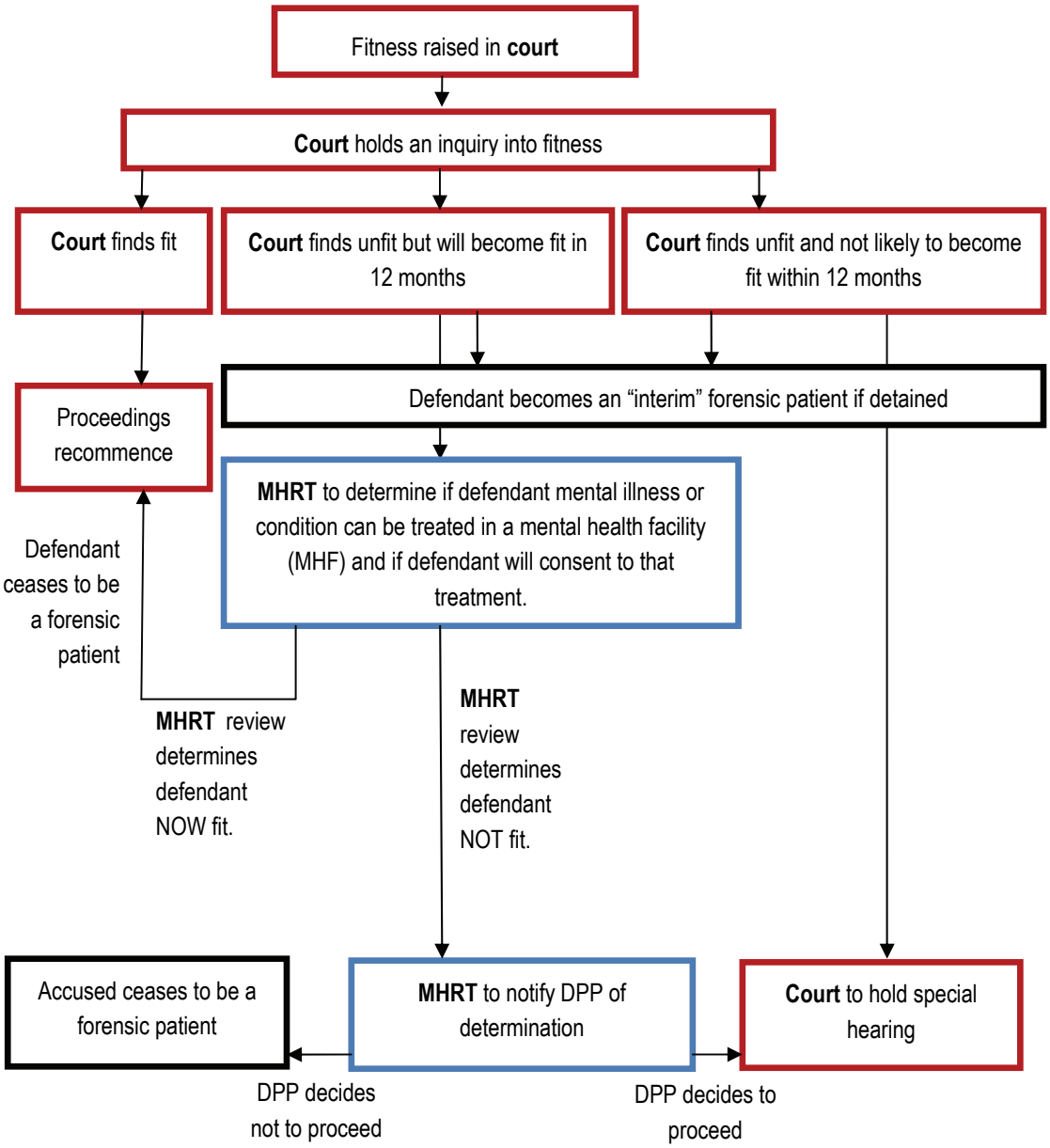
84. Unless released on bail.

85. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences,* Consultation Paper 6 (2010) [1.38].

it is the MHRT not the court that would make the determination of fitness. Removing the requirement of a further fitness inquiry should prevent a situation like *Waszczuk*[86] occurring, where the court disagrees with the MHRT determination of fitness. If, however, a defendant who has been adjudged to be fit by the MHRT relapses before trial, there is nothing to prevent the court, defence or prosecution raising fitness again.

Figure 6.2: Proposed regime for procedures following a finding of unfitness



86. *R v Waszczuk* [2012] NSWSC 380. This case is outlined above in para 6.22.

Submissions and consultations

6.33 The restructure of the legislative regime, proposed to streamline the process and prevent unnecessary duplication and delay, received unanimous stakeholder support.[87] Seven organisations including the ODPP, NSW Bar Association and the Law Society of NSW agreed that the court should make all initial findings relevant to fitness.[88] Significantly, the MHRT supported the proposed changes, and submitted that, in their opinion, the court can be equipped to receive sufficient evidence to ascertain all elements of fitness.[89] The MHRT also deemed it appropriate that the MHRT oversee people found unfit but considered likely to become fit.[90]

The Commission's view

6.34 In 1996, we doubted the capacity of courts to deal with defendants with cognitive and mental health impairments, and supported review by an expert tribunal.[91] However, since that time there have been practical changes. Many inquiries are now dealt with by a judge alone.[92] Courts are now better qualified to make informed decisions in this area.[93] The benefit of the expertise of the MHRT must also be weighed against the detriments of delay, duplication and the complexity of the existing procedures for determining fitness.

6.35 The current legislative regime creates situations where proceedings in relation to unfit defendants are delayed, which can be detrimental to the defendant, victims, families and the pursuit of justice. On balance we believe that it is appropriate for the court to make an initial finding in relation to the defendant's fitness. Referring an unfit person to the MHRT for a second inquiry into their fitness is an unnecessary step. A second inquiry is particularly unnecessary and disadvantageous for people with cognitive impairments. For this group unfitness is likely to be permanent and expediting a special hearing is appropriate.

6.36 At the end of a period during which the MHRT monitors the steps taken to ensure that a defendant is fit, it is again appropriate that there be one determination of fitness, not two. While there will be a few cases where the defendant's mental state deteriorates between the MHRT review and court, there is no limitation on the occasions when unfitness may be raised.

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87. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 4*;* Legal Aid NSW, *Submission MH18*, 8; NSW Bar Association, *Submission MH10*, 16; Law Society of NSW, *Submission MH13*, 7; Mental Health Review Tribunal, *Submission MH57,* 10; NSW, Public Defenders, *Submission MH26*, 25; Public Interest Advocacy Centre, *Submission MH21*, 15.
88. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 4; Legal Aid NSW, *Submission MH18*, 8; NSW Bar Association, *Submission MH10*, 16; Law Society of NSW, *Submission MH13*, 7; Mental Health Review Tribunal, *Submission MH57,* 10; NSW, Public Defenders, *Submission MH26*, 25; Public Interest Advocacy Centre, *Submission MH21,* 15.
89. Mental Health Review Tribunal, *Submission MH57,* 9*:* The MHRT recommends an extension of the Court Liaison Service or Community Forensic Mental Health Service to provide expert non-partisan advice to the court about the person's condition, treatment needs and risk.
90. Mental Health Review Tribunal, *Submission MH57,* 10.
91. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System,* Report 80 (1996) [5.15].
92. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 11. *Mental Health (Criminal Procedure) Amendment Act 2005* (NSW): Prior to 2006, juries generally determined fitness inquiries.
93. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [6.11].

6.37 The proposed changes to the procedure draw on the expertise of the court and the MHRT, and eliminate the duplication that arises when both the court and the MHRT are each required to determine the same issues on the basis of similar evidence. They had unanimous stakeholder support. Accordingly, we recommend adoption of the proposed changes.

Recommendation 6.1

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

(1) If the court finds a person unfit to be tried and unlikely to become fit, the court may hold a special hearing.

(2) If the court finds a person unfit to be tried and likely to become fit and it would be in the interests of justice to delay resolution pending that likelihood:

(a) The court:

(i) may adjourn the proceedings for a specified period of time, not exceeding 12 months

(ii) may grant bail, remand in custody, and make any other order

(iii) must refer the person to the Mental Health Review Tribunal.

(b) Until the end of the specified period of time, the Mental Health Review Tribunal must review the person's case periodically to determine whether or not the person has become fit to be tried:

(i) If the Mental Health Review Tribunal finds that the person has become fit to be tried, the Mental Health Review Tribunal should be required to notify the court and the Director of Public Prosecutions of its finding. This finding would operate to restore the presumption that the person is fit to be tried. The ordinary trial process should then continue.

(ii) If the person is still unfit to be tried at the end of the specified period of time, or, if on review, the Mental Health Review Tribunal finds that the person will not become fit to be tried during the specified period of time, the Mental Health Review Tribunal should be required to notify the court and Director of Public Prosecutions of its finding. The matter should then return to court and the special hearing procedure should be followed.

(3) Unless released on bail, a person found unfit to be tried becomes an interim forensic patient.

Part two: Areas for reform in the special hearing process

The special hearing

6.38 Under the current legislative regime, if the MHRT determines that an unfit person will not or has not become fit within 12 months,[94] and the DPP advises that proceedings against that person are to continue, then the court conducts a special hearing.[95] Special hearings are to be as close to a normal trial as is practicable.[96] The prosecution must prove guilt beyond a reasonable doubt.[97] The defendant may raise any defence available in criminal proceedings;[98] is entitled to give evidence;[99] and is to have legal representation.[100]

6.39 However, by definition and design, "special" hearings are different to normal criminal trials, and this is reflected in the procedures of the court. A defendant in a special hearing is presumed to plead not guilty;[101] the hearing is conducted by a judge alone, unless election for a jury is made;[102] and the legislation creates particular verdicts and disposition options.[103]

Incidence

6.40 Special hearings account for less than 2% of criminal trials conducted in the Supreme Court and District Courts in NSW.[104] There were 20 special hearings in the 2011/12 financial year, eight in 2010/2011, and 18 in 2009/10. The District Court heard 19 of the 20 special hearings in 2011/12, six of the seven in the 2010/11 period and 11 of 18 in 09/10. The remainder were heard in the Supreme Court.[105]

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94. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 16, s 47(5)(b).
95. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 19.
96. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 21(1).
97. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 19(2).
98. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 21(3)(c).
99. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 21(3)(d).
100. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 21(2). Unless the court otherwise allows.
101. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 21(3)(1).
102. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 21A.
103. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22, s 23.
104. NSW Bureau of Crime Statistics and Research, *New South Wales Criminal Courts Statistics 2011* (2012) 86: 1871 people were committed to trial in the Supreme and District Courts in NSW in 2011.
105. NSW Bureau of Crime Statistics and Research (ref: mai12/1100hc). Information supplied on 5 April 2013 has not been incorporated into this chapter due to time constraints: NSW Bureau of Crime Statistics and Research (ref: mai13/11186hc).

Table 6.2: Number of special hearings by jurisdiction

Financial year	Supreme Court	District Court	Total
2008/2009	2	9	11
2009/2010	7	11	18
2010/2011	1	7	8
2011/2012	1	19	20
TOTAL	11	46	57

Source: NSW Bureau of Crime Statistics and Research (ref: mai12/11000hc)

Objects

6.41 The special hearing was developed because an unfit person had no trial or opportunity for acquittal. Instead, defendants who were found unfit to stand trial were detained indefinitely at the Governor's pleasure. Detention was imposed without consideration as to whether an unfit person had committed the acts that constitute the offence charged.[106] This unsatisfactory situation was addressed by a 1974 NSW Health Commission report (the Edwards Report) that recommended a special hearing for unfit defendants and observed (in the language of that era):

> in the case of the mentally well, we do not assume guilt. We assume innocence and allow the accused a reasonable chance for it to be demonstrated that the charges brought against him are without foundation. But in the case of the mentally defective, we in effect assume guilt.[107]

6.42 The legislature responded to the Edwards Report with the *Crimes (Mental Disorder) Amendment Bill 1983* (NSW), which introduced the special hearing into law.[108] The then Minister for Health noted that the bill would give effect to a "scheme whereby mentally handicapped people ... have a proper opportunity, when charged with criminal offences, for their presumed innocence to be demonstrated".[109] This objective is now enshrined in s 19(2) of the MHFPA which states:

> A special hearing is a hearing for the purpose of ensuring, despite the unfitness of the person to be tried in accordance with the normal procedures, that the person is acquitted unless it can be proved to the requisite criminal standard of proof that, on the limited evidence available, the person committed the offence charged or any other offence available as an alternative to the offence charged.

106. *Mental Health Act 1958* (NSW) s 24; NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences,* Consultation Paper 6 (2010) [2.9].

107. NSW Health Commission Mental Health Act Review Committee*, Report* (1974) 77-78 (Edwards Report).

108. The special hearing put forward by the Edwards Report proposed that special hearings exclude the insanity defence. This suggestion was not adopted by the legislation. See the Edwards Report 77-85 proposed s 23A(10)(c).

109. New South Wales, *Parliamentary Debates*, Legislative Assembly, 22 November 1983, 3090 (L Brereton).

6.43 Accordingly, the primary objective of a special hearing is to create a forum whereby an unfit defendant may receive the benefit of the presumption of innocence and a fair trial, to the extent that this possible in the circumstances.[110]

Verdicts available

6.44 At the conclusion of a special hearing, a judge (or jury) can find:

- that the defendant is not guilty of the offence charged
- that the defendant is not guilty on grounds of mental illness (NGMI)
- that, on the limited evidence available, the defendant committed the offence charged (UNA), or
- that, on the limited evidence available, the defendant committed an available alternative offence.[111]

6.45 Where the defendant is found not guilty, the person is dealt with as if found not guilty at a normal trial and is discharged.[112] Where the finding is NGMI, the subsequent process is the same as a normal criminal trial with the same verdict.[113] A finding that "on the limited evidence available, the defendant person committed the offence charged"[114] or an available alternative offence[115] constitutes a finding of "qualified guilt".[116] A conviction cannot be recorded against the finding[117] yet it constitutes a bar to further prosecution,[118] is subject to appeal[119] and is to be taken as a conviction for the purpose of victim compensation.[120]

6.46 When the court finds that, on the limited evidence available, the defendant committed the offence or an available alternative offence, and the court, in a normal criminal trial, would have imposed a custodial sentence, the court can nominate a limiting term.[121] The limiting term is the maximum period for which the person can be a forensic patient and is based on the court's best estimate of the sentence the court would have imposed if the person had been found guilty of the offence at an ordinary trial.[122] A defendant in relation to whom a limiting term is determined

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110. See *Subramaniam v The Queen* [2004] HCA 51; 79 ALJR 116 [40] (Gleeson CJ, McHugh, Kirby, Hayne and Callinan JJ).
111. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22.
112. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 26.
113. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22(2), s 38, s 39(1), s 39(2): The defendant remains or becomes a forensic patient and is generally detained in such "manner as the Court thinks fit until released by due process of law". For an examination of the defence of mental illness see Chapter 3.
114. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22(1)(c).
115. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22(1)(d).
116. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22(3)(a).
117. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22(3)(a).
118. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22(3)(b), subject to s 28.
119. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22(3)(c).
120. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22(3)(d).
121. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 23.
122. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 23(1)(b). For an examination of limiting terms see Chapter 7.

becomes or remains a forensic patient and is referred to the MHRT to make determinations, on periodic review, concerning care, treatment and possible release.[123]

Submissions and consultations

6.47 In CP 6, we asked whether the special hearing process should continue in its present form. We proposed alternative models including the option for the court to acquit at an early stage in the proceedings if not satisfied that the prosecution had established a prima facie case, and a system of deferring the determination of fitness.[124]

6.48 Stakeholder submissions demonstrated unanimous in principle support for maintaining special hearings.[125] The NSW Bar Association viewed the special hearing as an important process because it gives the defendant an opportunity for acquittal, and provides victims and other participants with "some measure of finality".[126]

6.49 There was little support for the alternative models that were put forward for consideration. They were viewed as lacking in procedural fairness.[127] Legal Aid NSW[128] and the Law Society of NSW agreed that it was "essential that a finding of unfitness not operate to deny an accused the opportunity to be acquitted".[129] The Law Society of NSW considered that the alternative model to acquit in the absence of a prima facie case may be appropriate in summary matters,[130] but Legal Aid NSW believed that limiting the inquiry to a prima facie case would lower the standard of proof and restrict the opportunity for the accused to be acquitted.[131]

The Commission's view

6.50 Special hearings provide a forum whereby an unfit defendant is given an opportunity for acquittal, which is a fundamental requirement of the criminal justice system. Stakeholders were opposed to any significant change of direction in this area. We do not propose any substantial changes to the existing model for special hearings. However we have examined areas for improvement or clarification within the existing model.

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123. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 24, s 27, s 46, s 47. See Chapter 9.
124. 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 6.13-6.15.
125. NSW Bar Association, *Submission MH10,* 16; NSW Office of the Director of Public Prosecutions, *Submission MH5*, 5; Law Society of NSW, *Submission M13*, 7; Legal Aid NSW, *Submission MH18*, 8; NSW, Public Defenders, *Submission MH26*, 25.
126. NSW Bar Association, *Submission MH10*, 16.
127. NSW Bar Association, *Submission MH10*, 16.
128. Legal Aid NSW, *Submission MH18*, 8.
129. Law Society of NSW, *Submission M13*, 7.
130. Law Society of NSW, *Submission M13*, 7.
131. Legal Aid NSW, *Submission MH18*, 8.

Issues arising

6.51 In CP 6, we asked stakeholders to comment on two areas in relation to the special hearing process. First, we considered the conduct of special hearings and asked stakeholders if there should be greater flexibility in the way special hearings are conducted and if there should be a requirement for the defendant to be present. We also requested feedback on the verdicts available at a special hearing, and asked if those verdicts need to be reformulated to represent the process more accurately. Consultations and submissions revealed further procedural issues of concern to stakeholders.

6.52 Below we discuss four issues:

(1) non-appearance by a defendant

(2) verdicts after a special hearing

(3) procedural modifications and the need for support people in special hearings, and

(4) the role of legal practitioners who represent unfit clients.

Issue 1: non appearance by a defendant

6.53 In CP 6 we asked stakeholders to consider what procedural flexibility is appropriate in special hearings, and in particular we asked stakeholders to consider whether non-appearance by the defendant is acceptable. That is, should the ordinary rule that a defendant must be present at a criminal trial be relaxed by giving the court power to excuse the defendant from attendance?

6.54 There was little agreement among stakeholders as to whether the defendant should be permitted to be absent from the special hearing.[132] It was argued that a defendant's presence in a normal criminal trial assists the defendant to remain informed and to testify, where appropriate. If guilty, attendance at the trial may also give the defendant an opportunity to fully comprehend the nature and consequences of the unlawful act.[133]

6.55 However, these reasons have less force in a special hearing in those cases where the defendant's comprehension of events is limited. Attendance may have little benefit for some unfit defendants and may exacerbate their condition. Some unfit defendants may not be able to use the proceedings to comprehend the nature and consequences of their act.[134]

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132. Yes to the court permitting the defendant to be absent: NSW Bar Association, *Submission MH10,* 17; Law Society of NSW, *Submission M13*, 7. No to the court permitting the defendant to be absent: Homicide Victims' Support Group, *Submission MH20,* 10*;* NSW, Public Defenders, *Submission MH26*, 26.

133. Homicide Victims' Support Group, *Submission MH20,* 10*;* NSW, Public Defenders, *Submission MH26*, 26.

134. It was noted in consultation that there is a "pointlessness" in recognising the harm that has been done through a guilty verdict because the defendant does not understand the verdict: Victims of crime roundtable, *Consultation MH15*. Cf NSW Office of the Director of Public Prosecutions,

6.56 However the presence of the defendant can be important for people affected by the unlawful act. The Homicide Victims' Support Group (HVSG) stated that, from a victim's perspective, non-appearance by the defendant leaves the defendant free of "being forced to properly respond to the allegations with which they are charged". Non-appearance then renders the proceeding "meaningless" and justice would not be, or be seen to be, done.[135]

6.57 The Public Defenders asserted that appearance by the defendant increases the prospect that he or she may be able to participate in their defence. Attendance via audio-visual link was not a real substitute for "immediate physical consultation by counsel".[136]

6.58 Non-appearance by an unfit defendant was supported by some stakeholders where the defendant unduly disrupts the court or where appearance generates extreme anxiety or agitates the defendant's condition.[137] The NSW Bar Association submitted that the power to permit non-appearance needs to be "clearly defined" and used only when absolutely necessary where the defendant's condition is "utterly disruptive" or causes "undue distress to the defendant".[138] The ODPP added that non-appearance be permitted where it "can be demonstrated that the defendant's health will deteriorate under the stress of trial".[139]

The Commission's view

6.59 Appearance by the defendant in court for a special hearing may assist in the defendant's making a proper defence, to the best of his or her ability, facilitate the defendant's interaction with counsel, benefit victims and their families, and in appropriate cases, improve the defendant's ability to comprehend the nature of consequences of the unlawful act. It is important, for these reasons, that the defendant appears in court wherever this is possible. We therefore agree with submissions that non-appearance should only occur in exceptional circumstances.

6.60 However, there will be some cases where the benefits of the defendant's attendance at trial are not able to be realised, and there are strong countervailing reasons in favour of non-attendance. For example, if the defendant is unable to understand or participate in the trial and attendance is demonstrably producing deterioration in the defendant's health, or where the defendant is unable to control his or her behaviour so that he or she persistently disrupt proceedings, it may be desirable to permit non-attendance of the defendant or exclude the defendant from the special hearing.

Submission MH5; NSW, Public Defenders, *Submission MH26*, 26, where it was suggested attendance was necessary to encourage defendants to take responsibility for their conduct.

135. Homicide Victims' Support Group, *Submission MH20*, 10; NSW Bar Association, *Submission MH10,* 16.
136. NSW, Public Defenders, *Submission MH26*, 27.
137. NSW Bar Association, *Submission MH10,* 17; NSW Office of the Director of Public Prosecutions, *Submission MH5*, 5.
138. NSW Bar Association, *Submission MH10*, 17.
139. NSW Office of the Director of Public Prosecutions, *Submission MH5*, 5.

6.61 The decision about non-appearance or exclusion is one that involves weighing in the balance the issues discussed above, and it is therefore appropriate that the court be given a broad discretion to allow non-appearance, or even to exclude the defendant where appropriate. We anticipate that this discretion will be exercised rarely. In most cases there will be other measures that can be taken to ameliorate the effects of the hearing.

Recommendation 6.2

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that the court may permit the non-appearance of the defendant at a special hearing, or exclude the defendant from a special hearing.

Issue 2: verdicts

6.62 In CP 6 we asked if the finding that:

> on the limited evidence available, the *accused person committed the offence* charged (or an available alternative)

should be revised to read:

> on the limited evidence available, the accused person *was unfit to be tried and was not acquitted* of the offence charged (or an available offence) [140]

6.63 Some stakeholders agreed that the proposed terminology did accurately reflect the nature of the proceedings and findings,[141] but expressed concern that removal of the term "committed the offence" could diminish the seriousness of the unlawful act.[142] The current formulation recognises (albeit with qualifications) that the defendant did commit the unlawful act, which has three distinct advantages for stakeholders. First, recognition that the act was committed is seen by some to provide a nexus between the finding and the authority to order detention.[143] Secondly, removal of this aspect of the verdict could mean that some defendants are less likely to understand the significance of what they did and why they are under treatment and/or incarcerated.[144] For victims, the verdict in its current form is reported to give some sense of closure, and explicitly preserves access to victim's compensation.[145]

6.64 In CP 6 we also discussed the verdict of NGMI at special hearings. We asked, as defendants may be unable to actively participate in their defence and tender

140. 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 6.18.

141. Legal Aid NSW, *Submission MH18*, 9; NSW Office of the Director of Public Prosecutions, *Submission MH5*, 6; Law Society of NSW, *Submission M13*, 8.

142. NSW Bar Association, *Submission MH10,* 17; NSW, Public Defenders, *Submission MH26*, 27.

143. NSW, Public Defenders, *Submission MH26*, 27.

144. NSW Office of the Director of Public Prosecutions, *Submission MH5*, 6.

145. NSW Bar Association, *Submission MH10,* 17. But see Homicide Victims' Support Group, *Submission MH20*, 10-12: The Homicide Victims' Support Group asserts that NGMI and the qualified finding of guilt fail to "recognise the severity of the offence committed by the defendant".

evidence concerning their state of mind at the time of the offence, whether a verdict of NGMI after a special hearing may be particularly unsafe.[146] The Law Society of NSW agreed and considered that the verdict should be excluded at special hearings.[147] The NSW Bar Association suggested the introduction of a legislative mechanism whereby people found NGMI at a special hearing and who subsequently become fit can be afforded a normal trial if they showed that they were prevented from raising a genuine issue at the special hearing due to their unfitness.[148] The ODPP asserted that excluding the verdict would contradict the requirement that special hearings be as close to a normal trial as possible, and that exclusion could disadvantage unfit defendants.[149] Legal Aid NSW observed that a verdict of NGMI is necessary as it represents a finding that the defendant is not criminally responsible for his or her conduct, which is distinct from any other verdict available in special hearings.[150]

The Commission's view

6.65 We support retention of the current verdict. A finding that, on the limited evidence available, the defendant person committed the offence charged is a clear and accurate description of what happens as a result of a special hearing. The arguments in favour of change are not strong, nor was there consistent stakeholder support for change.

6.66 We also recommend retention of the defence of NGMI as an available verdict in appropriate cases. It is consistent with the requirement that a special hearing be run as close as possible to a normal criminal trial and that unfit defendants are able to access the same defences as an accused in a normal criminal trial. We can see no reason why, if there is evidence before the court that the defendant's mental state at the time of the offence was such that the defendant is entitled to the defence of NGMI, it should not be available to the defendant. It is a matter of logic that there are likely to be numerous cases where the defendant is unfit to be tried because of the same cognitive or mental health impairment that also entitles that person to the verdict of NGMI.

Issue 3: modifying court proceedings

6.67 Special hearings are held in a court room according to the traditions and procedures of normal criminal trials and these are likely to present particular challenges for unfit defendants. Stakeholders strongly supported adapting special hearings so as to take into account the needs and limitations of the defendant throughout the course of proceedings.[151]

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146. 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 6.19.
147. Law Society of NSW, *Submission MH13*, 8.
148. NSW Bar Association, *Submission MH10,* 17.
149. NSW Office of the Director of Public Prosecutions, *Submission MH5*, 7.
150. Legal Aid NSW, *Submission MH18*, 9.
151. Homicide Victims' Support Group, *Submission MH20*, 9; Legal Aid NSW, *Submission MH18*, 9; NSW Office of the Director of Public Prosecutions, *Submission MH5*, 5; Department of Human

6.68 Special hearings are necessarily imperfect. Trying an unfit person who may not be able to communicate properly or understand proceedings means that the proceedings must be flexible, and some compromises of standard criminal procedure may need to be made.[152] Special hearings must also take into account the seriousness of the offence, and there is a competing need to acknowledge the gravity of the situation and maintain judicial integrity by following prescribed court processes.[153] We note that there have been calls for limits on the level of informality permitted at special hearings. In *R v Zvonaric* Chief Justice Spigelman noted that:

> The very exigencies that give rise to the need for a special hearing are such as to indicate a greater than usual need to observe the formalities of court process. The very difficulty of obtaining proper instructions, with the consequent dependence by the court on the performance of the professional obligations by a legal practitioner, emphasises the desirability of following formal procedures.[154]

6.69 In Chapter 2, on fitness, we discuss steps that the court can take to support effective participation by the defendant which can then be taken into account when making a decision as to whether or not the defendant is unfit. For example, the court can take regular breaks, conduct proceedings slowly, and adopt plain English to explain proceedings and directions. These recommendations are put forward in regards to modifying the trial process so that a person otherwise unfit may undergo a normal criminal trial. However, similar modifications could occur in special hearings.

6.70 In its submission, the ODPP observed that the spectrum of fitness issues that may affect a person are sufficiently diverse that special hearings need to be flexible to accommodate a slightly different approach at each hearing.[155] The ODPP submitted that legislation should be suitably flexible to allow the case to be conducted so as to "most fairly present the evidence and to accommodate the needs of the accused".[156] The Public Defenders suggested that the need for freedom of mobility and unobstructed client/lawyer dialogue necessitates a presumption that the defendant should not be placed in the dock unless they pose a serious security risk.[157] Legal Aid NSW suggested that the courts could, where necessary, provide for a more informal procedure, such as holding the hearing in a place other than a court room and/or allowing the defendant to be accompanied by a support person.[158] The NSW

Services NSW (Juvenile Justice), *Submission MH28-2*, 12; NSW, Public Defenders, *Submission MH26*, 26; NSW Bar Association, *Submission MH10*, 16.

152. D Howard and B Westmore, *Crime and Mental Health Law in New South Wales* (LexisNexis Butterworths, 2nd ed, 2010) [5.64].

153. *R v Smith* [1999] NSWCCA 126 [46]: James J observed that special hearings produce a "fundamental contradiction".

154. *R v Zvonaric* [2001] NSWCCA 505 [19].

155. NSW Office of the Director of Public Prosecutions, *Submission MH5*, 5.

156. NSW Office of the Director of Public Prosecutions, *Submission MH5*, 5.

157. NSW, Public Defenders, *Submission MH26,* 26; *Criminal Procedure Act 1986* (NSW) s 34. Legislation prescribes that placement of the defendant in a normal criminal trial is at the judge's discretion: the judge may order an defendant person remain in the dock, or permit the defendant to remain on the floor of the court. For a discussion on docks in the courtroom see: D Tait, "Glass Cages in the Dock? Presenting the Defendant to the Jury" (2011) 86 *Chicago-Kent Law Review* 467.

158. Legal Aid NSW, *Submission MH18*, 9.

Bar Association agreed that procedures ought to be sufficiently flexible to accommodate the needs of an unfit defendant, but cautioned that proceedings should "not be so informal as to diminish the significance of proceedings from the point of view of the community and victim/s".[159]

Issue 4: support people

6.71 Legal Aid NSW,[160] the Public Defenders[161] and Juvenile Justice[162] suggested that it is desirable to provide a support person to assist the defendant to understand the process and make decisions. This engenders two areas of inquiry. The first is whether the relevant legal framework exists for such a role, and whether there are appropriate services to provide this support.

6.72 A support person in a special hearing could assist the defendant to communicate with their legal representative prior, during and after the hearing; aid the defendant to understand proceedings during the trial; and generally look after the defendant's wellbeing during the proceedings. The skills that would be needed by a support person would be, first, an ability to communicate with defendants with cognitive and mental health impairments and to develop rapport with them quickly, and second, the ability to understand and to explain in plain language the events of a criminal trial.

6.73 A guardian *ad litem* (GAL) ("next friend" or "tutor") generally stands in the shoes of a party who lacks capacity in matters relevant to the Children's Court[163] and civil proceedings. Such a role involves substitute decision making and has not been well developed in relation to criminal proceedings. The NSW Trustee and Guardian/Public Guardian submitted that it would be possible for a guardian to take a different role of facilitating decision making.[164] This model is, however, yet to be developed.

6.74 Juvenile Justice recommended extending the Criminal Justice Support Network (CJSN),[165] which currently assists people with an intellectual disability to interact with NSW Police and criminal procedures within Sydney and regional NSW. The CJSN is a network of trained volunteers who assist before, during and after court. The service operates to help the person understand the proceedings and assist the person to make a decision. This is a useful and appropriate model operating in the context of the criminal justice system. However the CJSN service does not currently assist people with mental health impairments, and expanding the service to include mental health issues would require a significant increase of resources for staff and training. Regardless, given the limited number of special hearings, development of the model in this context would be less resource intensive.

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159. NSW Bar Association, *Submission MH10*, 16.
160. Legal Aid NSW, *Submission MH18*, 9.
161. NSW, Public Defenders, *Submission MH26,* 26.
162. Department of Human Services NSW (Juvenile Justice), *Submission MH28-2*, 12.
163. See *Children and Young People (Care and Protection) Act 1998* (NSW) s 100, s 101.
164. NSW Public Guardian and Trustee and Guardian, *Consultation MH20*.
165. Department of Human Services NSW (Juvenile Justice), *Submission MH28*, 12.

The Commission's view

6.75 Courts presently take steps to modify court processes to facilitate the participation of defendants with cognitive and mental health impairments. On balance however, it is desirable that this practice should be formalised and that the MHFPA should contain a provision to this effect.

6.76 We consider the potential role of a support person for defendants below, in the context of the related issue of the legal representation of defendants in special hearings.

Recommendation 6.3

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to the effect that, prior to or at a special hearing, the court must consider whether modifications to court processes can be made or assistance provided to facilitate the defendant's effective participation in the special hearing.

Issue 5: representation

6.77 In this section we consider the consequences of an unfit defendant's limited ability to participate in proceedings, and how this impacts on the quality of legal representation and the course of legal proceedings. In submissions, stakeholders identified two key issues. First, legal practitioners for unfit defendants face a legal and ethical "grey area" when their client is unable to give proper instructions. Secondly, as unfit defendants are generally unable to give evidence in their own defence, unfit defendants may be particularly disadvantaged when being tried for an offence where the defendant's testimony is pertinent.

6.78 Section 21(2) of the MHFPA states that the defendant must (unless court permits otherwise) be represented and the "fact that the person has been found unfit to be tried for an offence is to be presumed not to be an impediment to the person's representation." Many stakeholders drew attention to the practical challenges of this assumption. An unfit defendant may not be able to give adequate instructions,[166] and, in some instances, may inadvertently direct counsel to act in a way that does not operate in the defendant's best interest.[167] Stakeholders who represent lawyers observed that this creates a situation where lawyers must act either on their own accord or against the instructions of their clients, which may leave them vulnerable to appeal or civil action.[168]

6.79 Appeal courts have been reluctant to allow appeals on the basis that a lawyer acted against an unfit defendant's instructions. The case law supports the notion that legal practitioners, proceeding responsibly and professionally, can act against

166. *R v Presser* [1958] VR 45. Part of the *Presser* test for a finding of unfitness is that an accused cannot give necessary instructions to counsel regarding the defence. See Chapter 2.

167. *R v Smith* [1999] NSWCCA 126.

168. Legal Aid NSW, *Submission MH18*, 8; NSW, Public Defenders, *Submission MH26*, 6. For an examination of the issues see M Barnett et al, "Psychological and Ethical Issues in the Relationship Between Lawyers and Mentally Ill Clients" (2007) 11 *University of Western Sydney Law Review* 64.

instructions in a special hearing.[169] The courts have, however, cautioned that the discretion of the legal representative is not absolute:

> At a special hearing the capacity of the accused to make decisions and give instructions is absent or at least diminished. Accordingly ... at a special hearing the accused 's legal representative has a greater power to make decisions, without receiving instructions from his client, than would be the case in an ordinary trial ... [but the power to make decisions is not] exclusively vested in the accused's legal representative to the exclusion of the accused ... [A] court should be cautious in finding a legislative intent that an accused person has been deprived of a fundamental right which he would have had in an ordinary trial, in the absence of clear legislative provision to that effect.[170]

6.80 Specific direction for legal practitioners who represent people unable to give sound instructions is not apparent in the case law or lawyers' professional ethics and practice codes.[171] Stakeholders proposed to this inquiry that legal rules and guidelines for practitioners need to be explicit in relation to special hearings.[172] There was general agreement amongst stakeholders that legal practitioners be given a greater degree of independence when acting for an unfit defendant. The practitioner should still have a duty to consider the views of the client, but it should be stated that the legal practitioner is not bound by the client's instructions where the practitioner is acting reasonably and responsibly.[173]

6.81 As unfit defendants are generally unable accurately and coherently to give evidence in their own defence, unfit defendants are particularly disadvantaged when being tried for an offence where the likelihood of a qualified finding of guilt is increased without the defendant's testimony. A submission gave an example of an unfit defendant charged with supply of a prohibited drug who was unable to give evidence to show that she had the drugs in her possession other than for the purposes of supply. The defendant was unable to testify because of an intellectual disability that limited coherency.[174]

6.82 Commentators have observed that issues like these demonstrate that "[t]he special hearing is intrinsically flawed because the defendant is unfit to answer the charges".[175] The High Court has pointed out, however, that deficiencies from the unfit defendants' inability to instruct or give evidence are recognised by the inclusion of the "limited evidence" element of the MHFPA[176] and the qualified finding of guilt.[177]

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169. D Howard and B Westmore, *Crime and Mental Health Law in New South Wales* (LexisNexis Butterworths, 2nd ed, 2010) [5.74]; *R v Williams* [2004] NSWCCA 224; *R v Zvonaric* [2001] NSWCCA 505; 54 NSWLR 1.
170. *R v Smith* [1999] NSWCCA 126 [47]-[48].
171. See Barristers Rules 2001 (NSW); Revised Professional Conduct and Practice Rules1995 (NSW).
172. Legal Aid NSW, *Submission MH18*, 8; NSW, Public Defenders, *Submission MH26*, 6.
173. Legal Aid NSW, *Submission MH18*, 9; NSW, Public Defenders, *Submission MH26*, 7.
174. Legal Aid NSW, *Submission MH18*, 8.
175. R L Seiden and S Chandrasekaran, "Special Hearings Under the Crimes Act: A Potentially Misconceived Adventure" (2010) 84 *Australian Law Journal* 553, 563.
176. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 19(2).
177. *Subramaniam v The Queen* [2004] HCA 51; 79 ALJR 116; *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22(1)(c), s 22(1)(d), s 23.

6.83 The Public Defenders also expressed concern about the ethical obligations of practitioners at a special hearing who feel obliged to raise NGMI despite explicit instructions not to.[178] The Public Defenders suggested introducing a mechanism whereby the Public Guardian can have a role in providing or supplementing instructions.[179]

The Commission's view

6.84 The submissions to this inquiry on the issue of how defendants in special hearings are supported and represented identify a number challenges issues. The two topics are inevitably interrelated. For instance would the role of a support person in a special hearing be to give instructions to the lawyer on behalf of a defendant, or to provide information on the basis of which the legal representative should make decisions, or to assist the defendant to make their own decisions so far as possible?

6.85 The satisfactory resolution of these issues requires further attention. Consequently, we recommend that the NSW Department of Attorney General and Justice bring together key stakeholders to consider these issues further and to develop recommendations relating to the appropriate role of support people and legal representatives in special hearings.

Recommendation 6.4

The Department of Attorney General and Justice should convene a working group of key stakeholders to give consideration to:

(a) defining the appropriate role of legal representatives and support people at special hearings

(b) consequential amendments to law and professional ethics rules, and

(c) the most appropriate organisation to provide support people.

178. The courts have reviewed circumstances where the defence of NGMI has been raised against client instructions, but have not had to determine the correctness of the lawyer's actions. In *R v Williams* [2004] NSWCCA 224 and *Dezfoslii v The Queen* [2007] NSWCCA 86 the court held that as the mental illness of the accused was so apparent, even if they allowed the appeal, they would be compelled to raise *Criminal Appeal Act 1912* (NSW) s 7(4) and detain the accused in strict custody.

179. NSW, Public Defenders, *Submission MH26.*

7. Powers of the court and MHRT following a finding of UNA or NGMI

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7.1 In this chapter we examine the orders that the court can make in cases where a person is unfit and not acquitted (UNA) at the special hearing, or is found not guilty by reason of mental illness (NGMI).

The current system

7.2 The legislative provisions relating to unfitness and the defence of mental illness apply only in the District and Supreme Courts.[1]

7.3 A feature which is common to both groups – those who are UNA and those who are found NGMI – is the absence of established criminal responsibility. In the case of unfitness, that is because the person cannot be afforded a fair trial so that his or her criminal responsibility is not fairly and conclusively established. In cases where the person is found NGMI, it is because the evidence proves that the person, at the time of the offence, was not responsible in law for his or her conduct. Nevertheless, in both cases the legal system goes as far as possible in the circumstances to provide a fair trial in the case of defendants found UNA and to establish that the acts constituting the offence were committed by the defendant in the case of NGMI.

7.4 When a court orders detention of a person who is UNA or NGMI, or conditional release of a person who is NGMI, the person becomes (or continues to be) a forensic patient until such time as he or she is unconditionally released.[2] While both groups are managed largely in the same way by the Mental Health Review Tribunal (MHRT) (discussed in Chapter 9) there are significant differences in court powers in relation to these two groups.

Unfit and not acquitted

7.5 We discuss special hearings in Chapter 6. At a special hearing:

- A person may be acquitted or found NGMI, both of which have the same effect as if the finding had been made at an ordinary trial.[3]
- The court may find that, "on the limited evidence available, the accused person committed the offence charged" (referred to as UNA in this report) or an offence available as an alternative.[4]

7.6 Where a person is UNA, the court must indicate whether, if the special hearing had been a normal trial against a person fit to be tried, it would have imposed a

1. See our recommendations regarding Local Courts in Chapter 12.
2. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 42. This can occur by order of the Mental Health Review Tribunal (MHRT) in either case or on expiration of the limiting term in the case of people who are UNA and who are not released earlier by the MHRT: see para 9.171-9.172.
3. If the person is acquitted, he or she is free to go: see *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22, s 26, s 52(1)(a). If the person is found NGMI, the orders available are the same as if the finding had been made at an ordinary trial: s 22(1)(b), s 22(2).
4. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22(c)-(d).

sentence of imprisonment. This process is discussed below and illustrated in Figure 7.1.

Sentence other than imprisonment

7.7 If the court would not have imposed a sentence of imprisonment, the court "may impose any other penalty or make any other order it might have made on conviction of the person for the relevant offence in a normal trial of criminal proceedings".[5] This could be a bond, which is a form of conditional release.[6] However, the person does not then become a forensic patient.[7] In contrast, if a person is conditionally released following a verdict of NGMI, that person becomes a forensic patient.[8] We discuss this issue in para 7.27.

Sentence of imprisonment

7.8 If the court would have sentenced the person to imprisonment, it must nominate a "limiting term", being the best estimate of the sentence the court would have considered appropriate if the special hearing was a normal trial against a person who was fit to be tried and had been found guilty.[9] A forensic patient must be released unconditionally when the limiting term expires (if not released at an earlier time by order of the MHRT). The limiting term is equivalent to the *total* sentence that would have been imposed, that is, the total of the non-parole period (where applicable) and the balance of the term.[10]

7.9 When a court sets a limiting term:

(1) It must refer the person to the MHRT and may make "such order with respect to the custody of the person as the court considers appropriate".[11]

(2) The MHRT must conduct a review under s 24 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA) to determine whether the person is suffering from:

(a) a mental illness, or

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5. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 23(2).
6. NSW Bureau of Crime Statistics and Research data (ref: mai1311186hc) shows that in the financial years 2008-2012 six people have been given a sentence other than imprisonment following a finding of UNA. Four have been given a bond with supervision, one a bond without supervision and one person received no penalty.
7. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 42. Or if a person is a forensic patient during special hearing processes, that person will cease to be a forensic patient: s 52(1)(b); *Mailes v Director of Public Prosecutions* [2006] NSWSC 267.
8. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 42; para 7.14.
9. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 23(1)(b).
10. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 23(1)(b). See also *R v Mitchell* [1999] NSWCCA 120; 108 A Crim R 85 [29]-[32]; *R v Mailes* [2004] NSWCCA 394; 62 NSWLR 181 [22]-[45]. When setting a limiting term the court is to take into account that a sentence of imprisonment imposed at a normal trial of a criminal proceeding may be subject to a non-parole period (whereas a limiting term is not): *Mental Health (Forensic Provisions) Act 1990* (NSW) s 23(6)(a).
11. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 24(1). If the court orders detention, the person remains or becomes a forensic patient: s 42(a)(i).

(b) a mental condition for which treatment is available in a mental health facility and, where the person is not in a mental health facility, whether the person objects to being detained in a mental health facility.[12]

(3) The MHRT must notify the court of its determination.[13]

(4) Upon receiving the MHRT's determination, the court may make an order under s 27 of the MHFPA that the person be detained, and may specify the place of that detention, either in a mental health facility or "a place other than a mental health facility", which is usually a prison.[14]

(5) Where an order for detention is made under s 24 and s 27, the person becomes a forensic patient (where an order is made under s 27, the MHRT conducts its initial review under s 45).

7.10 The Court of Criminal Appeal has said that the court has a discretion not to make an order for detention under s 27, with the result that the person must be released unconditionally.[15] However, recent case law suggests that the court has no discretion to order release under s 24 or s 27.[16]

7.11 Table 7.1 shows the number of reviews conducted by the MHRT following the imposition of a limiting term (under s 24 and following a final court determination under s 27). Table 7.2 shows the determinations by the MHRT following a s 24 review.

Table 7.1: MHRT s 24 determinations and s 45 initial reviews

	2009/10	2010/11	2011/12
Determination following imposition of a limiting term, but prior to final disposition by the court (s 24)	7	5	13
Initial review after a s 27 order (s 45)	3	0	5

Source: Mental Health Review Tribunal, Annual Reports 2009-2012

12. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 24(2).
13. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 24(3).
14. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 27; see also *AN (No 2) v The Queen* [2006] NSWCCA 218; 66 NSWLR 523 [45]-[56]; Mental Health Review Tribunal, *Submission MH67*, 9.
15. *AN (No 2) v The Queen* [2006] NSWCCA 218; 66 NSWLR 523 [57]-[62]; see also *Mental Health (Forensic Provisions) Act 1990* (NSW) s 51(1)(a), s 54.
16. *State of NSW v TD* [2013] NSWCA 32.

Figure 7.1: Court processes following a finding of UNA

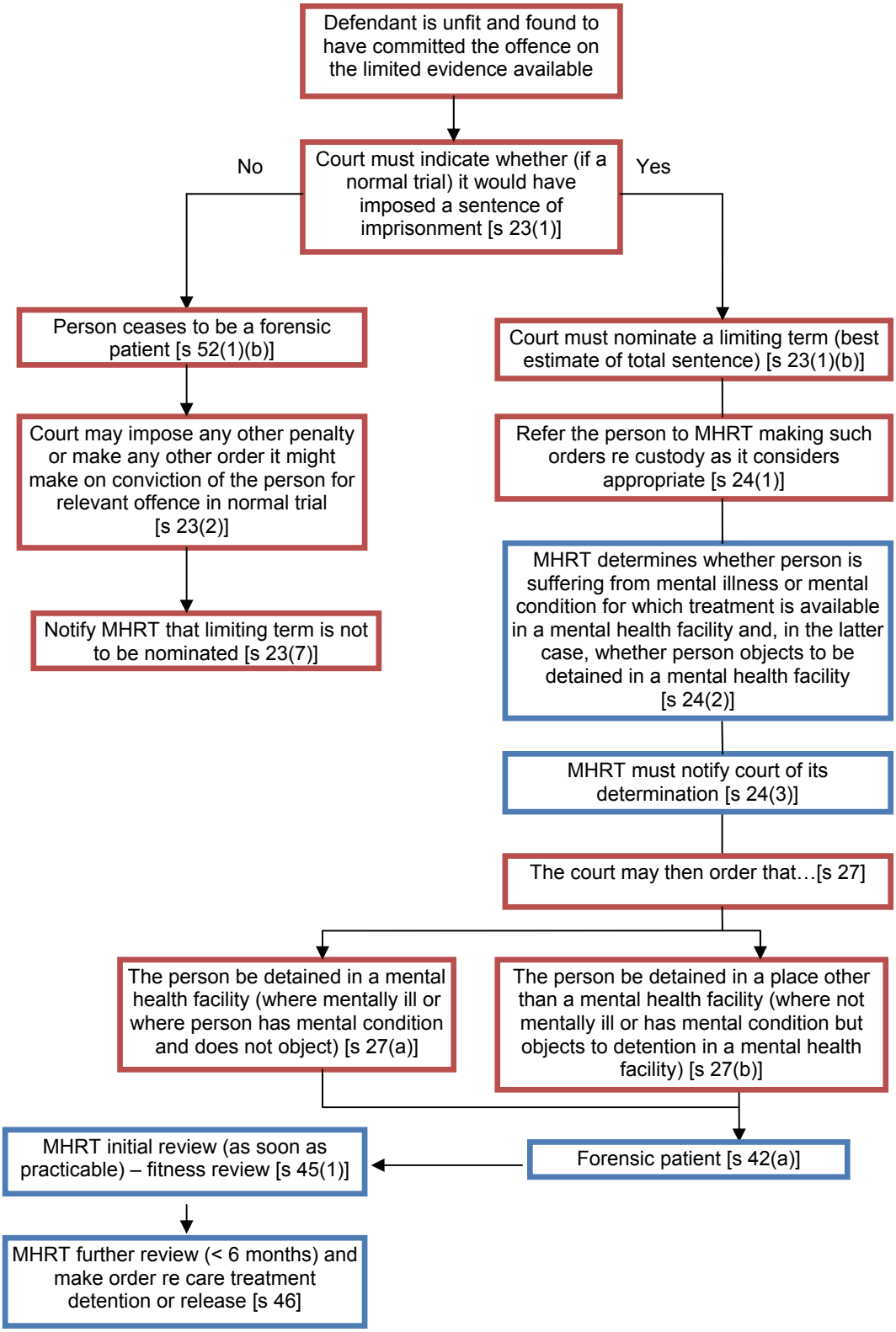


Table 7.2: Outcomes of MHRT s 24 determinations

	2009/10	2010/11	2011/12
Person is mentally ill	2	2	9
Person is suffering from mental condition and DOES object to being detained in a mental health facility	1	0	1
Person is suffering from mental condition and DOES NOT object to being detained in a mental health facility	0	1	1
Person is neither mentally ill or suffering from a mental condition	3	2	1

Source: Mental Health Review Tribunal, Annual Reports 2009-2012[17]

Not guilty by reason of mental illness

7.12 Section 39 of the MHFPA allows the court to order that the person be detained in such place and in such manner as the court thinks fit until released by due process of law or make such other order (including an order releasing the person from custody, either unconditionally or subject to conditions) as the court considers appropriate.[18] This provides for four types of order following a verdict of NGMI:

(1) detention

(2) conditional release

(3) unconditional release, and

(4) any other order the court thinks appropriate (it is unclear what this order may be).

However, since the defence of mental illness is almost always used in relation to very serious offences and in relation to people who have serious cognitive and mental health impairments, it is rarely appropriate for the court to unconditionally release a defendant or to make any other sort of order.

7.13 If the court orders unconditional release, the effect is the same as a discharge following an ordinary acquittal. Neither the court nor the MHRT retains any supervisory jurisdiction over the person.[19] Section 39 provides that the court can only order conditional or unconditional release where satisfied, on balance, that the

17. We note that the figures relating to s 24 determinations and the total of the outcomes of s 24 determinations are not equivalent. The MHRT has noted that this discrepancy may be due to an adjournment: Information supplied by the Mental Health Review Tribunal, 5 February 2013.

18. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 39(1).

19. See *Mental Health (Forensic Provisions) Act 1990* (NSW) s 51(1)(a). However, if the person is, or becomes, "mentally ill" the involuntary treatment provisions of the *Mental Health Act 2007* (NSW) may apply.

safety of the person or any member of the public will not be seriously endangered if the person is released.[20]

7.14 If the court makes an order for conditional release or an order for detention, the person becomes a "forensic patient" under the MHFPA, and is subject to the supervision of the MHRT.[21] The MHFPA does not specify the types of conditions the court may attach to an order for conditional release. Possible places of detention include a mental health facility or any "other place", however in practice the only available alternative appears to be a prison.[22]

7.15 There is very limited case law exploring the issue of factors relevant to court decisions to detain or conditionally (or unconditionally) release following a finding of NGMI. In cases where courts have ordered that the person be released, the factors that were considered included the person's diagnosis and response to and compliance with treatment before and after the offending conduct, the extent to which the person understands the need for, and is willing to accept ongoing treatment, the recommendations of treating and other psychiatrists and accommodation arrangements.[23] Similar considerations have also affected the court's decision as to the place of detention.[24]

7.16 Unlike the situation regarding people who are UNA:

- The court has no power to set a limit on the length of time for which the person is a forensic patient.[25]
- There is no requirement for the court to obtain a determination from the MHRT regarding the person's mental illness or mental condition.[26] Insofar as the court may need information about the person's mental state, or the availability of treatment in a mental health facility, the court must inform itself.

7.17 As illustrated in Figure 7.2, this process is far less complex that the court processes following a finding of UNA. Table 7.3 indicates the number of initial reviews conducted by the MHRT following a finding of NGMI.

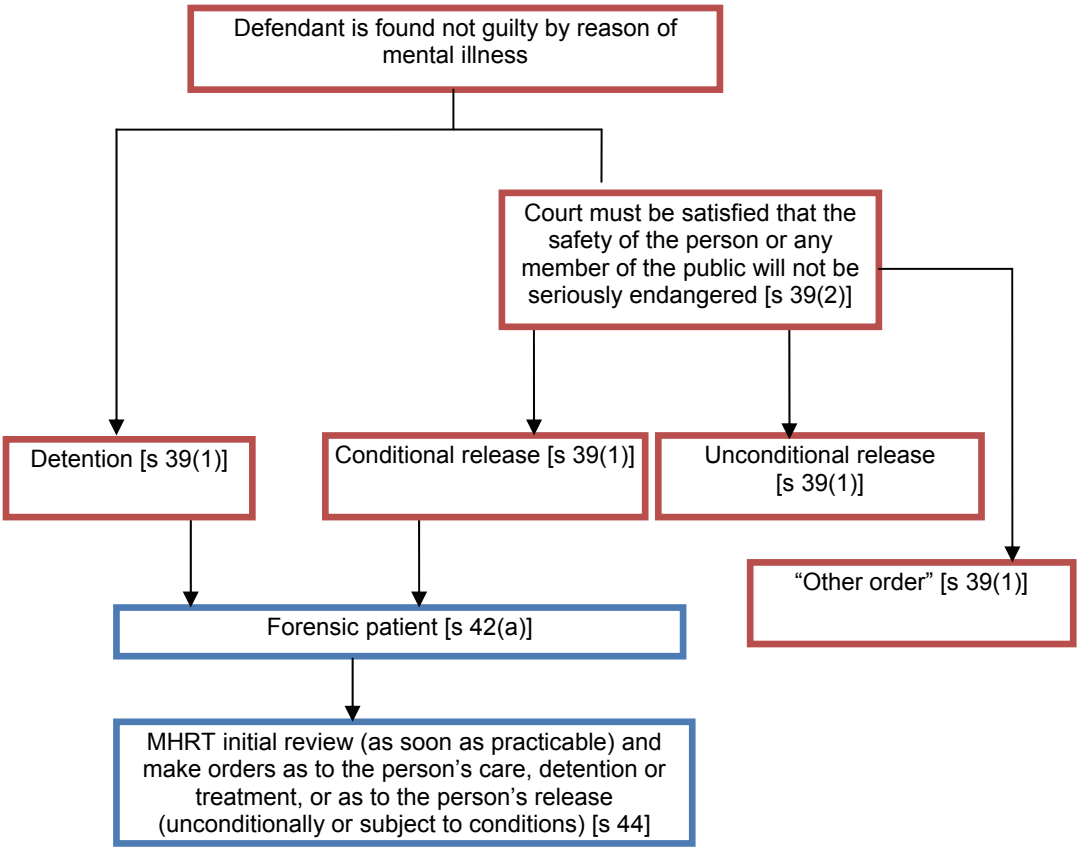
Table 7.3: Initial review of people found NGMI

	2009/10	2010/11	2011/12
Initial reviews of people found NGMI (s 44)	39	24	32

Source: Mental Health Review Tribunal, Annual Reports 2009-2012

20. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 39(2). See Chapter 8.
21. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 42(a)(i).
22. See *Mental Health (Forensic Provisions) Act 1990* (NSW) s 39(1), s 44(1), s 47(1)(a).
23. See *R v Line* [2004] NSWSC 1148 [19]; *R v Shan Shan Xu (No 2)* [2005] NSWSC 70 [71].
24. See, eg, *R v Saba* [2000] NSWSC 827 [37]-[44].
25. A person who has been found NGMI ceases to be a forensic patient if and when: (i) the MHRT makes order for the person's unconditional release; or (ii) the person is released subject to time-limited conditions, and the time specified for compliance with those conditions expires: *Mental Health (Forensic Provisions) Act 1990* (NSW) s 51(1).
26. Contrast the situation regarding people who are UNA: see *Mental Health (Forensic Provisions) Act 1990* (NSW) s 24.

Figure 7.2: Court processes following a finding of NGMI



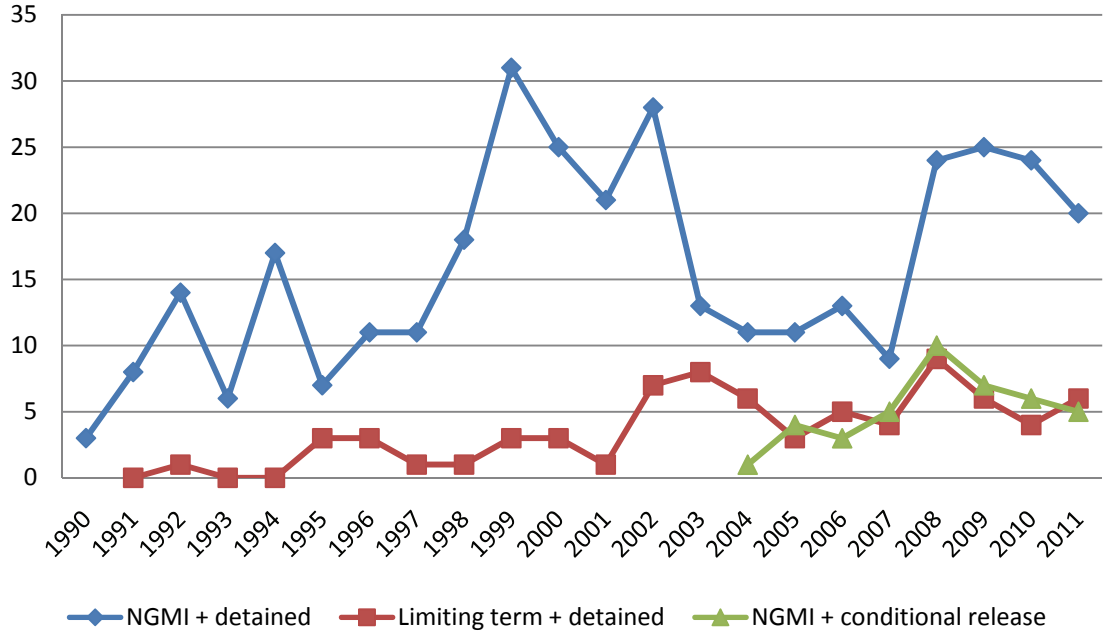
What happens to forensic patients?

7.18 Data is limited regarding the outcomes for people found UNA or NGMI, having passed through the court processes.

7.19 Figure 7.3 outlines the number of people that are detained or conditionally released following a finding of NGMI, and the number detained following a finding of UNA. (Note that the court only received the power to conditionally release people found NGMI in 2003).

7.20 At present, approximately 10% of forensic patients found UNA or NGMI are detained in correctional centres (12%, including Long Bay Prison Hospital). The significant majority of forensic patients found UNA or NGMI are detained in mental health facilities (63%) or conditionally released in the community (25%). This is illustrated in Table 7.4. A range of issues arise in relation to detention of people with cognitive impairment. These are addressed in Chapter 10.

Figure 7.3: Number of people who are detained or conditionally released by the court



Source: Mental Health Review Tribunal, Submission MH67, 11

Table 7.4: Location of forensic patients at October 2012

	NGMI	Unfit (awaiting finalisation)	Limiting term (UNA)	Total	%	Total excl unfit (awaiting finalisation)	%
Correctional Centre	18	9	15	42	11.6%	33	10.1%
Long Bay Prison Hospital	3	10	4	17	4.6%	7	2.1%
Mental Health Facility	195	13	10	218	60.1%	205	62.9%
Community	81	5	0	86	23.7%	81	24.9%
Total	297	37	29	363		326	

Source: Information supplied by the Mental Health Review Tribunal, October 2012

7.21 An analysis of forensic patients found NGMI after January 1990 and released (either unconditionally or conditionally) prior to 31 December 2010 was conducted by Heather Hayes.[27] Hayes examined client files of 346 people who received a verdict of NGMI between these dates. Of this group:

(1) 25% progressed through the forensic system and were unconditionally released.

27. H Hayes, *Not Guilty by Reason of Mental Illness: A 21 Year Retrospective Study of Released Forensic Patients in NSW* (Masters in Psychology Thesis, University of NSW, 2011).

(2) 32% were conditionally released: of these 25% remained in the community, 6% returned to detention and 1% were awaiting community placement at the date of census.

(3) 43% had not been released at the census date.[28]

7.22 Hayes was interested to discover how forensic patients were progressing through the forensic system and she therefore conducted an analysis of those who had been released; people in groups (1) and (2). She compared the length of time from apprehension until unconditional release of forensic patients with NSW Bureau of Crime Statistics and Research (BOCSAR) data of the average prison sentence imposed in relation to people convicted for the same offence in the same year.[29]

7.23 There was significant variation according to offence type. For offences such as attempted murder or sexual assault, time spent in the forensic system did not differ significantly from the average sentence length. However, for offences such as assault, armed robbery, or arson, forensic patients spent significantly more time in the forensic system than the average sentence for the same crime.[30] Forensic patients found NGMI who committed homicide offences spent "significantly shorter time" in the forensic system than the average sentence length of an offender convicted of a homicide.[31]

7.24 However, Hayes' study does not provide a reliable picture of the rate of progress through the forensic system compared with the prison system because it excludes the 43% of people in the forensic system who had not "progressed", that is, people who were still detained as forensic patients at the census date for the study. The picture is particularly unreliable for those forensic patients charged with homicide, since the great majority of those detained at the census date had committed homicide offences. Further, the BOCSAR data available to Hayes regarding length of prison sentences excluded life sentences.[32]

7.25 Boyd-Caine and Chappell also examined the forensic patient population in the 2003. Part of this study included an examination of forensic (93% of the sample) and correctional (7% of the sample) patients who committed homicide-related offences (which accounted for 51% of the forensic patient population at the time or 114 people).[33] Here, 58% of the subset was in the forensic system for less than five years, 17% for 6-10 years, and more than 11% for 11-15 years. This was examined

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28. H Hayes, *Not Guilty by Reason of Mental Illness: A 21 Year Retrospective Study of Released Forensic Patients in NSW* (Masters in Psychology Thesis, University of NSW, 2011) 20-21. Note that the data collected did not include clients who had been detained, but died during the period of the study. The corrected total figure therefore appears to be 364 forensic patients: Information supplied by H Hayes, 17 October 2012.
29. H Hayes, *Not Guilty by Reason of Mental Illness: A 21 Year Retrospective Study of Released Forensic Patients in NSW* (Masters in Psychology Thesis, University of NSW, 2011) 27-28.
30. H Hayes, *Not Guilty by Reason of Mental Illness: A 21 Year Retrospective Study of Released Forensic Patients in NSW* (Masters in Psychology Thesis, University of NSW, 2011) 28-29.
31. H Hayes, *Not Guilty by Reason of Mental Illness: A 21 Year Retrospective Study of Released Forensic Patients in NSW* (Masters in Psychology Thesis, University of NSW, 2011) 28.
32. H Hayes, *Not Guilty by Reason of Mental Illness: A 21 Year Retrospective Study of Released Forensic Patients in NSW* (Masters in Psychology Thesis, University of NSW, 2011) 28-30.
33. T Boyd-Caine and D Chappell, "The Forensic Patient Population in New South Wales" (2005) 17 *Current Issues in Criminal Justice* 5, 19-20.

against sentences for homicide-related offences. While the forensic data only represented a snapshot (rather than the total time in the system), the authors noted that:

> it is clear that some patients are spending periods under forensic orders comparable to those of sentenced offenders. However, as the forensic system is designed to allow for individual patient needs to be addressed, small numbers of patients spending long periods of time under forensic orders might simply be a reflection of the severity of their mental illness or poor responsiveness to treatment.[34]

7.26 Regarding recidivism, Hayes noted that "the low incidence of charges (19%), convictions (7%), violent convictions (3%) and imprisonment (3%) among conditionally released forensic patients in NSW is remarkable, particularly over a long follow-up period that ranged from seven months to 16.5 years". However there were instances of serious violence in the case of five forensic patients on conditional release, including an incident of homicide.[35] Hayes further noted that "outcomes for this group are considerably better" compared to sentenced offenders. She canvassed possible reasons for this, including the demographic characteristics of forensic patients and the potential success of the forensic system in achieving rehabilitative outcomes.[36]

Should court processes be made consistent?

Differences in court processes

7.27 Court powers in relation to people who are found UNA and NGMI differ in the following respects:

(1) The orders of the court: The range of orders that the court has at its disposal vary depending on whether a person is NGMI or UNA.

(2) Safety of the person and the public: The court cannot release someone found NGMI into the community unless satisfied that the safety of the person or any member of the public will not be seriously endangered by the person's release. Safety of the person and the public is not a prerequisite for release of a person found UNA (however it is taken into account insofar as community safety is one issue, among others, considered when sentencing).

(3) Determinations of the MHRT: There is a requirement to obtain a determination from the MHRT regarding the nature of a person's mental illness or mental condition after a person is found UNA and a limiting term is imposed but prior to making orders in relation to detention under s 27 of the MHFPA. There is no such requirement for people found NGMI.

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34. T Boyd-Caine and D Chappell, "The Forensic Patient Population in New South Wales" (2005) 17 *Current Issues in Criminal Justice* 5, 23.
35. H Hayes, *Not Guilty by Reason of Mental Illness: A 21 Year Retrospective Study of Released Forensic Patients in NSW* (Masters in Psychology Thesis, University of NSW, 2011) 42-43.
36. H Hayes, *Not Guilty by Reason of Mental Illness: A 21 Year Retrospective Study of Released Forensic Patients in NSW* (Masters in Psychology Thesis, University of NSW, 2011) 43.

(4) Limiting term: Unlike the situation of people who are UNA, the court has no power to set a limit on the length of time for which the conditions may apply, or for which the person may be detained as a forensic patient in relation to people found NGMI.

(5) Supervision by the MHRT: A person found UNA will not be a forensic patient following an order for conditional release by the court (a community based sentencing option) however a person found NGMI will become a forensic patient following an order for conditional release by the court.

(6) The relevance of a sentencing based approach: Sentencing principles are taken into account by the court when dealing with people who are UNA. The decision whether to order detention or some form of conditional release, and relevant limits to lengths of these dispositions, are governed by a sentencing framework. While some considerations may overlap, courts are not bound by sentencing considerations when dealing with people who are NGMI.

7.28 These differences may give rise to different outcomes, depending on whether the person is UNA or NGMI. Yet the people and cases that fall into the two categories share fundamental similarities:

(1) In neither case has criminal responsibility been established, either because the person has not had a fair trial, or has been found to be not responsible in law for his or her actions.

(2) The individual may benefit from a therapeutic response with a focus on care and treatment.

(3) The person's cognitive or mental health impairment may give rise to a need to impose restrictions on the person's liberty in order to ensure the safety of the person or the community.

(4) Generally, the same MHRT powers apply to both groups. The differences are minor and involve supplementary provisions in respect of people who are UNA and which relate to:

(i) the possibility that the person may eventually become fit, and

(ii) the practical effect of the sentencing-based limiting term.[37]

(5) The two categories overlap in practice. It is possible that a person may be both unfit to be tried and NGMI.[38] For example, a person may be mentally ill, which may mean that the person is unfit. At special hearing, their mental illness may be found to have affected their offending sufficiently for them to be found NGMI. Five people were found NGMI in special hearings during the 2011/12 financial year. Three in 2010/11, and 10 in 2009/10. This means 40% of all people who

37. The distinction may have a limited relevance to the decision by the court about what to do with a person who is UNA, to address the possibility that the person may one day become fit to be tried.

38. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22(1)(b) provides for a verdict of NGMI at a special hearing.

are dealt with by way of a special hearing have been found NGMI in the last three financial years.[39]

7.29 In most Australian and several overseas jurisdictions, the respective legislative frameworks require courts to apply the same principles and select from the same range of options irrespective of whether the person is UNA or NGMI.[40]

Should the distinction between court processes following a finding of UNA and NGMI be maintained?

7.30 In CP 6 we ask whether there is any reason to retain the distinction between the orders available to the court in cases where a person is UNA or NGMI.[41] Four stakeholders noted that there is no reason to retain the distinction.[42]

7.31 However, the NSW Bar Association submitted that there are good reasons to retain the distinction:[43]

> The differences are at the 'input' end - that is, the route by which the matters come through to court to the Tribunal. The current processes for NGMI and UNA are not simply 'labels' - it is important that the criminal justice system properly identify these as separate bases for forensic patient status; unfitness may be temporary and is a brake on further proceedings, whereas NGMI is a final verdict. Where unfitness is not temporary, the special hearing procedure still has important interests to address other than the therapeutic welfare of the accused found NGMI…

7.32 We agree that there are important distinctions between NGMI and UNA, however, these differences generally relate to:

(a) the importance of special hearing processes as a means of acquittal, and

(b) the possibility that a person found UNA may later become fit.

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39. NSW Bureau of Crime Statistics and Research (ref: mai12/11000hc revised).

40. *Crimes Act 1914* (Cth) s 20BC-20BH, s 20BJ-20BN; *Crimes Act 1900* (ACT) s 302-306, s 308, s 318-319, s 323-324, s 328-329, s 335 and *Mental Health (Treatment and Care) Act 1994* (ACT) pt 4, pt 8; *Criminal Code* (NT) s 43I(2), s 43X(2), s 43ZM, s 43ZN, pt IIA div 5; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 18(4), s 23, s 39, s 40(1), pt 5; *Mental Health Act 2000* (Qld) s 8-9, ch 7 pt 7 div 1-2; *Criminal Law Consolidation Act 1935* (SA) s 269F(B)(3), s 269G(B)(3)-(5), s 269M(B)(2), s 269N(B)(3)-(5), pt 8A div 4; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 18(2), s 21, s 24, s 29A, s 31B, s 31C, s 34-35; *Criminal Procedure (Insanity) Act 1964* (UK) c 84, s 5, sch 1A and *Mental Health Act 1983* (UK) c 20, s 37, s 41; *Criminal Code*, RSC 1985 (Can) s 672.45, s 672.47, s 672.54 (except that absolute discharge is available only in respect of people found NGMI: s 672.54(a)); 18 USC §4241, §4243, §4246 (however differences in process arise). Exceptions are WA: see *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 16(5), s 19(4) (unfit), cf s 20-22 (NGMI); and New Zealand, where the orders are the same but the provisions as to duration differ: *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 24(1), s 25, s 30-33.

41. 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 6.48.

42. Law Society of NSW, *Submission MH13*, 17; Legal Aid NSW, *Submission MH18*, 14; NSW, Public Defenders, *Submission MH26*, 41; Mental Health Review Tribunal, *Submission MH67*, 9.

43. NSW Bar Association, *Submission MH10*, 38.

7.33 As discussed in Chapter 6, we support the continuation of special hearing processes for people found unfit to stand trial. In Chapter 9, we discuss how to deal with the possibility that a person may become fit while being a forensic patient. Our question here, however, is focused on whether or not there are justifications for different approaches to court powers following a finding of UNA and NGMI. We can see very little to justify significant differences in court powers *following* a finding of UNA and NGMI. Such differences can lead to divergent and inconsistent outcomes for defendants.

The Commission's view

7.34 It is a basic principle of the criminal law that a person should not be amenable to punishment unless found guilty of an offence by due process of law. In neither the case of a person found UNA or a person found NGMI has the person been found guilty of a crime at a fair trial. On the other hand there is the countervailing consideration of risk of harm to others that arises in both cases. In fairness, people in these two classes of cases should be dealt with in the same way.

7.35 There appears to us to be no reasonable justification to maintain the existing differences in the way the MHFPA treats these two groups. Retention of distinct court powers, without reasonable justification, leads to an unnecessarily complex system which may be particularly difficult to understand for defendants, victims, and family members. It has the potential to lead to inconsistent and potentially unfair treatment of two similar groups which may be counter to the interests of the defendant and the interest of the community.

7.36 We therefore recommend that a consistent approach should be adopted following a finding of UNA and NGMI.

Recommendation 7.1

The powers available to a court following a finding of not guilty by reason of mental illness and the powers available to a court following a finding at a special hearing that a person has, on the limited evidence available, committed an offence ("a finding of unfit and not acquitted") should be consistent with each other.

7.37 In developing a consistent approach, we now turn to particular features of the system.

Time limits

The current position in NSW

7.38 Where a person is UNA and the court nominates a "limiting term", the decision to nominate a limiting term and the length of a limiting term is governed by sentencing principles.[44] The limiting term operates as the point at which a person must cease to

44. *R v Mitchell* [1999] NSWCCA 120; 108 A Crim R 85 [35]-[37]; *R v Mailes* [2003] NSWSC 707; 142 A Crim R 353 [60]-[74]; *Courtney v The Queen* [2007] NSWCCA 195; 172 A Crim R 371

be a forensic patient (however this may occur earlier; the limiting term is an upper limit). As we note below, the present limiting term approach is simply one approach to nominating a time limit.

7.39 In contrast, no time limit is applied to the duration for which a person found NGMI is subject to the forensic system.

7.40 A number of issues arise as a consequence. Below we canvass the issues that apply in relation to limiting terms for people found UNA, NGMI and broader issues in relation to consistency.

Unfit and not acquitted

7.41 Concerns arising in relation to people who are UNA and subject to a limiting term include:

- Forensic patients, a small number of whom still present a significant risk of harm to others at the end of their limiting term, must nevertheless be released. In the course of consultations we have heard of at least one case where a person has served repeated limiting terms for sexual offending.
- People may be released despite the fact that they have ongoing treatment needs. A time limit may compromise the care, treatment and safety focus of the forensic system. While there may be options available under the civil mental health system, such as involuntary detention and community treatment orders (CTOs), these will not be available to all forensic patients, in particular those who are not "mentally ill persons" under the *Mental Health Act 2007* (NSW). For this group of people the MHRT will have no scope to monitor, for example, accommodation and living conditions or participation in rehabilitative programs.
- The limiting term may create the expectation that the time frame is a sentence. A forensic patient may encounter difficulties accessing services as a result. For example, we were told that some people who are UNA and held in prison have been refused access to programs (which often prioritise "offenders" close to the end of their sentence) because they are not sufficiently close to the expiry of their limiting term.[45]
- The current approach to calculating the limiting term may lead to forensic patients being detained or subject to restrictions for longer than if they were convicted of the relevant offence at an ordinary trial (see further, para 7.63).

Not guilty by reason of mental illness

7.42 Issues arising in relation to people found NGMI (and therefore, not subject to a limiting term) include the concerns that:

- People are deterred from raising the defence because they are not prepared to accept an indeterminate outcome.

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[12]-[18]; see also *Smith v The Queen* [2007] NSWCCA 39; 169 A Crim R 265 [71], [77]-[90]; *R v Adams* [2002] NSWCCA 448. Different principles apply when the court is deciding what order to make in respect of a person who has been found NGMI: see *Mental Health (Forensic Provisions) Act 1990* (NSW) s 39.

45. For a discussion of the issues relevant to detaining forensic patients in correctional centres see Chapter 10.

- People are detained or subject to restrictions for longer than comparable convicted offenders or longer than they would have been had they been convicted and sentenced (though, as we note above, limited data is available).
- Indeterminate orders may affect a forensic patient's self esteem and response to treatment.
- The system is inconsistent with that which applies to people found UNA.

Inconsistent treatment of UNA and NGMI

7.43 Two starkly different approaches to time limits apply to people found UNA and NGMI. Adopting a consistent approach would raise the possibility of imposing a time limit on the detention of people who are NGMI, as well as the alternative possibility of abolishing the time limit applicable to people who are UNA.

7.44 Most other Australian jurisdictions place some form of time limit on the period for which forensic patients may be detained or subject to conditional release. Generally, those time limits apply both to people who are UNA and to those found NGMI. For example, the Commonwealth, the ACT, the NT, SA and Victoria all require the court to set a "limiting term" or "nominal term" for the detention and supervision of forensic patients.[46] There is no provision for any time limit on the detention or supervision of a forensic patient in WA, Queensland, Tasmania, the UK or Canada.[47] In NZ and the USA statutory time limits apply to the detention or supervision of people who are UNA but not to people found NGMI.[48]

Should there be a time limit?

7.45 Arguments in favour of a time limit:

(1) The absence of a time limit may mean that a person who is UNA or NGMI is detained or subjected to restrictions for longer than if he or she were convicted of the relevant offence at an ordinary trial.[49]

(2) Indeterminate orders deter people with cognitive and mental health impairments from relying on the defence of mental illness or raising fitness issues, even though this option is open to them, may be the most appropriate course of action, and may be in the interests of community safety.[50]

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46. *Crimes Act 1914* (Cth) s 20BC(2), s 20BJ(1); *Crimes Act 1900* (ACT) s 301, s 302; *Criminal Code* (NT) s 43ZG; *Criminal Law Consolidation Act 1935* (SA) s 269O(2); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 28(1).
47. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 38(1); *Mental Health Act 2000* (Qld) s 203, s 206, s 207; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 18, s 24; *Mental Health Act 1983* (UK) c 20, s 40(1)(b), s 69-75; *Criminal Code*, RSC 1985 (Can) s 672.81, see also s 672.851.
48. *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 30, cf s 33; 18 USC §4241(d)(1), cf §4243(f).
49. NSW Health Commission Mental Health Act Review Committee, *Report* (1974) 89-91; NSW, *Parliamentary Debates*, Legislative Assembly, 24 November 1982, 3005-6 (L Brereton); NSW, *Parliamentary Debates*, Legislative Assembly, 22 November 1983, 3090, 3111 (L Brereton).
50. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [5.31]; NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice*

(3) Indeterminate orders may affect a forensic patient's self esteem, confidence and hope for the future.[51]

7.46 Arguments against imposing a time limit:

(1) Time-limited orders lead to the result in some cases that the person must be released, unconditionally, at the end of the time limit in circumstances where he or she is at risk of causing harm to the public. However, many cases may be appropriate for management within the civil mental health system or through the guardianship system; this is discussed in Chapter 11.

(2) The forensic system has quite different objectives to sentencing, it focuses on treatment and safety, has support arrangements, and a person can be released at any point provided he or she no longer presents a risk of harm to the public (taking into account individual patient needs and other factors such as diagnosis, responsiveness to treatment and rehabilitation). Release should be determined by these factors, not a time limit set at the point the person enters the forensic system.

(3) The length of the time limit is set at the time of disposition, when the progress of the defendant's treatment and rehabilitation is hard to predict.

(4) The imposition of a time limit, which is generally set by reference to a hypothetical sentence, may create the expectation that the time limit is a sentence.

Submissions and consultations

7.47 In CP 6 we asked whether a time limit should apply to the length of time for which people who are UNA and/or people who are NGMI are subject to the forensic system.[52] Submissions were divided and reflected the diversity of arguments in favour and against imposition of time limits outlined above.

7.48 Legal Aid NSW, the Law Society of NSW and the Homicide Victims' Support Group (HVSG) submitted that a time limit should apply.[53] Both Legal Aid NSW and the Law Society of NSW noted that concerns about safety can be managed by transferring people to the civil mental health system or other arrangements at the end of the term.[54] Legal Aid NSW raised concerns that indeterminate orders:

System, Report 80 (1996) [6.29]; Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness*, Report of the National Inquiry into the Human Rights of People with Mental Illness (1993) 801-2.

51. In para 3.124 we discuss the issue that defendants are reluctant to raise NGMI due to the indeterminacy of the outcome.

52. 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 6.101.

53. Legal Aid NSW, *Submission MH18*, 22-23; Law Society of NSW, *Submission MH13*, 28; Homicide Victims' Support Group, *Submission MH20*, 17-18.

54. Legal Aid NSW, *Submission MH18*, 23; Law Society of NSW, *Submission MH13*, 28.

- mean that people are "left to languish" in the forensic system for longer than they would have otherwise been detained in the correctional system if tried and convicted under traditional criminal justice processes
- may "entrench a negative perception about a forensic patient's criminality"
- may affect a forensic patients' self esteem and confidence, which may negatively influence therapeutic outcomes
- may deter people from utilising NGMI or UNA, and
- mean that people are subject to greater restrictions than would have otherwise been imposed as part of the civil mental health system for an indeterminate period of time.[55]

7.49 The NSW Consumer Advisory Group (NSWCAG) noted that, broadly, it did not support the introduction of a time limit on the length of time a person can be held in the forensic system. NSWCAG noted that the system should maintain a health focus and should take into account individual patient needs and other factors such as diagnosis, and responsiveness to treatment and rehabilitation. It further noted that many forensic patients indicated that "they would not want to be released from the forensic system if it was believed that they were still of harm to themselves or others".[56]

7.50 However, the NSWCAG pointed to systemic issues that they believed caused inequality:

- Problems with the length of detention, which did not seem to be based on wellness. It is important that a forensic patients progress through the system and move towards release.
- Forensic patients being held in environments that are "far more restrictive than necessary due to having no alternative place to go" (due to "bed blockages" and staff shortages) and such environments affect leave privileges because of the very gradual and incremental approach to reducing restrictions. This issue was also raised in the course of consultations and has been raised by the MHRT in their Annual Report.[57]

Forensic patients are concerned that these issues, in combination with the indefinite nature of their detention, contribute to their slow movement through the system and prolong the period before they return to the community.[58]

7.51 The NSWCAG noted that step up and step down processes need to be enhanced to provide forensic patients with transparent avenues to progress through the system, which would also assist in developing goals and support a recovery focused system.[59] That is, forensic patients need guidance and resources to access and understand pathways to unconditional release. NSWCAG has therefore submitted

55. Legal Aid NSW, *Submission MH18*, 22.
56. NSW Consumer Advisory Group, *Submission MH11*, 40.
57. NSW Consumer Advisory Group, *Submission MH11*, 41; Mental Health Review Tribunal, *Annual Report 2011-12*, 2.
58. NSW Consumer Advisory Group, *Submission MH11*, 41.
59. NSW Consumer Advisory Group, *Submission MH11*, 41.

that an independent body should review forensic patients that have been detained for a lengthy period of time to ascertain why treatment has not been effective.[60]

7.52 Similar issues have been raised by the former President and former Forensic Team Leader of the MHRT, who noted that:

> We do not contend that indefinite detention itself is the flaw in the forensic system decision-making process in NSW. On the contrary … the purpose of indefinite detention is to be able to respond to the individual needs of each patient on a forensic order. Definite orders would not necessarily be capable of responding to the complexities of diagnoses, responsiveness to treatment, and access to leave privileges that are critical to the care, treatment and rehabilitation of forensic patients.[61]

However, they went on to caution that systems of indefinite detention are particularly susceptible to facilitating preventive detention and can lead to prioritisation of preventative aims over therapeutic or rehabilitative aims.[62]

7.53 The MHRT submitted that practical difficulties can arise where a person has, for example, an intellectual disability or personality disorder, but no mental illness. Where a time limit is imposed and approaching expiry, the person may still pose a serious risk to the community, but cannot be detained under the MHA.[63] We discuss this issue in Chapter 11.

7.54 It was also noted during consultations that a time limit can be used to negotiate access to particular services, for example, particular programs have limited resources and therefore target people who are about to exit custody. The time limit provides a clear date by which the service must be provided. Conversely, due to perceptions that a limiting term equates to a sentence a person may be prevented from accessing services because of the view that he or she will not be released for some time. This is similar to concerns expressed in a 2007 review of the forensic system:

> Generally, the Review has found that although people serving limiting terms in NSW can be released at any time prior to the expiry of the term, in general they are not.[64]

The MHRT has noted that it does not know of any patients being unconditionally released prior to the expiry of their limiting term. The MHRT further noted:

> Conditional release prior to the end of a limiting term is rare. The Tribunal is currently considering three applications, and is being assisted in its decision by legal submissions made on behalf of the Attorney General and the patient.[65]

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60. NSW Consumer Advisory Group, *Submission MH11*, 41-42.
61. T Boyd-Caine and D Chappell, "The Forensic Patient Population in New South Wales" (2005) 17 *Current Issues in Criminal Justice* 5, 26.
62. T Boyd-Caine and D Chappell, "The Forensic Patient Population in New South Wales" (2005) 17 *Current Issues in Criminal Justice* 5, 26.
63. Mental Health Review Tribunal, *Submission MH67*, 4.
64. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [5.38]; see also *R v Mailes* [2004] NSWCCA 394; 150 A Crim R 365 [33]-[37].
65. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 2; Mental Health Review Tribunal, *Submission MH67*, 5.

7.55 MHRT records reveal that approximately 10 out of 54 (19%) forensic patients have been detained beyond their limiting term as an involuntary patient under the MHA.[66]

7.56 The NSW Bar Association submitted that in relation to people who are UNA, sentencing principles are useful in providing a limit to the length of detention but the requirement that the MHRT consider whether the person has spent "sufficient time in custody" means that the limiting term is akin to a sentence instead of a cap.[67] In Chapter 9 we recommend the removal of this requirement.

7.57 Stakeholders' views were generally consistent in relation to people found UNA and NGMI, however in relation to NGMI, the NSW Bar Association was of the view that current provisions are adequate:

> The essential issue is that these persons be adequately reviewed and released when it is safe and appropriate to do so. It would be too 'hit and miss' to set an artificial cap for people found NGMI and then to transfer them to the civil system upon expiry of that term.[68]

7.58 Significantly, the MHRT submitted that it would not support the introduction of a time limit on those found NGMI, noting:

> The primary issue in this is risk. Those found NGMI are found so precisely because their condition led to the event occurring, therefore there is a public interest in ensuring that they are not released from supervision until that risk is manageable. It is not possible to set a time limit on how long that will take in any individual case.[69]

If there is a time limit, how should it be set?

7.59 We have identified four basic models for setting a time limit:

(1) the hypothetical sentence that would have been imposed had the person been convicted in the ordinary way of the offence charged

(2) a modified sentencing approach, for example where the hypothetical sentence is automatically reduced taking into account unknown mitigating factors

(3) a fixed statutory formula, or

(4) a time limit which is formulated adopting a risk management approach (for example, looking at the prospects of rehabilitation and future risk).

Hypothetical sentence based approach

7.60 Sentencing considerations include the general principles of retribution, denunciation, objective criminality, proportionality, and parity with co-accused,[70] as

66. Mental Health Review Tribunal, *Submission MH67*, 5.
67. NSW Bar Association, *Submission MH10*, 35-36.
68. NSW Bar Association, *Submission MH10*, 47.
69. Mental Health Review Tribunal, *Submission MH57*, 14.
70. See *Crimes (Sentencing Procedure) Act 1999* (NSW) s 3A; and see generally NSW Law Reform Commission, *Purposes of Sentencing*, Sentencing: Question Paper 1 (2012).

well as the special principles that apply when sentencing offenders with cognitive and mental health impairments.[71]

7.61 A sentencing-based time limit currently applies to people who are UNA. That is, the court is required to estimate the sentence the court would have imposed if the special hearing was an ordinary trial against a person who was fit to be tried and had been found guilty. We note that a limiting term is not a sentence. A person found UNA can be released at any time by the MHRT subject to considerations of safety. Sentencing principles are involved because fairness requires that a person found UNA should not be detained for longer than a person convicted in the ordinary way.

7.62 The current sentencing based approach has the benefit of consistency with the approach adopted in relation to equivalent convicted offenders. It also has the benefit of familiarity, as courts understand the sentencing process and the relevant considerations.

7.63 However, the following issues arise:

(1) **Sentencing principles may not be appropriate:** Sentencing principles are directed at determining the appropriate punishment for a particular offence. This approach may not be appropriate for defendants who are UNA and NGMI. The sentencing-based approach to disposition is an inherently retrospective exercise but a treatment focus has a future orientation. Further, although community safety is a factor that is considered by a sentencing court, the ability of the court to adjust for future risk is constrained by the principle of proportionality. Sentencing principles are not always consistent with the objectives of the forensic system.[72]

(2) **It may not be possible to apply sentencing principles with reasonable accuracy:** The "hypothetical sentence" approach is somewhat artificial, particularly when attempting to fix a sentence-based time limit in respect of a person who has been found not responsible in law. This may be particularly difficult in NGMI cases, where the person is found not responsible for their actions. This raises questions such as how the limiting term process should deal with subjective factors. The Commonwealth provisions, which apply a sentencing approach to fixing the time limit for people found NGMI, have been the subject of judicial criticism on these grounds.[73] In SA, where a sentence-based time limit applies to both groups (UNA and NGMI), the legislature attempted to mitigate the artificiality of a sentencing approach by providing that the mental impairment should not be taken into account when determining the hypothetical sentence that would have been imposed.[74] Such an approach appears to require that the determination be made by reference only to the

71. 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) [8.11].

72. See *Mental Health (Forensic Provisions) Act 1990* (NSW) s 40.

73. *R v Goodfellow* (1994) 33 NSWLR 308, 311; *R v Robinson* (2004) 11 VR 165, 174.

74. *Criminal Law Consolidation Act 1935* (SA) s 269O(2) Note 1.

objective circumstances of the offence and the subjective circumstances of the offender, unrelated to his or her mental state.

(3) **Limiting terms do not achieve outcomes commensurate with sentences:** The current process of applying a limiting term to people found UNA appears to result in the person spending longer in detention than the time that would be served by a person convicted in the ordinary way. For example:

(a) the court might not be aware of all the facts which are relevant to exercising the sentencing discretion because the person's unfitness for trial prevents him or her from bringing those facts to the attention of the court (including various mitigating factors)

(b) a person found UNA does not get the benefit of a discount for an early guilty plea, and

(c) the current provisions for fixing the limiting term in NSW require the court to nominate the total sentence that would have been imposed, that is, the total of the non-parole period and the balance of the term: many people found UNA spend their entire limiting term detained, whereas sentenced offenders may be eligible for parole and released.

(4) **Sentencing-based time limits may be misleading:** Sentencing-based limiting terms may create the impression that the person is being punished, despite not having been tried and convicted of any offence.

7.64 Despite these issues, sentencing principles may be a useful way of establishing a limit on the operation of the forensic system.[75]

A modified sentencing approach

7.65 The sentencing-related approach could be retained, with some modifications to counteract some of the problems raised above. For example:

- The court could impose a time limit equivalent to a hypothetical non-parole period rather than the total sentence.[76] However, this ignores the role of supervision on release and suggests there should be a community supervision period.
- Legislation could provide that certain mitigating factors be presumed when fixing the term. For example, it could be presumed that the person would have pleaded guilty at the first opportunity, and would have expressed remorse. [77] Alternatively, there could be a percentage-based discount for unknown mitigating or discounting factors[78] (although such an approach would be very artificial).

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75. See NSW, *Parliamentary Debates*, Legislative Assembly, 24 November 1982, 3006 (L Brereton).
76. See G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [6.42].
77. See *R v Mitchell* [1999] NSWCCA 120; 108 A Crim R 85 [47]-[48]; see also Public Interest Advocacy Centre, *Time for Change: Response to the Consultation Paper: Review of the Forensic Provisions of the Mental Health Act 1990 and the Mental Health (Criminal Procedure) Act 1990* (2007) 18.
78. A percentage-based approach applies to mitigation for a plea of guilty: see *R v Thomson* [2000] NSWCCA 309; 49 NSWLR 383.

Fixed statutory time limits

7.66 Alternatively, legislation could provide that time limits should be dealt with by having fixed time limits or a formula, such as:

(1) The Victorian model: legislation specifies "nominal terms" for murder or treason (25 years); "serious offences" (the maximum term of imprisonment for the offence); certain other offences (half the maximum term of imprisonment for the offence); and for all other offences, a discretionary period set by the court.[79]

(2) The New Zealand model: 10 years from the date of making the order if the offence is punishable by life imprisonment, or otherwise half the maximum term of imprisonment for the offence.[80]

(3) The maximum penalty for the offence.[81]

(4) Two-thirds of the maximum term of imprisonment for the offence, or 10 years, whichever is less.[82]

(5) The standard non-parole period for the offence (if relevant).

(6) The average or mid-range sentence for the offence, derived from sentencing statistics.[83] However, this may be arbitrary since sentencing statistics cover differing periods of time and it is unclear how the courts would be able to calculate the figure.

7.67 However, there is a significant range in the sentences that are imposed for particular offences and it may not be possible to develop a formulaic approach that is satisfactory. By failing to take into account the circumstances of each case, the relationship between the time limit and the offending conduct ceases to be proportionate and becomes arbitrary.[84] These issues could be mitigated by providing a discretion for the court to pronounce a period shorter or longer than the prescribed time limit in particular cases – though a clear basis for exercising this discretion would need to be prescribed.

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79. *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 28(1). If the person was found to have committed more than one offence, the nominal term is calculated by reference to the offence which carries the longest maximum term of imprisonment: s 28(2). A supervision order is, however, indefinite: s 27(1).

80. *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 30(1)-(2) (unfit only; people found NGMI are subject to an indefinite order: s 33). During that period, the executive government has a role in decisions about treatment, management and release: s 31 (unfit), see also and compare s 33(3) (NGMI). At the expiry of the time limit, if the person is still detained, his or her status is changed to "patient" or "care recipient", and all subsequent decisions about treatment, management or release are made by the health or disability systems: s 31(4).

81. 18 USC §4244(d)-(e) provides for the provisional sentencing of convicted offenders who have a "mental disease or defect" for the treatment of which the offender is in need of custody for "care or treatment in a suitable facility". A hospitalisation order made at the time of sentencing constitutes a provisional sentence to the maximum period of imprisonment applicable to the offence. If the person recovers sooner, he or she is brought back to court and finally sentenced.

82. Proposed in NSW Health Commission Mental Health Act Review Committee, *Report* (1974) 89-91. The Report did not recommend a time limit in respect of people found NGMI.

83. See G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [6.42].

84. See NSW Law Reform Commission, *Sentencing*, Report 79 (1996) [9.11], [9.17]; NSW Law Reform Commission, *Sentencing*, Discussion Paper 33 (1996) [6.46]-[6.66].

A risk management approach

7.68 A purely risk management based approach could be used to set a time limit (an approach that departs from sentencing principles/outcomes or fixed formula). This approach could take into account the likelihood of rehabilitation, the likely length and success of treatment (and impact on offending behaviour) and future risk. This approach has the benefit of consistency with the principles and factors that the MHRT take into account when managing forensic patients (see Chapters 8-9).

7.69 However, it is not an approach with which the courts are familiar. Additionally prediction of risk factors may be difficult at an early stage (for example, the person's response to medication may not be known). The logic for assessing this risk at the early stage is unclear, when the person will be very quickly subject to assessment from the perspective of risk and safety by the MHRT on an ongoing basis, and can be released at any time.

Submissions and consultations on the current approach

7.70 In CP 6 we asked whether sentencing principles should continue to apply to the court's decisions whether to detain or release a person who is UNA.[85] Generally, stakeholders submitted that sentencing principles should continue to be relevant to some aspects of the process.[86] However, many stakeholders also noted that the risks to the community should be the most important criteria.[87]

7.71 **Sentencing principles should be applied for reasons of fairness to the defendant.** Stakeholders noted that sentencing considerations are relevant in providing "limits" to detention.[88] The Public Defenders noted that the setting of a limiting term provides an:

> assurance that the forensic patient is not detained for longer than he or she would have been, had there been a conviction in a normal trial. We are of the view that this objective remains appropriate, although we acknowledge the problems, some of which are insurmountable, in a precise application of it.[89]

7.72 The Office of the Director of Public Prosecutions (ODPP) cautioned that criminal law should "not be extended so as to be used as a means to detain persons who represent a risk to public safety".[90] In other words, forensic patients should not be detained in response to their offending for longer than is fair against the benchmark of others who commit criminal offences. If there are safety concerns at the end of a period fair detention, the civil mental health system should be deployed.

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85. 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 6.45.
86. NSW Office of the Director of Public Prosecutions, *Submission MH5*, 11-12; NSW Bar Association, *Submission MH10,* 35; Legal Aid NSW, *Submission MH18*, 14; NSW, Public Defenders, *Submission MH26*, 39. See also Homicide Victims' Support Group, *Submission MH20,* 13.
87. NSW Bar Association, *Submission MH10*, 36; Law Society of NSW, *Submission MH13*, 16; Legal Aid NSW, *Submission MH18,* 14; Homicide Victims' Support Group, *Submission MH20*, 13.
88. NSW Bar Association, *Submission MH10*, 35; Legal Aid NSW, *Submission MH18*, 14; NSW, Public Defenders, *Submission MH26*, 39.
89. NSW, Public Defenders, *Submission MH26*, 39.
90. NSW Office of the Director of Public Prosecutions, *Submission MH5*, 11-12.

7.73 **Sentencing principles should be applied to recognise the interest of the victim and the community.** The ODPP noted that the application of sentencing principles "should apply principally to give victims and the public a sense that justice has been done in a manner comparable with normal criminal proceedings". The HVSG submitted that the "application of a custodial sentence provides the family of the victim with some sense that the death has been recognised and dealt with by law".[91] However, during the course of consultations, we noted that limiting term processes cause some confusion for victims who interpret the term as a sentence and may subsequently be distressed if the forensic patient is released earlier.

7.74 The NSW Bar Association noted that the process involves balancing interests such as providing victims, their families and the community a degree of closure as well as community protection against the consideration that there has been no conviction of the accused.[92] The NSW Bar Association also noted that the role of the MHRT has reduced problems with the application of sentencing principles.[93]

7.75 **The current approach imposes a limiting term that is not comparable to the sentence that would have otherwise been imposed.** A number of concerns were raised regarding the current approach:

- The application of a limiting term is not comparable to a sentence because it does not reflect a non-parole period.[94]
- The application of a limiting term is problematic because the accused does not get the benefit of a plea (where a person is unfit it is presumed that he or she would plead not guilty). According to the Public Defenders, this is a significant reason why practitioners may be less inclined to raise fitness issues.[95]

7.76 The MHRT has noted that it is problematic to apply general sentencing principles, such as deterrence, when calculating a limiting term. The only sentencing principle consistently applied is protection of the public.[96] The MHRT noted:

> that the current calculation of the limiting term tends to overestimate the real length of time a person would have served/been sentenced for given that certain discounts (e.g. early plea of guilty) are automatically unavailable. The legislation should allow for some adjustment of the limiting term in view of this inherent bias against those with a mental illness or cognitive impairment.
>
> The decision of the High Court in *Muldrock* also makes it clear that consideration of the subjective impact on the individual with a cognitive impairment should be considered in setting the limiting term.[97]

Submissions and consultations on alternative approaches

7.77 In CP 6 we asked if there is a time limit on what basis should it be determined?[98]

91. Homicide Victims' Support Group, *Submission MH20*, 13.
92. NSW Bar Association, *Submission MH10*, 35.
93. NSW Bar Association, *Submission MH10*, 35.
94. NSW, Public Defenders, *Submission MH26*, 39-40.
95. NSW, Public Defenders, *Submission MH26*, 40.
96. Mental Health Review Tribunal, *Submission MH57*, 14.
97. Mental Health Review Tribunal, *Submission MH57*, 14.

7.78 The Law Society of NSW noted that a formulaic approach, adopting the average non-parole period for a particular offence, is an attractive starting point but that this should be tied to the discretion of the court to vary the time taking into account factors including:

- the circumstances of the case
- the relationship between the impairment and offending, and
- the likely length of treatment needed to ensure community protection from serious harm.[99]

7.79 The HVSG submitted that an approach "which uses a fixed formula based on the maximum penalty for the offence" should be adopted.[100] However, the judge should have the discretion to reduce this and consider mitigating factors including that the person may have pleaded guilty if available or expressed remorse.[101] However, HVSG argued that the scope for discretion should be reduced in relation to serious offences.

7.80 Legal Aid NSW submitted that a limit which is equivalent to the non-parole period which would have been imposed if the person was convicted should be available.[102]

7.81 In CP 6 we also asked whether the same approach should be adopted in relation to time limits for people who are UNA and found NGMI.[103] Most stakeholders submitted that the same approach to setting time limits should be adopted for both groups.[104] However the NSW Bar Association disagreed.[105]

The Commission's view

7.82 In summary, our options are to:

(1) Retain separate systems.

(2) Remove the time limit which applies to people who are UNA.

(3) Apply a time limit for people who are NGMI.

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98. 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 6.102.
99. Law Society of NSW, *Submission MH13*, 28.
100. Homicide Victims' Support Group, *Submission MH20*, 17.
101. Homicide Victims' Support Group, *Submission MH20*, 17.
102. Legal Aid NSW, *Submission MH18*, 23.
103. 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 6.103.
104. Legal Aid NSW, *Submission MH18*, 23; Law Society of NSW, *Submission MH13*, 28; Homicide Victims' Support Group, *Submission MH20*, 17.
105. NSW Bar Association, *Submission MH10*, 48.

Should we retain separate systems?

7.83 There is no clear reason to retain separate systems in relation to time limits. While there may be a relationship between the index event and the impairment for people found NGMI, we also note that a person who is UNA:

- is likely to have immediate and ongoing needs with respect to cognitive or mental health impairment, and it may therefore be appropriate to manage this person until he or she becomes fit or is considered no longer to present a risk of harm to the public
- is likely to benefit from a system which is focused on care and treatment, for as long as is required to support the rehabilitative needs of the person, and
- may not have had the opportunity to demonstrate the nexus between his or her impairment and the offending conduct due to difficulties, for example, with presenting evidence (though we note that NGMI is available as a verdict at special hearing).

7.84 Additionally, stakeholders supported consistent systems and the arguments against applying a time limit – outlined in para 7.46 – apply equally to people found UNA. Similarly, the arguments in favour of a time limit apply equally to people found NGMI. We therefore do not support the retention of separate systems.

Should there be a time limit for both groups?

7.85 This leaves open the possibility of removing the limit which applies to people who are UNA or applying a time limit for people who are NGMI.

7.86 On balance, we are of the view that a time limit should apply to people who are UNA and NGMI. A time limit provides an important protection for forensic patients. It can help ensure fairness, so that forensic patients are not detained or managed within the forensic system for longer than they would have been following conviction. In particular, we were told repeatedly by stakeholders that indeterminate outcomes deter people from raising NGMI. This is likely to result in people being dealt with through the correctional system who should more appropriately be in the forensic system.

7.87 Applying a time limit to those who are found NGMI does raise issues of community safety upon the release date. However, any continuing therapeutic needs of the forensic patient may be dealt with through ongoing treatment and support in the community. If there are difficulties with the person accepting such treatment, the civil mental health system and the guardianship system will usually provide appropriate means of managing risk.

7.88 We acknowledge that there will be a few cases where there are ongoing concerns regarding community safety at the end of a time limit. There will be some people who continue to pose a risk to community safety at the end of a time limit. There are some such people already, but the numbers will increase when time limits are applied to those found NGMI. Where such people cannot be satisfactorily provided for via the mental health system and the guardianship system, we recommend a system whereby, with appropriate safeguards, it is possible for continuing detention to be ordered. These are addressed in detail in Chapter 11.

7.89 We note the concern expressed by stakeholders that the limiting term has been interpreted as a sentence. Very few UNA forensic patients have been released prior to the expiry of their limiting terms. The MHFPA should make it clear that a limiting term does not mean that a person must remain a forensic patient or be detained for the whole of that period; instead it applies as a maximum period.

How should the time limit be set?

7.90 We prefer an approach which requires the court to estimate the sentence that would apply to the defendant had that defendant been held criminally responsible at a normal trial. While we acknowledge that it may not be possible to apply a hypothetical sentence with absolute precision, we are of the view that this approach is the one that achieves the least arbitrary outcome. It is an approach with which the court is already familiar. We address the question of how to deal with people following a finding of UNA or NGMI who would not have faced a custodial sentence in para 7.118-7.140.

7.91 Currently, the MHFPA requires the court to impose "the best estimate of the sentence the Court would have considered appropriate if the special hearing had been a normal trial of criminal proceedings against a person who was fit to be tried for that offence and the person had been found guilty of that offence".[106] In order to take into account the concern that a hypothetical sentence approach often overestimates commensurate sentences, we recommend the following:

(1) The court should be required to estimate the sentence that would have been imposed on that person if found guilty at a normal trial, therefore taking into account the person's cognitive or mental health impairment. We note that under standard sentencing principles mental illness or cognitive impairment can act as a factor that can mitigate or lengthen a sentence, depending on the circumstances.

(2) The court should be required to take into account that, because the person is unfit or NGMI, it may not be possible to demonstrate particular mitigating or discounting factors (for example, a guilty plea or expression of remorse). Limiting terms should be be fair in comparison to those who are convicted at a normal trial. Because those people who are UNA or NGMI will generally be unable, because of their impairment, to plead guilty or to express remorse, they will not be entitled to the discount available to other defendants. We recommend that the court should have a broad discretion to discount the sentence. This approach will present courts with a difficult task because the factors that form the basis for the exercise of discretion to discount the sentence will not be present. However, an alternative approach of a percentage discount has the disadvantage of rigidity and arbitrariness.

Recommendation 7.2

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to the effect that:

106. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 23(1)(b).

(a) Where a person has been found unfit and not acquitted at a special hearing or not guilty by reason of mental illness at a special hearing or at a normal trial, the court must determine whether or not that person would have been sentenced to imprisonment if found guilty at a normal trial.

(b) Where the court determines that a sentence of imprisonment would have been imposed under Recommendation 7.2(a) the court must nominate a limiting term.

(c) The limiting term should be the court's best estimate of the length of the sentence of imprisonment that would have been imposed had that person been found guilty at a normal trial.

(d) When setting the limiting term, the court should be required to take into account that, because the person is unfit to stand trial or not guilty by reason of mental illness (or both), it may not be possible to demonstrate particular mitigating or discounting factors (for example, a guilty plea or expression of remorse).

(e) A person must cease to be a forensic patient at the expiry of his or her limiting term (if not released earlier by order of the Mental Health Review Tribunal).

Disposition of people found UNA or NGMI

7.92 As we have demonstrated above, the current systems that apply to people found UNA and NGMI differ significantly. We have recommended at Recommendation 7.1 that the powers of the court following a finding of UNA or NGMI should be consistent. In Recommendation 7.2 we recommend that the court be empowered to nominate limiting terms in relation both groups. This section addresses the question of what consistent process should be prescribed for those found UNA and NGMI.

7.93 We start by identifying key issues with the current approach. Having distilled the lessons to be learned from the current approaches, we go on to describe our proposed system.

Problems arising in the current system of disposition

7.94 We asked a range of questions regarding the operation of the current systems of disposition in CP 6 and during the course of consultations. In addition to the problem of inconsistency, some key issues were evident:

- The current system is confusing and complex, which can delay or block the progress of people through the forensic system.
- The court may not have the appropriate information and expertise to ensure that the optimal orders are being applied.

Confusion and complexity

7.95 As we note in para 7.9, following a finding of UNA and the imposition of a limiting term, the court must refer the person to the MHRT for a determination regarding the

person's impairment under s 24. Following this, the court may make a final order for detention under s 27. A number of problems arise with this procedure.

7.96 The powers of the court under s 24 and s 27 are not clear. The NSW Court of Criminal Appeal suggested in 2006 that s 27 confers a power to determine if a person should be detained (in addition to the place of detention).[107] However, more recent authority from the NSW Court of Appeal in contrast appears to hold s 27 does not include a power to release the person.[108]

7.97 In consultations it was also noted that the court will not always make final orders for detention under s 27, appearing to rely on the orders relating to detention made under s 24. This may lead to confusion about whether the person can be managed as a forensic patient. [109]

7.98 It appears, on the information available to us, that the court sometimes does not wish to make an order for detention under s 27. In the year 2011/12 the MHRT provided 13 determinations under s 24 of the MHFPA (following the imposition of a limiting term, but prior to final disposition of the court) but only five "initial reviews" after the court imposed an order for detention under s 27. This leaves more than half unaccounted for. It may be that some of these people have been unconditionally released and have not proceeded to MHRT supervision, despite the fact their offence was considered by the court to be serious enough to attract a sentence of imprisonment at a normal trial. The MHRT submitted to this inquiry that unconditional release is not an appropriate order for this group.[110]

7.99 The requirement under s 24 of the MHFPA to refer a person found UNA to the MHRT for a determination of the person's mental illness or mental condition prior to finalisation is also problematic. The MHRT submitted that this provision gives rise to "unnecessary duplication and consequent delay".[111]

7.100 Current NGMI processes can also lead to confusion. The MHRT submitted that courts have attempted to make time limited conditional release orders even though, under the MHFPA, once a person found NGMI becomes a forensic patient the length of supervision is a matter for the MHRT.[112] This may lead to confusion for the forensic patient who may have an expectation of release as a result of the time limited court order. This issue appears to be a by-product of the complexity of the current system.

7.101 In consultations it was also noted that sometimes the MHRT is not notified of final orders made by the court, preventing a person from being managed as a forensic patient or causing delay in the person's management. This may, in part, be due to gaps in legislative notification requirements regarding people found UNA and

107. *AN (No 2) v The Queen* [2006] NSWCCA 218 [48].
108. *State of NSW v TD* [2013] NSWCA 32 [46]-[47].
109. Mental Health Review Tribunal, *Submission MH57,* 10.
110. Mental Health Review Tribunal, *Submission MH57*, 13.
111. Mental Health Review Tribunal, *Submission MH57,* 10.
112. Mental Health Review Tribunal, *Submission MH57*, 14.

NGMI.[113] The MHRT, and previous reviews, have noted the importance of notifying the MHRT of the orders, as well as providing relevant material including the terms of the order, judgment, and relevant evidence.[114]

7.102 The complexity of the current system has led to confusion, inconsistency and delay. Of particular concern is that this confusion can lead to mismanagement of forensic patients and forensic patients who may pose a risk to safety being released and not referred to the MHRT. Our recommendations below deal with these issues by greatly simplifying the current process of disposition, clarifying the powers of the court and MHRT and removing unnecessary steps in the current process.

Decision making frameworks and expertise

7.103 People who have a cognitive or mental health impairment and have been found UNA or NGMI may need to be placed in an appropriate mental health facility, and/or require individualised treatment programs and care. Under the present system it is the court that makes initial disposition orders regarding the custody, treatment and/or release of the person. Yet the court may be underequipped or not have the relevant expertise to make such decisions.

7.104 An examination of some of the orders made by the court suggests that, in practice, the court will often defer to the MHRT to assist with decision making. Orders that have been imposed include that the defendant be:

- detained in an appropriate correctional centre, or other such facility or other place as the MHRT may determine[115]
- detained in Long Bay Prison hospital (which is designated as a correctional centre) or at such other place as determined by the MHRT, and[116]
- detained in the custody of Corrective Services NSW.[117]

These are orders to be detained in prison. The court has also requested that the MHRT consider transferring the person to a mental health facility, even though it has the power to make such orders.[118]

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113. For example, there is currently no express requirement for the court to inform the MHRT of the terms of the court's final orders under *Mental Health (Forensic Provisions) Act 1990* (NSW) s 27 in relation to a person who is UNA. In contrast, under s 39 following a finding of NGMI "the Registrar of the Court is to notify the Minister for Health and the Tribunal of the terms of the order".

114. Mental Health Review Tribunal, *Submission MH57*, 15; G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [7.7], Recommendation 18; *Inquest into the death of Scott Ashley Simpson* (Unreported, NSW Coroner's Court, Deputy State Coroner Magistrate Pinch, 17 July 2006) 5.

115. *R v Tarantello* [2011] NSWSC 383 [74]; *R v Coleman* [2010] NSWSC 177 [90]; *R v Fernando* [2011] NSWSC 1556 [62]; *R v PCB* [2012] NSWSC 482 [94]; *R v Sleiman* [2010] NSWSC 1206 [85]; *R v Melehan* [2010] NSWSC 210 [40]; *R v Doolan (No 2)* [2010] NSWSC 194 [48]; *R v Doolan* [2010] NSWSC 147 [153]; *R v Bailey* [2012] NSWSC 1074 [114]; *R v Aliwijaya* [2012] NSWSC 503 [48].

116. *R v Rodriguez* [2010] NSWSC 198 [60]; *R v Watson* [2011] NSWSC 839 [86]; *R v Waterlow* [2011] NSWSC 326 [31]; *R v Sevi* [2010] NSWSC 387 [42]; *R v Loughrey* [2011] NSWSC 1456 [72]; *R v Niazi* [2011] NSWSC 907 [23]; *R v Adam* [2010] NSWSC 1162 [85].

117. *R v RM* [2011] NSWSC 861 [33]; *R v Gardiner (No 1)* [2011] NSWSC 239 [42].

7.105 The MHRT noted that the court may occasionally order a person be detained in a mental health facility, however:

> The Tribunal is aware of real practical difficulties in complying with court orders of this kind. In particular, it is rare for a bed to be available in a mental health facility, unless the person being sentenced is already the occupant of that bed. As a result, persons who are ordered to be detained in a mental health facility will often, nonetheless, spend a period of time in a correctional setting.[119]

We note that following the recent decision in *State of NSW v TD*, failure to place a person in a mental health facility where an order is made by the court may constitute false imprisonment.[120]

7.106 The MHRT expressed concern that the court is not provided with high quality, objective evidence regarding the person's level of risk when making disposition decisions, and that there is an under reliance on medical or other expert evidence in relation to risk.[121] The MHRT observed that where there is expert evidence, it is often provided by experts who are not directly involved in the forensic system which means that advice "can be theoretical rather than practical, which does not assist the Court in determining the appropriate order which can be implemented in a particular case".[122] The MHRT recommends that the court be provided with "non-partisan" advice regarding a person's treatment needs, services available to meet these needs and the person's risk.[123] The MHRT stressed the importance of the court knowing the level of support required to manage risk and the actual availability of services and treatment within a person's community if considering release.[124] This is the type of information that the MHRT is required to obtain prior to making an order for conditional release "so as to tailor the conditions of release to the particular needs and circumstances of the individual".[125]

7.107 Inadequate information or expertise can have a significant consequence when making a decision to release:

> the person may not (at the time of the court order) have been linked into the community mental health services. The delay in connecting a person to the appropriate community support is often a time of high risk for the patient, and therefore for the community…
>
> Despite the low numbers of people released by the court the Tribunal is aware of a number of incidents where individuals who have been conditionally

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118. *R v Fernando* [2011] NSWSC 1556 [63]; *R v Waterlow* [2011] NSWSC 326 [31]; *R v Loughrey* [2011] NSWSC 1456 [73]. In one case where a person was ordered to be detained in a mental health facility (instead of a prison) the person had gone through a special hearing process and was likely to have been placed there by the MHRT: *R v JH* [2010] NSWSC 531 [41]-[43]. Cf *R v DC* [2012] NSWSC 1125 [73]. We discuss relevant considerations at para 7.15.
119. Mental Health Review Tribunal, *Submission MH67*, 1, 10-11.
120. *State of NSW v TD* [2013] NSWCA 32.
121. Mental Health Review Tribunal, *Submission MH57*, 13; Mental Health Review Tribunal, *Submission MH67*, 1.
122. Mental Health Review Tribunal, *Submission MH57*, 13.
123. Mental Health Review Tribunal, *Submission MH57*, 13.
124. Mental Health Review Tribunal, *Submission MH57*, 13; Mental Health Review Tribunal, *Submission MH67*, 1-2.
125. Mental Health Review Tribunal, *Submission MH67*, 2.

> released have committed [a] serious act of violence or where there has been significant deterioration in the person's condition within a very short time from the court ordering the person's conditional release.[126]

Coordinating services for people with cognitive impairment may present additional challenges due to limited services.[127]

7.108 Other stakeholders supported enhancing court decision making frameworks to be consistent with that applied by the MHRT, and increasing flexibility in the range of disposition options – allowing detention, conditional release and unconditional release for all people found UNA and NGMI. For example:

- Stakeholders supported the same orders for people found NGMI and UNA, broadly including detention and release (with or without conditions).[128]
- Stakeholders supported increased legislative guidance when making orders,[129] with two stakeholders noting that the MHFPA principles and conditions applied by the MHRT provide a useful framework to guide disposition decision making.[130] The HVSG did not oppose additional guidance "provided that, public safety remains the consideration of utmost importance to the court".[131]
- The MHRT highlighted that the considerations applied by the courts when making disposition decisions should be consistent with those applied by the MHRT.[132]

Conversely, the NSW Bar Association submitted that the issue of release should remain purely with the MHRT.[133] However, it also noted that the MHRT could be asked to provide recommendations in relation to release, if the judge thinks fit.[134] The Public Defenders considered that additional guidance is not necessary; noting that community safety is considered in court provisions relating to NGMI, and the

126. Mental Health Review Tribunal, *Submission MH67*, 2.
127. We discuss this in para 1.37-1.45.
128. 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) Issue 6.51; Law Society of NSW, *Submission MH13*, 17; Legal Aid NSW, *Submission MH18*, 15. See also Mental Health Review Tribunal, *Submission MH57*, 13: the MHRT supported the same orders for people found NGMI and people with a limiting term imposed. The Law Society of NSW, Legal Aid NSW and the Public Defenders supported consistency, submitting that conditional release should also be made available as an option following the imposition of a limiting term: Law Society of NSW, *Submission MH13*, 16; Legal Aid NSW, *Submission MH18*, 14; NSW, Public Defenders, *Submission MH26,* 41. The Public Defenders also noted the MHRT is better placed to make orders, and that matters should be referred to the MHRT: NSW, Public Defenders, *Submission MH26,* 44.
129. Stakeholders responded to the question of whether increased guidance was required when the court is making a disposition decision following a finding of NGMI: NSW Bar Association, *Submission MH10*, 37; Law Society of NSW, *Submission MH13*, 16; Legal Aid NSW, *Submission MH18*, 14; NSW Council for Civil Liberties, *Submission MH46*, 8-9. See also Mental Health Review Tribunal, *Submission MH57*, 21.
130. NSW Bar Association, *Submission MH10*, 37; NSW Council for Civil Liberties, *Submission MH46*, 8-9. See also Mental Health Review Tribunal, *Submission MH57*, 13.
131. Homicide Victims' Support Group, *Submission MH20*, 14.
132. Mental Health Review Tribunal, *Submission MH57*, 13, 21; Mental Health Review Tribunal, *Submission MH67*, 2.
133. NSW Bar Association, *Submission MH10*, 37.
134. NSW Bar Association, *Submission MH10*, 37.

range of factors considered by the court in previous cases appears to be appropriate.[135]

7.109 In summary, there is a lack of clarity relating to decision making about those found UNA and NGMI, including confusion about the distribution of decision making between the court and the MHRT. Disposition decisions should be made with appropriate information and expertise[136] However it appears that courts may be failing to make decisions, or making decisions that are based on imperfect information. This may even lead to people being released into the community when this present risks. A new process is required that is not only consistent but also clear, and which allocates decisions about forensic patients to those who have all relevant information and expertise to make safe and fair decisions.

A simplified approach to disposition

7.110 It is important that disposition decisions in relation to those found NGMI or UNA be made with adequate information and expertise. The court is not in an ideal position to make decisions regarding the place of detention, to impose conditions related to care and treatment, to assess the risks associated with release, or to take into account availability of appropriate services.

7.111 One way of dealing with these issues would be to improve court processes, by building a consistent and detailed framework of guidance for decision making and orders in relation to people found NGMI or UNA, and providing specialist advice to the court regarding the matters set out above. However, this approach would be expensive. It is also unlikely to be an effective use of court resources, given that any decision by a court is inevitably temporary. As soon as practicable after the court has made its decision the MHRT is required to review and make orders with respect to the forensic patient.

7.112 An alternative to providing the court with the skills and information it requires to make an informed and appropriate decision is to refer any person found UNA or NGMI as quickly as possible to the MHRT, which has been established with the expertise to make such decisions. If this approach was adopted, the court would first determine whether or not a sentence of imprisonment would be imposed during the course of a normal trial. Where a sentence of imprisonment would have been imposed, the court would then nominate a limiting term using the process described in Recommendation 7.2. The court would then simply make transitional orders pending initial review by the MHRT. We deal with cases where the court would not normally impose a sentence of imprisonment in para 7.118-7.140.

The Commission's view

7.113 Our preferred approach is for the court to refer the person to the MHRT for disposition as soon as possible after a finding of NGMI or UNA.

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135. NSW, Public Defenders, *Submission MH26*, 40-41.

136. See NSW Bar Association, *Submission MH10*, 42; Mental Health Review Tribunal, *Submission MH57*, 9, 13; Legal Aid NSW, *Submission MH18*, 16; Law Society of NSW, *Submission MH13,* 20; NSW, Public Defenders, *Submission MH26*, 44.

7.114 The MHRT has expertise and an ongoing monitoring role in relation to forensic patients. This approach has the advantages of consistency, simplicity and informed decision making. It will save the costs of providing the court with the information and expertise required to make an informed decision which, as we have already noted, is inevitably only a temporary one. It will deal with the risks to public safety, and the welfare of forensic patients and concerns regarding inappropriate release and inappropriate orders.

7.115 We therefore recommend that, after determining that a person is UNA or NGMI and also that the person would have been sentenced to imprisonment if sentenced at a normal trial and nominating a limiting term, the court should refer the person to the MHRT for disposition decisions. The MHRT has noted that it should review such a case "as soon as practicable".[137] However, due to the importance of speedy referral, we are of the view that the time frame for this MHRT review should be defined in the MHFPA (as is the time frame for regular reviews by the MHRT, see para 9.27). Such reviews should be conducted as soon as practicable, or in any case, within two months.

7.116 Following referral by the court, the MHRT would conduct a review of the forensic patient and would make the normal range of review decisions, as it does presently on any other review. This would, of course, include where the person should be detained as well as, where appropriate, whether the person is to be granted leave or release, unconditionally or subject to conditions.[138]

7.117 Supplementary provisions would be needed to support this referral to the MHRT. The making of transitional orders pending the MHRT's review is discussed in para 7.141-7.146. We note that there would also need to be mechanisms for referral, as well as processes to ensure that the person appears before the MHRT within the prescribed period.

Recommendation 7.3

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to the effect that:

(a) Where the court has nominated a limiting term, as described in Recommendation 7.2, the court must refer the person to the Mental Health Review Tribunal.

(b) The person should then become a forensic patient.

(c) The Mental Health Review Tribunal should be required to conduct an initial review as soon as practicable, or in any case within two months, and make decisions regarding:

  (i) the person's detention, care or treatment in a mental health facility or other place, or

  (ii) the person's release (either unconditionally or subject to conditions).

137. Information supplied by the Mental Health Review Tribunal, 5 February 2013.

138. See our discussion in Chapter 9.

What options should be available in relation to people who would have faced a non-custodial order at a normal trial?

7.118 As we recommend in Recommendation 7.2, after a finding of UNA or NGMI the court must make a decision as to whether or not it would have imposed a sentence of imprisonment. It is likely that in most cases such a sentence would have been imposed. However this will not always be the case.

7.119 We assume that where a person has an impairment and the offending is less serious, the issue of UNA or NGMI will not arise because diversion will be the appropriate course of action. We recommend in Report 135 that diversion be available in the District and Supreme Courts, that the supports available to those diverted be improved, and a specialist list for offenders with impairments who are at risk of imprisonment be established.[139] These recommendations will mean that people who offend and have impairments will be able to utilise diversion to ensure that they are placed in contact with services that will deal with the causes of their offending.

7.120 There may, however, be a group of offenders who were not suitable for diversion, and who are found UNA or NGMI but for whom a sentence of imprisonment is not appropriate. What options should be available to deal with those people?

Option 1: apply a community based sentencing option

7.121 One possibility would be to give the court powers to impose any penalty it might have imposed if the person had been convicted in the usual way. This is the option presently available under s 23(2) of the MHFPA in relation to people found UNA.

7.122 Sentencing principles and options are familiar to the court. This approach allows the court flexibility and access to a range of options. However, a bond is perhaps the most likely outcome for this group. The court is likely to attempt to ensure that the person is put in touch with services that will deal with the issues that caused their offending, and that their engagement with those services will be monitored.

7.123 However, sentencing options may not present the optimal framework for making orders in relation to people who are likely to have needs in relation to their cognitive and mental health impairments. If a person is unfit, he or she may have particular difficulty complying with conditions attached to traditional community based sentencing options. Non-compliance can lead to penalties, including imprisonment. Additionally, application of sentencing options would require the court to take into account punitive considerations, which is not appropriate for a group that is not convicted.

Option 2: manage as a forensic patient

7.124 A second option is to refer people who would not have faced imprisonment at a normal trial to the MHRT for orders and supervision as a forensic patient. Since this

139. See NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012).

group of people would not normally have been subject to a sentence of imprisonment the powers of the MHRT could be limited, for example:

- the period of MHRT supervision could be restricted, and
- a presumption of release could be imposed.

Release for this group would most likely involve conditions designed to ensure that treatment and services are provided to deal with the impairment and other issues that lie behind the offending behaviour. Detention may be possible, but only in exceptional circumstances.[140]

7.125 From 2004-2011, 23% of all people found NGMI and not unconditionally released by the court (42 of 179 people) reached the MHRT after being conditionally released by the court.[141] In such cases, the MHRT may continue to manage that forensic patient in the community until he or she is eventually unconditionally released. Some of this cohort may not have faced a custodial sentence if found guilty at a normal trial. Accordingly, management of offenders in the community where a custodial sentence has not been imposed is within the present experience of the MHRT.

7.126 If managed as a forensic patient, the following benefits would flow:

- Defendants would be managed by the MHRT, which is expert in responding to impairment, and would help ensure that the person is linked with treatment and services.
- The principles outlined in the MHFPA would be relevant, with a focus on care, treatment and safety, rather than a sentencing approach which includes punitive elements. Decisions would be made based on treatment, rehabilitation needs and risk.
- The MHRT would supervise the person, which would allow for regular review and variation (including reduction) of conditions where appropriate.
- The MHRT would handle a breach of conditions (rather than the court).
- The MHRT would monitor the person's fitness to be tried (if applicable).
- The MHRT would have the option of detention and compulsory mental health treatment if a person's condition deteriorates.
- The MHRT would have the option of ordering unconditional release at any stage.

7.127 The drawbacks of this approach include:

- Depending on how it is framed, this response could be perceived as too severe, especially as detention in the forensic system is a possibility.
- Despite the presumption of release, a person may be detained as a forensic patient, which is not an appropriate response to his or her offending behaviour

140. Also see our recommendation in Chapter 8 relating to the application of the principle of least restriction.

141. Mental Health Review Tribunal, *Submission MH67*, 11.

(however we note that where a person frequently breaches a bond he or she may face imprisonment).

- The difficulty in establishing the appropriate length of time for which a person should be a forensic patient.
- Potential additional costs associated with MHRT supervision (however, supervision by Corrective Services NSW in the community will also involve some cost).

7.128 There was support from stakeholders for people who are conditionally released under the current system to be forensic patients. Most stakeholders noted that, generally, a person should become a forensic patient when facing an order for conditional release.[142] The Law Society of NSW, Legal Aid NSW and the Public Defenders submitted that forensic patients should include people found UNA and in respect of whom a non-custodial order is made.[143] The MHRT submitted that:

> The Tribunal can see no reason to distinguish between people found NGMI and those found UNA (but not sentenced to a limiting term). The Tribunal considers that it would be appropriate that a court be able to conditionally release a person who has been the subject of a finding of UNA, and that the Tribunal have jurisdiction to review their conditional release for a finite period.[144]

7.129 However, the NSW Bar Association disagreed that MHRT supervision is useful in all cases involving a non-custodial order. In their view "there will be cases that can best be dealt with by non-custodial orders made by the court, with the court retaining power to deal with breaches – continued supervision by the court of its own order will be most effective in some cases".[145] The Association however noted that it would be appropriate for the court to order that the MHRT deal with breaches for particular individuals.[146]

7.130 If option 2 is adopted (subject to a presumption of release) the length of the period that the person is a forensic patient must be determined. As we note above, it is difficult to formulate and apply such a limiting term based on the length of the community based sentence that would apply if convicted. There is significant variation in the nature and severity of community based sentencing options that are not necessarily reflected in sentence length alone. For example, community service orders apply for a particular number of hours, rather than a specified time period.[147] Similarly, the severity of a bond will depend on not only the length of the bond, but the conditions that are attached. We see these difficulties as insuperable, and such a proposal as likely to lead to inconsistency and unfairness in orders.

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142. Law Society of NSW, *Submission MH13*, 17; NSW Bar Association, *Submission MH10*, 39; Legal Aid NSW, *Submission MH18*, 15.
143. Law Society of NSW, *Submission MH13*, 17; Legal Aid NSW, *Submission MH18*, 15; NSW, Public Defenders, *Submission MH26*, 41.
144. Mental Health Review Tribunal, *Submission MH67*, 9.
145. NSW Bar Association, *Submission MH10*, 38.
146. NSW Bar Association, *Submission MH10,* 38.
147. However the *Crimes (Administration of Sentences) Act 1999* (NSW) s 107 provides for a "maximum period" of 12-18 months for the order (unless extended), which is calculated based on the required number of hours under the community service order.

7.131 Alternatively a standard length of time could apply. We note that the average length of bonds for sentenced offenders in the higher courts was 22.3 months.[148] Two years could therefore form an appropriate standard period during which the person would be a forensic patient. We note the breadth of the powers of the MHRT, and that such a forensic patient is most likely to be subject to the provision of supervision in the community during this period of two years (if not unconditionally released prior).

Option 3: develop a new approach – a diversion style system for UNA or NGMI?

7.132 Arguably there will be significant variation in the personal circumstances and range of alleged offending committed by people found either UNA or NGMI. It may be that forensic patient status requiring monitoring and supervision by the MHRT is not necessary for everyone found UNA and NGMI who would not have been subject to imprisonment.

7.133 Where a person is found UNA or NGMI and a sentence of imprisonment is not appropriate, for example because the nature of their offending behaviour is not so serious, an approach to disposition that requires the person to connect with services in the community that are designed to deal with the causes of offending may be desirable. It may be possible to provide such access to treatment and services by crafting diversionary options: for instance referral to the "CRISP list" (discussed in Report 135) for a court supervised program.[149]

7.134 However, if a new system were to be adopted, a framework for court decision making and a set of disposition options would have to be created for what is likely to be a very small group of people. In para 7.103-7.109 (above) we discuss the difficulties that courts are likely to encounter when making decisions regarding this group, in particular we argue that courts are not well placed to make decisions regarding conditions with a focus on care, treatment and safety because such decisions would involve a great deal of information regarding available services, risk assessment and a close understanding of cognitive and mental health impairments. However referral to a specialist list such as the CRISP list would dispose of problems by referral to an expert decision maker.

7.135 Further, we note in our discussion in Chapter 12 that the forensic system should only be utilised in the Local Court in circumstances where diversion is not available. In Report 135 we recommend adoption of a broad range of diversion options for people with cognitive and mental health impairments. Such options could, and should, capture a large proportion of defendants who are UNA or NGMI who have committed minor offences. If a person was considered ineligible for diversion prior to finalisation of his or her matter, it would seem unlikely that the person will then be considered appropriate for diversion following finalisation.

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148. NSW Bureau of Crime Statistics and Research, *New South Wales Criminal Courts Statistics 2011* (2012) Table 3.10. We have recently received data from the NSW Bureau of Crime Statistics and Research (ref: mai1211186hc) for the 2008-2012 period indicating that only five people were given a bond following a finding of UNA in that period. The bond length has ranged from 3-5 years. However, because the data is so limited these numbers should be treated with caution.

149. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) Ch 12.

The Commission's view

7.136 It is likely that the number of cases in this cohort will be small.

7.137 A person found UNA or NGMI who would face a community based sentencing option is likely to have immediate needs associated with a cognitive or mental health impairment. If a sentencing approach is adopted it is very likely that a bond would be used to achieve these ends.

7.138 We are of the view the better alternative is to provide for a limited term of supervision and management in the community by the MHRT.

7.139 The MHRT process is expert at managing such offenders. It is experienced at managing people with cognitive and mental health impairments in the community and its processes are flexible. A range of conditions can be applied, fitness can be monitored, and unconditional release is available at any stage (including at initial review). Where there is serious deterioration of the person's mental state, the MHRT would have the option of ordering detention. While this would mean that defendants would be vulnerable to detention for a period of two years if they do not comply with conditions imposed by the MHRT, had those defendants instead been subject to a bond they would also have been subject to penalties for non-compliance for the period of the bond.

7.140 When such defendants are referred to the MHRT for orders, we recommend that a presumption of release apply. In most cases the MHRT would be likely to order conditional or unconditional release. However, we were told in consultations that there will be exceptional cases where the nature of offending is not severe enough to warrant detention in prison if convicted but the offending is a precursor to a significant deterioration of mental state, which means that the person presents a significant risk of serious physical or psychological harm to others and will require detention in a mental health facility. It is for this reason that we recommend release where possible, but leave open the option of detention where required for the needs of the patient and the public. The test for detention in such a case would be comparable to that for involuntary admission to the civil mental health system. The MHRT would also have the option of transfer to the civil system as described in Recommendation 8.2 As outlined in para 7.131 the person would be subject to MHRT supervision for a maximum of two years.

Recommendation 7.4

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to the effect that where the court determines that a person found unfit and not acquitted or not guilty by reason of mental illness would not have been sentenced to imprisonment if found guilty at a normal trial:

(a) The court should be required to refer the person to the Mental Health Review Tribunal.

(b) The person should become a forensic patient for a period of two years (if not unconditionally released earlier by order of the Mental Health Review Tribunal).

(c) The Mental Health Review Tribunal should be required to conduct an initial review as soon as practicable, or in any case within two months.

(d) The Mental Health Review Tribunal must not order that the person be detained at an initial review, or at further reviews, unless the person poses a significant risk of serious physical or psychological harm to others.

(e) The Mental Health Review Tribunal may transfer the person to the civil mental health system in accordance with Recommendation 8.2.

Transitional arrangements: referral from the court to the MHRT

7.141 When the court refers the person to the MHRT for disposition under Recommendations 7.3-7.4 it will invariably be necessary to make interim orders concerning the disposition of the defendant prior to review by the MHRT. Such interim orders would expire upon initial review by the MHRT. To place these decisions in context, it is likely that many people found UNA or NGMI will have been charged with very serious offences. In most cases it is likely that the court will find that, had they been fit or not impaired, a sentence of imprisonment would have been imposed.

7.142 There are several possible ways to provide for the court to make interim orders:

(1) The court could be given a power in general terms, allowing it to make any interim order with respect to custody or release as the court considers appropriate.

(2) Apply a bail framework, and instruct the court to do one or more of the following:

(a) grant the accused person bail in accordance with the *Bail Act 1978* (NSW)

(b) remand the accused person in custody pending MHRT review, or

(c) make any other order that the court considers appropriate.

A similar framework is presently applied by the court where a question of fitness is raised, and also following a finding of unfitness by the court.[150] Such orders or conditions could be made to expire upon initial review by the MHRT.

(3) Allow the court to make:

(a) an order that the person be detained in such place and in such manner as the court thinks fit, until initial review by the MHRT, or

(b) make such other order (including an order releasing the person from custody, either unconditionally or subject to conditions) as the court considers appropriate, until initial review by the MHRT, and

(c) direct the court that it can only make an order for release if it is satisfied, on the balance of probabilities, that the safety of the person or any member of

150. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 10(3), 14(b). See also s 17(2).

the public will not be seriously endangered by the person's release (as is currently provided under s 39 of the MHFPA).

7.143 The first approach has the benefit of flexibility. The second has the benefit of familiarity, as the court is familiar with the bail framework, and the court will have applied the bail framework in making all preceding decisions regarding custody (for example, where there were adjournments in the course of trial). The third has the benefit of most closely resembling the MHFPA framework that applies following the court's involvement. This process is effectively what the court is currently doing following a finding of NGMI.

7.144 We are not persuaded that the third option is an appropriate approach. It is essentially the approach which is adopted at present and the court would encounter difficulties and potential delays in determining the risk of harm presented by the defendant.

7.145 A bail framework may not be suitable as it is generally applied to determine how to deal with a defendant between court appearances, and assumes that the person will appear again before a court.

7.146 We are of the view that an approach which maximises flexibility is the most appropriate framework. What is contemplated is an interim order. Most defendants found UNA or NGMI will be already held in custody because of the serious nature of their offences and continuation of that arrangement will be appropriate until a detailed consideration of their case is made by the MHRT. Where custody is not appropriate release may be ordered with conditions, for example relating to the person's residence and treatment. Additionally, allowing the court to make any other order it considers appropriate allows it to continue arrangements where the person has already been placed in a mental health facility or linked to community care.

Recommendation 7.5

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to the effect that:

(a) When the court refers a matter to the Mental Health Review Tribunal as described in Recommendations 7.3 or 7.4, the court may:

  (i) order that the person be released subject to conditions or unconditionally

  (ii) order that the person be detained in a mental health facility or other place, or

  (iii) make such other orders as the court considers appropriate.

(b) Every such order should specify that it is an interim order pending further order by the Mental Health Review Tribunal.

Overview of the proposed process for disposition

7.147 Recommendations 7.3-7.5, together with our earlier recommendations in this chapter, mean that the steps would proceed as follows:

(1) A person is found NGMI or UNA at a special hearing or found NGMI at a normal trial.

(2) The court must determine whether or not the person would have been sentenced to imprisonment if found guilty at a normal trial:

(a) Where the person would have been sentenced to imprisonment the court must nominate a limiting term per the process described in Recommendation 7.2.

(b) Where the person would not have been sentenced to imprisonment the person should become a forensic patient for a period of no more than two years as described in Recommendation 7.4(b).

(3) The court must refer the person to the MHRT, handing over the judgment, limiting term information where applicable and other relevant materials to the MHRT.

(4) The court must make interim decisions with respect to custody or release to cover the period until review by the MHRT under the model proposed in Recommendation 7.5.

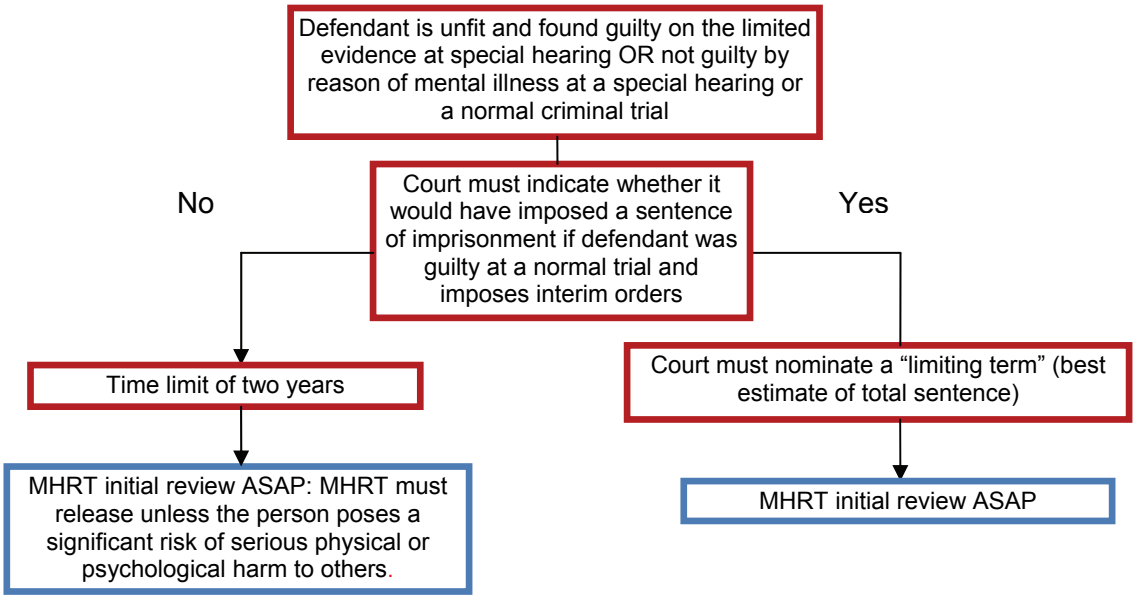
(5) The MHRT must conduct its initial review to determine whether it is appropriate to detain, release with conditions or unconditional release. In some instances the MHRT may adjourn to gather additional information:

(a) Where a person would have faced imprisonment if found guilty at a normal trial, the decision as to whether the person should be detained, the place of detention, and the nature of conditions, if any, would be applied using the framework that applies to the MHRT under the MHFPA (see Chapters 8 and 9). In particular, the MHRT would consider risk of harm.

(b) Where a person would not have faced a sentence of imprisonment if found guilty at a normal trial, the MHRT must not detain unless satisfied that the person poses a significant risk of serious physical or psychological harm to others. Here, the MHFPA framework would be used to apply relevant conditions, if any.

(6) The MHRT continues to conduct reviews, and will vary orders accordingly, until the person ceases to be a forensic patient.

Figure 7.4: Outline of proposed process following a finding of UNA or NGMI



Appeals on a finding of UNA or NGMI

7.148 Section 5(1) of the *Criminal Appeal Act 1912* (NSW) (CAA) makes provision for appeals against conviction and sentence following an ordinary trial as follows:

> A person convicted on indictment may appeal under this Act to the court:
>
> (a) against the person's conviction on any ground which involves a question of law alone, and
>
> (b) with the leave of the court, or upon the certificate of the judge of the court of trial that it is a fit case for appeal against the person's conviction on any ground of appeal which involves a question of fact alone, or question of mixed law and fact, or any other ground which appears to the court to be a sufficient ground of appeal, and
>
> (c) with the leave of the court against the sentence passed on the person's conviction.

Without modification, these provisions would not apply to cases where the person is UNA or NGMI because neither the finding of UNA nor a verdict of NGMI is "a conviction" in law.[151] Similarly, an order made by the court in respect of a person who is UNA or NGMI is not a "sentence". Special provision is accordingly made for appeals in relation to people found UNA or NGMI.

7.149 The CAA empowers the Court of Criminal Appeal (CCA) to review cases where the person is UNA or NGMI by equating those findings and consequent orders with a

151. A qualified finding of guilt at a special hearing is subject to appeal in the same manner as a verdict in an ordinary trial of criminal proceedings: *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22(3)(c). A verdict of NGMI, where the defence has not been set up by the defendant, is a special form of acquittal against which an appeal would ordinarily be precluded: *R v Foy* (1922) 39 WN (NSW) 20, 21; *Greig v The Queen* (1996) 89 A Crim R 254.

conviction and/or sentence.[152] As a result, other provisions of the Act which specify the manner in which ordinary appeals are to be determined also apply to appeals in cases involving people who are UNA or NGMI.[153]

Unfit and not acquitted

7.150 For the purposes of the CAA, the definition of "conviction" includes a finding of UNA at a special hearing.[154] "Sentence" is defined to include a limiting term or other order made in respect of a person who is UNA.[155] "Other order" relates to orders or penalties where a person would not have been imprisoned at a normal trial. A person who is found UNA may therefore appeal against that finding, and/or against the limiting term or other order made by the court, in the same manner as if the person had been convicted and sentenced at an ordinary trial.[156] Similarly, the Crown may appeal as of right against the insufficiency of any such limiting term or order.[157]

7.151 No problems or difficulties were identified by stakeholders with these provisions. We see no need for any change to them.

Not guilty by reason of mental illness

7.152 In relation to NGMI, s 5(2) of the CAA provides as follows:

> For the purposes of this Act a person acquitted on the ground of mental illness, where mental illness was not set up as a defence by the person, shall be deemed to be a person convicted, and any order to keep the person in custody shall be deemed to be a sentence.

7.153 A person found NGMI may, therefore, appeal against the finding of NGMI in the same manner as an appeal against conviction, but may do so only if the defence was not set up by him or her.

7.154 A number of difficulties arise from this provision. The first is determining whether or not the defendant set up the defence of mental illness. It is important to bear in mind that, at the time that discussions take place between the defendant and his or her legal representatives concerning the appropriate plea, it is likely that the defendant is mentally unwell. There may be cases where the defendant does not give clear or reliable instructions or has difficulty with decision making. There may also be cases where the defendant is opposed to raising the defence of NGMI but where the defendant is overridden by his or her lawyer who (taking into account all the evidence and the demeanour of the defendant) believes this to be the appropriate course of action.

---

152. *Criminal Appeal Act 1912* (NSW) s 2(1) (definitions of "sentence" and "conviction"), s 5(2).
153. See *Criminal Appeal Act 1912* (NSW) s 6 and supplementary provisions: s 6A, s 7(4).
154. *Criminal Appeal Act 1912* (NSW) s 2(1). See also *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22(3)(c).
155. *Criminal Appeal Act 1912* (NSW) s 2(1)(d).
156. See, eg, *R v Mailes (No 2)* (2004) 62 NSWLR 181.
157. *Criminal Appeal Act 1912* (NSW) s 2(1)(d), s 5D(1), s 6A. See, eg, *R v Adams* [2002] NSWCCA 448.

7.155 In response to such dilemmas, the CCA has adopted a broad interpretation of s 5(2), drawing a distinction between cases in which the defence is "set up" for the person by their legal representatives, and cases where it is set up by the person. A defence may be "set up" for the defendant for example where the defence was raised without, or contrary to, the defendant's instructions, or where the defendant was unfit to provide instructions.[158] Where the plea is set up for the person, that person may appeal against orders under s 39 of the MHFPA for detention, in the same manner as an ordinary appeal against sentence.[159] Nevertheless, this is a distinction which may be difficult to draw in practice.

7.156 Second, the limitation which allows appeals only in cases where the defence was not set up by the person concerned may have the following apparently unintended consequence. A defendant who set up the defence of mental illness and is found NGMI might wish to appeal against a "sentence", that is an order made by the trial court for detention or an order for release subject to conditions. However, the provisions of s 5 appear to mean that such a person has no avenue of appeal because the verdict of NGMI in such a case is not deemed to be a "conviction".[160]

7.157 In s 2(1)(e) of the CAA, "sentence" is defined as:

> (e) any order made by the court of trial in respect of a person under section 39 of the *Mental Health (Forensic Provisions) Act 1990* …

This suggests that an order for detention or conditional release following a finding of NGMI is a "sentence" and can be the subject of an appeal, regardless of whether or not the defence of mental illness was set up by the defendant. However, in *Peterson v The Queen* it was found that the defence of mental illness was set up by the defendant and:

> Accordingly, this Court has no jurisdiction to entertain the foreshadowed appeal ... The appeal against sentence is similarly incompetent. It could not succeed in any event because, as indicated, the order for detention that was made pursuant to the mandatory provisions of the relevant legislation.[161]

7.158 It is also unclear whether an order for conditional release following a finding of NGMI can be appealed, not being an order to "keep the person in custody" under s 5.[162] However, s 2(1)(e) might operate to cure this situation.

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158. An appellant may lead evidence to establish that the defence was raised without, or contrary to, his or her instructions. For examples of where this was successful, see *R v Williams* [2004] NSWCCA 224 [16]-[20]; *Dezfouli v The Queen* [2007] NSWCCA 86 [39]. Compare the unsuccessful outcomes in *R v Logan* [2004] NSWCCA 101 [31]-[36], [55]-[56], [59]-[60]; *Peterson v The Queen* [2007] NSWCCA 227 [11]-[12]; *R v Foy* (1922) 39 WN (NSW) 20, 21. The fact that defendants in such cases are or may be unfit to give instructions and may be acutely mentally ill at the time of the special hearing, is a relevant consideration and may displace the ordinary rule that a party is bound by the course taken by his or her legal representatives: see *R v Riddell* (2003) 140 A Crim R 549 [21]-[22]; *Dezfouli v The Queen* [2007] NSWCCA 86 [37], [46]; but contrast *Greig v The Queen* (1996) 89 A Crim R 254.
159. See *Criminal Appeal Act 1912* (NSW) s 5(2), s 7(4).
160. *Peterson v The Queen* [2007] NSWCCA 227; 73 NSWLR 134 [15]-[17]. However see para 7.157.
161. *Peterson v The Queen* [2007] NSWCCA 227; 73 NSWLR 134 [17]. At the time of the initial trial the court did not have the power to release people found NGMI.
162. *Criminal Appeal Act 1912* (NSW) s 5(2).

7.159 There is a further inconsistency. If a person is found NGMI on an appeal, the CCA may make an order for detention, conditional release or unconditional release.[163] However, in contrast with the equivalent power provided to the trial court under s 39 of the MHFPA, the CCA is not required to be satisfied that "the safety of the person or any member of the public will not be seriously endangered" before making an order for release. In CP 6, we asked whether the CCA should take into account the safety of the community and/or the person prior making an order for release[164] and all stakeholders who responded agreed.[165] However, under our recommendations above, it would be the MHRT and not the court that would make the initial orders for disposition of the defendant. Orders of the MHRT may be appealed to the Supreme Court or the Court of Appeal (see Chapter 9). Such an appeal would be subject to the considerations in the Part 5 of the MHFPA, including risk of harm to the public (see Chapter 8).

Is there a need for change?

7.160 In most jurisdictions, legislation provides for some form of appeal against findings and orders in cases where the person is UNA or NGMI.[166] In relation to NGMI, most jurisdictions allow for appeal against the verdict, and virtually all jurisdictions allow for appeal against subsequent orders. Tasmania and the NT limit appeals against a verdict of NGMI to situations where the defendant did not set up the verdict; However, the majority of jurisdictions do not make this distinction. This is outlined in Table 7.5.

Table 7.5: Verdicts of NGMI and subsequent orders in Australian jurisdictions

Jurisdiction	Verdict/finding	Orders
Queensland	Appeal any decision of the Mental Health Court.[167]	Can appeal any decision of the Mental Health Court.[168]
South Australia	Appeal against a declaration that a defendant is liable to supervision in the same way as an appeal against a conviction.[169] Allow appeal against a "key decision", which includes a decision whether	Can appeal a supervision order.[170]

163. *Criminal Appeal Act 1912* (NSW) s 7(4).

164. 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 6.69.

165. NSW Bar Association, *Submission MH10*, 43; Law Society of NSW, *Submission MH13*, 21; Legal Aid NSW, *Submission MH18*, 17; NSW, Public Defenders, *Submission MH26*, 44. We also asked whether the CCA required additional powers to assist in decision making and responses were mixed: NSW Bar Association, *Submission MH10*, 43; Law Society of NSW, *Submission MH13*, 21; Legal Aid NSW, *Submission MH18*, 17; NSW, Public Defenders, *Submission MH26*, 45.

166. See *Criminal Code* (NT) s 43X(3)(c), s 43ZB, s 406(2); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 19A, s 24AA, s 24A, s 28A, s 34, s 34A; *Mental Health Act 2000* (Qld) ch 8 pt 2; *Criminal Law Consolidation Act 1935* (SA) s 269Y; *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 12(4) and *Criminal Appeals Act 2004* (WA) s 25; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 36.

167. *Mental Health Act 2000* (Qld) ch 8 pt 2.

168. *Mental Health Act 2000* (Qld) ch 8 pt 2.

169. *Criminal Law Consolidation Act 1935* (SA) s 269Y

170. *Criminal Law Consolidation Act 1935* (SA) s 269Y.

	the defendant was, or was not, mentally competent to commit the offence charged.	
Tasmania	Appeal where acquitted on the ground of insanity where he or she did not "set up" defence.[171]	Can appeal forensic orders, continuing care orders, and community treatment orders.[172]
Victoria	Appeal against verdict of not guilty by reason of mental impairment on any ground of appeal, with leave of the Court of Appeal. Appeal must be allowed where: (a) the verdict of the jury is unreasonable or cannot be supported having regard to the evidence; or (b) as a result of an error or an irregularity in, or in relation to, the trial there has been a substantial miscarriage of justice; or (c) for any other reason there has been a substantial miscarriage of justice.[173]	Can appeal unconditional release and supervision orders.[174]
Western Australia	Appeal where acquitted on account of unsoundness of mind, and the prosecution can appeal in particular circumstances.[175]	Can appeal any order following an acquittal on account of unsoundness of mind.[176]
ACT	Appeals available in relation to "orders of the court", however it is unclear whether an order includes a finding of not guilty by reason of mental impairment.[177]	Can appeal some of the orders following a finding of NGMI; however the court's jurisdiction to make orders is limited where it is dealing with a serious offence.[178]
Northern Territory	Appeal against a finding that the person is not guilty of committing an offence because of his or her mental impairment where the defence of mental impairment was not "raised" by the person.[179]	Can appeal unconditional release and supervision orders.[180]

Submissions and consultations

7.161 Some stakeholders submitted that a verdict of NGMI should be able to be appealed in all instances, including where it was set up by the defendant.[181]

171. *Criminal Code* (Tas) s 399.
172. *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 36.
173. *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 24AA.
174. *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 24A, s 28A.
175. *Criminal Appeals Act 2004* (WA) s 25.
176. *Criminal Appeals Act 2004* (WA) s 25.
177. *Supreme Court Act 1933* (ACT) s 37E; *Criminal Code* (ACT) s 28. The rule against double jeopardy will generally prevent further proceedings in respect of an offence where the person has been acquitted: see discussion in *R v Ardler* [2004] ACTCA 4.
178. *Crimes Act 1900* (ACT) s 323, s 324; *Supreme Court Act 1933* (ACT) s 37E.
179. *Criminal Code* (NT) s 406(2).
180. *Criminal Code* (NT) s 43ZB, s 406(3).
181. Law Society of NSW, *Submission MH13*, 20; Legal Aid NSW, *Submission MH18*, 17; NSW, Public Defenders, *Submission MH26*, 44.

7.162 Many stakeholders suggested that the anomalies raised with regard to appeal of orders following a verdict of NGMI should be addressed;[182] and that the accused should be able to appeal against such orders regardless of whether the defence was set up by the defendant.[183]

The Commission's view

7.163 Under our proposed model of disposition, the court would determine:

(1) whether a person is NGMI, and

(2) the duration of the limiting term if the person would have been imprisoned at a normal trial.

7.164 We recommend that people found NGMI should be able to appeal against this finding regardless of whether the defence was set up by them. The current position in NSW is inconsistent with many other Australian jurisdictions in this respect. Given the likely mental state of the defendant when making decisions about whether or not to raise the defence, and the inherent difficulty in ascertaining this at a later time, we are of the view that an appeal against a finding of NGMI should not be limited.

7.165 We have recommended that the court set a limiting term for those found NGMI. Presently, where a limiting term is set for a person found UNA the length of the limiting term may be appealed by defence or prosecution. Stakeholders agreed that this is appropriate. Accordingly, we recommend that even where the defence of mental illness was set up by the accused, a person found to be NGMI should be able to appeal the duration of a limiting term. Similarly, the prosecution should also be able to appeal the duration of the limiting term as if it were a sentence.

Recommendation 7.6

The *Mental Health (Forensic Provisions) Act 1990* (NSW) and the *Criminal Appeal Act 1912* (NSW) should be amended to the effect that:

(1) A person found not guilty by reason of mental illness may appeal against:

(a) a verdict of not guilty by reason of mental illness, and

(b) the duration of a limiting term,

whether or not he or she set up the defence.

(2) The prosecution may appeal against the duration of a limiting term imposed by the court.

7.166 We note our Recommendations 7.3-7.5, that the MHRT make decisions to release or detain in cases of UNA or NGMI, will mean that:

- Orders regarding forensic patients can be appealed to the Supreme Court and the Court of Appeal. We note that the prosecution cannot appeal as of right;

182. NSW Bar Association, *Submission MH10*, 42.

183. Law Society of NSW, *Submission MH13*, 20; Legal Aid NSW, *Submission MH18*, 17; NSW, Public Defenders, *Submission MH26*, 44.

however the Attorney General can appeal a decision to release, as of right, on a question of law.[184]

- The question of risk to others is relevant to the MHRT's decision to release, and therefore will also be considered by the Court of Appeal in subsequent appeals.

7.167 However, if these recommendations are not adopted, it is appropriate to amend the CAA to deal with these issues.

Recommendation 7.7

If Recommendations 7.3-7.5 are not adopted, the *Criminal Appeal Act 1912* (NSW) should be amended to clarify that:

(a) The defendant may appeal a verdict of not guilty by reason of mental illness whether or not the defendant set up the defence.

(b) The defendant and prosecution may appeal an order following a finding of not guilty by reason of mental illness whether or not the defendant set up the defence.

(c) Before making an order for release of a person found not guilty by reason of mental illness, the Court of Criminal Appeal must be satisfied that the person's release would not pose a significant risk of serious physical or psychological harm to others.

184. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 77A.

8. Factors to guide decision making

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8.1 In this chapter, we look at the considerations that the court and the Mental Health Review Tribunal (MHRT) should have regard to when deciding what orders to make

about a person found not guilty by reason of mental illness (NGMI)[1] or a person found unfit and not acquitted at a special hearing (UNA).

8.2 We consider four issues: the threshold for ordering the release of such a person; whether a presumption of detention should apply in relation to release; whether the principle of least restriction should be included as a consideration in the MHRT's decision making; and the role of victims and carers in proceedings before the court and the MHRT.

Framework for decision making about forensic patients

8.3 There are two bodies that make decisions about the detention, release and treatment of forensic patients: the court, following a finding of NGMI or UNA, and the MHRT, which is responsible for ongoing supervision of the person as a forensic patient.

Decision making by the court

8.4 In Chapter 7 we deal with the powers of the court following a finding of NGMI or UNA. The powers of the court following a finding of NGMI are contained in s 39 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA), which relevantly states:

> **39 Effect of finding and declaration of mental illness**
>
> (1) If, on the trial of a person charged with an offence, the jury returns a special verdict that the accused person is not guilty by reason of mental illness, the Court may order that the person be detained in such place and in such manner as the Court thinks fit until released by due process of law or may make such other order (including an order releasing the person from custody, either unconditionally or subject to conditions) as the Court considers appropriate.
>
> (2) The Court is not to make an order under this section for the release of a person from custody unless it is satisfied, on the balance of probabilities, that the safety of the person or any member of the public will not be seriously endangered by the person's release.

8.5 Following a finding of UNA, the court must indicate whether, if the special hearing had been a normal trial against a person who was fit to be tried, the court would have imposed a sentence of imprisonment.[2] If so, it must set a limiting term and refer the person to the MHRT for determination as to whether the person has a mental illness, or has a mental condition and objects to being detained in a mental health facility.[3] The court has power to make orders with respect to custody or the

1. In Recommendation 3.6 we recommend that this finding be changed to one of "not criminally responsible by reason of cognitive or mental health impairment". In this chapter, for ease of reference, we refer to the current formulation.
2. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 23(1)(a).
3. See *Mental Health (Forensic Provisions) Act 1990* (NSW) s 23(1)(b), s 24.

person's place of detention.[4] Recent case law suggests that the court does not have the power to order release of a person found UNA for whom a limiting term is set.[5]

8.6 Alternatively, where the court would not have imposed a sentence of imprisonment at a normal trial, it may make any other order it could have made had the person been convicted.[6] This would include the power to order release of the person (for example, on a bond). However, the MHFPA does not contain any restriction on ordering the release of a person found UNA in the same way that s 39(2) applies in respect of people found NGMI.

8.7 In Chapter 7 we recommend that following a finding of NGMI or UNA, the court should be directed to refer the person to the MHRT for the making of orders about the person's detention, release and/or treatment.[7] Under our proposed model the court would not retain the power to make orders about the person's detention or release. However, for convenience, in this chapter we refer to the powers of the court as they currently stand.

Decision making by the MHRT

8.8 The MHRT is responsible for the majority of decisions about forensic patients. Under our proposed scheme in Chapter 7, it will be responsible for all decision making, with the court having a power only to make interim orders.

8.9 In Chapter 9 we canvass the powers of the MHRT relating to the review and supervision of forensic patients. Under the MHFPA, the MHRT is required to conduct an initial review of a forensic patient as soon as practicable after the finding of NGMI or UNA.[8]

8.10 After the initial review, the MHRT may review the person's case at any time, but must, in any event, review the person's case at least every six months.[9] At all further reviews, the MHRT may make an order as to:

(a) the patient's continued detention, care or treatment in a mental health facility or other place, or

(b) the patient's release, either conditionally or unconditionally.[10]

8.11 Where a person has been found UNA, the MHRT must also continue to assess whether he or she has become fit to be tried.[11]

---

4. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 24(1)(b), s 27.
5. See *State of NSW v TD* [2013] NSWCA 32; cf *AN (No 2) v The Queen* [2006] NSWCCA 218; 66 NSWLR 523 [45]-[56]. This issue is discussed further in Chapter 7: see para 7.10.
6. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 23(2).
7. See Recommendation 7.3.
8. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 44, s 45. The powers of the Mental Health Review Tribunal at an initial review are discussed in greater detail in Chapter 9: see para 9.26.
9. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 46(1). This is subject to two exceptions: see s 46(3)-(5).
10. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 47(1).

8.12 Additionally, the MHRT has the power to grant periods of leave from any place where a forensic patient is detained,[12] and may also order the transfer of a forensic patient to a mental health facility, correctional centre or other place.[13]

Matters to be taken into account in all decisions regarding forensic patients

8.13 When making orders about forensic patients, s 74 of the MHFPA sets out the matters to which the MHRT must take into account:

> **74 Matters for consideration**
> Without limiting any other matters the Tribunal may consider, the Tribunal must have regard to the following matters when determining what order to make about a person under this Part:
>
> (a) whether the person is suffering from a mental illness or other mental condition,
>
> (b) whether there are reasonable grounds for believing that 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,
>
> (c) the continuing condition of the person, including any likely deterioration in the person's condition, and the likely effects of any such deterioration,
>
> (d) in the case of a proposed release, a report by a forensic psychiatrist or other person of a class prescribed by the regulations, who is not currently involved in treating the person, as to the condition of the person and whether the safety of the person or any member of the public will be seriously endangered by the person's release,
>
> (e) in the case of the proposed release of a forensic patient subject to a limiting term, whether or not the patient has spent sufficient time in custody.

8.14 Section 68 of the *Mental Health Act 2007* (NSW) (MHA) also applies to the administration of the MHFPA with respect to forensic patients.[14] It relevantly provides:

> **68 Principles for care and treatment**
> It is the intention of Parliament that the following principles are, as far as practicable, to be given effect to with respect to the care and treatment of people with a mental illness or mental disorder …
>
> (a) people with a mental illness or mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given, ...
>
> (f) any restriction on the liberty of patients and other people with a mental illness or mental disorder and any interference with their rights, dignity and self respect is to be kept to the minimum necessary in the circumstances …

---

11. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 47(4).
12. See *Mental Health (Forensic Provisions) Act 1990* (NSW) s 49. The Director-General of the Department of Health also has a limited power to grant leave: s 50.
13. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 48.
14. See *Mental Health (Forensic Provisions) Act 1990* (NSW) s 76B(1).

8.15 The provisions of s 68 of the MHA appear to form part of the considerations to which the MHRT must have regard when making decisions about forensic patients. However, it is not clear that they are to be accorded the same weight as the factors set out in s 74 of the MHFPA. The principles in s 68 of the MHA are said to "give guidance in the administration of this Act and do not create, or confer on any person, any right or entitlement enforceable at law".[15] Furthermore, s 68 is stated to apply to the care and treatment of people with a mental illness or mental disorder, and therefore does not encompass forensic patients with cognitive impairments.

Additional matters to be taken into account for release or leave

8.16 Additionally, where the MHRT seeks to release a forensic patient, with or without conditions, the MHRT is subject to a constraint on the exercise of that discretion. Section 43 provides:

> **43 Criteria for release and matters to be considered by Tribunal**
> The Tribunal must not make an order for the release of a forensic patient unless it is satisfied, on the evidence available to it, that:
>
> (a) the safety of the patient or any member of the public will not be seriously endangered by the patient's release, and
>
> (b) other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the patient or that the patient does not require care.

8.17 Therefore, when making decisions involving release of a forensic patient the MHRT must consider the matters in s 74 of the MHFPA and s 68 of the MHA, as well as the matters in s 43. It appears to have been intended that s 74 applies to all decision making regarding forensic patients, with s 43 being an additional proscription when an order of release is being sought. However, s 74(d) and (e) contain matters that are only relevant to release decisions. The relationship between the two sections is therefore somewhat confusing.

8.18 There is also a similar constraint on discretion contained in s 49 of the MHFPA applying to a decision to grant a leave of absence to a forensic patient:

> **49 Tribunal may grant leave**
> (1) The Tribunal may make an order allowing a forensic patient to be absent from a mental health facility, correctional centre or other place for such period and subject to such terms and conditions, if any, as the Tribunal thinks fit.
>
> (2) An order may be made on the application of the patient or on the motion of the Tribunal.
>
> (3) The Tribunal must not make an order allowing a forensic patient to be absent from a mental health facility, correctional centre or other place unless it is satisfied, on the evidence available to it, that the safety of the patient or any member of the public will not be seriously endangered if the leave of absence is granted.

15. *Mental Health Act 2007* (NSW) s 195.

8.19 Again the decision to order a leave of absence must be made having regard to the factors listed in s 74 of the MHFPA and s 68 of the MHA.

Threshold for ordering the release of a forensic patient

8.20 In this section we consider whether the current provisions pertaining to decisions about the release of a forensic patient are in need of reform.

How has the current framework been applied?

8.21 In order for a forensic patient to be released or granted a leave of absence, the court or the MHRT must be satisfied that "the safety of the person or any member of the public will not be seriously endangered" by the person's release or leave.[16] One of the difficulties with the current framework is that there is very little guidance on what this phrase means. There do not appear to be any NSW judicial decisions which have dealt with this framework in any detail.

8.22 However, there is Victorian authority on the meaning of "likely to endanger" and "seriously endangered" in the equivalent Victorian legislation. In considering the phrase "likely to endanger", the Victorian Court of Appeal has recently affirmed that endangerment is about the risk of harm. Both the probability of the harm occurring and the gravity of the possible harm are relevant to assessing the nature of the risk, but the probability of a risk occurring is the "critical concept of endangerment".[17] Furthermore, according to the Court the risk of "serious endangerment" encompasses the gravity of the possible harm.[18] This means that a small risk of serious harm occurring may amount to serious endangerment, while a high risk of relatively trivial harm may not.[19]

Test for allowing release in other jurisdictions

8.23 The conditions that apply to decisions regarding the release of a forensic patient vary considerably between jurisdictions. Some jurisdictions contain a constraint on decision making involving release which is similar to s 43 of the MHFPA. Other jurisdictions require the decision maker to order the release of a forensic patient unless satisfied that the risk posed by the release justifies ongoing detention. Yet other jurisdictions contain no constraint in either direction, with the decision maker being directed to make any order it considers appropriate having regard to a list of relevant considerations.

8.24 Further, the way of expressing the degree of risk that is required in order for a forensic patient to be detained differs significantly between jurisdictions. Victoria has a similarly worded "seriously endangered" test to NSW.[20] In the NT, the test is

16. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 39(2), s 43(a), s 49(3).
17. *NOM v DPP* [2012] VSCA 198 [58].
18. *NOM v DPP* [2012] VSCA 198 [64].
19. *Re Percy, Farrell and RJO* (1998) 102 A Crim R 554, 566, cited in *NOM v DPP* [2012] VSCA 198 [63].
20. *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 32(2), s 35(3).

whether the safety of the public will or is likely to be "seriously at risk".[21] In SA and Tasmania, the relevant test is whether the person is "likely to endanger" another person or other people generally.[22] In the ACT the test for decision making by the court is whether "the accused is likely to be a danger to the community",[23] and on review by the ACT Civil and Administrative Tribunal (ACAT) it is whether "the person would be likely to do serious harm to others".[24] In Queensland, it is whether the person represents an "unacceptable risk" to the safety of others.[25] In WA the court is required to consider "the degree of risk that the release of the accused appears to present to the personal safety of people in the community or of any individual in the community".[26]

8.25 Table 8.1 sets out the relevant tests for ordering the release of a forensic patient in other jurisdictions.

Table 8.1: Test for release in other jurisdictions

Jurisdiction	Test for release	Legislation
Commonwealth	The Attorney-General must not order a person's release from detention unless the Attorney-General is satisfied that the person is not a threat or danger either to himself or herself or to the community.	*Crimes Act 1914* (Cth) s 20BL(2)
ACT	In making a decision which could include an order for detention, the Supreme Court or Magistrates Court shall consider the following criteria: ... (b) whether or not, if released— (i) the accused's health and safety is likely to be substantially impaired; or (ii) the accused is likely to be a danger to the community.	*Crimes Act 1900* (ACT) s 308
	In considering whether or not to order the release of a person, the ACAT shall have regard to the following: ... (b) whether or not, if released— (i) the person's health or safety would be, or would be likely to be, substantially impaired; or (ii) the person would be likely to do serious harm to others.	*Mental Health (Treatment and Care) Act 1994* (ACT) s 72(3)
NT	On completing the review under subsection (5), unless the court considers that the safety of the supervised person or the public will or is likely to be seriously at risk if the supervised person is released, the court must release the supervised person unconditionally.	*Criminal Code* (NT) s 43ZG(6)
	On completing the review of a custodial supervision order, the court must: (a) vary the supervision order to a non-custodial supervision order unless	*Criminal Code* (NT) s 43ZH(2)

21. *Criminal Code* (NT) s 43ZG(6), s 43ZH(2)(a).
22. *Criminal Law Consolidation Act 1935* (SA) s 269T(1)(b); *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 35(1)(b).
23. *Crimes Act 1900* (ACT) s 308(b)(i).
24. *Mental Health (Treatment and Care) Act 1994* (ACT) s 72(3).
25. *Mental Health Act 2000* (Qld) s 204(1), s 289(4).
26. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 28(3)(a), s 33(5)(a).

	satisfied on the evidence available that the safety of the supervised person or the public will be seriously at risk if the person is released on a non-custodial supervision order.	
	In determining whether to make an order under this Part, the court must have regard to the following matters: (a) whether the accused person or supervised person concerned is likely to, or would if released be likely to, endanger himself or herself or another person because of his or her mental impairment, condition or disability.	*Criminal Code* (NT) s 43ZN(1)
Queensland	The tribunal must not do either of the following unless it is satisfied the patient does not represent an unacceptable risk to the safety of the patient or others, having regard to the patient's mental illness or intellectual disability— (a) revoke the forensic order for the patient; (b) order or approve limited community treatment for the patient.	*Mental Health Act 2000* (Qld) s 204
SA	In deciding proceedings, the court should have regard to: ... (b) whether the defendant is, or would if released be, likely to endanger another person, or other persons generally.	*Criminal Law Consolidation Act 1935* (SA) s 269T
Tasmania	In determining proceedings under this Part, the court must ... have regard to- ... (b) whether the defendant is, or would if released be, likely to endanger another person or other persons generally.	*Criminal Justice (Mental Impairment) Act 1999* (Tas) s 35(1)
Victoria	The court must not vary a custodial supervision order to a non-custodial supervision order during the nominal term unless satisfied on the evidence available that the safety of the person subject to the order or members of the public will not be seriously endangered as a result of the release of the person on a non-custodial supervision order.	*Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 32(2)
	On a major review, the court— (a) if the supervision order is a custodial supervision order— (i) must vary the order to a non-custodial supervision order, unless satisfied on the evidence available that the safety of the person subject to the order or members of the public will be seriously endangered as a result of the release of the person on a non-custodial supervision order.	*Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 35(3)
	In deciding whether or not to make, vary or revoke an order under Part 3, 4 or 5 in relation to a person, to grant extended leave to a person or to revoke a grant of extended leave, the court must have regard to— ... (c) whether the person is, or would if released be, likely to endanger themselves, another person, or other people generally because of his or her mental impairment.	*Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 40(1)
WA	In deciding whether to recommend the release of a mentally impaired accused, the [Mentally Impaired Accused] Board is to have regard to these factors — (a) the degree of risk that the release of the accused appears to present to the personal safety of people in the community or of any individual in the community.	*Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 33(5)
Canada	Where a verdict of not criminally responsible on account of mental disorder has been rendered in respect of the accused and, in the opinion of the court or Review Board, the accused is not a significant threat to the safety of the public, the court or Review Board shall by order, direct that the accused be discharged absolutely.	*Criminal Code*, RSC 1985 s 672.54(a)

8.26 The test in Canada, whether the accused is a "significant threat to the safety of the public", has been interpreted by the Canadian Supreme Court to mean:

> The threat must also be 'significant', both in the sense that there must be a real risk of physical or psychological harm occurring to individuals in the community and in the sense that this potential harm must be serious. A minuscule risk of a grave harm will not suffice. Similarly, a high risk of trivial harm will not meet the threshold. Finally, the conduct or activity creating the harm must be criminal in nature. In short, [the Criminal Code requires] that the individual poses a significant risk of committing a serious criminal offence.[27]

Tests in other contexts

8.27 In a number of other contexts a decision maker is required to determine whether a person should be released or detained in custody. The way that these tests are framed may provide useful guidance in our consideration of the most appropriate test for the forensic system, although the difference in contexts must be recognised.

8.28 In the NSW civil mental health system, a person may be involuntarily detained in a mental health facility if he or she is found to be a "mentally ill person".[28] "Mentally ill person" is defined as:

> (1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:
>
> (a) for the person's own protection from serious harm, or
>
> (b) for the protection of others from serious harm.
>
> (2) In considering whether a person is a mentally ill person, 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.[29]

8.29 There is no constraint on the release of an involuntary civil patient such as appears in s 43 of the MHFPA. Furthermore, the MHRT interprets "serious harm" in the civil mental health context quite broadly, to include: physical harm; financial harm; harm to reputation or relationships; neglect of self; and neglect of others (including children).[30]

8.30 The *Crimes (High Risk Offenders) Act 2006* (NSW) allows the Supreme Court to make a continuing detention order for a high risk sex offender or a high risk violent offender who is to due to be released from custody within the following six months "if the Supreme Court is satisfied to a high degree of probability that the offender

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27. *Winko v British Columbia (Forensic Psychiatric Institute)* [1999] 2 SCR 625 [57] (citations omitted).
28. *Mental Health Act 2007* (NSW) s 12.
29. *Mental Health Act 2007* (NSW) s 14.
30. Mental Health Review Tribunal, *Civil Hearing Kit Section 1: Extending a Person's Involuntary Stay in Hospital* (2009) 1.2.

poses an unacceptable risk" of committing a serious sex offence or a serious violence offence if he or she is not kept under supervision.[31]

8.31 In the context of sentencing, the High Court has held that a sentence of indeterminate detention should be confined to those cases where it is necessary to protect society from physical harm (including sexual offences). A risk of the offender committing serious but non-violent offences, such as crimes involving financial loss or property damage, would not be sufficient.[32]

8.32 In England and Wales, sentencing options available for "dangerous offenders" apply where there is a significant risk to members of the public of serious harm. "Serious harm" is defined to mean "death or serious personal injury, whether physical or psychological".[33]

Submissions and consultations

8.33 In CP 6 we asked how the relevant degree of risk of harm should be expressed in the MHFPA.[34]

8.34 The Law Society of NSW and Legal Aid NSW suggested that it should be framed in terms of "likely to pose a significant risk of serious physical harm occasioned by criminal conduct to other members of the community".[35] The Public Defenders preferred the Canadian approach, suggesting that the threshold be one of a "significant threat to the safety of the public".[36] The NSW Bar Association submitted that the degree of risk should be "serious" and the harm should be "significant" (in the sense of "not insignificant").[37] It also suggested that there needed to be consistency between the tests used in s 39(2), s 43(a) and s 74(b) of the MHFPA.[38]

8.35 The MHRT submitted that the use of a test which assesses for "serious harm" is desirable insofar as it aligns the test with the one the Tribunal uses in the civil mental health system for determining whether someone is a "mentally ill person".[39]

8.36 We also asked what kind of possible harm should be relevant to decisions to detain or release people who are found UNA or NGMI.[40] The response from stakeholders was varied.

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31. *Crimes (High Risk Offenders) Act 2006* (NSW) s 5B, s 5E. There is a further requirement that adequate supervision would not provided by an extended supervision order, which can also be made under the Act: see s 5D(1), s 5G(1).
32. *Chester v The Queen* (1988) 165 CLR 611, 618-619. See also *Buckley v The Queen* [2006] HCA 7; 80 ALJR 605 [6].
33. *Criminal Justice Act 2003* (UK) c 44, s 224(3), s 226A.
34. 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 6.57.
35. Law Society of NSW, *Submission MH13*, 18; Legal Aid NSW, *Submission MH18*, 15.
36. NSW, Public Defenders, *Submission MH26*, 42.
37. NSW Bar Association, *Submission MH10*, 40.
38. NSW Bar Association, *Submission MH10*, 40.
39. Mental Health Review Tribunal, *Consultation MH38*; see also *Mental Health Act 2007* (NSW) s 14, s 38.

8.37 Most stakeholders agreed that harm should include physical harm.[41] The NSW Law Society and Legal Aid NSW submitted that the test should be one of "serious physical harm".[42] The NSW Council for Civil Liberties submitted that physical harm should be the only relevant type of harm,[43] while the NSW Bar Association, Corrective Services NSW, Homicide Victims' Support Group (HVSG) and the Public Defenders submitted that psychological harm should be included.[44] The NSW Bar Association also suggested the inclusion of significant damage to property,[45] and the Public Defenders submitted that it should extend to any kind of harm which is criminal in nature.[46] The MHRT was of the view that harm should include physical harm, psychological harm and financial harm.[47]

8.38 Four stakeholders submitted that harm should be explicitly defined in the MHFPA.[48]

Are there problems with the current framework?

8.39 We were not alerted to any problems in practice with the current legislative framework for determining the release of a forensic patient by the MHRT, which involves the use of the considerations specified by s 74 of the MHFPA and s 68 of the MHA, and the constraints on release contained in s 43 and s 49.[49]

8.40 However, the terminology used in the MHFPA may require review, in particular the requirement in s 43 that the MHRT must not release a forensic patient unless satisfied that "the safety of the patient or any member of the public will not be seriously endangered by the patient's release". There are two reasons why change may be desirable.

Inconsistency between civil and forensic mental health systems

8.41 First, there is an inconsistency in terminology in the tests for determining the detention of a patient across the forensic and civil mental health systems, notwithstanding that the same public interest in the safety of the person and others is involved. The test for detention in the civil mental health system looks to whether detention of the person is necessary for the protection of the person or others from

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40. 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 6.55.
41. NSW Bar Association, *Submission MH10*, 39; Law Society of NSW, *Submission MH13*, 18; Corrective Services NSW, *Submission MH17*, 9; Legal Aid NSW, *Submission MH18,* 15; NSW, Public Defenders, *Submission MH26*, 42; NSW Council for Civil Liberties, *Submission MH46*, 9.
42. Law Society of NSW, *Submission MH13*, 18; Legal Aid NSW, *Submission MH18*, 15.
43. NSW Council for Civil Liberties, *Submission MH46*, 9.
44. NSW Bar Association, *Submission MH10*, 39; Corrective Services NSW, *Submission MH17*, 9; Homicide Victims' Support Group, *Submission MH20*, 14; NSW, Public Defenders, *Submission MH26*, 42.
45. NSW Bar Association, *Submission MH10*, 39.
46. NSW, Public Defenders, *Submission MH26*, 42.
47. Mental Health Review Tribunal, *Consultation MH38*.
48. NSW Bar Association, *Submission MH10*, 39; Law Society of NSW, *Submission MH13*, 18; Legal Aid NSW, *Submission MH18*, 15; NSW, Public Defenders, *Submission MH26*, 42.
49. Note, however, that stakeholders raised concerns about the operation of *Mental Health (Forensic Provisions) Act 1990* (NSW), s 74(e). In Chapter 9 we recommend that this subsection be removed: see Recommendation 9.12.

serious harm.[50] This test is also used for forensic patients when determining whether to make an order for apprehension of a forensic patient,[51] and as a relevant factor to which the MHRT must have regard when making orders about a forensic patient.[52] The constraint on release in the forensic system, on the other hand, looks to whether the safety of the patient or any member of the public will be seriously endangered by the patient's release. We question whether the difference between the two contexts justifies the use of different tests for assessing risk.

Inconsistency with contemporary language of risk assessment

8.42 Secondly, having a constraint on the ordering of release which uses the language of whether "safety" will be "seriously endangered" may not be the most appropriate way of expressing the assessment which is to be made when deciding the release of a forensic patient.

8.43 There has been a general move in recent years away from the terminology of "dangerousness" towards the use of "risk".[53] Howard and Westmore explain this move on the basis that:

> 'Dangerousness' tends to suggest a static condition, whereas the measurement of risk involves not only some static components, but many variable and changeable components as well, and also needs to be balanced, where applicable, against strategies of risk minimisation.[54]

8.44 Ogloff and Davis, in a similar vein, state:

> The term dangerousness connoted a dichotomous state — either one is or is not 'dangerous'. Using the term risk assessment, essentially resulted in the term 'dangerousness' being divided into the following component parts: (1) risk factors — the variables used to predict aggression, (2) harm — the amount and type of aggression being predicted, and (3) risk level — the probability that harm will occur. Thus, risk assessment characterises the task the way it is currently construed.[55]

8.45 Dangerousness has been criticised as a vague and unhelpful way of expressing the risk of a particular individual causing harm.[56]

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50. *Mental Health Act 2007* (NSW) s 14.
51. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 68(1)(d).
52. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 74(b).
53. See D Howard and B Westmore, *Crime and Mental Health Law in New South Wales* (LexisNexis Butterworths, 2nd ed, 2010) 464; B McSherry, "Indefinite and Preventative Detention Legislation: From Caution to an Open Door" (2005) 29 *Criminal Law Journal* 94, 106; J R P Ogloff and M R Davis, "Assessing Risk for Violence in the Australian Context" in D Chappell and P Wilson (ed), *Issues in Australian Crime and Criminal Justice* (LexisNexis Butterworths, 2005) 301, 307, 320.
54. D Howard and B Westmore, *Crime and Mental Health Law in New South Wales* (LexisNexis Butterworths, 2nd ed, 2010) 464.
55. J R P Ogloff and M R Davis, "Assessing Risk for Violence in the Australian Context" in D Chappell and P Wilson (ed), *Issues in Australian Crime and Criminal Justice* (LexisNexis Butterworths, 2005) 301, 307.
56. See D Howard and B Westmore, *Crime and Mental Health Law in New South Wales* (LexisNexis Butterworths, 2nd ed, 2010) 476-7.

8.46 The use of "seriously endangered" in the MHFPA does not expressly encompass a risk assessment or risk minimisation approach. Strategies of risk management and risk minimisation are reflected to an extent in s 43, which looks to the safety of the person and of others rather than the dangerousness of the person. The reference in s 43(b) to the availability of less restrictive care is also couched in the language of *safe* and effective care. However, "safety" does not, of itself, indicate that assessment for release should take into account the nature of the risk, the likelihood of harm occurring, and whether risk minimisation strategies could mitigate that risk.

8.47 In practice, however, courts have interpreted "endangerment" to align it with contemporary ideas of risk assessment. Victorian case law has considered "seriously endangered" to be synonymous with risk. Notably, the Victorian Court of Appeal recently stated that: "the probability of any risk, be it high or low, is the critical concept of endangerment".[57] The Canadian Supreme Court has also interpreted "significant threat to the safety of the public" by reference to the risk of harm occurring to individuals in the community.[58]

8.48 Furthermore, clinicians and health professionals in the mental health field, whose opinions inform court and MHRT decision making, appear to have moved away from a "dangerousness" assessment towards one of risk assessment.[59] If courts and health professionals approach the question of "serious endangerment" in terms of an assessment of risk of harm, as it appears they do, then there is merit in updating the language in the MHFPA to reflect what is actually done in practice.

8.49 The current terminology of "seriously endangered" used to determine the release of a forensic patient was inserted into the original *Mental Health Act 1990* (NSW) and later transferred into the MHFPA.[60] It has been the standard applied to determine the release of forensic patients for over 20 years. However, it appears that there has been a subsequent move towards the express use of "risk" in more recent legislation dealing with decisions to detain or release a person. For example, the *Crimes (High Risk Offenders) Act 2006* (NSW) considers whether there is an "unacceptable risk" of an offender committing a serious sex offence or serious violence offence.[61]

8.50 More generally, there is also symbolic value in moving away from the use of dangerousness as the test for determining the release of forensic patients. The current test in s 43(a) of the MHFPA does not require consideration of whether the *forensic patient* is dangerous, but rather it asks whether public safety will be seriously endangered by the forensic patient's *release.* Notwithstanding this, assessing forensic patients in terms of the level of "danger" their release poses to

57. *NOM v DPP* [2012] VSCA 198 [58].
58. *Winko v British Columbia (Forensic Psychiatric Institute)* [1999] 2 SCR 625 [57].
59. See D Howard and B Westmore, *Crime and Mental Health Law in New South Wales* (LexisNexis Butterworths, 2nd ed, 2010) 476-7; J R P Ogloff and M R Davis, "Assessing Risk for Violence in the Australian Context" in D Chappell and P Wilson (ed), *Issues in Australian Crime and Criminal Justice* (LexisNexis Butterworths, 2005) 301, 307, 320.
60. See *Mental Health Act 1990* (NSW) s 80(2), s 81(2), s 82(4), repealed by *Mental Health Act 2007* (NSW) s 200; *Mental Health Act 2007* (NSW) sch 7.7 [28], repealed by *Statute Law (Miscellaneous Provisions) Act 2008* (NSW) sch 4.
61. *Crimes (High Risk Offenders) Act 2006* (NSW) s 5B, s 5E.

others may result in inappropriate labelling.[62] While issues of safety are clearly important, the use of "seriously endangered" as a test may be a remnant of the historical context of the forensic system in NSW, which originated in times in which no, or no useful, treatment might be available for people with cognitive and mental health impairments, and where there was a perception that this group was dangerous no matter what the person's individual condition might be.[63] However there is now a detailed system of treatment, review and release for forensic patients. References to risk, rather than endangerment, would appear to be a more accurate and contemporary way of assessing forensic patients for release.

8.51 The primary arguments against updating the terminology in the MHFPA are the longstanding use of "seriously endangered" as the criteria for release, and the fact that there are no cases in NSW which explore the meaning of this phrase, indicating that it may not be causing problems in practice. However the MHRT, which is responsible for the majority of release decisions, has expressed support for moving to a risk of harm test.[64]

The Commission's view

Changing the terminology

8.52 We recommend that the current test for determining the release of a forensic patient should be changed from a test of "seriously endangered" to a test that expressly requires consideration of the risk of harm. Our recommendation does not involve any reduction in the weight attached to the safety of the community. Rather, it is intended to update the terminology used in the MHFPA.

8.53 Case law indicates that the test of "seriously endangered" is interpreted by reference to risk of harm. The argument in favour of change, therefore, does not hinge on any difficulty with the interpretation of this provision by the courts. However, the legislation is used not only by lawyers but also by others, in particular healthcare professionals whose opinions inform the decisions of the MHRT and the courts. There is merit in adopting terminology which reflects the language and approach currently used by these professionals. The MHRT supports this change.

8.54 A risk-based threshold for release should require that there be no significant risk of serious harm. The use of the term "serious harm" aligns the test more closely with that used in the civil mental health system, making the standards used in the MHRT's decision making more consistent. Given that the assessment of risk will determine whether the forensic patient may be released, or must be subject to ongoing detention, the risk of harm must be serious enough to justify the continued restriction on the person's liberty. "Significant" risk of "serious" harm is an appropriate hurdle. Consistent with judicial authority, this means that a miniscule risk of a grave harm will not suffice. Similarly, a high risk of trivial harm will not meet the threshold.

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62. D Howard and B Westmore, *Crime and Mental Health Law in New South Wales* (LexisNexis Butterworths, 2nd ed, 2010) 464.
63. See G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [2.1].
64. Mental Health Review Tribunal, *Consultation MH38*.

Specific amendments to the MHFPA

8.55 Section 74 of the MHFPA provides the MHRT with guidance as to the matters that are relevant to all of its decisions relating to forensic patients. It is appropriate that this overarching list of considerations requires that the Tribunal take into account a broad range of possible harms. Therefore, we do not recommend any amendments to the requirement that the MHRT take into account whether there are reasonable grounds for believing that care, treatment or control is necessary for the protection of the person or others from "serious harm" in s 74(b).

8.56 However, the matters relevant to release under s 43 properly involve a somewhat different and more narrowly confined set of considerations. For this reason, we recommend restricting the types of harm that must be considered in that section to physical or psychological harm to members of the public. The inclusion of these types of harm in decisions about release was supported by stakeholders.

8.57 Section 43(a) should provide that the MHRT may only make an order for release if the person's release would not pose a significant risk of serious physical or psychological harm to others. Under this approach the MHRT *must* order continued detention where there is a significant risk of serious physical or psychological harm, but *may* also order continuing detention if there is a risk of other types of serious harm.

8.58 We also recommend amendment to s 43(b). Rather than preventing release unless less restrictive care is appropriate and reasonably available, as is currently the case, we recommend that the availability of treatment, support or supervision in the community be a relevant consideration for the MHRT to take into account in determining release.[65] The language of "support, supervision or treatment" more accurately describes the needs of forensic patients with a cognitive impairment as well as those with a mental illness, as the former are unlikely to require "care".

8.59 Section 74(d) of the MHFPA requires an independent report assessing risk in the case of a proposed release. That report is required to deal with the "condition of the person and whether the safety of the person or the public will be seriously endangered by the person's release". We recommend that s 74(d) be amended to adopt the same terminology that we propose for s 43(a). Furthermore, as s 74(d) relates only to release decisions, we suggest that consideration be given to relocating it to s 43. In any event, to avoid confusion we recommend that s 43 should expressly refer to the considerations contained in s 74 of the MHFPA and s 68 of the MHA.

8.60 Section 49(3) of the MHFPA deals with the granting of leave. Leave involves a temporary absence of a forensic patient with a specified time for return. In conformity with our recommendations above, we recommend that s 49(3) be amended in a manner similar to that proposed for s 43(a).

8.61 Finally, in Chapter 7 we recommend that the power to make orders for detention and release of a person following a finding of NGMI or UNA be removed from the court and left to the MHRT. If this recommendation is not adopted, then we consider

65. See para 8.88-8.89 for a discussion of the problems associated with the current wording of s 43(b).

that the court's power to order the release of a person found NGMI or UNA should be subject to a similar constraint on discretion to that which we are proposing for the MHRT.

Recommendation 8.1

(1) Section 43 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that in making a decision about release, including conditional release, the Mental Health Review Tribunal:

(a) may make such an order only if it is satisfied that the person's release would not pose a significant risk of serious physical or psychological harm to others

(b) must consider:

(i) the matters contained in s 74 of the *Mental Health (Forensic Provisions) Act 1990* (NSW)

(ii) the principles contained in s 68 of the *Mental Health Act 2007* (NSW), and

(iii) whether the person requires further support, supervision or treatment, and if so, whether effective and appropriate support, supervision or treatment would be available to the person in the community upon release.

(2) Section 49(3) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that the Mental Health Review Tribunal may make an order allowing a forensic patient to be absent from a mental health facility, correctional centre or other place only if it is satisfied that the person's leave of absence would not constitute a significant risk of serious physical or psychological harm to others.

(3) Section 74(d) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to adopt the same terminology proposed for s 43(a) in Recommendation 8.1(1).

(4) If Recommendations 7.3-7.5 are not adopted and the court retains the power to order the release of a defendant following a finding of not guilty by reason of mental illness or a finding of unfit and not acquitted, then the legislation should provide that the court may make an order for release only if it is satisfied that the person's release would not pose a significant risk of serious physical or psychological harm to others.

Should a risk of self-harm prevent the release of a forensic patient?

8.62 The safety of the person, as well as the safety of the public, is a relevant consideration in any decision the MHRT makes concerning a forensic patient.[66] Additionally, both the MHRT and the court *cannot* make an order for release of a person unless satisfied that the person's *own safety* would not be seriously

66. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 74(b).

endangered by the release.[67] The same constraint applies to the MHRT when making an order granting a forensic patient leave of absence.[68]

8.63 There are obvious reasons of community protection why a person who poses a risk of harm to the public should not be released. However, the public interest in protecting others from harm is quite different from the public interest in protecting a person from harming themselves. In respect of the latter, it is much more difficult to justify the person's ongoing detention as a forensic patient as being in the public interest. In this situation, the risk of self-harm upon release should arguably be considered against the risks to the person's health and well-being were they to be kept in continued detention. It may not be appropriate to require the MHRT to continue to order the detention of a forensic patient who poses a risk only of self-harm. There may be better options for managing a risk of self-harm, such as management in the civil mental health system, or through guardianship arrangements.

8.64 Similarly, s 49 of the MHFPA precludes the granting of a leave of absence unless the safety of the person will not be seriously endangered by the grant of leave. Leave is the first step towards the granting of release. If a person is prevented from taking leave from the place where he or she is being detained, then it is less likely that an order for conditional release will be made. The forensic patient will not have had an opportunity to demonstrate his or her ability to manage in the community.[69] Therefore, it may also not be appropriate to prevent a leave of absence from being granted where a forensic patient is at risk solely of self-harm.

8.65 It is unlikely that this issue is one which will arise frequently in practice. The MHRT has informed us that the number of cases where a forensic patient presents only a risk to themselves, as opposed to a risk to other members of the public as well, is likely to be quite small.[70]

8.66 In Queensland, and in Victoria during the period of the nominal term,[71] a person cannot be released where they are at risk of harming themselves.[72] In the NT, and in Victoria following completion of the nominal term, a person must be released unless they present a risk of harm to themselves.[73] In the ACT, risk of self-harm is simply one factor for the court or ACAT to take into account when making a decision.[74] In SA, Tasmania and WA, risk of self-harm is not a relevant factor.[75]

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67. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 39(2), s 43(a).
68. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 49(3).
69. See G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [8.5].
70. Mental Health Review Tribunal, *Consultation MH38*.
71. A nominal term is similar to a limiting term for people found UNA in NSW, although there is no entitlement to be unconditionally released at the end of a nominal term: see *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 28, s 35; cf *Mental Health (Forensic Provisions) Act 1990* (NSW) s 52(2).
72. *Mental Health Act 2000* (Qld) s 204(1), s 289(4); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 32(2).
73. *Criminal Code* (NT) s 43ZG(6), s 43ZH(2)(a); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 35(3).
74. *Crimes Act 1900* (ACT) s 308(b)(i); *Mental Health (Treatment and Care) Act 1994* (ACT) s 72(3)(b).

Submissions and consultations

8.67 In CP 6 we asked:

- To what extent (if any) should the court take into account a person's risk of harm to him- or herself, as distinct from the risk (if any) to other members of the community?
- Should the court be provided with a power to refer a person to the civil jurisdiction of the MHRT, or to another appropriate agency, if the person poses a risk of harm to no-one but him or herself?
- In what circumstances, and to what extent, should the Forensic Division of the MHRT be required to have regard to a risk of harm only to the person concerned, in the absence of any risk to others?[76]

8.68 There was a general consensus amongst stakeholders that, where the risk of harm is limited solely to self-harm, the person should not be detained within the forensic system and should instead be transferred to the civil mental health system.[77]

The Commission's view

8.69 In our view, limiting the discretion of the MHRT by preventing it from ordering leave or release where a person presents only a risk of self-harm is not justified. It is for this reason that we recommend that the reference to the person's own safety in s 43(a) and s 49(3) of the MHFPA be removed. Where there is a risk solely of self-harm, the MHRT should be able to order that the person be released or granted a leave of absence if satisfied that it is appropriate to do so in the circumstances. The MHRT would still have the option of ordering continued detention, but it would no longer be under an obligation to do so.

8.70 Nevertheless, we regard the risk of self-harm as an important consideration which should be taken into account by the MHRT when deciding whether or not to order the release of a forensic patient. This is underscored by the objectives of Part 5 of the MHFPA, which include providing for the "care, treatment and control" of forensic patients. For this reason, we do not recommend amendment to the other provisions of the MHFPA which refer to self-harm. With regards to:

- **Section 39(2) (release following finding of NGMI):** under our proposed model in Chapter 7 the court will refer the person to the MHRT for disposition as soon as possible after a finding of UNA or NGMI. The court will only have an ability to

75. *Criminal Law Consolidation Act 1935* (SA) s 269T(1)(b); *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 35(1)(b); *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 28(3)(a), s 33(5)(a).
76. 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 6.53, 6.54, 6.98.
77. NSW Bar Association, *Submission MH10*, 39; NSW Consumer Advisory Group, *Submission MH11*, 24; Law Society of NSW, *Submission MH13*, 18; Corrective Services NSW, *Submission MH17*, 8; Legal Aid NSW, *Submission MH18*, 15; Public Interest Advocacy Centre, *Submission MH21,* 18; NSW, Public Defenders, *Submission MH26*, 42; Mental Health Review Tribunal, *Submission MH67*, 2.

make interim orders. The question of whether it would be appropriate to release a person at risk of self-harm should be left for the MHRT to determine.

- **Section 74(b) and (d) (matters for consideration):** when making an order about a forensic patient, the MHRT should be required to have regard to the safety of the patient and protection of the patient from self-harm (although the MHRT will no longer be bound to order detention where a risk of self-harm exists).

8.71 Furthermore, where a patient poses solely a risk to himself or herself, as opposed to a risk to other members of the public, the MHRT should be given the power to transfer that person to the civil mental health system, provided that the person meets the criteria for admission. Alternatively, where there are guardianship arrangements in place under the *Guardianship Act 1987* (NSW) that would be sufficient to manage a risk of self-harm, under our recommendation the MHRT will have the discretion to release a forensic patient into the care of a guardian.

8.72 Where a person's risk of self-harm is the only reason for keeping him or her in detention or under supervision (that is, if there was no risk of self-harm the person could be unconditionally released), then the person should be released or transferred into the civil mental health system. He or she should not remain a forensic patient. However, we do not propose placing any obligation on the MHRT to take such a course of action. We consider that our proposed recommendation regarding the release and transfer of forensic patients who pose only a risk of self-harm, coupled with the principle of least restriction in Recommendation 8.3, will be sufficient to protect against unnecessary detention within the forensic system for these types of patients.

Recommendation 8.2

(1) The reference to the safety of the patient in s 43(a) and s 49(3) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be removed.

(2) Where a person:

(a) presents a risk of harm solely to himself or herself, as opposed to a risk of harm to others, and

(b) meets the criteria for admission as an involuntary patient under the *Mental Health Act 2007* (NSW),

then the Mental Health Review Tribunal should have the power to transfer that person into the civil mental health system, in addition to anything else it can do under the *Mental Health (Forensic Provisions) Act 1990* (NSW).

Presumption in favour of detention

8.73 The relevant provisions of the MHFPA pertaining to release and leave[78] give rise to a presumption in favour of detention when making decisions about the release or

78. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 39(2), s 43(a), s 49(3).

leave of forensic patients. That is, the person will remain in detention unless it can be positively established that their release or leave of absence will not present a serious danger to the public or to themselves.

8.74 Not all jurisdictions have a presumption in favour of detention when determining the release of forensic patients. A presumption in favour of detention applies in Queensland, under the *Crimes Act 1914* (Cth) and in the US.[79] In Victoria a presumption in favour of detention applies to a person found UNA or NGMI during the period of the person's nominal term, but this shifts to a presumption in favour of release at the end of the nominal term.[80] In the NT a presumption in favour of release applies at all stages of a person's detention.[81] In SA, Tasmania and WA, there is no presumption in favour of release *or* detention. Rather, the decision maker may make any order it considers appropriate.[82]

8.75 The NSW civil mental health system does not have a presumption in favour of detention.[83] The justification for having a presumption in favour of detention for a forensic patient could be said to be the person's involvement in the criminal justice system. However, there is a concern that a presumption in favour of detention operates as an undue restriction on a forensic patient's liberty, in circumstances where the person has not been convicted of an offence.

8.76 In this section we consider whether the presumption in favour of detention should be retained in the MHFPA.

Submissions and consultations

8.77 In CP 6 we asked whether a presumption in favour of detention should continue to apply when courts are making decisions about people who are UNA or NGMI.[84]

8.78 Responses to this question were mixed. Some stakeholders argued that the presumption in favour of detention should continue to apply.[85] The HVSG was of the view that the presumption in favour of detention should continue, because a principle of least restriction[86] would not provide enough protection in circumstances where the defendant had committed a violent offence or had attempted to intimidate members of the victim's family while in detention.[87] The MHRT considered that the need to guard against risk to the public, which in the case of forensic patients was

79. See *Mental Health Act 2000* (Qld) s 204(1), *Crimes Act 1914* (Cth) s 20BL(2); 18 USC §4243(d)-(f), §4246(d)-(e).
80. *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 32(2), s 35(3)(a).
81. *Criminal Code* (NT) s 43ZG(6), s 43ZH(2).
82. See *Criminal Law Consolidation Act 1935* (SA) s 269T; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 35; *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 33(5).
83. See *Mental Health Act 2007* (NSW) s 38, s 40, s 42, s 43.
84. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences*, Consultation Paper 6 (2012) Issue 6.58.
85. NSW Office of the Director of Public Prosecutions, *Submission MH5*, 12; NSW Bar Association, *Submission MH10*, 40; Homicide Victims' Support Group, *Submission MH20*, 14; Mental Health Review Tribunal, *Submission MH67*, 3.
86. See para 8.83.
87. Homicide Victims' Support Group, *Submission MH20*, 14.

demonstrated rather than theoretical, justified a continuing presumption in favour of detention.[88]

8.79 However, other stakeholders were of the view that there should not be a presumption in favour of detention.[89] The NSW Bar Association advocated the retention of the presumption at the court stage of the proceedings, but suggested that the presumption should be reversed for decisions made by the MHRT, given that the Tribunal is better placed than the court to undertake a thorough determination of risk.[90] The Public Interest Advocacy Centre (PIAC) submitted that the onus should be on those seeking to keep a forensic patient in detention to satisfy the MHRT that the patient is a serious risk to public safety.[91]

The Commission's view

8.80 On balance, we are of the view that the presumption in favour of detention should be retained. A finding that a person is UNA or NGMI means that it has been established as far as is possible on the available evidence that the person committed the act in question, even though the person cannot be held responsible in law for his or her actions. In these circumstances, the safety of the community should be an important consideration.

8.81 Risk of harm is difficult to evaluate, requiring a prediction of future conduct based on past and present circumstances. Our concern is that reversing the presumption of detention may lead to forensic patients who pose a risk of harm to the community being released or granted a leave of absence, because that risk of harm could not be positively established. Therefore, our view is that it is appropriate to retain the presumption in favour of detention. The risk of a forensic patient being unnecessarily detained can be better mitigated by including a more direct requirement to apply the principle of least restriction, which we recommend below. This approach accords with that taken in a number of other jurisdictions.

8.82 However, as we recommend in para 8.69, the reference to self-harm should be removed from the presumption in favour of detention. We also recommend in Chapter 7 that a presumption in favour of release should apply where a person found UNA or NGMI would not have been sentenced to a term of imprisonment if convicted at an ordinary trial.[92]

The principle of least restriction

8.83 The "principle of least restriction" aims to protect the bodily integrity and personal liberty of people undergoing treatment for mental illness or impairment. According to

88. Mental Health Review Tribunal, *Submission MH67*, 3.
89. NSW Bar Association, *Submission MH10*, 40; Law Society of NSW, *Submission MH13*, 18; Legal Aid NSW, *Submission MH18*, 15-16; Public Interest Advocacy Centre, *Submission MH21*, 18; NSW, Public Defenders, *Submission MH26*, 42.
90. NSW Bar Association, *Submission MH10*, 40.
91. Public Interest Advocacy Centre, *Submission MH21*, 18.
92. See Recommendation 7.4.

the United Nations, it means that "[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".[93]

8.84 A patient's right to be treated in the least restrictive manner is explicitly stated in the Australian Health Ministers' *Mental Health Statement of Rights and Responsibilities,*[94] and arguably underpins the *Australian National Statement of Principles for Forensic Mental Health.*[95] It is a well established and broadly applied principle in the Australian forensic mental health field, and is contained in the legislation providing for forensic patients in the majority of Australian jurisdictions.[96]

8.85 Section 68 of the MHA contains a formulation of the principle of least restriction,[97] and this principle extends to the administration of the MHFPA as it applies to forensic patients.[98]

8.86 The Victorian Court of Appeal has emphasised that, in the forensic system, the principle of least restriction is derived from notions of freedom and personal autonomy:

> Any application of the principle … necessarily implies that interference with that person's freedom or personal autonomy is required to the extent consistent with the safety of the community.[99]

8.87 There is a tension in applying the principle of least restriction in the context of making a decision about the release of a forensic patient. Forensic patients have been found to have done acts constituting an offence, usually an offence of a serious nature, and the safety of members of the public is a key consideration when making decisions about their release. The need to protect the public from harm must be balanced against the interests of the forensic patient in receiving care and treatment in the least restrictive environment. In NSW, s 43 of the MHFPA seeks to do this by providing:

> The Tribunal must not make an order for the release of a forensic patient unless it is satisfied, on the evidence available to it, that:

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93. *The Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, GA Res 46/119, UN GAOR, 46th sess, 75th plen mtg, UN Doc A/RES/46/119 (17 December 1991) annex ("*Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*") principle 9(1).
94. Standing Council on Health, *Mental Health Statement of Rights and Responsibilities* (2012) 7.
95. Australian Health Ministers' Advisory Council, Mental Health Standing Committee, *National Statement of Principles for Forensic Mental Health* (2006) 2. The Preamble states that the principles are underpinned by national and international frameworks, including the United Nations resolution on *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* and the Australian Health Ministers' *Mental Health Statement of Rights and Responsibilities*.
96. *Mental Health (Treatment and Care) Act 1994* (ACT) s 7(d), s 9; *Criminal Code* (NT) s 43ZM; *Mental Health Act 2000* (Qld) s 9; *Criminal Law Consolidation Act 1935* (SA) s 296S; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 34; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 39; *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 33(5)(e).
97. See para 8.14.
98. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 76B(1).
99. *NOM v DPP* [2012] VSCA 198 [69].

(a) the safety of the patient or any member of the public will not be seriously endangered by the patient's release, and

(b) other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available in the circumstances or that the patient does not require care.

8.88 Section 43(b) operates as a constraint on the release of a forensic patient, and seems to state that in order to release a forensic patient there must be care that is less restrictive than detaining the patient, that is safe, effective, appropriate and reasonably available (or that no care is required). While s 43(b) uses "other care of a less restrictive kind", a phrase which is usually associated with the principle of least restriction, this subsection does not appear to embody a principle of least restriction. The MHRT is permitted to release a forensic patient where less restrictive care is available, but is not obliged to consider whether the forensic patient should be stepped down into a less restrictive environment.

8.89 By contrast, in the civil mental health system, before a decision can be made to *detain* a civil patient it must first be established that there is no other care of a less restrictive kind which is appropriate and reasonably available.[100]

8.90 Although there is a principle of least restriction contained in s 68 of the MHA which applies to forensic patients, the surrounding legislative framework limits the weight afforded to this factor. For example:

- section 68 of the MHA states that "[i]t is the intention of Parliament that these principles are, as far as practicable, given effect to"
- section 195 of the MHA states that the principles in s 68 are intended to "give guidance in the administration of this Act and do not create, or confer on any person, any right or entitlement enforceable at law"
- section 76B of the MHFPA states that the principles in s 68 of the MHA apply "subject to this Act or any other Act or law", and
- the principle of least restriction in s 68 of the MHA is expressed to apply to people with a mental illness or mental disorder, and as such does not encompass forensic patients with cognitive impairments.

8.91 The current legislation is framed in such a way that the principle of least restriction is relevant, but is not prioritised. The provisions of the MHFPA directly relevant to release do not include this principle.

8.92 NSW is the only Australian jurisdiction that does not express the principle of least restriction as being directly applicable to decision making regarding forensic patients. The review of the NSW forensic system conducted in 2007 (the 2007 Forensic Review) recommended that the principle of least restriction be included in the MHFPA as a relevant factor for the MHRT to take into account in making orders about forensic patients, but this was ultimately not implemented.[101] In the NT, SA,

100. See *Mental Health Act 2007* (NSW) s 12(1)(b).

101. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [8.38]-[8.39].

Tasmania and Victoria, legislation requires that when a court is making decisions about the release or detention of a forensic patient, the court *must* apply the principle that restrictions on a person's freedom and personal autonomy are to be kept to the minimum that is consistent with the safety of the community.[102] In the ACT and Queensland, the principle of least restriction applies as a general direction in relation to all decisions about people with mental illness.[103] In WA, the principle of least restriction "consistent with the need to protect the health or safety of the accused or any other person" is a relevant factor to be taken into account when deciding release.[104]

Submissions and consultations

Should the principle of least restriction apply to decision making?

8.93 In CP 6 we asked:

- whether a requirement to impose only the least restriction should apply to all decisions regarding forensic patients, and
- how any such principle of least restriction should be expressed in the MHFPA, and whether it should be expressed differently for the purpose of different types of decisions.[105]

8.94 There was a broad consensus among stakeholders that a requirement to impose only the least restriction should apply to all decisions regarding forensic patients.[106]

8.95 The NSW Consumer Advisory Group (NSWCAG) submitted that the provision of care which is more restrictive than necessary is a significant barrier to ensuring effective treatment and recovery for forensic patients.[107] The NSW Council for Civil Liberties submitted that the requirement that "the safety of the patient or any member of the public will not be seriously endangered by the patient's release" contained in s 39, s 43 and s 49 of the MHFPA currently sets a threshold which is almost impossible for forensic patients to meet, with the effect that those people are detained or subject to forensic orders for far longer than is necessary to meet their psychosocial support needs.[108]

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102. *Criminal Code* (NT) s 43ZM; *Criminal Law Consolidation Act 1935* (SA) s 269S; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 34; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 39.
103. *Mental Health (Treatment and Care) Act 1994* (ACT) s 9; *Mental Health Act 2000* (Qld) s 9.
104. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 33(5).
105. 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 6.99, 6.100.
106. NSW Consumer Advisory Group, *Submission MH11,* 40; Law Society of NSW, *Submission MH13*, 27; Legal Aid NSW, *Submission MH18*, 22; NSW Council for Civil Liberties, *Submission MH46*, 11.
107. NSW Consumer Advisory Group, *Submission MH11,* 40.
108. NSW Council for Civil Liberties, *Submission MH46*, 11.

8.96 The NSW Bar Association noted, however, that the risk to public safety must be a paramount consideration in determining what the least restrictive disposition is.[109] According to the MHRT, the critical issue is that it be confident that the patient has received a sufficient period of assessment and treatment to manage any risk issues which may arise in the individual case.[110]

What should the principle of least restriction be consistent with?

8.97 In CP 6 we also asked if, in deciding what order to make in respect of a person who is UNA or NGMI, the court should be required to apply a principle of least restriction consistent with:

(a) the safety of the community

(b) the safety of the person concerned, and/or

(c) some other object(s)?[111]

8.98 Four stakeholders submitted that a principle of least restriction consistent with the safety of the community is the most appropriate.[112] The Public Defenders noted that the safety of the person concerned should also be relevant.[113]

8.99 Corrective Services NSW submitted that the principle of least restriction should be considered with regard to matters such as: the safety of the community; suitability and availability of support and treatment options; and risk of physical or psychological harm posed by the more restrictive option.[114]

8.100 The MHRT noted that the principle of least restriction makes the availability of resources an important part of the equation, for the following reasons:

> While the Tribunal supports that the principle of 'least restrictive' environment consistent with 'safe and effective care' should apply to forensic patients as it does to civil involuntary patients, there is a risk that the application of this principle by the Courts would consider the theoretical 'least restrictive' rather than considering what 'safe and effective care' can be delivered within the available resources. This is key in the forensic system where resources are limited and arguably 'top heavy' with more high secure mental health beds than medium secure mental health beds. This necessarily means that queues develop for placement in the medium secure units and therefore an individual may need to stay in an environment that is not the 'least restrictive' in an absolute sense, but is rather the 'least restrictive option consistent with safe and effective care' available at a particular point in time. The primacy of public safety

109. NSW Bar Association, *Submission MH10*, 47.

110. Mental Health Review Tribunal, *Submission MH57*, 21.

111. 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 6.59.

112. NSW Bar Association, *Submission MH10*, 40; Law Society of NSW, *Submission MH13*, 19; Legal Aid NSW, *Submission MH18*, 16; NSW, Public Defenders, *Submission MH26*, 43.

113. NSW, Public Defenders, *Submission MH26*, 43.

114. Corrective Services NSW, *Submission MH17*, 17.

> in the forensic mental health system means that this practical reality needs to be considered when balancing least restrictive with safe and effective care.[115]

The Commission's view

8.101 The principle of least restriction is recognised in national and international statements of principle underpinning the treatment of people with cognitive and mental health impairments. It reflects the high importance placed on liberty and personal autonomy in the forensic system and in society. Its use is strongly supported by stakeholders, and indeed stakeholders suggested that the lack of a principle of least restriction operates as a real disadvantage to forensic patients.

8.102 In NSW, the principle of least restriction as it applies to forensic patients is currently contained in s 68 of the MHA. However, that principle is expressed in aspirational language, and does not feature in the list of considerations under s 74 of the MHFPA which the MHRT is directed to apply in its decision making about forensic patients.[116] Further, s 68 of the MHA is drafted in the language of mental illness, and does not refer to the needs of forensic patients with cognitive impairments.

8.103 In our view, application of the principle of least restriction is an important way of ensuring that, in a system where decisions about leave or release are predicated on risk to the community, the interests of the forensic patient are properly recognised. The current scheme of MHRT decision making provided for under the MHFPA places insufficient weight on the principle of least restriction, as the MHRT is not expressly directed to consider whether there is a less restrictive environment that could still satisfy the need for community protection. We recommend that the principle of least restriction be included as a consideration to which the MHRT must have regard (in balance with other factors) under s 74 of the MHFPA when making decisions about a forensic patient. This is consistent with the recommendation made in the 2007 Forensic Review.

8.104 We appreciate the tension that is inherent in trying to strike a balance between providing a forensic patient with the least restrictive environment and the need to protect the public from harm. For this reason, we recommend that the principle of least restriction be applied to the extent that it is consistent with the safety of the forensic patient and the public. This approach will allow the principle to operate in conjunction with the presumption in favour of detention. A principle of least restriction consistent with the safety of the forensic patient and the public means that a more restrictive environment should only be imposed on a patient to the extent that it is necessary to protect against a risk of harm to the person or to others. If there is a less restrictive alternative that would achieve the same aim, then that alternative should be applied.

8.105 Although in CP 6 we asked whether *the court* should be required to apply the principle of least restriction, given we recommend in Chapter 7 that the MHRT have sole responsibility for making decisions about forensic patients, we do not propose to make any recommendation regarding the court's decision making.

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115. Mental Health Review Tribunal, *Submission MH57*, 21.

116. See para 8.13.

8.106 A significant issue for the practical operation of the principle of least restriction is the availability of resources. A requirement for the MHRT to apply the principle of least restriction will be of little value if there are insufficient resources to allow forensic patients to be provided with a less restrictive environment. As the MHRT has highlighted, what is theoretically available to a patient may differ markedly to what is available in reality. A lack of services and resources can mean that the principle of least restriction is not capable of being achieved.

8.107 In this regard, we note that the NSW Government's state plan, *NSW 2021*, specifically targets improved mental health outcomes and the increased provision of individualised support services for people with a disability.[117] The recently established Mental Health Commission of NSW is also charged with developing a strategic plan for mental health services in NSW and focusing on systemic mental health issues.[118] Consistent with these Government priorities, the availability of resources to allow forensic patients to be progressively stepped down into less restrictive treatment is an important issue that deserves further attention. Given the fundamental importance of the principle of least restriction in the management of people with cognitive and mental health impairments, it is concerning that a lack of resources could be preventing its fulfilment.

8.108 Finally, we note that in Recommendation 8.1 we recommend that s 43(b) be amended to provide greater clarity.

Recommendation 8.3

Section 74 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to include, as a consideration to which the Mental Health Review Tribunal must have regard, that a forensic patient should be provided with the least restrictive environment necessary to protect against serious harm to the forensic patient or to others.

The role of victims and carers in court proceedings

8.109 In ordinary criminal proceedings in NSW, a victim of an offence or alleged offence is entitled to notification of hearings and information regarding the investigation and prosecution of the offence.[119] If the defendant is convicted, the victim is also entitled to counselling and compensation, funded by the State and/or the offender,[120] and the ability to provide a written victim impact statement to the court before it sentences the offender.[121]

117. NSW Government, *NSW 2021: A Plan to Make NSW Number One* (2011) 24, 29.
118. See *Mental Health Commission Act 2012* (NSW) s 12.
119. Charter of Rights for Victims of Crime, s 6.4, s 6.5: *Victims Rights Act 1996* (NSW) s 6.
120. *Victims Support and Rehabilitation Act 1996* (NSW) s 5(1), pt 2 div 3-5 (compensation from Fund), div 8-9 (recovery of compensation from offenders), pt 4 div 1-2 (orders for offender to compensate victim), pt 5 (compensation levy payable by offender).
121. *Crimes (Sentencing Procedure) Act 1999* (NSW) s 28, see also s 3A(g). The Act provides for victim impact statements to be received only in relation to certain offences: s 27. In relation to other offences, there is a common law principle that a court may have regard to the harm done to the victim by commission of the crime: *Siganto v The Queen* [1998] HCA 74; 194 CLR 656 [29].

8.110 However, if the defendant is found UNA or NGMI, then he or she is not convicted of the offence in question. It appears that compensation and counselling entitlements remain open to victims in these circumstances,[122] but the ability to provide a victim impact statement is less clear.

8.111 The legislative provisions regarding victim impact statements appear to apply only in the context of sentencing following conviction.[123] The MHFPA, on the other hand, neither requires nor prohibits consideration by the court of the views of victims when determining what orders to make following a finding of UNA or NGMI. Judges sometimes accept the views of victims following a finding of UNA or NGMI,[124] and sometimes do not.[125] In several other Australian jurisdictions, specific legislative provision is made for victims to be notified of, informed about, and to participate in proceedings (including by submitting a victim impact statement) when courts are making orders in respect of people who are found UNA or NGMI.[126]

8.112 A related issue for defendants with cognitive and mental health impairments is to what extent the views of their carers[127] should be taken into account. In most Australian jurisdictions, legislation facilitates the involvement of family members in the court process.[128] Depending on the definition in the legislation given to that phrase, and the particular carer's relationship with the defendant, this may encompass carers as well. However, in NSW the legislation is silent on this point. A carer may be able to provide the court with information relevant to the defendant's treatment history or the risk of harm if the defendant is released, which may not be obtainable from any other source.

8.113 There are two stages of the court process where the views of victims and carers may be relevant. The first is where the court sets a limiting term. Currently this occurs following a finding of UNA, and in Chapter 7 we recommend that limiting terms also be introduced for a finding of NGMI. As limiting terms are to be determined in accordance with sentencing principles,[129] it may be appropriate for the views of victims to be taken into account in the same way as they are following

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122. See *Victims Rights Act 1996* (NSW) s 6.3; *Victims Support and Rehabilitation Act 1996* (NSW) s 5(1A) (entitlement to compensation arises from being the victim of an "act of violence", which extends to "conduct of a person that would constitute an offence were it not for the fact that the person cannot, or might not, be held to be criminally responsible for the conduct because of the person's age or mental illness or impairment").
123. *Crimes (Sentencing Procedure) Act 1999* (NSW) s 28.
124. See, eg, *R v Melehan* [2010] NSWSC 210 [42]; *R v Chong* [2012] NSWSC 1309 [42].
125. See, eg, *DMA* [2001] NSWSC 1042; 126 A Crim R 264 [26], where Sperling J held that he was precluded by law from taking into account the effect of the victim's death on the victim's family when fixing a limiting term.
126. *Criminal Code* (NT) s 43A, s 43ZL(1)-(2), s 43ZN(2), s 43ZP; *Mental Health Act 2000* (Qld) s 284, s 285; *Criminal Law Consolidation Act 1935* (SA) s 269R, s 269T(2)-(3), s 269Z; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 33, s 35(2)(b); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 38C, s 38E, s 40(2)(c)-(d), s 42-46. See also *Criminal Code*, RSC 1985 (Can) s 672.5(5.1), (14)-(15.2).
127. See para 8.151 for the definition of "primary carer".
128. *Criminal Code* (NT) s 43A, s 43ZL, s 43ZN, s 43ZP; *Mental Health Act 2000* (Qld) s 284, s 285 (as a "concerned person"); *Criminal Law Consolidation Act 1935* (SA) s 269A ("next of kin"), s 269R, s 269T(2), s 269Z; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 3, s 33, s 35; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 3(1) ("family member"), s 38C-s 38F, s 40(2)(c)-(d), s 42-s 46. See also *Criminal Code*, RSC 1985 (Can) s 675.5(4)-(5).
129. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 23(1)(b); see also Recommendation 7.2.

sentencing upon conviction. The second circumstance is where the court proposes to make an order for release of the defendant following a finding of UNA or NGMI. This does not currently occur frequently. Under our recommendations in Chapter 7, the court would refer the person to the MHRT to make orders. However, in the event that the court has the power to order release, victims and carers may wish to have their views heard before the court makes this decision.

8.114 In this section of the report we consider whether legislation should facilitate greater victim involvement following a finding of UNA or NGMI.

Submissions and consultations

8.115 In CP 6 we asked whether, in relation to court proceedings involving people who are found UNA or NGMI, the current provisions concerning notification to and participation by victims and carers are adequate and appropriate.[130] Responses were mixed.

8.116 Some stakeholders believed that the current notification and participation provisions for victims and carers were adequate and appropriate.[131] However, a number of other stakeholders were of the view that victims should be provided with an opportunity to tender victim impact statements following a finding of UNA or NGMI.

8.117 The Office of the Director of Public Prosecutions submitted that victim impact statements should be permitted because: a victim's concerns about safety can be relevant to a decision about release, including what conditions to impose; information from the victim can assist in rehabilitation of the defendant, particularly as victims in these types of cases are often known to the defendant; and it allows a voice for victims in the proceedings where the victim has not given evidence.[132]

8.118 The NSW Bar Association submitted that victims should be permitted to make victim impact statements to the court but that these ought not to be taken into account in the disposition of the case. Where the victim may wish for specific restrictions to be attached to the defendant's release, victims should be permitted to make representations to the court on these matters. The NSW Bar Association considered that the most appropriate way for carers to be involved was as witnesses in the proceedings, to be determined on a case by case basis by the lawyers involved.[133]

8.119 The HVSG supported the opportunity to provide a victim impact statement at all court hearings, because it assists the counselling and treatment process for the victim, as well as assisting the court in determining orders for the defendant.[134] It submitted that this opportunity to participate should also extend to carers.[135] A similar submission from the family of a victim, where the defendant had been found

130. 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 6.60.

131. Law Society of NSW, *Submission MH13,* 19; Legal Aid NSW, *Submission MH18*, 16.

132. NSW Office of the Director of Public Prosecutions, *Submission MH5*, 12.

133. NSW Bar Association, *Submission MH10*, 41.

134. Homicide Victims' Support Group, *Submission MH20*, 19.

135. Homicide Victims' Support Group, *Submission MH20*, 20.

NGMI, noted that the ability to tender a letter to the court about the impact of the victim's death was important in having their loss and grief acknowledged, and for the court to recognise that there had been a victim of the act, even though the defendant had not been found criminally responsible.[136]

8.120 The MHRT suggested that a lack of victim participation at the court stage results in the subsequent Tribunal proceedings being the only opportunity for victim participation:

> Although the verdicts for forensic patients are not convictions and should remain as such, victims often express to the Tribunal their frustration at not being 'heard' by the Court. Victims, understandably, then wish to express their views to the Tribunal, but this is not the appropriate forum as the focus of the Tribunal is on the care, treatment and rehabilitation of the offender and the Tribunal is unable to look behind the decision of the Court.[137]

8.121 The Public Defenders was in favour of notification, but not participation, of victims in the process following a finding of UNA or NGMI, unless the victim can make a contribution to the relevant issues for determination. It was however, in favour of notification of and participation by carers, due to their unique interests and knowledge with respect to the defendant.[138]

8.122 PIAC did not support the introduction of victim impact statements, on the basis that they are relevant only to the sentencing process, where the effect of the crime is taken into account in determining an appropriate sentence. However, PIAC suggested that victims of alleged crimes could give evidence on the risk of harm to themselves and those close to them if a forensic patient is released, preferably through the provision of legal representation for victims.[139]

The Commission's view

8.123 In our view, the provisions for making a victim impact statement under the *Crimes (Sentencing Procedure) Act 1999* (NSW) should be extended to apply in circumstances where the defendant has been found UNA or NGMI, as well as convicted. This is for two reasons.

8.124 First, a victim impact statement can play an important role in the grieving process for victims of crime. The impact of a crime on its victims is not diminished in any way by virtue of the fact that the defendant cannot be held legally responsible for his or her actions. The tendering of victim impact statements is an important way of giving victims a "voice" before the court. It will also assist in alleviating problems identified by the NSWCAG and the MHRT, whereby victims seek to put their views before the Tribunal as the only avenue in which they may be heard.

8.125 Secondly, we have recommended in Chapter 7 that the court set a limiting term for people found UNA and NGMI by reference to sentencing principles.[140] Given that

136. A Vaughan and E Vaughan, *Submission MH8*, 3.
137. Mental Health Review Tribunal, *Submission MH57*, 13.
138. NSW, Public Defenders, *Submission MH26*, 43.
139. Public Interest Advocacy Centre, *Submission MH21*, 19.
140. Recommendation 7.2.

victim impact statements can be taken into account by a court in the ordinary course of sentencing a convicted offender for certain specified offences,[141] it is appropriate for victim impact statements to be similarly taken into account in setting a limiting term.

8.126 We note the concern of some stakeholders that victim impact statements are intended to follow conviction for a crime, and people found UNA and NGMI have not been convicted of an offence. However, under this recommendation a victim impact statement would be only taken into account in setting a limiting term, that is, the maximum period for which the defendant can be detained. A decision to release the defendant focuses not on the effect of the crime but rather on the risk of harm that the defendant poses at the time release is being sought.

8.127 We are also of the view that there should be a separate ability for the court to receive representations from victims when it is proposing to make an order for release. Currently the court has the power to order release of the defendant following a finding of NGMI, and in certain circumstances following a finding of UNA, although we recommend in Chapter 7 that this power be transferred to the MHRT.

8.128 Victims and carers are in a unique position to provide important and relevant information to the court regarding the risk, if any, that the defendant poses, either to the particular victim or carer or to the community more generally. Information from victims and carers may also be useful in tailoring appropriate conditions should an order be made for the defendant's release. There are likely to be few cases where a court orders release. Nevertheless, we recommend that where the court seeks to order the release of a defendant found UNA or NGMI, either with or without conditions, the court should be able to accept representations from victims and carers as to the risk of harm that the defendant's release may present, and whether any specific conditions should be imposed. There was broad consensus among stakeholders that participation by victims and carers in assessing risk of harm on release is useful and appropriate.

Recommendation 8.4

(1) The provisions relating to the making of a victim impact statement to the court under Part 3, Division 2 of the *Crimes (Sentencing Procedure) Act 1999* (NSW) should be extended to apply to circumstances where the defendant is found unfit and not acquitted or not guilty by reason of mental illness under the *Mental Health (Forensic Provisions) Act 1990* (NSW).

(2) If Recommendations 7.3-7.5 are not adopted and the court retains the power to order the release of a defendant following a finding of not guilty by reason of mental illness or a finding of unfit and not acquitted, the court should be permitted to invite representations from victims and carers of the defendant regarding:

(a) the risk, if any, that the defendant's release may pose to a victim or carer

141. See *Crimes (Sentencing Procedure) Act 1999* (NSW) pt 3, div 2.

(b) the conditions, if any, that should be imposed on the defendant's release, and

(c) any other matter which may impact on the court's decision to order release.

The role of victims and carers in MHRT proceedings

8.129 A separate question arises in relation to the role that victims and carers should play in reviews before the MHRT. Unlike the court process following a finding of UNA or NGMI, which is intended to be determinative, the MHRT is required to review the status of a forensic patient every six months.[142] At those reviews the MHRT makes orders regarding the forensic patient's detention, care or treatment, and whether the forensic patient should be released.[143] Given the frequency of the reviews, and the focus on the treatment needs of the forensic patient, the appropriate role for victims and carers is likely to be different than that which should apply before a court.

8.130 In CP 6 we asked whether the current provisions concerning notification to, and participation by, victims and carers in the proceedings of the MHRT are adequate and appropriate and, if not, what else should be provided.[144]

Victims

Current law

8.131 The MHFPA and MHA contain limited provisions dealing with the participation of victims in MHRT proceedings, despite the fact that victims may have "genuine and legitimate concerns" for their safety and the safety of others if the forensic patient were to be released.[145] Under the MHFPA, if a forensic patient is released or granted a leave of absence, the MHRT may impose a condition concerning the association or non association with victims or members of victims' families.[146] We note that in many cases victims and forensic patients are part of the same family. A victim[147] may also apply directly to the MHRT for an order varying or imposing a "non association condition" or a "place restriction condition" (that is, a condition prohibiting or restricting the forensic patient from visiting certain places),[148] and victim may appeal the MHRT's decision about such an order to the Supreme

142. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 46(1).

143. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 47(1).

144. 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 6.80, 6.81.

145. M Barnett and R Hayes, "The Role of Victims in NSW Forensic Patient Proceedings" (2009) 13 *University of Western Sydney Law Review* 7, 17.

146. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 75(i).

147. Defined to mean a person who was a primary victim of an act of violence committed by the forensic patient, and includes the immediate family of the victim: *Mental Health (Forensic Provisions) Act 1990* (NSW) s 41; *Victims Support and Rehabilitation Act 1996* (NSW) s 7, s 9.

148. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 76.

Court.[149] However, these provisions only apply once the MHRT has made the decision to release the forensic patient or grant a leave of absence.

8.132 The MHFPA contains no express provision regarding the participation of victims in review hearings conducted by the MHRT. Section 151(3) of the MHA provides that MHRT proceedings are to be open to the public, thereby providing victims with the ability to attend proceedings, but there is no entitlement in the legislation granting victims a right to be heard. Section 76A of the MHFPA allows the MHRT to communicate with any person it thinks fit. This could extend to communication with victims, but it is within the MHRT's discretion whether this occurs.

8.133 Section 160 of the MHA provides that regulations may be made concerning the role of victims and family members in Tribunal proceedings, including notification of Tribunal proceedings or decisions. At the time of writing this report no regulations had been made concerning these matters.

8.134 However, the MHRT, in conjunction with the Statewide Forensic Mental Health Directorate, has released a Forensic Procedural Note which deals with the role of victims in MHRT proceedings. Victims may subscribe to a "victim register", and elect to be notified about any or all of: upcoming hearings; the making of a decision by the MHRT; or that the forensic patient has absconded. Registered victims may also provide a written statement to the MHRT to be included in the papers to be considered at the forensic patient's hearing. The statement should address the "care, treatment, detention and release" of the forensic patient, and any relevant information about the risk of serious danger to individuals or the community if the forensic patient was to be released.[150] Additionally, victims may attend the hearing by telephone, videolink or in person, if they choose to do so. Victims, however, are not entitled to be legally represented before the MHRT and do not have the right to cross-examine witnesses or obtain access to relevant documents.[151]

8.135 In practice, it appears that the MHRT will advise the victim if the forensic patient is seeking release or a leave of absence at an upcoming hearing, given that these are usually the hearings with which victims are most concerned and where they may wish to attend or participate.[152]

8.136 Thus, the MHFPA does not currently regulate victim participation in MHRT proceedings. It appears to have been contemplated that this would be dealt with by regulation and, although this has not happened, the MHRT has developed a procedure for victim participation by way of its Forensic Procedural Note.

8.137 Although the participation of victims in hearings is important, the MHRT has indicated that in some situations the presence of victims may create difficulties because of the behaviour of some victims in hearings, and because of the intensely personal medical issues that are sometimes relevant to decisions of the Tribunal. In

149. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 77A(3).
150. Mental Health Review Tribunal, *Forensic Procedural Note* (2008) 30.
151. Mental Health Review Tribunal, *Forensic Procedural Note* (2008) 30-31.
152. Forensic process roundtable, *Consultation MH35*.

this context we note that, while hearings of the MHRT are public the MHRT has the power to close hearings and to take other related steps.[153]

8.138 In most other Australian jurisdictions, legislation expressly allows victims to provide a report to the body entrusted with reviewing the status of a forensic patient.[154]

Submissions and consultations

8.139 Stakeholder responses on the question of victim participation in MHRT proceedings revealed markedly opposing views. The NSW Bar Association considered that the current provisions were generally adequate, but emphasised the need for victims to be able to make appropriate representations to the MHRT on conditions they desired as part of the forensic patient's release.[155]

8.140 The HVSG advocated for greater victim participation at MHRT proceedings. It suggested that victim impact statements, and any other pertinent information that victims wish to raise, should be considered at six monthly reviews of the forensic patient. Furthermore, the HSVG submitted that victims should be entitled to legal representation at MHRT reviews, as having to represent their own interests creates an added and unnecessary burden upon victims which only increases levels of distress.[156]

8.141 At the opposite end of the spectrum, the NSWCAG was in favour of more limited victim involvement in MHRT reviews. The NSWCAG argued that continual victim participation unduly focuses proceedings on the index offence, rather than the care and treatment of the forensic patient.[157] Furthermore, some victims choose to participate in each six monthly review by the MHRT, while others choose not to participate in the process at all. The NSWCAG has observed that forensic patients with "active victims" appear to move much more slowly through the forensic system than those who have no victim participation at all.[158]

8.142 The MHRT was also in favour of more limited victim participation in review proceedings, due to the potentially detrimental effects for both the victim and the forensic patient. It noted:

> There is a real concern for the welfare of both the victim and the patient when victims regularly attend routine care and treatment reviews. There is a real risk of (and anecdotal evidence of) revictimisation through frequent exposure to the forensic patient. Victims also often express frustration at the frequency of the review cycle and that the focus of the hearing is only on the forensic patient

153. *Mental Health Act 2007* (NSW) s 151(3)-(4).
154. *Criminal Code* (NT) s 43ZL, s 43ZN(2); *Mental Health Act 2000* (Qld) s 5(e)(ii), s 464, s 465; *Criminal Law Consolidation Act 1935* (SA) s 269R, s 269T(2); *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 33, s 35(2); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 38C, s 40(2)(c)-(d), s 42 (however, note that victims may be called to give evidence and be cross-examined on any report they make to the court: s 46); *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 33(5)(f).
155. NSW Bar Association, *Submission MH10*, 41, 44.
156. Homicide Victims' Support Group, *Submission MH20*, 19-20.
157. NSW Consumer Advisory Group, *Submission MH11*, 29.
158. NSW Consumer Advisory Group, *Submission MH11*, 29.

> where there is no question of leave or release, even though the only issue before the Tribunal is the patient's care and treatment.
>
> From the patient's perspective there is also the potential deleterious effect of having victims expressing anger and at times quite blatant threats on such a frequent basis. There is also an understandable inhibitive factor to the victims' attendance at these hearings not only on the patient and any of their family members in attendance, but even on the treating teams and the Tribunal members who do not wish to canvass sensitive personal issues in the presence of the victims.[159]

8.143 The MHRT suggested that the victim's role and right to notice should only apply when the issue of leave or release is before the Tribunal, consistent with the provisions of the Charter of Victims Rights, and that otherwise victims should not have the right to attend Tribunal hearings without the leave of the MHRT.[160]

8.144 There was also a concern among stakeholders that attendance by victims at review proceedings could infringe upon the privacy of forensic patients.[161] The Law Society of NSW and Legal Aid NSW both suggested that it would be inappropriate for the victim to be in attendance during some stages of the review hearing due to privacy concerns, for example, when the forensic patient's medical history was being detailed.[162] This may be particularly so given that under the MHA a victim is not entitled to access the forensic patient's medical records,[163] and other types of disclosure to the victim may also be limited.[164] In such circumstances the MHRT should be able to use its discretion to limit the attendance of the victim during those parts of the hearing.[165]

The Commission's view

8.145 Victims have an important perspective that is particularly relevant to issues of leave and release. They may have legitimate concerns about their safety or the safety of family members. It is important that the MHRT take these perspectives into consideration when making decisions about leave and release. The MHRT acknowledges the significance of victims' participation in its Forensic Procedural Note, and its practice in notifying victims when a review involving leave or release is coming up is commendable.

8.146 In addition, Recommendation 8.4, which proposes that victims should have the ability to tender a victim impact statement to the court following a finding of UNA or NGMI, will allow the victim an opportunity to express their views in a more appropriate forum, where the treatment needs of the forensic patient is not the primary concern. It will also mean that hearings of the MHRT are no longer the only opportunity for victims to be heard.

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159. Mental Health Review Tribunal, *Submission MH57*, 24.
160. Mental Health Review Tribunal, *Submission MH57*, 24.
161. See NSW Consumer Advisory Group, *Submission MH11*, 30.
162. Law Society of NSW, *Submission MH13*, 23; Legal Aid NSW, *Submission MH18*, 18-19.
163. *Mental Health Act 2007* (NSW) s 156.
164. *Mental Health Act 2007* (NSW) s 189.
165. The Mental Health Review Tribunal has the discretion to close a review hearing to the public: see *Mental Health Act 2007* (NSW) s 151(4). See also Law Society of NSW, *Submission MH13*, 23; Legal Aid NSW, *Submission MH18*, 18-19.

8.147 Notwithstanding these developments, there appear to be some continuing problems in relation to victim participation before the MHRT. Hearings of the MHRT are public hearings, and under the Forensic Procedural Note a victim is entitled to attend all of the review hearings if they so desire. However, the MHRT has reported situations in which victim participation may result in revictimisation, impact upon the privacy rights of forensic patients, and may in some circumstances be detrimental to the forensic patient's recovery. The MHRT also noted inappropriate behaviour in hearings on the part of some victims.

8.148 The MHRT has a discretion to order that a hearing be conducted wholly or partly in private where it is considered desirable to do so, for the welfare of a person who has a matter before the MHRT, or for any other reason.[166] We consider that the problems raised by the MHRT are best dealt with on a case by case basis by the exercise of this discretion to hold hearings in private. Furthermore, the MHRT can and does regulate the circumstances in which victims may make representations as part of a review hearing, and it should continue to manage this as considered appropriate.

8.149 Having regard to these considerations, we make no recommendation for a change in the law relating to the role of victims in proceedings before the MHRT.

Carers

Current law

8.150 In contrast to victim participation in MHRT proceedings, there are a number of legislative provisions which deal with the rights of a carer of a forensic patient.

8.151 The MHA states that a primary carer of a forensic patient is the guardian or parent of the patient, or a person nominated by the patient to be his or her primary carer. If none of these exist, then a primary carer is the spouse of the patient, any person who is primarily responsible for providing care to the patient (other than wholly or substantially on a commercial basis), or a close friend or relative.[167] A primary carer has a number of entitlements under the MHFPA. He or she may make an application to extend the period between MHRT reviews up to a maximum of 12 months,[168] receive confidential information about the forensic patient,[169] and, where a forensic patient is to be released or granted leave from a mental health facility, an authorised medical officer must take reasonable steps to consult the carer in relation to the planning of the person's release, subsequent treatment or any other action.[170]

8.152 The MHFPA does not expressly provide for the notification of, or participation by, carers in proceedings of the Forensic Division of the MHRT, although there is a

166. *Mental Health Act 2007* (NSW) s 151(3)-(4).
167. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 76B(4); *Mental Health Act 2007* (NSW) s 71, s 72.
168. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 46(4).
169. *Mental Health Act 2007* (NSW) s 189(1)(c).
170. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 76G(1).

general principle that the role of carers and their rights to be kept informed should be given effect.[171] The views of a carer may, at the MHRT's discretion, be taken into account pursuant to the general provision in the MHFPA that the MHRT may communicate with any persons it thinks fit.[172]

8.153 In most other jurisdictions, legislation allows for family members or next of kin to participate in review proceedings.[173] Depending on the definition given to those phrases in the legislation, and the particular carer's relationship with the forensic patient, this may or may not encompass a primary carer.[174]

Submissions and consultations

8.154 The NSW Bar Association was of the view that the involvement of carers should be encouraged, but that this may be most appropriately determined on a case by case basis.[175] The Law Society of NSW and Legal Aid NSW suggested that there should be a formal requirement for carers to be notified about MHRT proceedings.[176] The Law Society of NSW submitted that legislation should provide for the MHRT to take into account the views of carers, particularly on decisions regarding release.[177] The HVSG submitted that carers should be given the opportunity to be heard before the MHRT, as they are often in a position of confidence with the forensic patient which should not be overlooked.[178]

The Commission's view

8.155 We agree with the submissions of stakeholders that carers can play an important role in MHRT review proceedings, either by providing information that may be relevant to the care and treatment of the forensic patient or by making submissions relating to an application by the forensic patient for leave or release. We also note that NSW is one of the only jurisdictions in Australia that does not have an express right of participation for family members or carers in proceedings concerning forensic patients, this currently being left to the discretion of the MHRT to contact the carer if considered appropriate.

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171. *Mental Health Act 2007* (NSW) s 68(j); *Mental Health (Forensic Provisions) Act 1990* (NSW) s 76B(1).
172. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 76A(1).
173. *Criminal Code* (NT) s 43ZL, s 43ZN(2); *Criminal Law Consolidation Act 1935* (SA) s 269R, s 269T(2); *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 33, s 35(2)-(3); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 38C, s 40(2)(c)-(d), s 42. In Queensland there is no express provision relating to family members or carers, but a carer may be able to put material before the Tribunal as a "concerned person": *Mental Health Act 2000* (Qld) s 464, s 465.
174. See *Criminal Code* (NT) s 43A ("next of kin" means a parent, spouse, de facto partner, sibling, child or primary carer); *Criminal Law Consolidation Act 1935* (SA) s 269A ("next of kin" means a spouse, domestic partner, parents and children); *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 3 ("next of kin" means a person's spouse, parents or children, any other person who is the primary carer, a person who is in a caring relationship within the meaning of the *Relationships Act 2003* (Tas) or any other class of person prescribed by the regulations); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 3(1) ("family member" means a spouse or domestic partner, parent, guardian, sibling or child of the person, or a child of the person's spouse or domestic partner).
175. NSW Bar Association, *Submission MH10*, 41, 44.
176. Law Society of NSW, *Submission MH13*, 23; Legal Aid NSW, *Submission MH18*, 19.
177. Law Society of NSW, *Submission MH13*, 23.
178. Homicide Victims' Support Group, *Submission MH20*, 20.

8.156 We recommend that a regulation be made under s 160 of the MHA to require that carers be notified of upcoming MHRT reviews, and be given the opportunity to make submissions to the MHRT on relevant matters pertaining to the care, treatment, control or release of the forensic patient. In this context, we suggest that the definition of "primary carer" contained in the MHA be used.

8.157 We appreciate that this recommendation may encompass broader participation rights than those which are given to victims, but we consider that the role of a carer, particularly their intimate relationship with the forensic patient, will often mean that the carer can make a greater contribution to the Tribunal's deliberations. Furthermore, given that under the MHA a primary carer is entitled to access the forensic patient's confidential information, privacy concerns will not operate in respect of a carer in the same way that they might for a victim.

8.158 We recognise that there will often be situations where the carer is also a victim of the forensic patient. In these situations, we believe that the person should still be given the broader rights of participation afforded to carers.

8.159 Finally, we note that most other Australian jurisdictions allow for the forensic patient's family members to participate in review proceedings. As we did not consult specifically on this issue, it is not appropriate for us to make any recommendations in this regard. However, our preliminary view is that it would be desirable to include family members in the MHRT review hearing process.

Recommendation 8.5

(1) A regulation should be made under s 160 of the *Mental Health Act 2007* (NSW) to:

(a) require a primary carer of a forensic patient to be notified about forthcoming review hearings by the Mental Health Review Tribunal concerning the forensic patient, and

(b) permit the primary carer, with the leave of the Tribunal, to make representations in relation to matters relevant to its deliberations.

(2) "Primary carer" should have the meaning given to it under s 71 and s 72 of the *Mental Health Act 2007* (NSW).

9. Management of forensic patients

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9.1 The forensic system in NSW is established by the provisions of Part 5 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA) in conjunction with the *Mental Health Act 2007* (NSW) (MHA). The legislative framework provides for the care, treatment, detention and release of forensic patients, overseen by a specialist Forensic Division of the Mental Health Review Tribunal (MHRT).

9.2 In this chapter, we consider the decision making functions, powers and procedures of the MHRT in respect of forensic patients. These include, in particular, the requirement for the MHRT to conduct periodic and ad hoc reviews of the case of each forensic patient, and the MHRT's powers to make orders regarding the detention, release, care and treatment of forensic patients.

The Forensic Division of the MHRT

9.3 Part 5 of the MHFPA, which establishes the system for review, detention and release of forensic patients, contains the following statement of objects:

> (a) to protect the safety of members of the public,
>
> (b) to provide for the care, treatment and control of persons subject to criminal proceedings who are suffering from a mental illness or mental condition,
>
> (c) to facilitate the care, treatment and control of any of those persons in correctional centres through community treatment orders,
>
> (d) to facilitate the provision of hospital care or care in the community through community treatment orders for any of those persons who require involuntary treatment,
>
> (e) to give an opportunity for those persons to have access to appropriate care.[1]

9.4 The Forensic Division of the MHRT was established by the *Mental Health Legislation Amendment (Forensic Provisions) Act 2008* (NSW).[2] It has the power,

1. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 40. See also s 76B which imports certain objects and principles from the *Mental Health Act 2007* (NSW), subject to the other provisions of the *Mental Health (Forensic Provisions) Act 1990* (NSW).
2. *Mental Health Legislation Amendment (Forensic Provisions) Act 2008* (NSW) s 3, sch 1 [14]; see *Mental Health (Forensic Provisions) Act 1990* (NSW) pt 5 div 7.

previously held by the executive government, to make orders for the care, detention and release of forensic patients,[3] and is responsible for conducting reviews of forensic patients. The Forensic Division is constituted by the President or a Deputy President, an expert member and another member, drawn from a panel of Deputy Presidents, psychiatrists and other people appointed for the purpose by Govenor.[4] In this report, references to the MHRT should be taken as references to its Forensic Division unless otherwise stated.

9.5 The MHRT has a number of main functions in respect of forensic patients:

(1) Conducting periodic and other reviews.

(2) Making determinations about whether the person is to be released or detained.

(3) If the person is not to be released, where the person is to be detained.

(4) Making determinations about whether the person is to be transferred from a correctional centre to a mental health facility.

(5) If the person is to be released, or granted leave, setting any conditions to which that release or leave is subject.

(6) Reviewing breaches of conditions of release or leave and making consequent orders.

(7) Authorising compulsory medical treatment.

9.6 In general, the functions of the MHRT with regard to forensic patients are the same irrespective of whether the person was found not guilty by reason of mental illness (NGMI) or unfit and not acquitted (UNA) at a special hearing.[5] The MHRT also has a role in reviewing correctional patients, that is, sentenced offenders who are transferred from a correctional centre to a mental health facility.[6] We do not address correctional patients in this report.

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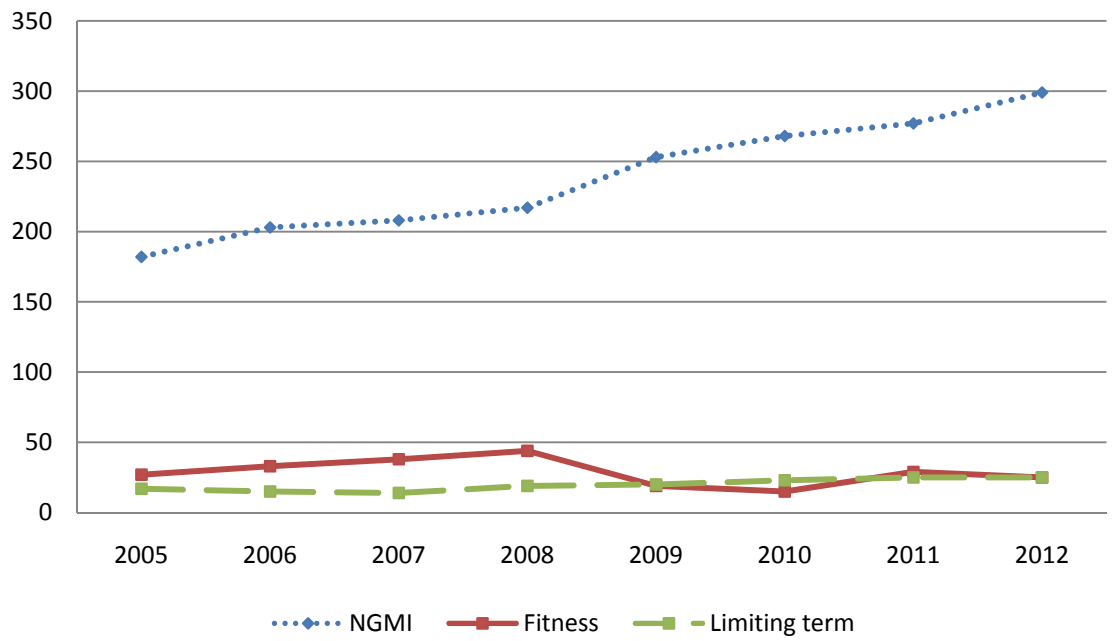
3. See *Mental Health (Forensic Provisions) Act 1990* (NSW) pt 5 especially s 73.
4. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 73; *Mental Health Act 2007* (NSW) s 141.
5. The Mental Health Review Tribunal has three additional functions in respect of a forensic patient who is UNA, including an additional requirement for release: see para 9.157.
6. *Mental Health (Forensic Provisions) Act 1990* (NSW) pt 5, div 4.

Figure 9.1: Number of forensic patients by type (at 30 June)



Source: Mental Health Review Tribunal, Annual Reports 2005-2012

9.7 Figure 9.1 outlines the number of forensic patients in NSW taken as snapshots in June of each year. The "fitness" group refers to people who have been found unfit, but who have not yet had a finding at special hearing.

The definition of forensic patient

9.8 Forensic patients are those people who are found:

- UNA, and in respect of whom the court sets a limiting term and makes an order for detention, and[7]
- NGMI at a trial or special hearing, and in respect of whom the court makes an order for conditional release, or detention.[8]

9.9 The current legislative definition of "forensic patient" does not include people who are UNA and in respect of whom the court makes a non-custodial order.[9] Accordingly, such people are not subject to the forensic system or to the jurisdiction of the Forensic Division of the MHRT. In Chapter 7 we recommend that all people found UNA or NGMI should be referred to the MHRT for appropriate orders.

When does a person become a forensic patient?

9.10 "Forensic patient" is currently defined in s 42 of the MHFPA as:

7. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 27, s 42(a)(i).
8. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 39, s 42(a)(i).
9. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 52(1)(b).

(a) a person who is detained in a mental health facility, correctional centre or other place, or released from custody subject to conditions, pursuant to an order under:

(i) section 14, 17(3), 24, 25, 27 or 39, or

(ii) section 7(4) of the *Criminal Appeal Act 1912* (including that subsection as applied by section 5AA (5) of that Act),

(b) a person who is a member of a class of persons prescribed by the regulations for the purposes of this section.

9.11 This means that the current definition of forensic patient applies to a person detained, or released subject to conditions (not including bail conditions) where an order is made by the court to:

(1) Detain a person following a finding by a court of unfitness, pending a determination by the MHRT of whether the person is likely to become fit (s 14, see also s 16).

(2) Detain a person who is unfit, but is likely to become fit within 12 months of the finding of unfitness (such a person may not be detained for more than 12 months) (s 17(3)).

(3) Detain a person following the imposition of a limiting term after a special hearing – while awaiting a determination of the MHRT, but prior to the court making a final order (s 24).

(4) Detain or release a person conditionally following a finding of NGMI at a special hearing (s 25).

(5) Detain a person following the imposition of a limiting term at a special hearing (s 27).

(6) Detain or release a person conditionally following a finding of NGMI (s 39; s7 of the *Criminal Appeal Act 1912* (NSW)).

9.12 Orders under (1)-(3) operate prior to court finalisation of a matter, although there is some debate regarding whether (3) operates to include people within the definition on an interim or final basis (see para 9.15). Additionally, despite application of the definition to people who are "detained … or released from custody subject to conditions", people released on bail following a finding of unfitness are not considered to be within the definition of forensic patient.

When does a person cease to be a forensic patient?

9.13 Prior to finalisation/disposition of a matter during special hearing processes, a person ceases to be a forensic patient where:

(1) the person is released on bail

(2) the person becomes fit

(3) the Director of Public Prosecutions (DPP) advises that there will be no further proceedings in relation to the charge

(4) charges are dismissed

(5) the person is found not guilty, or

(6) a limiting term is not nominated.[10]

9.14 Following finalisation, a person ceases to be a forensic patient where he or she is released unconditionally by the MHRT or the court. Additionally, where a person is UNA the person also ceases to be forensic patient when:

(1) his or her limiting term expires

(2) he or she is reclassified as an involuntary civil patient by the MHRT, or

(3) the person, having been found unfit, is found to have become fit.[11]

What issues arise?

9.15 The definition of forensic patient is confusing and opaque, causing problems in practice. For example, where a person has been found UNA and a limiting term has been nominated, the court makes a decision regarding custody under s 24 of the MHFPA and refers the person to the MHRT for determination of that person's impairment type (before making final orders). It is unclear whether the person becomes a forensic patient on an interim basis (that is, until the person returns to court) or a continuing basis (until released unconditionally by the MHRT) – with different views expressed by courts.[12] This is important because, where the court does not make an order under s 27, it is unclear whether s 24 continues to have effect or whether the person ceases to be a forensic patient. This is an issue we discuss in Chapter 7, and is resolved, in part, by our recommended simplification of court processes.

9.16 Further, a person may be released on bail following a fitness hearing (and therefore, not included within the definition of forensic patient). However a treating team may mistakenly consider that person to be a forensic patient. Where there is a need to involuntarily detain a person, the treating team may request a breach notice from the MHRT. The MHRT would not have the power to provide this. An example is outlined in Case study 9.1.

Case study 9.1
[A] patient [was] found unfit to be tried and bailed under s. 14 of the [MHFPA] pending the Tribunal's determination on his fitness. The man

10. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 42, s 52.
11. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 51, s 52(2)
12. *AN (No 2) v The Queen* [2006] NSWCCA 218; 66 NSWLR 523 [55]; *State of NSW v TD* [2013] NSWCA 32 [46]-[47]. See also Information supplied by the Mental Health Review Tribunal, 5 February 2013, 1.

> went on to commit a further offence. His treating team refused to schedule him and instead asked the Tribunal to issue an order for breach under s. 68 of the [MHFPA]. However, as the man was on bail, rather than on leave or conditional release, the prerequisites for the exercise of the Tribunal's power were not available.[13]

9.17 Understanding whether the person is a forensic patient on an interim basis or a continuing basis also has implications regarding the MHRT's range of powers. For example, the MHRT cannot release a person who has been remanded pending a return to court.[14]

9.18 This lack of clarity can cause problems in practice and makes the legislation very difficult to navigate. It can lead to confusion regarding who should and should not be managed as a forensic patient.

The Commission's view

9.19 The approach to defining "forensic patient" would benefit from greater clarity, which would be best achieved if the MHFPA sets out who falls within the definition of forensic patient:

- during special hearing processes (that is, on an interim basis), and
- following court disposition (on a final basis).

9.20 This approach would have the benefits of:

- Clarifying when court orders result in a person becoming a forensic patient (on an interim or final basis).
- Clarifying which provisions of the MHFPA (and related powers of the MHRT) apply to which group, instead of relying on implicit assumptions, which are at times confusing and vague.

9.21 This is consistent with the approach adopted in the review of the NSW forensic system conducted in 2007 (the 2007 Forensic Review.) That review raised issues with the definition provided in the now repealed *Mental Health Act 1990* (NSW), noted gaps in the definition, and argued that a narrative definition "would provide greater clarity and consistency regarding the operation of the forensic mental health system and those who are covered by it; and would protect against technical gaps in coverage".[15]

9.22 In order to achieve the required change we recommend that the definition should be divided to reflect those who are being managed on an interim basis and forensic patients who have had a finding at a special hearing or trial. The provisions of the MHFPA should indicate whether such provisions apply to forensic patients, interim forensic patients or both. In para 1.62-1.67 we address the complexity of the legislation in general and recommend that the MHFPA should be reviewed with a view to improving the comprehensibility and clarity of the legislation.

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13. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 12.
14. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 47(2).
15. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [3.6].

9.23 In Recommendations 7.3-7.5 we recommend that all people found UNA or NGMI be referred to the MHRT as forensic patients. In Recommendation 8.2 we recommend that where a person only presents a risk of harm to him or herself the MHRT should have the power to transfer that person into the civil mental health system (provided he or she meets the relevant criteria for admission).

9.24 The definition of forensic patient would therefore be simplified and should be amended accordingly.

Recommendation 9.1

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

(a) Where a person has been found unfit to be tried by the court, that person should be an "interim forensic patient".

(b) A person ceases to be an "interim forensic patient" when:

- (i) the person is released on bail
- (ii) the person is found to have become fit
- (iii) the Director of Public Prosecutions advises that no further proceedings will be taken
- (iv) the charges are dismissed
- (v) he or she is acquitted, or
- (vi) he or she is found unfit and not acquitted or not guilty by reason of mental illness (in which case the person becomes a forensic patient).

(c) Where a person is found unfit and not acquitted or not guilty by reason of mental illness that person should be a "forensic patient".

(d) A person ceases to be a "forensic patient" when:

- (i) the Mental Health Review Tribunal releases the person unconditionally
- (ii) the Mental Health Review Tribunal reclassifies the person as a civil involuntary patient
- (iii) the person's limiting term expires, or
- (iv) the person, having been found unfit, is found to have become fit.

(e) Provisions in the *Mental Health (Forensic Provisions) Act 1990* (NSW) should refer to "interim forensic patients", "forensic patients" or both, as relevant.

Review of forensic patients

9.25 "Initial reviews" are conducted by the MHRT as soon as practicable after:

- a person is found NGMI and the court makes an order for detention or conditional release, or

- the person has been found unfit and the court makes an order for detention and nominates a limiting term.[16]

9.26 Where a person is NGMI, the initial review involves assessing the person's case and making orders in relation to the person's care, treatment, detention or conditional or unconditional release (s 44).[17] Where a person is UNA and the person is ordered to be detained subject to a limiting term, the MHRT must assess the person's fitness to be tried at the initial review (s 45), which is regularly assessed in future reviews.[18] We are told that in practice, the MHRT will conduct a s 46 review (which includes consideration of care and treatment) in conjunction with a s 45 initial review.[19]

9.27 After the initial review, the MHRT may review the person's case again at any time, but must review the person's case at least every six months.[20] However, where the person is subject to a community treatment order (CTO) in a correctional centre (used to provide treatment and management of a person's mental illness in custody)[21] that person's case must be reviewed every three months.[22] The six monthly review cycle may be extended to a maximum of 12 months, on the motion of the MHRT or on the application of the patient or the primary carer of the patient, where the MHRT is satisfied that:

(a) there are reasonable grounds to grant the application, or

(b) an earlier review is not required because:

(i) there has been no change since the last review in the patient's condition, and

(ii) there is no apparent need for any change in existing orders relating to the patient, and

(iii) an earlier review may be detrimental to the condition of the patient.[23]

9.28 At all further reviews, the MHRT may make an order as to the patient's:

- continued detention, care or treatment in a mental health facility or other place
- transfer to or from a mental health facility, or
- release, either conditionally or unconditionally.[24]

---

16. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 44-45.
17. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 44.
18. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 46-47.
19. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 3.
20. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 46(1). This is subject to two exceptions: see s 46(3)-(5).
21. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [4.25].
22. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 46(3).
23. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 46(4)-(5).
24. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 47-48. On an initial review the Tribunal must make an order; on a subsequent review the Tribunal may make an order.

The MHRT also has the power to grant periods of leave from any place where a person is detained,[25] but only if satisfied that it is safe to do so.[26] Otherwise, it must order that the person be detained or continue to be detained.

9.29 In addition, the MHRT must review the person's case if he or she is apprehended following breach of a condition of leave or release; and whenever it is requested to do so by certain authorities.[27] There is, however, no provision for the forensic patient to apply for a review.

Table 9.1: MHRT reviews of forensic patients

Reviews	2009/10	2010/11	2011/12
Regular reviews of forensic patients (s 46(1))	601	615	651
Review following apprehension following an alleged breach of condition	3	10	27
Extend review period to 12 months	16	25	38
Adjournments	39	20	33
Decision not forwarded/completed due to change in circumstances	3	8	8

Source: Mental Health Review Tribunal, Annual Reports 2009-2012

9.30 Table 9.1 outlines the nature and frequency of reviews conducted by the MHRT. Table 9.2 indicates the outcomes of those reviews.

9.31 The MHA allows for adjournment of proceedings for such reasons as the MHRT considers fit. Where proceedings are adjourned a person who is in a mental health facility will continue to be detained there, unless discharged or allowed to be absent under the provisions of the MHA and MHFPA.[28] The MHRT noted that adjournments may arise where required information or reports are unavailable. This may be associated with:

- delays with the treating team
- the unavailability of doctors
- the need to wait for information from the court (for example, a decision relating to fitness, or disposition of other charges)
- new or revised medication being trialled, where the effectiveness is not yet clear, and

25. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 49. The Director-General of the Department of Health also has a limited power to grant leave: s 50.
26. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 43.
27. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 68(2).The authorities are the Minister for Health, the Attorney General, the Minister for Justice, the Minister for Juvenile Justice, the Director-General of the Department of Health, or the medical superintendent of the mental health facility in which the patient is detained: s 46(2).
28. *Mental Health Act 2007* (NSW) s 155.

- delays in linking people to services in the community.[29]

9.32 A decision may not be forwarded or completed due to a change in circumstances where a "significant event" occurs between the hearing date and the date on which orders are made. In such circumstances the MHRT may consider it inappropriate to make the order that was contemplated and a further hearing may be required. For example, a significant event may be that the forensic patient has absconded.[30]

Table 9.2: Outcome of MHRT reviews

Outcome of review	2009/10	2010/11	2011/12
No change in conditions of detention	348	415	455
Transfer to another facility	78	93	85
Revocation of order for transfer to a mental health facility	0	3	0
Grant of leave of absence	87	61	79
Revocation of leave of absence	1	0	2
Conditional release	10	14	8
No change to conditional release	146	135	134
Variation of conditions of release	28	29	37
Revocation of conditions of release	6	2	6
Unconditional release	14	11	7
Non-association or place restriction on leave or release	4	9	8

Source: Mental Health Review Tribunal, Annual Reports 2009-12

Should the review cycle be changed?

Patient initiated review

9.33 In CP 6 we asked whether the MHFPA should provide for a forensic patient to be able to apply for a review of his or her case. Most stakeholders that responded to this question submitted that this should be permitted.[31]

9.34 The NSW Council for Civil Liberties noted that such a power is "an important protection for forensic patients where new issues arise in relation to their treatment conditions in between regular reviews".[32]

29. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 3-4.
30. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 4.
31. 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 6.74; NSW Bar Association, *Submission MH10*, 43; NSW Consumer Advisory Group, *Submission MH11*, 26-27; Law Society of NSW, *Submission MH13*, 21-22; Legal Aid NSW, *Submission MH18*, 17; NSW Council for Civil Liberties, *Submission MH46*, 9.

9.35 Some stakeholders also noted that the number of reviews could be limited or a framework created to minimise frivolous applications. For example, the NSW Bar Association suggested limiting the number of applications within a given period.[33] The Law Society of NSW and Legal Aid NSW suggested attaching conditions that are similar to s 65(3) of the MHA to minimise frivolous applications.[34] This section provides that:

> (3) An application may be made only if:
>
> (a) there has been a substantial or material change in the circumstances surrounding the making of the order, or
>
> (b) relevant information that was not available when the order was made has become available.

9.36 The NSW Consumer Advisory Group (NSWCAG) submitted that the MHFPA should recognise the right of forensic patients to apply for review and that such a review should occur as soon as practicable.[35] The NSWCAG also raised additional practical concerns regarding the current operation of the system:

- Forensic patients have expressed reluctance to request reviews because of the time involved in preparing their case and receiving a response from the MHRT – at which point six month review would occur anyway.
- Forensic patients indicated that "reliance on treating staff to participate in the review process is also problematic as they are concerned that it may impact their relationship with the treating team".

The NSWCAG also noted that some forensic patients would like a way of appealing decisions without their treating team being involved.[36]

9.37 The NSW Council for Civil Liberties submitted that there is "little understanding" that a forensic patient may bring their own conditional or unconditional release application – with independent evidence provided in support. Expert evidence is generally provided by forensic psychiatrists attached to Justice Health,[37] but there is no system in place to facilitate access to a wider range of experts, to enable the forensic patient to contest the treating teams' characterisation of his or her impairment and needs.[38]

9.38 The MHRT submitted that, in practice, it does allow for forensic patients to apply for a review of their case:

> although the Tribunal in practice currently allows for forensic patients to apply for a review of his or her case, and is happy for patients to be able to express a desire for a review, there should be no compulsion for the Tribunal to continuously respond to such requests as some patients would wish to have

32. NSW Council for Civil Liberties, *Submission MH46*, 9.
33. NSW Bar Association, *Submission MH10*, 43.
34. Law Society of NSW, *Submission MH13*, 21-22; Legal Aid NSW, *Submission MH18*, 17.
35. NSW Consumer Advisory Group, *Submission MH11*, 27.
36. NSW Consumer Advisory Group, *Submission MH11*, 26-27.
37. Now the Justice & Forensic Mental Health Network.
38. NSW Council for Civil Liberties, *Submission MH46*, 10.

their matter reviewed each week seeking release etc where no evidence exists to support such an application.[39]

9.39 The Homicide Victims' Support Group (HVSG) noted that six-monthly reviews are "frequent enough to achieve the MHRT's objectives and [we] do not see a need to allow a defendant to apply for a further review".[40] More frequent reviews would undoubtedly have a significant impact on victims, particularly where questions of leave or release are addressed. In Chapter 8 we address the role and involvement of victims in MHRT proceedings.

Frequency of statutory reviews

9.40 The MHRT suggested the review cycle be modified for forensic patients found NGMI or UNA as follows:

- MHRT initially to conduct review as soon as practicable and consider the treatment plan for the forensic patient.
- Formal three member panel reviews should occur at least once every 12 months.
- Less extensive reviews by a single member should occur in between formal reviews (by either the President or Deputy President). This would provide the opportunity to check the patient's progress and monitor any issues identified at formal hearings. Formal reports would not be required, simply oral evidence or brief updates.

The MHRT submitted that this would provide flexibility in the use of its resources.[41]

9.41 The issue of frequency of review was also addressed in the 2007 Forensic Review. The review looked at several options for reducing the review cycles but did not recommend adopting annual reviews "as a general course", noting "the strong support expressed in submissions for retaining the existing framework".[42] In particular, there were concerns about the protection of the rights and interests of forensic patients and ensuring that forensic patients are progressed towards release into the community.[43] The review did, however, recognise that flexibility may be required in some circumstances, "for example where there is evidence that the review would be distressing or anti-therapeutic for a particular patient, or a patient requests further time to prepare for a particular review".[44]

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39. Mental Health Review Tribunal, *Submission MH57*, 19.
40. Homicide Victims' Support Group, *Submission MH20*, 15.
41. Mental Health Review Tribunal, *Submission MH57*, 19.
42. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [7.15].
43. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [7.14].
44. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [7.15].

Adjourning reviews

9.42 In consultations the MHRT also suggested that the system could benefit from additional flexibility around the timing of reviews, particularly where a short period of additional time is required to receive an assessment or report.[45]

9.43 We outlined the practical circumstances that may lead to an adjournment in para 9.31. While the review cycle can be extended to a maximum of 12 months under the existing provisions,[46] and adjournments are permitted under the MHA,[47] a full panel is required to make this decision.[48] In certain circumstances, for example where a forensic patient is waiting for an assessment report, it would appear to be unnecessarily cumbersome and expensive to convene a full panel simply to adjourn a matter.

9.44 Section 73(4) of the MHFPA says that regulations may provide that specified functions of the MHRT under the MHFPA be carried out by a Tribunal constituted by the President or a Deputy President. Such regulations could provide for the function of adjourning reviews.

The Commission's view

9.45 The issue of patient initiated review is closely linked to that of frequency of review. It is important that patients are able to have their situation reviewed independently and regularly. However, reviews are presently conducted automatically every six months, without requiring an application from the patient. There will necessarily be significant time and effort devoted to such reviews, including the time of the patient, the treating team and the MHRT. Further, review is of particular importance when there has been a change of circumstances or there is new information justifying a change in the MHRT's order. Such a change will often involve an improvement in the patient's health, and demonstrating that such a change is consistent and stable over time will be important. In the circumstances, six monthly intervals would seem to be appropriate and reasonable, particularly in view of the fact that the MHRT already exercises discretion to permit patient initiated reviews, so that any urgent matters could be dealt with in this way.

9.46 The arguments in favour of patient initiated reviews are therefore not strong, given the regularity and frequency of the present review arrangements. We note also the risks, costs and stresses (including potential stress to victims) of more frequent reviews.

9.47 If the proposal of the MHRT for full review every 12 months were to be adopted the argument for patient initiated reviews becomes stronger. However, on balance we do not recommend change to the current arrangements for review.

9.48 We note the MHRT's concerns regarding the inflexibility of the current process to adjourn review applications, particularly where all that is required is a short

45. Mental Health Review Tribunal, *Consultation MH39*.
46. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 46(5).
47. *Mental Health Act 2007* (NSW) s 155.
48 *Mental Health (Forensic Provisions) Act 1990* (NSW) s 73.

additional period of time for the outcome of an assessment or to gather additional evidence. It is wasteful of resources for the MHRT to have to convene a full panel to consider such issues. Accordingly we recommend empowering the President or a Deputy President to permit short adjournments where there are delays in accessing information necessary for the MHRT to conduct its reviews. This could be achieved by amending the *Mental Health (Forensic Provisions) Regulation 2009* (NSW) or creating a new regulation, to specify that, for the purposes of the function of adjourning a review under the MHFPA, the Forensic Division may be constituted by the President or a Deputy President of the MHRT.

Recommendation 9.2

A regulation should specify that, for the purposes of the function of adjourning a review under the *Mental Health (Forensic Provisions) Act 1990* (NSW), the Forensic Division of the Mental Health Review Tribunal may be constituted by the President or a Deputy President of the Tribunal sitting alone.

Powers in relation to leave and conditional release

9.49 The MHRT has powers to make orders for leave or release:

- **Leave:** The MHRT may make an order allowing a forensic patient to be absent from a mental health facility, or correctional centre for such a period and subject to such conditions as the MHRT thinks fit.[49] Leave can range from escorted ground leave to unsupervised overnight or weekend leave.[50]
- **Release:** The MHRT may make an order as to the person's release (either conditionally or unconditionally).[51]

9.50 By using leave and conditional release "the forensic mental health system is able to assess, monitor and progress a forensic patient's capacity to be released back into the community".[52] These mechanisms can also assist with transition back into the community by enhancing social skills, establishing a structure for ongoing support in the community and allowing for assessment of the person's capacity to manage in the community and of risk to community safety.[53]

9.51 Table 9.2 outlines the outcomes of reviews conducted by the MHRT.

Considerations in relation to leave and release

9.52 There are various criteria which are relevant to MHRT decisions regarding leave and release:

49. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 49.
50. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [8.8]; NSW Health, *Forensic Mental Health Services, Policy Directive* (2012) 10.
51. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 44(2)(b), s 47(1)(b).
52. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [8.5].
53. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [8.5].

> **43 Criteria for release and matters to be considered by Tribunal**
> The Tribunal must not make an order for the release of a forensic patient unless it is satisfied, on the evidence available to it, that:
>
> (a) the safety of the patient or any member of the public will not be seriously endangered by the patient's release, and
>
> (b) other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the patient or that the patient does not require care.
>
> **49 Tribunal may grant leave**
> …
>
> (3) The Tribunal must not make an order allowing a forensic patient to be absent from a mental health facility, correctional centre or other place unless it is satisfied, on the evidence available to it, that the safety of the patient or any member of the public will not be seriously endangered if the leave of absence is granted.
>
> **74 Matters for consideration**
> Without limiting any other matters the Tribunal may consider, the Tribunal must have regard to the following matters when determining what order to make about a person under this Part:
>
> (a) whether the person is suffering from a mental illness or other mental condition,
>
> (b) whether there are reasonable grounds for believing that 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,
>
> (c) the continuing condition of the person, including any likely deterioration in the person's condition, and the likely effects of any such deterioration,
>
> (d) in the case of a proposed release, a report by a forensic psychiatrist or other person of a class prescribed by the regulations, who is not currently involved in treating the person, as to the condition of the person and whether the safety of the person or any member of the public will be seriously endangered by the person's release,
>
> (e) in the case of the proposed release of a forensic patient subject to a limiting term, whether or not the patient has spent sufficient time in custody.

9.53 The principles in s 68 of the *Mental Health Act 2007* (NSW) also apply to forensic patients (para 8.14), as do the objects outlined in para 9.3. In Chapter 8 we review these provisions in greater detail and make recommendations to improve the MHRT's decision making framework.

Change to any conditions?

9.54 Currently, s 74(a) requires the MHRT to consider whether the person is suffering from a mental illness or other mental condition. As we note in Report 135, "mental

condition" is negatively defined to mean "a condition of disability of mind not including either mental illness or developmental disability of mind".[54]

9.55 The conditions listed were inserted by the *Mental Health Legislation Amendment (Forensic Provisions) Act 2008* (NSW),[55] which implemented a range of recommendations made in the 2007 Forensic Review, including listing a series of considerations.[56] However, the 2007 review recommended the inclusion of the "nature of the person's condition", which appears broader than the language adopted in s 74(a).[57]

9.56 The MHRT has noted that the vast majority (over 90%) of forensic patients have a primary diagnosis of mental illness. However, there is a high rate of complex needs, for example:

> drug and alcohol (55%); personality disorder (16%); head injury; cognitive difficulties arising from prolonged mental illness; intellectual disability; or aged related issues such as dementia.[58]

Of the approximately 387 forensic patients, about 10 (2.6%) have only an intellectual disability.[59]

9.57 In Report 135 we note that "mental condition" appears to be a "catch all" phrase, to recognise a wider range of mental states than those covered under the MHA.[60] However, the term appears to exclude intellectual disability and other impairments that might be considered a "developmental disability of the mind".[61]

9.58 We outline the importance of recognising cognitive impairment in the MHFPA in para 1.37-1.45. In Report 135, we recommend definitions of cognitive and mental health impairment to be used in legislation where appropriate.[62] Given the number of people managed by the MHRT who have cognitive impairments, or complex needs that include cognitive impairment, the inclusion of these impairments is important. We therefore recommend replacing the requirement that the MHRT have regard to "whether the person is suffering from a mental illness or other mental condition" with a requirement that it have regard to "the nature of a person's cognitive or mental health impairment".

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54. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 3; NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) [5.27].
55. *Mental Health Legislation Amendment (Forensic Provisions) Act 2008* (NSW) sch 1 [14].
56. See NSW, *Parliamentary Debates*, Legislative Assembly, 27 June 2008, 9540-2 (P Lynch).
57. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) Recommendation 26.
58. Mental Health Review Tribunal, *Submission MH67*, 5.
59. Mental Health Review Tribunal, *Submission MH67*, 5. This figure was taken from mid 2012.
60. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) [5.27]. See also *Perry v Forbes* (Unreported, Supreme Court of NSW, Smart J, 21 May 1993).
61. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) [5.22].
62. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) Recommendations 5.1-5.2.

9.59 For similar reasons, we are also of the view that s 40 of the MHFPA (the objects clause outlined in para 9.3) which refers to "care, treatment and control of persons subject to criminal proceedings who are suffering from a mental illness or mental condition" should be replaced with the words "care, treatment and control of persons subject to criminal proceedings who have a cognitive or mental health impairment".

Recommendation 9.3

(1) Section 40(b) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be replaced with "to provide for the care, treatment and control of persons subject to criminal proceedings who have a cognitive or mental health impairment".

(2) Section 74(a) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be replaced with "the nature of the person's cognitive or mental health impairment".

Additional considerations required?

9.60 The MHRT has submitted that additional considerations could be included in relation to decisions for release:

> A non-exhaustive list could also be created of further issues that the Tribunal should consider prior to release. This could include the Tribunal having regard to the nature and circumstances of the index event; the patient's condition at the time of the index event (NB present condition already covered under s74); and the patient's treatment history before and after the index event. While this is part of a good risk assessment it is not always included as risk assessments can be 'point in time' rather than holistic. However, it is critical that the Tribunal is confident that the patient has received a sufficient period of assessment and treatment to manage any risk issues in the individual case and explicitly providing for these issues to be addressed prior to release would ensure that these issues are considered by all participants involved in the care, treatment, and management of forensic patients.[63]

9.61 The submission of the MHRT appears to reflect concerns about the nature, type and consistency of information presented to the MHRT, rather than the principles and factors relevant to its decision.

9.62 We agree that some or all of these matters may be important to assessing risk; however, we do not think that it is necessary to amend the MHRT's decision making framework to reflect this. The current framework is broad and sufficiently flexible to allow for consideration of a multitude of factors, and already has a clear risk management focus. Additionally, in some cases information such as the patient's treatment history prior to the index event or the patient's condition at the time of the index event may not readily be available. This may be because the index event is the first episode of serious mental illness, or because it is the first time the forensic patient is properly assessed.

9.63 The concerns of the MHRT would appear to be more appropriately dealt with by regulation of the information that should be included in a report by the psychiatrist or

63. Mental Health Review Tribunal, *Submission MH57*, 21.

other prescribed person for the purposes of s 74(d) of the MHFPA. The *Mental Health (Forensic Provisions) Regulation 2009* (NSW) prescribes the class of people eligible to provide a report for the purposes of risk assessment. Regulations could also make additional provision relating to the content of such a report under s 74(d) including a requirement that the information provided should include the nature and circumstances of the index event, the patient's condition at the time of the index event and the patient's treatment history before and after the index event, so far as that treatment history is available. Such a regulation could be supported by guidelines produced by the MHRT that would further explain the needs and expectations of the MHRT.

Recommendation 9.4

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should allow regulations to provide for the types of information that may be included in a report under s 74(d) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) including, where such information is available:

(a) the nature and circumstances of the index event

(b) the patient's condition at the time of the index event, and

(c) the patient's treatment history before and after the index event.

Conditions which may be imposed

9.64 The conditions which the MHRT may attach to an order for leave or release include, but are not limited to, conditions in relation to:

(a) the appointment of a case manager, psychiatrist or other health care professional to assist in the care and treatment of the patient,

(b) the care, treatment and review of the patient by persons referred to in paragraph (a), including home visits to the patient,

(c) medication,

(d) accommodation and living conditions,

(e) enrolment and participation in educational, training, rehabilitation, recreational, therapeutic or other programs,

(f) the use or non-use of alcohol and other drugs,

(g) drug testing and other medical tests,

(h) agreements as to conduct,

(i) association or non association with victims or members of victims' families,

(j) prohibitions or restrictions on frequenting or visiting places,

(k) overseas or interstate travel.[64]

9.65 In CP 6 we asked whether the provisions regarding conditions that may attach to leave or release are adequate, and if not, what changes should be made.[65] Most stakeholders that responded to this issue noted that the provisions were generally adequate and appropriate.[66] The NSW Council for Civil Liberties observed that decision making in relation to leave and conditions is effectively shared between the MHRT and service providers.[67]

9.66 The Law Society of NSW and Legal Aid NSW expressed concern that drug testing was applied as a standard condition even where there is no history of substance abuse.[68] However, this appears to be a matter concerning the way the legislation is interpreted by the MHRT, rather than a matter requiring legislative amendment.

The Commission's view

9.67 In the absence of any problems identified by stakeholders we are of the view that the provisions relating to the conditions which may be imposed by the MHRT do not require legislative amendment. In view of the concerns expressed by some stakeholders about the standard conditions included by the MHRT in orders for leave or release, the MHRT may wish to review these standards conditions, or to consider the provision of information to Tribunal members concerning the appropriate inclusion, or otherwise, of standard conditions.

Notification requirements

9.68 The MHRT must inform the Minister for Police, the Minister for Health and the Attorney General of any order it makes for the release of a forensic patient, including the date of release.[69] The provision appears to be a relic from the days when the executive government could instigate the return to custody of forensic patients who were conditionally released into the community.[70] Previous reviews, including one by this Commission, have recommended that the requirement to notify the Minister for Police should be removed.[71]

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64. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 75(1). The Tribunal may also impose conditions in relation to other matters: s 75(2). See also "Appendix 2: Conditional Release Template": D Howard and B Westmore, *Crime and Mental Health Law in New South Wales* (LexisNexis Butterworths, 2nd ed, 2010) 778-779.
65. 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 6.75.
66. NSW Bar Association, *Submission MH10*, 43; Law Society of NSW, *Submission MH13*, 22; Legal Aid NSW, *Submission MH18*, 18; Mental Health Review Tribunal, *Submission MH57*, 20.
67. NSW Council for Civil Liberties, *Submission MH46,* 9.
68. Law Society of NSW, *Submission MH13*, 22; Legal Aid NSW, *Submission MH18*, 18.
69. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 76A(6). The Attorney General and the Minister for Health may exercise a right of appeal against the decision of the Mental Health Review Tribunal: s 77A.
70. See *Mental Health Act 1990* (NSW) s 83-84 (now repealed).
71. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [8.52], Recommendation 28; NSW Law Reform Commission, *People with an Intellectual Disability in the Criminal Justice System*, Report 80 (1996) [5.56], Recommendation 20(c).

9.69 There may be an argument for continued notification of the Attorney General and the Minister for Health, both of whom have rights of appeal against decisions of the MHRT.[72] We discuss appeal processes in para 9.202-9.209. The appeal provisions in s 77A permit appeals by forensic patients, victims and "persons", with leave of the Supreme Court. The Minister for Health can appeal release determinations, as of right, and the Attorney General can appeal release decisions, as of right, on a question of law. Section 77A(7) refers to the time limit for appeal following notification by the MHRT of the Attorney General and the Minister for Health, but does not refer to the Minister of Police.

9.70 In CP 6 we asked whether the MHFPA should be amended to abolish the requirement for the MHRT to notify the Minister for Police, the Minister for Health, and/or the Attorney General of an order for release.[73] There were varied responses from stakeholders. The NSWCAG, Legal Aid NSW and the Law Society of NSW noted that the MHFPA should abolish the requirement to notify the Minister for Police.[74] Two stakeholders noted that this requirement contributes to stigmatisation of forensic patients.[75] The NSWCAG submitted that once the MHRT has unconditionally released a forensic patient it is inappropriate to continue monitoring that person.[76]

9.71 However, the NSW Bar Association submitted that notifications should remain as a "safety net", noting that the Attorney General and Minister for Health have the right to appeal and therefore it is appropriate that they be notified. The Bar Association suggested that it is appropriate to notify the Minister for Police as the Minister can bring relevant information to the attention of the Attorney General.[77]

9.72 The MHRT stated that it understands that the rationale for notifying the Minister for Police is to allow for safe management of the forensic patient in the community. This would ensure that if the forensic patient was arrested, the NSW Police Force would be aware that the person is a forensic patient and be in a position to notify the MHRT as soon as possible after arrest and to take appropriate measures to have the forensic patient assessed.[78] The MHRT suggested that, in order to achieve this, it may be more appropriate to notify the Commissioner of Police than the Minister for Police.[79]

9.73 The 2007 Forensic Review considered the issue of notification of the Minister for Police. The review concluded that it:

> is not convinced of the need to notify the Minister for Police of the release of a forensic patient in every case, given that the person will only be released if the

72. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 77A.
73. 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 6.76.
74. NSW Consumer Advisory Group, *Submission MH11*, 27; Legal Aid NSW, *Submission MH18*, 18; Law Society of NSW, *Submission MH13*, 22.
75. NSW Consumer Advisory Group, *Submission MH11*, 27; Legal Aid NSW, *Submission MH18*, 18.
76. NSW Consumer Advisory Group, *Submission MH11*, 27.
77. NSW Bar Association, *Submission MH10*, 44.
78. Mental Health Review Tribunal, *Submission MH67*, 12.
79. Mental Health Review Tribunal, *Submission MH67*, 12.

> decision-maker is satisfied that he or she does not constitute a risk of serious danger to the public, and that the significant majority of patients do not commit acts of violence after their release.[80]

The Commission's view

9.74 On balance, we recommend that the requirement to notify the Minister for Police in s 76A(6) should be repealed. This recommendation is in accordance with our previous recommendation in Report 80 and with the recommendation of the 2007 Forensic Review.

9.75 The Attorney General and Minister for Health should continue to be notified regarding release because of their entitlement to appeal those release decisions. In our view it is more appropriate to include this requirement in s 77A, which deals with appeals against the MHRT's decisions.

9.76 The requirement to notify the Minister for Police does not appear to have any beneficial practical consequences. Insofar as the NSW Police Force may need to be notified in relation to the conditional release of forensic patients, it is appropriate to deal with this by information sharing arrangements between agencies responsible for supervising or supporting forensic patients. We deal with information sharing in para 9.111-9.122.

Recommendation 9.5

(1) The requirement in s 76A(6) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) that the Mental Health Review Tribunal must inform the Minister for Police of any order it makes for the release of a person and the date of the person's release should be removed.

(2) The requirement in s 76A(6) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) that the Mental Health Review Tribunal must inform the Attorney General and Minister for Health of any order it makes for the release of a person and the date of the person's release should be moved to s 77A.

The relationship between the MHRT and other agencies

Agencies responsible for the management of forensic patients

9.77 In order to manage forensic patients under the MHFPA the MHRT needs agencies or individuals to provide information to assist it with decision making and to provide the services that enable MHRT orders to be implemented. For example, treating teams provide information and make recommendations to the MHRT regarding leave or release of a forensic patient. The MHRT might need access to assessments or reports regarding risk prior to ordering release or to identify services to which a forensic patient can be linked in the community.

80. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [8.52].

9.78 As discussed in para 9.25-9.28, the MHRT can make a range of orders about a forensic patient's detention, care or treatment in a mental health facility, correctional centre or other place. The MHRT can also make orders about the patient's release, either conditionally or unconditionally.[81] For example, the MHRT might order that a forensic patient be transferred from prison to a mental health facility,[82] that a forensic patient in the community accept a particular social worker as his or her case manager or that the forensic patient reside in particular accommodation.[83] While such orders generally bind a forensic patient, the making of such orders also require the cooperation and participation of agencies and service providers. Support is critical in ensuring access to leave and other factors relevant to a forensic patient's progression through the system.

9.79 There are various provisions in the MHFPA that govern the relationship between agencies and the MHRT. Section 76K of the MHFPA requires Health, Corrective Services, Juvenile Justice and "any other government Department or agency responsible for the detention, care or treatment of a forensic patient" to "use their best endeavours to comply with a request made to them under [the] Act by the Tribunal if the request is consistent with the discharge of their responsibilities and does not unduly prejudice the discharge of their functions".[84]

9.80 In addition to this requirement that agencies use their best endeavours to comply with MHRT requests, the MHRT has:

(1) The power to "request" information from:

(a) the Department of Health,

(b) a Local Health District

(c) the Commissioner of Corrective Services

(d) the Director General of Juvenile Justice

(e) the Director General of Ageing, Disability and Home Care (ADHC)

(f) the Chief Executive of Justice Health, and

(g) the Chief Executive of Royal Alexandra Hospital for Children,

as to whether or not action has been taken, and what actions have been taken, in relation to orders made by the MHRT. A person or body must comply with any reasonable request made by the MHRT under this provision.[85]

(2) The power to issue a summons, requiring the person to whom the summons is addressed to attend as a witness at a meeting of the MHRT and produce any

81. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 47(1).

82. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 48.

83. Extracted from "Appendix 2: Conditional Release Template": D Howard and B Westmore, *Crime and Mental Health Law in New South Wales* (LexisNexis Butterworths, 2nd ed, 2010) 778-779.

84. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 76K(1). See also s 76J; *Mental Health (Forensic Provisions) Regulation 2009* (NSW) cl 14; *Mental Health Act 2007* (NSW) s 162A.

85. *Mental Health Act 2007* (NSW) s 162A; *Mental Health Regulation 2007* (NSW) cl 47A.

documents in their possession or control relating to any matter before the MHRT and matters specified in the summons.[86]

(3) Contempt powers, providing that a person must not refuse, neglect or for any reason fail to obey or comply with an order, direction, decision or determination under the MHA and MHFPA. Failure to do so is an offence with a maximum penalty of 50 penalty units.[87]

9.81 The MHRT has told us that it frequently uses its power to request information from agencies. For example, it may obtain a forensic patient's custodial history from Corrective Services, criminal history from the NSW Police Force and reports of the treating team from Local Health Districts.[88] Sometimes the MHRT will write to an agency following a hearing asking for specific information regarding the action being taken to assist in relation to a patient.[89] Additionally, the MHRT may issue a summons to obtain information from a private medical practitioner, and on rare occasions, a summons requiring private medical practitioners to attend a hearing [90]

Problems with information, services and compliance

9.82 A range of issues appear to arise concerning the relationship between the MHRT and other agencies and individuals. Difficulties identified by the MHRT include:

(1) Securing the information required to make appropriate decisions.

(2) Availability of services for the support of forensic patients to allow them to progress through the forensic system to leave and release.

(3) Failure to comply, or delays in complying, with requests or orders of the MHRT.

Securing information

9.83 The MHRT notes that it sometimes has difficulty in accessing information and assessments needed to make decisions about a forensic patient and to identify appropriate services. For example, it noted that it has occasionally requested neuropsychological assessments "but the treating team has refused to do so if it considers that the assessment is not justified and/or has concerns about who will fund such an assessment".[91] The MHRT has also noted that it has asked that a forensic patient regularly undertake drug testing, but this may be declined by community teams, usually due to cost.[92]

9.84 Case study 9.2 is an example where an assessment was required to access particular services, but where funding for such an assessment was unavailable.

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86. *Mental Health Act 2007* (NSW) s 157(1).
87. *Mental Health Act 2007* (NSW) s 161.
88. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 5.
89. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 5.
90. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 5.
91. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 6.
92. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 6.

9.85 Despite the power to request information of particular agencies, the MHRT has noted that some agencies routinely refuse to provide information unless a summons is issued.[93] Declining to provide information may be associated with privacy concerns. We discuss information sharing arrangements in para 9.111-9.122.

Availability of and responsibility for services

9.86 The MHRT has also noted that there are problems relating to gaps in services and difficulties identifying responsible agencies for forensic patients with cognitive impairments. For example, Corrective Services NSW accepts responsibility for forensic patients with cognitive impairments in prison but there are inherent limitations to the services that can be provided in this context; Justice Health is not involved unless the forensic patient also has a mental illness; and ADHC "sees no role for itself until the person is to be released into the community". [94]

9.87 The MHRT provided the example of a forensic patient who was diagnosed with dementia, but was too young to access nursing home assistance through ADHC.[95] The MHRT commented that it often "finds itself trying to coordinate the activities of various agencies and to negotiate their roles to seek any progress for patients".[96]

9.88 Particular difficulties also arise in accessing services where a forensic patient has complex needs – for example a mental illness together with substance abuse issues, or a personality disorder, or cognitive impairment. Such issues are common when dealing with forensic patients.[97] Case study 9.2 illustrates this problem.

Case study 9.2

[A] young forensic patient (found NGMI) was conditionally released by the court. He has an intellectual disability, as well as a mental illness. He ordinarily resided with his father, who has recently been diagnosed with a terminal illness, meaning that there are real concerns about the patient's housing and support. An assessment is needed to see if the patient is eligible for [ADHC] support. If done privately, it will cost $1000 which cannot be funded by the family. There is no public psychologist able to do the assessment through the Community Forensic Mental Health Service. While plainly needing support, the Tribunal cannot make the necessary orders that allow that support to be obtained.[98]

Difficulties in complying with MHRT orders and requests

9.89 Limited facilities, services and information may mean that an order of the MHRT (or the court) is not implemented or an order cannot be made. For instance, even where there is a court order for detention in a mental health facility, a place may not be available and the forensic patient can spend time in a correctional centre,

93. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 5.
94. Mental Health Review Tribunal, *Annual Report 2010-11*, 3.
95. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 7.
96. Mental Health Review Tribunal, *Annual Report 2010-11*, 3.
97. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 6.
98. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 6-7.

sometimes amounting to several years.[99] Similarly, the MHRT may order that a patient be transferred to a different mental health facility "and patients wait more than a year for a bed to become available".[100]

9.90 Where a forensic patient is in a correctional centre, the MHRT has submitted that the Commissioner for Corrective Services has sometimes refused to allow the transfers of some forensic patients due to "security concerns or classification issues".[101] We note that the MHFPA provides that the Commissioner for Corrective Services has an overriding discretion in relation to detention and transfer of forensic patients detained in correctional centres,[102] and considerations of "security, good order and safety" also determine the way in which the Commissioner exercises its functions, including to the extent of overriding orders.[103] However, this can slow the progress of these patients through the forensic system.[104] This is discussed in greater detail in Chapter 10.

Causes of the identified problems

9.91 The first and most serious cause of the difficulties identified above would appear to be the availability of resources. Agencies may be willing to support orders, but places are not available into which a patient can be transferred or the funding is not available. This resource problem appears to be most acute in relation to forensic patients who have cognitive impairments.

9.92 The allocation of scarce resources is an issue for government and cannot be solved by law reform. However, there may be scope to enhance the way that resources are deployed and improve agency support of the management of forensic patients. In many cases, the choice does not appear to be solely about whether resources will be expended, but where they will be expended. For instance, if a forensic patient with a cognitive impairment spends the whole of their limiting term in a correctional centre, resources are expended by Corrective Services NSW. Those resources may be better deployed, and the community better protected, if the same resources were used to provide support and behavioural change programs in the community. Achieving such change involves interagency collaboration.

9.93 A further cause of difficulties would appear to be the unwillingness of agencies to accept responsibility for forensic patients or doubts and concerns about who is the appropriate responsible agency.

9.94 It would appear also to be the case that there are some instances where agencies could comply with orders or requests of the MHRT, but that they do not do so.

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99. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 7.
100. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 7.
101. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 8.
102 *Mental Health (Forensic Provisions) Act 1990* (NSW) s 77C.
103. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 76C.
104. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 8.

Addressing the identified problems

9.95 Several strategies have been suggested to deal with the problems identified above. They are the improvement of interagency collaboration and cooperation, defining of agency roles in legislation, and the improvement of the contempt powers in the MHFPA.

Inter-agency collaboration and cooperation

9.96 The issue of the need for interagency cooperation in the forensic system was addressed in the 2007 Forensic Review, which noted the "significant need for interagency work to reduce the ad hoc support system that currently operates, and the importance of a whole-of-government approach that places patient care at the centre".[105]

9.97 The Review recommended that:

(1) the MHRT be empowered to require agencies specified in release plans to comply with their obligations under that plan and to cooperate with other relevant agencies,[106] and

(2) the Minister for Health develop an agreement with the MHRT and other Ministers responsible for the agencies involved in supervising, treating and caring for forensic patients "to provide an administrative framework to facilitate agency and patient compliance with the conditions of release, and the release plan".[107]

Section 76K, set out above (requiring agencies to use their "best endeavours" to comply with requests made to them by the MHRT) was designed to "enhance the capacity of the [MHRT] to assist in developing coordinated service plans for patients on release" along the lines suggested by the review.[108] However, as far as we are aware, no agreement or administrative framework has been developed to support agency and patient compliance with conditions of leave or release.[109]

9.98 In CP 6 we asked the related question - whether legislation should provide for specific roles for an agency or agencies in relation to supporting and supervising forensic patients in the community.[110] The NSW Bar Association noted that legislation could enhance the general requirement for cooperation.[111] However, the Law Society of NSW and Legal Aid NSW submitted that legislation should not stipulate specific roles for agencies. They noted that s 76K(1) is expressed in

105. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [8.58].
106. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) Recommendation 29.
107. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) Recommendation 30.
108. NSW, *Parliamentary Debates*, Legislative Council, 28 October 2008, 10 622 (P Sharpe).
109. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 8-9.
110. 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 6.77.
111. NSW Bar Association, *Submission MH29*, 44.

general terms to recognise the resourcing constraints of agencies and legislating roles would not address problems such as resource limitations, and may even have a negative impact on present arrangements.[112] Additionally, such an approach may limit flexibility in the way forensic patients are managed and may hinder cooperation.[113]

The Commission's view

9.99 Difficulties with the implementation of orders of the MHRT frequently appear to be a consequence of the absence of resources and facilities. These matters cannot be remedied by any change to the MHFPA, and are a matter for government. However it would appear that some of the difficulties that arise in relation to forensic patients relate to lack of agreement about which agency is responsible for provision of services. Other problems relate to the issue of where resources should be expended. Are they most beneficially and effectively expended, for example, in correctional centres or in providing community supports, in prevention or in crisis management?

9.100 It is highly desirable that there be agreement about roles, and collaboration and integration in the delivery of services. We agree with the views of Legal Aid NSW and the Law Society of NSW that specific roles for agencies do not need to be detailed in the legislation. However, it is important that arrangements are in place to support coordinated management of forensic patients, and particularly that those arrangements should allow for flexibility and collaboration between services where forensic patients do not fit within existing service paradigms. In particular, attention needs to be given as a matter of urgency to making proper provision for forensic patients who have cognitive impairments and/or complex needs.

9.101 We recommend the establishment of a Forensic Working Group, to consist of representatives from key bodies involved in the supervision of forensic patients. The group should develop and facilitate the implementation and maintenance of a framework of protocols providing for agency responsibilities in relation to forensic patients. The framework should include agency responsibilities, agency response arrangements to MHRT requests and strategies to deal with cognitive impairment and complex needs. The Forensic Working Group should also identify barriers to effective management and supervision of forensic patients and develop priority actions to deal with these barriers.

Recommendation 9.6

(1) A Forensic Working Group should be established, comprised of representatives from the Mental Health Review Tribunal and senior officers from Corrective Services NSW, Juvenile Justice NSW, Ministry of Health, Justice and Forensic Mental Health Network, Ageing, Disability and Home Care, NSW Police Force, Mental Health Commission of NSW and other agencies involved in supervising and caring for forensic patients.

112. Law Society of NSW, *Submission MH13*, 22; Legal Aid NSW, *Submission MH18*, 18.

113. Legal Aid NSW, *Submission MH18*, 18.

(2) The Forensic Working Group should develop a framework for cross-agency supervision and support of forensic patients including:

(a) agency responsibilities regarding forensic patients, including funding and arrangement of particular assessments and services

(b) agency response arrangements and expected response time to Mental Health Review Tribunal requests, and

(c) strategies to deal with people with cognitive impairments and complex needs.

(3) The Forensic Working Group should identify barriers to effective management and supervision of forensic patients and develop priority actions to deal with these barriers.

Enhancing the contempt powers of the MHRT?

9.102 The 2007 Forensic Review noted that, where orders are made "in relation to the place in which a forensic patient should be detained, or the type of leave to which the person should have access, it would be expected that the relevant agencies should comply with that order".[114] It noted that there are some circumstances in which an agency may be unable to comply with orders – for example where places are unavailable in a mental health facility. The review also noted that there have been several cases of non-compliance that do not appear to be justified, such as unauthorised transfer of a patient from a facility specified in an order, or failure to transfer patients as ordered, and unauthorised segregation of forensic patients for administrative purposes.[115] It states its concern about this in strong terms:

> the legal enforceability of orders in relation to the detention, care, treatment and release of forensic patients is fundamental to the effective operation of the forensic mental health system. If a … determining body … makes a particular order it has a reasonable expectation that it will be implemented. If agencies responsible for the detention, care and treatment of patients are able to determine – at their own discretion – whether or not they will comply with an order, this would undermine the integrity and consistency of the framework, as well as the rule of law, and would infringe the human rights of those detained within it.[116]

9.103 The 2007 Forensic Review recommended:

- [i]f any public sector agency or official is not able to comply with a Tribunal order in relation to the detention, care, treatment and release of a forensic … patient within one month of it being made (or date specified in the order), the agency must forward a written report to the President of the Tribunal providing reasons for such non-compliance;

- [i]f the President is satisfied that the non-compliance was not justified in the circumstances, he or she may report the matter to the Supreme Court; and

114. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [5.74].
115. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [5.75].
116. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [5.77].

- the Supreme Court may deal with the matter as if it were a contempt of the Court, subject to a defence of reasonable excuse.[117]

9.104 As we noted above, contempt powers are already available for non-compliance with an order, direction, decision or determination of the MHRT. However, the provision operates by creating a summary offence and we are not aware of any prosecutions for contempt under the MHA.[118] The MHRT has noted a number of practical challenges in using these provisions. First, there is a six month time limit to commence proceedings, and failure to comply with orders may not become known to the MHRT until after six months has elapsed. Secondly, it appears that the MHRT has limited scope to initiate proceedings for contempt – it will generally refer such matters to the Ministry of Health or Department of Attorney General and Justice (DAGJ). Finally, there will be practical problems with bringing contempt proceedings against a government agency.[119]

9.105 The MHRT has submitted that contempt powers along the lines of the powers available to the Administrative Decisions Tribunal (ADT) should be available,[120] as was recommended by the Forensic Review.[121] Under this approach, the MHRT would be able to report contempt to the Supreme Court, and the Supreme Court may deal with these as contempt of the court (subject to the defence of reasonable excuse). Presently, the ADT can report matters including:

- failure to attend in obedience of a summons
- failure to produce a document or other thing in the person's custody or control in accordance with a summons
- failure to answer a question after being called as a witness before the ADT
- wilful threats, misbehaviour, interruption, and obstruction
- publishing material after a non-publication order, and
- doing any other thing that would be considered contempt of court.[122]

9.106 The ADT has noted that the "categories or classes of conduct referred to in each of those sub-sections would … if proven amount to contempt if the proceedings were in the Supreme Court".[123] In the case of ADT proceedings, a party will generally apply to the ADT asking it to report suspected contempt to the Supreme Court;[124] however, in *Daintree Cafe Pty Ltd v Jacfun Pty Ltd,* the ADT noted that it "would rarely move on its own motion, although one can foresee circumstances where the facts or circumstances were so clear that the [ADT] could itself exercise its referring

117. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) Recommendation 16.
118. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 5.
119. Information supplied by the Mental Health Review Tribunal, 18 March 2013.
120. *Administrative Decisions Tribunal Act 1997* (NSW) s 131; Information supplied by the Mental Health Review Tribunal, 5 February 2013, 5.
121. See para 9.103.
122. *Administrative Decisions Tribunal Act 1997* (NSW) s 131.
123. *Daintree Cafe Pty Ltd v Jacfun Pty Ltd* [2002] NSWADT 188 [16].
124. See *Makris v Lafiatis* [2008] NSWADT 189.

power".[125] Where an application has been made, the ADT would then examine whether it considers that the alleged contemnor is guilty of contempt and decide whether or not it will refer the matter to the Supreme Court.[126] Where a matter is referred to the Supreme Court, the Supreme Court would have discretion whether or not to deal with it as contempt.[127]

9.107 Part 55 of the *Supreme Court Rules 1970* (NSW) deals with contempt processes. Where contempt is committed, but not in connection with proceedings in the court, proceedings for punishment of the contempt must be commenced by summons (which includes the statement of charge).[128] Where, pursuant to a power conferred by or under an Act, a court or other body or person (for example, the ADT) refers or reports a matter to the court with a view to the court dealing with a possible contempt of the court, body or person, the registrar is required to take advice from the Crown Solicitor as to whether he or she should take proceedings for contempt and unless otherwise ordered by the court, act on this advice.[129]

The Commission's view

9.108 In practice, it would appear that the key impediments to the implementation of MHRT orders are related to resources and service coordination. These problems cannot be resolved by an improved contempt power. There are also great practical difficulties in using contempt powers against a government department. Contempt powers appear to be very rarely used in practice. It is desirable that these matters be dealt with by agreement through the Forensic Working Group recommended above rather than by litigation.

9.109 We note also that other mechanisms to ensure compliance with some orders may now be more appealing to those who represent forensic patients. For example, in the recent case of *State of NSW v TD*, the respondent was held in a prison despite the court ordering detention in a mental health facility. The Court of Appeal found that there was no "lawful order or authority justifying detention in a prison". The detention was therefore unlawful.[130] Where the MHRT orders transfer of a person from a correctional centre to a mental health facility and there are delays in complying with this order, it could be argued that the forensic patient is unlawfully detained.

9.110 Nevertheless, it is desirable that the MHRT have a contempt power that can be used in appropriate cases, and the present provision in s 161 of the MHA appears to be unlike comparable tribunal contempt powers and difficult to utilise. The MHRT should have an effective contempt power and the form recommended in the 2007 Forensic Review appears to be a good model. However the MHRT's contempt power is situated in the MHA, which is currently under review.[131] Any such power

125. *Daintree Cafe Pty Ltd v Jacfun Pty Ltd* [2002] NSWADT 188 [24].
126. *Daintree Cafe Pty Ltd v Jacfun Pty Ltd* [2002] NSWADT 188 [32]-[33].
127. *Daintree Cafe Pty Ltd v Jacfun Pty Ltd* [2002] NSWADT 188 [34].
128. *Supreme Court Rules 1970* (NSW) r 55.6-55.7.
129. *Supreme Court Rules 1970* (NSW) r 55.11(6).
130. *State of NSW v TD* [2013] NSWCA 32 [75]-[76].
131. The MHRT has made a submission to the review of the *Mental Health Act 2007* (NSW): Information supplied by the Mental Health Review Tribunal, 5 February 2013, 5.

would be used in relation to civil patients and correctional patients, as well as forensic patients, and civil and correctional patients are beyond the scope of this review. This cohort represents a significant proportion of the MHRT's clients. We therefore do not make a recommendation for change at this time, and suggest that the current review of the MHA should review and revise the contempt power in s 161 of the MHA.

Information sharing

9.111 A problem related to those analysed above is that of information sharing between agencies that provide services to forensic patients.

9.112 The *Health Records and Information Privacy Act 2002* (NSW) (HRIPA) precludes organisations from using health information for a purpose other than the purpose for which it was collected. Exceptions apply, for example, where the individual consents, where the secondary purpose is directly related to the primary purpose (and the individual would reasonably expect it to be used in that manner) and where disclosure is required to lessen or prevent a serious and imminent threat to the life, health or safety of the individual or other person or a serious threat to public health or public safety.[132] Similar exceptions apply to disclosure of health information.[133] Authorisation under legislation can also exempt bodies from complying.[134]

Do any issues arise?

9.113 In its recent Annual Report the MHRT wrote that a:

> problem that continues to cause the Tribunal concern is the apparent lack of sharing of forensic patient records between treating teams that operate in different Health 'silos'. By default, the Tribunal has become the only repository of comprehensive forensic patient histories. The proper sharing of information is as important to patient rehabilitation and welfare as it is to risk management and community safety.[135]

9.114 The MHRT noted that while the legislation specifies how agencies should deal with the MHRT it does not specify how agencies should deal with each other. This causes issues where multiple agencies are dealing with a forensic patient:

> It is vital that for the safe management of forensic patients the legislation allows for the passing of information between agencies without the consent of the forensic patient. This provision needs to apply both when more than one agency or service is involved in a case simultaneously, and when a case is being handed over from one agency or service to another. The current barriers to information sharing present a major obstacle to safe and effective risk management.[136]

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132. *Health Records and Information Privacy Act 2002* (NSW) sch 1, HPP10.
133. *Health Records and Information Privacy Act 2002* (NSW) sch 1, HPP11.
134. See, eg, *Health Records and Information Privacy Act 2002* (NSW) s 23, sch 1 HPP11(2).
135. Mental Health Review Tribunal, *Annual Report 2011-12*, 3.
136. Mental Health Review Tribunal, *Submission MH57*, 23.

9.115 In consultations the following issues were noted:

- Separate area districts of Health may not be able to share information – for example, a treating team may be unable to access information it needs to effectively treat a forensic patient because a different Local Area District refuses to provide information due to concerns regarding patient privacy.[137]
- There is limited sharing of information between different service providers or criminal justice agencies, such as hospitals, police and the patient's general practitioner.[138] The MHRT pointed to an example where two forensic patients, who carried out an offence together, had a shared psychosis (a folie à deux). Here, the management of risk requires the exchange of information between the respective treating teams.[139]
- Services do not know what has been done by other service providers (for example, medications that have been trialled).
- Multiple assessments are conducted because agencies cannot access work completed by previous agencies, thereby duplicating work and wasting resources.
- Monitoring trends in patient behaviour is difficult – for example, signs of imminent mental deterioration may not be known to other service providers.

9.116 Similarly, the MHRT often needs access to information to deal with care and treatment issues, and it expressed concern that private practitioners require a subpoena before they release the information, which can cause delays.[140]

9.117 Currently, the MHFPA does make provision for the creation of information sharing protocols between Corrective Services, Human Services and Health, which allows agencies to share or exchange information concerning forensic patients.[141] Protocols exist between Health and Juvenile Justice, and between Health and Corrective Services.[142]

9.118 The MHRT submitted that there should be a general exception to privacy legislation to support the exchange of information between agencies involved in the "care, treatment and management of forensic patients". The MHRT noted that the patient consent provisions may not resolve the problem because the patient may be unable or unwilling to consent.[143]

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137. See also Mental Health Review Tribunal, *Submission MH67*, 8.
138. See also Mental Health Review Tribunal, *Submission MH67*, 8.
139. Mental Health Review Tribunal, *Submission MH67*, 8.
140. Mental Health Review Tribunal, *Submission MH57*, 23.
141. *Mental Health (Forensic Provisions) Act 1990 (*NSW) s 76J. See also *Mental Health (Forensic Provisions) Regulation 2009* (NSW) cl 14.
142. *Information Sharing Protocol (Section 76J of the Mental Health (Forensic Provisions) Act 1990) between Director-General, NSW Department of Health and Commissioner of Corrective Services in relation to Forensic Patients and Correctional Patients* (2011); *Information Sharing Protocol (Section 76J of the Mental Health (Forensic Provisions) Act 1990) between Director-General, NSW Department of Health and Director-General, NSW Department of Human Services in relation to Juvenile Forensic Patients and Juvenile Correctional Patients* (2009).
143. Mental Health Review Tribunal, *Submission MH67*, 8.

How can these issues be addressed?

9.119 There are a number of options to deal with the issues raised by the MHRT, including one or more of the following:

(1) Increased sharing of information through mechanisms such as consent and the existing exceptions or permissions under privacy legislation. This could be supported through clarified information sharing arrangements in an MOU or protocol. This would not require additional regulation, and would involve formalising arrangements within the existing privacy framework.

(2) Developing a regulation, privacy code or public interest direction.[144] These mechanisms can be used to modify, interpret or add to privacy principles and make detailed, long-term exemptions from various privacy principles.[145] Regulations and codes are made by the Minister for Health and public interest directions are made by the NSW Privacy Commissioner.[146] Public interest directions will generally operate on a time limited basis, and may be renewed.[147]

(3) Creating a specific exemption in the MHFPA that explicitly allows for the sharing of information in certain circumstances. A specific legislative exemption essentially permits lawful non-compliance with privacy principles. For example, an organisation is not bound by limits on the uses of health information where the organisation is lawfully authorised or not required to comply, or non-compliance is otherwise permitted under an Act or any other law.[148]

The Commission's view

9.120 The discussion above suggests that there may be privacy issues that prevent the sharing of information relating to forensic patients. However it is also clear that there are existing mechanisms to deal with many of these issues, both within privacy legislation and through agreement between relevant agencies.

9.121 Concerns of public safety, the health of forensic patients, and the efficient administration of justice in the MHRT persuade us that information sharing arrangements relating to forensic patients require review to determine the nature and extent of existing problems; the avenues that already exist to deal with the identified problems through existing mechanisms; how those avenues may be efficiently utilised; and whether any change to legislation is required.

9.122 We therefore recommend that the Forensic Working Group, recommended above, work with the NSW Privacy Commissioner to review information sharing arrangements and make relevant recommendations to the Minster for Health.

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144. *Health Records and Information Privacy Act 2002* (NSW) s 38, s 62, s 75.

145. See our discussion in NSW Law Reform Commission, *Protecting Privacy in New South Wales*, Report 127 (2010) [7.1]-[7.2].

146. These are made under the *Health Records and Information Privacy Act 2002* (NSW) s 40, s 62; see NSW Information and Privacy Commission, "Exemptions and Codes made under the HRIP Act" <www.ipc.nsw.gov.au/privacy/privacy_forgovernment/govt_privacy/privacy_hripexemptions.html>.

147. NSW Information and Privacy Commission, "Health Public Interest Directions" <www.ipc.nsw.gov.au/privacy/privacy_forgovernment/govt_privacy/privacy_hripadirections.html>

148. *Health Records and Information Privacy Act 2002* (NSW) sch 1, HPP11(2).

Recommendation 9.7

(1) The Forensic Working Group recommended in Recommendation 9.6 should work with the NSW Privacy Commissioner to review information sharing arrangements in relation to forensic patients to determine:

(a) the nature and extent of existing problems

(b) the avenues that already exist to deal with the identified problems

(c) how those avenues may be efficiently used, and

(d) whether any change to legislation is required.

(2) The Forensic Working Group should provide a report to the Minister for Health addressing any actions required to improve information sharing arrangements.

Making arrangement for release

9.123 Under s 76G of the MHFPA:

> (1) The authorised medical officer of a mental health facility in which a forensic patient is detained must, if the person is to be released or granted leave under this Part, take all reasonably practicable steps to ensure that the person and any primary carer of the person are consulted in relation to planning the person's release and leave and any subsequent treatment or other action considered in relation to the person.
>
> (2) In planning the release of any such person and any subsequent treatment or other action considered in relation to any such person, the authorised medical officer must take all reasonably practicable steps to consult with agencies involved in providing relevant services to the person, any primary carer of the person and any dependent children or other dependants of the person.
>
> (3) The authorised medical officer must take all reasonably practicable steps to provide a person who is released or given leave of absence from the mental health facility with appropriate information as to follow-up care.[149]

9.124 No equivalent requirement applies in respect of forensic patients who are being released from a place other than a mental health facility (for example, correctional centres).[150]

9.125 In CP 6 we asked whether any legislative changes should be made in relation to the making and implementation of orders for leave and/or conditional release of forensic patients.[151] Legal Aid NSW and the Law Society of NSW noted that there should be uniform requirements in relation to forensic patients being released, regardless of

149. See also and compare the *Mental Health Act 2007* (NSW) s 79.

150. For issues relating to the detention of forensic patients in correctional centres, see Chapter 10.

151. 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 6.78.

whether that patient is released from a mental health facility or place other than a mental health facility.[152]

9.126 The MHRT submitted that it:

> agrees that this would be a useful adjunct to the appropriate care of forensic patients held in a correctional setting. Indeed, the Tribunal is concerned that limiting term forensic patients receive very limited support in terms of planning for release into the community. It does however raise the issue of which agency would be responsible for that arrangement in a correctional setting.[153]

9.127 Where a forensic patient is not detained in a mental health facility, he or she is almost certain to be detained in a correctional centre.[154] While it is undoubtedly important to make proper arrangements for forensic patients who are being released from a correctional centre, there is no legislative requirement that applies in those cases and no equivalent in such cases to an "authorised medical officer" who would make such arrangements.

9.128 This issue would become even more important with the introduction of limiting terms for all forensic patients.[155] With a finite period available for treatment and support to manage risk (subject to a continuation of detention under the MHA in appropriate cases), it is critical that forensic patients progress through the system and into support in the community prior to the expiry of their limiting term. Planning to support leave and release of forensic patients in prison or a detention centre is necessary to achieve this progression.

9.129 We therefore recommend that the Commissioner of Corrective Services and the Chief Executive of Juvenile Justice develop processes to support planning and arrangements for leave or release of forensic patients, including subsequent treatment or other action required in relation to forensic patients. Planning for release should include consultation with the forensic patient, the forensic patient's carer, dependents and relevant agencies. Section 76G of the MHFPA should be amended to reflect this consultation requirement.

Recommendation 9.8

(1) The Commissioner of Corrective Services NSW and the Chief Executive of Juvenile Justice NSW should develop processes to support planning and arrangements for leave or release of forensic patients, including subsequent treatment or other action required.

(2) Section 76G of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that the Commissioner of Corrective Services NSW and the Chief Executive of Juvenile Justice NSW should take all reasonably practicable steps to ensure that the forensic patient, any primary carer, dependents, and agencies involved in providing services to that person are consulted when making arrangements for leave or release of a forensic patient.

152. Legal Aid NSW, *Submission MH18*, 18; Law Society of NSW, *Submission MH13*, 23.
153. Mental Health Review Tribunal, *Submission MH67*, 13.
154. Mental Health Review Tribunal, *Submission MH67*, 10.
155. See Recommendation 7.2.

Breach of conditions of leave or release

9.130 If "it appears" to the President of the MHRT that a forensic patient has breached a condition, or "has suffered a deterioration of mental condition and is at risk of causing serious harm to himself or herself or to any member of the public because of his or her mental condition", the President may make an order for the apprehension of the person by the police.[156]

9.131 When the person has been apprehended, the MHRT must review his or her case. On such a review, the person "may request the Tribunal to investigate the evidence on which the order for the person's apprehension was made and may adduce other evidence for the consideration of the Tribunal".[157] The MHRT may either confirm the person's release or leave (with or without conditions), or may make an order for the person's detention, care or treatment in a mental health facility, correctional centre or other place.[158]

9.132 In CP 6 we asked whether the procedures relating to breaches of orders are adequate and appropriate, and if not, what else should be provided.[159] Most stakeholders who responded to this issue noted that current provisions are adequate and appropriate.[160] However, a few concerns were raised regarding the operation of the current regime including:

- the manner in which breach of conditions is brought to the attention of the MHRT and the means by which the MHRT may inform itself, and
- breach procedures and the role of mental health facilities.

We address these concerns below.

Monitoring and reporting breaches

9.133 The HVSG expressed concerns about the effectiveness of reporting of breach and monitoring of conditions and submitted that more guidance is required regarding how a breach can be brought to the attention of the MHRT. For example, can a member of the public alert the MHRT to a breach and how can the Tribunal be notified?[161] The HVSG submitted that the MHFPA should be modified to allow members of the public to notify the MHRT of a breach and that it should be mandatory for service providers treating the patient to notify the MHRT of a breach:

156. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 68-69, s 72.
157. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 69(1).
158. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 68(2), 69(2).
159. 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 6.79.
160. NSW Bar Association, *Submission MH10*, 44; Legal Aid NSW, *Submission MH18*, 18; Law Society of NSW, *Submission MH13*, 23.
161. Homicide Victims' Support Group, *Submission MH20*, 16.

> Without providing for appropriate mechanisms to monitor the patient's progress after release, there is a risk that his/her condition could deteriorate unreported and therefore put the safety of the community at further risk.[162]

The HVSG was the only stakeholder to raise this issue.

9.134 We agree with the HSVG that it is important that information be available about the mechanisms available to report breaches. However we do not agree that this is an issue that requires legislation. It appears to be an issue that is best managed through the provision of information by the MHRT to the public and to relevant service providers regarding how breaches are, and can be, reported. This could be provided on the MHRT website, where it could be easily amended and updated.

Recommendation 9.9

The Mental Health Review Tribunal should make information publicly available regarding how breaches under s 68 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) can be reported.

Managing breach processes

9.135 The MHRT has identified a number of areas requiring clarification relating to the way that breach processes can be managed by mental health facilities and has also submitted that there is some confusion regarding whether forensic patients can be admitted into mental health facilities as an involuntary patient, without the MHRT's authorisation.

Involuntary detention of forensic patients

9.136 There is doubt about whether the MHA provisions relating to involuntary detention apply to forensic patients. As a consequence:

(1) where forensic patients have been conditionally released and later present at an emergency room (for example, where there has been a deterioration of their mental state), the treating team may not be aware that the person is a forensic patient and may detain a person under s 18 of the MHA without the power to do so, and

(2) a treating team, or first responders in a crisis, may refuse to detain and treat a person where it is known that the person is a forensic patient: in such circumstances the team may wait to contact the MHRT to ask for a breach order to be issued before the person can be held lawfully and given treatment (see Case study 9.3 below) and treatment may be delayed.[163]

9.137 There have also been occasions where a person is released on bail following a fitness hearing and the treating team mistakenly considers the person to be a

162. Homicide Victims' Support Group, *Submission MH20*, 16.

163. Mental Health Review Tribunal, *Submission MH57*, 22; Information supplied by the Mental Health Review Tribunal, 5 February 2013, 11-12.

forensic patient and requests a breach notice from the MHRT before dealing with that person as an involuntary patient (see Case study 9.1 above).

9.138 The MHRT considers that clarification of powers to detain without the need for a breach notice would reduce confusion and delay.[164]

Case study 9.3

An elderly woman had been conditionally released to a nursing home with dementia. Her condition deteriorated until she was in a psychotic state and needed hospitalisation. Police assistance was needed to take her to hospital. Police would not act without an order under s. 68 by the Tribunal. Ultimately the patient was scheduled under the MHA to allow her to be brought to hospital urgently, although for the reasons discussed above, this may not have been lawful.[165]

9.139 The MHRT supports an amendment to the MHA to ensure that conditionally released patients can also be involuntarily detained under the MHA, instead of waiting for the treating team to contact the MHRT to issue a breach order before lawful detention.[166] This issue is presently addressed in the Health Legislation Amendment Bill 2013, which inserts a new section in Part 5 of the MHFPA to say:

> Nothing in this Part limits the application of the *Mental Health Act 2007* to a person who has been granted conditional release or leave of absence under this Part.[167]

The Bill also provides for amendment to the MHA to ensure that authorised medical officers notify the MHRT if the officer becomes aware that a person detained is a forensic patient.[168]

9.140 We agree that this issue should be clarified in the legislation and support amendment to address the issues outlined above. It is clearly undesirable for there to be a delay in treating a person who has a serious mental health problem because of misunderstanding of the law or lacunae in the law. Accordingly we support clarification of legislation in this respect.

Recommendation 9.10

A provision should be included in either the *Mental Health (Forensic Provisions) Act 1990* (NSW) or *Mental Health Act 2007* (NSW) to clarify that where a forensic patient is in the community, he or she can still be detained under the civil provisions of the *Mental Health Act 2007* (NSW).

Managing breach

9.141 While CTOs are available to manage forensic patients, conditions regarding treatment and care are generally managed through the MHRT's power to impose

164. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 11-12.
165. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 11-12.
166. Mental Health Review Tribunal, *Submission MH57*, 22.
167. Health Legislation Amendment Bill 2013 (NSW) sch 6 cl 4.
168. Health Legislation Amendment Bill 2013 (NSW) sch 5 cl 2.

conditions upon release of forensic patients. In consultations it was noted that some mental health service providers may be unsure of their powers and options in dealing with breach of these conditions. This may be problematic where there is significant deterioration of a person's mental state and he or she is, quite appropriately, taken to a mental health facility before the MHRT has had the opportunity to review the breach following apprehension.

9.142 The MHRT advised that it has requested the Ministry of Health Legal Branch explore amendment of the MHFPA breach provisions to allow for breach of orders to be managed in a similar way to breach of a CTO.[169] Currently, breach provisions for CTOs under the *Mental Health Act 2007* (NSW) provide that the Director of Community Treatment at a mental health facility may issue a notice requiring the person to accompany a staff member to a mental health facility. Failure to do so may lead to a breach order, with the result that a police officer may apprehend a person subject to that order and take that person to a mental health facility. [170] The following provision of the MHA applies following breach of a CTO:

> **60 Procedures at facility after breach notice or breach order**
> (1) An affected person who is at a mental health facility as a result of the giving of a breach notice or a breach order:
>
> (a) may be given treatment in accordance with the community treatment order, and
>
> (b) may be assessed by a medical practitioner for involuntary admission to a mental health facility.
>
> (2) A person who is at a mental health facility as a result of a breach notice or breach order may be released after treatment if treatment is accepted or may be dealt with at the mental health facility or taken to another declared mental health facility if treatment is refused.

9.143 Following the issue of a breach order, an authorised medical officer must review the person's mental condition within 12 hours and determine whether the person is mentally ill or mentally disordered. The authorised medical officer may provide treatment in accordance with a CTO, and may detain a person in a mental health facility for further observation or treatment where the person is mentally ill or mentally disordered. The person can be detained until the CTO expires, or the person is discharged under the Act.[171]

9.144 The MHRT submitted that:

> When an order for apprehension is made the Act needs to provide similarly to the CTO breach provision:
>
> a) That the person is to be considered detained for the purpose of assessment and treatment.

169. Mental Health Review Tribunal, *Submission MH57*, 22.
170. *Mental Health Act 2007* (NSW) s 58-59.
171. *Mental Health Act 2007* (NSW) s 61.

b) That the person's mental state is to be assessed by a medical practitioner[172]

9.145 This is in part addressed by the Health Legislation Amendment Bill 2013, which inserts a new subsection, s 68(4):

> An apprehension order under this section authorises the detention of the person at the mental health facility, correctional centre or other place specified in the order.[173]

9.146 The MHRT also supported provision of an adjournment period where required to assess a forensic patient's response to treatment, before the MHRT makes its final decision regarding revocation of leave or release.[174]

9.147 Regarding adjournments, we note that the MHRT already has a general power to adjourn proceedings.[175] In Recommendation 9.2 we recommend that the President or Deputy President of the Mental Health Review Tribunal be permitted to adjourn proceedings in particular circumstances, including where a short period of adjournment is required to assess responsiveness to treatment after admission for breach.

9.148 It is important that forensic patients are appropriately managed following an alleged breach, and that there be no doubt about the power of mental health facilities to treat them, and to detain them for treatment where necessary, where a person has a mental illness and treatment and care is required prior to an MHRT review. It is therefore important to clarify the rights and responsibilities of mental health service providers when dealing with breach of an order for conditional release, so that it is apparent that they have the powers required to deal with the person and can avoid delay in providing treatment. We recommend amendment of s 68 of the MHFPA to permit the MHRT to specify that a forensic patient can be provided treatment, assessed, and detained in a mental health facility, where an order for apprehension is made, until review by the MHRT.

Recommendation 9.11

Section 68 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should allow the Mental Health Review Tribunal, when making an order for apprehension, to specify that, pending review of a breach by the Tribunal:

(a) the forensic patient may continue to be given treatment in accordance with the terms of conditional release imposed by the Tribunal

(b) a medical practitioner must assess the forensic patient's mental state, and

(c) the forensic patient may be detained in a mental health facility for the purposes of assessment and treatment.

172. Mental Health Review Tribunal, *Submission MH57*, 22.
173. Health Legislation Amendment Bill 2013 (NSW) sch 6 cl 3.
174. Mental Health Review Tribunal, *Submission MH57*, 22.
175. See para 9.31.

Additional functions of the MHRT

9.149 Presently, s 76A(1) of the MHFPA provides that "[f]or the purposes of a review, the Tribunal may communicate with any persons, take any action and make any recommendations it thinks fit". The MHRT submitted that s 76A should be clarified so that the ability of the MHRT to inform itself in any way it thinks fit apply pre and post hearing and in the performance of its functions generally (instead of simply in relation to review hearings). This, the MHRT noted, would be particularly useful in assessing whether a breach of an order has occurred.[176]

9.150 The MHRT indicated that it performs functions outside of its review functions, for example:

- Identification of structural issues that impact on the care of civil and forensic patients, which the MHRT may raise with treating teams or at meetings with senior officers from agencies.
- Involvement in research projects – the MHRT has a significant amount of data that can be examined to inform policy. It intends to work closely with the Mental Health Commission on research projects.

The MHRT has noted that it would be useful to clarify and recognise these aspects of its role. It would help ensure that it is not breaching non-disclosure provisions in the MHA, which prohibit disclosure outside of its functions.[177]

9.151 In a submission to the review of the MHA the MHRT suggested:

> that its functions should be defined in the Act as including a) any functions conferred on it by the Act and the [MHFPA]; b) liaise with and make recommendations to any persons, entities or agencies who provide mental health services or are involved in dealing with persons who have a mental illness; c) liaise with the Mental Health Commissioner; d) to collect data as necessary to assist it in carrying out its functions and e) such other functions as may be conferred by regulation for time to time.[178]

9.152 The MHRT expressed concern that the power to communicate, take action and make recommendations under s 76A of the MHFPA applies only for the purposes of a review and this "does not adequately recognise the broader role that the Tribunal performs in practice, without which the system would not be able to function effectively".[179] The MHRT submitted that it should be made clear that, for the purposes of carrying out all its functions under the Act, it can communicate with any people, take any action and make any recommendations it thinks fit.[180]

9.153 We agree that the MHRT has important experience and expertise that should be used to contribute to systemic changes and improvements in the mental health and forensic systems. That experience, and the data held by the MHRT, is also an

176. Mental Health Review Tribunal, *Submission MH57*, 25.
177. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 9-10; *Mental Health Act 2007* (NSW) s 189.
178. Quoted in information supplied by the Mental Health Review Tribunal, 5 February 2013, 10.
179. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 10.
180. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 10.

important resource for research that may further contribute to the development and improvement of those systems.

9.154 Section s 189 of the MHA already makes provision for the MHRT to disclose information in connection with the administration or execution of the MHA and the MHFPA. Further, s 189(1)(d1) provides for disclosure of research information in accordance with HRIPA.

9.155 The review provisions in s 76A of the MHFPA do not appear to us to be the appropriate location for a general provision that authorises the MHRT to make a contribution to the systemic improvement and development of the forensic system. Authorisation of contributions to research appears to us to be already dealt with by the provisions of s 189 of the MHA.

9.156 If it is thought that the MHRT requires statutory authority to support its role in contributing to systemic development of the forensic system then that matter appears to us to be best dealt with through the review of the MHA which is presently under way, and to which the MHRT has already made submissions.

Additional functions regarding forensic patients who are unfit and not acquitted

9.157 The MHRT has three functions in respect of forensic patients who are UNA that require consideration. They relate to:

- the possibility that a UNA forensic patient may become fit to be tried
- a prohibition on releasing a UNA forensic patient until he or she has been detained for a "sufficient" time, and
- the effect of the expiry of the limiting term.[181]

Possibility of becoming fit

9.158 Whenever the MHRT reviews a forensic patient who is UNA, the MHRT makes a "recommendation" about (or determines) the forensic patient's fitness and must notify the court that made the finding of unfitness and the DPP if, on a review, the Tribunal is of the opinion that the person has become fit to be tried for an offence (meaning the offence with which the person was charged).[182] If the person has become fit but the DPP determines that no further proceedings will be taken in respect of the offence, the person ceases to be a forensic patient and must be released.[183]

181. Forensic patients who present a risk of harm at the end of their limiting term are discussed in Chapter 11.

182. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 45(2)-(3), s 47(4)-(5).

183. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 29, s 52(4)(b), s 54.

9.159 Particular jurisdictions allow for a permanent finding of unfitness in certain circumstances, for example, where the person has been unfit for some time,[184] or it is unlikely that a person will ever become fit and the person does not pose a significant threat to the public.[185]

Are current provisions appropriate?

9.160 In CP 6 we asked whether:

- current provisions relating to people who become fit to be tried are adequate and appropriate, and
- legislation should specify circumstances in which, or a period after which, fitness ceases to be an issue.[186]

9.161 Stakeholders submitted that the current provisions relating to people who are UNA who become fit to be tried are adequate and appropriate.[187] There was some limited support for a finding of permanent unfitness.[188] However, Legal Aid NSW noted the reservation that a permanent finding of unfitness "denies the forensic patient an opportunity to face trial and be acquitted".[189]

9.162 The MHRT has noted that there are occasions where a person becomes fit after finalisation of the matter by the court:

> A recent example is a forensic patient who had been found unfit to be tried on a range of offences and sentenced to a limiting term. The patient did not have a cognitive impairment, but did have a delusional disorder with persistent delusions of police corruption and persecution. The evidence was the delusions would significantly interfere with his ability to participate in a trial, as he would incorporate the court officials into those delusional beliefs and the beliefs would render him unable to give his account. A change in the medication regime led to a marked reduction in his preoccupation with his delusions, and the development of insight. The more recent psychiatric evidence was that he appeared to have trust in his legal team and trust that the Court process would be run fairly. The Tribunal concluded that the patient now fit for trial and advised the Court and the DPP accordingly.[190]

It also noted that while the requirement to consider fitness is not "overly burdensome", where the person's unfitness "is attributable to an intellectual

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184. For example, in Queensland, the time period is seven years for offences to which a penalty of life imprisonment applies, or three years for all other offences: *Mental Health Act 2000* (Qld) s 215, s 283. Further proceedings cannot be taken against the person for the relevant offence: s 216(3)-(4), s 283.
185. *Criminal Code*, RSC 1985 (Can) s 672.851. This includes an additional requirement to consider whether a stay of proceedings is in the interests of the proper administration of justice.
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 6.82, 6.84.
187. NSW Bar Association, *Submission MH10*, 44; Law Society of NSW, *Submission MH13*, 24; Legal Aid NSW, *Submission MH18*, 19. However, NSW Consumer Advisory Group, *Submission MH11*, 32 noted that legislation should be "adjusted so that if the DPP determines there is not enough evidence to continue charges, a person who is UNA is released".
188. Law Society of NSW, *Submission MH13*, 24; Legal Aid NSW, *Submission MH18*, 19.
189. Legal Aid NSW, *Submission MH18*, 19.
190. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 13.

disability, cognitive impairment or a deteriorating condition such as dementia", the requirement to consider fitness at each review may not be beneficial.[191]

The Commission's view

9.163 In relation to the issue of a permanent finding of unfitness in appropriate cases, our model proposed in Chapter 7, and adoption of Recommendations 8.1-8.3 would mean that where a person is UNA and does not present a significant risk of serious physical or psychological harm to others, the person should be released by the MHRT. There is no evidence to suggest that the requirement that the MHRT consider fitness when conducting its regular reviews of forensic patients is particularly resource intensive, or creates problems of a practical nature. We remain of the view that the current system is satisfactory in this respect.

Sufficient time in custody

9.164 If the MHRT is considering the release of a forensic patient who is UNA, it must have regard to "whether or not the patient has spent sufficient time in custody".[192] The MHFPA provides no guidance as to the meaning of "sufficient" in this context. There has been only limited judicial consideration of the provision, with a tendency to regard it as being implicitly, although perhaps not exclusively, punitive in intent.[193] If that is correct, then the provision violates the right of the unfit accused person not to be punished other than following conviction at a fair trial.[194]

9.165 Furthermore, a punitive approach is inconsistent with the legislated objects of the forensic system, and with the MHRT's central role of overseeing the provision of treatment to forensic (and civil) patients with a view to promoting patient recovery and protecting the community from harm.[195]

9.166 In CP 6 we asked whether the requirement that the MHRT have regard to whether a forensic patient who is UNA has spent "sufficient" time in custody should be abrogated.[196]

9.167 All stakeholders that responded to this issue agreed that this requirement should be abrogated.[197] The NSWCAG and the NSW Bar Association submitted that this

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191. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 13.
192. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 74(e).
193. See *AN (No 2) v The Queen* [2006] NSWCCA 218; 66 NSWLR 523 [64]-[66], [77]; *DPP v Mills* [2000] NSWCA 236 [39], quoted with approval in *Smith v The Queen* [2007] NSWCCA 39 [63]. The provision has been criticised: see G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [8.44]-[8.45], [8.50], Recommendation 28; NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) [5.54], Recommendation 20(a).
194. The right not to be convicted of (and consequently punished for) a criminal offence other than after a fair trial is fundamental to the Australian criminal justice system: *Jago v District Court of NSW* (1989) 168 CLR 23; *Dietrich v The Queen* (1992) 177 CLR 292.
195. See, eg, *Mental Health (Forensic Provisions) Act 1990* (NSW) s 40; *Mental Health Act 2007* (NSW) s 3, s 68. See also Chapter 8.
196. 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 6.85.

requirement is punitive in nature, and the Public Defenders argued that this requirement is contrary to underlying principles of the forensic system. The MHRT highlighted that there is a "lack of facilities which offer treatment and/or rehabilitation programs in a detained environment (eg aged care, brain injury, and in many cases intellectual disability)".[198] The consequence is that people spend a substantial proportion of their limiting term "detained and without access to appropriate programs which perversely means they may not have a sufficient period of treatment or rehabilitation to address their needs and risk issues prior to the expiry of their limiting term".[199] The requirement that a person spend "sufficient time in custody" may serve to delay access to programs and services that are critical to rehabilitation, and thereby increase the risk to the community upon release.

9.168 Howard and Westmore have argued that:

> A strong argument can be made that this criterion should be abandoned altogether by future amendment to the legislation. Community protection will be taken into account before a release decision can be made in any event. Of the remaining functions of sentencing, it is difficult to see the logic or necessity of applying any of these to a forensic patient who is serving a limiting term. Danger to the public or to the patient may in reality be the only criterion that can be justified as a matter of policy.[200]

9.169 We agree that the requirement that a person who is UNA spend "sufficient time in custody" is both unclear and inconsistent with the objectives of the forensic system.

9.170 As we discuss in Chapter 8, the MHFPA already contains extensive mechanisms for dealing with risk of harm. Accordingly, we recommend the removal of this consideration from the framework of MHRT decision making.

Recommendation 9.12

The provision in s 74(e) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) requiring the Mental Health Review Tribunal to consider whether the forensic patient has spent "sufficient time in custody" should be removed.

When a person ceases to be a forensic patient

9.171 In general, a person ceases to be a forensic patient when one of the following occurs:

- the MHRT or a court orders that the person be released unconditionally, or[201]

197. NSW Bar Association, *Submission MH10*, 45; NSW Consumer Advisory Group, *Submission MH11*, 33; Law Society of NSW, *Submission MH13*, 24; Legal Aid NSW, *Submission MH18*, 19; NSW, Public Defenders, *Submission MH26*, 45; Mental Health Review Tribunal, *Submission MH57*, 21.
198. Mental Health Review Tribunal, *Submission MH57*, 21.
199. Mental Health Review Tribunal, *Submission MH57*, 21.
200. D Howard and B Westmore, *Crime and Mental Health Law in New South Wales* (LexisNexis Butterworths, 2nd ed, 2010) 161.
201. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 51(1)(a).

- the person has been released subject to time-limited conditions, and the time limit for compliance with the conditions expires.[202]

9.172 Additionally, a person who is UNA ceases to be a forensic patient if:

- the MHRT reclassifies the person as a civil "involuntary patient" under the MHA (this occurs where the person would cease to be a forensic patient within six months after the date of the review)[203]
- the limiting term expires,[204] or
- the person, having been found unfit, is found to have become fit.[205]

9.173 In CP 6 we asked whether the provisions of the MHFPA which define the circumstances in which a person ceases to be a forensic patient are sufficient and appropriate. If not, are there any additional circumstances in which a person should cease to be a forensic patient?[206]

9.174 Most stakeholders that responded to this question noted that current provisions are appropriate,[207] subject to the concerns about the time limits outlined in para 7.48-7.51.[208]

Arrangements for continuing care

9.175 We have discussed the importance of making arrangements for the release of forensic patients generally in para 9.124-9.130. It is also important to make arrangements for continuing care where a person ceases to be a forensic patient, for example, upon expiry of a limiting term. In Chapter 7, we recommend that there be limiting terms for all forensic patients, including those who are NGMI. This will mean that that there will be a greater number of forensic patients who will require arrangements for continuing care upon cessation of their forensic status.

9.176 For forensic patients who have a mental health impairment, the MHA provides a framework for decisions and for care. For this group, if continuing detention is required the MHRT may reclassify the person and continue to detain him or her as an "involuntary patient" where the MHA criteria are satisfied.[209] Additionally, the MHFPA provides that a person who ceases to be a forensic patient may choose to

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202. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 51(1)(b).
203. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 52(2)(b), s 53(1).
204. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 52(2)(a).
205. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 53(3). See also para 9.13.
206. 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 6.86.
207. NSW Bar Association, *Submission MH10*, 45; Legal Aid NSW, *Submission MH18*, 19; Law Society of NSW, *Submission MH13*, 24; Mental Health Review Tribunal, *Submission MH57*, 22.
208. NSW Consumer Advisory Group, *Submission MH11*, 33; Legal Aid NSW, *Submission MH18*, 19.
209. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 53; and see *Mental Health Act 2007* (NSW) ch 3 especially pt 1. It may also be possible to make a Community Treatment Order in respect of the person: see *Mental Health (Forensic Provisions) Act 1990* (NSW) s 67; *Mental Health Act 2007* (NSW) ch 3 pt 3.

remain in a mental health facility as a voluntary mental health patient.[210] The MHA also provides a framework for community treatment.

9.177 In Chapter 11 we make proposals for dealing with forensic patients who present a risk of harm to others at the end of their limiting term. We note that gaps arise in the civil system, and recommend a scheme of continuing management and supervision.

9.178 However, for those who have cognitive impairments no legal framework exists to refer people into arrangements for their continuing care for example, through a formal referral to disability services or to the Guardianship Tribunal.

9.179 In CP 6 we asked whether there should be provisions referring a person who is UNA into other care, support and/or supervision arrangements at the expiry of a limiting term and if so, what they should be.[211]

9.180 The NSW Bar Association, Law Society of NSW and Legal Aid NSW agreed that there should be provisions referring a person who is UNA into other care, support and/or supervision arrangements at the expiry of the limiting term.[212] The NSW Bar Association submitted that there should be a clear pathway for reengagement and appropriate discharge planning.[213] Legal Aid NSW warned that such a provision should be carefully worded, to avoid the problems described in para 9.98.[214]

9.181 We agree that continuing care is an important issue for forensic patients and the community, and that there appear to be particular gaps where the patient has a cognitive impairment. In Chapter 1, we discuss the issues that forensic patients with cognitive impairments are likely to encounter. Many of these issues are related to the limited services available for this group.

9.182 These issues relate mainly to service delivery, which is not a matter best dealt with through legislation. As we discuss in para 9.99-9.101, this is a matter requiring interagency collaboration and agreement, including arrangements for the MHRT to notify services at the end of a limiting term, and those services adopting the responsibility for care. We therefore recommend that the Forensic Working Group recommended in Recommendation 9.6 also address the issue of arrangements for continuing care where a person ceases to be a forensic patient.

Recommendation 9.13

The Forensic Working Group recommended in Recommendation 9.6 should develop arrangements for continuing care when a person ceases to be a forensic patient, including in particular arrangements for people who have cognitive impairments or complex needs.

210. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 76H.

211. 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 6.87.

212. NSW Bar Association, *Submission MH10*, 45; Legal Aid NSW, *Submission MH18*, 19; Law Society of NSW, *Submission MH13*, 24.

213. NSW Bar Association, *Submission MH10*, 45.

214. Legal Aid NSW, *Submission MH18*, 19.

Entitlement to release

9.183 It might be assumed that, when a person ceases to be a forensic patient, he or she is entitled to be released into the community unless there is some other lawful basis on which to continue to detain the person. However, that is not always the case under the provisions of the MHFPA:

(1) If a person has ceased to be a forensic patient because the MHRT has reclassified the person as an "involuntary patient", the civil provisions of the MHA provide a lawful basis for the person's continuing detention.[215] The civil provisions of the MHA do not authorise the detention of involuntary patients in correctional centres. However, if the person is detained in a correctional centre immediately prior to reclassification, s 53(2) of the MHFPA says that the MHRT "may" order that a person classified as an involuntary patient be transferred from a correctional centre to a mental health facility, but does not require the MHRT to order that the person be transferred to a mental health facility.

(2) Where a person ceases to be a forensic patient and is not reclassified as an involuntary patient, the MHFPA requires that he or she must be discharged from a mental health facility.[216] However, there is no equivalent provision in respect of a person who is detained in a correctional centre or "other place" immediately prior to the termination of his or her status as a forensic patient. While this situation can be remedied by the MHRT ordering a patient's unconditional release,[217] or transfer to a mental health facility from which he or she could be discharged,[218] there may be no practical reason for an order for release, or transfer followed by an order.

(3) If a person ceases to be a forensic patient because he or she was UNA and has become fit and no further proceedings are to be taken, there is no clear provision for his or her discharge from custody. The MHFPA provides as follows:

> If the Director of Public Prosecutions advises the Minister for Health that a person will not be further proceeded against, the Minister for Health must, after having informed the Minister for Police of the date of the person's release, do all such things within the power of the Minister for Health to order the person's release from detention or to otherwise ensure the person's release from detention.[219]

These provisions fall short of an absolute entitlement to release.

215. See generally *Mental Health Act 2007* (NSW) ch 3.
216. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 54.
217. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 47(1)(b).
218. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 48.
219. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 29(3).

Submissions and consultations

9.184 In CP 6 we asked whether the provisions regarding entitlement to be released from detention upon ceasing to be a forensic patient are adequate and appropriate and, if not, what else should be provided.[220]

9.185 Stakeholders generally agreed that the MHFPA should be amended to require the discharge of a person who is detained in a correctional centre or place other than a mental health facility upon ceasing to be a forensic patient and who is not reclassified an involuntary patient.[221] The NSW Bar Association agreed that the anomalies identified by the Commission should be addressed.[222] Similarly, Corrective Services NSW agreed that the MHFPA requires amendment to clarify the entitlement to release where a person ceases to be a forensic patient.[223]

The Commission's view

9.186 It appears incongruous that the MHFPA does not explicitly require release from a correctional centre upon expiry of the person's forensic status. We recommend amendment of the MHFPA to clarify the entitlement of the person to be released from detention, wherever detained, when the person ceases to be a forensic patient (unless there is another lawful basis upon which to detain that person).

9.187 We also suggest a minor amendment to the drafting of s 53(2) of the MHFPA to reflect that where a person is reclassified as an involuntary patient, the MHRT "must" instead of "may" order that the person be transferred from a correctional centre to a mental health facility.

Recommendation 9.14

(1) Section 53(2) of the *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that the Tribunal **must** order that a patient classified as an involuntary patient under this section be transferred from a correctional centre to a mental health facility.

(2) A forensic patient who is detained in a mental health facility, correctional centre, or other place, should be discharged from that place of detention when he or she ceases to be a forensic patient, unless there is another lawful basis upon which to detain that person.

Jurisdictional issues

9.188 The MHRT submitted that the provisions of the MHFPA relating to when a person ceases to be a forensic patient are broadly appropriate however it identified

220. 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 6.88.

221. Law Society of NSW, *Submission MH13*, 25; Corrective Services NSW, *Submission MH17,* 10; Legal Aid NSW, *Submission MH18*, 20.

222. NSW Bar Association, *Submission MH10,* 45.

223. Corrective Services NSW, *Submission MH17,* 10.

problems in relation to forensic patients who leave NSW, either with or without the MHRT's approval.[224]

What issues arise?

9.189 The MHFPA does not currently take into account circumstances in which a forensic patient leaves NSW with, or without, the MHRT's approval in its review arrangements.[225] In such circumstances, the MHRT must continue to hold regular reviews.

9.190 Where the patient has absconded and cannot be located, a review serves no useful purpose.

9.191 Although it occurs infrequently, the court or the MHRT may conditionally release a forensic patient to a different state. In such circumstances, the MHRT reports that a significant amount of work goes into linking people with local mental health services. However, once a forensic patient resides a different jurisdiction, the MHRT finds reviewing those patients to be challenging. It is difficult for the MHRT to obtain information from interstate agencies, and its powers to require that information are limited. The MHRT also reports that in two current cases in which interstate transfer has occurred, the forensic patient appears well. Unconditional release has been ordered for one case and may be contemplated for the other. However, obtaining information to make an order for unconditional release is challenging.[226]

9.192 In certain circumstances, the MHRT may be unable to transfer a forensic patient to another state, even though the transfer may be the best way to access supports and manage risks (for example, where the family is located intestate and is able to provide support). The MHRT:

> supports the establishment of interstate agreements to allow for forensic patients to return to their home State so that they are able to receive support from their family and friends. While the importance of support structures in the recovery and rehabilitation of people with a mental illness has been well documented, this is particularly important for persons of Aboriginal and Torres Strait Islander heritage. The Tribunal has identified a number of forensic patients who would be eligible for such a scheme not only with Victoria but also Queensland, Tasmania, and Western Australia.[227]

9.193 Section 176 of the MHA permits the transfer of forensic patients detained in a mental health facility in NSW to other states if permitted under "corresponding law" of the other state and in accordance with regulations. However, the MHRT has noted that arrangements are only in place with Queensland and Victoria to deal with forensic patients who abscond.[228]

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224. Mental Health Review Tribunal, *Submission MH57*, 22.
225. See discussion in Mental Health Review Tribunal, *Submission MH57*, 22-23.
226. Information supplied by the Mental Health Review Tribunal, 19 February 2013.
227. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 15.
228. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 14-15.

How can these issues be addressed?

9.194 In the cases where forensic patients leave NSW with the approval of the MHRT the MHRT supports a clause like the one employed in Queensland.[229] Section 173 of the *Mental Health Act 2000* (Qld) permits the Queensland Mental Health Review Tribunal to approve an application permitting a forensic patient to move outside of the jurisdiction where "it is satisfied appropriate arrangements exist for the patient's treatment or care at the place where the patient is to move". The Queensland Tribunal may impose "reasonable conditions" on the approval. Under s 204(2) of the Act:

> (2) The tribunal must not revoke the forensic order for the patient if the patient has moved out of Queensland under chapter 5, part 1, division 3 or section 288B, unless—
>
> (a) 2 years has elapsed after the patient's moving out of Queensland; and
>
> (b) it is satisfied the patient is not likely to move back to Queensland.

9.195 Therefore, under the Queensland approach, where a person remains out of the state his or her forensic patient status can cease to have effect after two years.

9.196 Suspension of the forensic patient's status would allow the MHRT to halt reviews while the person is outside of NSW, but also allow the person to be reviewed and managed if he or she re-enters the jurisdiction for a nominated period of time.[230] The MHRT has submitted that a provision along these lines would allow it to release unconditionally a forensic patient where that patient is absent from NSW for two years and is now established in another jurisdiction.[231]

9.197 Where a person leaves the jurisdiction without the MHRT's approval, the MHRT submits that the person's forensic status should be suspended while he or she is outside the jurisdiction, but there should be no expiry of the status (or expiry after a long period).[232] As far as the Commission is aware, the primary purpose of suspending the forensic patient's forensic status would be to release the MHRT from its requirement to conduct regular reviews while the person remained out of the jurisdiction, which would be an inappropriate use of the MHRT's time in the circumstances.

The Commission's view

9.198 The discussion above raises a range of issues that may cause some practical problems for the MHRT:

(1) Inflexibility in review arrangements where a forensic patient has absconded.

(2) Inflexibility in review arrangements where a forensic patient has been transferred to a different jurisdiction with the MHRT's approval.

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229. Mental Health Review Tribunal, *Submission MH57*, 22-23.
230. Mental Health Review Tribunal, *Submission MH57*, 22-23.
231. Information supplied by the Mental Health Review Tribunal, 5 February 2013, 14.
232. Mental Health Review Tribunal, *Submission MH57,* 23.

(3) Limited inter-jurisdictional arrangements to support the transfer of forensic patients in appropriate circumstances.

9.199 Where a forensic patient has absconded and cannot be located, we are of the view that it is appropriate for the MHRT to suspend reviews until the forensic patient is located. It would also be appropriate for the limiting term period to be suspended until the forensic patient is located.

Recommendation 9.15

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that, where a forensic patient has left NSW without the Mental Health Review Tribunal's approval, during that period of absence:

(a) the Tribunal may suspend reviews,

(b) the operation of the limiting term should be suspended.

9.200 Where a forensic patient has been transferred to another jurisdiction *with* the permission of the MHRT, it is important that appropriate arrangements are in place to monitor and support the forensic patient. The MHRT currently ensures that arrangements are made for appropriate care and support but asks that its obligations to review such patients regularly be removed. At this time, we do not recommend modification of review arrangements in relation to forensic patients who leave NSW with the permission of the MHRT. While there may be practical difficulties in obtaining the information required for such reviews where a person is outside NSW, we note that the person has not yet been considered appropriate for unconditional release by the MHRT. The requirement to review the forensic patient is an important safeguard. It ensures regular monitoring and reporting and that orders can be made in the event that serious problems arise with the forensic patient.

9.201 There are two possible solutions to this difficulty. One is to make the information required at review easier to obtain and more reliable. The other is to create inter-jurisdictional arrangements whereby the responsibility to review forensic patients can be transferred to the place in which the patient is to reside. These are issues requiring agreement and resolution between multiple jurisdictions. We strongly support the development of appropriate arrangements for the transfer of forensic patents to other jurisdictions; however it is beyond the scope of our review to make recommendations on this issue.

Appeals against MHRT findings and orders

9.202 Decisions by the Forensic Division of the MHRT may be appealed to the Supreme Court or Court of Appeal in circumstances prescribed by the MHFPA.[233]

9.203 A forensic patient may apply for leave to appeal either to the Court of Appeal regarding release, or to the Supreme Court in relation to other determinations.[234] In

233. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 77A.

234. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 77A(1), s 77A(4).

contrast, the Minister for Health may appeal in either instance as of right.[235] The Attorney General has a right of appeal to the Court of Appeal in relation to a decision by the MHRT regarding the release of a person, but only on a question of law.[236] A victim of a forensic patient may, with leave, appeal against a determination by the MHRT regarding non-association and/or place restriction conditions attached to the patient's release or leave of absence from a mental health facility or other place.[237]

9.204 The appellate court may affirm the MHRT's determination, may make such order as it considers the MHRT should have made, or may remit the matter to the MHRT for rehearing.[238]

Should appeal mechanisms be modified?

9.205 In CP 6 we asked whether the provisions for appeal against decisions by the MHRT are adequate and appropriate and, if not, how they should be modified.[239]

9.206 The NSW Bar Association and Legal Aid NSW noted that current provisions are adequate and appropriate.[240] However, Legal Aid NSW and the Law Society of NSW noted that applications should be made in the Supreme Court instead of the Court of Appeal.[241] Legal Aid NSW noted that the Supreme Court already has jurisdiction in relation to other MHRT determinations.[242]

9.207 The NSWCAG queried the right of the Attorney General and Minister for Health to appeal decisions made by the MHRT:

> NSW CAG questions the capacity of both of these bodies to have the knowledge to make a fair appeal when they are not involved in the direct care and treatment of these individuals. We therefore recommend further consideration of the right to appeal against MHRT decisions sitting with the Minister for Health and the Attorney General as well as the requirement for the MHRT to notify them of an order of release.[243]

However, we note that Health is likely to be involved in the care, support and treatment of forensic patients, and appeals by the Attorney General are limited to questions of law.

9.208 The current appeal mechanisms are a consequence of the removal of executive discretion following recommendations in the 2007 Forensic Review. In that review, it was recommended that decisions involving a forensic patient's conditional or

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235. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 77A(2), s 77A(5).
236. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 77A(6).
237. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 77A(3).
238. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 77A(9).
239. 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 6.89.
240. NSW Bar Association, *Submission MH10*, 45; Legal Aid NSW, *Submission MH18*, 20.
241. Law Society of NSW, *Submission MH13*, 25; Legal Aid NSW, *Submission MH18*, 20.
242. Legal Aid NSW, *Submission MH18*, 20.
243. NSW Consumer Advisory Group, *Submission MH11*, 27.

unconditional release "should be subject to appeal to a single judge of the Common Law Division of the NSW Supreme Court, while release decisions should be subject to appeal to the Court of Appeal".[244] Permitting appeal by the Attorney General and Minister for Health was also included due to "the public interest involved in such decisions".[245]

9.209 There do not appear to be any problems in practice in relation to the current operation of appeal mechanisms. We therefore do not recommend any change at this time.

244. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [5.72].

245. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [5.72].

10. Forensic patients detained in correctional centres

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10.1 The aims of the forensic system are to protect the community and to provide treatment and services for forensic patients to resolve the issues that caused their offending behaviour or caused them to be unfit. As treatment and services have an effect, and the risk to public safety decreases, the need for security is reduced, and forensic patients are transferred to less secure environments and gradually permitted more freedom. These steps towards eventual release depend on the availability of suitable facilities with appropriate levels of security.

10.2 However, in NSW, as in many other jurisdictions, there are insufficient facilities able to provide both the required level of security and also the treatment and services needed by some forensic patients. Consequently, some are held in correctional centres. In this chapter we use the term "correctional centres" to include detention centres and all facilities administered by Corrective Services NSW (CSNSW). We note that CSNSW has specialist facilities for people with cognitive and mental health impairments, including forensic patients, such as the Long Bay Prison Hospital and Mental Health Screening Units. We describe these facilities below. We do not include in our definition of "correctional centres" those facilities that are not operated jointly or wholly by CSNSW.

10.3 A number of problems have been identified in relation to detaining forensic patients in correctional centres. These include problems with providing appropriate therapeutic treatment and services; the potentially detrimental effect of the correctional centre environment on those with cognitive and mental health impairments; and difficulty providing programs involving monitored re-integration into the community. The problems appear to be particularly acute for forensic patients with cognitive impairments.

10.4 Other jurisdictions have responded to the challenges of detaining forensic patients in correctional facilities in various ways, including prohibiting forensic patients being held in such facilities; restricting the situations in which forensic patients can be held in correctional facilities; and providing that the placement of forensic patients be determined by an independent tribunal, but subordinating the tribunal's decisions to considerations of security and service availability. This latter option is the one substantially adopted in NSW.

10.5 This chapter reviews the problems that arise with detention of forensic patients in correctional centres, and considers recent reports relevant to this topic. We then outline present practice in NSW and the legal provisions relevant to forensic patients in correctional institutions. We examine the approach of other jurisdictions and consider whether the current approach in NSW is appropriate or whether reform is needed.

Problems with detention of forensic patients in correctional centres

Issues

10.6 One significant problem with the detention of forensic patients in correctional centres is that the environment may have a negative effect on the health and psychological wellbeing of those with cognitive and mental health impairments. There also may be difficulties in making provision for the therapeutic needs of such patients in a correctional institution.[1] There may be problems in identifying deterioration in a person's condition and in monitoring people with mental health and cognitive impairments.[2]

10.7 These difficulties were thrown into sharp relief by a 2006 coronial inquest into the suicide of a forensic patient who was detained in a correctional centre.[3] While on remand for another offence, this inmate, who had paranoid schizophrenia and a long history of violence and mental illness, killed a cellmate during a psychotic episode. He was found not guilty due to mental illness (NGMI) and became a forensic patient. He returned to prison where, because of his previous conduct, he was segregated and reportedly spent 22 hours per day in a cell. Within a short time, the forensic patient committed suicide.

10.8 The Coroner identified systemic issues with the prison system and mental illness, including failures in the process for identifying mental illness and obstacles to accessing hospitalisation and necessary care. In particular, psychiatric evidence was submitted to the Coroner to the effect that prolonged periods in solitary

1 NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) [11.18]; G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [3.11], [8.23].

2 *Inquest into the death of Scott Ashley Simpson* (Unreported, NSW Coroner's Court, Deputy State Coroner Magistrate Pinch, 17 July 2006).

3. *Inquest into the death of Scott Ashley Simpson* (Unreported, NSW Coroner's Court, Deputy State Coroner Magistrate Pinch, 17 July 2006).

confinement would most likely exacerbate an inmate's paranoia, with one psychiatrist stating:

> Solitary confinement is not medical treatment. There is no circumstance in which it is appropriate in the care of a mentally ill person.[4]

10.9 Second, the forensic system works on a "step down" basis, so that when they are well enough patients are permitted increasing levels of freedom, but with careful monitoring. It may be difficult or impossible for the patient to demonstrate qualification for this progression when in a correctional centre. This appears to be a particular problem for forensic patients with cognitive impairments.

10.10 Third, limiting terms are the nominated length of time for which a person remains a forensic patient, yet limiting terms appear to be administered as if they were equivalent to the non-parole term of a sentence.[5] This results in some forensic patients being incarcerated for longer than offenders convicted and sentenced in the ordinary way, and being excluded from important step down programs and placement in services.[6]

10.11 Fourth, particular problems arise when forensic patients with cognitive impairments are detained in correctional centres. There is a notable absence of secure facilities in the community where forensic patients with cognitive impairments can be detained and appropriately treated or managed, and of infrastructure to assist them in the community in supported accommodation or otherwise. Prison appears to be the default option. In these cases, correctional centres may be "filling the gap" caused by a lack of services and appropriate secure units.[7]

Previous reports

10.12 Many of the problems mentioned above have been identified in previous reports.

Report 80

10.13 In 1996, we released our report on people with an intellectual disability and the criminal justice system (Report 80). That report dealt with people with intellectual disability within the whole prison population, not only forensic patients. The report suggested that the prison environment was totally inappropriate for the people with intellectual disability, who require secure or supervised accommodation with individualised habilitative programs.[8]

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4. *Inquest into the death of Scott Ashley Simpson* (Unreported, NSW Coroner's Court, Deputy State Coroner Magistrate Pinch, 17 July 2006).
5. In consultation, the Mental Health Review Tribunal advised that it had no record of any forensic patient being released prior to the end of their limiting term: Mental Health Review Tribunal, *Consultation MH38*.
6. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007).
7. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System,* Report 80 (1996) Ch 11.
8. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System,* Report 80 (1996) [11.2].

10.14 The Report pointed to the vulnerability of people with intellectual disability in the prison setting, and observed that the emotional and psychological consequences of prison are more onerous for such people than for the general prison population. People with intellectual disability may be negatively influenced in prison, may find prison anti-therapeutic, and prison life may be particularly burdensome due to the way it disrupts normal routines. The Report concluded that placing people with intellectual disability in prison was an uncompassionate and ineffective response to a complex problem, and quoted submissions which argued that where a person does not or cannot understand why he or she is in prison, punishment is both "meaningless and cruel".[9]

10.15 Report 80 recommended the establishment of secure units for unfit forensic patients, and units that focus on care, treatment, instruction and rehabilitation for forensic patients with cognitive impairments found unfit and not acquitted (UNA) following a special hearing.[10] In the Report, the Commission supported a model where, in most cases, high level supervision and intensive programs within secure units would meet both the individual's needs and the community's requirement for safety. The secure units would be exclusively available to forensic patients; the units would have strict admission criteria and be regularly monitored.[11] The units would be run by the Department of Community Services (as it then was) in consultation with CSNSW. The role of management would not be custodial, but rehabilitative,[12] and only a minority of forensic patients with an intellectual disability would require secure accommodation.[13]

The Framework Report

10.16 The Framework Report was commissioned by the Intellectual Disability Rights Service and the NSW Council for Intellectual Disability[14] to devise a framework for managing people with an intellectual disability who come into contact with the criminal justice system.[15] The Report detailed the gap in service providers for people with intellectual disability who may be at risk of coming into contact with the criminal justice system. In regards to people with an intellectual disability in correctional centres, the Report supported the 1996 recommendations of this

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9. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System,* Report 80 (1996) [11.18].
10. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22(1)(c)-(d); NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System,* Report 80 (1996) Recommendation 57.
11. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System,* Report 80 (1996) [11.26].
12. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System,* Report 80 (1996) [11.28].
13. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System,* Report 80 (1996) [11.25].
14. With funding from the then Department of Ageing, Disability and Home Care, and the Law and Justice Foundation of NSW.
15. 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* (2001).

Commission, and directed readers to an article authored by consultant Jim Simpson for a comprehensive implementation strategy.[16]

10.17 At that time, Simpson recommended expanding access to the secure units proposed in Report 80 to any person in the prison population with a qualifying intellectual disability. He suggested that the units be operated by the then Department of Aging, Disability and Home Care, and that a tribunal be given the decision making role in regards to the transfer, security arrangements and oversight of the forensic population. He recommended that community safety be the guiding principle in areas such as the level of security and release. Subject to community protection considerations, the secure option should conform to the principles and applications of the *Disability Services Act 1993* (DSA), to ensure that it provides an "adequate habilitative and rehabilitative environment".[17] The principles of the DSA determine that people with disabilities have the same protections, access to services and rights as people without disabilities, and the DSA applications direct service-providers to structure their approach to meet these goals.[18]

10.18 However, Simpson also notes that the principles of the DSA and safety concerns can sometimes be irreconcilable. Where people require a high level of security this may produce an "overt and considerable discordance with the objects, principles and applications in the DSA".[19] The author conceded that in circumstances in which people with intellectual disability require a high level of security, such as tall fences or locked doors, they might have to be housed in prison, where security is the prime consideration.[20]

The 2007 Forensic Review

10.19 The *Review of the New South Wales Forensic Mental Health Legislation* (2007 Forensic Review) was released in August 2007, and had a significant impact upon the management of forensic patients in the areas of oversight, review and release. The report was the catalyst for legislative change to the forensic system which transferred decisions relating to release of forensic patients from the executive branch to the MHRT.[21]

10.20 The 2007 Forensic Review stressed the inappropriateness of forensic patients being subject to the same controls and disciplines in correctional centres as other

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16. J Simpson, *Options to Imprisonment: Legal And Related Issues Concerning The Department Of Community Services Providing Restrictive Services To Alleged Offenders With Intellectual Disabilities: A Discussion Paper,* written for the Department Of Community Services (1997).

17 J Simpson, *Options to Imprisonment: Legal And Related Issues Concerning The Department Of Community Services Providing Restrictive Services To Alleged Offenders With Intellectual Disabilities: A Discussion Paper,* written for the Department Of Community Services (1997) 35, 36.

18 *Disability Services Act 1993* (NSW) sch 1.

19. J Simpson, *Options to Imprisonment: Legal And Related Issues Concerning The Department Of Community Services Providing Restrictive Services To Alleged Offenders With Intellectual Disabilities: A Discussion Paper,* written for the Department Of Community Services (1997), 27.

20. J Simpson, *Options to Imprisonment: Legal And Related Issues Concerning The Department Of Community Services Providing Restrictive Services To Alleged Offenders With Intellectual Disabilities: A Discussion Paper,* written for the Department Of Community Services (1997) 21, 23, 25.

21 NSW, *Parliamentary Debates*, Legislative Assembly, 27 June 2008, 9540-2 (P Lynch).

inmates. It pointed out that placement in correctional centres had an onerous effect on forensic patients,[22] with "drastic effects on liberty, but no value for treatment".[23]

10.21 The 2007 Forensic Review observed that limiting terms were being administered as if equivalent to a term of imprisonment.[24] Consequently, forensic patients in correctional centres were not being released or stepped down in security terms prior to the end date on their limiting terms. This practice was considered inconsistent with the original purpose of the limiting term, and the report suggested that it resulted in discrimination against forensic patients contrary to the law and Australia's obligations under international instruments.[25]

10.22 The 2007 Forensic Review put forward recommendations, including a new forensic patient classification scheme in lieu of the prisoner classification system contained in *Crimes (Administration of Sentences) Act 1999* (NSW). This scheme would enable forensic patients in prison to access step down programs, and to be conditionally or unconditionally released before the expiry of their limiting terms. The scheme also would include protocols addressing therapeutic and security matters.[26]

10.23 Many of the review's recommendations relating to forensic patients in correctional centres were not adopted by government. However, as a result of the review it was provided that forensic and correctional patients[27] are separately identified and that Community Treatment Orders be made available to prison inmates, including forensic patients.[28]

Forensic patients in correctional centres in NSW

10.24 A forensic patient detained in custody is generally placed within a specialised mental health unit.[29] However, a forensic patient may be detained in a correctional centre because he or she cannot be safely managed other than in a high security environment;[30] no place is available in mental health facility outside CSNSW;[31] or the forensic patient is ineligible for a place in a mental health facility because he or

22. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [3.11] (cited *R v Mailes* [2004] NSWCCA 394; 150 A Crim R 365, 373-374).
23. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) 11.
24 G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [2.7].
25. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [1.24], [2.7].
26. G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) Recommendations 22, 23.
27. A person (other than a forensic patient) who has been transferred from a correctional centre to a mental health facility while serving a sentence of imprisonment, or while on remand, and who has not been classified by the Mental Health Review Tribunal as an involuntary patient: *Mental Health (Forensic Provisions) Act 1990* (NSW) s 41.
28. See the *Mental Health (Forensic Provisions) Act 1990* (NSW) s 41, s 67.
29 Sixty percent of forensic patients were held in a mental health facility in October 2012. See Table 7.4 in Chapter 7.
30. Consider *R v Adams* (2003) 58 NSWLR 1; *Courtney v The Queen* [2007] NSWCCA 195.
31. See *Inquest into the death of Scott Ashley Simpson* (Unreported, NSW Coroner's Court, Deputy State Coroner Magistrate Pinch, 17 July 2006).

she is no longer mentally ill[32] or has an impairment other than a mental illness for which no forensic facilities exist in NSW.[33]

Number of forensic patients in correctional centres

10.25 The CSNSW Inmate Census for June 30 2012 reports that forensic patients represented 0.8% of the prison population, with 50 forensic patients in full-time custody in NSW prisons. Thirty-three forensic patients were categorised as undergoing an "indeterminate term": this includes people found unfit where a limiting term had not yet been set and people found NGMI. Seventeen forensic patients were recorded as having had a limiting term imposed – that is they were found unfit and not acquitted (UNA).[34]

10.26 In October 2012, the MHRT reported that 11% of all forensic patients were held in correctional centres, with a further 5% in Long Bay Prison Hospital. Forty forensic patients in correctional centres were reported as undergoing an "indeterminate term" and 19 reported as UNA. (The MHRT information was recorded three months after the Census, which may account for difference in the numbers).[35]

10.27 For a snapshot of forensic patient placement in October 2012 see Table 7.4 in Chapter 7.

Facilities for forensic patients in correctional centres

10.28 CSNSW provides various facilities and supports for inmates with cognitive and mental health impairments, including, but not limited to, forensic patients:

(1) **Long Bay Hospital**: An 85 bed facility located within Long Bay Correctional Centre for people with mental health impairments and medical issues.

(2) **Mental Health Screening Units:** The units provide services for men and women at Silverwater Metropolitan Remand and Reception Centre (MRRC) and the Silverwater Women's Correctional Centre. The Mental Health Screening Unit at MRRC is a purpose-built 43 bed facility, which provides assessment and treatment of mentally ill inmates from NSW. The unit is comprised of a 13 bed high dependency unit (including three assessment cells) and two 15 bed sub-acute pods. The Mental Health Screening Unit in Silverwater Women's Correctional Centre is a 10 bed facility for women.

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32. For example, if the person had a disorder, such as acute clinical depression or a substance-related disorder, which has resolved. See also the *Mental Health Act 2007* (NSW) s 166(1)(c)-(3): if the Supreme Court finds that a forensic patient is wrongly detained in a mental health facility, the court must order that the person be transferred to a correctional facility.

33. See *Agha v The Queen* [2008] NSWCCA 153 (intellectual disability); *Mailes v DPP* [2006] NSWSC 267 [6] (intellectual disability); *R v Adams* (2003) 58 NSWLR 1 (personality disorder); *Courtney v The Queen* [2007] NSWCCA 195 (personality disorder). See also G James, *Review of the Forensic Provisions of the Mental Health Act 1990 and the Mental Health (Criminal Procedure) Act 1990*, Consultation Paper (2006) 14, 42.

34. S Corben, "NSW Inmate Census 2012, Summary of Characteristics", *Corrective Services NSW* (2012) Section 2.

35. Information supplied by the Mental Health Review Tribunal, 13 October 2012.

Patients receive a comprehensive Discharge Management Plan in order to facilitate the appropriate clinical and correctional pathway.[36]

(3) **Additional Support Units:** Statewide Disability Services (SDS) comprises a multidisciplinary team that provides advice, programs and assessment of people with disabilities, including forensic patients with cognitive impairment. SDS provides reports to the MHRT and links forensic patients with cognitive impairment to community agencies.[37] SDS oversees the running of three Additional Support Units (ASUs) within Long Bay Correctional Centre. These units accommodate inmates with cognitive impairments who require placement outside the general prison population and include an assessment unit; therapeutic programs unit; and a pre-release unit with employment programs and post release support programs. Access to the units is via recommendation from the SDS Placement Committee after an inmate is referred by CSNSW staff or an external source; is known to SDS; has an acquired brain injury or IQ below 80; or is otherwise suitable for placement. Suitability is assessed with reference to the inmate's ability to cope in the general prison population and the requirement for protection, as well as the inmate's need to participate in specialist programming.[38]

10.29 Adjacent to Long Bay Correctional Centre is the Forensic Hospital, which provides secure specialist mental healthcare for people with mental health impairments who have been in contact with the criminal justice system.[39] The Forensic Hospital provides an alternative to prison for forensic patients who have mental health impairments or complex needs. It is not administered by CSNSW but by Justice Health, and is not a correctional centre.

Management of forensic patients by CSNSW

10.30 CSNSW noted in its submission to this reference that the practice of holding forensic patients in correctional centres is imposed upon, rather than sought by, CSNSW. The submission outlined the current processes employed by CSNSW to manage people with cognitive and mental health impairments, including forensic patients, in correctional centres.[40] The relevant parts of the submission are summarised below.

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36 Corrective Services NSW, "Mental Health Screening Unit" <http://www.correctiveservices.nsw.gov.au/offender-management/offender-services-and-programs/at-risk-offenders/mental-health-screening-unit>; For an in depth overview of the goals and development of the mental health screening unit see J Adams et al, "A Prison Mental Health Screening Unit: A First for NSW" (2009) 17 *Australas Psychiatry* 2, 90.

37. Information supplied by Corrective Services NSW, 25 March 2013.

38. Corrective Services NSW, "Additional Support Units", <http://www.correctiveservices.nsw.gov.au/offender-management/offender-services-and-programs/statewide-disability-services/additional-support-units>.

39. It is only one such facility. Others include the Bunya unit at Concord Hospital and Morisset Hospital.

40. Corrective Services NSW, *Submission MH17*, 10-14 (edited).

Admission, classification and management. A person's forensic patient status is captured when that person enters custody (or has a change in legal status) by CSNSW and Sentence Administration staff. The status is recorded in the "Offender Integrated Management System" so that the person's status as a forensic patient is visible to all staff that comes into contact with the forensic patient. Receiving officers also notify Justice Health, which immediately becomes responsible for the care and treatment of the forensic patient. Forensic patients are assessed by Justice Health who determine, among other things, what placement is appropriate.

Forensic patient status is relevant to security classification. Any issues that are considered likely to affect the security of a correctional centre or an inmate's placement, classification and/or security are entered into the patient's case management file. Issues may include a propensity to self harm, or pre-existing acute cognitive or mental health impairment. Advice about classification may be given by the Mental Health Team. Inmates are to be involved in the decision making process by being given the opportunity to provide input into the case plan.

CSNSW notes that forensic patients are not a uniform group and that it cannot apply one program or process to all forensic patients. There is a high level of co-morbidity, and forensic patients may have complex presentations including co-existing serious mental illness, substance abuse disorders, personality disorders, and anxiety disorders. Where this manifests in behaviours that pose a serious risk to the self or others, special management and placement may be warranted.

Protection. Forensic patients will be placed in protection if the nature of the offence, mental health impairment, or reduced coping capability renders them unable to integrate with the general prison population. The most common category assigned to a forensic patient on a protection order is "Special Management Assessment for Placement" (SMAP). Forensic patients with a SMAP designation are given special consideration prior to placement in the general prison population. Importantly, CSNSW notes that SMAP areas in correctional centres do not resemble the "protection yards of old, and offenders managed in these areas can have the same level of access to work, programs and services as offender in the mainstream".

Segregation. Placement in segregation is based on "risk status" identified by a mental health assessment. Case management policy provides that an inmate's case plan must be reviewed when he or she is placed in segregation, and any indication of mental health deterioration results in a team meeting to determine the case plan. Justice Health is required to visit each person subject to segregation daily.

Segregation is not routine. CSNSW notes that there are stringent rules around placing any inmate in segregation, which must "never be used because of a shortage of other accommodation". Segregation may be employed to manage a high level of dangerousness, however. Of the five forensic patients subject to segregation at the time of the submission, three were segregated following incidents in which they either killed or seriously injured another inmate.

Personality and Behaviour Disorder Unit (PBDU). This unit, established in 2008, is aimed at reducing the use of segregation as a tool to manage high risk forensic patients. The PBDU is a state-wide mobile team which provides "high-level and intensive multi-disciplinary

expertise to correctional centres managing offenders with a severe personality disorder and challenging behaviours". The PBDU will conduct a clinical assessment of the forensic patient, which looks at the effects of the environment, staff practices and other factors, and develops an individualised case plan, with an ultimate goal to allow the "safe progression of these difficult offenders to least restrictive management". CSNSW reports that the program has reduced the level of days in "safe cell placement" for all offenders by 89%.

Services and facilities. Additional Support Units at Long Bay Correctional Centre were introduced to accommodate and meet the respective needs of people with cognitive impairments in the prison system, and the opening of the Long Bay Hospital and the Mental Health Screening Units at Silverwater Correctional Centre provides a way to divert "people with acute mental illness from custody". There are, however, limitations to these services. CSNSW observes that the Long Bay Hospital is unable to manage forensic patients posing a serious risk to staff, and there remains no separate secure facility appropriate for people with cognitive and other disabilities.

The legislative framework

The courts

10.31 Section 39 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA) provides that, where a person is found NGMI, the court may order that the person be detained in such a place and in such a manner as the court thinks fit. Alternatively, the court may make such other order (including an order releasing the person from custody, either unconditionally or subject to conditions) as the court considers appropriate. A person detained or conditionally released under s 39 becomes a forensic patient.[41]

10.32 Where a person is found UNA and the court imposes a limiting term, the court must refer the person to the MHRT, and may make such orders with respect to the person's custody as the court considers appropriate.[42] The MHRT makes certain prescribed determinations about the person's mental illness or condition.[43] The person then returns to court and the court may make a decision under s 27 of the MHFPA to detain the person in a mental health facility, or in a place other than a mental health facility. In practice, that "other place" is generally a correctional centre.[44]

10.33 In *State of NSW v TD*,[45] the court made an order under s 27 that an individual be detained in a mental health facility. In fact, TD was detained in a correctional centre for a period of time, where TD became distressed and unwell. A claim for unlawful imprisonment was made. The plaintiff succeeded in this claim in the Supreme

41 *Mental Health (Forensic Provisions) Act 1990* (NSW) s 42.

42 *Mental Health (Forensic Provisions) Act 1990* (NSW) s 24(1).

43 *Mental Health (Forensic Provisions) Act 1990* (NSW) s 24(2).

44. See Chapter 7 for a detailed discussion on limiting terms.

45 *State of NSW v TD* [2013] NSWCA 32.

Court[46] and on appeal to the Court of Appeal.[47] The Court of Appeal held that an order entitling the State to deprive a person of his or her liberty does not justify detention in any place the State deems appropriate. The lawfulness of the detention depends on compliance with the terms of the order.[48]

10.34 CSNSW has responded to the ruling in *TD* by transferring 11 patients from correctional centres to the Forensic Hospital in compliance with orders. Second, all beds in the Long Bay Hospital have been designated "mental health beds", within the meaning of the *Mental Health Act 2007* (NSW), increasing the available beds for forensic patients from 40 to 84. Forensic patients that now remain within the correctional system have an order either directing placement in a correctional centre or authorising placement pending bed availability in the Forensic Hospital. Third, CSNSW has instituted a policy to immediately transfer any patient with a court or MHRT order directing placement in the Forensic Hospital to the Forensic Hospital irrespective of whether Justice Health and the Forensic Mental Health Network has a bed available for the placement.[49]

The MHRT

10.35 After court disposition, forensic patients are referred to and managed by the MHRT. The MHRT conducts an initial review as soon as practicable after a person is found NGMI, where the court has made an order for detention or conditional release.[50] Where a person is UNA and a limiting term is nominated, the MHRT must conduct reviews that include consideration of the defendant's fitness and the individual's care and treatment.[51]

10.36 After the initial reviews, the MHRT may review a forensic patient's case at any time, but must review the person's case at least every six months.[52] Where the person is subject to a community treatment order (CTO) in a correctional centre (used to provide treatment and management of a person's mental illness in custody),[53] that person must be reviewed every three months.[54]

10.37 The MHRT may make orders about the patient's continued detention, care or treatment in a mental health facility, correctional centre or other place, or the patient's release either unconditionally or subject to conditions.[55] The MHRT submitted that it places a forensic patient in a correctional centre where it considers that either no practical alternative exists appropriate to the forensic patient, or that a

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46 *TD v State of NSW* [2010] NSWSC 368.

47 *State of NSW v TD* [2013] NSWCA 32.

48. *State of NSW v TD* [2013] NSWCA 32 [48], [54].

49. Information supplied by Corrective Services NSW, 25 March 2013.

50. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 44, s 46.

51. See Chapter 9.

52. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 46(1). This is subject to two exceptions: see s 46(3)-(5).

53. See G James, *Review of the New South Wales Forensic Mental Health Legislation* (2007) [4.25].

54 For further consideration of these issues, see Chapter 9.

55 *Mental Health (Forensic Provisions) Act 1990* (NSW) s 47.

correctional centre is best placed to address the patient's criminogenic and security needs.[56]

Corrective Services NSW

10.38 Forensic patients who are detained in correctional centres, including mental health facilities that are part of correctional centres, are subject to the provisions of the *Crimes (Administration of Sentences) Act 1999* (NSW).

10.39 There are limits on the obligation of the Commissioner of CSNSW to comply with any order under the MHFPA or act within the agreed protocol.[57] Section 76C of the Act provides that nothing in the Act or any order made under the Act prevents the Commissioner from exercising a function in relation to a forensic patient if the function is "exercised for the purpose of maintaining the security, good order or safety, in any way," of the centre or its inmates.[58] Thus, security concerns may override decisions and orders relating to the place of detention of a forensic patient. CSNSW has advised that this provision has only been used on three occasions.[59]

10.40 Further, s 77C of the MHFPA provides that if an order is made by a court, the MHRT or the Director General "specifying that a forensic patient is to be detained in or transferred to a specified correctional centre or detention centre", the Commissioner of CSNSW may disregard the order and "cause the patient to be detained in any correctional centre or detention centre".

10.41 Section 76K of the MHFPA also directs that CSNSW and other agencies responsible for the management of forensic patients must use "their best endeavours to comply with a request made to them under this Act by the Tribunal", unless the request is inconsistent with the discharge of responsibilities or unduly prejudices the discharge of functions of that agency.[60] This section is intended to impose a duty on the relevant departments to comply with requests of the MHRT,[61] including requests for psychiatric intervention, assessment or treatment.

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56 Mental Health Review Tribunal, *Submission MH57*, 19.

57 *Security Conditions Protocol (s76D of the* Mental Health (Forensic Provisions) Act 1990*) between Director-General NSW Department of Health and Commissioner of Corrective Services in relation to Forensic and Correctional Patients* (2011) 9.1.

58 *Mental Health (Forensic Provisions) Act 1990* (NSW) s 76C(1).

59. In one case the Commissioner determined that the safety of staff and other inmates could not be guaranteed if a particularly violent forensic patient remained at Long Bay Hospital. This decision was supported by the treating psychiatrists. The two other cases involved forensic patients requiring a strict protection regime unavailable in the correctional centre location determined by the court or Mental Health Review Tribunal: Information supplied by Corrective Services NSW, 25 March 2013.

60 *Mental Health (Forensic Provisions) Act 1990* (NSW) s 76K.

61 Explanatory Note, Mental Health Legislation Amendment (Forensic Provisions) Bill 2008 (NSW) 6.

Options for reform

Approaches adopted in other jurisdictions

10.42 The appropriate placement of forensic patients is an issue with which other jurisdictions have also struggled. We conducted a review of Australia and New Zealand (NZ), and identified four distinct approaches across the various jurisdictions. These are:

(1) **No provision made for detaining forensic patients in correctional centres, or such detention is expressly prohibited:** Tasmania and NZ prohibit the detention of forensic patients in correctional centres.[62] In Tasmania, all forensic patients are held in "secure mental health units" which accommodate people with cognitive and mental health impairments.[63] NZ legislation prescribes that when mental illness is apparent, "special patients" are to be held in a hospital, and people with intellectual disabilities are to be detained in a "secure facility", where the objective is to provide care in a secure environment. The NZ legislation expressly excludes prisons from the definition of "secure facility".[64]

In NZ, secure facilities are supplied by the National and Regional Intellectual Disability Secure Services, and include hospital level secure services and "secure cottages". There are approximately 150 people housed in these facilities, which are staffed by multidisciplinary teams specialising in intellectual disability.[65]

(2) **Forensic patients may be detained in a correctional centre when there is no practicable alternative:** In Victoria, SA, the ACT and NT, legislation prescribes that forensic patients are only to be detained in correctional centres when there is no practicable alternative.[66] In the ACT, courts must consider "the principle that a person should not be detained in a correctional centre unless no reasonable option is available".[67] This is part of broad criteria for detention, which also includes the nature and extent of any mental impairment, the nature of the charged offence, and any recommendation made by the ACT Civil and

62. *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 18, s 21, s 24 (for definition of "secure mental health unit" see s 3), *Mental Health Act 1996* (Tas) s 3; *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 24; *Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003* (NZ) s 9(1), s 9(4).

63. *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 18, s 21, s 24 (for definition of "secure mental health unit" see s 3), *Mental Health Act 1996* (Tas) s 3: see information on Wilfred Lopes Secure Mental Health Unit Summary at <http://www.dhhs.tas.gov.au/service_information/services_files/mental_health_services/forensic_mental_health_service/wilfred_lopes_centre>.

64. *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 24; *Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003* (NZ) s 9(1), s 9(4).

65 New Zealand Ministry of Health, "Intellectual Disability (Compulsory Care and Rehabilitation) Act, 2003" <http://www.health.govt.nz/our-work/disability-services/intellectual-disability-compulsory-care-and-rehabilitation-act-2003>.

66. *Criminal Code* (NT) s 43ZA(1)(a)(i), s 43ZA(2); *Criminal Law Consolidation Act 1935* (SA) s 269O, s 269V; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 26(2)(a)(ii), s 26(4); *Crimes Act 1900* (ACT) s 308, s 318-9, s 323-4.

67. *Crimes Act 1900* (ACT) s 308(d).

Administrative Tribunal (ACAT) about how the forensic patient should be dealt with.

NT legislation prescribes that a court can commit an accused person found NGMI[68] or UNA[69] to custody in a prison[70] but that it "must not make a custodial supervision order that commits the accused to a prison unless it is satisfied that there is no practical alternative given the circumstances of the person".[71] In SA, the Minister gives directions on the custody, supervision and care of people committed to detention under the relevant legislation.[72] The Minister may, "if there is no practical alternative", direct that a defendant be kept in custody in a prison.[73]

In Victoria, the court must not make a supervision order committing a person to custody in a prison unless it is satisfied that there is no practicable alternative in the circumstances.[74] Practical alternatives include approved mental health services and placements,[75] and residential treatment facilities or institutions for people with cognitive impairments overseen by the Department of Human Services.[76] The court must not make a supervision order that commits a person to custody in these institutions or to receive services in these facilities unless it receives a certificate stating that the facilities or services necessary for the order are available.[77]

If a forensic patient is detained in a correctional centre but is eligible for placement in a residential facility, he or she can also be transferred to a residential treatment facility or a residential institution by an order of the Minister pursuant to the *Disability Act 2006* (Vic).[78] The provision outlines the matters to be considered when deciding whether a forensic patient should be transferred to a residential unit. The factors include: whether any physical, mental or emotional risk to which the person has been or may be exposed in prison is significantly greater than the risk to which a person without an intellectual disability would be exposed; whether the person would be more appropriately placed in a residential treatment facility or residential institution; and any other matters the Secretary to the Department of Justice considers relevant.[79]

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68. *Criminal Code* (NT) s 43I(2)(a), s 43X(2)(a).
69. *Criminal Code* (NT) s 43X(3).
70. *Criminal Code* (NT) s 43ZA(1)(a).
71. *Criminal Code* (NT) s 43ZA(2).
72. *Criminal Law Consolidation Act 1935* (SA) s 269V(1).
73. *Criminal Law Consolidation Act 1935* (SA) s 269V(2)(b).
74. *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 26(4); *R v Mijac* [2010] VSC 670*; Re Major Review of Derek Ernest Percy* [2010] VSC 179.
75. *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 26(8).
76. *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 26(9).
77. *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 26(3).
78. *Disability Act 2006* (Vic) s180.
79. *Disability Act 2006* (Vic) s180(7).

(3) **Forensic patients may be detained in correctional centres with no requirement for the court to consider an alternative:** This is the current situation in the forensic systems of Queensland and WA.[80]

(4) **Placements of forensic patients to be determined by an independent Tribunal, but its decisions are subordinated to considerations of security and service availability:** This option is the one presently adopted in NSW.

Submissions

10.43 In CP 6, we asked whether the MHFPA should be amended to exclude the detention of forensic patients in correctional centres.[81] Express prohibition received wide stakeholder support.[82] However, stakeholders also drew attention to the practical challenges that express prohibition would create, including a lack of alternative arrangements.

10.44 The NSW Consumer Advisory Group (NSWCAG) argued that detaining forensic patients in correctional centres affords insufficient distinction between people found NGMI or UNA and those found criminally responsible for a crime.[83] Since correctional centres are "punitive by nature", NSWCAG described the practice of detaining forensic patients in correctional centres as both "morally wrong" and "unethical and inappropriate".[84] The Public Interest Advocacy Centre (PIAC) agreed with NSWCAG and stressed that the detention of forensic patients in correctional centres cannot be justified by the accepted rationales for sentencing such as retribution, deterrence or rehabilitation. Concerns were raised that correctional centres do not provide a suitable environment for treatment, care and recovery, and detention in correctional centres may in fact exacerbate a person's mental illness.[85] NSWCAG and PIAC cautioned that the current practice of detaining forensic patients in correctional centres is an unfortunate "throw back" to a time when mental illness was criminalised.[86]

10.45 The NSW Bar Association and Legal Aid NSW supported prohibiting forensic patients from being detained in correctional centres, while also acknowledging that resource constraints provide a major obstacle to any viable alternative.[87] This was also evident in the CSNSW submission, which noted that "the requirement of

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80. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 16(5), s 19(4), s 20-22, s 24(1); *Criminal Code* (Qld) s 645, s 647.
81. 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 6.90.
82. NSW Bar Association, *Submission MH10*, 45; NSW Consumer Advisory Group, *Submission MH11,* 34-35; NSW Council for Intellectual Disabilities, *Submission MH12*, 3; Law Society of NSW, *Submission MH13*, 25; Legal Aid NSW, *Submission MH18*, 20; Public Interest Advocacy Centre, *Submission MH21*, 21-22.
83. NSW Consumer Advisory Group, *Submission MH11,* 35.
84. NSW Consumer Advisory Group, *Submission MH11,* 34-35.
85. NSW Consumer Advisory Group, *Submission MH11,* 34-35; Public Interest Advocacy Centre, *Submission MH21*, 21-22.
86. NSW Consumer Advisory Group, *Submission MH11,* 35; Public Interest Advocacy Centre, *Submission MH21*, 21.
87. NSW Bar Association, *Submission MH10*, 45-46; Legal Aid NSW, *Submission MH18*, 20.

accommodating forensic patients in correctional centres is one imposed rather than sought by [CSNSW]".[88] CSNSW noted that "there appears to be no ... secure facility for people with intellectual and other cognitive disabilities" and that the provision of such a facility "would appear to be a necessary concomitant of legislative change that excluded the detention of forensic patients in correctional centres". [89]

10.46 The MHRT advised that some forensic patients with advanced dementia have been accommodated in nursing homes through a conditional release order. The MHRT pointed out that this is not an ideal solution: before a person could be ordered to be detained in a nursing home there needs to be "real attention paid to the security available at that nursing home and its capacity to manage the risk associated with forensic patients whose cognitive condition is deteriorating".[90]

10.47 Forensic patients with cognitive impairments have treatment requirements distinct from patients with mental health impairments or complex needs. When the choice for detention is limited to a correctional centre or a mental health facility, often the better option for placement of people with cognitive impairments will be a correctional centre.[91] Legal Aid NSW explain:

> Because of the inadequacies of the current mental health system to accommodate forensic patients who do not have a mental illness, we have found that there is a small group of forensic patients who in fact prefer to be housed in correctional facilities rather than in mental health facilities. While a proportion of these forensic patients lack the insight as to what is in their best interests, some of them have practical and reasonable grounds for expressing this choice. In a mental health facility, which is geared towards mental health treatment in a medical framework, the forensic patient is subject to compulsory treatment, and might receive inappropriate or ineffective treatment with side effects that decrease his or her quality of life, as well as have certain freedoms curtailed.[92]

10.48 The situation was summed up by the MHRT, which submitted:

> It is important to retain the provision allowing for the detention of forensic patients in correctional centres… not all forensic patients fit a mental health rehabilitation model and at present there are no other facilities available. Even if facilities do come on line for the cognitively impaired, there are still a small number of patients who fit neither model for whom corrective services rehabilitation may be most appropriate… for those who do not have a mental illness, mental condition, or cognitive impairment, the correctional centre system is the only viable pathway to address their criminogenic risk factors. There needs to be the ability under the legislation for these people to progress through corrective services rehabilitation pathways and be supervised in the community by parole.[93]

88. Corrective Services NSW, *Submission MH17*, 10.
89. Corrective Services NSW, *Submission MH17*, 11.
90. Mental Health Review Tribunal, *Submission MH67*, 10.
91. NSW Bar Association, *Submission MH10*, 45-46; Legal Aid NSW, *Submission MH18*, 20.
92. Legal Aid NSW, *Submission MH18*, 20.
93. Mental Health Review Tribunal, *Submission MH57*, 19.

The Commission's view

10.49 Taking into consideration the submissions of stakeholders to this review and the conclusions of previous reviews, we agree that forensic patients should not be detained in correctional centres. However, at this point we do not recommend a total prohibition on such detention. Until there are other options for detention of forensic patients that provide secure environments (where needed) together with treatment and services, a prohibition on detention of forensic patients in correctional centres would be impractical and could, if implemented, potentially be a threat to community safety.

10.50 The resolution of the problems that we have identified, and that have been noted by previous reviews, depends upon the provision of resources for facilities for forensic patients. Secure facilities are required, but also the range of facilities must be adequate so that forensic patients can be stepped down towards leave and release in a timely fashion. In particular the lack of secure units for people with cognitive impairments in the forensic system should be addressed. These are matters for government and not outcomes that can be achieved solely by law reform.

10.51 However, strong concerns about detention of forensic patients in correctional centres have been raised consistently over many years. We find that it is appropriate to acknowledge these concerns in law by providing, as other jurisdictions have done, that forensic patients should only be detained in correctional centres where there is no other practical alternative. We recommend that the MHFPA be amended to this effect.

10.52 Such an amendment may have no immediate practical effect. However, it would serve as a reminder of the appropriate approach to decisions about detention of forensic patients. As more suitable facilities become available, it would ensure that decisions about detention are made in favour of detention outside correctional centres wherever this is possible and appropriate.

10.53 There are some additional issues that should be addressed as a matter of priority. We remain concerned that limiting terms are being administered as if they were non-parole periods, and that where a limiting term is set the whole term may be served in a correctional centre. This is of particular concern given our recommendation that limiting terms be set also for those found NMGI. A limiting term is the maximum period for which the person is to be classified a forensic patient, not the period for which the person must be detained. It is of the greatest importance, for community safety and the welfare of the patient, that while a person is classified as a forensic patient, treatment and services be provided to deal with issues of health, to address the behaviours that brought the person into the criminal justice system and to prepare that person for reintegration into the community, wherever that is possible.

10.54 We also have particular concerns about the detention of forensic patients with cognitive impairments. We note the steps taken by CSNSW to provide for those with cognitive impairments. Nevertheless, consideration should be given to the provision of secure facilities that are not correctional centres where issues of safety and service delivery can be provided for.

10.55 We recognise the complexity and difficulty of these issues and the challenges of their implementation in practice. Accordingly we propose that the Forensic Working Group referred to in Chapter 9 develop a strategy and implementation plan relating to the detention of forensic patients and that, as a priority, the Working Group consider the provision of facilities for people with cognitive impairments.

Recommendation 10.1

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should provide that forensic patients should only be detained in correctional centres where there is no other practical alternative.

Recommendation 10.2

The Forensic Working Group recommended in Recommendation 9.6 should develop a strategy and an implementation plan relating to:

(a) as a priority, the provision of facilities outside correctional centres for forensic patients who have cognitive impairments, and

(b) management of forensic patients within correctional centres that facilitates leave and release during the limiting term.

11. Forensic patients who present a risk of harm at the end of their limiting term

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11.1 In Chapter 7 we recommend that both people found not guilty by reason of mental illness (NGMI) and people found unfit and not acquitted at a special hearing (UNA) should be given a limiting term, to be calculated according to sentencing principles.[1] There may be some forensic patients who reach the end of a limiting term and still present a serious risk of harm to others if released into the community without the continued oversight of the Mental Health Review Tribunal (MHRT). There are likely to be very few such patients.

11.2 Nevertheless, in these circumstances, the issue arises whether there should be an ability for forensic patients to be detained or subject to continuing supervision in the community as a forensic patient beyond the expiry of their limiting term if they present a risk of harm to others. That is the focus of this chapter.

1. Recommendation 7.2.

Current framework

11.3 Currently under the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA), when a person's limiting term expires he or she ceases to be a forensic patient and, if he or she is being held in a mental health facility, must be released, or transferred into the civil mental health system.[2] The Forensic Division of the MHRT no longer retains supervision over that person.

11.4 There are, however, a number of other arrangements which may be used to manage forensic patients at the end of their limiting term who are at risk of harming themselves or others.

Civil mental health system

11.5 Where a forensic patient is approaching the end of his or her limiting term, the MHRT may reclassify him or her as an involuntary civil patient under the *Mental Health Act 2007* (NSW) (MHA).[3] This step may provide appropriate continuing care for many forensic patients, as well as providing protection for the community. Approximately one-fifth of forensic patients are currently transferred into the civil mental health system at the expiry of their limiting term.[4]

11.6 However, not all forensic patients will meet the admission requirement of being a "mentally ill person",[5] in order to be reclassified as an involuntary civil patient. In particular, people with a cognitive impairment or personality disorder will not, in the absence of a co-existing mental illness, come within the definition of "mentally ill person". Furthermore, patients detained under the civil mental health system can be released from a mental health facility more easily than forensic patients, on the decision of an authorised medical officer,[6] rather than requiring an order from the MHRT.

Guardianship

11.7 Guardianship arrangements may provide an alternative means of intervention for a forensic patient who has been released at the end of his or her limiting term. The Guardianship Tribunal can make an order appointing a guardian for a person who, by reason of a disability (including an intellectual disability or a mental illness) is totally or partially incapable of managing his or her person.[7] A guardianship order may include whatever powers for the guardian the Guardianship Tribunal considers appropriate.[8] Relevantly, the Tribunal may appoint a guardian to exercise a

2. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 52(2), s 53, s 54. The Act does not expressly require a forensic patient who is being held other than in a mental health facility to be released at the expiry of their limiting term. We discuss this issue and make recommendations for change in Chapter 9: see para 9.183-9.187.
3. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 53.
4. Mental Health Review Tribunal, *Submission MH67*, 5.
5. *Mental Health Act 2007* (NSW) s 12, s 14.
6. *Mental Health Act 2007* (NSW) s 41-43.
7. *Guardianship Act 1987* (NSW) s 3, s 14.
8. *Guardianship Act 1987* (NSW) s 16.

"restrictive practices" function. "Restrictive practices" are practices which restrict a person's movements or freedom, such as physical restraint or exclusionary "time out".[9] Guardians with a restrictive practices function can authorise the use of restrictive practices against the person subject to the order. Where this function has not been specifically granted to the guardian, it can be sought by requesting a review of the guardianship order.[10]

11.8 Therefore, it is possible for a guardian to authorise the detention of a person who continues to pose a risk of harm to others but who has ceased to be a forensic patient. However, the general principles underpinning the *Guardianship Act 1987* (NSW) state that the welfare and interests of a person with a disability "should be given paramount consideration".[11] These general principles focus solely on the best interests of the person subject to the order. The need for community protection is not a relevant principle. As there is no express legislative authorisation for the use of guardianship orders to detain a person who is at risk of harming others, a decision to restrain or detain a person subject to a guardianship order must be consistent with their best interests.[12]

11.9 There can sometimes be a tension between what is in the person's best interests and what is necessary to protect the community from harm.[13] Indeed, the notion of detention for the protection of the community can be difficult to reconcile with the function of guardianship as a substitute form of decision making. The Public Guardian has stated that it will consent to the confinement of a person for whom it is a guardian "where it is demonstrably in their interests", insofar as it prevents them from carrying out conduct (such as violent behaviour) which could expose them to criminal sanctions.[14] This is an indirect way of authorising confinement for community protection purposes.

11.10 However, to rely solely on guardianship arrangements to manage or detain a person who presents a significant risk of harm to the community may not always be sufficient to manage that risk. It is not the guardian's role to safeguard the community, although the guardian's decisions may have that effect.

Community Justice Program

11.11 The Community Justice Program, operated by the Office of the Senior Practitioner within Ageing, Disability and Home Care (ADHC), can be an option for the ongoing management of people with an intellectual disability who have ceased to be forensic

9. NSW Guardianship Tribunal, *Position Statement on Management of Challenging Behaviours in People with Dementia* (2006) 2.
10. See NSW Guardianship Tribunal, *Position Statement: Behaviour Intervention and Support in Applications Relating to a Person with an Intellectual Disability* (2004) 1.
11. *Guardianship Act 1987* (NSW) s 4(a).
12. See NSW Council for Intellectual Disability, *Submission MH12*, 2.
13. The difficulty of reconciling the best interests of the person with the need for community protection has been recognised elsewhere: NSW Sentencing Council, *Penalties Relating to Sexual Assault Offences in New South Wales*, Report (2009) [9.104]; 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* (2001) 54.
14. Legislative Council Standing Committee on Social Issues, Parliament of NSW, *Substitute Decision-Making for People Lacking Capacity* (2010) [10.4].

patients. The program provides accommodation and support services for people with an intellectual disability exiting the criminal justice system in order to minimise reoffending.[15] Intensive accommodation by way of 24 hour supervision in a safe environment is available for high risk clients.[16] To qualify for admission into the program, a person must:

- meet the ADHC criteria of having an "intellectual disability"
- have established contact with the criminal justice system and have served time in custody
- be at risk of serious reoffending, and
- lack other service availability.[17]

11.12 "Contact with the criminal justice system" and "risk of serious reoffending" means that:

- the person has served a custodial sentence, and has demonstrated a significant or imminent risk of reoffending and/or placing themself at risk of harm, or
- the person has allegedly committed a serious offence (eg murder, serious assault, sexual assault or serious arson), has been remanded into custody and subsequently received non-custodial orders, and has demonstrated a significant or imminent risk of reoffending and/or placing themself at risk of harm.[18]

11.13 However, the program only has a limited number of places available and demand exceeds availability.[19] Placement is only available to people who meet the ADHC definition of "intellectual disability", meaning some patients with cognitive impairments that do not meet this criteria will fall outside its scope. Furthermore, the Community Justice Program relies on guardianship arrangements as the legal framework for service delivery where the client does not, or cannot, consent to the program.[20]

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15. NSW Department of Human Services (Ageing, Disability and Home Care: Office of the Senior Practitioner), *Community Justice Program: Program Guidelines* (2010) 4-5. The Guidelines do not expressly make reference to forensic patients, but we are informed by stakeholders that forensic patients have been conditionally released into the Community Justice Program: NSW Council for Intellectual Disability, *Submission MH12*, 2; Mental Health Review Tribunal, *Submission MH67*, 6.
16. NSW Department of Human Services (Ageing, Disability and Home Care: Office of the Senior Practitioner), *Community Justice Program: Program Guidelines* (2010) 23.
17. NSW Department of Human Services (Ageing, Disability and Home Care: Office of the Senior Practitioner), *Community Justice Program: Program Guidelines* (2010) 10-11.
18. NSW Department of Human Services (Ageing, Disability and Home Care: Office of the Senior Practitioner), *Community Justice Program: Program Guidelines* (2010) 11.
19. The number of referrals to the Community Justice Program exceeds the number of available places: M Frize, "Supporting Offenders with an Intellectual Disability in the Community ... 10 Years On" (Presentation delivered at the NSW Council for Intellectual Disability conference, 17 February 2012) 34.
20. NSW Department of Human Services (Ageing, Disability and Home Care: Office of the Senior Practitioner), *Community Justice Program: Service Model Description, Intensive Residential Support Service* (2010) 16.

Conclusion

11.14 The options canvassed above lead to the conclusion that there will be a limited number of forensic patients who, at the end of their limiting term, present a risk of harm to the community or to themselves and for whom there are no existing options for management, given that:

- not all forensic patients will fall within the criteria for admission into the civil mental health system
- the legal framework of guardianship does not include a focus on community safety, and
- the Community Justice Program is limited in its scope and availability, and relies on the guardianship system as the legal framework to deliver services and restrict movement where the client does not, or cannot, consent.

11.15 Below we consider how many people might require ongoing management at the end of a limiting term, and how many might not already be catered for by the options outlined above.

Number of patients likely to be in need of ongoing management

11.16 The MHRT estimates that there would only be one or two cases each year where a person found UNA will both pose an ongoing risk of harm to others at the expiry of their limiting term and that risk cannot be dealt with under the civil mental health system.[21] However, those found UNA who received a limiting term represent only about 9% of forensic patients with finalised matters.[22]

11.17 The significant majority of the forensic population – over 90% – have been found NGMI. Limiting terms do not currently apply to people who are NGMI. These patients can only be released if the MHRT is satisfied that the patient's release would not seriously endanger the safety of the public.[23] However, in Chapter 7 we recommend that a limiting term should be nominated for forensic patients who are found NGMI.[24] This would increase the number of forensic patients who reach the end of a limiting term and, as a corollary, increase the number of forensic patients who may present as a risk at the end of a limiting term. It can be extrapolated therefore that the number of people who present a risk at the end of a limiting term will increase if our recommendation is implemented.

11.18 It is extremely difficult to predict the size of this increase. If those found UNA presently constitute about 9% of forensic patients, it may be that the number of people who present as a risk at the end of a limiting term and who cannot be otherwise dealt with satisfactorily will increase from an estimated 1-2 per year to

21. Forensic process roundtable, *Consultation MH35*.
22. See Chapter 7, Table 7.4. As at October 2012 there were 297 forensic patients who had been found NGMI and 29 forensic patients who had been found UNA and received a limiting term. These figures exclude forensic patients who have been found unfit and are awaiting finalisation of their matter.
23. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 43.
24. Recommendation 7.2.

10-20 per year. However, this estimate cannot be made with any confidence, for a number of reasons. First, those who are currently found UNA and receive a limiting term are likely to include more people with cognitive impairments than is the cohort of those found NGMI. Forensic patients with cognitive impairments, unless they have a co-existing mental illness, cannot be dealt with under the provisions of the MHA at the end of the limiting term. Secondly, the changes we recommend in chapters 3 and 12 in relation to NGMI, as well as our proposal to introduce a limiting term for NGMI, may increase the number of people who enter this plea. Lastly, the sentencing-based approach to setting a limiting term which we have suggested in Recommendation 7.2 may result in shorter limiting terms being imposed than is currently the case. Although this will increase the fairness of the system for many people, it may mean that some people will reach the end of a limiting term when they still pose a risk to the community.

11.19 It does seem, however, that the number of forensic patients who would need to be considered for a scheme of ongoing management at the end of a limiting term would continue to remain relatively small. Many forensic patients who present an ongoing risk will be able to be diverted into the civil mental health system, guardianship arrangements or the Community Justice Program at the expiry of their limiting term, which will be sufficient to manage the risk of harm. The concern, therefore, is for the small number of patients who continue to pose a risk of harm at the expiry of their limiting term and who cannot be adequately managed through other means.

11.20 We consider below the introduction of a scheme that will provide for the ongoing detention and supervision as a forensic patient of those people who pose a risk to the community that cannot otherwise be managed at the end of their limiting term. Any such scheme involves detention, of people who were mentally or cognitively impaired at the time of the offence or at the time of trial or both, for longer than the corresponding sentence imposed after conviction at an ordinary trial. Such a scheme should, accordingly, be entertained only after the most careful consideration.

Relevant principles

11.21 Preventative detention is detention not because of something a person has done, but because of something it is feared the person might do.[25] The High Court has stated, mostly recently in the context of legislation involving powers to detain sentenced prisoners beyond the completion of their sentence, that while constitutionally permissible, preventative detention is inconsistent with the general principle that involuntary detention should only be imposed as a consequence of a finding of criminal guilt for past acts.[26]

11.22 Preventative detention deprives a person of their right to liberty, a fundamental human right to which they would otherwise be entitled.[27] Detention of this nature

25. *McGarry v The Queen* [2001] HCA 62; 207 CLR 121 [61] (Kirby J).
26. *Fardon v A-G (Qld)* [2004] HCA 46; 223 CLR 575 [80] (Gummow J), [197] (Hayne J). See also *Kable v DPP (NSW)* (1996) 189 CLR 51, 106 (Gaudron J), 108 (McHugh J), 132 (Gummow J).
27. *Fardon v A-G (Qld)* [2004] HCA 46; 223 CLR 575 [150] (Kirby J).

may also violate the prohibition on arbitrary detention contained in article 9 of the International Covenant on Civil and Political Rights (ICCPR), unless it is based on grounds and procedures established by law, reasons are given and court control of the detention is available.[28] Detention of offenders for the protection of the community has been variously described by the High Court as "extraordinary",[29] "exceptional",[30] "not lightly to be made"[31] and "to be sparingly exercised, and then only in clear cases".[32] The Court is vigilant in ensuring that occasions for such preventative detention are not abused or extended for illegitimate purposes.[33]

11.23 However, the courts and international bodies have distinguished, as an exception to this principle, regimes for detention of people with mental illness who may pose a risk to the community.[34] In NSW, the detention of people who have been found UNA or NGMI is justified by the risk their release poses to others (that is, "what they might do") even when they have been found not to be criminally responsible for their acts and not subject to punishment.

11.24 In this chapter we are considering extending the management of forensic patients (including by way of detention) who have been set a limiting term and who would otherwise be entitled to be unconditionally released at the expiry of that term. In our view, strong justification is required for this step.

11.25 In what circumstances then should ongoing detention of a forensic patient beyond their limiting term be permissible? To be consistent with the principles of domestic and international law, such a scheme should contain clear grounds and procedures established in advance, reasons for the detention should be required and court control of the decision should be available. Furthermore, the criteria for the making of an order extending a person's limiting term should be sufficiently narrow that they are satisfied only in exceptional cases for legitimate purposes.

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28. Human Rights Committee, *General Comment No 8: Right to Liberty and Security of Persons*, 16th sess, UN Doc CCPR/C/GC/8 (30 June 1982) [4]. See also Human Rights Committee, *Views: Communication No 1090/2002*, 79th sess, UN Doc CCPR/C/79/D/1090/2002 (6 November 2003) [7.3]-[7.4] ("*Rameka v New Zealand*"); Human Rights Committee, *Views: Communication No 1629/2007*, 98th sess, UN Doc CCPR/C/98/D/1629/2007 (18 March 2010) [7.3]-[7.4] ("*Fardon v Australia*"); Human Rights Committee, *Views: Communication No 1635/2007*, 98th sess, UN Doc CCPR/C/98/D/1635/2007 (18 March 2010) [7.3]-[7.4] ("*Tillman v Australia*").
29. *Chester v The Queen* (1988) 165 CLR 611, 619; *McGarry v The Queen* [2001] HCA 62; 207 CLR 121 [61] (Kirby J).
30. *Buckley v The Queen* [2006] HCA 7; 80 ALJR 605 [7], [40].
31. *McGarry v The Queen* [2001] HCA 62; 207 CLR 121 [31].
32. *R v Moffatt* [1998] 2 VR 229, 255 (Hayne JA), approved by the High Court in *Thompson v The Queen* [1999] HCA 43; 73 ALJR 1319 [19] (Kirby J); *Buckley v The Queen* [2006] HCA 7; 80 ALJR 605 [44].
33. *Fardon v A-G (Qld)* [2004] HCA 46; 223 CLR 575 [217] (Heydon & Callinan JJ), see also [153] (Kirby J).
34. *Chu Kheng Lim v Minister for Immigration* (1992) 176 CLR 1, 28 (Brennan, Deane & Dawson JJ), 55 (Gaudron J); *Fardon v A-G (Qld)* [2004] HCA 46; 223 CLR 575 [2] (Gleeson CJ) ("No one would doubt the power of the Queensland Government to legislate for the detention of such people if they were mentally ill"); Human Rights Committee, *Views: Communication No 1629/2007*, 98th sess, UN Doc CCPR/C/98/D/1629/2007 (18 March 2010) [7.3] ("*Fardon v Australia*"); Human Rights Committee, *Views: Communication No 1635/2007*, 98th sess, UN Doc CCPR/C/98/D/1635/2007 (18 March 2010) [7.3] ("*Tillman v Australia*").

11.26 In this regard, it is clear that the need for protection of the community can be the only justification for the making of an order. Detention for treatment or punitive reasons should not justify the extension of a person's limiting term.

11.27 In Chapter 8 we recommend that the test for release of a forensic patient be formulated in terms of whether the forensic patient's release poses a significant risk of serious physical or psychological harm to others.[35] If this is the test for detention or release of a forensic patient during their limiting term, then by implication the test for detention beyond a limiting term should adopt this standard, at least as a minimum. Arguably the test should be even stricter.

Submissions and consultations

11.28 We discussed the options for managing forensic patients who present a risk of harm at the end of their limiting term at a roundtable with stakeholders on 9 October 2012,[36] and we also separately consulted with the MHRT.

11.29 Stakeholders were generally wary of introducing a scheme of preventative detention that would operate beyond the expiry of a limiting term. There was concern that a scheme of extended detention would detract from the provision of services in the community, and that there should instead be greater attention directed towards improving services. Stakeholders were also concerned that it may be unfair to create a general scheme of preventative detention for forensic patients, when there is no general scheme that applies to convicted offenders.[37]

11.30 The MHRT submitted that the ability in the MHFPA to transfer forensic patients into the civil mental health system at the expiry of their limiting term adequately provides for the ongoing treatment of people with mental illnesses when they cease to be a forensic patient. However, the MHRT expressed concern that there are people who have a cognitive impairment, or a mental condition to which the MHA does not apply, who pose a significant risk to the public but who do not meet the criteria for transfer into the civil system.[38] The MHRT submitted that from a risk management perspective, it is imperative that there be an ability to manage a forensic patient beyond their limiting term where there is a risk of harm to the public.

Options for reform

11.31 There are several possible ways to deal with the continued risk of harm posed by a forensic patient at the end of their limiting term. Approaches include applying existing legislation providing for preventative detention of convicted offenders to forensic patients, extending a person's status as a forensic patient in appropriate

35. See Recommendation 8.1.
36. Forensic process roundtable, *Consultation MH35*.
37. At the time of consultation the only scheme of preventative detention in NSW applied to serious sex offenders. This has now been extended to high risk violent offenders: *Crimes (Serious Sex Offenders) Amendment Act 2013* (NSW).
38. Mental Health Review Tribunal, *Submission MH57*, 23.

cases, or developing alternative forms of supervision. We discuss a number of approaches below.

11.32 Preventative detention of those at risk of causing serious harm to the community is not novel. Currently in NSW preventative detention may be ordered for high risk sex offenders and high risk violent offenders. Our starting point below is therefore to describe and consider the existing preventative detention schemes for high risk offenders.

Option 1: Apply or adapt the scheme for continued supervision of high risk offenders

The scheme

11.33 Continued supervision of high risk sex offenders and high risk violent offenders is dealt with by the *Crimes (High Risk Offenders) Act 2006* (NSW) (CHROA). Under the CHROA, the State (acting through the Attorney General) may apply to the Supreme Court for an "extended supervision order" or a "continuing detention order" in respect of a high risk sex offender or high risk violent offender who is due to be released from custody within the following six months.[39]

11.34 The inclusion of high risk violent offenders within the CHROA was provided for by the *Crimes (Serious Sex Offenders) Amendment Act 2013* (NSW), following a recommendation of the NSW Sentencing Council to this effect.[40]

11.35 The CHROA applies to sex offenders and violent offenders over the age of 18 years who have been sentenced to imprisonment following conviction for a serious sex offence or a serious violence offence respectively.[41] "Serious sex offence" is defined by reference to specific offences in the *Crimes Act 1900* (NSW).[42] "Serious violence offence" is defined to mean a serious indictable offence that is constituted by a person:

> (a) engaging in conduct that causes the death of another person or grievous bodily harm to another person, with the intention of causing, or while being reckless as to causing, the death of another person or grievous or actual bodily harm to another person, or
>
> (b) attempting to commit, or conspiring with or inciting another person to commit, an offence of a kind referred to in paragraph (a).[43]

11.36 A sex offender or violent offender is classed as a "high risk sex offender" or "high risk violent offender" where the Supreme Court is satisfied to a high degree of probability that the offender poses an unacceptable risk of committing a serious sex

39. *Crimes (High Risk Offenders) Act 2006* (NSW) s 5I, s 6, s 13B, s 14.
40. NSW Sentencing Council, *High-Risk Violent Offenders: Sentencing and Post-Custody Management Options*, Report (2012) Recommendation 4.
41. *Crimes (High Risk Offenders) Act 2006* (NSW) s 4 (definition of "sex offender" and "violent offender").
42. *Crimes (High Risk Offenders) Act 2006* (NSW) s 5(1).
43. *Crimes (High Risk Offenders) Act 2006* (NSW) s 5A.

offence or serious violence offence (as the case may be) if he or she is not kept under supervision.[44]

11.37 The Supreme Court may make a continuing detention order or an extended supervision order in respect of such offenders. The CHROA provides a list of considerations to which the court must have regard when making this decision.[45] In the case of a continuing detention order, the court must also be satisfied that adequate supervision would not be provided by an extended supervision order.[46] A continuing detention order will require the offender to be detained in a correctional centre for the duration of the order.[47] An extended supervision order may direct the offender to comply with such conditions as the court may consider appropriate. These can include, for example, a requirement to report to a corrective services officer, participate in treatment and rehabilitation programs, wear electronic monitoring equipment, or not associate or make contact with specific people.[48]

The process

11.38 Upon an application by the State, a preliminary hearing is to be held within 28 days. If the Supreme Court is satisfied that the matters alleged in the application would, if proved, justify the making of an extended supervision or continuing detention order, it must order that two qualified psychiatrists or psychologists separately examine the offender and furnish a report to the court.[49] The Supreme Court may also make an interim order for supervision or detention for a period not exceeding 28 days.[50]

11.39 A continuing detention order or extended supervision order can be made for a period of up to five years, although the State may make subsequent applications for further orders.[51] However, the Supreme Court does not always make orders for the full five years, particularly where the order is one of continuing detention.[52]

11.40 It should be noted that the provisions in the CHROA have come under judicial scrutiny a number of times, in particular, what is meant by the phrase "unacceptable risk".[53]

Legality of the scheme

11.41 In *Fardon v Attorney-General (Qld)*[54] the High Court upheld the constitutionality of the *Dangerous Prisoners (Sexual Offenders) Act 2003* (Qld), which is in terms

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44. *Crimes (High Risk Offenders) Act 2006* (NSW) s 5B(2), s 5E(2).
45. *Crimes (High Risk Offenders) Act 2006* (NSW) s 9(3), s 17(4).
46. *Crimes (High Risk Offenders) Act 2006* (NSW) s 5D(1), s 5G(1).
47. *Crimes (High Risk Offenders) Act 2006* (NSW) s 20.
48. *Crimes (High Risk Offenders) Act 2006* (NSW) s 11.
49. *Crimes (High Risk Offenders) Act 2006* (NSW) s 7, s 15.
50. *Crimes (High Risk Offenders) Act 2006* (NSW) s 10A, s 10C(1), s 18A, s 18C(1). The interim order may be renewed, but the total period cannot exceed three months: s 10C(2), s 18C(2).
51. *Crimes (High Risk Offenders) Act 2006* (NSW) s 10, s 18.
52. NSW Sentencing Council, *Penalties Relating to Sexual Assault Offences in NSW*, Report (2009) Appendix B; see also, eg, *State of NSW v Brookes* [2010] NSWSC 728; *State of NSW v Thomas (Final)* [2009] NSWSC 1410.
53. See the discussion in NSW Sentencing Council, *High-Risk Violent Offenders: Sentencing and Post-Custody Management Options*, Report (2012) [4.160]-[4.173].

similar to the CHROA. The Court referred to the long history of preventative detention schemes as part of its finding that the Act did not impair the institutional integrity of the Queensland Supreme Court.[55] However, in *Fardon v Australia* and *Tillman v Australia*, the UN Human Rights Committee found that both the Queensland and NSW legislation were contrary to the prohibition on arbitrary detention contained in article 9 of the ICCPR.[56] In respect of the CHROA, the UN Human Rights Committee stated:

> The [CHROA], on the one hand, requires the Court to have regard to the opinion of psychiatric experts on future dangerousness but, on the other hand, requires the Court to make a finding of fact of dangerousness. While Courts are free to accept or reject expert opinion and are required to consider all other available relevant evidence, the reality is that the Courts must make a finding of fact on the suspected future behaviour of a past offender which may or may not materialise. To avoid arbitrariness, in these circumstances, the State party should have demonstrated that the [offender's] rehabilitation could not have been achieved by means less intrusive than continued imprisonment or even detention.[57]

11.42 The Australian Government has disputed these findings, submitting that it did in fact demonstrate that there were no less restrictive means available to meet the objectives of the legislative schemes.[58]

11.43 Therefore, preventative detention of offenders for community protection purposes does not of itself contravene article 9 of the ICCPR, but it must be demonstrated that less intrusive alternatives have been expressly considered and found to be unsuitable.

Service delivery integration

11.44 In its Report, *Post-Custody Management Options for High Risk Violent Offenders*, the NSW Sentencing Council expressed concern about the possible difficulty that high risk violent offenders who are subject to supervision in the community may have in gaining access to the full range of support services that they require.[59] To this end, it recommended that legislation be introduced which requires State government agencies to cooperate with each other to provide appropriate services

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54. *Fardon v A-G (Qld)* [2004] HCA 46; 223 CLR 575.
55. *Fardon v A-G (Qld)* [2004] HCA 46; 223 CLR 575 [13], [20] (Gleeson CJ), [83] (Gummow J), [217] (Callinan & Heydon JJ).
56. Human Rights Committee, *Views: Communication No 1629/2007*, 98th sess, UN Doc CCPR/C/98/D/1629/2007 (18 March 2010) [7.4] ("*Fardon v Australia*"); Human Rights Committee, *Views: Communication No 1635/2007*, 98th sess, UN Doc CCPR/C/98/D/1635/2007 (18 March 2010) [7.4] ("*Tillman v Australia*").
57. Human Rights Committee, *Views: Communication No 1635/2007*, 98th sess, UN Doc CCPR/C/98/D/1635/2007 (18 March 2010) [7.4(4)] ("*Tillman v Australia*").
58. Australian Government, "Response of the Australian Government to the Views of the Committee in Communication No. 1635/2007 Tillman v Australia and Communication No. 1629/2007 Fardon v Australia", Communication to the Human Rights Committee [16] <http://www.ag.gov.au/RightsAndProtections/HumanRights/DisabilityStandards/Documents/TillmanvAustralia-AustralianGovernmentResponse.pdf>.
59. NSW Sentencing Council, *High-Risk Violent Offenders: Sentencing and Post-Custody Management Options*, Report (2012) [5.28].

to high risk violent offenders who are on community-based supervision orders, and to require information to be shared between agencies to facilitate such support.[60]

11.45 This recommendation was based on the scheme in operation in England and Wales known as the Multi-Agency Public Protection Arrangements (MAPPA).[61] Under that model, the relevant legislation imposes a duty on a number of named agencies to cooperate with the responsible MAPPA authority in the provision of services to high risk offenders in the community.[62] However, this recommendation was not implemented by the recent *Crimes (Serious Sex Offenders) Amendment Act 2013* (NSW).

Application to forensic patients

11.46 One possible way of managing a forensic patient who presents a risk of harm at the end of their limiting term would be to apply the scheme under the CHROA to forensic patients.

11.47 However, the CHROA would require amendment to deal with forensic patients. The scheme under this Act has been designed for convicted offenders who are serving a term of imprisonment. Forensic patients have not been convicted of an offence and, in a large majority of cases, will be held in a mental health facility, or even on conditional release, rather than in prison. Further, there already exists the MHRT, an expert tribunal that makes decisions about the management, detention and release of forensic patients, and it is arguably in the interests of the public and the patient that it continue to supervise forensic patients during any extended period of detention.

11.48 The issue of cost is also important. The process for obtaining an order under the CHROA can be costly and time consuming,[63] but the scheme has only been applied to a small number of people.[64] Given that there are potentially a higher number of forensic patients to which the scheme could apply, costs are likely to increase.

11.49 Notwithstanding this, the scheme under the CHROA has a number of advantages. First, the decision to extend a person's detention is made by a Supreme Court judge. Decision making at this level is arguably appropriate given the challenge to the fundamental principles of human rights that is presented by detention solely for the purpose of community protection. Secondly, there are a number of safeguards in place which ensure the power to order detention is only used in very exceptional cases. There is a requirement for two independent experts to examine the person and the threshold for the making of the order by the Supreme Court is high. Finally,

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60. NSW Sentencing Council, *High-Risk Violent Offenders: Sentencing and Post-Custody Management Options*, Report (2012) Recommendation 3.
61. NSW Sentencing Council, *High-Risk Violent Offenders: Sentencing and Post-Custody Management Options*, Report (2012) [5.27]-[5.33].
62. *Criminal Justice Act 2003* (UK) c 44, s 325(3), cited in NSW Sentencing Council, *High-Risk Violent Offenders: Sentencing and Post-Custody Management Options*, Report (2012) [5.32].
63. NSW Sentencing Council, *Penalties Relating to Sexual Assault Offences in NSW*, Report (2009) [9.146].
64. As at 1 September 2010, 27 offenders were the subject of extended supervision orders and only two offenders were the subject of continuing detention orders: NSW Department of Justice & Attorney General, *Review of the Crimes (Serious Sex Offenders) Act 2006*, Report (2010) 20.

consistency between the processes and procedures that apply to forensic patients at the end of a limiting term, and those that apply to convicted offenders at completion of a sentence, is desirable.

11.50 We note with approval the express requirement in the recommendations of the Sentencing Council for agencies to cooperate with one another in service delivery, although this was not implemented by the recent legislative amendments. Lack of cooperation between service providers has been identified by stakeholders as a significant barrier in the successful reintegration of forensic patients back into the community. Stakeholders at our roundtable consultation in October 2012 were generally in support of the Sentencing Council's recommendation to adopt a UK MAPPA style approach to inter-agency cooperation.[65] If NSW is to take the step of continuing the detention of forensic patients beyond their limiting term, or of offenders beyond their sentence, that continued detention should not be because of a failure of service delivery but only because there are no other options available to ensure the safety of the community.

Option 2: Proposal by the Mental Health Review Tribunal

11.51 The MHRT has proposed an alternative system of ongoing supervision and/or detention for patients who reach the expiry of their limiting term and present a significant risk of serious harm to others due to a mental condition or developmental disability, but who do not meet the criteria for involuntary detention in the civil mental health system.[66]

11.52 Under this proposal:[67]

(1) The MHRT may, at a review, classify a patient as a "Compulsory Patient" if the patient's limiting term will expire in the following six months.

(2) A Compulsory Patient classification may be made if the MHRT is satisfied that:

(a) the person is suffering from a mental condition or developmental disability and, owing to that condition, there are reasonable grounds for care, treatment and control of the person to be necessary:

(i) for the person's own protection from serious harm, or

(ii) for the protection of others from serious harm, and

(b) no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available.

(3) Following a classification of a person as a Compulsory Patient, the MHRT may order the patient's continued detention in a mental health facility or elsewhere, or discharge the patient into the community subject to a Compulsory Supervision Order.

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65. Forensic process roundtable, *Consultation MH35*.
66. Mental Health Review Tribunal, *Submission MH57*, 30.
67. Mental Health Review Tribunal, *Submission MH57*, 31-39.

(4) A Compulsory Supervision Order may be made if the MHRT decides that:

(a) no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the patient and that the patient would benefit from the order, and

(b) an agency (nominated in the order) has an appropriate supervision plan for the patient and is capable of implementing it.

(5) The Compulsory Patient's status must be reviewed every three months, although this period may be extended.

(6) On review, the treating team/supervising agency bears the onus of demonstrating that the person continues to pose a risk, and that there is no less restrictive alternative available. The MHRT may continue, vary or revoke an order for detention or supervision.

(7) There should be a similar appeal mechanism from MHRT decisions as that which is available to civil patients under the MHA.

11.53 We asked for submissions on the MHRT's proposal at our roundtable consultation in October 2012. Stakeholders expressed concern at the lack of judicial safeguard in the MHRT proposal, as the decision to classify a person as a Compulsory Patient and thereby order their continued detention is to be made by the MHRT. Stakeholders also noted that there is no general system of preventative detention for convicted offenders who pose a risk of harm at the end of their sentence, and therefore a system of ongoing detention for forensic patients may operate to treat people with cognitive and mental health impairments in a discriminatory manner.[68]

11.54 The advantage of the MHRT's proposal is that it has been developed specifically for forensic patients who present a risk of harm at the expiry of their limiting term, rather than being adapted from a scheme of preventative detention designed for convicted high risk offenders. The decision to classify a person as a Compulsory Patient is made by the MHRT, which will be responsible for monitoring the person during both their limiting term and their period as a Compulsory Patient and, because it is a specialist tribunal, may be better placed than a court to assess risk. It allows for ongoing supervision and review by the MHRT, which is important in ensuring that the person is appropriately managed in accordance with their treatment needs. Finally, the requirement for it to be positively established at a review that the person continues to present a risk of harm and that no other care of a less restrictive kind is available ensures so far as is possible that the person will not be subject to any greater restrictions than are necessary.

11.55 The criteria for the making of a Compulsory Patient classification and a Compulsory Supervision Order have been drafted to align with the respective tests in the civil mental health system for involuntary detention and the making of a compulsory treatment order.[69] There is merit in adopting an approach that allows for consistency, so far as possible, with provisions for involuntary detention of civil

68. Forensic process roundtable, *Consultation MH35.*

69. *Mental Health Act 2007* (NSW) s 12, s 14, s 53.

patients, and which allows the MHRT to adopt a decision making framework with which it is already familiar.

11.56 However, the test for Compulsory Patient status is set at a fairly low threshold: there needs only to be "reasonable grounds" for believing that care, treatment and control is necessary for the protection from serious harm. This low threshold is inconsistent with the general proposition, discussed above, that preventative detention is an extraordinary step to be reserved for exceptional cases only. Where a forensic patient would otherwise be entitled to be unconditionally released at the expiry of their limiting term, aligning the test for extension of their term with the less onerous test applicable in the civil mental health system may not be appropriate.

11.57 Furthermore, the making of a Compulsory Supervision Order is predicated on an agency having an appropriate supervision plan for the patient and being able to implement it. We note that the same requirement applies for the making of a compulsory treatment order under the civil mental health system. However, we are concerned that the release of a Compulsory Patient would be conditional on the availability of services, rather than a decision to release being made on its merits, and requiring service providers to respond. A Compulsory Patient should not be subject to detention beyond the length of their limiting term because of a shortage of resources or a decision to allocate resources elsewhere.

11.58 Finally, three monthly reviews may be unrealistic and counterproductive. Where a patient is still a risk of harm at the end of their limiting term, it is unlikely that a change in their level of risk will occur within such a short period. It may be more desirable and a better utilisation of resources to align the reviews with those which currently occur for forensic patients, namely at six monthly intervals.[70]

Option 3: Reverse the current presumption of detention when the limiting term is reached

11.59 In decisions regarding the release of a forensic patient during their limiting term, a "presumption in favour of detention" currently applies: the MHRT *must not* make an order for release unless it is satisfied that the safety of the patient or any member of the public *will not* be seriously endangered by the patient's release.[71]

11.60 Another option for reform is to reverse the presumption in favour of detention at the end of a forensic patient's limiting term. That is, rather than unconditionally discharging the patient at the end of their limiting term, as is currently the position,[72] there could be a provision that, at the end of a forensic patient's limiting term, the MHRT *must* make an order for release unless it is satisfied that the safety of the

70. See *Mental Health (Forensic Provisions) Act 1990* (NSW) s 46.

71. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 43(a). The MHRT must also be satisfied that less restrictive care is appropriate and reasonably available or that the patient does not require care: see s 43(b).

72. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 52(2), s 54.

patient or any member of the public *will* be seriously endangered by the patient's release. This approach is currently in place in Victoria.[73]

11.61 Under this option:

(a) forensic patients would generally be released upon expiry of their limiting term, although they may be detained if they present a clear risk to themself or the public

(b) the MHRT would have the power to impose conditions on a person's release at the expiry of their limiting term, if necessary to protect the safety of the person or the public, and

(c) the forensic patient's detention or conditional release would be subject to the usual regular reviews by the MHRT.

11.62 This option has the benefit of allowing the MHRT to continue to manage a forensic patient beyond the expiry of their limiting term where considered necessary to manage that person's risk of harm, while at the same time only permitting ongoing detention where it can be positively established that the person's release would seriously endanger the public. Such an approach gives greater flexibility than the current position under the MHFPA where, at the expiry of their limiting term, the person ceases to be a forensic patient and must be transferred into the civil system or unconditionally discharged. Furthermore, save for the shift in presumption, a forensic patient would be treated in the same way beyond the expiry of their limiting term as they are during it. Minimal legislative change would be required to give effect to this option.

11.63 However, having recommended the introduction of limiting terms for both people found UNA and NGMI, we are not persuaded that reversing the presumption of detention is an appropriate option for managing risk of harm. It may be viewed as effectively removing the limiting term, as there will no longer be a definite end date for release for any forensic patient. The certainty of release would be removed for all forensic patients in order to provide for a very few exceptional cases involving people who continue to pose a serious risk of harm at the end of their limiting term.

Option 4: Civil scheme of involuntary detention for people with cognitive impairments

11.64 As the MHRT has noted, one of the problems with the current law is the lack of options for managing a person beyond the expiry of his or her limiting term who does not meet the criteria for admission into the civil mental health system.[74] Primarily, this pertains to forensic patients with cognitive impairments. There is no

73. *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 28, s 32, s 35. However, the Victorian Law Reform Commission has recently been asked to review the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, including whether changes should be made to the provisions governing supervision and review: see Victorian Law Reform Commission, "Crimes (Mental Impairment): Terms of Reference" (24 August 2012) <http://www.lawreform.vic.gov.au/projects/crimes-mental-impairment/crimes-mental-impairment-terms-reference>.

74. Mental Health Review Tribunal, *Submission MH57*, 23.

parallel system of involuntary detention for people with cognitive impairments, such as that which applies to people with a mental illness under the MHA. Guardianship arrangements are strongly focused on the best interests of the person and are not designed to manage ongoing risk of harm to the public. The Community Justice Program is an important initiative, but it is a non-legal framework that applies only to those who meet the ADHC definition of "intellectual disability" and relies on consent to admission (either by the person or through their guardian).

11.65 One possible option for reform, therefore, would be to create a civil system of involuntary detention or supervision for people with cognitive impairments.

11.66 In Victoria, the *Disability Act 2006* (Vic) allows for the making of a civil "supervised treatment order", to enable the detention of a person with an intellectual disability who poses a significant risk of serious harm to others.[75] The scheme was established specifically in response to a report of the Victorian Law Reform Commission, which noted the lack of an equivalent to involuntary detention in the civil mental health system for people with an intellectual disability.[76]

11.67 Under that scheme, a supervised treatment order may be made by the Victorian Civil and Administrative Tribunal on application by a disability services provider.[77] There must be a previously exhibited pattern of violent or dangerous behaviour and a significant risk of serious harm to another person which cannot be substantially reduced by less restrictive means.[78]

11.68 A supervised treatment order must require the person to reside in premises approved by the disability services provider, and it may also attach conditions or require the person to participate in specified treatment.[79] It cannot be in force for a period greater than one year, although consecutive applications can be made.[80]

11.69 In our view the introduction of a scheme of involuntary detention for people with cognitive impairments is not a feasible option for reform, for a number of reasons. First, while it may be desirable to create a secure facility for people with cognitive impairments as an alternative to detaining them in prison, the creation of a general civil scheme for the involuntary detention of people with cognitive impairments is outside the scope of our review and is likely to have significant resource and service delivery implications.[81] Secondly, we have not consulted with stakeholders on this option although, on the basis of our consultations, we expect that there would be

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75. *Disability Act 2006* (Vic) s 183.
76. Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care*, Final Report (2003) [1.21]-[1.24]; Victoria, *Parliamentary Debates*, Legislative Assembly, 1 March 2006, 417 (SM Garbutt).
77. *Disability Act 2006* (Vic) s 191(1). This may include people serving a custodial supervision order under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) and who are being held in a residential treatment facility for the compulsory treatment of people with an intellectual disability: see *Disability Act 2006* (Vic) s 152.
78. *Disability Act 2006* (Vic) s 191(6).
79. *Disability Act 2006* (Vic) s 193(3)(b), (4).
80. *Disability Act 2006* (Vic) s 193(3)(d), (5).
81. We do, however, recommend that an action plan be developed to provide for additional and improved options for the detention, care and community support of forensic patients with a cognitive impairment: see Recommendation 1.1.

concerns within the community about the introduction of such a scheme. Finally, it addresses only the problem of people with cognitive impairments who pose a risk of harm at their end of their limiting term. It leaves untouched people with complex needs, or personality disorders, who may not fit within the definition of "mentally ill person" in the MHA nor be considered to have a cognitive impairment.

Option 5: Requirement to release at the end of a limiting term

11.70 The final option is simply to keep the legislative scheme as it currently stands: at the end of a limiting term, a forensic patient ceases to be classified as such. If the person meets the criteria for involuntary admission under the MHA then the MHRT could reclassify him or her as a civil patient. Otherwise, the person will be discharged. Guardianship orders could be made in appropriate cases.

11.71 This is the current situation for those found UNA, but would represent a significant change for the NGMI group, which is a greater number.

11.72 Under this option there will be some forensic patients who pose a risk of harm to the public who are released back into the community at the end of their limiting term. However, it could be argued that forensic patients should be treated no differently than convicted offenders, who are released at the end of their sentence regardless of the risk of harm that they may pose to the community (other than high risk sex offenders and high risk violent offenders).

11.73 We do not consider this option desirable. In light of the evidence from the MHRT that there are forensic patients, albeit perhaps not very many, who continue to present a risk of harm at the end of their limiting term, and in light of recent legislative changes which extend preventative detention to high risk violent offenders, an automatic requirement to release does not appear desirable. Furthermore, the introduction of a limiting term for people found both UNA and NGMI will increase the likelihood of forensic patients reaching the end of their limiting term and being a risk of harm to the public. In those exceptional circumstances, there needs to be a way for the MHRT to continue to manage people as forensic patients in order to prevent harm occurring to the community.

The Commission's view

Should there be a scheme to manage forensic patients who present a risk of harm at the end of their limiting term?

11.74 The continued management of forensic patients beyond the expiry of their limiting term, particularly by way of detention, is an exceptional step. The entitlement of a person to be released as a forensic patient at the expiry of their limiting term should not be abrogated unless for good reason.

11.75 We note the concerns of Australian courts and international tribunals about preventative detention in the criminal context and their view that such a step should be taken only in exceptional circumstances and with suitable protections. We take seriously the views of many stakeholders attending our roundtable consultation that

forensic patients should not be subject to further restrictions on their liberty following the expiry of their limiting term, apart from those that may be imposed under civil regimes.

11.76 There is no generally applicable scheme of preventative detention for convicted offenders in the criminal justice system except for high risk sex offenders and high risk violent offenders, for whom the Supreme Court considers that there is an unacceptable risk of serious reoffending. We are informed by the MHRT and by others in consultation, that there are a small number of forensic patients who present a serious risk to the community at the end of a limiting term and who cannot be managed in any way other than by continuation as a forensic patient. This number is likely to increase with the implementation of Recommendation 7.2 that people found NGMI should be given a limiting term. We expect that the group of forensic patients with whom we are concerned will have committed similar offences, and be at a similar unacceptable risk of serious reoffending, as those convicted offenders currently covered by the CHROA.

11.77 In these circumstances, despite the concerns outlined above about preventative detention, we are persuaded on balance that the need for community protection justifies making provision to extend a person's forensic patient status, subject to careful safeguards. In our view this is an appropriate counterbalance to our recommendation that limiting terms be applied to people found NGMI.

Which model should apply?

11.78 We favour a scheme for forensic patients that is consistent with the provisions that apply to offenders subject to a sentence of imprisonment. Therefore we recommend a scheme that entrusts to the Supreme Court the decision to extend a person's forensic patient status beyond the expiry of his or her limiting term. Such an extraordinary step, with serious consequences for the forensic patient, should be taken only by an independent judge and only following satisfaction to a high standard. While the MHRT is an expert tribunal for the ongoing review of the status of forensic patients, continued detention at the end of a limiting term is a different and significant decision and it is appropriate that that decision be taken by a different and independent decision maker at a high level. The significance accorded to this decision in respect of high risk offenders is indicated by the requirement in the CHROA that an order be made by the Supreme Court, and we can discern no reason why any different or lesser significance should be accorded to decisions about the continued detention of forensic patients.

11.79 Consistency with the CHROA does not, however, mean that the scheme applying to forensic patients should be precisely the same. As we discuss in para 11.47, as a matter of practicality, an ongoing management scheme for forensic patients should differ from that which will apply to convicted offenders serving a term of imprisonment in some respects. For instance the CHROA is framed around the fact that the person concerned has committed a serious offence and the risk that justifies continued detention or supervision is the unacceptable risk of serious reoffending. Because forensic patients have not been convicted of an offence, the nature of the risk must be differently framed. The CHROA also assumes that the person concerned is held under a sentence of imprisonment, whereas this is not the case for forensic patients.

11.80 Further, forensic patients are regularly reviewed and managed by an expert body, the MHRT, in accordance with the legislative framework of the MHFPA. If continued detention or supervision were to be ordered at the end of a limiting term it is highly desirable that the MHRT should continue that process during the period of continued detention or supervision.

11.81 Our preferred model is therefore a hybrid of the scheme established under the CHROA and the scheme proposed by the MHRT. Under this model, the initial decision to extend a person's forensic patient status would be made by the Supreme Court using, for the most part, the process set out in the CHROA. However, instead of ordering continued detention (or extended supervision), the Supreme Court would order a continuation of the person's status as a forensic patient. If the Supreme Court makes an order to extend the forensic patient's status, the matter would be referred back to the MHRT, where the person would continue to be managed as a forensic patient. The provisions that allow for extension orders could be included in an amended CHROA, or in the MHFPA.

11.82 In outline, the process would be as follows:

(1) Six months prior to the expiry of the forensic patient's limiting term, a Minister responsible for administering the MHFPA, acting on behalf of the State, may apply to the Supreme Court for extension of a person's forensic patient status (an "extension order").

(2) The provisions in the CHROA pertaining to pre-trial procedures and the making of interim orders should be followed. This includes a pre-trial hearing and the commissioning of two independent expert reports.

(3) The test for the making of an order should be consistent with that in the CHROA to the greatest extent possible: the Supreme Court may make an extension order if the Supreme Court is satisfied to a high degree of probability that:

(a) the person poses an unacceptable risk of causing serious physical or psychological harm to others if the person were to cease to be a forensic patient, and

(b) that risk cannot be adequately managed by other less restrictive means (for example, reclassification as an involuntary patient under the civil mental health system or the making of a guardianship order).

(4) In making the order the Supreme Court is to have regard to certain considerations, including:

(a) the safety of the community

(b) the reports prepared by the independent experts appointed by the court, and any other expert reports submitted by the parties

(c) any orders or decisions of the MHRT

(d) the person's level of compliance with any obligations imposed while they are a forensic patient, especially while they were on leave or conditional release

(e) the views of the court at the time the limiting term was imposed, and

(f) a report from the forensic patient's treating team which would include information about the need for ongoing management of the person as a forensic patient and the reasons why arrangements that do not involve continued supervision or detention, including measures available under civil mental health and guardianship systems, are not appropriate.

(5) The Supreme Court may make an order for up to five years, although subsequent applications may be made. In determining the length of the order, the court must have regard to whether the person's level of risk is likely to change significantly.

(6) If an order is made, the person is referred back to the MHRT for ongoing management as a forensic patient.

(7) The MHRT is to review the person every six months. It may make any of the orders that it has the power to make in respect of a forensic patient except an order for unconditional release.

(8) The Supreme Court may make an order at any time revoking the extension order, on the application of either the State or the forensic patient, including on the ground that circumstances have changed significantly so as to render the extension order unnecessary.

(9) At the end of the extension order the person would cease to be a forensic patient unless another order is sought and made.

Test for the making of an extension order

11.83 Under our proposed scheme, the test for the making of an extension order is twofold. First, the Supreme Court must be satisfied to a high degree of probability that the person presents an unacceptable risk of causing serious physical or psychological harm to another person if an extension order is not made. This high threshold creates parity with the test for high risk sex offenders and high risk violent offenders to the greatest extent possible and reflects the seriousness of the consequences of an extension order.

11.84 The CHROA determines the extension of a person's detention and supervision by reference to the risk of criminal reoffending. Forensic patients have in strict legal terms not been found to have "offended" and their impairments may mean that, though they may do unlawful acts, they may not "offend" in the future. The test of "unacceptable risk of the person causing serious physical or psychological harm to others" is, we believe, more appropriate in the context of forensic patients. It indicates that only clear risks with grave consequences for other members of the community can justify the making of an order. The terminology is also consistent with our proposed test for decision making under the MHFPA.[82]

11.85 The second part of the test requires the Supreme Court to be satisfied to a high degree of probability that the risk cannot be adequately managed through less restrictive means. This directs the Supreme Court to consider whether alternative

82. See Recommendation 8.1.

arrangements, such as transfer into the civil mental health system or the making of a guardianship order, would be sufficient to manage the risk of harm posed by the person. The availability of other non-legal programs, such as the Community Justice Program, could also be taken into account by the Court. This requirement will ensure that extension orders are only made where there is no other way of adequately managing the risk. It will also prevent a "net widening" of the application of this scheme. In reality, we expect that there will be many cases where the civil mental health system, a guardianship order or entry into the Community Justice Program will be sufficient to manage the person's risk. We are aware, for example, that guardianship orders have been used as an alternative to a continuing detention order under the CHROA.[83]

Factors to be taken into account

11.86 The factors that we recommend the Supreme Court should take into consideration when making the order are broadly consistent with those that currently apply under the CHROA, but adapted for forensic patients.[84] The reports prepared by the treating professionals and the independent experts will obviously provide crucial information on the person's behaviour as a forensic patient, on the reasons why a need for ongoing management arises, and the extent to which the person can be reasonably and practicably managed through alternative means.

Length of the order

11.87 The length of the order is set at a maximum period of five years, although subsequent orders can be made. This length of time is consistent with the CHROA. When deciding the length of the order, the Supreme Court should take into consideration whether the person's level of risk is likely to change significantly. A longer order may have greater justification where a forensic patient's level of risk is likely to be unchanging, perhaps because the person is unresponsive to treatment or other interventions. It follows that a shorter order may be appropriate where a forensic patient accepts and is responding to forms of treatment or interventions which could affect the level of risk. In any event, the length of the order will be offset by the six monthly reviews conducted by the MHRT, which will provide opportunities for review of the forensic patient's condition and conditional and supervised release in appropriate cases. We would anticipate that, given the ongoing supervision of forensic patients by the MHRT, the court may be inclined to make longer orders for forensic patients in appropriate cases.

Test on review by the MHRT

11.88 We consider that on review the MHRT should apply the same tests that it applies for any other forensic patients under the MHFPA, except that where an extension order has been made by the Supreme Court, the MHRT should not be able to order unconditional release. The Supreme Court order will be authority for the continuation of the person's forensic patient status beyond the expiry of their limiting term, but once this judicial authority is obtained the person will continue to be

83. NSW Sentencing Council, *Penalties Relating to Sexual Assault Offences in NSW*, Report (2009) [6.67].

84. See *Crimes (High Risk Offenders) Act 2006* (NSW) s 9, s 17.

managed as a forensic patient in the usual way. We do not see that there is need for the creation of a separate scheme of ongoing management. To do so would be likely to cause undue confusion and duplication.

11.89 The limitation on the power of the MHRT to make orders for unconditional release for this group of patients will still allow the MHRT to respond to changing levels of risk, by ordering leave and conditional release in appropriate cases. However, where an extension order is made, we expect it would be unlikely that a person would satisfy the requirements for conditional release.

Additional issues

11.90 The CHROA allows for an order made under that Act to be varied or revoked by the Supreme Court at any time on application by the State or the offender,[85] including where the Court is satisfied that circumstances have changed sufficiently so as to render the order unnecessary.[86] We recommend that the Supreme Court have a similar power in relation to an order extending a person's forensic patient status. We also recommend that the provisions in the CHROA relating to rights of appeal, costs and victim statements[87] should be applied to forensic patients.

11.91 Certain provisions of the MHFPA will also require consequential amendment, such as the meaning of "forensic patient" and the circumstances in which a person ceases to be a forensic patient.[88]

11.92 Finally, the provision of support and supervision to a forensic patient may be required to reduce that person's level of risk of harm to others. It would be unjust if such services or supports were not delivered, with the consequence that the person remained detained as a forensic patient under this proposed regime. Ongoing supervision or detention as a forensic patient should only be justified where this is the only way of adequately managing a risk of harm to others, and not because of a lack of available services. In Chapter 9 we recommend that a Forensic Working Group be established to develop a framework for cross agency supervision and support of forensic patients, including information sharing arrangements and arrangements for continuing care when a person ceases to be a forensic patient.[89] That Working Group could beneficially consider implementation of the scheme proposed in this chapter. Service availability is of even greater importance for forensic patients who are retained within the forensic system beyond their limiting term. Accordingly, we support the Sentencing Council recommendation in favour of inter-agency cooperation in the provision of services.

Recommendation 11.1

(1) A provision should be included in the *Crimes (High Risk Offenders) Act 2006* (NSW) or the *Mental Health (Forensic Provisions) Act 1990* (NSW) to allow for a person's forensic patient status to be extended

85. *Crimes (High Risk Offenders) Act 2006* (NSW) s 13, s 19.
86. *Crimes (High Risk Offenders) Act 2006* (NSW) s 13(1B), s 19(1B).
87. *Crimes (High Risk Offenders) Act 2006* (NSW) pt 4.
88. See *Mental Health (Forensic Provisions) Act 1990* (NSW) s 42, s 52.
89. Recommendations 9.6, 9.7, 9.13.

beyond the expiry of the person's limiting term in defined circumstances.

(2) The Supreme Court should make the decision to extend a person's forensic patient status, broadly following the process for the making of an extended supervision order or continuing detention order under the *Crimes (High Risk Offenders) Act 2006* (NSW). The scheme should include the following features:

(a) Six months prior to the expiry of the forensic patient's limiting term, a Minister responsible for the administration of the *Mental Health (Forensic Provisions) Act 1990* (NSW), acting on behalf of the State, may apply to the Supreme Court for extension of a person's forensic patient status (an "extension order") if there are reasonable grounds to believe that the person poses an unacceptable risk of causing serious physical or psychological harm to others if the person were to cease to be a forensic patient.

(b) The provisions in the *Crimes (High Risk Offenders) Act 2006* (NSW) relating to pre-trial procedures and the making of interim orders should be followed, including provision for a pre-trial hearing and the commissioning of two independent expert reports.

(c) The Supreme Court should be able to make an extension order for a forensic patient if the court is satisfied to a high degree of probability that:

(i) the person poses an unacceptable risk of causing serious physical or psychological harm to others if the person were to cease to be a forensic patient, and

(ii) that risk cannot be adequately managed by other less restrictive means (such as reclassification as an involuntary patient under the civil mental health system or through the making of a guardianship order).

(d) In making the order the Supreme Court should have regard to the following considerations:

(i) the safety of the community

(ii) the reports prepared by the independent experts appointed by the court, and any other expert reports submitted by the parties

(iii) any orders or decisions of the Mental Health Review Tribunal

(iv) the person's level of compliance with any obligations imposed while a forensic patient including while on leave or conditional release

(v) the views of the court at the time the limiting term was imposed

(vi) a report from the forensic patient's treating team as to the need for ongoing management of the person as a forensic patient and the reasons why alternative arrangements are not suitable.

(e) The Supreme Court should be able to make an extension order for up to five years, although subsequent applications may be

made. In determining the length of the order, the court should have regard to whether the person's level of risk is likely to change significantly.

(f) If an order is made, the person should be referred back to the Mental Health Review Tribunal for ongoing management as a forensic patient.

(g) The Mental Health Review Tribunal should review the person every six months and may make any order in relation to that person that it can make for a forensic patient, except an order for unconditional release.

(4) The Supreme Court should be able to make an order at any time revoking an extension order on the application of the State or the forensic patient, including on the ground that circumstances have changed significantly so as to render the extension order unnecessary.

(5) The scheme should include the provisions of Part 4 of the *Crimes (High Risk Offenders) Act 2006* (NSW).

12. Fitness and NGMI in the Local and Children's Courts

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12.1 In this chapter we consider the current application and operation of fitness procedures and the defence of mental illness in the Local and Children's Courts. We identify significant deficiencies with the current regime, and we recommend revision so these courts may apply the provisions on fitness and the defence of mental illness that are contained in the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA).

Fitness procedures in the Local Court

12.2 The Local Court deals with the vast majority of criminal matters in NSW.[1] Its jurisdiction has been expanded, with the result that it now regularly determines relatively serious cases.[2]

12.3 The requirement that a defendant be fit to be tried is a fundamental tenet of the common law applicable in all courts, including the Local Court. A defendant must be fit to plead to the charge against him or her, and to stand trial for that charge. In NSW, a person's fitness is determined in accordance with the *Presser* criteria.[3] We review the *Presser* test in Chapter 2. In essence, that test requires a consideration of whether or not the defendant can do those things that are necessary if a fair trial is to take place, including being able to: understand the charge; generally understand the proceedings and evidence; and provide instructions to counsel.

12.4 While a defendant must be fit to be tried in any court, the District and Supreme Courts have prescribed procedures that follow a finding of unfitness and the courts have particular powers to deal with defendants who are found unfit and are not acquitted (UNA) at a special hearing. However, this legal framework, which we discuss in Chapters 6 and 7, does not apply in the Local Court.

12.5 An outline is provided below to remind readers of the procedures for dealing with fitness in the Supreme and District Courts. This is followed by an outline of the options available in the Local Court.

Supreme and District Courts

12.6 The procedures following a finding of unfitness in the Supreme and District Courts are found in Part 2 of the MHFPA.[4] Briefly, where a court finds a person unfit it first refers the defendant to the Mental Health Review Tribunal (MHRT), which assesses the defendant and makes a determination about whether the defendant is likely to become fit within 12 months.[5]

12.7 Broadly speaking, if the MHRT finds the person likely to become fit within 12 months, he or she remains under the supervision of the MHRT until it determines that the person has become fit or the 12 month period expires.[6] For some defendants, appropriate treatment will improve their health, and they can be tried in the usual way. During this period of review and treatment, unless the defendant is released on bail, he or she becomes a forensic patient.[7] Where a defendant is

1. In 2011, 115 206 people were charged in the Local Court of NSW. Of these 6% received a prison sentence, with an average length of minimum/fixed terms of 5.7 months. The District Court registered 3540 cases, and 138 cases were registered in the Supreme Court: NSW Bureau of Crime Statistics and Research, *NSW Local Court Summary Statistics* 2007–2011.
2. A list of indictable offences that can now be heard summarily in the Local Court of NSW is itemised at *Criminal Procedure Act 1986* (NSW) ch 5 and sch 1.
3. *R v Presser* [1958] VR 45, 48.
4. For a detailed examination of procedures that follow a finding of unfitness see Chapter 6.
5. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 16.
6. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 47.
7. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 14, s 42.

found to be unfit to stand trial and likely to remain so for a period of 12 months or the period of 12 months expires, the court conducts a special hearing.[8] Special hearings reflect, as far as is possible, a normal criminal trial, although the orders available at the completion of the hearing are limited.

12.8 At a special hearing, the court may:

- acquit the defendant
- find the defendant not guilty by reason of mental illness (NGMI), or
- find that, on the limited evidence available, the defendant committed the offence charged, that is unfit and not aquitted (UNA).

Either of the latter two findings is highly likely to have the outcome that the defendant will be detained and referred to the MHRT as a forensic patient. These matters are discussed in Chapter 7.

12.9 In Chapters 2, 6 and 7 of this report we make recommendations to simplify, update and improve the test for fitness and the procedures following a finding of unfitness in the Supreme and District Courts, in particular to streamline the process for dealing with fitness cases.

Current regime in the Local Court

12.10 When the Local Court holds a fitness inquiry it is not required to follow the processes of the MHFPA, nor does it have the consequent powers in relation to the disposition of the person.[9] Currently, when fitness is raised in the Local Court the court may:

(1) determine whether the defendant is fit to stand trial, having regard to the *Presser* criteria,[10] and if the defendant is unfit:

  (a) divert the defendant under Part 3 of the MHFPA, or

  (b) discharge the defendant.

(2) divert the defendant without first making a determination concerning the defendant's fitness, or

(3) adjourn or stay proceedings.

These options are explored further below.

8. Subject to advice from the Director of Public Prosecutions: *Mental Health (Forensic Provisions) Act 1990* (NSW) s 19(2). For a discussion on special hearings see Chapter 6.

9. *Mackie v Hunt* (1989) 19 NSWLR 130, 135-6 (referring to the precursor to s 32, *Crimes Act 1900* (NSW) s 428W).

10 See Local Court of NSW, *Submission MH4*, 1. *Presser* is discussed in Chapter 2.

Diversion

12.11 Section 32 and s 33 of the MHFPA allow the Local Court to divert defendants who have a cognitive or mental health impairment into treatment. These provisions are considered in Report 135.[11] Section 32 allows the court to dismiss the charge and discharge an eligible defendant unconditionally or subject to conditions. Such conditions can involve compliance with a plan for treatment or engagement with services. Section 33 allows the court to refer a mentally ill person to a mental health facility for assessment. In relation to minor offences, the person may not return to court. In relation to more serious matters, the person may return after treatment. These provisions can be invoked at the commencement of proceedings or at any time during the course of proceedings before a magistrate. They can therefore be used in relation to people who are, or may be, unfit.

12.12 The Local Court also has other powers that may be used for diversionary purposes, including granting bail with conditions that may include engagement with services. The court may also engage defendants with services as a sentencing option following conviction.

Discharge

12.13 There may be situations in which a magistrate decides that a defendant is unfit but it is not appropriate to deal with the defendant in accordance with the diversionary procedures outlined above. For example, diversion under s 32 may not be appropriate because the alleged offence is serious, the defendant has an extensive criminal history, or previous diversion under the MHFPA was not effective.[12]

12.14 If diversion is not appropriate it would appear that the only option available to the court is to discharge the defendant. The common law position is dealt with in *Mantell v Molyneaux.*[13] In that case it was held, following the decision of the High Court of Australia in *Ngatayi v The Queen,*[14] that if a defendant is found not fit to be tried and there is no applicable statutory procedure, then he or she must be discharged. Paradoxically, diversion may therefore be available for less serious offences, but for more serious offences the Local Court must dismiss the charges. The court then has no powers to refer the defendant to treatment or services that may deal with the causes of offending. In some circumstances, if the offence is an indictable offence, the Crown may choose to proceed by way of *ex officio* indictment in the District Court where fitness procedures are subject to Part 2 of the MHFPA.[15]

Adjournment or a stay of proceedings

12.15 Magistrates have the power to adjourn proceedings and can use that power if proceedings against a defendant are likely to be an abuse of process. However, any

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11. See NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) Ch 9, 10.
12. See Local Court of NSW, *Submission MH4,* 2; *Mantell v Molyneux* [2006] NSWSC 955; 68 NSWLR 46.
13. *Mantell v Molyneux* [2006] NSWSC 955; 68 NSWLR 46 [28].
14. *Ngatayi v The Queen* (1980)147 CLR 1, 7-8.
15. *Mantell v Molyneux* [2006] NSWSC 955; 68 NSWLR 46 [28]; *Grassby v R* (1989) 168 CLR 1, 14; *Criminal Procedure Act 1986* (NSW) s 8(2)-(3).

trial must be relisted within two years from the date of adjournment.[16] Therefore adjournment may be appropriate where unfitness is temporary, but it is of limited utility if the unfitness is enduring.[17] Where the cause of the defendant's unfitness is responsive to treatment, bail conditions may be used to secure treatment.

12.16 The Local Court can order a permanent stay of proceedings to prevent an unfair trial.[18] The power to stay proceedings resides in the magistrate when hearing a summary offence or an indictable offence heard summarily.[19] A stay of proceedings more usually occurs where there has been undue delay equating to an abuse of process,[20] and is an "extreme step" that is not widely employed.[21] It is not a power designed or suited to assist in the case of unfitness.

12.17 In *R v KF*,[22] an application to permanently stay proceedings for an indictable offence to be heard summarily was made by a defendant who claimed to be unfit to be tried. In this case the magistrate did not find the defendant to be unfit. However, the magistrate observed that there is a "hiatus in respect of legislative direction on fitness to be tried issues in the Local Court"[23] and that the appropriate process when a defendant is found unfit in the Local Court is to dismiss the charge and discharge the defendant.[24]

A guilty plea when unfit

12.18 It has been suggested that, in practice, unfit defendants in the Local Court frequently plead guilty.[25] O'Carroll argues that they may do so in order to expedite proceedings, to accept incentives such as a reduced charge or sentence reduction, and/or because they do not understand the charge or the consequences of the charge.[26] This unsatisfactory situation was highlighted in the 2010 Queensland Court of Appeal case *R v AAM*,[27] in which the defendant pleaded guilty to 15 summary offences in the Toowoomba Magistrates Court between 2001 and 2003. The defendant had a significant intellectual impairment, and was later found permanently unfit by the Mental Health Court.[28] The Queensland Court of Appeal set aside the Magistrates Court's convictions. President McMurdo criticised the lack of processes to deal with unfit defendants in the Magistrates Court, and

16. *Criminal Procedure Act 1986* (NSW) s 40(3).
17. D Howard and B Westmore, *Crime and Mental Health Law in New South Wales* (LexisNexis Butterworths, 2nd ed, 2010) 261.
18. *Jago v District Court of NSW* (1989) 168 CLR 23, 25, 31.
19. *DPP v Shirvanian* (1998) 102 A Crim R 180, 185; *Jago v District Court of NSW* (1989) 168 CLR 23*; R v KF* [2011] NSWLC 14 [9].
20. *Jago v District Court of NSW* (1989) 168 CLR 23.
21. *Jago v District Court of NSW* (1989) 168 CLR 23, 30.
22. *R v KF* [2011] NSWLC 14.
23. *R v KF* [2011] NSWLC 14 [8].
24. *R v KF* [2011] NSWLC 14 [14].
25. B O'Carroll, "Intellectual Disabilities and the Determination of Fitness to Plead in the Magistrates' Courts" (2013) 37 *Criminal Law Journal* 51, 58.
26. B O'Carroll, "Intellectual Disabilities and the Determination of Fitness to Plead in the Magistrates' Courts" (2013) 37 *Criminal Law Journal* 51, 57.
27. *R v AAM; Ex parte A-G (Qld)* [2010] QCA 305.
28. *R v AAM; Ex parte A-G (Qld)* [2010] QCA 305 [3], [5].

recommended that law reform was needed to address the "hiatus in the existing criminal justice system".[29]

12.19 O'Carroll argues that a guilty plea may have considerable impacts on an unfit defendant's life. For instance, a criminal record may further increase the difficulties that a person with a cognitive or mental health impairment has in accessing appropriate housing and employment. Unfit defendants may accrue a lengthy criminal history and risk receiving a custodial sentence.[30]

Conclusion

12.20 In summary, the current situation in the Local Court is anomalous and unsatisfactory. Defendants charged with minor offences may be diverted, whereas those charged with more serious offences may have to be discharged without supervision or treatment.[31] The absence of a defined legislative pathway for unfitness in the Local Court also means that it is possible for defendants to lose the chance of outright acquittal in appropriate cases, either after a special hearing or after treatment has enabled them to be fit for a normal trial. It would also appear that some unfit defendants plead guilty and are wrongly convicted and punished.[32]

Jurisdictional review

12.21 In Tasmania, the ACT, SA and WA, legislation prescribes procedures and powers for courts of summary jurisdiction where defendants are found to be unfit.[33]

12.22 Tasmanian legislation makes little distinction between fitness in the Local and Supreme Courts, except that fitness in the Supreme Court is to be determined by a jury rather than by the judicial officer.[34] In both cases the court can, in agreement with the parties, dispense with an investigation into fitness and record a finding of unfit to stand trial.[35] Following a finding of unfitness both courts must proceed to conduct a special hearing, at which a number of verdicts are available.[36]

12.23 Pursuant to the *Criminal Law Consolidation Act 1935* (SA), SA fitness procedures[37] also apply to all courts.[38]

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29. *R v AAM; Ex parte A-G (Qld)* [2010] QCA 305 [9].
30. B O'Carroll, "Intellectual Disabilities and the Determination of Fitness to Plead in the Magistrates' Courts" (2013) 37 *Criminal Law Journal* 51, 51-52.
31. Where the prosecution does not elect to proceed with an *ex officio* indictment in the District Court: *Mantell v Molyneux* [2006] NSWSC 955; 68 NSWLR 46.
32. B O'Carroll, "Intellectual Disabilities and the Determination of Fitness to Plead in the Magistrates' Courts" (2013) 37 *Criminal Law Journal* 51, 57.
33. See *Crimes Act 1900* (ACT) pt 13 div 13.1, 13.2, 13.4, 13.6; *Criminal Law Consolidation Act 1935* (SA) pt 8A, especially s 269A(1) (definition of "judge"); *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) pt 2-3; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 4(1), pt 2; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 5; *Criminal Procedure (Mentally Impaired Persons) Act 2003* (NZ) s 4(1) (definition of "court").
34. *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 12.
35. *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 19(a).
36 *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 15, s 17.
37. These procedures are described in Chapter 6.
38. *Criminal Law Consolidation Act 1935* (SA) s 296A (definition of "judge" includes a magistrate).

12.24 In WA, the question of whether a defendant is fit to stand trial may be raised in a court of summary jurisdiction at any time before or during the trial.[39] The court decides on the balance of probabilities after inquiring into the question and informing itself in any way the court thinks fit.[40] If the court finds that the defendant is not fit to stand trial, and will not become fit within six months, then it must make an order dismissing the charge and either release the defendant or make a custody order.[41] A custody order has the effect that the defendant will be detained in an "authorised hospital", a "declared place", a detention centre, or a prison, as determined by the Mentally Impaired Accused Review Board, until released by an order of the Governor.[42] A custody order can only be made where the statutory penalty for the alleged offence is imprisonment and the court is satisfied that a custody order is appropriate, having regard to factors such as the strength of the evidence, the nature and circumstances of the alleged offence, the defendant's personal circumstances and the public interest.[43]

12.25 Similarly, unfitness procedures in the ACT apply in both the Magistrates and Supreme Courts. If a question of unfitness is raised in the Magistrates Court, and the court is satisfied that there is a real and substantial question about the defendant's fitness to plead, the court must adjourn the trial and reserve the question for investigation.[44] The court must then conduct an investigation into whether the defendant is unfit to plead.[45] If the court finds the defendant unfit to plead and unlikely to become fit within 12 months, then it must conduct a further hearing, similar in nature to a special hearing.[46] If, at the hearing, the Magistrates Court is satisfied beyond reasonable doubt that the defendant engaged in the conduct required for the offence charged, the court may make any orders it considers appropriate, including the detention of the defendant in custody until the ACT Civil and Administrative Tribunal (ACAT) orders otherwise,[47] or the referral of the defendant to ACAT for the making of a mental health order.[48] Where a person has been found unfit in respect of a "serious offence",[49] the magistrate *must* order detention or referral to ACAT.[50]

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39. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 11(1)(a).
40. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 12. For the test that applies in determining fitness in all courts in WA, see s 9.
41. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 16(2), s 16(5).
42. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 24(1).
43. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 16(6).
44. *Crimes Act 1900* (ACT) s 314(1), s 315.
45. *Crimes Act 1900* (ACT) s 315A.
46. *Crimes Act 1900* (ACT) s 315C.
47. Exercising its jurisdiction under the *Mental Health (Treatment and Care) Act 1994* (ACT).
48. *Crimes Act 1900* (ACT) s 335(4). A "mental health order" is an order for the involuntary detention, care or treatment of a person who has a mental illness or is mentally dysfunctional, and where there are reasonable grounds for believing that the person is likely to do serious harm to themselves or to someone else, or suffer serious mental or physical deterioration: see *Mental Health (Treatment and Care) Act 1994* (ACT) s 28, s 36.
49. Defined as an offence involving actual or threatened violence or an offence against s 27(3) or (4) of the *Crimes Act 1900* (ACT): see s 334(8).
50. *Crimes Act 1900* (ACT) s 335(2).

12.26 The Victorian Magistrates' Court does not have jurisdiction to hear fitness cases,[51] and both Queensland[52] and the NT's fitness regimes[53] exclude the Local Court.

Submissions and consultations

Should the Local Court have fitness procedures?

12.27 In CP 6 we asked whether fitness procedures should apply in the Local Court and, if so, how they should be framed.[54] We proposed for discussion a simplified procedure that could apply in the Local Court, namely that the Local Court have the power to order reports, inquire into fitness and make orders - including orders for diversion, or an order that the defendant become a forensic patient.[55]

12.28 Implementing a statutory fitness regime in the Local Court received wide support from stakeholders.[56] However, concerns were raised about the consequences of this step; for example, the potential of any fitness regime to: diminish the role of diversion; facilitate the extended detention of defendants who would otherwise be released; strain resources; and increase the forensic population.

12.29 The majority of stakeholders supported a fitness regime that would operate only when options for diversion were exhausted.[57] It was argued that diversion is usually the most appropriate option when faced with an unfit defendant in the Local Court, and prioritising diversion would limit the number of potential fitness inquiries and defendants entering the forensic system. Importantly, diversion procedures help to ensure that defendants will not be inappropriately detained.

12.30 A number of submissions raised concerns about the possibility that the introduction of fitness procedures in the Local Court might result in the detention of people found unfit to be tried as forensic patients where the charges against them are not serious.[58] To ameliorate these concerns, the Chief Magistrate of the Local Court submitted that procedures to order that an unfit defendant become a forensic patient could be limited to particular offences (for example, offences that involve an element of subjective intent and/or indictable offences that may be dealt with

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51. *CL v Lee* [2010] VSC 517; 29 VR 570.
52. *Mental Health Act 2000* (Qld) s 256 (applies only to indictable offences).
53. *Criminal Code* (NT) s 43L (the question of fitness is to be determined by a jury).
54. 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 6.11.
55. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences*, Consultation Paper 6 (2010) [1.48].
56. Local Court of NSW, *Submission MH4,* 1-2; Shopfront Youth Legal Centre, *Submission MH7*, 15; NSW Bar Association, *Submission MH10*, 14-15; NSW Consumer Advisory Group, *Submission MH11*, 15-16; Law Society of NSW, *Submission MH13*, 6; Legal Aid NSW, *Submission MH18*, 7; Public Interest Advocacy Centre, *Submission MH21*, 15-16; Children's Court of NSW, *Submission MH24*, 1-2; NSW, Public Defenders, *Submission MH26*, 22-3.
57. Local Court of NSW, *Submission MH4*, 1-2; Shopfront Youth Legal Centre, *Submission MH7*, 15; NSW Bar Association, *Submission MH10*, 14-15; Public Interest Advocacy Centre, *Submission MH21*, 15-16; NSW, Public Defenders, *Submission MH26*, 22-3.
58. Shopfront Youth Legal Centre, *Submission MH7*, 15; NSW Bar Association, *Submission MH10*, 14; NSW Consumer Advisory Group, *Submission MH11*, 15.

summarily).[59] We note also that under the fitness regime provided for in the MHFPA, the court and the MHRT have options other than detention open to them when making orders about unfit defendants.[60]

12.31 The NSW Police Force opposed the extension of fitness procedures, primarily because, it was said, the Local Court does not have sufficient resources to support such a proposal.[61] It was submitted that the costly and complex procedures which follow an inquiry into unfitness, while appropriate for serious offences, may be disproportionately burdensome in relation to minor offences.

Options for Local Court fitness procedures

12.32 With the exception of the reservations of the NSW Police Force concerning cost, all submissions supported extending fitness procedures to the Local Court in some form.[62] Some submissions supported the "simplified fitness procedure" suggested for discussion in CP 6, while others proposed alternative models, including transfer to the District Court and extending the current fitness procedures available to the District and Supreme Courts to the Local Court.[63]

12.33 Below we review the proposal suggested in CP 6 and two other options that arise from submissions, and conclude that extending the operation of fitness provisions in the MHFPA to the Local Court provides the most practicable solution.

12.34 **Option 1: Simplified fitness procedure.** In CP 6, we proposed that magistrates have the power to:

- order a psychological assessment of the defendant
- determine the question of fitness
- determine whether the defendant should be
  - (a) acquitted
  - (b) diverted under Part 3 of the MHFPA, or
  - (c) made a forensic patient and referred to the supervision of the MHRT.[64]

12.35 The Local Court observed that the current powers exercisable by a magistrate already include most of these options.[65] Fitness may be determined by reference to

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59. Local Court of NSW, *Submission MH4*, 3.
60. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 14, s 47(2).
61. NSW Police Force, *Submission MH47*, 4.
62. Local Court of NSW, *Submission MH4*, 1-2; Shopfront Youth Legal Centre, *Submission MH7*, 15; NSW Bar Association, *Submission MH10*, 14-15; NSW Consumer Advisory Group, *Submission MH11*, 15-16; Law Society of NSW, *Submission MH13*, 6; Legal Aid NSW, *Submission MH18*, 7; Public Interest Advocacy Centre, *Submission MH21*, 15-16; Children's Court of NSW, *Submission MH24*, 1-2; NSW, Public Defenders, *Submission MH26*, 22-23.
63. NSW Bar Association, *Submission MH10*, 14-15; NSW, Public Defenders, *Submission MH26*, 22-23.
64. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences*, Consultation Paper 6 (2010) [1.48].

the *Presser* test and the magistrate has a discretion to discharge or divert.[66] The Local Court pointed out that:

> it would be erroneous to assume that, in the absence of a statutory scheme, the Local Court does not deal with cases in which fitness to stand trial is in issue.[67]

The Local Court supported the addition of a power to detain defendants as forensic patients alongside its existing powers, and this also received support from the Law Society of NSW, Legal Aid NSW and the Children's Court. [68]

12.36 However, other stakeholders expressed concern about potential inconsistency and confusion created by having two fitness regimes.[69] The NSW Bar Association also questioned the appropriateness of a "simplified" fitness procedure given the importance of the often complicated issue of fitness.[70]

12.37 **Option 2: Transfer cases involving fitness to the District Court.** Where the question of fitness is raised, another option is for the case to be transferred to the District Court for the determination of fitness in accordance with the process set out in Part 2 of the MHFPA.

12.38 The Public Interest Advocacy Centre (PIAC) supported the general determination of fitness in the Local Court and the subsequent ability for the magistrate to make orders discharging or diverting the defendant. However, PIAC submitted that the Local Court is not the appropriate forum for questions of fitness where there are serious and real risks to members of the community if the defendant is not held in a secure environment. PIAC proposed that magistrates be given a general power of referral to the District Court when unfitness is raised and there is a finding, on the balance of probabilities, that the defendant's release would represent a serious risk of harm to the community.[71] We note that PIAC's proposal would require magistrates to make a prima facie finding of the risk posed by the defendant, in circumstances where the defendant's fitness to be tried has not been determined. This may be a complex and time consuming task for magistrates to undertake, and such an interlocutory hearing is likely to increase costs and delay.

12.39 In Report 80, *People with an Intellectual Disability and the Criminal Justice System*, we considered the viability of transferring fitness issues from the Local Court to the District Court, but did not support transfer at that time. We concluded that magistrates are capable of holding a fitness inquiry with the assistance of appropriate expert reports, and that transfer would cause unnecessary delay.[72]

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65. Local Court of NSW, *Submission MH4*, 3.
66. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 32, s 33.
67. Local Court of NSW, *Submission MH4*, 1.
68. Law Society of NSW, *Submission MH13*, 6; Legal Aid NSW, *Submission MH18*, 7; Children's Court of NSW, *Submission MH24*, 1.
69. NSW Bar Association, *Submission MH10*, 14-15; NSW, Public Defenders, *Submission MH26*, 22-3.
70. NSW Bar Association, *Submission MH10*, 15.
71. Public Interest Advocacy Centre, *Submission MH21*, 16.
72. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) [5.74].

12.40 **Option 3: Extend the MHFPA.** In Report 80 we recommended a procedure that sought to limit the number of fitness inquiries that would come before the Local Court.[73] We proposed that, where the issue of fitness is raised (whether by the defence, the prosecution or the court), the magistrate would first consider the possible application of s 32 or s 33 of the MHFPA. At this stage, fitness would not need to be established according to the *Presser* criteria. The complex issue of fitness would only need to be considered in a minority of cases where diversion was not appropriate.

12.41 If diversion is not appropriate, the Local Court could hold a fitness inquiry. If the defendant was found unfit to be tried, we proposed that the matter proceed according to the fitness and special hearing procedures currently applicable in the District and Supreme Courts.

The Commission's view

12.42 The present situation in the Local Court for defendants who are, or may be, unfit is unsatisfactory and should be addressed. It is important that the procedures in the Local Court for defendants who are, or may be, unfit are adapted to the needs of a court that deals with a wide range of cases. Where possible, consistently with the interests of fairness and justice, procedures should be simple and inexpensive.

12.43 We therefore recommend that, when an issue of fitness is raised in the Local Court, the court should first consider the appropriateness of diversion under s 32 and s 33 of the MHFPA. Diversion does not impose a conviction but does involve referral to treatment or services that can deal with the causes of offending.

12.44 Noting in this context our recommendations in Report 135 for the improvement of these provisions for diversion,[74] the recommended changes would increase the availability and effectiveness of diversion and be available for a wider range of cases. Fitness procedures, which are more complex and costly, should be deployed only in relation to serious offences where diversion is not appropriate.

12.45 If diversion is inappropriate, then the existing procedures under the statutory fitness regime of the MHFPA should apply in the Local Court. This approach has the advantage of consistency across the courts of NSW. Our recommendations in this report provide for the improvement and simplification of these procedures. Allowing these procedures to be applied in the Local Court would avoid the delay and expense of referring such cases to the District Court.

12.46 We note the concerns of stakeholders that making the provisions of Part 2 of the MHFPA available in Local Courts may mean that a defendant will be made a forensic patient in relation to trivial matters. However, the availability of diversion and the requirement that it be considered prior to any determination of fitness would meet that objection. We note also that, under Part 2 of the MHFPA, detention as a

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73. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) Recommendation 23.

74. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) Ch 9, 10.

forensic patient is not inevitable, and other options are available, including treatment in the community.

Recommendation 12.1

(1) The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended so that Part 2 of the Act, dealing with fitness to be tried, applies in the Local Court.

(2) The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that, if the question of fitness is raised in the Local Court under Part 2 of the Act, the court must first consider whether it should make an order under s 32 or s 33 of the Act.

Fitness in committal proceedings in the Local Court

Current law

12.47 Committal proceedings occur in the Local Court when a person is charged with an indictable offence that is not to be heard summarily.[75] These proceedings are a preliminary assessment of the evidence against the defendant to determine whether there is sufficient evidence to warrant the person being required to stand trial.[76] Committal proceedings provide an opportunity for early discharge,[77] and, importantly, allow the defendant to screen and test the evidence in appropriate cases.[78]

12.48 Fitness procedures under the MHFPA do not apply to committal proceedings,[79] and in practice fitness is rarely raised at committal. This may be because the defence wants to receive the benefit of hearing the prosecution case.[80] The effect of raising fitness in a committal hearing would appear to be that the magistrate is required to discontinue the proceedings.[81] The prosecution may then choose to file an *ex officio* indictment in a higher court where the issue of fitness can be raised and applicable procedures followed;[82] however, the opportunity of testing the prosecution case at a committal hearing is then lost.

12.49 The effect of raising fitness in a committal proceeding arose in the NT case of *Ebatarinjan v Deland*[83] which reviewed the provisions of the *Justices Act* (NT). As with the current situation in NSW, the NT did not have a legislative regime at that time to deal with unfitness in committal proceedings.

75. See *Criminal Procedure Act 1986* (NSW) pt 2.
76. *Criminal Procedure Act 1986* (NSW) s 3 (definition of "committal proceedings"); Local Court of NSW, *Submission MH4*, 3.
77. See *Criminal Procedure Act 1986* (NSW) s 66.
78. *Grassby v The Queen* (1989) 168 CLR 1, 15.
79. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 31.
80. NSW, Public Defenders, *Submission MH26*, 23.
81. *Ebatarinja v Deland* [1998] HCA 62; (1998) 194 CLR 444; *R v Plummer* [2012] NTSC 30; cf *Pioch v Lauder* (1976) 13 ALR 266.
82. *Ebatarinja v Deland* [1998] HCA 62; 194 CLR 444 [34].
83. *Ebatarinja v Deland* [1998] HCA 62; 194 CLR 444.

12.50 The case concerned a defendant who was illiterate and speech and hearing impaired, and who had been charged with murder and two other indictable offences. During the course of the committal proceedings the magistrate stated a special case to the Supreme Court asking whether the proceedings should be stayed if the magistrate could not be satisfied that the defendant understood the nature of the proceedings. The Director of Public Prosecutions then filed an *ex officio* indictment with the Supreme Court. The Supreme Court stayed the *ex officio* indictment until the conclusion of the committal. Justice Mildren determined that, as the defendant was not required to plead at committal, there was no bar to those proceedings continuing and found that the question of fitness was properly reserved until the time to plead was reached. The magistrate was directed to proceed with committal and comply with the *Justices Act* (NT) as far as was possible.[84]

12.51 The High Court reversed the decision, holding that any committal proceedings would be invalid. It held that s 106 of the *Justices Act* (NT) prescribed proceedings to be held in the "presence or hearing of the defendant", and this had more than a mere formal significance. It required that the defendant both hear and comprehend the charge.[85] Further, s 110 and s 111 of that Act, which required that the defendant be given the opportunity to answer the charge/s, could not be fulfilled, which had the effect of nullifying the committal proceedings. The High Court held that the correct procedure would be for the Crown to proceed by way of an *ex officio* indictment.[86] In the result, the defendant lost the opportunity of testing the prosecution case at a committal hearing.

12.52 There do not appear to be any options to resolve all the difficulties associated with fitness in relation to committal proceedings. The consequence of stopping the committal proceedings when fitness is raised and proceeding by way of *ex officio* indictment, is that the advantage to the defendant of testing the evidence at committal proceeding is lost. The defendant's unfitness may place that individual at a significant disadvantage in committal proceedings, yet the defendant's lawyers may wish to test the evidence and have the chance of acquittal. On the other hand, if committal proceedings take place, an unfit defendant may be disadvantaged compared with defendants who are fit, because the person may not, for example, be able to communicate effectively with counsel.

12.53 Under s 33 of the MHFPA, a defendant could be referred to a mental health facility for treatment, and returned to court when the person's mental health had improved. However, the diversionary mechanisms in Part 3 of the MHFPA do not presently apply to committal proceedings.[87]

12.54 In Report 135 we recommend that s 33 of the MHFPA should be extended so that, where a defendant appears to be acutely mentally ill in the course of a committal hearing, the Local Court can make an order that the defendant be detained in a mental health facility for assessment and possible treatment. The defendant would

84. *R v Roland Ebaterinja* (1997) 6 NTLR 107.
85. *Ebatarinja v Deland* [1998] HCA 62; 194 CLR 444 [24], [25].
86. *Ebatarinja v Deland* [1998] HCA 62; 194 CLR 444 [34].
87. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 31.

then be returned to the court.[88] We note, however that this proposal applies only for people who have a mental illness under the *Mental Health Act 2007* (NSW), and it would not provide an avenue for others, such as people with cognitive impairments.

Jurisdictional review

12.55 The majority of Australian jurisdictions have legislation in place which enables the court conducting committal proceedings, when fitness is raised during committal, to reserve the question of fitness for the trial court.[89]

12.56 The need for explicit legislative provisions to reserve fitness and continue committal proceedings was thrown into sharp relief by *Ebatarinjan v Deland.*[90] In response to the High Court's findings in that case, the NT legislature introduced s 43M of the *Criminal Code* (NT).[91] Section 43M prescribes that a person is not to be discharged only because the question of fitness has been raised during the committal proceeding;[92] if the defendant is committed to trial then the question of fitness is reserved for the trial court;[93] and the committal is to be completed in accordance with the *Justices Act* (NT), whether or not s 106 or s 110 are complied with.[94] In 2010, the NT legislature repealed s 106 and s 111, and amended s 110 of the *Justices Act*[95] to the effect that, where a question of fitness is raised during committal proceedings, the proceedings must be completed, regardless of whether or not the defendant is capable of understanding the explanation required to be given as to his or her right to answer the charge, give evidence and call witnesses.[96]

12.57 Prior to *Ebatarinjan,* SA, WA and the ACT already had legislation in place directing the Local Court to reserve the question of fitness until committal proceedings are finalised.[97] Tasmania and Victoria introduced similar legislation after *Ebatarinjan*.[98]

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88. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) Recommendations 10.3, 10.8.
89. *Criminal Code* (NT), s 43M; *Crimes Act 1900* (ACT) s 314(2); *Criminal Law Consolidation Act 1935* (SA) s 269J(4); *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 17(2); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 8; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 10(2); *R v Plummer* [2012] NTSC 30.
90. *Ebatarinja v Deland* [1998] HCA 62; 194 CLR 444. See para 12.49-12.51.
91. Northern Territory, *Parliamentary Debates*, Legislative Assembly, 23 May 2002 (P Toyne); cf *R v Plummer* [2012] NTSC 30.
92. *Criminal Code* (NT) s 43M(1)(a).
93. *Criminal Code* (NT) s 43M(1)(c).
94. *Criminal Code* (NT) s 43M(1)(b).
95. *Justice Legislation Amendment (Committals Reform) Act* (NT) s 7, s 9. We discuss s 106, s 110 and s 111 above in para 12.51.
96. See *Criminal Code* (NT) s 43M(b); *Justices Act* (NT) s 110.
97. *Crimes Act 1900* (ACT) s 314(2); *Criminal Law Consolidation Act 1935* (SA) s 269J(4); *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 17(2).
98. *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 8; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 10(2).

Submissions and consultations

12.58 In CP 6, we asked if legislation should provide for the situation where a committal hearing is to be held in respect of a defendant who appears to be unfit, and if so, how it should be framed.[99]

12.59 Stakeholders generally agreed that fitness procedures in committal hearings should be possible and that legislation should provide for this.[100] However, submissions raised a number of concerns and competing considerations inherent in any option for reform.

12.60 The Law Society of NSW argued that committal proceedings have an important curial function for the defendant, allowing the defence to test the case against them.[101] Interrupting a committal hearing to investigate fitness may mean that the defendant does not receive the benefit of a committal. However, Legal Aid NSW pointed to the need to determine the question of fitness early so as to "reduce delay, uncertainty and costs".[102] The Local Court pointed out that determining the question of fitness during committal would have serious resource implications for both the Local Court and the Office of the Director of Public Prosecutions (ODPP). If the Local Court is to hear fitness questions at committal, it is likely that the majority of fitness inquiries would be held in front of a magistrate; the court would require that fitness proceedings be run with the same level of competence as those in the higher courts, and this would require the attendance of "properly instructed practitioners from the ODPP" and "ongoing judicial education" for magistrates.[103]

Options for reform

12.61 Given the problems identified above, we consider inaction to be untenable, and we do not canvass it here. We have considered three options below.

12.62 **Option 1: Immediate referral to a higher court.** The MHFPA could be amended to provide that, when an issue of fitness is raised, the Local Court should dispense with committal proceedings and immediately refer the matter to the District or Supreme Court to hold a fitness hearing.[104] In effect, this is what currently occurs in NSW when fitness is raised, the defendant is discharged and the prosecution follows up with an *ex officio* indictment. This proposal would streamline the process so that the first procedure to occur in the higher court would be a fitness inquiry. The disadvantage of this option is that the defendant would lose the benefit of a committal proceeding.

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99. 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 6.12.
100. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 5*;* NSW Bar Association*, Submission MH10,* 15; Law Society of NSW, *Submission MH13*, 7; Legal Aid NSW, *Submission MH18*, 8.
101. Law Society of NSW, *Submission MH13*, 7.
102. Legal Aid NSW, *Submission MH18*, 8.
103. Local Court of NSW, *Submission MH4*, 4.
104. Children's Court of NSW, *Submission MH24*, 2. This is akin to the procedure under the *Crimes Act 1914* (Cth) s 20B.

12.63 **Option 2: Reserve the question of fitness.** The MHFPA could be amended to provide that, if an issue of fitness is raised, the Local Court should continue with committal proceedings and reserve the question of fitness for determination by the District or Supreme Court if the defendant is committed.[105] This is akin to the position in the ACT, Victoria, SA, Tasmania, WA and the NT.[106] Under this option the defendant would retain the benefit of committal proceedings. However, it also means that a committal hearing would be conducted when the defendant was unfit and unable to participate effectively in the proceedings.

12.64 **Option 3: Magistrate to hold the relevant fitness inquiry**. A disadvantage of this option, noted by the Local Court, is that holding a fitness inquiry during the course of committal proceedings would significantly increase the workload and staffing requirements of the Local Court.[107] The defendant would lose the advantage of the committal proceeding and the matter would still have to be referred to the District or Supreme Court for a special hearing.

The Commission's view

12.65 No option resolves all of the identified problems. On balance we recommend that Option 2 be adopted, for two reasons. First, it appears to be the option that is least disadvantageous to the defendant, and second, it is consistent with the approach of most Australian jurisdictions.

12.66 The advantage of a committal hearing would be reduced for an unfit defendant compared with a fit defendant, because an unfit defendant cannot participate effectively in the proceedings. However, the benefit to the defendant would be reduced rather than removed entirely, because the defendant's legal representative would be able to hear and test the evidence.

12.67 We note also our recommendation in Report 135 relating to the use of s 33 of the MHFPA when issues of fitness arise in committal hearings.

Recommendation 12.2

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to the effect that, if the question of fitness is raised at a committal hearing in the Local Court:

(a) the committal hearing must be completed

(b) the defendant must not be discharged only because the question has been raised, and

(c) if the defendant is committed for trial, the trial court must consider the question of fitness.

105. NSW Office of the Director of Public Prosecutions, *Submission MH5*, 5.

106. *Crimes Act 1900* (ACT) s 314; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 8; *Criminal Law Consolidation Act 1935* (SA) s 269J(4); *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 10(2); *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 17(2); *Criminal Code* (NT) s 43M.

107. Local Court of NSW, *Submission MH4*, 4.

The defence of mental illness in the Local Court

The law relating to defendants who are NGMI

12.68 The current provisions relating to the defence of mental illness are dealt with in Part 4 of the MHFPA. The criteria for the special verdict of NGMI are in s 38(1), which provides:

> If, in an indictment or information, an act or omission is charged against a person as an offence and it is given in evidence on the trial of the person for the offence that the person was mentally ill, so as not to be responsible, according to law, for his or her action at the time when the act was done or omission made, then, if it appears to the jury before which the person is tried that the person did the act or made the omission charged, but was mentally ill at the time when the person did or made the same, the jury must return a special verdict that the accused person is not guilty by reason of mental illness.

12.69 The phrase "so as not to be responsible, according to law" refers to the common law *M'Naghten* rules,[108] which define the defence of mental illness in the following way:

> The defendant was labouring under a defect of reason caused by disease of the mind and, because of the disease the defendant either:
>
> - did not know the nature and quality of the act, or
> - did not know that the act was wrong.

12.70 The usual consequence of a finding of NGMI is that the defendant becomes a forensic patient.[109] The court is not to order the release of such a person from custody unless it is satisfied, on the balance of probabilities, that the safety of the person or any member of the public will not be seriously endangered by the person's release.[110]

12.71 We review the defence of mental illness in Chapter 3, where we recommend, among other things, updating and codifying the legal test. The remainder of the present chapter refers to the defence in its current form.

NGMI in the Local Court

12.72 It would appear that the common law *M'Naghten* rules apply in the Local Court. However, the provisions governing the operation of NGMI in Part 4 of the MHFPA do not. That is clear from the reference to "the jury" in section 38(1) of the MHFPA, there being no jury trials in the Local Court whereas trials in the Supreme Court and the District Court are usually with a jury.

12.73 The consequence of Part 4 of the MHFPA not applying in Local Court proceedings is that the procedures governing the detention and release of people found NGMI

108. *M'Naghten's Case* (1843) 10 Cl & Fin 200; 8 ER 718.
109. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 39, s 42.
110. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 39(2).

under s 38(1) do not apply in the Local Court. Accordingly, it appears that the only course available to a magistrate if the defence is made out is to discharge the defendant.[111]

12.74 The case of *R v McMahon*[112] is a rare instance in which the common law mental illness defence was considered and demonstrates the confusion that surrounds application of this defence in the Local Court. McMahon was convicted in the Local Court of 18 counts of committing an act of aggravated cruelty upon an animal (among other offences). During the Local Court proceedings, the defence of mental illness was raised unsuccessfully because the magistrate erroneously concluded that the defendant's self-induced intoxication precluded his mental condition from being taken into account.

12.75 On the basis of this error, Judge Berman allowed an appeal, finding that the appellant had been mentally ill at the time of committing the offence. Submissions were then made regarding the options available following the successful defence of mental illness at common law. The Crown argued that:

> despite the recommendations of the Law Reform Commission in 1996 and later the urgence [sic] of Howard and Westmore, having acquitted the appellant according to common law, there are no tools available to you to order anything but his immediate release.[113]

12.76 Judge Berman recognised the significant ramifications both for McMahon, and for future appellants, but determined that the magistrate was not able to make any order other than release.[114]

12.77 The fact that a defendant found NGMI in the Local Court must be discharged under common law creates an anomaly similar to that noted above in relation to fitness procedures: the more serious the crime, the greater the likelihood that diversion will not be suitable and the defendant will be discharged. This raises some concerns about the safety of the public and the defendant.

12.78 It is important, however, to put the deficiencies of the law in context. The submission of the Local Court to this inquiry suggested that the mental illness defence is "virtually never raised" in Local Court proceedings for a number of reasons.[115] First, because of the potential for lengthy detention as a forensic patient, the defence is generally only raised in relation to very serious indictable offences, such as those involving homicide, which are not heard in the Local Court. Secondly, the diversionary provisions of Part 3 of the MHFPA give magistrates power to divert defendants with cognitive and mental health impairments, thus avoiding consideration of the defendant's guilt or otherwise. Thirdly, there is a general

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111. D Howard and B Westmore, *Crime and Mental Health Law in New South Wales* (LexisNexis Butterworths, 2nd ed, 2010) 323; NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) [6.46]; *R v McMahon* [2006] NSWDC 81; *R v McMahon* (Unreported, NSW District Court, Berman DCJ, 3 November 2006 and 10 November 2006).
112. *R v McMahon* [2006] NSWDC 81.
113. *R v McMahon* (Unreported, NSW District Court, Berman DCJ, 3 November 2006) [2].
114. *R v McMahon* (Unreported, NSW District Court, Berman DCJ, 10 November 2006).
115. Local Court of NSW, *Submission MH4*, 4.

unawareness that less serious offenders who successfully raise NGMI need to be discharged under the common law. It may be that if the operation of NGMI in the Local Court was better and more widely understood more defendants would raise it.

Jurisdictional review

12.79 In Tasmania, SA and WA, the legislative provisions pertaining to the defence of mental illness apply both when the defence is raised in the Local Court and in the higher courts.[116] The courts in all three jurisdictions can make a wide range of orders following a finding of NGMI, including orders to detain or release the defendant.[117] However, in Tasmania, when the magistrate is of the opinion that a forensic order should be made (that is, an order requiring the defendant to be detained in a secure mental health unit or released into the supervision of the Chief Forensic Psychiatrist), the magistrate may refer the matter to the Supreme Court for determination.[118]

12.80 In the ACT, where a defendant pleads NGMI in the Magistrates' Court, the magistrate must make a finding of NGMI if the he or she considers it appropriate to do so, and the prosecution agrees to the finding.[119] Following a finding of NGMI the Magistrates' Court may refer the defendant to ACAT for a recommendation as to how he or she should be dealt with, or may make any other order considered appropriate, including an order that the defendant be detained in custody until ACAT orders otherwise, or that the defendant submit to the jurisdiction of ACAT to allow a mental health order to be made.[120] However, where a finding of NGMI is made in respect of a "serious offence",[121] the Magistrates' Court must order that the defendant be detained in custody until ACAT orders otherwise or refer the defendant to ACAT for the making of a mental health order.[122] The Magistrates' Court does not have discretion to discharge the defendant.[123]

12.81 In Victoria, the defence of mental impairment applies to summary offences and indictable offences heard and determined summarily in the Magistrates' Court.[124] If a person is found not guilty because of mental impairment, the Magistrates' Court must discharge the person.[125] Unlike the County and Supreme Courts, the Magistrates' Court cannot impose a supervision order, either custodial or non-custodial, or apply any conditions.[126] The Victorian legislation reflects the current

116. *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 4(1), pt 3; *Criminal Law Consolidation Act 1935* (SA) pt 8A, div 2, s 269(A) ("judge" includes a magistrate); *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) pt 2-3.
117. *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 21(1); *Criminal Law Consolidation Act 1935* (SA) s 269O; *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 22.
118. *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 21A, s 24, s 29A.
119. *Crimes Act 1900* (ACT) s 327.
120. *Crimes Act 1900* (ACT) s 328.
121. An offence involving actual or threatened violence, or an offence against s 27(3) or (4) of the *Crimes Act 1900* (ACT): *Crimes Act 1900* (ACT) s 325.
122. *Crimes Act 1900* (ACT) s 329.
123. Cf *Crimes Act 1900* (ACT) s 328(1)(b), which permits the court to make any other order it deems appropriate in cases where the offence was not "serious".
124. *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 5(1).
125. *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 5(2).
126. *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 23, s 24.

common law position in NSW, where a defendant who has not been diverted but found NGMI must be discharged.

12.82 In Queensland and the NT, the statutory defence of NGMI does not extend to the Local Court.[127]

Submissions and consultations

12.83 In CP 6 we asked whether the statutory regime for the defence of mental illness in Part 4 of the MHFPA should be available in the Local Court.[128] With the exception of a submission from the NSW Police Force,[129] all submissions were in favour of making a statutory defence of mental illness available in the Local Court in some form.[130]

12.84 In considering the appropriate legal framework for NGMI in the Local Court, stakeholders raised the following considerations:

- the need for consistency in NSW courts
- the primacy of diversion
- the need to limit detention, and
- resource limitations.

12.85 The current differences between the powers of the Local, District and Supreme Courts with respect to defendants with cognitive and mental health impairments reflects the separate development of the respective courts - in particular, the fact that magistrates previously dealt only with relatively trivial offences.[131] That is no longer the case, since the Local Court now shares jurisdiction with the District Court in respect of a large number of offences which are triable both summarily and on indictment. The Local Court submission stated:

> Extension of the defence would provide a measure of clarity in the event that the defence of mental illness was raised in the Local Court, which may well occur more often in the future should the trend towards increasing the Court's jurisdiction to hear more serious offences continue.[132]

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127. *Criminal Code* (Qld) s 645, s 647; *Criminal Code* (NT) s 43C.
128. 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 6.36.
129. NSW Police Force, *Submission MH47*, 8. This submission stated that "the defence of mental illness is already available at law in any court exercising criminal jurisdiction, including the Local Court of NSW".
130. Local Court of NSW, *Submission MH4*, 4-5; NSW Office of the Director of Prosecutions, *Submission MH5*, 9; Shopfront Youth Legal Centre, *Submission MH7*, 15; NSW Bar Association, *Submission MH10*, 29-30; Law Society of NSW, *Submission MH13*, 13; Legal Aid NSW, *Submission MH18*, 12; NSW, Public Defenders, *Submission MH26*, 35.
131. See *Justices Act 1902* (NSW) pt 4 div 1 (as originally enacted), which confers jurisdiction on Courts of Petty Sessions to hear only committal, but not trial, proceedings in respect of indictable offences; see also *Pioch v Lauder* (1976) 13 ALR 266, 271-272; *R v Horseferry Rd Magistrates Court* [2006] 3 All ER 719, 730-736.
132. Local Court of NSW, *Submission MH4,* 4.

12.86 Likewise, the ODPP submitted that "consistency in practice and in procedure should be promoted within and between jurisdictions".[133]

12.87 Submissions expressed a clear preference for diversionary options under s 32 and s 33 of the MHFPA being considered before a trial involving the defence of mental illness is contemplated. Restricting the operation of the mental illness defence to situations in which diversion is not appropriate would also ease the resource implications of introducing NGMI provisions.[134]

12.88 In stakeholder consultations, extending the statutory regime for NGMI received support because it provides an avenue for acquittal – the person is found not guilty due to mental illness. A number of submissions, however, raised concerns that applying Part 4 of the MHFPA to defendants in the Local Court would create the risk that defendants who had committed offences that were not serious may become forensic patients and be subject to extended or indefinite detention.[135]

12.89 The Local Court only supported the introduction of the NGMI regime for indictable offences tried summarily.[136] It was said that this would avoid complexity and ensure defendants were not inappropriately detained. Conversely, submissions from the Law Society of NSW, NSW Bar Association, Legal Aid NSW and the Public Defenders supported the defence being made available in all cases.[137]

The Commission's view

12.90 In Report 80, we stated with respect to the defence of mental illness:

> The Commission now considers that the same procedures should apply in all courts for this defence, with necessary amendments to take into account their different procedures; for example, juries are not used in the Local Courts. Thus the magistrate would have the ability to set a limiting term for a person found not guilty on the grounds of mental impairment, within the limits of their sentencing powers. The Commission also recommends that the magistrate should first consider the appropriateness of the simpler procedures available under s 32-33 of the MHCP Act. Therefore, it seems likely that mental impairment will only be an issue in a small number of Local Court trials. Additionally, it should be noted that the Commission's other recommendations in relation to the defence should make its consequences less harsh for the defendant.[138]

12.91 We continue to support the extension of Part 4 of the MHFPA to the Local Court, as do most stakeholders.

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133. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 9.
134. Shopfront Youth Legal Centre, *Submission MH7,* 15.
135. Local Court of NSW, *Submission MH4,* 4-5; Shopfront Youth Legal Centre, *Submission MH7,* 15; NSW Bar Association, *Submission MH10,* 29-30; Public Interest Advocacy Centre, *Submission MH21,* 21.
136. Local Court of NSW, *Submission MH4,* 4-5.
137. Law Society of NSW, *Submission MH13*, 13; NSW Bar Association, *Submission MH10,* 30; Legal Aid NSW, *Submission MH18,* 12; NSW, Public Defenders, *Submission MH26,* 35.
138. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System*, Report 80 (1996) [6.48].

12.92 The Local Court deals with many less serious offences and, in the interests of proportionality, we recommend that where a matter is dealt with in the Local Court the court should first consider the appropriateness of diversion under Part 3 of the MHFPA. We recognise that this recommendation may have case management implications. These may be dealt with by amending the Practice Note for criminal proceedings in the Local Court[139] to provide for procedures relating to preliminary hearings, adjournments and any other matters, so that diversion under s 32 and s 33 is considered before NGMI or fitness is raised.

12.93 The recommendations of Report 135[140] would allow for court monitoring of diversion and, if implemented, make diversion more suitable for more serious cases than it is now. In cases where diversion is not appropriate, the jurisdiction of Part 4 of the MHFPA should be extended to include the Local Court. In the case of more serious offences heard summarily, it is relevant that a finding of NGMI gives rise to options that provide for the treatment of the defendant in the forensic system as well as for the protection of the public.

12.94 We agree with the comments of some stakeholders in consultation that defendants who successfully raise NGMI are entitled to the chance of acquittal because they have been found not guilty, rather than diverted. However, acquittal in the context of a finding of NGMI has serious consequences. Where there is a finding of NGMI, the defendant would face the risk of detention as a forensic patient. However, we note that the MHRT has a number of options available to it, including treatment in the community in appropriate cases. In the case of offences dealt with in the Local Court the nature and seriousness of offending will be relevant in considering issues of community safety under the MHFPA.

Recommendation 12.3

(1) The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended so that Part 4 of the Act, dealing with the defence of mental illness, applies in the Local Court.

(2) The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that, if the defence of mental illness is proposed to be raised in the Local Court under Part 4 of the Act, the court must first consider whether it should make an order under s 32 or s 33 of the Act.

139. See Local Court of NSW, *Practice Note Crim 1 - Case Management of Criminal Proceedings in the Local Court*, 1 July 2012.

140. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) Recommendations 9.4, 9.8.

Fitness and NGMI in the Children's Court

Introduction

12.95 The remainder of this chapter discusses fitness to be tried and the defence of mental illness as it applies to children and young people with a cognitive or mental health impairment in the Children's Court.

12.96 The jurisdiction of the Children's Court extends to include more serious offences than the Local Court. The Children's Court has jurisdiction to deal with all offences committed before a young person turns 18, except "serious children's indictable offences".[141] These are offences of homicide and offences punishable by life imprisonment or imprisonment for 25 years.[142] The Children's Court hears and determines committal proceedings in respect of serious children's indictable offences which are then dealt with in the Supreme or District Court.

12.97 In Consultation Paper 11 (CP 11), we considered the ways in which the cognitive and mental health impairments of children and young people may differ from those of adults.[143] Some young people present particular challenges in the areas of fitness and the defence of mental illness because their mental illness may be emerging. There may be problems in arriving at a definitive diagnosis because a young person's neurological, psychosocial and cognitive abilities are still in development. This issue was discussed in Report 135[144] and in CP 11.[145]

12.98 A child under 10 years of age has no criminal liability.[146] There is a rebuttable presumption, referred to as *doli incapax,* that a child aged between 10 and 14 does not have the mental capacity to form the intent required for criminal liability.[147] The existence of a child's cognitive or mental health impairment may be relevant to determining whether the prosecution can successfully rebut this presumption.[148] Thus issues of fitness, NGMI and criminal responsibility may be interconnected in the case of young people.

141. The Children's Court "has jurisdiction to hear and determine … proceedings in respect of any offence (whether indictable or otherwise) other than a serious children's indictable offence" or a "traffic offence": *Children (Criminal Proceedings) Act 1987* (NSW) s 28(1)(a), s 28(2), s 3(1). Compare the jurisdiction of Local Court of NSW: see *Criminal Procedure Act 1986* (NSW) s 5-7, sch 1.
142. *Children (Criminal Proceedings) Act 1987* (NSW) s 28(1)(a), s 28(2), s 3(1).
143. NSW Law Reform Commission, *Young People with Cognitive and Mental Health Impairments in the Criminal Justice System,* Consultation Paper 11 (2010) [1.11]-[1.20].
144. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion,* Report 135 (2012) Ch 14.
145. NSW Law Reform Commission, *Young People with Cognitive and Mental Health Impairments in the Criminal Justice System*, Consultation Paper 11 (2010) [1.16].
146. *Children (Criminal Proceedings) Act 1987* (NSW) s 5.
147. *R v BP; R v SW* [2006] NSWCCA 172 [27].
148. *R v AN* [2005] NSWCCA 239 [19], [22]-[32].

Fitness procedures in the Children's Court

12.99 The Children's Court, like the Local Court, has no specific power to determine questions of fitness or to deal with an unfit defendant. The Children's Court can transfer proceedings for an indictable offence to a higher court,[149] where the MHFPA fitness regime is in place, but the Children's Court would be required to conduct a committal hearing prior to transfer, and the defendant must be fit for the committal to proceed.[150]

12.100 The diversion provisions in s 32 and s 33 of the MHFPA apply in the Children's Court. There are additional diversion provisions in the *Young Offenders Act* 1997 (NSW) (YOA). As we discussed in Report 135, the YOA contains little provision for young people with impairments and the application of measures under the YOA (cautions and youth justice conferences) require consent and may not be appropriate if fitness is in issue.[151]

Submissions and consultations

12.101 In CP 11, we asked whether legislative powers and procedures dealing with unfit defendants should be extended to the Children's Court.[152] All submissions supported introducing fitness procedures in the Children's Court.[153]

Arguments in favour of extending fitness procedures to the Children's Court

12.102 Submissions emphasised the needs of young people and the objectives of the Children's Court. It was submitted that young defendants have a particular vulnerability,[154] and diversionary programs are more appropriate for this group than for them to be dealt with in the criminal justice system.[155] Stakeholders expressed concern about the impact of detention on young people, and showed a clear preference for alternative methods of care and control.[156]

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149. *Children (Criminal Proceedings) Act 1987* (NSW) s 31.

150. *Ebatarinja v Deland* [1998] HCA 62; 194 CLR 444. Unfitness and committal proceedings in the Children's Court is discussed below: see para 12.118-12.121.

151. See *Young Offenders Act 1997* (NSW) s 19(b), s 26(b); NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) [14.25], [14.32]-[14.33].

152 NSW Law Reform Commission, *Young People with Cognitive and Mental Health Impairments in the Criminal Justice System*, Consultation Paper 11 (2010) Issue 11.23.

153 NSW Bar Association, *Submission MH29,* 1-2; Department of Human Services NSW (Juvenile Justice), *Submission MH35-1*, 20-21; Law Society of NSW, *Submission MH36*, 13; NSW Office of the Director of Public Prosecutions, *Submission MH37*, 1; Shopfront Youth Legal Centre, *Submission MH41*, 14; Children's Court of NSW, *Submission MH43*, 10; Children's Court of NSW, *Submission MH24,* 1; Legal Aid NSW, *Submission MH18*, 7.

154 Department of Human Services NSW (Juvenile Justice), *Submission MH35-1*, 20-21; Law Society of NSW, *Submission MH36*, 13; Shopfront Youth Legal Centre, *Submission MH41,* 14.

155. Law Society of NSW, *Submission MH36,* 13; Children's Court of NSW, *Submission MH43,* 12.

156 Shopfront Youth Legal Centre, *Submission MH41,* 14; Children's Court of NSW, *Submission MH43*, 10.

12.103 The Children's Court suggested that, because in most cases the severity of offending and the need to protect the public is considerably different in that court, fitness procedures should be framed differently from those at higher court level:

> Laws and procedures which would result in all or most young people who are unfit being required to go into custody would be draconian and counterproductive.[157]

12.104 For those reasons, the ODPP suggested fitness procedures should only be applicable to indictable offences.[158] The Shopfront Youth Legal Centre also expressed concern about extended detention for young people.[159] However, Juvenile Justice supported referral to the MHRT of young people found unfit to help ensure appropriate care and treatment.[160]

12.105 Some stakeholders expressed concern that the *Presser* standards for fitness may not be the most appropriate for young people,[161] on the basis that young people differ from adults in decision making capacities - particularly reasoning - and understanding consequences. Their minds are still developing and, in some cases, a mental illness may be emerging.[162] While the Children's Court advocated a reframing of the orders a court can make on a finding of unfitness, it submitted that *Presser*, when applied in a "common sense" fashion, remains adequate for determining fitness.[163] This submission was mirrored by the ODPP, which considered that the *Presser* standards are:

> clear principles of fairness to be applied across the board to any accused of whatever age. The fact that someone is younger will obviously be factored in, for instance, on his or her capacity to understand the offence with which s/he is charged or the ability to properly instruct his or her legal representatives.[164]

Concerns relating to the extension of fitness procedures to the Children's Court

12.106 Although there was broad support for extending fitness procedures to the Children's Court, a number of concerns were also expressed.

12.107 The first concern relates to the relationship between diversion and the proposed fitness procedures. Diversion is an even greater priority in the case of children and young people than in the case of adults.[165] There was wide support from stakeholders for the proposal that a fitness inquiry should only occur in the

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157. Children's Court of NSW, *Submission MH43*, 10.
158 NSW Office of the Director of Public Prosecutions, *Submission MH37*, 1.
159. Shopfront Youth Legal Centre, *Submission MH41*, 14.
160. Department of Human Services NSW (Juvenile Justice), *Submission MH35-1*, 20.
161. Department of Human Services NSW (Juvenile Justice), *Submission MH35-1,* 14; Law Society of NSW, *Submission MH36,* 13.
162. NSW Office of the Director of Public Prosecutions, *Submission MH37,* 1; Law Society of NSW *Submission MH36,* 13; Department of Human Services NSW (Juvenile Justice), *Submission MH35-1,* 14.
163. Children's Court of NSW, *Submission MH43,* 10.
164. NSW Office of the Director of Public Prosecutions, *Submission MH37*, 2.
165. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) Ch 14.

Children's Court when the court has found diversion to be inappropriate.[166] This approach is consistent with our recommendation above in relation to the Local Court.

12.108 We also note that the MHFPA grants the court discretion to dispense with a fitness inquiry and discharge the defendant where the nature of charges are trivial or the nature of the impairment makes dismissal appropriate.[167] The court's power to dismiss charges, together with a requirement to consider diversion first, would limit the number of fitness inquiries in practice, confining them to the more serious cases.

12.109 Some stakeholders expressed concern about whether the *Presser* criteria adequately take account of the fact that, for young people, it may not be possible to diagnose the precise nature and extent of their cognitive or mental health impairment.[168] However, the *Presser* criteria do not rely on diagnosis of the defendant's impairment, but focus on the capacity of the defendant to carry out tasks that are essential if the defendant is to make an appropriate plea and engage with a trial. Further, the Children's Court is a specialist court experienced in applying considerations relevant to children and young people in its decisions. The Children's Court and the ODPP both submitted that the *Presser* standards are adequate and wide enough to encompass issues particular to the young.[169]

12.110 Stakeholders also expressed concerns that young people who are found unfit under the existing forensic system could be detained in custody through the course of fitness proceedings. The Children's Court was among numerous stakeholders which raised the effect a finding of unfitness may have if the fitness regime of the MHFPA is introduced. We note, however, that remand in custody is not inevitable. The court has broad powers under s 14 of the MHFPA to adjourn proceedings, grant bail, remand or impose any other order it sees fit after a finding of unfitness. We note also our recommendations in Chapter 6 for the simplification of the procedures that apply after a finding of unfitness. Similarly, after a limiting term has been set and the defendant referred to the MHRT, the Tribunal has wide powers that include ordering treatment in the community.

Jurisdictional review

12.111 In the ACT, WA, SA and Tasmania[170] the fitness provisions available to Magistrates Courts extend to the Children's Court. Where diversionary options are inapplicable,[171] the Children's Court can conduct fitness inquiries and make orders

166. See, eg, Law Society of NSW, *Submission MH36*, 13; Children's Court of NSW, *Submission MH43,* 12.

167. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 10(4).

168. Department of Human Services NSW (Juvenile Justice), *Submission MH35-1*, 21; Law Society of NSW, *Submission MH36*, 13-14.

169. Children's Court of NSW, *Submission MH43,* 10; NSW Office of the Director of Public Prosecutions, *Submission MH37*, 2.

170. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 4, pt 3 div 1; *Criminal Law Consolidation Act 1935* (SA) pt 8A div 2-3; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 4, pt 2.

171. See, eg, *Young Offenders Act 1994* (WA) s 49; *Youth Justice Act 1997* (Tas) s 105(2).

involving treatment as a forensic patient, as described in paragraphs 12.21-12.26 above.

12.112 Queensland's fitness regime only applies to indictable offences.[172] When fitness is raised in summary proceedings, it appears that the defendant is to be discharged.[173]

12.113 In Victoria a committal hearing must be conducted when fitness is raised in relation to an indictable offence, followed by a fitness inquiry in the Supreme or County Court.[174] The Victorian Supreme Court described this situation, whereby even the most minor of indictable offences must be dealt with by way of committal, as entirely "unsatisfactory" and recommended that the legislation be amended to provide the Children's Court with the jurisdiction to deal with and make appropriate orders with regard to fitness.[175] There are no fitness procedures available when a defendant is charged with a summary offence in the Children's Court, although some defendants may access the Children's Court Clinic, which reports to the court and provides limited treatment options.[176]

12.114 There is no fitness regime applicable to the Children's Court in the NT.[177] The charge is dismissed or the defendant is diverted into treatment.[178]

The Commission's view

12.115 We support the extension of fitness procedures in the MHFPA to all offences heard in the Children's Court. These procedures are unlikely to be employed frequently, but it is important that they be available in appropriate cases.

12.116 Consistent with our recommendations in relation to the Local Court, we recommend that, when unfitness is raised, the court must first consider whether or not the matter can be dealt with by diversion under s 32 or s 33 of the MHFPA. We anticipate that diversion under s 32 of the MHFPA will be suitable in most cases.

12.117 We take seriously the concerns of stakeholders that a finding of unfitness could result in disproportionate periods of detention, either during the determination of fitness or after a finding of UNA. However, we note that detention is not inevitable, during or after the determination of fitness, and that the court and the MHRT can provide for treatment to take place in the community in appropriate cases. In the case of young people, community treatment options are likely to be the most suitable in many cases.

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172. Or where a "simple offence" is related to an indictable offence: *Mental Health Act 2000* (Qld) s 256, s 257(3).
173. *R v AAM* [2010] QCA 305 [9]: McMurdo P observed that law reform was needed to address this "hiatus in the existing criminal justice system".
174. *Crimes (Mental Impairment and Unfitness to be Tried Act) 1997* (Vic) s 8(1).
175. *CL v Lee* [2010] VSC 517; 29 VR 570 [80], [81].
176. See Children's Court of Victoria, "Children's Court Clinic" (2009) <http://www.childrenscourt.vic.gov.au>.
177. *Criminal Code* (NT) s 43L (the question of fitness is to be determined by a jury); *Youth Justice Act* (NT) s 52, s 53 (the Youth Justice Court is a court of summary jurisdiction, able to deal with all charges (summary or indictable) committed by a youth).
178. *Mental Health and Related Services Act* (NT) s 73A(1)-(2).

Recommendation 12.4

(1) The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended so that Part 2 of the Act, dealing with fitness to be tried, applies in the Children's Court.

(2) The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that, if the question of fitness is raised in the Children's Court under Part 2 of the Act, the court must first consider whether it should make an order under s 32 or s 33 of the Act.

Fitness in committal proceedings in the Children's Court

12.118 The Children's Court has jurisdiction to hear and determine committal proceedings regarding any indictable offence not heard summarily and serious children's indictable offences.[179]

12.119 Where fitness is raised, committal proceedings in the Children's Court are affected in the same manner as in the Local Court.[180] There is a legal and procedural gap which can result in the dismissal of serious charges against an unfit person; and/or an unfit person, on an *ex officio* indictment, standing before a higher court without the benefit of a committal. The case of *Police v AR* is instructive on the issues that unfitness in committal proceedings can generate.[181] When 17 years old, AR committed a number of offences ranging from possession of prohibited drugs to aggravated robbery. A considerable body of unchallenged expert medical evidence clearly established that AR was unfit due to cognitive impairment. The Court came to the view that, while diversion under s 32 of the MHFPA was appropriate for some of the offences alleged to have been committed by AR, it was not appropriate for the more serious offences, as "the more serious the offending the more important ... the public interest in punishment being imposed for the protection of the community".[182] In relation to these more serious offences, the Court held that the offences could not be properly disposed of in a summary manner and relied on *Ebatarinja v Deland* to hold that the defendant's unfitness to plead meant that a committal hearing could not be conducted.[183] Consequently, the more serious charges against the defendant were dismissed. However, the Court noted that the

179. The Children's Court conducts committal proceedings in respect of serious children's indictable offences and other indictable offences where either the defendant elects to "take his or her trial according to law" or the Children's Court finds that the charge may not be properly disposed of in a summary manner: *Children (Criminal Proceedings) Act 1987* (NSW) s 28(1)(b), s 31(2)-(4).

180. See para 12.47-12.66.

181. *Police v AR* (Unreported, Children's Court of New South Wales, Marien J, 18 November 2009): see Children's Court of New South Wales, *Children's Law News*, Number 8 (May 2010).

182. *Police v AR* (Unreported, Children's Court of New South Wales, Marien J, 18 November 2009) [50]-[53]: see Children's Court of New South Wales, *Children's Law News*, Number 8 (May 2010) 23-4.

183. *Police v AR* (Unreported, Children's Court of New South Wales, Marien J, 18 November 2009) [59]: see Children's Court of New South Wales, *Children's Law News*, Number 8 (May 2010) 12. Also see para 12.49-12.51.

prosecution could lay an *ex officio* indictment against the defendant with respect to those charges in the District Court.[184]

The Commission's view

12.120 The law in the Children's Court in relation to fitness and committal proceedings produces the same unsatisfactory result as pertains in the Local Court.[185] An unfit young person accused of an indictable offence will not receive the benefit of a committal hearing if his or her unfitness is raised during or prior to committal proceedings.

12.121 Noting our discussion in relation to the Local Court, above, we make the same recommendation in relation to committal proceedings in the Children's Court as we make in relation to the Local Court at Recommendation 12.2. Implementation of this recommendation will mean that an unfit young person accused of an indictable offence (including a serious children's indictable offence) will receive the benefit of a committal hearing prior to a fitness determination in the higher court.

Recommendation 12.5

The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to the effect that, if the question of fitness is raised at a committal hearing in the Children's Court:

(a) the committal hearing must be completed

(b) the defendant must not be discharged only because the question has been raised, and

(c) if the defendant is committed for trial, the trial court must consider the question of fitness.

The defence of mental illness in the Children's Court

12.122 Similar to the position in the Local Court, it appears that the common law *M'Naghten* rules would apply to the defence of mental illness in the Children's Court. Accordingly, for the same reasons as apply to the Local Court, a young defendant found NGMI in the Children's Court must be diverted or discharged. Given that the Children's Court deals with a wider range of more serious offences than the Local Court, the argument for an NGMI regime has potentially greater force in this context.[186]

184. *Police v AR* (Unreported, Children's Court of New South Wales, Marien J, 18 November 2009) [62]: see Children's Court of New South Wales, *Children's Law News*, Number 8 (May 2010) 25.

185. See para 12.65-12.67.

186. See NSW Law Reform Commission, *Young People with Cognitive and Mental Health Impairments in the Criminal Justice System*, Consultation Paper 11 (2010) [5.23].

12.123 In CP 11, we asked whether the statutory defence of mental illness should be available in the Children's Court, and if so, whether the processes following a finding of NGMI should be different to those available in the higher courts.[187]

Submissions and consultations

12.124 We received strong stakeholder support to make the defence of NGMI and the subsequent disposition orders available to the Children's Court.[188] However, there was concern about indeterminate detention for individuals found NGMI, for whom there is currently no limiting term, and the inappropriateness of that regime in the case of young people.[189] The ODPP suggested that NGMI be available only in relation to indictable offences,[190] where there may be a public interest in detaining the offender. The Shopfront Youth Legal Centre suggested that, where it is necessary to detain or confine young people for the purposes of treatment, this should occur within a therapeutic facility appropriate for adolescents.[191]

12.125 Several stakeholders pointed out that young people may have an emerging mental illness that is difficult to diagnose, which may affect the content of a psychiatric report concerning the defendant's mental state at the time of the offence and whether it meets the test for NGMI.[192] It was suggested that additional legislative provisions might need to be introduced to address the special needs of young people, with emphasis on the acceptance of an emerging condition within the defence of mental illness.[193]

12.126 The Children's Court expressed clear support for the introduction of the MHFPA regime, and did not envisage any complications with applying the current formulation.[194]

12.127 The two key concerns of stakeholders about the proposal to extend the law relating to NGMI to children and young people were similar to their concerns about the extension of the fitness regime to the Children's Court. They were that diversion should be considered before NGMI, the appropriateness of the common law test and suitability of disposition options. The first of these concerns has been discussed above in relation to fitness procedures.

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187. NSW Law Reform Commission, *Young People with Cognitive and Mental Health Impairments in the Criminal Justice System*, Consultation Paper 11 (2010) Issue 11.27.
188. Department of Human Services NSW (Juvenile Justice), *Submission MH35-1*, 22; Shopfront Youth Legal Centre, *Submission MH41*, 15; Children's Court of NSW, *Submission MH43*, 10; NSW Office of the Director of Public Prosecutions, *Submission MH37*, 4; Law Society of NSW, *Submission MH36*, 15.
189. Law Society of NSW, *Submission MH36,* 15; Shopfront Youth Legal Centre, *Submission MH41*, 15; Children's Court of NSW, *Submission MH43,* 10.
190. NSW Office of the Director of Public Prosecutions, *Submission MH37*, 4.
191. Shopfront Youth Legal Centre, *Submission MH41*, 15.
192. Department of Human Services NSW (Juvenile Justice), *Submission MH35-1*, 22; Law Society of NSW, *Submission MH36*, 15; Shopfront Youth Legal Centre, *Submission MH41*, 15.
193. Shopfront Youth Legal Centre, *Submission MH41*, 15; Law Society of NSW, *Submission MH36*, 15.
194. Children's Court of NSW, *Submission MH43*, 11.

12.128 In CP 11 we discussed cases in which the defence of NGMI was successful for young people charged with homicide offences in the Supreme Court, and considered how, in those cases, the elements of the defence were adapted to the particular manifestations of cognitive and mental health impairments for young people[195] and in relation to developing impairments.[196] Nevertheless, some stakeholders expressed a general concern that the developmental issues of young people might not be properly taken into account by the current test for NGMI.

12.129 In Report 135 we propose new definitions for cognitive and mental health impairment[197] and in this report we recommend that these apply, with some amendments, to NGMI.[198] These definitions do not require an agreed diagnosis, rather they refer to the impact that the defendant's cognitive or mental health impairment has on the person and his or her actions. Adoption of these definitions would materially assist in ensuring that the defence of NGMI is adaptable to young people affected by a developing mental illness. The law would be applied by the Children's Court, which is a specialist court with extensive experience of those issues in relation to children and young people.

12.130 Some stakeholders also expressed concern that the application of the MHFPA procedures to a young person found NGMI would result in indeterminate detention being imposed. On this point we refer to our recommendations that there be limiting terms for those found NGMI, set by the court.[199] We note also that the court and the MHRT have broad powers with regards to disposition. On a finding of NGMI the court can make any order it sees fit, including orders for custody, or conditional or unconditional release consistent with community safety.[200] While the MHRT can order continued detention in a mental health facility, correctional centre or other place,[201] the MHRT can also make a community treatment order,[202] or an order for conditional or unconditional release into the community.[203]

The Commission's view

12.131 We support extension of Part 4 of the MHFPA to all offences heard in the Children's Court. The defence of NGMI is unlikely to be employed frequently, but it is important that it be available in appropriate cases.

12.132 Consistent with our recommendations in relation to both the Local Court and the Children's Court we recommend that, when the defence of NGMI is raised in the Children's Court, the Court must first consider whether or not the matter can be

195. *R v JH* [2010] NSWSC 531 [31]–[34].
196. *R v SE* [2009] NSWSC 785; NSW Law Reform Commission, *Young People with Cognitive and Mental Health Impairments in the Criminal Justice System*, Consultation Paper 11 (2010) [5.17]-[5.21].
197. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion,* Report 135 (2012) Recommendations 5.1, 5.2.
198 See Recommendation 3.2.
199. See Recommendation 7.2.
200. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 39. See also Chapter 7.
201. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 47(1).
202. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 67.
203. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 47(1)(b). See also Chapter 7.

dealt with by diversion under s 32 or s 33 of the MHFPA. We anticipate that diversion under s 32 of the MHFPA would be suitable in most cases. There would, however, be some cases where diversion is not appropriate.

12.133 We take seriously the concerns of stakeholders that a finding of NGMI could result in a disproportionate period of detention. However, this should be addressed by our recommendations on the introduction of limiting terms for those found NGMI, and that these terms must be set by the court. We also note that a young person who is found NGMI is likely to require appropriate treatment and supervision, and the MHRT is the expert body to oversee that treatment. We note also that a finding of NGMI will not always result in detention. The MHRT has wide disposition powers that include treatment in the community.

Recommendation 12.6

(1) The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended so that Part 4 of the Act, dealing with the defence of mental illness, applies in the Children's Court.

(2) The *Mental Health (Forensic Provisions) Act 1990* (NSW) should be amended to provide that, if the defence of mental illness is proposed to be raised in the Children's Court under Part 4 of the Act, the Court must first consider whether it should make an order under s 32 or s 33 of the Act.

13. Apprehended violence orders

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13.1 In Report 80, *People with an Intellectual Disability and the Criminal Justice System*, we noted that apprehended violence orders (AVOs) can cause difficulties for people with an intellectual disability.[1] We recommended that there be further consideration,

1. NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System,* Report 80 (1996) [8.45]-[8.48].

with assistance from the NSW Police Force and the then Department of Community Services, of AVOs involving this group.

13.2 During consultations for the current reference, a number of stakeholders again raised concerns about the use of AVOs against people with cognitive and mental health impairments. In particular, stakeholders suggested that this group of people experienced difficulties in understanding and complying with the terms of an AVO, and that sometimes AVOs were being applied for without sufficient regard to their circumstances. Because of difficulties in understanding the nature and terms of orders, breaches of orders can easily occur. Breaches constitute an offence, and thus people with cognitive and mental health impairments become involved with the criminal justice system.

13.3 As a result of these concerns expressed by stakeholders, we sought further information about the use and impact of AVOs in relation to people with cognitive and mental health impairments. We found very little published information. Consequently, in Consultation Paper 11 (CP 11), we asked about the incidence of AVOs being taken out against young people with cognitive and mental health impairments.[2] Taking into account these submissions, we also sought further information about the incidence of, and problems associated with, AVOs taken out against adults with cognitive and mental health impairments. To this end, we released Question Paper 1 (QP 1).[3]

13.4 Given the scope of this review, in this chapter we only consider the impact of AVOs on people with cognitive and mental health impairments as defendants, rather than as victims.[4] We hope and anticipate that the information, case studies, analysis and recommendations in this chapter will serve to inform broader and more extensive study of this issue.

13.5 At the time of writing, the Legal Policy and Criminal Law Review Division of the NSW Department of Attorney General and Justice (DAGJ) is carrying out a statutory review of the legislation establishing the AVO framework, the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) ("the statutory review"). This follows the report of the NSW Legislative Council Standing Committee on Social Issues, entitled "Domestic violence trends and issues in NSW", published in August 2012. The issue of AVOs and domestic violence more generally is one of considerable scope and importance, but our focus here is on the specific issue of AVOs made against people with cognitive and mental health impairments. Insofar as other reviews make recommendations of relevance to this cohort, we will refer to and incorporate those recommendations.

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2. NSW Law Reform Commission, *Young People with Cognitive and Mental Health Impairments in the Criminal Justice System*, Consultation Paper 11 (2010) Issue 11.11.

3. NSW Law Reform Commission, *Apprehended Violence Orders,* People with Cognitive and Mental Health Impairments in the Criminal Justice System: Question Paper 1 (2012).

4. The *Crimes (Domestic and Personal Violence) Act 2007* (NSW) currently makes some provision for people with disabilities who apply for orders for their protection. For example, s 48 makes provision for application by a person's guardian and s 49 makes certain provision for applications by police where the person in need of protection has an intellectual disability. See also s 16(2), s 19(2). For an indication of some of the problems faced by victims who have an intellectual disability, see NSW Law Reform Commission*, People with an Intellectual Disability and the Criminal Justice System,* Report 80 (1996) [8.45]-[8.46].

The legal framework for AVOs in NSW

Introduction

13.6 The making of an AVO is provided for under the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) (CDPVA). An AVO is a court order designed to protect a person (known as the "protected person") from violence, intimidation and stalking by the person against whom the AVO is made ("the defendant").[5]

13.7 An AVO is a civil order, which means it will not be recorded on a defendant's criminal record. However, an AVO can impose significant restrictions on a defendant's freedom of movement and behaviour and contravention of an order is a criminal offence.[6]

13.8 The AVO framework was first introduced in NSW in 1982 in response to increasing recognition of domestic violence as a social and legal issue. Since that time, the legislation has been expanded to include a wide range of domestic and non-domestic relationships, as well as a wider range of threatening behaviours.[7]

13.9 AVOs are the primary legal means by which a person may seek protection against threatened acts of violence, particularly domestic violence. However, they form only one aspect of domestic violence prevention. Other legal frameworks, such as those pertaining to family law, child protection law and criminal law will impact upon domestic violence outcomes.[8] Non-legal responses are equally crucial, including support and accommodation services for victims, behavioural change programs for perpetrators, and community education.[9] Recognising this, the NSW Government has committed to developing a "Domestic and Family Violence Framework", which will provide a whole-of-government response to the issue of domestic violence. The completed Framework is due to be released for public consultation in June 2013.[10]

Types of AVOs and making an application

13.10 There are two types of AVOs: apprehended domestic violence orders (ADVOs) and apprehended personal violence orders (APVOs).

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5. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 9(2)(a), s 10(2)(a).
6. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 14.
7. See NSW Law Reform Commission, *Apprehended Violence Orders: Part 15A of the Crimes Act*, Discussion Paper 45 (2002) 16-23.
8. See Australian Law Reform Commission and NSW Law Reform Commission, *Family Violence - A National Legal Response*, ALRC Report 114 and NSWLRC Report 128 (2010) [4.1].
9. National Council to Reduce Violence Against Women and Their Children, *Time for Action: The National Council's Plan for Australia to Reduce Violence Against Women and Their Children, 2009-2021* (2009) 16-20. See also Legislative Council Standing Committee on Social Issues, Parliament of NSW, *Domestic Violence Trends and Issues in NSW* (2012) xxi-xxii.
10. NSW Department of Family and Community Services, Women NSW, "Domestic and Family Violence Framework" (2012) <http://www.women.nsw.gov.au/violence_prevention/Domestic_and_Family_Violence_Framework>.

13.11 An ADVO may be made against a defendant with whom the protected person is in a domestic relationship.[11] "Domestic relationship" is defined broadly and includes current and former spouses, housemates, residents of the same residential care facility, paid and unpaid carers, and relatives.[12] An APVO may be made against a defendant with whom the protected person is not in a domestic relationship.[13] This could include, for example, a neighbour, work colleague or friend.

13.12 An application for an AVO may be made by the protected person or by a police officer on the protected person's behalf.[14] The protection granted can also extend to other people with whom the protected person is in a domestic relationship, such as children.[15]

13.13 A police officer *must* apply for an AVO on behalf of a protected person where the police officer suspects that a domestic violence offence, a child abuse offence or an offence of stalking has occurred or is likely to occur.[16] A "domestic violence offence" is a personal violence offence where the parties are or have been in a domestic relationship.[17] An application need not be made if the police officer believes that the protected person intends to make the application themselves, or there is a "good reason" not to make the application.[18]

13.14 For present purposes, the primary distinction between ADVOs and APVOs is that the police are required to apply for an ADVO where it is suspected that a domestic violence offence has occurred or is likely to occur, whereas in the case of an APVO, police have greater discretion. The requirement for police to apply for an AVO was introduced into the legislation in 1992[19] in recognition of the fact that many victims of domestic violence are unable, because of physical or emotional pressure from the perpetrator, to apply for an AVO on their own behalf.[20] At the time, there was a concern that police officers were not always applying for AVOs on behalf of women and children who were in need of protection.[21]

13.15 The registrar has a discretion to refuse an application for an APVO but does not have the same discretion in relation to an ADVO.[22] There are also differences

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11. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 16(1).
12. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 5.
13. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 18.
14. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 48(2).
15. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 38, s 48(4)(c).
16. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 27(1), s 49(1).
17. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 11. "Personal violence offence" is defined in s 4.
18. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 27(4), s 49(4).
19. See *Firearms Legislation (Amendment) Act 1992* (NSW) sch 5 [6]. Prior to 2007 this provision was contained in the *Crimes Act 1900* (NSW) s 562C(3).
20. Joint Select Committee Upon Gun Law Reform, Parliament of NSW, *Report of the Joint Select Committee Upon Gun Law Reform* (1991) 69. See also NSW Department of Attorney General, Criminal Law Review Division, *A Review of the Law Pertaining to Apprehended Violence Orders as Contained in Part 15A of the Crimes Act 1900 (NSW)*, Discussion Paper (1995) 15; *R v Glen* (Unreported, NSW Court of Criminal Appeal, 19 December 1994) (Simpson J).
21. Joint Select Committee Upon Gun Law Reform, Parliament of NSW, *Report of the Joint Select Committee Upon Gun Law Reform* (1991) 69-71.
22. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 53.

between the two orders pertaining to the availability of alternative dispute resolution mechanisms and costs.[23]

Granting an AVO

13.16 There are three different stages at which an AVO may be made.

13.17 A *provisional* AVO can be made by an authorised officer[24] upon application by a police officer, where the police officer has good reason to believe that a provisional order needs to be made immediately to ensure the safety of the protected person or to prevent substantial damage to property.[25]

13.18 An *interim* order may be made by the court if it is necessary or appropriate to do so in the circumstances, and may be made in the absence of the defendant.[26] If an interim order is made the court is to require the defendant to appear at a further hearing as soon as practicable.[27]

13.19 The court may make a *final* AVO, which is to be in force for such a period of time as the court considers necessary to ensure the safety and protection of the protected person.[28]

13.20 The defendant may consent to the making of a final AVO or an interim AVO, in which case the court does not need to satisfy itself of the particulars of the application.[29]

13.21 Every AVO contains three standard restrictions, prohibiting the defendant from: assaulting, harassing or threatening the protected person; engaging in intimidating conduct; and stalking the protected person.[30] The court may impose any other conditions it considers appropriate,[31] but only to the extent that these are necessary for the safety of the protected person.[32]

13.22 The court is required to explain to the parties the effect of the order, the consequences that may flow from contravention of the order and the rights of the parties.[33] It must also cause a written explanation to be provided to this effect.[34]

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23. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 21, s 99.
24. Defined to mean a Magistrate, Children's Magistrate, Registrar of the Local Court or the Children's Court or an employee of the Attorney General's Department authorised as such: *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 3; *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW) s 3.
25. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 25, s 26.
26. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 22.
27. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 22(5).
28. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 79.
29. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 78.
30. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 36.
31. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 35.
32. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 17(3), s 20(3).
33. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 76(1).
34. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 76(3).

Matters to be considered by the court when deciding to make an AVO

13.23 The court may make an AVO if, on the balance of probabilities, it is satisfied that the applicant has reasonable grounds to fear, and in fact fears, the commission of a personal violence offence, intimidation or stalking.[35]

13.24 Section 17 of the CDPVA details the matters to be considered by the court when making an ADVO, providing relevantly as follows:

> (1) In deciding whether or not to make an apprehended domestic violence order, the court must consider the safety and protection of the protected person and any child directly or indirectly affected by the conduct of the defendant alleged in the application for the order.
>
> (2) Without limiting subsection (1), in deciding whether or not to make an apprehended domestic violence order, the court is to consider:
>
> (a) in the case of an order that would prohibit or restrict access to the defendant's residence—the effects and consequences on the safety and protection of the protected person and any children living or ordinarily living at the residence if an order prohibiting or restricting access to the residence is not made, and
>
> (b) any hardship that may be caused by making or not making the order, particularly to the protected person and any children, and
>
> (c) the accommodation needs of all relevant parties, in particular the protected person and any children, and
>
> (d) any other relevant matter.
>
> (3) When making an apprehended domestic violence order, the court is to ensure that the order imposes only those prohibitions and restrictions on the defendant that, in the opinion of the court, are necessary for the safety and protection of the protected person, and any child directly or indirectly affected by the conduct of the defendant alleged in the application for the order, and the protected person's property.

13.25 Section 20 of the CDPVA, which applies to the making of an APVO, is expressed in identical terms.

13.26 Notably, the court is not expressly directed to consider the defendant's capacity to understand and comply with an AVO when deciding whether or not to make an order. In *Farthing v Phipps*,[36] the NSW District Court held that the defendant's lack of capacity constituted a "relevant matter" under s 17(2)(d) of the CDPVA for the court to take into account in deciding whether or not make an ADVO.

13.27 In that case Ms Phipps and Mr Farthing were placed by Ageing, Disability and Home Care (ADHC) in shared accommodation. This common living arrangement led to Ms Phipps abusing and assaulting Mr Farthing. As the Court put it, this conduct was attributable to Ms Phipps' "psychological makeup". Mr Farthing sought an ADVO against Ms Phipps.

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35. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 16(1), s 19(1). There are circumstances in which actual fear by the protected person is not required: see s 16(2), s 19(2).

36. *Farthing v Phipps* [2010] NSWDC 317; 12 DCLR (NSW) 158.

13.28 In overturning the Local Court's decision to issue an ADVO, Judge Lakatos stated:

> I conclude that it is not appropriate to make a domestic violence order, because the weight of the evidence convinces me that such an order and its terms would not be properly understood by Ms Phipps, and accordingly that she would place herself at risk of breaching those orders in a fashion which is unintended by her. Furthermore, I conclude that the making of any order would not serve to protect Mr Farthing but it would simply expose Ms Phipps to the criminal process in circumstances where given her cognitive capacity, it would be unfair to do so.[37]

13.29 His Honour found that the CDPVA proceeded on the basis that an order directed to the defendant would be understood by that defendant and acted upon. As a matter of principle, if the court concludes that the order will not have this effect, then that is a substantial reason under s 17 not to make the order.[38] Furthermore, where the defendant cannot comprehend the order, meaning that he or she may unwittingly breach the order and expose him or herself to imprisonment, that would be a sufficient other reason why an order should not be made.[39]

13.30 In QP 1, we asked whether there has been any change to the practice of the courts since the decision in *Farthing v Phipps*.[40] None of the submissions we received were aware of any case in which *Farthing v Phipps* had been subsequently applied.[41]

13.31 However, the reasoning in *Farthing v Phipps* needs to be considered in the context of the facts which applied in that case. The evidence before the District Court was that Ms Phipps and Mr Farthing were no longer sharing accommodation. There was the likelihood of their coming into contact in certain circumstances, and on those occasions their supervisors would take extra steps to ensure that there would be no abusive conduct by Ms Phipps.[42] Although the affidavit evidence of Mr Farthing suggested that he was still in fear of abuse and violence from Ms Phipps,[43] it appears that the need for an ADVO had dissipated significantly. A different outcome may have been reached in that case had the defendant's behaviour continued to pose a real threat.

Failure to comply with an AVO

13.32 It is a criminal offence to knowingly contravene a prohibition or restriction contained in an AVO.[44] The maximum penalty is two years imprisonment or a fine of $5500, or both. Furthermore, unless the court orders otherwise, a person who breaches an AVO in a manner that involves an act of violence must be sentenced to a term of

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37. *Farthing v Phipps* [2010] NSWDC 317; 12 DCLR (NSW) 158 [37].
38. *Farthing v Phipps* [2010] NSWDC 317; 12 DCLR (NSW) 158 [33].
39. *Farthing v Phipps* [2010] NSWDC 317; 12 DCLR (NSW) 158 [33].
40. NSW Law Reform Commission, *Apprehended Violence Orders,* People with Cognitive and Mental Health Impairments in the Criminal Justice System: Question Paper 1 (2012) Question 2.
41. Chief Magistrate of the Local Court of NSW, *Submission MH49*, 1; Shopfront Youth Legal Centre, *Submission MH52*, 2; Legal Aid NSW, *Submission MH55*, 4; NSW Department of Family and Community Services, *Submission MH59*, 5; Law Society of NSW, *Submission MH60*, 2.
42. *Farthing v Phipps* [2010] NSWDC 317; 12 DCLR (NSW) 158 [5].
43. *Farthing v Phipps* [2010] NSWDC 317; 12 DCLR (NSW) 158 [6].
44. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 14(1).

imprisonment.[45] Consent on the part of the protected person is not a defence to the charge.[46]

13.33 There is a question about the extent to which a defendant's cognitive or mental health impairment is relevant in determining whether the defendant "knowingly" contravened the AVO. In *Farthing v Phipps*, Judge Lakatos stated:

> Even though the 'knowingly' must refer to contravention in my opinion it is implicit in that particular notion that one cannot knowingly contravene something if one does not understand what the prohibition is.[47]

13.34 Similarly, in Report 103, *Apprehended Violence Orders*, we concluded that it is implicit in the legislation that a person with a severe intellectual disability will be incapable of understanding the terms of an order and thereby incapable of "knowingly" breaching it.[48]

13.35 In practice, therefore, it appears that a person who is incapable of understanding the terms of an AVO due to a cognitive or mental health impairment would not be convicted of knowingly contravening an order, even though there is no direct legislative or judicial statement to this effect.

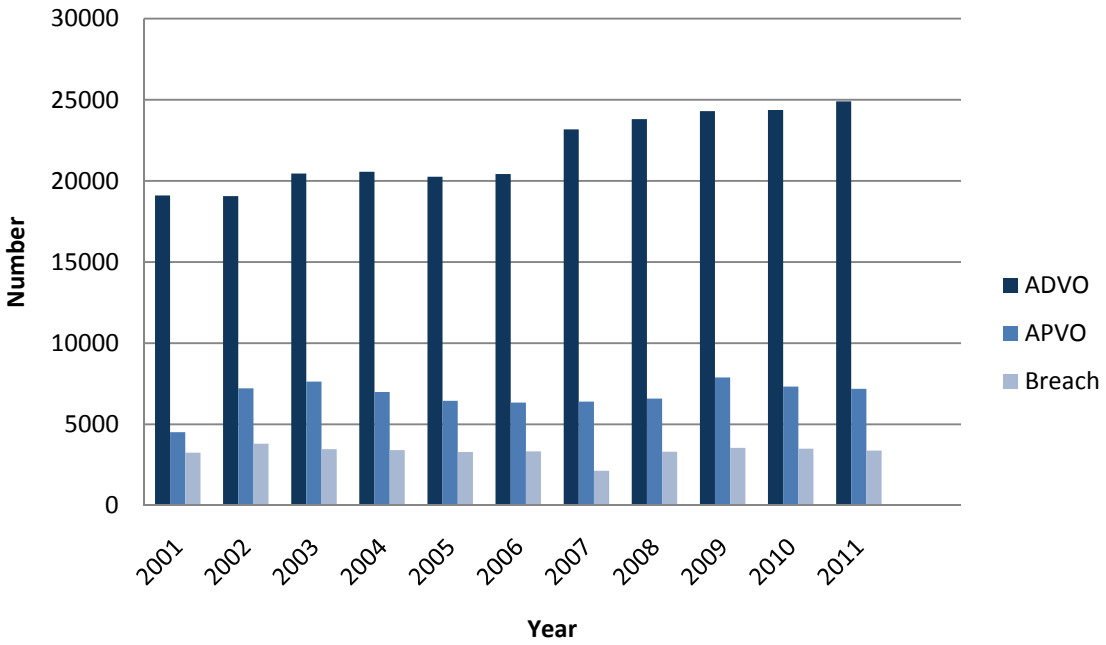
Incidence of AVOs and people with cognitive and mental health impairments

13.36 The number of AVOs made in the last 10 years has risen significantly, from 26 621 in 2001 to 32 097 in 2011.[49] This increase may be attributable at least in part to legislative changes introduced in 2007, which require an AVO to be made automatically where the defendant is charged with certain serious personal violence offences.[50] However, the number of convictions for breach of an AVO has remained consistently small despite the increase in the number of orders made, at around 3000 to 4000 convictions per year.[51] This means that convictions for breach of an AVO represent only around 10-15% of the total number of AVOs made each year. During the period from October 2008 to September 2012 the most common penalties for breach of an ADVO were the imposition of a good behaviour bond

45. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 14(4).
46. See *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 14.
47 *Farthing v Phipps* [2010] NSWDC 317; 12 DCLR (NSW) 158 [22].
48. NSW Law Reform Commission, *Apprehended Violence Orders*, Report 103 (2003) [6.20].
49. NSW Bureau of Crime Statistics and Research, *Apprehended Violence Orders* <http://www.bocsar.nsw.gov.au/lawlink/bocsar/ll_bocsar.nsf/pages/bocsar_court_stats>. These figures refer to the number of final AVOs issued in the Local Court. They do not include interim orders or orders made in the Children's Court or Higher Courts: see NSW Bureau of Crime Statistics and Research, *New South Wales Criminal Courts Statistics 2011* (2012) 138.
50. See Legislative Council Standing Committee on Social Issues, Parliament of NSW, *Domestic Violence Trends and Issues in NSW* (2012) [7]. See also the second reading speech for the Crimes (Domestic and Personal Violence) Bill 2007: NSW, *Parliamentary Debates,* Legislative Council, 16 November 2007, 4327 (T Gadiel).
51. Data supplied by the NSW Bureau of Crime Statistics and Research (ref: kg12-11001). These figures include the number of people found guilty in the Local and Higher Courts, where breach of an AVO was the principal offence charged. Legislative changes in 2007 may mean that the figures before and after this date are not directly comparable.

without supervision (21%), a fine (18%), a good behaviour bond with supervision (16%) and imprisonment (15%).[52] The primary penalties for breach of an APVO during the same period were a fine (27%) and a good behaviour bond without supervision (26%).[53]

Figure 13.1: AVO trends, NSW 2001 - 2011



Source: NSW Bureau of Crime Statistics and Research, Apprehended Violence Orders;[54] NSW Bureau of Crime Statistics and Research (ref: kg12-11001)

13.37 There is a lack of empirical evidence regarding the incidence of AVOs taken out against people with cognitive and mental health impairments. This may be partly because the issue of a person's impairment is not always raised in AVO proceedings, particularly if the person is not legally represented, or because it may not always be apparent to a police officer or a court that a person has an impairment.

13.38 Some stakeholders were able to provide us with relevant empirical evidence. The Hunter Community Legal Centre advised that in the 12 months to 1 September 2012 it had provided advice and assistance to about 40 defendants to AVO

52. This is based on sentences imposed in the Local Court for breach of ADVO as the principal offence between October 2008 and September 2012 (13 156 cases in total): information extracted from the Judicial Commission of NSW, Judicial Information Research System: Local Courts, s 14(1) of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) at January 2013.

53. This is based on sentences imposed in the Local Court for breach of APVO as the principal offence between October 2008 and September 2012 (1172 cases in total): information extracted from the Judicial Commission of NSW, Judicial Information Research System: Local Courts, s 14(1) of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) at January 2013.

54. Excel spreadsheet, accessible at: <http://www.bocsar.nsw.gov.au/lawlink/bocsar/ll_bocsar.nsf/pages/bocsar_court_stats>.

proceedings who had an intellectual disability.[55] The NSW Department of Family and Community Services (DFACS) informed us that the Western Region of ADHC identified 10 current clients who have had AVOs made against them in the last two years, all of whom have a mild or moderate intellectual disability.[56]

13.39 More generally the experience reported by stakeholders is that AVOs are commonly being taken out against people with cognitive and mental health impairments,[57] and that these orders are regularly breached.[58] On the basis of the experience of stakeholders, it is possible to hypothesise that the breach rate of AVOs may be higher for defendants with cognitive and mental health impairments. The information available at this time does not allow us to conclude with any certainty that this is the case. Nevertheless, the consequences of an AVO, and particularly of breach, mean that there is value in considering what can be done to make the AVO framework fairer for this cohort.

Circumstances in which AVOs are being taken out against people with cognitive and mental health impairments

13.40 In QP 1 we asked stakeholders to provide us with examples of circumstances in which AVOs are being taken out against people with cognitive and mental health impairments.[59]

13.41 Legal Aid NSW advised that, in its experience, the most common circumstances in which AVOs are made against people with cognitive and mental health impairments are where the impaired person is engaging in:

(a) aggressive behaviour in a family, carer or group home setting, or

(b) stalking or harassment of a person in pursuit of a relationship with them.[60]

13.42 This is consistent with the information and case examples provided by other stakeholders. There appear to be three primary categories in which AVOs are taken out against defendants with cognitive and mental health impairments:

- ADVOs taken out on behalf of family members (such as a parent)
- ADVOs taken out on behalf of a paid carer, and

55. NSW Law Reform Commission analysis of information supplied by the Hunter Community Legal Centre: see Hunter Community Legal Centre, *Submission MH58*, 2; Information supplied by the Hunter Community Legal Centre, 5 February 2013.
56. NSW Department of Family and Community Services, *Submission MH59,* 2.
57. Law Society of NSW, *Submission MH36,* 8; Shopfront Youth Legal Centre, *Submission MH52*, 2; Legal Aid NSW, *Submission MH55*, 3; Law Society of NSW, *Submission MH60*, 2.
58. Law Society of NSW, *Submission MH36,* 9; Legal Aid NSW, *Submission MH38,* 6; Shopfront Youth Legal Centre, *Submission MH52*, 2; Hunter Community Legal Centre, *Submission MH58*, 2; NSW Department of Family and Community Services, *Submission MH59,* 2; Law Society of NSW, *Submission MH60*, 2.
59. NSW Law Reform Commission, *Apprehended Violence Orders,* People with Cognitive and Mental Health Impairments in the Criminal Justice System: Question Paper 1 (2012) Questions 2-3.
60. Legal Aid NSW, *Submission MH55*, 3.

- APVOs taken out on behalf of neighbours, friends or strangers, where the defendant is engaging in stalking or harassing behaviour.

13.43 Particularly in the case of parents and carers, it appears that AVOs are being applied for where the person with a cognitive or mental health impairment has engaged in actual violence, and either the police are called to assist, or it is believed that an AVO is the only remaining way of dealing with the person's behaviour.[61] Many submissions noted that parents and carers in these circumstances make AVO applications very reluctantly, or do not desire one at all, but an application is made by the police officer who is called to attend.[62] The case studies that have been provided to us indicate that, in a great number of cases, the behaviour in relation to which the AVO is sought is linked to the defendant's cognitive or mental health impairment.

13.44 We were not provided with any examples of AVOs being taken out against people with cognitive and mental health impairments in a traditional domestic violence setting - that is, where domestic violence is being perpetrated by the more powerful family member against a more vulnerable one - although it has been indicated by stakeholders that this does sometimes occur.[63] The information we have received suggests that there are a range of situations in which AVOs are taken out against people with cognitive and mental health impairments, many of which do not match the most commonly found manifestations of domestic and personal violence in the general population.

Family members

13.45 In QP 1 we asked whether parents are seeking AVOs against children (including adult children) with cognitive and mental health impairments.[64]

13.46 Many stakeholders informed us that it was not uncommon for AVOs to be sought on behalf of a parent against a child with a cognitive or mental health impairment.[65] In these circumstances, the child's impairment will often have been compounded by alcohol or drug use or by violent and/or illegal behaviour.[66]

13.47 In some cases, parents may reluctantly seek an AVO to assist them to deal with their child's behavioural issues,[67] or as a way of obtaining access to healthcare

61. Apprehended Violence Legal Issues Coordinating Committee, *Consultation MH12.*
62. Shopfront Youth Legal Centre, *Submission MH52,* 6; Legal Aid NSW, *Submission MH55,* 8; NSW Department of Family and Community Services, *Submission MH59,* 15.
63. Women's Legal Services NSW, *Submission MH54*, 7; Apprehended Violence Legal Issues Coordinating Committee, *Consultation MH12*.
64. NSW Law Reform Commission, *Apprehended Violence Orders,* People with Cognitive and Mental Health Impairments in the Criminal Justice System: Question Paper 1 (2012) Question 6.
65. Chief Magistrate of the Local Court of NSW, *Submission MH49*, 3 ; Children's Court of NSW, *Submission MH50*, 5; Shopfront Youth Legal Centre, *Submission MH52*, 5; Legal Aid NSW, *Submission MH55*, 8; NSW Department of Family and Community Services, *Submission MH59,* 15.
66. Chief Magistrate of the Local Court of NSW, *Submission MH49*, 3; Legal Aid NSW, *Submission MH55,* 8; NSW Department of Family and Community Services, *Submission MH59*, 15.
67. Legal Aid NSW, *Submission MH38*, 6; Children's Court of NSW, *Submission MH50,* 5; NSW Department of Family and Community Services, *Submission MH59*, 15.

services for their child.[68] DFACS provided us with an example of a mother who took out an AVO against her adult son as she was desperate for him to be provided with permanent ADHC accommodation. As a result of the order, ADHC was required to find emergency accommodation for the son as he was not allowed to return home.[69] Legal Aid NSW informed us that family members who seek an AVO are sometimes just seeking help for the defendant, and unfortunately the AVO mechanism may be the only way this can occur.[70]

Case study 13.1

A client with a moderate intellectual disability was aggressive towards his parents in the family home. The mother took out an AVO against the client as a result of which he was unable to live in the family home. ADHC Community Support Team was involved and had to find immediate accommodation and care for this man. The mother had very mixed emotions about the action she had taken and the son was not able to understand that he could not see his mother or father. The mother eventually resumed contact with her son.[71]

13.48 In other cases, AVOs may not be intentionally sought. Parents may contact police to seek assistance with an incident that has escalated and which they cannot handle. They may be unaware that the police are required to apply for an ADVO if they form the view that a domestic violence offence has occurred. Often this is not the sort of outcome that parents want.[72]

Case study 13.2

Sam, aged 23 years, suffers from major depression, Asperger's disorder and [attention deficit hyperactivity disorder]. Sam lives at home with his mother and stepfather who are his carers.

Earlier this year Sam had a disagreement with his stepfather and damaged an internal door before attempting to leave the home. Sam's stepfather attempted to prevent Sam from leaving and during a scuffle between Sam and his stepfather the police were called.

The police charged Sam with malicious damage and applied for an AVO against Sam on behalf of his mother and stepfather. Neither Sam's mother nor stepfather wanted police to apply for the AVO.

Sam subsequently repaired the damage to the internal door.[73]

13.49 It is not clear that AVOs taken out in these circumstances are always effective,[74] particularly as family members may have only needed a circuit-breaker and may

68. Legal Aid NSW, *Submission MH55,* 8; NSW Department of Family and Community Services, *Submission MH59,* 15.
69. NSW Department of Family and Community Services, *Submission MH59,* 14.
70. Legal Aid NSW, *Submission MH55,* 3.
71. NSW Department of Family and Community Services, *Submission MH59*, 4.
72. Shopfront Youth Legal Centre, *Submission MH52,* 6; Legal Aid NSW, *Submission MH55*, 8; Law Society of NSW, *Submission MH60*, 4.
73. Hunter Community Legal Centre, *Submission MH58,* 5-6.
74. Chief Magistrate of the Local Court of NSW, *Submission MH49,* 3; NSW Trustee and Guardian, *Submission MH56*, 7; NSW Department of Family and Community Services, *Submission MH59,* 15.

later reconcile. Other strategies to change behaviour were supported by some stakeholders.[75] DFACS informed us that, as a behaviour management strategy, AVOs can be ineffective where enforcement of the order by the parent or the police is inconsistent.[76] AVOs can have the effect of prohibiting a child from having contact with family members or from visiting the family home, which may be the only stable feature of the child's lifestyle.[77]

Paid carers

13.50 A number of stakeholders were aware of circumstances in which an AVO had been taken out against a person with cognitive or mental health impairment on behalf of a paid carer, particularly in a residential care facility.[78] Stakeholders noted that this was sometimes a way of managing disruptive or violent behaviour.[79]

13.51 The relationship between a paid carer and a client is classified as a "domestic relationship", which means that the provisions for making an ADVO will apply.[80] Significantly, it means that police must apply for an ADVO on behalf of a paid carer where violence by the client has occurred or is likely to occur.[81] We were informed by stakeholders that police are sometimes called to a residential facility to manage the behaviour of a resident. However, it may then be incumbent on the police officer to apply for an ADVO on the carer's behalf, even if this is contrary to the carer's wishes.[82] DFACS reported that carers may find the making of AVOs in these circumstances traumatic.[83] The Law Society of NSW noted that this well-intentioned change to the definition of "domestic relationship" in the CDPVA has had the unfortunate side effect of causing an increase in orders taken out against vulnerable people in care.[84] We deal later in this chapter with the issue of whether paid carers should continue to be included in the definition of "domestic relationship".

13.52 The use of AVOs on behalf of paid carers against their clients may compromise the carer's ability to maintain rapport and continue in a supportive relationship with the client.[85] Nor is the use of AVOs likely to bring about any lasting beneficial change to

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75. Children's Court of NSW, *Submission MH50*, 5; Legal Aid NSW, *Submission MH55*, 9; NSW Department of Family and Community Services, *Submission MH59,* 16.
76. NSW Department of Family and Community Services, *Submission MH59,* 15.
77. Legal Aid NSW, *Submission MH55*, 8; NSW Trustee and Guardian, *Submission MH56,* 7.
78. Children's Court of NSW, *Submission MH50*, 4; Shopfront Youth Legal Centre, *Submission MH52,* 5; Legal Aid NSW, *Submission MH55,* 7; NSW Trustee and Guardian, *Submission MH56*, 6; NSW Department of Family and Community Services, *Submission MH59,* 13.
79. Children's Court of NSW, *Submission MH50,* 4; Legal Aid NSW, *Submission MH55,* 7; NSW Department of Family and Community Services, *Submission MH59,* 13; Shopfront Youth Legal Centre, Submission to Department of Attorney General and Justice, *Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007,* 18 November 2011, 2.
80. See *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 5(f), s 15.
81. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 27(1)(a), s 49(1)(a).
82. See Department of Human Services NSW (Community Services), *Submission MH35-2*, 8-9; Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH35-4*, 4.
83. NSW Department of Family and Community Services, *Submission MH59*, 14.
84. Law Society of NSW, *Submission MH60*, 3.
85. Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH35-4,* 4; Legal Aid NSW; *Submission MH55,* 6; NSW Department of Family and Community Services, *Submission MH59*, 14.

the person's behaviour.[86] Conversely, it can have significant detrimental effects for a person with a cognitive or mental health impairment. It will often mean that they will need to be discharged from the residential facility where they are living, or relocated so as to avoid coming into contact with the protected person.[87] Alternatively, if the person remains in the residential facility, then he or she can be at risk of breaching the terms of the AVO.[88] Significantly, this may also restrict their ability to access residential facilities in the future, since many programs exclude people with a history of violent offences.[89]

Case study 13.3

An AVO was taken out against an individual with an intellectual disability by one of their residential support workers. The worker continued to be rostered on shifts in the home, thereby heightening the risk of the AVO being breached.[90]

Neighbours, friends and strangers

13.53 Stakeholders provided us with a number of examples where APVOs had been taken out against people with cognitive and mental health impairments who had been displaying aggressive or threatening behaviour towards others with whom they were not in a domestic relationship.

Case study 13.4

A Legal Aid NSW client developed a fixation on his female neighbour. The neighbour had been friendly to him in the past and in his mind he considered her to be his girlfriend, despite the fact that the neighbour was already in a relationship.

The client relentlessly pursued the neighbour and pleaded with her to go out with him. He would regularly wait for her to arrive or leave home and then approach her, make phone calls, berate her when he saw her with her boyfriend, grab her arm, and stand in front of the car so she could not drive away.

The neighbour and her family obtained an AVO against the client. He continually breached the order and assaulted the neighbour's boyfriend and other family members. The client's family refused intervention of professionals, in part because they did not completely accept that their son had an intellectual disability.[91]

86. NSW Department of Family and Community Services, *Submission MH59*, 13.
87. Legal Aid NSW, *Submission MH55*, 6; NSW Trustee and Guardian, *Submission MH56*, 6; People with Disability Australia Incorporated, Submission to Department of Attorney General and Justice, *Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007*, November 2011, 25.
88. People with Disability Australia Incorporated, Submission to Department of Attorney General and Justice, *Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007*, November 2011, 25.
89. Legal Aid NSW, *Submission MH55*, 8.
90. NSW Department of Family and Community Services, *Submission MH59,* 2-3 (edited).
91. Legal Aid NSW, *Submission MH55*, 6 (edited).

Case study 13.5

Brad has a mild intellectual disability and a psychotic illness in addition to cerebral palsy and epilepsy. Further, he has been diagnosed as suffering from post traumatic stress disorder, severe depression and moderate anxiety disorder.

An APVO application was made against Brad by police in relation to stalking his counsellor, Sarah. Brad believed that Sarah was his girlfriend and told police that he had been following her to protect her. When Sarah confirmed to police that she was no longer Brad's therapist and that the relationship had always been a professional one, the police took out an APVO against Brad.[92]

Case study 13.6

A woman with a diagnosis of mild intellectual disability and borderline personality disorder had an AVO taken out against her by a shopping centre. She had previously accessed this centre in order to meet men for sexual activity and frequently engaged in aggressive behaviour towards other clients who also frequented the centre. Complaints were made to the centre management by shoppers and shop keepers regarding her behaviour and the impact on their trade. When the AVO was made, she understood that security at the centre would call police and that other people would see her being asked to leave the shopping centre. The woman stopped her behaviour.[93]

13.54 In these case studies the behaviour displayed by the defendant, while understandably threatening to others, appears also to be a consequence of the defendant's cognitive or mental health impairment.

Understanding and complying with AVOs

Do people with cognitive and mental health impairments have difficulty understanding AVOs?

13.55 A person's ability to comprehend the terms of an AVO is important because it has a direct effect on their ability to comply with the order. In QP 1 we asked whether people with cognitive and mental health impairments have difficulty understanding the terms of an AVO due to their impairment.[94] Stakeholders informed us that, in their experience, this was the case.[95] There appear to be two primary reasons for this.

92. Shopfront Youth Legal Centre, *Submission MH52*, 4 (edited).
93. NSW Department of Family and Community Services, *Submission MH59*, 3-4 (edited).
94. NSW Law Reform Commission, *Apprehended Violence Orders,* People with Cognitive and Mental Health Impairments in the Criminal Justice System: Question Paper 1 (2012) Question 2.
95. NSW Department of Family and Community Services, *Submission MH59*, 3; Shopfront Youth Legal Centre, *Submission MH52*, 2; Legal Aid NSW, *Submission MH55*, 4; Law Society of NSW, *Submission MH60*, 2. See also Department of Human Services NSW (Juvenile Justice), *Submission MH35-1*, 12; Law Society of NSW, *Submission MH36*, 10; Legal Aid NSW, *Submission MH38,* 6.

Problems with understanding what the order means

13.56 Stakeholders suggested that people with cognitive and mental health impairments typically have difficulty in understanding the conditions contained in an AVO. The Shopfront Youth Legal Centre (SYLC) noted that even though defendants will usually receive a copy of the AVO, people with cognitive and mental health impairments often have problems with literacy and understanding the language in which AVO conditions are expressed.[96] The Law Society of NSW also suggested that the wording of an AVO, such as the prohibition on assaulting, threatening, intimidating or stalking a protected person, can be difficult for a person with a cognitive or mental health impairment to understand.[97] Juvenile Justice explained that young people with cognitive and mental health impairments, in particular, have difficulty understanding and remembering conditions contained in an AVO that include a lengthy list or are phrased in complex language.[98] DFACS noted that defendants with cognitive or mental health impairments can have difficulty understanding distance requirements and remembering the conditions of the AVO. They may find it difficult to generalise the intent of the order across different situations and environments, and scan ahead in order to avoid contact with the protected person.[99]

Case study 13.7

A woman with an impairment was a Women's Domestic Violence Court Advocacy Services client. She was a defendant in an AVO matter due to her harassment of a young man. She was very unwell when the AVO was made and could not understand that she was not allowed to contact the young man she was harassing. It was explained to her many times at Court on the day of the mention, but she was unable to comprehend the "no contact" clause. As a result, the woman breached the AVO on a number of occasions.

The woman was then hospitalised for some months and had her medication changed. To the knowledge of WDVCAS the client has not breached her AVO since. She became healthier and as a result developed a clearer understanding of the implications of the AVO.[100]

Case study 13.8

In the case of Brad (case study 13.5), who had an APVO taken out against him on behalf of his counsellor Sarah, one of the conditions of the APVO was that Brad not go within 50 metres of the health centre where Sarah worked.

Brad had difficulty understanding and complying with the order. Within a week of the final order being made, he was arrested for breaching the 50-metre condition. It was alleged that he was seen walking past the health centre one day, and sitting on a bus bench across the road on another occasion.

96. Shopfront Youth Legal Centre, *Submission MH52*, 2.
97. Law Society of NSW, *Submission MH36*, 10; Law Society of NSW, *Submission MH60*, 2.
98. Department of Human Services NSW (Juvenile Justice), *Submission MH35-1*, 12.
99 NSW Department of Family and Community Services, *Submission MH59,* 7.
100. Legal Aid NSW, *Submission MH55*, 4 (edited).

> Brad did not understand the conditions imposed upon him, as he had very little concept of the meaning of 50 metres.[101]

13.57 Notwithstanding the fact that defendants with cognitive and mental health impairments will often have difficulty understanding the terms of an AVO, DFACS submitted that this is not invariably the case. Defendants with cognitive and mental health impairments are more likely to understand the terms of an AVO where the conditions of the order are simple and can be easily followed, such as a condition not to enter specific premises or not to speak to a specific person.[102]

> **Case study 13.9**
>
> A client with a borderline level of intellectual disability formed a relationship with a woman which eventually ended at the request of the woman. The client would not leave her alone, made threats against her and wanted the relationship to continue. The woman's father took out an AVO against the client in order to stop him from harassing her. The client understood in very concrete terms that he was not allowed to talk with her or see her or the police would be called. The client stopped his behaviour towards the woman.[103]

Lack of legal representation

13.58 Stakeholders also identified the lack of legal representation as another reason why defendants with cognitive and mental health impairments experience difficulties understanding the terms of an AVO.[104]

13.59 Legal Aid NSW only provides representation for defendants in respect of AVO applications where there is an associated criminal charge or there are otherwise exceptional circumstances.[105] However, Legal Aid is currently trialling an AVO duty representation service for defendants in the Mt Druitt Local Court, to assist in achieving workable orders.[106]

13.60 Defendants who are unrepresented may be unable to properly defend an AVO application or to negotiate workable conditions.[107] They are also more likely to consent to an AVO because they are not able to understand or participate effectively in the court system.[108] This lack of legal representation can be particularly problematic for defendants with cognitive and mental health

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101. Shopfront Youth Legal Centre, *Submission MH52*, 4 (edited).
102. NSW Department of Family and Community Services, *Submission MH59*, 3.
103. NSW Department of Family and Community Services, *Submission MH59*, 4.
104. Shopfront Youth Legal Centre, *Submission MH52,* 3. See also Legal Aid NSW, *Submission MH55*, 10; NSW Trustee and Guardian, *Submission MH56,* 3.
105. See Legal Aid NSW, *Submission MH55*, 10. "Exceptional circumstances" may include where the defendant has an intellectual disability: see NSW Law Reform Commission, *Apprehended Violence Orders,* Report 103 (2003) 6 (footnote 16).
106. See Legislative Council Standing Committee on Social Issues, Parliament of NSW, *Domestic Violence Trends and Issues in NSW* (2012) [10.87]-[10.89].
107. Shopfront Youth Legal Centre, Submission to Legislative Council Standing Committee on Social Issues, Parliament of NSW, *Inquiry into Domestic Violence Trends and Issues in NSW*, 23 September 2011, 8.
108. Legal Aid NSW, *Submission MH55*, 10. See also NSW Law Reform Commission, *Apprehended Violence Orders,* Report 103 (2003) [7.78].

impairments, who will not have a representative to assist them to understand the terms of the AVO or to seek tailored conditions which are suitable for their circumstances. The experience of Legal Aid NSW is that the likelihood of breaches of AVOs is reduced where the implications of the AVO are clearly explained.[109] The court is required by the CDPVA to explain the effect of the order and the consequences of contravention to the protected person and the defendant,[110] but with a heavy workload it is not always possible for a magistrate to explain the AVO conditions to the defendant as thoroughly as they may like.[111]

Do people with cognitive and mental health impairments have difficulty complying with AVOs?

13.61 Stakeholders also informed us that people with cognitive and mental health impairments often have difficulty complying with the terms of an AVO.[112] This is partly due to a lack of understanding of the terms of the order, but also partly because people with cognitive and mental health impairments can experience difficulty in complying with the order. Compliance may be difficult due to:

- impulsivity, emotional immaturity or an inability for the person to control his or her behaviour (such as where the person has a mental illness of a psychotic nature)[113]
- drug and alcohol use, inadequate housing or the threat of homelessness[114]
- the fluctuating nature of many mental illnesses, meaning that a defendant may have the capacity to comply with the order at the time it is made, but his or her condition may deteriorate during the duration of the order, affecting the defendant's ability to comply[115]
- unstable relationships characterised by periods of conflict, followed by periods of harmony. In the time between the incident and the court hearing, the relationship with the protected person may have moved to one of peace, and the protected person may wish to resume contact with the defendant[116]

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109. Legal Aid NSW, *Submission MH55*, 4. See also NSW Department of Family and Community Services, *Submission MH59,* 3.
110. See *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 76.
111. See Legislative Council Standing Committee on Social Issues, Parliament of NSW, *Domestic Violence Trends and Issues in NSW* (2012) [10.68].
112. Public Interest Advocacy Centre, *Submission MH51,* 3; Shopfront Youth Legal Centre, *Submission MH52,* 3; Legal Aid NSW, *Submission MH55,* 5; Hunter Community Legal Centre, *Submission MH58,* 3; NSW Department of Family and Community Services, *Submission MH59,* 6; Law Society of NSW, *Submission MH60*, 3.
113. Public Interest Advocacy Centre, *Submission MH51,* 3; Shopfront Youth Legal Centre, *Submission MH52,* 3; Legal Aid NSW, *Submission MH55,* 5; Hunter Community Legal Centre, *Submission MH58,* 3; Law Society of NSW, *Submission MH60*, 3.
114. Shopfront Youth Legal Centre, *Submission MH52*, 3; Legal Aid NSW, *Submission MH55*, 6.
115. NSW Trustee and Guardian, *Submission MH56,* 4-5.
116. NSW Department of Family and Community Services, *Submission MH59*, 7.

- an inability to engage in "higher order" thinking to consider the consequences of the person's actions, thereby breaching an AVO without really thinking about it,[117] or
- difficulty resisting peer pressure.[118]

Case study 13.10

A Legal Aid NSW client had obtained multiple mental health diagnoses from different professionals. He was wanted by police across two states for breaching bail and AVOs, and not appearing in court.

While the client may have understood he had an AVO in place, his decision-making and reactivity were driven by his mental state and his inability to function and respond appropriately to "normal" situations or conflict as a result of inconsistent treatment of his mental health condition.[119]

13.62 Submissions also asserted that people with cognitive and mental health impairments often have trouble understanding that consent by the protected person is not a defence to breach of an AVO. Particularly where the AVO is taken out on behalf of a family member, it is not uncommon for that family member to subsequently seek to reconcile with the defendant. If the defendant makes contact with the protected person, even at the latter's invitation or request, the defendant will be in breach of the AVO. This difficulty was emphasised repeatedly in submissions.[120]

Case study 13.11

Ivan had depression and lived at home with his parents.

Following an altercation between Ivan and his father, police attended the house. Ivan was taken to hospital where he was assessed for involuntary admission under the *Mental Health Act 2007* (NSW) but later discharged. Meanwhile the police took out provisional orders for the protection of both of Ivan's parents. These orders prohibited him from going back to the house or approaching or contacting either of his parents.

On discharge from hospital, Ivan had to find somewhere else to stay. A few days later he spoke with his mother on the phone and she agreed that he could come back to the house to pick up some of his belongings. He did not understand that the AVO prohibited him from doing this. His mother did not seem to understand this either, or at least she thought there would be no breach of the order if she consented.

When Ivan attended his parents' house, his father was at home and an argument ensued which resulted in the police being called. Ivan was

117. NSW Department of Family and Community Services, *Submission MH59*, 7. See also Legal Aid NSW, *Submission MH55*, 5.
118. NSW Department of Family and Community Services, *Submission MH59*, 7.
119. Legal Aid NSW, *Submission MH55*, 3 (edited).
120. Public Interest Advocacy Centre, *Submission MH40*, 32; Shopfront Youth Legal Centre, *Submission MH41,* 8; Legal Aid NSW, *Submission MH55,* 6; Hunter Community Legal Centre, *Submission MH58*, 3; Shopfront Youth Legal Centre, Submission to Department of Attorney General and Justice, *Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007,* 18 November 2011, 13.

charged with contravening the AVO and was initially refused bail overnight.[121]

Support services for defendants

13.63 Another common theme which emerged from submissions is that legal remedies alone will frequently be ineffective in providing protection from violence, especially where the defendant has a cognitive or mental health impairment. Non-legal approaches are also required, such as support services to assist people to deal with the underlying causes of their behaviour and to change behaviours. In the absence of such supports, defendants with cognitive and mental health impairments are at greater risk of breaching the terms of an AVO and of being subject to further AVOs, sometimes repeatedly.

13.64 Stakeholders suggested a number of options that might respond to these problems:

- behavioural support or therapeutic services[122]
- a care plan, which could be similar to a diversionary order under s 32 of the *Mental Health (Forensic Provisions) Act 2007* (NSW) (MHFPA) or a Community Treatment Order under the *Mental Health Act 2007* (NSW), which consists of treatment, counselling, support, management and other strategies aimed at addressing the defendant's behaviour[123]
- the use of Court Referral of Eligible Defendants into Treatment (CREDIT) when an AVO is deemed unsuitable[124]
- a coordinated response among parents, carers, service providers and police to address challenging behaviour[125]
- creation of positions similar to Domestic Violence Liaison Officers, who specialise in responding to intimidating behaviour by people with cognitive and mental health impairments,[126] and
- social support, particularly mentoring.[127]

13.65 Stakeholders envisaged that the provision of services to such defendants could operate either alongside an AVO, or as an alternative to the making of an order.

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121. Shopfront Youth Legal Centre, Submission to Department of Attorney General and Justice, *Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007,* 18 November 2011, 12 (edited).
122. Law Society of NSW, *Submission MH36,* 9; Shopfront Youth Legal Centre, *Submission MH52,* 6; NSW Trustee and Guardian, *Submission MH56,* 8; NSW Department of Family and Community Services, *Submission MH59*, 9; Law Society of NSW, *Submission MH60,* 4.
123. Legal Aid NSW, *Submission MH55*, 5; NSW Department of Family and Community Services, *Submission MH59*, 9.
124. Children's Court of NSW, *Submission MH50*, 3.
125. Children's Court of NSW, *Submission MH50*, 5; NSW Department of Family and Community Services, *Submission MH59,* 9.
126. Legal Aid NSW, *Submission MH55*, 7, 9.
127. Women in Prison Advocacy Network, *Submission MH53*, 4.

13.66 A case management approach to the making of AVOs against defendants with cognitive and mental health impairments has also been suggested, to ensure adequate understanding of the terms of the AVO and to monitor compliance.[128] DFACS suggested that this kind of role could be performed by a court liaison service.[129]

13.67 These stakeholder views are consistent with our broader finding, in Report 135 and in this report, that an integration of the criminal justice system and social and psychological services is necessary to ensure that people with cognitive and mental health impairments do not become persistently entangled in the criminal justice system, with the costs attendant upon that trajectory.

13.68 We are limited in the recommendations that we can make about service delivery. However, without proper emphasis on addressing the causes of their behaviour, defendants with cognitive and mental health impairments will continue to be involved in the AVO process. Where the making of an order is ineffective because of a defendant's impairment, this will be to the detriment of the defendant, the protected person and ultimately the community.

Legal policy issues

13.69 The NSW government has a long-term commitment to improving legal protections for victims and potential victims of violence. However, that legislation presents a number of difficulties for people with cognitive and mental health impairments.

13.70 First, defendants with such impairments may not be able to comply with AVOs, either because their impairment prevents them from understanding the order or because they cannot adequately control their behaviour. The defendant's capacity to understand and comply with an AVO is not routinely taken into account by the courts. Since breach of an AVO is an offence, a person with a cognitive or mental health impairment may breach an order they do not understand or cannot comply with, and in consequence be on a "slippery slope" into the criminal justice system.

13.71 Second, improvements designed to strengthen the protective nature of the CDPVA may have unintended effects on people with cognitive and mental health impairments. The CDPVA has been amended so that the targets of violence do not generally have to take responsibility for applying for orders. The legislation pro-actively encourages applications by the NSW Police Force and constrains police discretion in relation to applications.[130] The CDPVA provides that where certain offences are charged or committed an AVO must be made, unless the court is satisfied that an order is not required.[131]

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128. People with Disability Australia Incorporated, Submission to Department of Attorney General and Justice, *Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007*, November 2011, 25.

129. NSW Department of Family and Community Services, *Submission MH59*, 10.

130. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 27, s 49.

131. An AVO must be made where a serious offence is charged or where the defendant pleads guilty to, or is found guilty of, a domestic violence offence or an offence of stalking or intimidation: *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 39, s 40.

13.72 However, these developments have had some unwelcome consequences for defendants with cognitive and mental health impairments. Families and professional carers may call the police to respond to an incident of violence, and the police may then be constrained, or judge it appropriate, to make an application for an AVO even when the family member or carer is opposed to such a course of action. The likelihood of breach, or of other consequences such as the isolation of the defendant from important social supports, appears to be high in these circumstances.

13.73 All victims and potential victims of violence are entitled to protection. However, in circumstances where the defendant has a cognitive or mental health impairment, AVOs may not provide that protection in all cases. If the defendant does not understand and/or cannot comply with an AVO, that order will not provide effective protection for the applicant.

13.74 Information from stakeholders indicates that where the defendant has a cognitive or mental health impairment, AVOs can be effective in some cases. In other cases, however, effective protection requires interventions by disability and other services to change behaviours. Integrated or collaborative work by police and service providers to decide the most effective and suitable response to the violence appears to be the most useful way of providing protection from violence and preventing defendants with cognitive and mental health impairments from further (sometimes repeated) involvement with the criminal justice system.

13.75 In the remainder of this chapter we make recommendations as to how the AVO framework can best resolve the problems faced by these defendants.

Ways of taking the defendant's cognitive and mental health impairment into account

Consideration of the defendant's capacity when making an AVO

13.76 Although information from stakeholders indicates that some defendants with cognitive and mental health impairments have difficulty understanding and complying with the terms of an AVO, the legislative structure of AVO decision making does not expressly require the defendant's capacity to be taken into consideration.

13.77 As some stakeholders have pointed out, this leads to the anomalous situation whereby a defendant can lack the necessary *mens rea* to be guilty of a criminal offence but may still have an enforceable AVO made against him or her.[132] The District Court decision in *Farthing v Phipps*, that the defendant's capacity could be a relevant factor for the court in deciding whether or not to make an AVO, does not appear to have gained currency.

132. Shopfront Youth Legal Centre, *Submission MH41,* 9; Children's Court of NSW, *Submission MH50*, 1; Shopfront Youth Legal Centre, Submission to Department of Attorney General and Justice, *Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007,* 18 November 2011, 11.

13.78 The key issue for consideration is how the defendant's capacity should be taken into account. If lack of capacity is relevant to the decision whether or not to make an order, the court may be faced with a difficult choice. It has before it an applicant who is entitled to protection, but it is being asked to make an order that, due to the defendant's lack of capacity, may fail to provide that protection.

13.79 In QP 1 we asked whether the CDPVA should be amended to provide that an AVO may not be made against a person who does not have the capacity to understand or comply with it.[133]

13.80 Many submissions supported this amendment, albeit in different formulations.[134] Some stakeholders suggested that the court should not be able to make an AVO unless it had first satisfied itself that the defendant was capable of understanding and complying with the terms of the order.[135]

13.81 Other submissions suggested that the CDPVA be amended so that the defendant's capacity to understand and comply with the terms of the AVO should be expressly considered by the court in deciding whether or not to exercise its discretion to make an order.[136] Stakeholders suggested that this could be achieved by:

(a) a requirement in the CDPVA that an AVO may only be made if it is appropriate in all the circumstances, which may include a consideration of the defendant's capacity to understand and comply with the order[137]

(b) prior to making an AVO, a requirement that the court consider whether the defendant has or is likely to have any understanding of the orders and the nature of breach, and whether the AVO is the most appropriate mechanism for the protection of a person,[138] or

(c) amending s 17 and s 20 of the CDPVA so that the cognitive or mental health impairment of the defendant is expressly stated to be a relevant factor to be

133. NSW Law Reform Commission, *Apprehended Violence Orders,* People with Cognitive and Mental Health Impairments in the Criminal Justice System: Question Paper 1 (2012) Question 2(2).

134. Children's Court of NSW, *Submission MH50*, 2; Shopfront Youth Legal Centre, *Submission MH52*, 2; Legal Aid NSW, *Submission MH55*, 5; Hunter Community Legal Centre, *Submission MH58*, 4; NSW Department of Family and Community Services, *Submission MH59*, 5; Law Society of NSW, *Submission MH60*, 2. See also Intellectual Disability Rights Service Inc, Submission to Department of Attorney General and Justice, *Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007,* 18 November 2011, 6.

135. Department of Human Services NSW (Juvenile Justice), *Submission MH35-1*, 12; Law Society of NSW, *Submission MH36*, 8; Shopfront Youth Legal Centre, *Submission MH41,* 9; Hunter Community Legal Centre, *Submission MH58,* 4; Law Society of NSW, *Submission MH60*, 2.

136. Shopfront Youth Legal Centre, *Submission MH52,* 2; Women's Legal Services NSW, *Submission MH54*, 7; NSW Trustee and Guardian, *Submission MH56,* 3.

137. Shopfront Youth Legal Centre, *Submission MH52*, 2. See also Children's Court of NSW, *Submission MH50,* 3. This formulation is also supported by the Legislative Council Standing Committee on Social Issues: see Legislative Council Standing Committee on Social Issues, Parliament of NSW, *Domestic Violence Trends and Issues in NSW* (2012) [16.49].

138. Women's Legal Services NSW, *Submission MH54*, 7.

taken into account by the court in determining whether an ADVO or APVO should be made.[139]

13.82 The Chief Magistrate of the Local Court noted that, where the issue of the defendant's capacity is raised, the material before the court may not be consistent or conclusive enough to enable a proper assessment of the defendant's ability to understand an AVO.[140] In that regard, DFACS suggested that where the court is considering making an AVO against a person with a cognitive or mental health impairment, a formal assessment of the person should be undertaken, and recommendations made to the court about the individual's capacity to understand and comply with the AVO.[141]

13.83 The Chief Magistrate and Women's Legal Services NSW opposed amendment of the CDPVA to the effect that an AVO may not be made against a person who does not have the capacity to understand or comply with it. The Chief Magistrate stated:

> I appreciate the undesirability of a defendant with a cognitive or mental health impairment becoming involved in the criminal justice process … However, in the absence of any other measure, it seems equally undesirable for a person in need of protection to have no recourse to the protective capacity of the [CDPVA] in circumstances where he or she harbours genuine and reasonable fears.[142]

The Chief Magistrate submitted that consideration of the defendant's capacity should be considered at the stage of determining whether a breach of the AVO has occurred.

13.84 Women's Legal Services NSW stated that women are frequently exposed to violent, harassing and intimidating behaviour by their partner or children who have a cognitive or mental health impairment, and they should not be denied the protection of an AVO in these circumstances.[143]

13.85 Finally, we note that stakeholders reported that AVOs can in fact be effective in some cases even though the defendant has a cognitive or mental health impairment.

Conditions and wording of the AVO

13.86 A different response to issues of capacity is to increase the likelihood that defendants with cognitive and mental health impairments will be able to understand the terms of an AVO. Stakeholders suggested there should be:

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139. NSW Trustee and Guardian, *Submission MH56*, 3. See also Intellectual Disability Rights Service Inc, Submission to Department of Attorney General and Justice, *Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007,* 18 November 2011, 7.
140. Chief Magistrate of the Local Court of NSW, *Submission MH49*, 1.
141. NSW Department of Family and Community Services, *Submission MH59*, 5.
142. Chief Magistrate of the Local Court of NSW, *Submission MH49*, 2.
143. Women's Legal Services NSW, *Submission MH54*, 7.

(a) a requirement that any conditions attached to an AVO be reasonable, having regard to the ability of the defendant to comply with those conditions[144]

(b) an ability for the court to obtain an expert report on the cognitive capacity of the defendant to ensure as much as possible that the wording of the orders is appropriate,[145] and

(c) accessible information formats for defendants with cognitive and mental health impairments.[146]

13.87 Attention also could be directed towards ensuring that the terms of the order respond to the defendant's impairment. So, for example, where the defendant has an intellectual disability, an order that the defendant not go within a kilometre of a defined place could be replaced with an order that the defendant can understand and comply with, and which provides the same protection.

13.88 The Legislative Council Standing Committee on Social Issues noted the importance of tailoring AVO conditions for each individual set of circumstances. Ensuring that the order is practicable and workable, as well as taking steps to ensure that the defendant understands the order will, in its view, fundamentally decrease the likelihood of breaches.[147]

Legal representation and court support

13.89 SYLC submitted that defendants with cognitive and mental health impairments should be provided with legal representation and court support to help safeguard against inappropriate, unworkable or poorly understood AVOs.[148] Similarly, DFACS suggested that it was important that such defendants be provided with immediate support to help them understand what is happening.[149]

13.90 The issue of legal representation for defendants to AVO proceedings is a longstanding one which is not restricted to defendants with cognitive and mental health impairments. A Discussion Paper published by the Department of Attorney General in 1995 suggested that "it would appear beneficial in the long term to avail [AVO] defendants of legal aid on a less restrictive basis".[150] This issue was recently revisited by the Legislative Council Standing Committee on Social Issues, which recommended that DAGJ implement a best practice defendant legal advice and support program across NSW Local Courts. The Committee considered that

144. Children's Court of NSW, *Submission MH50*, 2.
145. Women's Legal Services NSW, *Submission MH54*, 8.
146. NSW Department of Family and Community Services, *Submission MH59*, 3.
147. Legislative Council Standing Committee on Social Issues, Parliament of NSW, *Domestic Violence Trends and Issues in NSW* (2012) [9.159], [10.33].
148. Shopfront Youth Legal Centre, *Submission MH52*, 7.
149. NSW Department of Family and Community Services, *Submission MH59*, 3.
150. NSW Department of Attorney General, Criminal Law Review Division, *A Review of the Law Pertaining to Apprehended Violence Orders as Contained in Part 15A of the Crimes Act 1900 (NSW)*, Discussion Paper (1995) 14.

increased legal representation and court support would lead to improved compliance with the terms of AVOs.[151]

13.91 However, as we note in Report 135, many lawyers do not have experience or expertise in working with clients with impairments and may require help from experts such as the Statewide Community and Court Liaison Service (SCCLS) to assist them to respond to defendants with cognitive and mental health impairments.[152]

Alternatives to conviction for breach of an AVO

13.92 It was suggested in submissions that, when a person with a cognitive or mental health impairment breaches the terms of an AVO, there should be greater utilisation of alternatives to recording a conviction, such as the use of s 10 of the *Crimes (Sentencing Procedure) Act 1999* (NSW) (which allows discharge of the defendant on the condition of a good behaviour bond or compliance with an intervention program), the use of diversion under s 32 or s 33 of the MHFPA and, in the case of young people, a youth justice conference under the *Young Offenders Act 1997* (NSW).[153]

13.93 These alternatives are already available when a defendant is charged with contravening an AVO, but it may be the case that they are underutilised in practice. In SYLC's experience, there is a reluctance among some magistrates to apply s 32 of the MHFPA to matters involving violence or breach of an AVO.[154] Consistent with our recommendations in Report 135, we suggest that diversion under s 32 and s 33 of the MHFPA should be more widely used.

13.94 In Report 135 we also make a number of recommendations to improve the diversionary options available to defendants with cognitive and mental health impairments. These included a pre-court diversion option to be handled by police, the expansion of the SCCLS and the CREDIT program to all courts across NSW and the creation of a Court Referral for Integrated Service Provision list.

13.95 We consider that the implementation of these recommendations would also benefit defendants with cognitive and mental health impairments charged with breaching the conditions of an AVO. Where breach is a consequence of the defendant's impairment, s 32 orders may provide a framework within which more effective ways of protecting the person at risk, perhaps through integrated service delivery, may be implemented and further breaches prevented.

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151. See Legislative Council Standing Committee on Social Issues, Parliament of NSW, *Domestic Violence Trends and Issues in NSW* (2012) [10.96].
152. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion,* Report 135 (2012) [7.5], [7.72], Recommendation 7.2.
153. Children's Court of NSW, *Submission MH50*, 3; Public Interest Advocacy Centre, *Submission MH51,* 3-4; Shopfront Youth Legal Centre, *Submission MH52,* 4.
154. Shopfront Youth Legal Centre, *Submission MH52*, 4. However, there is also evidence that s 32 is generally under-used for all types of offences: see NSW Law Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion,* Report 135 (2012) [9.41].

The Commission's view

13.96 The issues we have canvassed above give rise to the following legal and policy questions:

(1) Should the defendant's cognitive or mental health impairment be made a mandatory consideration when deciding:

(a) whether to make an AVO, and/or

(b) the terms of the order?

(2) Should magistrates be provided with expert assistance when making an AVO against a defendant with a cognitive or mental health impairment, in the form of:

(a) identification and assessment services pertaining to the defendant's cognitive or mental health impairment, and/or

(b) legal representation for the defendant?

(3) Are the currently available responses to breach of an AVO sufficient having regard to a defendant's cognitive or mental health impairment?

The relevance of the defendant's impairment to the discretion to make an AVO

13.97 Applications for an AVO where the defendant has a cognitive or mental health impairment give rise to competing concerns. The interests of the defendant may mean that it is undesirable to make an order because it cannot be understood or complied with and is likely to expose the defendant to subsequent prosecution for breach. On the other hand, the applicant is entitled to legal protection from threatening or violent behaviour and those interests require the making of an order where the applicant has genuine and reasonable concerns for his or her safety.

13.98 Section 17 and s 20 of the CDPVA, which provide for the matters to be considered by the court in making an ADVO or an APVO, appropriately prioritise the safety of the applicant.[155] However, without limiting that requirement, the court may also take into account other factors. In our view, the best way to balance the competing concerns outlined above is to provide that, where the defendant's capacity to understand and comply with the terms of an AVO is significantly affected by a cognitive or mental health impairment, that should be a relevant factor for the court to take into account in deciding whether to make an AVO.

13.99 What is relevant is not the defendant's impairment in itself, but how that impairment impacts upon the defendant's capacity. This is similar to the approach taken in *Farthing v Phipps.*

13.100 The court has an existing discretion to decline to make an AVO, but in our view it is desirable in the circumstances to give the court greater legislative clarity as to when

155. The safety and protection of the protected person is the first consideration for the court and is set out in subsection (1). Subsection (2) of both sections provides further relevant considerations for the court, but they are to be taken into account "[w]ithout limiting subsection (1)". Section 9 and s 10, which provide for the objects of the Act, also prioritise the safety of all people.

that discretion should be exercised. Therefore, we consider that an express legislative direction in the CDPVA is required, to direct the court to consider the defendant's capacity to understand and comply with a proposed order where the defendant has a cognitive or mental health impairment.

13.101 The court's response to a defendant's impairment will depend on the circumstances of each case. At one end of the spectrum, the defendant's impairment may not be severe enough to impede understanding of the order or compliance with it. We are concerned to exclude cases where a perpetrator of violence may seek to use a cognitive or mental health impairment of a minor nature in order to avoid an AVO. For this reason, we recommend that the person's capacity should be *significantly* affected by an impairment in order to be relevant to the court's discretion whether or not to make an AVO. At the other end of the spectrum, the defendant may be so unable to understand or comply with the order that the order affords no protection to the person at risk and would be likely to result in breach. This may be an appropriate case for the court to use its discretion to decline to make an order. Between these extremes there is a continuum of circumstances where an order would be effective in protecting the person at risk to a varying degree, and it is in these cases where we consider that a court should weigh the defendant's capacity to understand and comply with an AVO with the protection that an AVO is likely to afford to the person at risk.

13.102 We anticipate that in most cases the interests of the applicant in protection will predominate. However, there will be some situations in which the court may legitimately find the defendant's impairment a reason not to make an order, or to modify the order which would otherwise have been made. It may also then be apparent that other ways of dealing with the situation should be deployed. For instance, it may be that an application is made on the initiative of the police, but where the person in need of protection does not wish the order to be made. Subsequent to the incident that instigated police involvement, it may be that services have intervened and taken steps that make the applicant safe. If there are also doubts about the effectiveness of an order that arise from the defendant's impairment, the court may well be disinclined to exercise its discretion in favour of making an order. This essentially was the situation that arose in *Farthing v Phipps*.

13.103 Some cases involving defendants with cognitive and mental health impairments will present magistrates with problems that cannot be solved by means of an AVO. Where an applicant has genuine and reasonable fears for his or her safety, the court is likely to make an order. However the magistrate may also be cognisant that the defendant will not understand it or be able to comply with it, so that it will not protect the applicant. Further it may be apparent that a person with a cognitive and mental health impairment is at a high risk of breaching the order. The costs to the State and to the defendant if this occurs are likely to be significant. The appropriate solution in such cases is to ensure that effective extra-legal mechanisms to deal with the violence are deployed and we make suggestions below as to how this could occur.[156]

156. See para 13.112.

The terms and wording of AVOs

13.104 The experience of stakeholders demonstrates the importance of orders that the defendant can understand and can comply with, taking into account his or her cognitive or mental health impairment.

13.105 Therefore, we recommend that where a defendant's cognitive or mental health impairment impacts upon his or her ability to understand an AVO, the court should be directed to consider whether the AVO can be drafted in plain language, or otherwise in such a way that will allow the defendant to understand it.

13.106 Further, we recommend that the court should be required to give consideration to tailoring the conditions imposed in the order, so that the applicant is protected but the conditions take into account the defendant's capacity to understand and comply with the order.

13.107 As discussed above,[157] the standard AVO conditions are expressed in language which is likely to be difficult for a defendant with a cognitive or mental health impairment to understand.[158] The additional orders are also frequently expressed in technical and complex language.[159] In our view, all defendants, and in particular defendants with cognitive and mental health impairments, would be assisted by the standard conditions of an AVO being expressed in clear, simple language. Therefore, we recommend that a review of the standard and commonly used additional AVO conditions be conducted, with a view to expressing them in plain English. We consider that the Apprehended Violence Legal Issues Coordinating Committee, an interagency group comprising government and non-government membership and chaired by the Criminal Law Review Division of DAGJ, could oversee a process designed to achieve this aim.

Providing expert assistance to magistrates when making an AVO

13.108 We note the concern of the Chief Magistrate of the Local Court that magistrates may be under-resourced and ill-equipped to make an assessment as to the extent and effect of a defendant's cognitive or mental health impairment. Furthermore, magistrates making AVOs are often acting under pressure in a busy court list. If they are to make orders that provide effective protection in cases where the defendant has a cognitive or mental health impairment, they require support and assistance.

13.109 We consider that this assistance should be of two types, non-legal and legal.

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157. See para 13.56.

158. And perhaps also for defendants without cognitive or mental health impairments: see *Farthing v Phipps* [2010] NSWDC 317; 12 DCLR (NSW) 158 [21]. For instance, what behaviours are covered by an order prohibiting the defendant from "assaulting, molesting, harassing, threatening or otherwise interfering" with the protected person? See *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 36(a).

159. See, eg, the sample orders provided on the LawAssist website: NSW Department of Attorney General and Justice, Law Access, "Forms - Apprehended Violence Orders" (14 February 2013) LawAssist <http://www.lawassist.lawaccess.nsw.gov.au/lawassist/lawassist_avo/lawassist_forms_avo.html>.

13.110 **Non-legal assistance:** First, courts require non-legal assistance to provide advice about the defendant's cognitive or mental health impairment so that the court can make the most appropriate and effective orders, and to identify appropriate services that can provide extra-legal measures to assist in protecting against threats and violence towards applicants.

13.111 We consider that the SCCLS is the most appropriate organisation to fill this role. In Report 135 we recommend that the SCCLS be expanded to provide coverage at all Local Courts, and also that it should be extended to provide expertise in relation to cognitive impairment as well as mental health impairment.[160] Where an issue arises concerning a defendant with a cognitive or mental health impairment in the context of an AVO application, the SCCLS should be consulted to provide assistance to the court. Under the current model, a defendant can be referred to the SCCLS by the court, the defendant's lawyer, the police prosecutor or Corrective Services NSW.[161] We envisage that these referral pathways should continue to apply in the case of an application for an AVO.

13.112 Similar to the process that occurs in criminal proceedings, if referral to the SCCLS has not already been made (for example by police or Legal Aid) the magistrate would adjourn the proceedings or put the matter back in the list[162] and refer the defendant to the SCCLS for assessment. The SCCLS would undertake an assessment of the defendant and provide a report to the court about the nature and extent of the defendant's cognitive or mental health impairment, and the consequences of any impairment for the application before the court. That advice might relate, for example, to any features of the defendant's impairment which may affect his or her ability to understand or comply with the terms of an order (such as the ability to read or process information, compulsive behaviour or delusions), and extra legal measures such as services that may assist in dealing with the violence.

13.113 The SCCLS report is likely to assist in informing the court's decision as to whether an AVO should be made, the type of order that is appropriate and what conditions should be imposed in any order.

13.114 This referral power should apply even where the defendant consents to the making of the AVO. We do not propose a screening process for all defendants who consent to an AVO. However, where the court or the police are aware of, or suspect, the existence of a cognitive or mental health impairment, then the defendant should be referred to the SCCLS for assessment.

13.115 This referral power is not intended to affect the ability of the applicant or the defendant to put before the court additional evidence as to the defendant's ability to understand and comply with the terms of an AVO.

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160. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) Recommendation 7.1.

161. D Bradford and N Smith, *An Evaluation of the NSW Court Liaison Services* (NSW Bureau of Crime Statistics and Research, 2009) 10.

162. The court has a general power to adjourn proceedings at any stage: see *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 65.

13.116 **Legal assistance:** Secondly, the ability of a defendant with a cognitive or mental health impairment to understand and comply with the terms of an AVO, and the probability that the terms of the order will be appropriate, is likely to be increased where the defendant has legal representation.

13.117 In this regard, we agree with the recommendation of the Legislative Council Standing Committee on Social Issues that legal representation should be more widely available to defendants to AVO proceedings.[163] While we acknowledge the cost implications of such a step, we suggest that these would be offset by ameliorating the difficulties for courts in managing cases where a defendant with an impairment is unrepresented, the consequences arising from an AVO which is ineffective, and the cost of prosecution of subsequent breaches.

13.118 We understand that the Legal Aid pilot duty solicitor service for defendants to AVO proceedings is still in the trial phase.[164] If that program is not implemented across all Local Courts in NSW, we recommend that Legal Aid extend its legal representation service to defendants to AVO applications who have cognitive and mental health impairments.

The response of the court to breach of an AVO

13.119 Section 14 of the CDPVA provides that an offence of contravening an AVO must be committed "knowingly". This may mean that there are now many cases where the offence is not made out because the defendant has a cognitive or mental health impairment and cannot understand or comply with the order. Nevertheless, where a defendant with a cognitive or mental health impairment is charged with an offence of breach of an AVO, the court should consider, in the first instance, the utility of an order for diversion under s 32 of the MHFPA. Such an order would provide a framework for the intervention of services that may provide more effective protection than conviction for breach would do. Examples of such interventions were provided by stakeholders in response to QP 1.[165]

13.120 We acknowledge the perception that magistrates are unwilling to consider the use of s 32 in relation to breach of AVOs. We understand this reticence in the context of the present flawed provisions of s 32 identified in Report 135. However, in that report, we recommend improvements to the way the provision now operates. Such reforms would make a s 32 order more effective and therefore a more attractive option for the courts. The involvement of CREDIT would assist the court with framing a suitable diversion plan under s 32 to prevent violence and threats occurring in the future. Our recommendations in Report 135 would also ensure that the engagement of the defendant with the diversion plan would be managed by CREDIT and that the court could continue to monitor the defendant where appropriate.

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163. Legislative Council Standing Committee on Social Issues, Parliament of NSW, *Domestic Violence Trends and Issues in NSW* (2012) [10.96], Recommendation 63.

164. See Legislative Council Standing Committee on Social Issues, Parliament of NSW, *Domestic Violence Trends and Issues in NSW* (2012) [10.87].

165. See para 13.64.

Recommendation 13.1

(1) Section 17 and s 20 of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) should be amended to provide that an additional relevant matter to be considered by the court when deciding whether or not to make an apprehended violence order is the defendant's capacity to understand and comply with the terms of an order, where that capacity is significantly affected by a cognitive or mental health impairment.

(2) The *Crimes (Domestic and Personal Violence) Act 2007* (NSW) should be amended to provide that, in making an apprehended violence order against a defendant whose capacity to understand and comply with the terms of an order is significantly affected by a cognitive or mental health impairment, the court must consider:

(a) whether the order can be drafted using language that the defendant can understand, and

(b) whether the conditions contained in the order can be modified, without compromising the protections afforded to the protected person, to enable the defendant to understand and comply with those conditions.

(3) The Apprehended Violence Legal Issues Coordinating Committee should convene a working group to revise the standard and common additional conditions for an apprehended violence order and redraft them in plain English.

(4) The expansion of the Statewide Community and Court Liaison Service (SCCLS) recommended in Recommendation 7.1 of Report 135 should include provision for identification and assessment services for defendants to apprehended violence order applications.

(5) Where an apprehended violence order application is made and the defendant appears to the court to have a cognitive or mental health impairment:

(a) the court may refer the defendant to the SCCLS for assessment, and adjourn the proceedings pending the outcome of the assessment

(b) the SCCLS should provide a report to the court which addresses:

(i) the nature and extent of the defendant's cognitive or mental health impairment (if any), and

(ii) as far as can be ascertained, the consequences of that impairment for the application before the court.

(6) Recommendations 13.1(4)-(5) should also apply where the defendant consents to the making of the apprehended violence order.

(7) Where a defendant with a cognitive or mental health impairment is charged under s 14 of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW), the court should be required to consider whether it should make an order under s 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) for diversion of the defendant to services that will deal the causes of the offending.

(8) The *Crimes (Domestic and Personal Violence) Act 2007* (NSW) should include the definitions of "cognitive impairment" and "mental health impairment" set out in Recommendations 5.1 and 5.2 of Report 135.

(9) Legal Aid NSW should extend provision of legal representation to defendants to apprehended violence order applications who have a cognitive or mental health impairment.

Mandatory applications by the police

13.121 Where a police officer believes that a domestic violence offence, a stalking offence or a child abuse offence has occurred or is likely to occur, the police officer *must* apply for an AVO on behalf of the person in need of protection.[166] The only exceptions to this requirement are where the protected person intends to make the application themselves, or the police officer believes there is "good reason" not to make the application.[167] As discussed above,[168] legislative amendments in 1992 introduced this mandatory requirement for police to apply for an AVO so as to provide better protection for victims of domestic violence.

13.122 "Domestic violence offence" is defined to mean a personal violence offence committed where the parties are or have been in a domestic relationship.[169] Section 5 of the CDPVA relevantly includes in the definition of "domestic relationship" circumstances where a person:

> (e) is living or has lived as a long-term resident in the same residential facility as the other person and at the same time as the other person…
>
> (f) has or has had a relationship involving his or her dependence on the ongoing paid or unpaid care of the other person.

13.123 These circumstances were added when the definition was amended in 1999,[170] with the rationale said to be to recognise "the range of domestic contexts in which people live".[171] The expanded definition of domestic relationship has had the consequence that police are required to apply for an AVO where there is actual or threatened violence in a residential care setting or where paid or unpaid care is being provided.

13.124 The requirement for police to apply for an AVO appears to operate in a particularly disadvantageous manner for defendants with cognitive and mental health impairments and their carers. It is not uncommon for parents or carers of people with cognitive and mental health impairments to call the police to assist with

166. See *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 27(1), s 49(1).
167. See *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 27(4), s 49(4).
168. See para 13.14.
169. *Crimes (Domestic and Personal Violence) Act 2007* (NSW) s 11. "Personal violence offence" is defined in s 4.
170. Into what was then s 562A(3) of the *Crimes Act 1900* (NSW): see *Crimes Amendment (Apprehended Violence) Act 1999* (NSW) sch 1 [6].
171. See the second reading speech for the Crimes Amendment (Apprehended Violence) Bill 1999: NSW, *Parliamentary Debates,* Legislative Council, 25 November 1999, 3675 (J W Shaw).

managing a situation which has escalated. If the conditions outlined above are fulfilled, police are obliged to apply for an AVO on behalf of the parent or carer, even if it is against their wishes,[172] and even though the defendant's cognitive or mental health impairment may make any such order ineffective.

13.125 Additionally, information from stakeholders indicates that the mandatory obligation on police to apply for an AVO is ill suited to the protection of carers in residential care settings. In such situations there will typically be alternative ways of managing challenging behaviour. These alternatives, which include dealing with the problem that provoked the violent behaviour, or introducing behaviour modification measures, were emphasised by key stakeholders. Furthermore, AVOs taken out on behalf of paid carers can have particularly deleterious effects for clients, especially if those clients do not have the capacity to understand or comply with an order.

13.126 We recognise that there are some circumstances where it will be good practice for police to apply for an AVO even where a carer is unwilling for this step to be taken. For instance, a carer who is also a family member may be unwilling to take out an AVO because of fear, or because they may incur criticism from other family members. However, currently police do not have discretion whether or not to act in such a situation.

13.127 The mandatory police application requirement is made particularly difficult in this context by virtue of the fact that s 5(f) of the CDPVA is not clear on whether, for a domestic relationship to exist, the "cared for" person must be the alleged victim or the perpetrator. This difficulty has been recognised by the NSW Police Force.[173] Its mandated response is that action *must* be taken when the people involved fall under this definition, regardless of the role the "cared for" person has in the alleged offence.[174]

13.128 Long-term residents of the same residential facility are also classed as being in a domestic relationship. It is, of course, important that residents be protected from abuse by other residents. However, the classifying of residents as being in a "domestic relationship", and the resulting requirement for police to apply for an AVO, means that AVOs may be taken out in circumstances where this may not be the most effective method of dealing with the abusive behaviour, particularly where the behaviour stems from the person's cognitive or mental health impairment. It may also mean that the person against whom the AVO is made must be relocated or discharged from the residential facility so as to avoid being in breach of the AVO. In some cases this may not be the best or most effective solution to the problem and may impact adversely upon the person's access to services and accommodation.

13.129 Thus, in our view there are two aspects of the legislative framework which require reconsideration in the context of defendants with cognitive and mental health impairments where the application is by a carer or relates to people living together

172. Department of Human Services NSW (Ageing, Disability and Home Care), *Submission MH35-4*, 4; Shopfront Youth Legal Centre, *Submission MH52*, 6; Legal Aid NSW, *Submission MH55,* 8.

173. NSW Police Force, Submission to Department of Attorney General and Justice, *Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007*, 21 November 2011, 3.

174. NSW Police Force, Submission to Department of Attorney General and Justice, *Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007*, 21 November 2011, 3.

in residential facilities. They are the requirement for police to apply for an AVO when a domestic violence offence has occurred or is likely to occur, and the definition of "domestic relationship" insofar as it includes paid carers and residents of long-term residential facilities. We consider below how each of these issues may be better dealt with.

Changing the requirement for police to apply for an AVO

13.130 In this section we consider whether there should be a change to the police requirement to apply for an AVO for situations where the defendant has a cognitive or mental health impairment.

Submissions and consultations

13.131 In QP 1 we focused on the mandatory application requirement as it applies in a care setting, and we asked whether there should be an exception to the requirement for police to apply for an AVO in situations involving residential care of a person with a cognitive or mental health impairment.[175] This suggestion was supported by some stakeholders.[176] Alternatively, it has been suggested that the requirement for a police officer to apply for an AVO should apply where an AVO is being sought on behalf of a client, but not where it is sought by a carer.[177]

13.132 Some stakeholders suggested that a defendant's impaired capacity should constitute a "good reason" for a police officer not to make an application for an AVO.[178] Guidelines could be developed to assist police officers in the exercise of that discretion.[179]

13.133 However, DFACS opposed any legislative amendment to the scope of police discretion in the manner outlined in QP 1. In its view, to remove the requirement for police to apply for an AVO would weaken the protection available for residents who are abused by other residents or carers. Where the person in need of protection is a carer, DFACS submitted there are usually alternative ways of managing the situation so as to make an AVO unnecessary, such as appropriate rostering, behaviour support intervention, staff training and the relocation of clients to a more appropriate care environment.[180] Similarly, Women's Legal Services NSW was of the view that it should be the responsibility of the court, rather than the police, to

175. NSW Law Reform Commission, *Apprehended Violence Orders,* People with Cognitive and Mental Health Impairments in the Criminal Justice System: Question Paper 1 (2012) Question 4(1).

176. Shopfront Youth Legal Centre, *Submission MH52*, 4; Legal Aid NSW, *Submission MH55,* 7; Hunter Community Legal Centre, *Submission MH58,* 5; Law Society of NSW, *Submission MH60*, 3.

177. Intellectual Disability Rights Service Inc, Submission to Department of Attorney General and Justice, *Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007,* 18 November 2011, 3.

178. Shopfront Youth Legal Centre, *Submission MH52*, 5; NSW Trustee and Guardian, *Submission MH56*, 5; Hunter Community Legal Centre, *Submission MH58,* 6; Intellectual Disability Rights Service Inc, Submission to Department of Attorney General and Justice, *Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007,* 18 November 2011, 5.

179. NSW Trustee and Guardian, *Submission MH56*, 5.

180. NSW Department of Family and Community Services, *Submission MH59*, 11.

determine whether an AVO is appropriate, although the wishes of carers should be taken into account by the court when an AVO has been applied for on their behalf by the police.[181]

The Commission's view

13.134 The requirement for police to apply for an AVO was developed as a policy response to assist victims of domestic violence. However, it appears to be operating to oblige police officers to apply for an AVO against a defendant with a cognitive or mental health impairment in circumstances which may fall outside those originally intended. Particularly where an AVO is an unintended consequence of a police call-out and is not desired by the protected person, an AVO may not be the best or most effective protection against future violence and may have negative consequences for the defendant by restricting access to family members or care facilities.

13.135 However, we do not propose legislative change to the discretion given to police officers in these circumstances. To do so would be inconsistent with recent legislative initiatives and would be likely to have consequences beyond those which are canvassed in the scope of this review.

13.136 Police do have some limited discretion under the current framework, in that an officer may decline to make an application for an AVO where there is "good reason" not to do so. "Good reason" should, in our view, include some circumstances where a defendant has a cognitive or mental health impairment. However, in order that police can exercise their discretion effectively they require guidance as to the course of action they should take when dealing with defendants with cognitive and mental health impairments.

13.137 We therefore recommend that the NSW Police Force develop guidelines to assist police officers in determining the circumstances in which there is good reason, arising from a person's cognitive or mental health impairment, not to apply for an AVO against them. While the exact nature of those guidelines is a matter for the NSW Police Force, as a matter of good policy we envisage that relevant considerations in the exercise of the discretion could include:

- the circumstances in which the police officer was called to attend the scene
- the likelihood that an AVO will provide effective protection for the person in need of protection
- the defendant's capacity to understand and comply with the terms of an AVO (as far as it can be ascertained by the police officer)
- the wishes of the person in need of protection, and
- the availability of other resources to protect the person in need of protection.

13.138 We consider that these guidelines should extend to all situations where the police obligation to apply for an AVO arises, and not just in the care setting. Greater guidance in the exercise of the police discretion will, in our view, assist in avoiding

181. Women's Legal Services NSW, *Submission MH54*, 9.

unnecessary or ineffective AVOs being applied for against defendants with cognitive and mental health impairments.

Recommendation 13.2

(1) The NSW Police Force should develop guidelines for determining the circumstances in which a defendant's cognitive or mental health impairment will constitute "good reason" for a police officer not to make an apprehended violence order application, within the meaning of s 27(4)(b) and s 49(4)(b) of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW).

(2) Relevant considerations in the exercise of the discretion could include:

(a) the circumstances in which the police officer was called to attend the scene

(b) the likelihood that an apprehended violence order will provide effective protection for the person in need of protection

(c) the defendant's capacity to understand and comply with the terms of an apprehended violence order (as far as it can be ascertained by the police officer)

(d) the wishes of the person in need of protection, and

(e) the availability of other resources to protect the person in need of protection.

Amending the definition of "domestic relationship"

13.139 In this section we consider whether the definition of "domestic relationship" should continue to include relationships between people living as long term residents in residential facilities, and relationships involving paid or unpaid care. There are two options that may resolve the identified problems.

Option 1: Amend the definition of "domestic relationship" to remove paid carers and long-term residents of residential facilities

13.140 One option is to amend the definition of "domestic relationship" to remove from s 5 of the CDPVA the relationship between paid carers and clients, and/or people living together in residential facilities. This would mean that police would no longer be required to apply for ADVOs for these types of relationships. Rather, where a paid carer or long-term resident is in need of protection from another resident, he or she could utilise the mechanism for the making of an APVO, which gives greater discretion to police officers.

13.141 There was some stakeholder support for amending the definition of "domestic relationship" in this way,[182] although we did not specifically consult on this option.

182. Chief Magistrate of the Local Court of NSW, *Submission MH49*, 2-3; Shopfront Youth Legal Centre, *Submission MH52*, 5; Law Society of NSW, *Submission MH60*, 3.

On the other hand, Women's Legal Services NSW opposed the narrowing of the definition, concerned that it would restrict the protection available to applicants.[183]

13.142 This option for reform is the subject of consideration by the current statutory review of the CDPVA.[184] The Legislative Council Standing Committee on Social Issues also recommended that the definition of "domestic relationship" be amended to exclude these categories of relationship. It considered that the current definition is not working as effectively as it could, because it captures people who are not in domestic or family-like relationships.[185]

Option 2: Clarify that the paid carer-client relationship is one way

13.143 Another option would be to amend the definition of "domestic relationship" in s 5(f) of the CDPVA to clarify that the paid carer and client relationship only classifies as a domestic relationship where a client is seeking an AVO against a paid carer. This would mean that an ADVO would be automatically sought by a police officer on behalf of a client against a paid carer, but not on behalf of a paid carer against a client. A carer would need to make an application for an APVO if he or she was in need of protection. An ADVO would still apply as between residents of residential facilities.

13.144 We did not specifically raise this proposal with stakeholders. However, this approach has been endorsed by the NSW Police Force, which suggested that, if paid care is retained within the definition of "domestic relationship", then only the "vulnerable person" should be captured within that definition.[186]

13.145 This approach has the benefit that clients retain the protection of an ADVO where they are subject to abuse by a paid carer or another resident but it avoids a mandatory AVO being applied for on behalf of a paid carer. A carer would still have the option of making an application for protection. However, given the views of stakeholders expressed to this inquiry about the undesirability and likely ineffectiveness of such a course of action, and given the resources available to paid carers to manage these problems in other ways, we would anticipate that such applications would be limited in number.

The Commission's view

13.146 Well-intentioned changes to the definition of "domestic relationship" in the CDPVA appear to have led to an increase in AVOs taken out for the protection of paid carers. There will be some circumstances where paid carers will need protection from clients who engage in abusive behaviour and they should not be denied this protection where it is necessary and effective. However, the *mandating* of AVOs for the protection of paid carers from their clients is not the most desirable way of

183. Women's Legal Services NSW, *Submission MH54*, 5.

184. NSW Department of Attorney General and Justice, *Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007*, Discussion Paper (2011) 7-8.

185. See Legislative Council Standing Committee on Social Issues, Parliament of NSW, *Domestic Violence Trends and Issues in NSW* (2012) [9.43], Recommendation 49.

186. NSW Police Force, Submission to Department of Attorney General and Justice, *Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007*, 21 November 2011, 3.

dealing with this issue. Although Recommendation 13.2 will assist in giving greater guidance to police officers as to when to decline to make an application, in our view the mandatory police requirement should not apply at all in the case of paid carers. We note in particular the opinions of stakeholders about the limited utility of AVOs in these circumstances to provide effective protection against violence by people with cognitive and mental health impairments and the availability of other, possibly more effective, methods of providing protection.

13.147 For these reasons, we believe that the current legal framework should be amended. We note that this issue is presently being addressed by the statutory review of the CDPVA, and in that context these provisions are the subject of further consultation and consideration. Accordingly, we recommend that DAGJ consider the following options.

13.148 First, to the extent that the statutory review recommends restricting the definition of "domestic relationship" in s 5 of the CDPVA to exclude paid carers and/or long-term residents of residential facilities, we would support that recommendation. If this amendment were made, an APVO could be used for the protection of those in a care relationship, so that protection would be available, but applications would not be mandated.

13.149 Otherwise, we recommend that consideration be given to the amendment of s 5(f) of the CDPVA to clarify that a "domestic relationship" will only exist where, in the case of paid care, a client seeks an AVO against a paid carer. A carer in need of protection could seek an APVO where necessary.

Recommendation 13.3

If the statutory review of the *Crimes (Domestic and Personal Violence) Act 2007* (NSW) recommends that paid care be retained within the definition of "domestic relationship" in s 5(f) of the Act, the NSW Department of Attorney General and Justice should give further consideration to whether s 5(f) should be amended to clarify that a paid carer and client relationship will only qualify as a "domestic relationship" where the client is seeking an apprehended violence order against a paid carer.

14. Forensic material

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14.1 In NSW, fingerprints, DNA samples and other forensic material of some offenders can be retained by the NSW Police Force to assist in the investigation of crime. The legislation regulating the retention and destruction of forensic material, the *Crimes (Forensic Procedures) Act 2000* (NSW) (CFPA), is intended to strike a balance between promoting the efficient investigation of crime and protecting privacy rights. Our terms of reference for this review ask us to consider Part 10 of the CFPA, which sets out the circumstances in which forensic samples must be destroyed. In particular, Part 10 does not specify what should happen to forensic material collected from people who are:

- subject to a diversionary order under s 32 or s 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA)
- found not guilty by reason of mental illness (NGMI), or
- found unfit and not acquitted at a special hearing (UNA).

We were asked to consider how Part 10 should apply to these groups.

14.2 In Consultation Paper 8 (CP 8), we concluded that the CFPA allows forensic material collected in these circumstances to be retained indefinitely,[1] and this conclusion was not challenged in any submissions. However, the NSW Police Force has advised us that it is their practice to destroy samples collected from defendants discharged under s 32 or s 33 of the MHFPA and those found NGMI or UNA.[2]

14.3 In this chapter we consider whether the CFPA should require destruction of such forensic material. We recommend that material taken from people found NGMI or UNA should be retained. However, we recommend that material taken from people diverted under s 32 or s 33 of the MHFPA should, if the defendant is discharged unconditionally, be destroyed. If the defendant is conditionally discharged, the material should be retained only for the period during which it is possible for the court to deal with the original charge.

14.4 We note that a Forensic Working Party, headed by Acting Supreme Court Justice Graham Barr, is currently reviewing the CFPA.[3]

The current legal framework in NSW

Collecting and storing forensic material

14.5 In NSW, the collection of forensic material, and the storage of that material, is regulated by the CFPA. Forensic material includes fingerprints, footprints, casts, impressions, and samples taken from a person's body for such purposes as testing for his or her DNA.[4] The collection of forensic material is known as a "forensic procedure".[5] The CFPA contains separate provisions regulating forensic procedures in relation to suspects, people convicted of serious indictable offences, volunteers, children and other groups. Our concern in this chapter is with forensic material taken from suspects who are later diverted or found NGMI or UNA.

14.6 The CFPA allows for forensic procedures to be carried out by consent or by order of a senior police officer, Magistrate or other authorised officer.[6] A forensic procedure must not be carried out on a suspect unless there are reasonable grounds to believe that the procedure might produce evidence tending to confirm or disprove that the suspect has committed a particular offence.[7]

14.7 If the suspect is an adult who is incapable of understanding the general nature and effect of a forensic procedure, or is incapable of indicating consent to a forensic procedure being carried out, then a forensic procedure cannot be carried out

1. See NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Forensic Samples,* Consultation Paper 8 (2010) [1.1], [1.18], [1.38].
2. Information supplied by the NSW Commissioner of Police, 17 September 2012.
3. K Keneally, "Major Review of State's DNA Forensics Procedures" (News Release, 6 April 2010); NSW, *Parliamentary Debates*, Legislative Assembly, 20 April 2010, 21 825 (J Hatzistergos).
4. *Crimes (Forensic Procedures) Act 2000* (NSW) s 3(1).
5. *Crimes (Forensic Procedures) Act 2000* (NSW) s 3(1).
6. *Crimes (Forensic Procedures) Act 2000* (NSW) pt 3-5.
7. *Crimes (Forensic Procedures) Act 2000* (NSW) s 11(2)-(3), s 20(c), s 24(2)-(3).

following the usual process.[8] Instead, an order authorising the procedure must be made by a Magistrate (or an authorised officer of the court in the case of an interim order) and an interview friend or legal representative must, if reasonably practicable, be present while the procedure is carried out.[9]

14.8 The CFPA anticipates that evidence of forensic material or the results of analysis of forensic material might be admitted as evidence in court.[10] It also provides for DNA profiles to be stored on a database for the purpose of investigating other crimes.[11]

14.9 Australian states and territories use a common system for the storage of forensic materials through the National Criminal Investigation DNA Database (NCIDD) and the National Automated Fingerprint Identification System.[12] The NCIDD does not include the name of the person who provided the sample, but uses numeric identifiers.[13] Information on the NCIDD which is provided by NSW may only be transmitted to other jurisdictions to be used in the investigation or conduct of proceedings for an offence, or to identify a missing or deceased person.[14] A DNA profile is retained on the NCIDD until such time as it is required to be removed pursuant to the relevant legislative requirements of the jurisdiction (state, territory or Commonwealth) from which the DNA profile was taken. Once destroyed, the only remnant of the DNA profile is its destruction date.[15] We explain the requirements of NSW legislation relating to destruction of material below.

Destroying forensic material

14.10 Section 88 of the CFPA provides that forensic material taken from suspects must be destroyed in certain situations, including where:

- twelve months have passed since the forensic material was obtained, and criminal proceedings have not been instituted or have been discontinued (unless a warrant for the suspect's arrest has been issued)[16]
- the person has been found to have committed an offence but no conviction is recorded,[17] and
- the person has been acquitted.[18]

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8. *Crimes (Forensic Procedures) Act 2000* (NSW) s 3(1), s 7, s 17.
9. *Crimes (Forensic Procedures) Act 2000* (NSW) s 23, s 54.
10. *Crimes (Forensic Procedures) Act 2000* (NSW) pt 9.
11. *Crimes (Forensic Procedures) Act 2000* (NSW) pt 11.
12. CrimTrac, "Biometric Services" <http://www.crimtrac.gov.au/our_services/BiometricServices.html>.
13. CrimTrac, "Biometric Services" <http://www.crimtrac.gov.au/our_services/BiometricServices.html>.
14. *Crimes (Forensic Procedures) Act 2000* (NSW) s 97(1A).
15. CrimTrac, "NCIDD – Protection of Privacy" <http://www.crimtrac.gov.au/our_services/PrivacyandLegalSafeguards.html>.
16. *Crimes (Forensic Procedures) Act 2000* (NSW) s 88(2). A magistrate can extend the 12 month period on application by a police officer or the Director of Public Prosecutions, if satisfied that there are special reasons for doing so: s 88(5)-(6).
17. *Crimes (Forensic Procedures) Act 2000* (NSW) s 88(4)(a).
18. *Crimes (Forensic Procedures) Act 2000* (NSW) s 88(4)(b).

14.11 If the CFPA requires the destruction of a suspect's forensic material, evidence about the material is inadmissible if the prosecution seeks to lead it in any proceedings against the suspect.[19] It is also an offence to record a person's DNA in the DNA database system where the DNA was obtained from forensic material that should have been destroyed.[20] Similarly, it is an offence to retain or store in a DNA database any identifying information about a person obtained from forensic material after the time that that material was to be destroyed.[21]

14.12 As we discuss in para 14.1, there is no reference in the CFPA as to how forensic material taken from defendants who are diverted or found NGMI or UNA should be treated. Contrary to other circumstances where a defendant is not convicted, there is no express requirement for the destruction of forensic material taken from defendants who are dealt with in this way.[22]

14.13 The difficulty arises from the fact that people who are diverted or found NGMI or UNA have neither been convicted nor acquitted, and do not fall neatly into the categories established by the CFPA. However, this difficulty does not extend to every instance where a defendant has a cognitive or mental health impairment. Other defendants with such impairments may rely on infanticide or substantial impairment.[23] In these cases they must be convicted or acquitted and the CFPA applies to these verdicts in the usual way.

Approaches to the retention or destruction of forensic material

14.14 We have identified four different approaches to the retention or destruction of forensic material in Australia and overseas. NSW is an example of the *compulsory destruction* of materials, except in circumstances defined by statute. A closely related approach is *retention on request*, where material is destroyed unless the investigative agency obtains a court order. On the other hand, *destruction on request* means that all material is retained unless the person from whom the sample was taken makes an application for destruction. Finally, some jurisdictions have a *compulsory retention* regime, under which all material is retained regardless of the outcome of proceedings.

Compulsory destruction

14.15 The Commonwealth, Tasmania, Victoria and Queensland all have legislation similar to s 88 of the CFPA requiring the compulsory destruction of forensic materials

19. *Crimes (Forensic Procedures) Act 2000* (NSW) s 83.
20. *Crimes (Forensic Procedures) Act 2000* (NSW) s 91.
21. *Crimes (Forensic Procedures) Act 2000* (NSW) s 94.
22. See NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Forensic Samples*, Consultation Paper 8 (2010) [1.18], [1.38].
23. For example, a woman with a cognitive or mental health impairment may be convicted of infanticide rather than murder, where the criteria for that offence/defence are met. A person with a cognitive or mental health impairment may be convicted of manslaughter, rather than murder where the criteria for the partial defence of substantial impairment are met. Cases qualifying, or potentially qualifying, for the offence/defence of infanticide or for the partial defence of substantial impairment result in outright acquittal or conviction for murder, infanticide or manslaughter following a plea or a trial. See further Chapters 4-5.

where proceedings are not commenced, are discontinued, or the person is acquitted.[24] Only Queensland specifically provides that forensic material may be retained where a person is not proceeded against for an indictable offence because he or she has been found unfit for trial due to mental illness.[25]

14.16 In NZ, bodily samples and identifying records must be destroyed after 24 months if: the person is not charged with an offence; the charge is withdrawn; the person is acquitted; or the person is convicted but the offence is not an imprisonable offence or another specified offence.[26] A person's DNA profile may be retained on the Police DNA profile databank if the person is convicted of an imprisonable offence or another specified offence.[27] The NZ legislation expressly provides that a conviction includes an acquittal on account of insanity and a finding that the person is unfit to stand trial.[28]

14.17 In England and Wales, recent legislative amendments which have been passed but not yet come into force require that forensic material be destroyed except in certain circumstances.[29] The list of exceptions includes forensic material taken from a person who is convicted of a "recordable offence",[30] and a person arrested for or charged with a "qualifying offence" in specified circumstances.[31] If a person is given a penalty notice, fingerprints and DNA profiles can be retained for two years.[32] A finding that a person is not guilty by reason of insanity, or is under a disability and has done the act charged[33] (a finding equivalent to UNA) is treated as a conviction for these purposes.[34] This means that forensic material collected from such defendants may be retained indefinitely.

Retention on request

14.18 Victorian legislation allows the retention of forensic material only from a person who is found guilty, on application to a court. A member of the police force must apply to the convicting court, the Magistrates' Court, or where appropriate the Children's Court, for an order permitting the retention of any sample taken, no later than six months after the final determination of any appeal against the verdict (or the expiry

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24. *Crimes Act 1914* (Cth) s 23YD; *Forensic Procedures Act 2000* (Tas) s 51(2); *Crimes Act 1958* (Vic) s 464ZG; *Police Powers and Responsibilities Act 2000* (Qld) s 490(1). The legislation in these states is based on the Model Forensic Procedures Bill 2000 developed by the Model Criminal Code Officers Committee of the Standing Committee of Attorneys-General.
25. *Police Powers and Responsibilities Act 2000* (Qld) s 490(2)(d).
26. *Criminal Investigations (Bodily Samples) Act 1995* (NZ) s 60(1).
27. *Criminal Investigations (Bodily Samples) Act 1995* (NZ) s 26(a).
28. *Criminal Investigations (Bodily Samples) Act 1995* (NZ) s 2.
29. *Police and Criminal Evidence Act 1984* (UK) c 60, s 63D(3).
30. *Police and Criminal Evidence Act 1984* (UK) c 60, s 63I. "Recordable offence" is any offence punishable by imprisonment and includes a number of other specified offences: see *National Police Records (Recordable Offences) Regulations 2000* (UK) SI 2000/1139.
31. *Police and Criminal Evidence Act 1984* (UK) c 60, s 63F. "Qualifying offence" is defined in s 65A.
32. *Police and Criminal Evidence Act 1984* (UK) c 60, s 63L.
33. "Disability" encompasses any kind of disability which impacts upon the defendant's fitness to be tried: see generally, England and Wales, Law Commission, *Unfitness to Plead,* Consultation Paper 197 (2010) [2.44]-[2.46].
34. *Police and Criminal Evidence Act 1984* (UK) c 60, s 65B(1)(c)-(d).

of any appeal period).[35] The legislation specifically provides that the same procedure applies where a person is found not guilty by reason of mental impairment (except where the offence is heard summarily).[36]

Destruction on request

14.19 In the ACT, a suspect may apply to the court for an order that his or her forensic material be destroyed after a year has passed since the material was collected, so long as proceedings have been concluded (or were never commenced) and the suspect was not convicted.[37] This legislation does not make specific provision for those who are diverted or found UNA or NGMI, but it seems that people in this group would be able to apply for destruction as they have not been convicted of an offence.

14.20 In WA, forensic material must be destroyed after two years if the person is not charged or the charge is finalised without a finding of guilt, and the person makes a request to the Commissioner of Police.[38] This suggests that a person who is diverted would be able to request destruction. However if the suspect is found to be unfit to stand trial, or is found not guilty by reason of unsoundness of mind, destruction on request is not available and any forensic material collected is retained.[39]

Compulsory retention

14.21 In SA, only victims and volunteers are able to apply for destruction of forensic material, while the material taken from suspects is retained indefinitely regardless of the outcome of proceedings.[40] In the NT, forensic material may be retained for the period that the Commissioner of Police thinks fit.[41]

Preferred approach

14.22 Destruction of samples is compulsory where there has been no conviction in the Commonwealth, NSW, Tasmania, Victoria and Queensland, and may be ordered on request in the ACT and WA.

14.23 A model that requires destruction on request presents particular difficulties for people with cognitive and mental health impairments, as well as for some other groups. In this particularly complex area of the law, we expect that people with cognitive and mental health impairments would experience significantly greater difficulty than the general population in requesting destruction of their forensic material. We find the destruction on request model an inappropriate approach in

35. *Crimes Act 1958* (Vic) s 464ZFB(1).
36. *Crimes Act 1958* (Vic) s 464ZFB(1A)-(1B).
37. *Crimes (Forensic Procedures) Act 2000* (ACT) s 92(1)-(3).
38. *Criminal Investigation (Identifying People) Act 2002* (WA) s 66, s 67, s 69.
39. *Criminal Investigation (Identifying People) Act 2002* (WA) s 67(3)(a)-(b).
40. *Criminal Law (Forensic Procedures) Act 2007* (SA) s 39.
41. *Police Administration Act* (NT) s 147C(1).

relation to forensic material collected from defendants who are diverted or found UNA or NGMI. The CFPA presently requires the compulsory destruction of forensic material when proceedings are finalised and no conviction is recorded. We regard this as sound policy, and consequently we have made recommendations that are consistent with that approach.

DNA, law enforcement and privacy

14.24 As noted above, forensic material includes footprints, fingerprints and bodily samples. However in this section we will focus particularly on the issues that arise regarding the retention of DNA profiles on a database. The retention of DNA profiles is of particular value for law enforcement purposes, and also raises particular privacy concerns.

Why retain DNA samples?

14.25 When there is biological material left at a crime scene (such as blood, saliva, semen or tissue) and the police have a suspect, DNA from the crime scene can be compared with DNA from the suspect. This type of investigation does not require the use of a DNA database. However where there is no suspect, the DNA from the crime scene can be compared with DNA profiles retained on a DNA database. Sometimes this results in a match and the identification of a previously unknown suspect, or "cold hit". Presence of a person's DNA at a crime scene is not determinative of guilt, but in many cases it is likely to have important evidentiary value. The use of information contained in DNA databases has led to "a significant number of convictions in jurisdictions such as the United Kingdom, New Zealand and the United States".[42] Between 2002 and 2008, use of the NCIDD has reportedly resulted in over 16 000 "cold links" in Australia (instances where DNA taken at a crime scene has been linked to the DNA of a known offender in the database).[43]

14.26 DNA databases are of value to investigators because evidence suggests that the reoffending rate is high, particularly in cases where the first offence is one of break and enter, robbery, disorderly conduct or property damage.[44] Retaining the DNA profile of an offender increases the likelihood that the offender will be detected if he or she commits future crimes. However, DNA databases can only be of assistance when there is DNA present at a crime scene and when the identity of the offender is in doubt. This is not likely to occur in the majority of cases.[45] A DNA database rarely

42. J Gans and G Urbas, *DNA Identification in the Criminal Justice System,* Trends and Issues in Criminal Justice No 226 (Australian Institute of Criminology, 2002) 3; R Napper, "A National DNA Database: The United Kingdom Experience" (2000) 32 *Australian Journal of Forensic Sciences* 65, 66.
43. W T M Dunsmuir, C Tran and D Weatherburn, *Assessing the Impact of Mandatory DNA Testing of Prison Inmates in NSW on Clearance, Charge and Conviction Rates for Selected Crime Categories*, Legislative Evaluation Series No L17 (NSW Bureau of Crime Statistics and Research, 2008) 1.
44. See J Holmes, *Re-offending in NSW,* Bureau Brief No 56 (NSW Bureau of Crime Statistics and Research, 2012) 1-2, which found that of the 78 500 adults and juveniles convicted of an offence in a NSW court in 1994, almost 60% were reconvicted within 15 years.
45. H Wallace, "The UK National DNA Database: Balancing Crime Detection, Human Rights and Privacy" (2006) 7 *EMBO Reports* 26, 28.

contributes to the investigation of white collar crime, domestic violence offences, or serious violent or sexual offences where the identity of the offender is not in issue. The retention of DNA on a database is also unlikely to assist in the exoneration of an innocent person, as the identity of the innocent person will be known and his or her DNA can be compared to that found at the crime scene.[46]

14.27 While DNA databases only contribute to the investigation of certain types of crimes, their use is extremely valuable for some otherwise unsolvable crimes. The effective identification and prosecution of crime has a range of benefits. The public is assured that offenders are brought to justice and that the community is protected from their criminal conduct. Victims of crime, or a victim's family, are given some finality by the assurance that the investigation into the crime has been resolved. Finally, the use of forensic material may encourage guilty pleas in cases where a linkage is established, thereby avoiding often traumatic, lengthy and costly court proceedings in the interests of both victims and law enforcement agencies.[47]

Protection of individual privacy and civil liberties

14.28 The CFPA seeks to balance the value of forensic samples for criminal investigation purposes against privacy issues. Compulsory destruction of forensic samples in certain situations is an important element of the privacy protections built into the Act. Other privacy protections include "matching rules" that limit the use of samples taken for one purpose from use for an unrelated purpose. Breach of these rules is a criminal offence.[48]

14.29 The safeguards found in the CFPA reflect a general recognition in law of the value of privacy.[49] This recognition is found in international instruments, most notably the *International Covenant on Civil and Political Rights*, which Australia has ratified and which recognises privacy as a human right.[50] It is also found in broader privacy protections relating to information collected from individuals by government agencies such as the *Privacy and Personal Information Protection Act 1998* (NSW) and the *Health Records and Information Privacy Act 2002* (NSW).

14.30 The Model Criminal Law Officers Committee, when developing model forensic procedures laws for Australia, argued that destruction was *necessary* in cases where charges are not proved or are withdrawn:

> Where no offence is proved or the charges are dropped the suspect should be entitled to be treated in no way different from anyone else in the community. To do otherwise would undermine the justice system by enabling police to take

46. H Wallace, "The UK National DNA Database: Balancing Crime Detection, Human Rights and Privacy" (2006) 7 *EMBO Reports* 26, 27.
47. NSW, *Parliamentary Debates*, Legislative Assembly, 31 May 2000, 6295 (P Whelan).
48. *Crimes (Forensic Procedures) Act 2000* (NSW) s 92, s 93.
49. For the importance of privacy in law, see generally, NSW Law Reform Commission, *Invasion of Privacy*, Report 120 (2009); NSW Law Reform Commission, *Privacy Principles*, Report 123 (2009); Australian Law Reform Commission, *For Your Information: Australian Privacy Law and Practice*, Report 108 (2008).
50. *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) art 17.

> action which would result in the giving and retention of forensic material regardless of whether it is shown later to be justified.[51]

14.31 During parliamentary debates, many members of the NSW Parliament also indicated that rules concerning the destruction of forensic material were important to address civil liberty and personal privacy concerns.[52]

14.32 Our recommendations below in relation to retention or destruction of forensic material seek to balance the law enforcement value of the forensic material with the privacy rights of the individual.

Diversion

14.33 The Local Court has the power under s 32 and s 33 of the MHFPA to divert defendants out of criminal proceedings. While the CFPA does not require destruction of forensic material taken from people who are diverted,[53] it is the current police practice to destroy these samples.[54]

14.34 Section 32 provides that where a defendant is developmentally disabled or has a mental illness or condition, the magistrate may dismiss the charge and discharge the defendant into the care of a responsible person, on the condition that the defendant attend for assessment or treatment, or discharge the defendant unconditionally.[55] Such an order is to be made when it is "more appropriate to deal with the defendant in accordance with the provisions of this Part than otherwise in accordance with law".[56] If the defendant fails to comply with a condition of the diversion order, the magistrate may deal with the charge as if the defendant had not been discharged.[57] This provision is used to connect defendants with treatment or services that will deal with the causes of their offending behaviour.

14.35 Section 33 provides that where a defendant has a mental illness, the magistrate may order that the defendant be taken to, and detained in, a mental health facility for assessment, or discharge the defendant unconditionally or subject to conditions.[58] This section also provides for the defendant to be brought back before the magistrate to be further dealt with in relation to the charge. If this does not occur within six months of the defendant being dealt with under s 33, the charge is taken to have been dismissed.[59] Section 33 is generally used in relation to people who are

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51. Model Criminal Code Officers Committee of the Standing Committee of Attorneys-General, *Model Forensic Procedures Bill and The Proposed National DNA Database*, Discussion Paper (1999) 83.
52. See NSW, *Parliamentary Debates*, Legislative Assembly, 7 June 2000, 6736 (M Richardson); NSW, *Parliamentary Debates*, Legislative Assembly, 7 June 2000, 6805-8 (C Burton, J Mills); NSW, *Parliamentary Debates*, Legislative Council, 21 June 2000, 7295 (L Rhiannon).
53. See *Crimes (Forensic Procedures) Act 2000* (NSW) s 88.
54. Information supplied by the NSW Commissioner of Police, 17 September 2012.
55. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 32(1), (3).
56. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 32(1)(b).
57. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 32(3D).
58. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 33(1).
59. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 33(2).

seriously mentally ill at the time they appear in court such that they will be involuntarily admitted to a mental health facility.

14.36 In Report 135, we recommend some amendments to these sections to increase and clarify the diversionary options available.[60] We also recommended the extension of these powers to the District and Supreme Courts.[61]

Should forensic material be retained when a defendant is diverted?

14.37 It is not possible to estimate precisely the value of forensic material taken from people who are diverted. On the one hand, it is likely that a number of those diverted will have committed the act in question, and therefore may present a higher risk of reoffending than individuals who have been acquitted. This weighs in favour of retention. On the other hand, diversion currently only takes place in the Local Court and those diverted are likely to have been charged with less serious offences,[62] meaning that the retention of the forensic material is less important.

14.38 Diversion under s 32 or s 33 of the MHFPA takes place before any finding of guilt or otherwise has been made. The defendant still has the benefit of the presumption of innocence and arguably his or her privacy rights should remain unimpaired. It would be fair to treat such a person in the same way as defendants who are acquitted. There is a particular anomaly in the fact that forensic material from defendants who are convicted but have no conviction recorded must be destroyed,[63] while material from those who are diverted, and still presumed innocent, may be retained.

Submissions and consultations

14.39 We asked stakeholders whether the CFPA should be amended to require the destruction of forensic material taken from a suspect following a diversionary order under s 32 or s 33 of the MHFPA.[64]

14.40 The majority of submissions agreed that the CFPA should be amended to provide for the destruction of forensic material in these circumstances.[65] Submissions emphasised the absence of a conviction[66] and the Shopfront Youth Legal Centre

60. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion,* Report 135 (2012) Recommendation 9.4.

61. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion,* Report 135 (2012) Recommendation 13.2.

62. Courts have indicated that the seriousness of the offence charged is relevant to the decision to divert under s 32, and the power to make a final diversionary order under s 33 is only likely to be used for less serious offences: see NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion,* Report 135 (2012) [9.11], [10.34].

63. *Crimes (Forensic Procedures) Act 2000* (NSW) s 88(4)(a); Legal Aid NSW, *Submission MH18*, 37.

64. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Forensic Samples*, Consultation Paper 8 (2010) Issue 8.1.

65. Shopfront Youth Legal Centre, *Submission MH7*, 15; Law Society of NSW, *Submission MH13*, 53; Legal Aid NSW, *Submission MH18*, 37; Department of Human Services NSW (Juvenile Justice), *Submission MH28-2,* 17; NSW, Public Defenders, *Submission MH26,* 55.

66. Shopfront Youth Legal Centre, *Submission MH7*, 15; NSW Bar Association, *Submission MH10*, 62; NSW Consumer Advisory Group, *Submission MH11*, 59.

(SYLC) noted that "the defendant may in fact be innocent".[67] The Brain Injury Association of NSW pointed out that a person who is innocent may choose to apply for diversion "because of their inability to cope with the demands of a hearing".[68]

14.41 Among those who supported the destruction of forensic material, there was agreement that if the defendant is discharged unconditionally, the material should be destroyed as soon as possible.[69] If the discharge is conditional, there are several ways to specify the time at which the material should be destroyed. The Law Society of NSW and Legal Aid NSW suggested it should occur when the person has complied with the conditions set by the court.[70] However, the existing legislation does not create an effective regime for the courts to monitor the compliance of people who are discharged conditionally,[71] so it would not be easy for those responsible for the destruction of samples to ascertain whether the defendant has complied with the conditions.

14.42 SYLC proposed that forensic material should be destroyed if the proceedings are not brought back to court within six months,[72] and the Public Defenders suggested that forensic material should be destroyed after the expiration of any conditions.[73] These submissions appear to be based on an assumption that proceedings may not be taken for the original charge after this point in time. However the NSW Bar Association suggested that the material should be retained for a further period (perhaps six months) to allow for further proceedings if diversion is unsuccessful.[74] While the MHFPA states that the court may deal with the original charge if the defendant fails to comply with a condition within six months of the diversion order being made,[75] it is not clear that this time limit prevents the court from dealing with the original charge after the six months has expired.[76]

14.43 Not all submissions supported the destruction of forensic material taken from defendants who are diverted. The NSW Police Force did not support the proposed amendment.[77] In favour of retaining the forensic material, the Office of the Director of Public Prosecutions pointed to the issues we outlined in CP 8, that is, the public interest in ensuring that crime is investigated and solved with efficiency and

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67. Shopfront Youth Legal Centre, *Submission MH7*, 15.
68. Brain Injury Association of NSW, *Submission MH19*, 28.
69. Shopfront Youth Legal Centre, *Submission MH7*, 15; Law Society of NSW, *Submission MH13*, 53; Legal Aid NSW, *Submission MH18*, 37; Department of Human Services NSW (Juvenile Justice), *Submission MH28-2,* 17; NSW, Public Defenders, *Submission MH26,* 55.
70. Law Society of NSW, *Submission MH13*, 53; Legal Aid NSW, *Submission MH18*, 37.
71. See NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion,* Report 135 (2012) [9.45]-[9.53].
72. Shopfront Youth Legal Centre, *Submission MH7,* 15; NSW, Public Defenders, *Submission MH26,* 55.
73. NSW, Public Defenders, *Submission MH26,* 55.
74. NSW Bar Association, *Submission MH10,* 62.
75. See *Mental Health (Forensic Provisions) Act 1990* (NSW) s 32(3D).
76. Implementation of our Recommendations in Report 135 would resolve this uncertainty: see NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion,* Report 135 (2012) Recommendations 9.3, 9.4, 9.8.
77. NSW Police Force, *Submission MH47*, 21.

accuracy. However this submission also conceded that "the competing arguments against retaining the material are very strong".[78]

14.44 SYLC suggested that the police should have a discretion to apply for retention and proposed that such a procedure would be useful in "cases involving serious charges where the prosecution case appears strong, or where the defendant is diverted under s 32 or s 33 after an admission of guilt".[79]

14.45 In Report 135, we make recommendations that are intended to encourage the use of diversionary options, including the extension of these diversionary options to the District and Supreme Courts.[80] If implemented, it is likely that defendants who are charged with more serious offences will, in appropriate cases, be diverted for assessment and treatment. As the NSW Bar Association submitted, there would be a stronger case for the retention of forensic samples in such cases.[81]

The Commission's view

14.46 We acknowledge the submissions calling for the retention of all forensic material obtained from people diverted, in the interests of effective and efficient law enforcement. Such an approach would be likely to make some contribution to law enforcement. However, in light of the fact that none of those diverted has been found guilty, we consider it inappropriate to retain forensic material taken in these circumstances.

14.47 We are persuaded that forensic material taken from people who are diverted should, for the most part, be treated in the same way as that from people who are acquitted or who have been found to have committed the offence but no conviction has been recorded – that is, the material should be destroyed. This is the current practice in NSW, but we recommend that the CFPA should be amended to clarify the position. Our exact recommendations on this issue are dependent on the extent to which our recommendations in Report 135 are adopted and enacted into law.

If the current statutory regime is maintained

14.48 We recommend that forensic material should be destroyed as soon as possible if the defendant is discharged unconditionally under s 32 or s 33 of the MHFPA.

14.49 If the discharge is conditional, forensic material should be retained only for the period during which it is possible for the court to deal with the original charge. As noted above, there is some uncertainty about precisely when that time period expires. Implementation of our recommendations in Report 135 would clarify when the period expires. If a defendant breaches a condition imposed under s 32 of the MHFPA and the magistrate deals with the charge as if the defendant had not been

78. NSW Office of the Director of Public Prosecutions, *Submission MH5*, 16.
79. Shopfront Youth Legal Centre, *Submission MH7*, 15.
80. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion,* Report 135 (2012) Recommendation 13.2.
81. NSW Bar Association, *Submission MH10*, 62.

discharged,[82] the forensic material should be dealt with under the normal provisions of the CFPA.

14.50 Under s 33, a defendant may be brought back before the court even where he or she has not failed to comply with a condition (for example, when the defendant is well enough to face charges). In this case, the forensic material should be dealt with under the normal provisions of the CFPA. However, if the person is sent to a mental health facility under s 33, but not brought back before the court, then the charge will be taken to be dismissed on the expiration of a period of six months after the date of the diversion order.[83] We recommend that, in this circumstance, forensic material should be destroyed as soon as practicable after the date the charge is taken to be dismissed.

If s 32 and s 33 are amended

14.51 In Report 135 we recommend that instead of discharging a defendant under s 32 and reinstituting proceedings if there is a breach of a condition, the court should be empowered to dismiss charges either unconditionally, on the basis that a satisfactory diversion plan is in place, or after the completion of a diversion plan. If this recommendation is implemented, we recommend that the CFPA should be amended to provide that when charges are dismissed under s 32, forensic material must be destroyed.

14.52 In Report 135 we also recommend amending s 33 so that it contains two clear options, under which the court may:

(1) dismiss the charge and order that the defendant be taken to and detained in a mental health facility for assessment,[84] or

(2) order that the defendant be taken to and detained in a mental health facility for assessment, and returned to the court if released from that facility or found not to have a mental illness or mental disorder.[85]

Again, if this recommendation is implemented, the CFPA should be amended to provide that if charges are dismissed under s 33, forensic material should be destroyed.

Applications for retention to be permitted in certain circumstances

14.53 Although as a general rule we recommend that forensic material should be destroyed in cases of diversion, there are some situations in which the public interest in crime prevention may tip the scales in favour of retention. We recommend that a court should be able to make an order for retention of forensic material on the application of a police officer or the Director of Public Prosecutions

82. See *Mental Health (Forensic Provisions) Act 1990* (NSW) s 32(3D).

83. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 33(2).

84. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion,* Report 135 (2012) Recommendation 10.1.

85. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion,* Report 135 (2012) Recommendation 10.3.

(DPP) if such an order is justified in all the circumstances of the case. Relevant considerations would include:

- the gravity of the alleged offence
- the circumstances in which the offence is alleged to have been committed, and
- the person's cognitive and mental health impairment.

14.54 These provisions reflect (so far as they are relevant to decisions about retention of forensic material) those matters that are prescribed in s 24(4) of the CFPA in relation to court orders for the carrying out of forensic procedures. The gravity of the offence is clearly relevant to the public interest in law enforcement. The nature and extent of the person's impairment may weigh both in favour of and against retention, depending on the circumstances of the case. The circumstances in which the offence was committed and the person's impairment may together alter the court's assessment of the seriousness of the offence. For example, a person with a cognitive impairment may commit an offence without understanding its nature and seriousness.

Recommendation 14.1

(1) Section 88(4) of the *Crimes (Forensic Procedures) Act 2000* (NSW) should be amended to the following effect:

(a) If forensic material has been taken from a person who is a suspect and the charge against the person is dismissed under s 32 or s 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW):

(i) if the person is discharged unconditionally (whether into the care of a responsible person or not), then the forensic material relating to the charge must be destroyed as soon as practicable,

(ii) if the person is discharged subject to conditions, then the forensic material relating to the charge must be destroyed as soon as practicable after the expiry of the six month period referred to in s 32(3)(A) or s 33(2), unless further proceedings are brought in relation to the charge.

(b) Notwithstanding the above, the court may make an order for retention of forensic material on the application of a police officer or the Director of Public Prosecutions if such an order is justified in all the circumstances of the case, having regard to:

(i) the gravity of the alleged offence

(ii) the circumstances in which the offence is alleged to have been committed, and

(iii) the person's cognitive and mental health impairment.

(2) Alternatively, if Recommendations 9.4-9.9 of Report 135 are adopted, s 88(4) of the *Crimes (Forensic Procedures) Act 2000* (NSW) should be amended to the following effect:

(a) If forensic material has been taken from a person who is a suspect, the material relating to the charge must be destroyed as soon as practicable in the following circumstances:

(i) the charge against the person is dismissed under s 32 or s 33 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) and the person is discharged unconditionally

(ii) the charge is dismissed under s 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) and the person is discharged on the basis that a satisfactory diversion plan is in place, or

(iii) the charge is dismissed under s 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) after the defendant has undertaken a diversion plan.

(b) Notwithstanding the above, the court may make an order for retention of forensic material on the application of a police officer or the Director of Public Prosecutions if such an order is justified in all the circumstances of the case, having regard to:

(i) the gravity of the alleged offence

(ii) the circumstances in which the offence is alleged to have been committed, and

(iii) the person's cognitive and mental health impairment.

Not guilty by reason of mental illness

14.55 A special verdict of NGMI involves a finding that the defendant committed the acts constituting the crime of which he or she is charged, but because of mental illness cannot be held criminally responsible.[86] A defendant found NGMI is not convicted of the offence and the special verdict does not form part of his or her criminal history for the purposes of sentencing for any subsequent offence.[87]

14.56 Section 39 of the MHFPA provides that, following a verdict of NGMI, the court may order detention, conditional release or unconditional release. If the court orders unconditional release, the effect is the same as a discharge following an ordinary acquittal. If the court makes an order for conditional release or an order for detention, the person becomes a forensic patient under the MHFPA, and is subject to the jurisdiction of the Mental Health Review Tribunal.[88] Defendants who plead NGMI have usually been charged with serious offences. This appears to be because a finding of NGMI currently results in a defendant being held as a forensic patient without a set release date, and so NGMI is a less attractive option for relatively minor offences.[89]

86. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 38(1).
87. *Heatley v The Queen* [2008] NSWCCA 226 [41]-[43].
88. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 42(a)(i).
89. See Chapter 3, para 3.12. This may also be because currently the statutory verdict of NGMI does not appear to be available in the Local Court: see para 12.72-12.73.

14.57 As we have discussed above, the CFPA contains no express provision dealing with instances where a defendant is found NGMI and it appears that forensic material taken from such defendants may be retained indefinitely.[90] The issue for consideration is whether forensic material taken from a person who has been found NGMI should be treated in the same way as material from a defendant found guilty, even though the former has not been held criminally responsible and has not been convicted of an offence. The alternative is to treat a person found NGMI in the same way as a person who is acquitted or found to have committed the act charged but no conviction recorded – even though the former has been found to have committed an act constituting a crime.

14.58 In choosing between these two alternatives, we seek the most effective option which also strikes an appropriate balance between the facilitation of law enforcement and the protection of privacy. Law enforcement issues would have particular weight in the case of people found NGMI if it were clear that they are at a higher risk of reoffending than convicted offenders. However, the evidence is unclear. A NSW study of the reoffending rates of released prisoners found that people with mental health disorders and co-morbid substance abuse were at a higher risk of reoffending than prisoners who had only a mental health disorder or only a substance abuse disorder, or neither.[91] However, people with NGMI verdicts have not been convicted, and it is not clear that their risk of reoffending would be similar.

14.59 A study of 197 people found NGMI from January 1990 and released into the community conditionally or unconditionally in NSW prior to December 2010 found that rates of reoffending were low. Conditionally released patients had a "low incidence of charges (19%), convictions (7%) and violent convictions (3%)". Unconditionally released patients also had a low rate of reoffending following unconditional release into the community (12%).[92] A study of people released from New York forensic hospitals after an NGMI verdict found very low rates of rearrest within two years (14% of males, 2% of females) compared with other people released from prison (56% of males, 42% of females).[93]

14.60 It is also unclear whether a person found NGMI should retain his or her full right to privacy in relation to forensic samples. On the one hand, such a person has often been found to have committed a very serious act, frequently involving the taking of a life. In these circumstances, there may be greater justification for intrusion into a person's privacy. On the other hand, since a person found NGMI has not been convicted of an offence, it could be argued that the person's existing privacy rights should remain intact.

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90. For a further discussion of this issue, see NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Forensic Samples,* Consultation Paper 8 (2010) [1.17]-[1.18].

91. N Smith and L Trimboli, *Comorbid Substance and Non-Substance Mental Health Disorders and Re-offending Among NSW Prisoners,* Crime and Justice Bulletin No 140 (NSW Bureau of Crime Statistics and Research, 2010) 9.

92. H Hayes, *Not Guilty by Reason of Mental Illness: A 21 Year Retrospective Study of Released Forensic Patients in NSW* (Masters in Psychology Thesis, University of NSW, 2011) 20, 35, 42.

93. R Miraglia and D Hall, "The Effect of Length of Hospitalization on Re-Arrest Among Insanity Plea Acquittees" (2011) 39 *Journal of the American Academy of Psychiatry and the Law* 524, 530.

14.61 All other states and territories, as well as NZ and the UK, treat forensic material taken from those found NGMI in the same way as material taken from convicted offenders.

Submissions and consultations

14.62 In CP 8 we asked if the CFPA should be amended to require the destruction of forensic material taken from a suspect following a finding of NGMI.[94]

14.63 Some stakeholders submitted that the CFPA should be amended to require the destruction of forensic material taken from defendants found NGMI, but these submissions did not provide reasons for their view.[95] Others argued that because the defendant in such cases has been found to have committed the act charged, the public interest in efficient and effective law enforcement must take priority over the public interest in privacy.[96] In consultation, representatives of victim support groups indicated that they considered that when there has been a verdict of NGMI, forensic material should be retained in order to facilitate the investigation of unsolved crimes.[97]

14.64 The Public Defenders suggested that the way to "best resolve the competing concerns" is to allow police to apply to a court for retention of the relevant forensic material.[98]

The Commission's view

14.65 We are of the view that the forensic material of people found NGMI should be treated in the same way as people who have been convicted, and that it should be retained.

14.66 Unlike people diverted, people found NGMI have been found to have committed the act charged, and as a practical matter the offence concerned is often of a serious nature. For these reasons we agree with those who argued that the public interest in law enforcement should, in these cases, prevail over privacy rights.

14.67 We are fortified in this view by the fact that forensic material is retained in virtually all other equivalent jurisdictions in relation to people who are found NGMI or its equivalent.

14.68 To remove any uncertainty, we recommend that the CFPA be amended to provide that, for the purposes of s 88, a verdict of NGMI should be treated in the same way as a conviction.

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94. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Forensic Samples*, Consultation Paper 8 (2010) Issue 8.2.
95. Law Society of NSW, *Submission MH13*, 53; Legal Aid NSW, *Submission MH18*, 37; Department of Human Services NSW (Juvenile Justice), *Submission MH28-2*, 17.
96. NSW Bar Association *Submission MH10*, 62; NSW, Public Defenders *Submission MH26*, 56.
97. Victims of crime roundtable, *Consultation MH15.*
98. NSW, Public Defenders, *Submission MH26*, 56.

Recommendation 14.2

The *Crimes (Forensic Procedures) Act 2000* (NSW) should be amended to provide that for the purposes of s 88, a finding that a person is not guilty by reason of mental illness is equivalent to a conviction.

Unfit to be tried

14.69 In proceedings in the Supreme and District Courts, the court may find a defendant unfit to be tried.[99] So far as is presently relevant, the following may occur:

(1) The person may, after an adjournment, become fit to go to trial.[100] In this case, s 88 of the CFPA would govern the retention or destruction of forensic material in the usual way.

(2) The DPP may decide not to proceed with the charge.[101] In this case, it would appear that the proceedings would be "discontinued" within the meaning of s 88(2)(c) of the CFPA and any forensic material would need to be destroyed as soon as practicable.[102]

(3) The court may conduct a special hearing for the purpose of determining whether it can be proved that, on the limited evidence available, the person committed the offence charged (or an alternative offence).[103]

14.70 At a special hearing, there are three possible verdicts:

(1) The defendant may be acquitted,[104] and s 88(4)(b) of the CFPA would require forensic material to be destroyed.

(2) The court may find the defendant NGMI.[105]

(3) The court may find "that on the limited evidence available, the accused person committed the offence charged" or an alternative offence (that is, a finding of UNA).[106] Section 22 of the MHFPA makes clear that such a verdict "constitutes a qualified finding of guilt and does not constitute a basis in law for any conviction for the offence to which the finding relates".[107] However, there is no

99. A defendant may also be found unfit in the Local Court, but the provisions of the *Mental Health (Forensic Provisions) Act 1990* (NSW) regarding referral to the Mental Health Review Tribunal and special hearings do not currently apply in the Local Court. In Chapter 12 we recommend that the fitness procedures in the *Mental Health (Forensic Provisions) Act 1990* (NSW) be extended to the Local Court: see Recommendation 12.1.
100. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 13, s 30(1), s 45.
101. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 19(1), s 29.
102. *Crimes (Forensic Procedures) Act 2000* (NSW) s 88(2)(c).
103. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 19(1), s 30(2).
104. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22(1)(a).
105. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22(1)(b), (2).
106. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22(1)(c)-(d).
107. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22(3)(a).

reference in Part 10 of the CFPA to such a finding, and there is therefore no requirement for the destruction of the forensic material.[108]

14.71 In CP 8, we asked if the CFPA should be amended to require the destruction of forensic material following:

(a) a decision by the DPP not to continue with the proceedings, or

(b) a finding at a special hearing that, on the limited evidence available, the defendant has committed an offence.

Where proceedings are discontinued

14.72 In most Australian jurisdictions, when the DPP decides not to continue with the proceedings, forensic material is treated in the same way as material collected from those acquitted.[109] However in Queensland and WA, there is no special hearing process and the forensic material of those found unfit to stand trial is treated in the same way as material from a convicted person.[110]

14.73 Submissions were largely in favour of the compulsory destruction of material collected from defendants following a decision by the DPP not to continue with the proceedings.[111]

14.74 We agree that where the DPP declines to proceed against a person who has been found unfit to stand trial (even if that person later becomes fit), the person retains the presumption of innocence. Their forensic material should be treated in the same way as the material of an acquitted person. As the CFPA already provides for destruction on the discontinuation of proceedings, we need not make any recommendation on that matter.

Where there is a finding of UNA

14.75 A finding at a special hearing that a person has committed the offence charged is different to a finding that the person committed the offence following a plea of guilty or an ordinary trial according to law. A finding of UNA does not constitute a conviction.[112]

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108. For a further discussion of this issue, see NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Forensic Samples*, Consultation Paper 8 (2010) [1.33]-[1.38].

109. *Crimes Act 1914* (Cth) s 23YD(2); *Crimes Act 1958* (Vic) s 464ZG(3)(b); *Forensic Procedures Act 2000* (Tas) s 51(2); *Crimes (Forensic Procedures) Act 2000* (ACT) s 92; *Criminal Law (Forensic Procedures) Act 2007* (SA) s 39; *Police Administration Act* (NT) s 147C.

110. *Police Powers and Responsibilities Act 2000* (Qld) s 490(1)(b), s 490(2)(d); *Criminal Investigation (Identifying People) Act 2002* (WA) s 67(1)(c), s 67(3)(a); *Criminal Investigations (Bodily Samples) Act 1995* (NZ) s 2(1). In Queensland, when a person is found permanently unfit to be tried, proceedings are discontinued: *Mental Health Act 2000* (Qld) s 283.

111. NSW Bar Association, *Submission MH10,* 62; NSW Consumer Advisory Group, *Submission MH11,* 59; Law Society of NSW, *Submission MH13,* 53; Legal Aid NSW, *Submission MH18,* 37; NSW, Public Defenders, *Submission MH26,* 56.

112. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22.

14.76 On the other hand, a special hearing "is to be conducted as nearly as possible as if it were a trial of criminal proceedings".[113] The person must be represented, the person's legal practitioner may exercise the person's right to challenge jurors, and any defence that could ordinarily be raised at trial may be raised at the special hearing.[114] The special hearing is the best that can be achieved when the defendant is not able to participate effectively in the process. When considering whether to retain forensic material, a finding of UNA at a special hearing is entitled to significant weight, even though it does not amount to a conviction at law.

14.77 Special hearings are currently only held in relation to District and Supreme Court matters, so they usually involve allegations of serious crimes.[115] We have no direct evidence of recidivism rates for those people found UNA. There is a risk, albeit unquantifiable, that the defendant may reoffend. Furthermore, forensic materials taken from those convicted are retained, lending weight to a similar approach for people found UNA, given it has been established on the limited evidence available that the person has committed an offence.

Other jurisdictions

14.78 Six Australian jurisdictions have a special hearing procedure that can result in a qualified finding of guilt. Of these, the NT and SA treat all forensic material taken from suspects in the same way, regardless of the verdict. In the ACT, forensic material can be destroyed on request if the person is "not convicted",[116] and this provision would appear to cover the case of a person with a qualified finding of guilt. In Victoria, the police can only apply for retention of material when a person is found guilty,[117] so it appears the police could not apply when there is a qualified finding. In Tasmania, as in NSW, the legislation requires destruction only when the defendant is acquitted,[118] so it appears that if there is a qualified finding of guilt the material may be retained.

14.79 In England and Wales, legislative amendments passed but not yet in force provide that the equivalent to a finding of UNA in England and Wales constitutes a conviction for the purposes of the retention and destruction of forensic material,[119] meaning that any forensic material collected from such a person can be retained indefinitely.[120]

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113. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 21(1).
114. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 21(3).
115. In Chapter 12 we recommend that the special hearing process be extended to the Local and Children's Courts, but only where an order under the *Mental Health (Forensic Provisions) Act 1990* (NSW) s 32 or s 33 is not considered appropriate: see Recommendations 12.1, 12.4.
116. *Crimes (Forensic Procedures) Act 2000* (ACT) s 92.
117. *Crimes Act 1958* (Vic) s 464ZFB(1)(b).
118. *Forensic Procedures Act 2000* (Tas) s 51(4).
119. *Police and Criminal Evidence Act 1984* (UK) c 60, s 65B(1)(d).
120. Where the offence in question is a "recordable offence": see *Police and Criminal Evidence Act 1984* (UK) c 60, s 63I.

Submissions and consultations

14.80 In CP 8 we asked whether the CFPA should be amended to require the destruction as soon as practicable of forensic material taken from a suspect following a finding at a special hearing that, on the limited evidence available, the defendant committed an offence.[121]

14.81 Submissions were mixed on this issue, with two supporting an amendment requiring destruction as soon as practicable,[122] two suggesting that the material should be retained for the period during which the defendant may become fit to be tried[123] and three indicating that the material should be retained indefinitely.[124] Few submissions provided reasons for their respective views, but the NSW Bar Association noted that the issue of public protection was relevant to its support for retaining the material.[125]

The Commission's view

14.82 We have given weight to the fact that a person found to have committed an offence at a special hearing has not been convicted at law. Despite this, we consider that forensic material taken from a person who has been found UNA should be retained. Although retaining the material does interfere with the privacy rights of the person involved, we consider that the fact that the person has been found at a special hearing to have committed an offence is a sufficient justification for the interference.

14.83 To remove any uncertainty, we recommend that the CFPA be amended to provide that for the purposes of s 88, a finding of UNA should be treated in the same way as a conviction.

14.84 We note that a verdict of NGMI is available to the court after a special hearing.[126] Where there is a special hearing and a person is found NGMI, Recommendation 14.2 in relation to the treatment of forensic material from defendants found NGMI should apply.

Recommendation 14.3

The *Crimes (Forensic Procedures) Act 2000* (NSW) should be amended to provide that for the purposes of s 88, a finding at a special hearing that a person has, on the limited evidence available, committed an offence is equivalent to a conviction.

121. NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Forensic Samples*, Consultation Paper 8 (2010) Issue 8.3.
122. NSW Consumer Advisory Group, *Submission MH11*, 59; NSW, Public Defenders, *Submission MH26*, 56.
123. Law Society of NSW, *Submission MH13*, 53; Legal Aid NSW, *Submission MH18*, 37.
124. NSW Office of the Director of Public Prosecutions, *Submission MH5,* 16; NSW Bar Association, *Submission MH10,* 62; NSW Police Force, *Submission MH47*, 21.
125. NSW Bar Association, *Submission MH10,* 62.
126. *Mental Health (Forensic Provisions) Act 1990* (NSW) s 22(1)(b).

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 Alan Vaughan and Ms Elaine Vaughan, 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) Limited, 08 August 2010

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 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 Mental Health Review Tribunal, 21 March 2012
MH49 Chief Magistrate of the Local Court of NSW, 30 August 2012
MH50 Children's Court of NSW, 5 September 2012
MH51 Public Interest Advocacy Centre, 30 August 2012
MH52 Shopfront Youth Legal Centre, 31 August 2012
MH53 Women in Prison Advocacy Network, 7 September 2012
MH54 Women's Legal Services NSW, 7 September 2012
MH55 Legal Aid NSW, 14 September 2012
MH56 NSW Trustee and Guardian, 17 September 2012
MH57 Mental Health Review Tribunal, 10 September 2012
MH58 Hunter Community Legal Centre, 13 September 2012
MH59 NSW Department of Family and Community Services, 25 September 2012
MH60 Law Society of NSW, 15 October 2012
MH61 Mr Mark Ierace SC, Senior Public Defender, 30 November 2012
MH62 Mr Lloyd Babb SC, Director of Public Prosecutions, 17 December 2012
MH63 Law Society of NSW, 17 December 2012
MH64 NSW Bar Association, 21 December 2012
MH65 Mental Health Review Tribunal, 9 January 2013
MH66 NSW Police Force, 21 December 2012
MH67 Mental Health Review Tribunal, 5 February 2013
MH68 Legal Aid NSW, 19 December 2012
CMH1 Confidential Submission, 30 June 2010
CMH2 Confidential Submission, 3 March 2011

A list of preliminary submissions can be found in NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012) Appendix B.

Appendix B
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 Julia 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

Disability Advisory Council (MH33)

12 September 2012

Mr Laurie Glanfield AM, Director General, Department of Attorney General and Justice, Chair

Mr Geoffrey Beatson, People with cognitive disabilities

Mr Lance Feeney, People living with HIV and AIDS

Mr Darren Fittler, Blind people and people with vision impairments

Ms Elizabeth Grieves, People with brain injuries

Ms Julia Haraksin, Manager, Diversity Services, Department of Attorney General and Justice

Mr Alastair McEwin, Deaf people

Ms Julie Shead, People with physical disability

Tests for fitness and NGMI roundtable (MH34)

25 September 2012

Dr Stephen Allnutt, Clinical Director, Community Forensic Mental Health Service

Ms Robyn Clarke, Legal Aid NSW

Mr John Gallagher, Law Society of NSW

Professor David Greenberg, Clinical Director, Statewide Community and Court Liaison Service, Justice Health

Professor Susan Hayes, University of Sydney

Professor Dan Howard SC, President, Mental Health Review Tribunal

Ms Lida Kaban, A/Deputy President, Mental Health Review Tribunal

Dr Arlie Loughnan, University of Sydney

Ms Ka Ki Ng, NSW Consumer Advisory Group

Mr David Patch, Crown Prosecutor, NSW Bar Association

Ms Johanna Pheils, A/Deputy Solicitor, Office of Director of Public Prosecutions

Senior Sergeant Allan Treadwell, NSW Police Force

Forensic process roundtable (MH35)

9 October 2012

Ms Robyn Clarke, Legal Aid NSW
Mr Peter Dodd, Public Interest Advocacy Centre
Assistant Commissioner Luke Grant, Strategic Policy and Planning, Corrective Services NSW
Ms Sarah Hanson, Forensic Team Leader, Mental Health Review Tribunal
Mr Mark Ierace SC, Senior Public Defender
Ms Lida Kaban, A/Deputy President, Mental Health Review Tribunal
Mr Peter McGee, Law Society of NSW
Mr Trevor Perry, Manager, Service Development and Quality, Mental Health
Ms Johanna Pheils, A/Deputy Solicitor, Office of Director of Public Prosecutions
Ms Naomi Prince, Team Leader (Chief Psychologist) Personality & Behavioural Disorders Unit, Corrective Services NSW
Ms Tami Sokol, Public Interest Advocacy Centre
Senior Sergeant Allan Treadwell, NSW Police Force
Mr Gabriel Wendler, NSW Bar Association

Supreme Court of NSW (MH36)

9 October 2012

The Hon Justice Peter McClellan, Chief Judge at Common Law
The Hon Justice Richard Button
The Hon Justice Peter Johnstone

Senior Public Defender (MH37 and MH39)

11 October 2012, 12 November 2012

Mr Mark Ierace SC, Senior Public Defender

Mental Health Review Tribunal (MH38)

24 October 2012

Professor Dan Howard SC, President, Mental Health Review Tribunal
Ms Lida Kaban, A/Deputy President, Mental Health Review Tribunal
Ms Sarah Hanson, Forensic Team Leader, Mental Health Review Tribunal

Appendix C
Fitness case study list

R v Aliwijaya [2011] NSWSC 924

R v Aliwijaya [2012] NSWSC 503

R v Bailey [2011] NSWSC 1228

R v Briggs [2012] NSWSC 977

R v Bugmy [2009] NSWSC 1215

R v Bugmy [2010] NSWSC 1473

R v Songsangkong [2008] NSWDC 122

R v Chong [2011] NSWSC 914

R v Coleman [2009] NSWSC 457

DG, Dept of Environment, Climate Change and Water [2011] NSWLEC 87

R v Gallagher [2012] NSWSC 484

R v Grant [2008] NSWSC 784

R v Gu [2009] NSWSC 25

R v Hussein [2011] NSWDC 103

R v Holt [2009] NSWDC 147

R v JH [2009] NSWSC 551

KF [2011] NSWLC 14

McKenzie [2009] NSWDC 267

R v Newbury [2012] NSWSC 34

Rush [2009] NSWDC 325

R v Sharrouf [2008] NSWSC 1450

R v Smith [2008] NSWDC 23

R v Smith [2009] NSWSC 1337

R v Smith [2011] NSWDC 233

R v Sutcliffe [2008] NSWDC 327

R v Tarantello [2010] NSWSC 469

R v Walker [2008] NSWSC 462

R v Waszczuk [2011] NSWSC 212

R v Waszczuk [2012] NSWSC 380

R v Wilkinson [2008] NSWSC 1237

Appendix D
Defence of mental illness: jurisdictional review

STATE	LEGISLATION
ACT	***Criminal Code* (ACT)**
	Chapter 2, Part 2.3, Division 2.3.2 Lack of capacity—mental impairment **27 Definition—*mental impairment*** (1) In this Act: ***mental impairment*** includes senility, intellectual disability, mental illness, brain damage and severe personality disorder. (2) In this section: ***mental illness*** is an underlying pathological infirmity of the mind, whether of long or short duration and whether permanent or temporary, but does not include a condition (a ***reactive condition***) resulting from the reaction of a healthy mind to extraordinary external stimuli. (3) However, a reactive condition may be evidence of a mental illness if it involves some abnormality and is prone to recur. **28 Mental impairment and criminal responsibility** (1) A person is not criminally responsible for an offence if, when carrying out the conduct required for the offence, the person was suffering from a mental impairment that had the effect that— (a) the person did not know the nature and quality of the conduct; or (b) the person did not know that the conduct was wrong; or (c) the person could not control the conduct. (2) For subsection (1) (b), a person does not know that conduct is wrong if the person cannot reason with a moderate degree of sense and composure about whether the conduct, as seen by a reasonable person, is wrong. (3) The question whether a person was suffering from a mental impairment is a question of fact. (4) A person is presumed not to have been suffering from a mental impairment. (5) The presumption is displaced only if it is proved on the balance of probabilities (by the prosecution or defence) that the person was suffering from a mental impairment. (6) The prosecution may rely on this section only if the court gives leave. (7) If the trier of fact is satisfied that a person is not criminally responsible for an offence only because of mental impairment, it must— (a) for an offence dealt with before the Supreme Court—return or enter a special verdict that the person is not guilty of the offence because of mental impairment; or (b) for any other offence—find the person not guilty of the offence because of mental impairment. **29 Mental impairment and other defences** (1) A person cannot rely on a mental impairment to deny voluntariness or the existence of a fault element, but may rely on mental impairment to deny criminal responsibility. (2) If the trier of fact is satisfied that a person carried out conduct because of a delusion caused by a mental impairment, the delusion itself cannot be relied on as a defence, but the person may rely on the mental impairment to deny criminal responsibility.

NT	***Criminal Code* (NT)**
	Division 1 Preliminary **43A Definitions** In this part ... *mental illness* means an underlying pathological infirmity of the mind, whether of long or short duration and whether permanent or temporary, but does not include a condition that results from the reaction of a healthy mind to extraordinary stimuli (although such a condition may be evidence of a mental illness if it involves some abnormality and is prone to recur). *mental impairment* includes senility, intellectual disability, mental illness, brain damage and involuntary intoxication ... **Division 2 Mental Impairment** **43C Defence of mental impairment** (1) The defence of mental impairment is established if the court finds that a person charged with an offence was, at the time of carrying out the conduct constituting the offence, suffering from a mental impairment and as a consequence of that impairment: (a) he or she did not know the nature and quality of the conduct; (b) he or she did not know that the conduct was wrong (that is he or she could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong); or (c) he or she was not able to control his or her actions. (2) If the defence of mental impairment is established, the person must be found not guilty because of mental impairment.
QLD	***Criminal Code* (Qld)**
	27 Insanity (1) A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission the person is in such a state of mental disease or natural mental infirmity as to deprive the person of capacity to understand what the person is doing, or of capacity to control the person's actions, or of capacity to know that the person ought not to do the act or make the omission. (2) A person whose mind, at the time of the person's doing or omitting to do an act, is affected by delusions on some specific matter or matters, but who is not otherwise entitled to the benefit of subsection (1), is criminally responsible for the act or omission to the same extent as if the real state of things had been such as the person was induced by the delusions to believe to exist.
SA	***Criminal Law Consolidation Act 1935* (SA)**
	Part A – Mental Impairment **Division 1 – Preliminary** **269A Interpretation** In this part ... *mental illness* means a pathological infirmity of the mind (including a temporary one of short duration)[1]; *mental impairment* includes— (a) a mental illness; or (b) an intellectual disability; or (c) a disability or impairment of the mind resulting from senility, but does not include intoxication ... Note— A condition that results from the reaction of a healthy mind to extraordinary external stimuli is not a mental illness, although such a condition may be evidence of mental illness if it involves some abnormality and is prone to recur (see *R v Falconer* (1990) 171 CLR 30) ...

	Division 2 – Mental competence to commit offences **269C Mental competence** A person is mentally incompetent to commit an offence if, at the time of the conduct alleged to give rise to the offence, the person is suffering from a mental impairment and, in consequence of the mental impairment— (a) does not know the nature and quality of the conduct; or (b) does not know that the conduct is wrong; or (c) is unable to control the conduct.
TAS	***Criminal Code* (Tas)**
	16 Insanity (1) A person is not criminally responsible for an act done or an omission made by him – (a) when afflicted with mental disease to such an extent as to render him incapable of – (i) understanding the physical character of such act or omission; or (ii) knowing that such act or omission was one which he ought not to do or make; or (b) when such act or omission was done or made under an impulse which, by reason of mental disease, he was in substance deprived of any power to resist. (2) The fact that a person was, at the time at which he is alleged to have done an act or made an omission, incapable of controlling his conduct generally, is relevant to the question whether he did such act or made such omission under an impulse which by reason of mental disease he was in substance deprived of any power to resist. (3) A person whose mind at the time of his doing an act or making an omission is affected by a delusion on some specific matter, but who is not otherwise exempted from criminal responsibility under the foregoing provisions of this section, is criminally responsible for the act or omission to the same extent as if the fact which he was induced by such delusion to believe to exist really existed. (4) For the purpose of this section the term *mental disease* includes natural imbecility.
VIC	***Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic)**
	Prt 4 – Defence of Mental Impairment **20 Defence of mental impairment** (1) The defence of mental impairment is established for a person charged with an offence if, at the time of engaging in conduct constituting the offence, the person was suffering from a mental impairment that had the effect that— (a) he or she did not know the nature and quality of the conduct; or (b) he or she did not know that the conduct was wrong (that is, he or she could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong). (2) If the defence of mental impairment is established, the person must be found not guilty because of mental impairment ... **25 Abrogation of defence of insanity** (1) The common law defence of insanity is abrogated. (2) A jury is not entitled in any criminal trial to return a verdict of not guilty on account of insanity.
WA	***Criminal Code* (WA)**
	1 Terms used (1) In this Code, unless the context otherwise indicates – … The term *mental illness* means an underlying pathological infirmity of the mind, whether of short or long duration and whether permanent or temporary, but does not include a condition that results from the reaction of a healthy mind to extraordinary stimuli; The term *mental impairment* means intellectual disability, mental illness, brain damage or senility; ...

	27 Insanity (1) A person is not criminally responsible for an act or omission on account of unsoundness of mind if at the time of doing the act or making the omission he is in such a state of mental impairment as to deprive him of capacity to understand what he is doing, or of capacity to control his actions, or of capacity to know that he ought not to do the act or make the omission. (2) A person whose mind, at the time of his doing or omitting to do an act, is affected by delusions on some specific matter or matters, but who is not otherwise entitled to the benefit of subsection (1), is criminally responsible for the act or omission to the same extent as if the real state of things had been such as he was induced by the delusions to believe to exist.
Cth	***Criminal Code* (Cth)**
	7.3 Mental impairment (1) A person is not criminally responsible for an offence if, at the time of carrying out the conduct constituting the offence, the person was suffering from a mental impairment that had the effect that: (a) the person did not know the nature and quality of the conduct; or (b) the person did not know that the conduct was wrong (that is, the person could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong); or (c) the person was unable to control the conduct. (2) The question whether the person was suffering from a mental impairment is one of fact. (3) A person is presumed not to have been suffering from such a mental impairment. The presumption is only displaced if it is proved on the balance of probabilities (by the prosecution or the defence) that the person was suffering from such a mental impairment. (4) The prosecution can only rely on this section if the court gives leave. (5) The tribunal of fact must return a special verdict that a person is not guilty of an offence because of mental impairment if and only if it is satisfied that the person is not criminally responsible for the offence only because of a mental impairment. (6) A person cannot rely on a mental impairment to deny voluntariness or the existence of a fault element but may rely on this section to deny criminal responsibility. (7) If the tribunal of fact is satisfied that a person carried out conduct as a result of a delusion caused by a mental impairment, the delusion cannot otherwise be relied on as a defence. (8) In this Code: *mental impairment* includes senility, intellectual disability, mental illness, brain damage and severe personality disorder. (9) The reference in subsection (8) to mental illness is a reference to an underlying pathological infirmity of the mind, whether of long or short duration and whether permanent or temporary, but does not include a condition that results from the reaction of a healthy mind to extraordinary external stimuli. However, such a condition may be evidence of a mental illness if it involves some abnormality and is prone to recur.
NZ	***Crimes Act 1961* (NZ)**
	23 Insanity (1) Every one shall be presumed to be sane at the time of doing or omitting any act until the contrary is proved. (2) No person shall be convicted of an offence by reason of an act done or omitted by him when labouring under natural imbecility or disease of the mind to such an extent as to render him incapable— (a) of understanding the nature and quality of the act or omission; or (b) of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong. (3) Insanity before or after the time when he did or omitted the act, and insane delusions, though only partial, may be evidence that the offender was, at the time when he did or omitted the act, in such a condition of mind as to render him irresponsible for the act or omission. (4) The fact that by virtue of this section any person has not been or is not liable to be convicted of an offence shall not affect the question whether any other person who is alleged to be a party to that offence is guilty of that offence.

USA	United States Code Tit 18 Pt 1 §17.
	Insanity defense (a) Affirmative Defense.—It is an affirmative defense to a prosecution under any Federal statute that, at the time of the commission of the acts constituting the offense, the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his acts. Mental disease or defect does not otherwise constitute a defense. (b) Burden of Proof.—The defendant has the burden of proving the defense of insanity by clear and convincing evidence.
Canada	***Criminal Code* RSC 1985 (Canada)**
	Interpretation **2** In this Act ... "mental disorder" means a disease of the mind; ... **Pt1 s 16 Defence of mental disorder** (1) No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong. (2) Every person is presumed not to suffer from a mental disorder so as to be exempt from criminal responsibility by virtue of subsection (1), until the contrary is proved on the balance of probabilities. (3) The burden of proof that an accused was suffering from a mental disorder so as to be exempt from criminal responsibility is on the party that raises the issue.
Int. Criminal Court	***Rome Statute of the International Criminal Court,* opened for signature 17 July 1998, 2187 UNTS 90 (entered into force 1 July 2002).**
	Article 31 Grounds for excluding criminal responsibility (1) In addition to other grounds for excluding criminal responsibility provided for in this Statute, a person shall not be criminally responsible if, at the time of that person's conduct: (a) The person suffers from a mental disease or defect that destroys that person's capacity to appreciate the unlawfulness or nature of his or her conduct, or capacity to control his or her conduct to conform to the requirements of law; ...

Appendix E
Substantial impairment case list in date order

R v Chen [2012] NSWSC 1000
R v DR [2012] NSWSC 922
R v Renzo da-Pra [2012] NSWSC 607
R v Goodridge [2012] NSWSC 378
R v Neave [2012] NSWSC 229
R v Fahda [2012] NSWSC 114
R v MB [2011] NSWSC 1376 (Juvenile)
R v Biddle [2011] NSWSC 1262
R v Shiels [2011] NSWSC 1177
R v LTN [2011] NSWSC 614
R v Mathers [2011] NSWSC 339
R v Borg [2010] NSWSC 951
R v Lechmana [2010] NSWSC 849
R v Potts [2010] NSWSC 731
R v Cavanagh [2010] NSWSC 670
R v Worrall [2010] NSWSC 593
R v Sevi [2010] NSWSC 387
R v Glanville [2010] NSWSC 364
R v Gabriel [2010] NSWSC 13
R v Naa [2009] NSWSC 1077
R v TN [2009] NSWSC 918
R v White [2009] NSWSC 809
R v Valiukas [2009] NSWSC 808
R v SE [2009] NSWSC 785
R v Hevesi-Nagy [2009] NSWSC 755
R v Dowley [2009] NSWSC 722
R v Zeilaa [2009] NSWSC 532
R v Paddock [2009] NSWSC 369
R v Fisher [2009] NSWSC 348
R v Maric [2009] NSWSC 346
R v Ham [2009] NSWSC 296
R v Stewart [2008] NSWSC 1359
R v Podesta [2008] NSWSC 1204
R v Faehndrich [2008] NSWSC 877
R v Ferguson [2008] NSWSC 761
R v Soon [2008] NSWSC 622
R v Gabor Zhia [2008] NSWSC 145
R v Mawson [2007] NSWSC 1473
R v Antaky [2007] NSWSC 1047
R v JS [2007] NSWSC 809
R v Zaro [2007] NSWSC 756
R v Cavanough [2007] NSWSC 561
R v Leach [2007] NSWSC 429
R v Durrant [2007] NSWSC 428
R v Sutton [2007] NSWSC 295
R v Heatley [2006] NSWSC 1199
R v Christov [2006] NSWSC 972
R v Wetherall [2006] NSWSC 486
R v RG [2006] NSWSC 21
R v Laurie [2005] NSWSC 1361
Zeng v R [2005] NSWSC 1344
R v Massei [2005] NSWSC 1030
R v Jennings [2005] NSWSC 789
R v Daniels [2005] NSWSC 745
R v Gagalowicz [2005] NSWSC 675
R v Hantis [2005] NSWSC 549
R v Adanguidi [2005] NSWSC 519

Appendix F
Categories of post-partum mental illnesses

Title	Description	Prevalence	Relationship with childbirth
Post-partum blues	Tearfulness, anxiety, fatigue and irritability.[1] Blues occur during the first ten days after birth, are transient and "do not impair functioning".[2]	70% women.[3]	Associated with a lack of sleep and general stress related to the demands of motherhood.[4]
Post-partum depression	Depression, with onset within 4-6 weeks postpartum.[5]	8-9% women.[6]	Prevalence is similar to general population.[7] A temporal connection with childbirth is usually attributed to lack of sleep, adjustment to new circumstances and general stress rather than, for instance, changes in hormones.[8]

1. I Yalom et al, "Postpartum Blues Syndrome: A Description and Related Variables" (1968) 18 *Archives of General Psychiatry* 16, 16.
2. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) 423.
3. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) 423.
4. B McSherry, "The Return of the Raging Hormones Theory: Premenstrual Syndrome, Postpartum Disorders and Criminal Responsibility" (1993) 15 *Sydney Law Review* 292, 293.
5. The DSM-IV specifies 4 weeks: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000) 423; the ICD-10 specifies 6 weeks: World Health Organization, *International Classification of Diseases* (2010) F53.
6. P Cooper et al, "Non-Psychotic Psychiatric Disorder after Childbirth: A Prospective Study of Prevalence, Incidence, Course and Nature" (1988) 152 *British Journal of Psychiatry* 799, 802; M O'Hara, D Neunaber and E Zekoski, "Prospective Study of Postpartum Depression: Prevalence, Course and Predictive Factors" (1984) 93(2) *Journal of Abnormal Psychology* 158, 163; S Campbell and J Cohn, "Prevalence and Correlates of Postpartum Depression in First-Time Mothers" (1991) 100(4) *Journal of Abnormal Psychology* 594, 597.
7. P Cooper et al, "Non-Psychotic Psychiatric Disorder after Childbirth: A Prospective Study of Prevalence, Incidence, Course and Nature" (1988) 152 *British Journal of Psychiatry* 799, 805. See also S Campbell and J Cohn, "Prevalence and Correlates of Postpartum Depression in First-Time Mothers" (1991) 100(4) *Journal of Abnormal Psychology* 594, 597-598; M O'Hara, D Neunaber and E Zekoski, "Prospective Study of Postpartum Depression: Prevalence, Course and Predictive Factors" (1984) 93(2) *Journal of Abnormal Psychology* 158, 167 (the authors of this study noted that their finding was not definitive, and further research was needed).
8. B McSherry, "The Return of the Raging Hormones Theory: Premenstrual Syndrome, Postpartum Disorders and Criminal Responsibility" (1993) 15 *Sydney Law Review* 292, 294; T Porter and H Gavin, "Infanticide and Neonaticide: A Review of 40 Years of Research Literature on Incidence and Causes" (2010) 11 *Trauma, Violence and Abuse* 99, 102.

Title	Description	Prevalence	Relationship with childbirth
Post-partum psychosis	Psychosis, with onset within 4-6 weeks postpartum.	0.1-0.2% women.[9]	Women are at significantly higher risk of psychosis in the first month post-partum.[10] However, the cause of this increased risk is not known: it may be a result of hormonal changes, complications with the birth, lack of sleep and other stress.[11] A woman may have an underlying disposition which manifests itself during a particularly vulnerable period in her life, or she may have previously been hospitalised for psychiatric reasons.[12]

9. U Valdimarsdottir, "Psychotic Illness in First-Time Mothers with No Previous Psychiatric Hospitalizations: A Population-Based Study" (2009) 6(2) *PLOS Medicine* 194, 196; S Tschinkel et al, "Postpartum Psychosis: Two Cohorts Compared, 1875-1924 and 1994-2005" (2007) 37 *Psychological Medicine* 529, 532; R Kendell, J Chalmers and C Platz, "Epistemology of Puerperal Psychoses" (1987) 150 *British Journal of Psychiatry* 662, 666, 667.

10. U Valdimarsdottir, "Psychotic Illness in First-Time Mothers with No Previous Psychiatric Hospitalizations: A Population-Based Study" (2009) 6(2) *PLOS Medicine* 194, 197; R Kendell, J Chalmers and C Platz, "Epidemiology of Puerperal Psychoses" (1987) 150 *British Journal of Psychiatry* 662, 663.

11. R Ogle and D Maier-Katkin, "A Rationale for Infanticide Laws" (1993) *Criminal Law Review* 903, 907-908; B McSherry, "The Return of the Raging Hormones Theory: Premenstrual Syndrome, Postpartum Disorders and Criminal Responsibility" (1993) 15(1) *Sydney Law Review* 292, 295; S Tschinkel et al, "Postpartum psychosis: Two Cohorts Compared, 1875-1924 and 1994-2005" (2007) 37 *Psychological Medicine* 529, 534; R Kendell, J Chalmers and C Platz, "Epidemiology of Puerperal Psychoses" (1987) 150 *British Journal of Psychiatry* 662, 671.

12. In one Swedish study, nearly half of the women hospitalised for psychosis within the first 90 days after giving birth had been previously hospitalised for a psychiatric disorder: U Valdimarsdottir, "Psychotic Illness in First-Time Mothers with No Previous Psychiatric Hospitalizations: A Population-Based Study" (2009) 6(2) *PLOS Medicine* 194, 196. See also R Kendell, J Chalmers and C Platz, "Epidemiology of Puerperal Psychoses" (1987) 150 *British Journal of Psychiatry* 662, 668-669.

Bibliography

Adams, J et al, "A Prison Mental Health Screening Unit: A First for NSW" (2009) 17 *Australas Psychiatry* 2

Allnutt, S, Samuels, A and O'Driscoll, C, "The Insanity Defence: From Wild Beasts to M'Naghten" (2007) 15 *Australasian Psychiatry* 292

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Text Revision, 2000)

Australian Bureau of Statistics, *Labour Force, Australia: Labour Force Status and Other Characteristics of Families* (2011)

Australian Health Ministers' Advisory Council, Mental Health Standing Committee, *National Statement of Principles for Forensic Mental Health* (2006)

Australian Law Reform Commission and NSW Law Reform Commission, *Family Violence – A National Legal Response,* ALRC Report 114 and NSWLRC Report 128 (2010)

Australian Law Reform Commission, *For Your Information: Australian Privacy Law and Practice*, Report 108 (2008)

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

Barnett, M and Hayes, R, "The Role of Victims in NSW Forensic Patient Proceedings" (2009) 13 *University of Western Sydney Law Review* 7

Barnett, M et al, "Psychological and Ethical Issues in the Relationship Between Lawyers and Mentally Ill Clients" (2007) 11 *University of Western Sydney Law Review* 64

Bartels, L, "Safe Haven Laws, Baby Hatches and Anonymous Hospital Birth: Examining Infant Abandonment, Neonaticide and Infanticide in Australia" (2012) 36 *Criminal Law Journal* 19

Bergin, P, *The Crime of Infanticide: A Case for its Abolition in New South Wales* (Paper submitted for the Research Paper Unit, Faculty of Law, Australian National University, 2004)

Birgden, A and Thomson, D, "The Assessment of Fitness to Stand Trial for Defendants with an Intellectual Disability: A Proposed Assessment Procedure Involving Mental Health Professionals and Lawyers" (1999) 6 *Psychiatry, Psychology and Law* 207

Boyd-Caine, T and Chappell, D, "The Forensic Patient Population in New South Wales" (2005) 17 *Current Issues in Criminal Justice* 5

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

Bronitt, S and McSherry, B, *Principles of Criminal Law* (Thomson, 2nd ed, 2005)

Bronitt, S and McSherry, B, *Principles of Criminal Law* (Thomson, 3rd ed, 2010)

Bruce, C, "Ethics and the Mentally Impaired" (Paper presented at the Public Defenders Criminal Law Conference 2011, Taronga Centre, 27 February 2011)

Buchanan, A, "Competency to Stand Trial and the Seriousness of the Charge" (2006) 34 *Journal of the American Academy of Psychiatry and the Law* 458

Campbell, S and Cohn, J, "Prevalence and Correlates of Postpartum Depression in First-Time Mothers" (1991) 100(4) *Journal of Abnormal Psychology* 594

Card, R, *Card, Cross & Jones Criminal Law* (Oxford University Press, 18th ed, 2008)

Carne, J, "The Unimportance of M'Naghten's" (2003) 15 *Judicial Officers' Bulletin* 91

Committee on Mentally Abnormal Offenders, *Report of the Committee of Mentally Abnormal Offenders* (1975)

Cooper, P et al, "Non-Psychotic Psychiatric Disorder after Childbirth: A Prospective Study of Prevalence, Incidence, Course and Nature" (1988) 152 *British Journal of Psychiatry* 799

Corben, S, "NSW Inmate Census 2012, Summary of Characteristics", *Corrective Services NSW* (2012)

Craig, L and Bittman, M, "The Effects of Children on Adults' Time-Use: Analysis of the Incremental Time Costs Of Children in Australia", *Social Policy Research Centre Discussion Paper No 143* (2005)

Criminal Law Officers Committee of the Standing Committee of Attorneys-General, *Model Criminal Code Chapter 2: General Principles of Criminal Responsibility*, Final Report (1992)

Cumes, G, "Reform of Diminished Responsibility in New South Wales" (1999) 6(2) *Psychiatry, Psychology and Law* 175

De Bortoli, L, Coles, J and Dolan, M, "Maternal Infanticide in Australia: Mental Disturbance During the Postpartum Period" (2012) *Psychiatry, Psychology and Law* 1

Dunsmuir, W T M, Tran, C and Weatherburn, D, *Assessing the Impact of Mandatory DNA Testing of Prison Inmates in NSW on Clearance, Charge and Conviction Rates for Selected Crime Categories*, Legislative Evaluation Series No L17 (NSW Bureau of Crime Statistics and Research, 2008)

England and Wales, Criminal Law Review Committee, *Offences against the Person,* Fourteenth Report (1980)

England and Wales, Law Commission, *Murder, Manslaughter and Infanticide,* Report 304 (2006)

England and Wales, Law Commission, *Partial Defences to Murder,* Final Report (2004)

England and Wales, Law Commission, *Unfitness to Plead,* Consultation Paper 197 (2010)

Frize, M, "Supporting Offenders with an Intellectual Disability in the Community ... 10 Years On" (Presentation delivered at the NSW Council for Intellectual Disability conference, 17 February 2012)

Gans, J and Urbas, G, *DNA Identification in the Criminal Justice System,* Trends and Issues in Criminal Justice No 226 (Australian Institute of Criminology, 2002)

Great Britain, *Royal Commission on Capital Punishment 1949-1953*, Cmd 8932 (1953)

Hayes, H, *Not Guilty by Reason of Mental Illness: A 21 Year Retrospective Study of Released Forensic Patients in NSW* (Masters in Psychology Thesis, University of NSW, 2011)

Hemming, A, "It's Time to Abolish Diminished Responsibility, the Coach and Horses' Defence through Criminal Responsibility for Murder" (2008) 10 *University of Notre Dame Australia Law Review* 1

Hemming, A, "Killing the Goose and Keeping the Golden Nest Egg" (2008) 8 *Queensland University of Technology Law and Justice Journal* 342

Holmes, J, *Re-offending in NSW,* Bureau Brief No 56 (NSW Bureau of Crime Statistics and Research, 2012)

Howard, D and Westmore, B, *Crime and Mental Health Law in New South Wales* (LexisNexis Butterworths, 2nd ed, 2010)

Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness*, Report of the National Inquiry into the Human Rights of People with Mental Illness (1993)

Ierace, M, "Fitness To Be Tried" (Paper presented at the University of NSW Law Faculty CLE/CPD day, 5 November 2010)

Intellectual Disability Rights Service Inc, Submission to Department of Attorney General and Justice, *Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007,* 18 November 2011

James, G, Feneley, J and Hanson, S, "The Mental Health Legislation Amendment (Forensic Provisions) Act" (2009) 21 *Judicial Officers' Bulletin* 19

James, G, *Review of the Forensic Provisions of the Mental Health Act 1990 and the Mental Health (Criminal Procedure) Act 1990*, Consultation Paper (2006)

James, G, *Review of the New South Wales Forensic Mental Health Legislation* (2007)

Joint Select Committee Upon Gun Law Reform, Parliament of NSW, *Report of the Joint Select Committee Upon Gun Law Reform* (1991)

Judicial Commission of NSW, *Equality Before the Law Bench Book*

Judicial Commission of NSW, *Partial Defences to Murder in NSW 1990-2004,* Research Monograph 28 (2006)

Judicial Commission of NSW, *Sentenced Homicides in New South Wales 1994-2001*, Research Monograph 23 (2004)

Kendell, R, Chalmers, J and Platz, C, "Epidemiology of Puerperal Psychoses" (1987) 150 *British Journal of Psychiatry* 662

Kramer, KJ, *Unwilling Mothers Unwanted Babies* (University of British Columbia Print, 2006)

Lansdowne, R, "Infanticide: Psychiatrists in the Plea Bargaining Process" (1990) 16 *Monash University Law Review* 41

Law Reform Commission of Western Australia, *Review of the Law of Homicide,* Final Report (2007)

Legislative Council Standing Committee on Social Issues, Parliament of NSW, *Substitute Decision-Making for People Lacking Capacity* (2010)

Legislative Council Standing Committee on Social Issues, Parliament of NSW, *Domestic Violence Trends and Issues in NSW* (2012)

Local Court of NSW, *Practice Note Crim 1 - Case Management of Criminal Proceedings in the Local Court*, 1 July 2012

Loughnan, A, "The 'Strange' Case of the Infanticide Doctrine" (2012) *Oxford Journal of Legal Studies* 1

McSherry, B, "Indefinite and Preventative Detention Legislation: From Caution to an Open Door" (2005) 29 *Criminal Law Journal* 94

McSherry, B, "The Return of the Raging Hormones Theory: Premenstrual Syndrome, Postpartum Disorders and Criminal Responsibility" (1993) 15 *Sydney Law Review* 292

Mental Health Review Tribunal, *Annual Report 2009-10*

Mental Health Review Tribunal, *Annual Report 2010-11*

Mental Health Review Tribunal, *Annual Report 2011-12*

Mental Health Review Tribunal, *Civil Hearing Kit Section 1: Extending a Person's Involuntary Stay in Hospital* (2009)

Miraglia, R and Hall, D, "The Effect of Length of Hospitalization on Re-Arrest Among Insanity Plea Acquittees*"* (2011) 39 *Journal of the American Academy of Psychiatry and the Law* 524

Model Criminal Code Officers Committee of the Standing Committee of Attorneys-General, *Model Criminal Code: Chapter 5 Fatal Offences Against the Person,* Discussion Paper (1998)

Model Criminal Code Officers Committee of the Standing Committee of Attorneys-General, *Model Forensic Procedures Bill and The Proposed National DNA Database*, Discussion Paper (1999)

Napper, R, "A National DNA Database: The United Kingdom Experience*"* (2000) 32 *Australian Journal of Forensic Sciences* 65

National Council to Reduce Violence Against Women and Their Children, *Time for Action: The National Council's Plan for Australia to Reduce Violence Against Women and Their Children, 2009-2021* (2009)

New Zealand, Law Commission, *Battered Defendants: Victims of Domestic Violence Who Offend,* Preliminary Paper 41 (2000)

New Zealand, Law Commission, *Mental Impairment Decision-Making and the Insanity Defence*, Report 120 (2010)

NSW Bureau of Crime Statistics and Research, *Apprehended Violence Orders granted from 1996* (2011)

NSW Bureau of Crime Statistics and Research, *New South Wales Criminal Courts Statistics 2011* (2012)

NSW Bureau of Crime Statistics and Research, *NSW Local Court Summary Statistics 2007–2011* (2012)

NSW Criminal Law Committee, *Report of the NSW Criminal Law Committee on Proposed Amendments to the Criminal Law and Procedure* (1973)

NSW Department of Attorney General and Justice*, Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007,* Discussion Paper (2011)

NSW Department of Attorney General, Criminal Law Review Division, *A Review of the Law Pertaining to Apprehended Violence Orders as Contained in Part 15A of the Crimes Act 1900 (NSW)*, Discussion Paper (1995)

NSW Department of Human Services (Ageing, Disability and Home Care: Office of the Senior Practitioner), *Community Justice Program: Program Guidelines* (2010)

NSW Department of Human Services (Ageing, Disability and Home Care: Office of the Senior Practitioner), *Community Justice Program: Service Model Description, Intensive Residential Support Service* (2010)

NSW Department of Justice and Attorney General, *Review of the Crimes (Serious Sex Offenders) Act 2006*, Report (2010)

NSW Government, *NSW 2021: A Plan to Make NSW Number One* (2011)

NSW Guardianship Tribunal, *Position Statement on Management of Challenging Behaviours in People with Dementia* (2006)

NSW Guardianship Tribunal, *Position Statement: Behaviour Intervention and Support in Applications Relating to a Person with an Intellectual Disability* (2004)

NSW Health Commission Mental Health Act Review Committee, *Report* (1974)

NSW Law Reform Commission, *Apprehended Violence Orders,* People with Cognitive and Mental Health Impairments in the Criminal Justice System: Question Paper 1 (2012)

NSW Law Reform Commission, *Apprehended Violence Orders,* Report 103 (2003)

NSW Law Reform Commission, *Apprehended Violence Orders: Part 15A of the Crimes Act*, Discussion Paper 45 (2002)

NSW Law Reform Commission, *Fitness to Plead Guilty*, People with Cognitive and Mental Health Impairments and the Criminal Justice System: Question Paper 2 (2012)

NSW Law Reform Commission, *Invasion of Privacy*, Report 120 (2009)

NSW Law Reform Commission, *Partial Defences to Murder: Diminished Responsibility,* Report 82 (1997)

NSW Law Reform Commission, *Partial Defences to Murder: Provocation and Infanticide*, Report 83 (1997)

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

NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Diversion*, Report 135 (2012)

NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences*, Consultation Paper 6 (2010)

NSW Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Forensic Samples,* Consultation Paper 8 (2010)

NSW Law Reform Commission, *Privacy Principles*, Report 123 (2009)

NSW Law Reform Commission*, Protecting Privacy in New South Wales*, Report 127 (2010)

NSW Law Reform Commission, *Purposes of Sentencing*, Sentencing: Question Paper 1 (2012)

NSW Law Reform Commission, *Sentencing*, Discussion Paper 33 (1996)

NSW Law Reform Commission, *Sentencing*, Report 79 (1996)

NSW Law Reform Commission, *Young People with Cognitive and Mental Health Impairments in the Criminal Justice System*, Consultation Paper 11 (2010)

NSW Office of the Director of Public Prosecutions, *Prosecution Guidelines* (2007)

NSW Sentencing Council, *High-Risk Violent Offenders: Sentencing and Post-Custody Management Options*, Report (2012)

NSW Sentencing Council, *Penalties Relating to Sexual Assault Offences in New South Wales*, Report (2009)

O'Carroll, B, "Intellectual Disabilities and the Determination of Fitness to Plead in the Magistrates' Courts" (2013) 37 *Criminal Law Journal* 51

O'Hara, M, Neunaber, D and Zekoski, E, "Prospective Study of Postpartum Depression: Prevalence, Course and Predictive Factors" (1984) 93(2) *Journal of Abnormal Psychology* 158

Ogle, R and Maier-Katkin, D, "A Rationale for Infanticide Laws" (1993) *Criminal Law Review* 903

Ogloff, J R P and Davis, M R, "Assessing Risk for Violence in the Australian Context" in D Chappell and P Wilson (ed), *Issues in Australian Crime and Criminal Justice* (LexisNexis Butterworths, 2005) 301

Osborne, J, "The Crime of Infanticide: Throwing the Baby out with the Bathwater" (1987) 6 *Canadian Journal of Family Law* 47

People with Disability Australia Incorporated, Submission to Department of Attorney General and Justice, *Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007*, November 2011

Porter, T and Gavin, H, "Infanticide and Neonaticide: A Review of 40 Years of Research Literature on Incidence and Causes" (2010) 11 *Trauma, Violence and Abuse* 99

Public Interest Advocacy Centre, *Time for Change: Response to the Consultation Paper: Review of the Forensic Provisions of the Mental Health Act 1990 and the Mental Health (Criminal Procedure) Act 1990* (2007)

Resnick, PJ, "Murder of the Newborn: A Psychiatric Review of Neonaticide" (1970) 126 *American Journal of Psychiatry* 1414

Rosenfeld, B and Ritchie, K, "Competence to Stand Trial: Clinician Reliability and the Role of Offense Severity" (1998) 43 *Journal of Forensic Sciences* 151

Rubenzer, S, *Competency to Stand Trial: Legal Issues and Developments in Assessment* (2002)

Seiden, R L and Chandrasekaran, S, "Special Hearings Under the Crimes Act: A Potentially Misconceived Adventure" (2010) 84 *Australian Law Journal* 553

Shopfront Youth Legal Centre, Submission to Department of Attorney General and Justice, *Statutory Review of the Crimes (Domestic and Personal Violence) Act 2007,* 18 November 2011

Shopfront Youth Legal Centre, Submission to Legislative Council Standing Committee on Social Issues, Parliament of NSW, *Inquiry into Domestic Violence Trends and Issues in NSW*, 23 September 2011

Shwartz, LL and Isser, NK, *Child Homicide: Parents Who Kill* (CRC Press, 2007)

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

Smith, N and Trimboli, L, *Comorbid Substance and Non-Substance Mental Health Disorders and Re-offending Among NSW Prisoners,* Crime and Justice Bulletin No 140 (NSW Bureau of Crime Statistics and Research, 2010)

Standing Council on Health, *Mental Health Statement of Rights and Responsibilities* (2012)

Tait, D, "Glass Cages in the Dock? Presenting the Defendant to the Jury" (2011) 86 *Chicago-Kent Law Review* 467

Tschinkel, S et al, "Postpartum Psychosis: Two Cohorts Compared, 1875-1924 and 1994-2005" (2007) 37 *Psychological Medicine* 529

Valdimarsdottir, U, "Psychotic Illness in First-Time Mothers with No Previous Psychiatric Hospitalizations: A Population-Based Study" (2009) 6(2) *PLOS Medicine* 194

Victorian Law Reform Commission, *Defences to Homicide,* Final Report (2004)

Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care*, Final Report (2003)

Walker, N, *Crime and Insanity in England* (University Press, 1968)

Wallace, H, "The UK National DNA Database: Balancing Crime Detection, Human Rights and Privacy" (2006) 7 *EMBO Reports* 26

Wilczynski, A, *Child Homicide* (Greenwich Medical Media, 1997)

Wills, A, "Neonaticide: The Necessity of Syndrome Evidence When Safe Haven Legislation Falls Short" (2004) 77 *Temple Law Review* 1001

World Health Organization, *International Classification of Diseases* (2010)

Yalom, I et al, "'Postpartum Blues' Syndrome: A Description and Related Variables" (1968) 18 *Archives of General Psychiatry* 16

Yeo, S, "Commonwealth and International Perspectives on the Insanity Defence" (2008) 32 *Criminal Law Journal* 7

Yeo, S, "English Reform of Partial Defences to Murder: Lessons for New South Wales" (2010) 22 *Current Issues in Criminal Justice* 1

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