Submission to the Consultation Paper
Review of the Forensic Provisions of the *Mental Health Act 1990* and the *Mental Health (Criminal Procedure) Act 1990*

April 2007

Mental Health Coordinating Council

Mental Health Coordinating Council
Rose Cottage. Callan Park.
Rozelle, NSW 2039

MHCC is the state peak body for non-government organisations working for mental health throughout NSW. MHCC represents the views and interests of over 160 NGOs in the formation of policy and acts as a liaison between the government and non-government sectors. Our member organisations specialise in the provision of services and support for people with a disability due to mental illness.

MHCC represents the interests of its members on a number of National and State boards, committees and reference groups including:

National Organisations
- Department of Health and Aged Care Suicide Prevention Strategy
- Mental Health Council of Australia (MHCA)

State Organisations (NSW)
- ACROD Management Committee
- FONGA (Forum of Non-Government Agencies) NCOSS
- Health Care Complaints Commission (HCCC) Consumer Consultative Committee
- Institute of Psychiatry, Consumer Advocate Training Consultative Committee
- Mental Health Association (MHA), Mental Health Promotion Advisory Committee
- NCOSS Health Policy Advisory Group (HPAG)
- Office of the Protective Commissioner Disability Group Interagency Committee
- PIAC Forensic and Mental Illness in Prison Network
- PIAC Forensic Sub-Committee – Review of Forensic Provisions
- Quality Management Services (QMS) Human Service Organisation

State Government Departments (NSW)
- Attorney General's Department, Law Reform Commission, Flexible Service Delivery Consultative Committee.
- Community Housing Disability Consultative Committee, Office of Community Housing
- Department of Education & Training, Disabilities Community Consultative Committee
- Department of Housing – NGO Advisory Group
- Dual Diagnosis (MISA) TAFE Training Project / Steering Committee
- NSW Community Housing Disability Consultative Committee
- NSW Mental Health Review Systems Committee
- NSW Health Mental Health Implementation Committee
- NSW Health Mental Health Priority Taskforce
- NSW Health, Housing and Supported Accommodation Initiative (HASI)
    - Steering Committee
    - Advisory Committee
    - Evaluation Committee
- NSW Health NGO Advisory Group
- NSW Suicide Prevention Committee
- NHDAO Program Council
- Justice Health Consumer and Community Group
- Justice Health Family and Carer Liaison Project Steering Committee
- NSW Health, Centre for Mental Health, HASI Forum

- Services Industry Reference Group. (Mental Health Course Development)
- The New Joint Guarantee of Service (JGOS)

MHCC welcome the opportunity to respond to Consultation Paper and thank The Hon Greg James QC and those who assisted in preparing the paper for presenting the community with a review that described complex legal issues in a manner that was clear, concise and accessible to interested stakeholders without a legal background.

Nevertheless, the community would have expected greater transparency with regard to access to the Taskforce and its deliberations prior to the publication of the consultation paper. In a letter to the Minister attached to the consultation paper, The Hon Greg James QC thanked several individuals for their assistance in preparing the consultation paper, however, it is unclear whether these persons constitute the Task Force or not. In any event, we would expect to have those involved to be listed in their capacity as Taskforce Members.

Over the three year period since the Select Committee on Mental Health, *Inquiry into Mental Health Services in NSW,* and the subsequent discussion papers including *The Review of the Mental Health Act 1990,* MHCC have undertaken extensive consultation across the sector, both facilitated by themselves and in collaboration with NCOSS. We have attended consultations held by other NGO peaks, initiated meetings with public interest advocacy and legal services, disability rights organisations, talked to legal and clinical experts, mental health service providers, consumers and carers, and sat on forensic interest group committees.

MHCC facilitated several reference groups who met regularly over a two and a half year period, to discuss the Inquiry and subsequent Discussion Papers on the Review of *The Mental Health Act 1990,* and the *Draft Exposure Bill of the Mental Health Act 2006*. These groups represented a broad spectrum of stakeholders with interest in forensic reform including consumers and carers.

For the purposes of clarity for those reading this submission that may not be acquainted in detail with the consultation paper and the forensic provisions of the Act, we have included the options listed and some explanations that refer directly to the legislation.

In this submission, we have chosen to comment on the issue of Executive Discretion, which we wish to highlight in greatest depth before commenting briefly on options regarding other matters presented in the consultation paper.

Executive Discretion

The issue of primary concern to MHCC and its members, identified in the consultation paper is that of Executive Discretion. This matter has been consistently raised by stakeholders during the last fifteen years, and particularly highlighted since the Select Committee on Mental Health, *Inquiry into Mental Health Services in NSW* (2002). We consider Executive Discretion as paramount to all other considerations relating to the management of forensic patients under the Act. MHCC report without reservation, that in no consultative forums, meetings or individual conversations have we been presented with any argument for the preservation of the status quo.

Whilst wishing to acknowledge Victims of Crime interests (which we address later in this submission, pg.7. 32) we suggest that maintaining Executive Discretion on decisions pertaining to the release of forensic patients reflects Government's interest in maintaining control of the law and order agenda, with an eye on the negative impact to electoral outcomes generated by the victims' lobby, media hype and community perceptions of an association between mental illness and criminal violence.

The Mental Health Review Tribunal (MHRT) in one of its several roles in the forensic jurisdiction undertakes to make recommendations concerning a person's detention, care and treatment, and whether it is appropriate to release a forensic patient conditionally or unconditionally. Our understanding is that the existing rationale behind retention of Executive Discretion is that the MHRT is not constituted to consider broader community issues, which are the province of the Executive.

In following the objects and principles of the *Mental Health Act 1990*, which include delivery of the *"best possible care in the least restrictive environment,"* [1] the MHRT seeks to maintain a balance between these objectives, whilst bearing in mind the United Nations (UN) *Human Rights Principles for the Protection of Persons with a Mental Illness and for the Improvement of Mental Health Care,* 46/119, (ratified by the UN General Assembly in 1991), the NSW Mental Health Service delivery standards, and by minimising patient risk to self and the community. We suggest that the combined expertise of the multidisciplinary tribunal contains the appropriate expertise to formulate decisions on release and management of forensic patients, whereas Executive decisions may be clouded by political imperative, and reflect personally held beliefs or the absence of knowledge about mental illness.

MHRT recommendations are based upon evidence presented at hearings during which a patient almost always appears with a representing lawyer, where expert evidence is submitted both in documentary and oral form from a patient's treating team, family and other interested persons.

[1] Article 9(1) and (4) International Covenant on Civil and Political Rights (freedom from arbitrary detention and deprivation of liberty and right to judicial review of detention); Principle 17 of the United Nations 'Principles for the protection of persons with mental illness and the improvement of mental health care'; United Nations High Commissioner for Human Rights, Adopted by the First United National Congress on the Prevention of Crime and the Treatment of Offenders, Geneva 1955.

From this evidence, detailed recommendations are presented to the Minister with associated documentation, which have been subject to rigorous scrutiny.

Frequently, cases may take upwards of more than 1 year, and are often outstanding at the time the 6 month statutory review takes place. The impact particularly on liberal leave privileges, conditional and unconditional release, may result in acceptance of compromise at variance to the Tribunal's recommendations because should more extensive privileges be sought, extended delays are likely to be the consequence.

MHCC understand from questions raised by Democrat Senator, The Hon. Dr Arthur Chesterfield Evans to The Hon. John Hatzistergos (reported in Hansard transcript of the Health Estimates Committee 30:4 September 2006), that no recommendations for conditional or unconditional release have been accepted since the beginning of 2006. The figures, recorded in the MHRT annual report would seem to indicate that a substantial number of recommendations for conditional or unconditional release are rejected outright by the Minister, and that these figures have escalated over the last two years. This has undoubtedly impacted on the already stretched resources of the forensic system, and we submit in relation to UN Principles [2] and National mental health and forensic standards that this may constitute a human rights abuse to a number of forensic patients who remain incarcerated.

Removal of Executive Discretion has been under discussion for more than a quarter of a century. A Royal Commission at that time, the Mental Health Act Implementation Monitoring Committee in 1992, a survey conducted by Brian Burdekin in the Burdekin Report in 1993,[3] the NSW Law Reform Commission in 1996 and the Senate Select Committee on Mental Health (Recommendation 58), all unreservedly recommended removal of Executive Discretion concerning release of forensic patients. Indeed, it is a poor reflection of the value with which human rights are held in NSW that it remains one of the few jurisdictions (other than WA and the Commonwealth) among Western democracies that has perpetuated an archaic system that contravenes International conventions;[4] breaches national concepts of the rule of law; that is morally unacceptable; inequitable; open to abuse; inconsistent; lacking in transparency and contra to the stated Objects of the Act.

Both Victoria and Queensland have sought to reform their system by abandoning Executive Discretion, although neither system adopted is exactly represented in the options presented in the Hon Greg James Consultation Paper.

---

[2] Principle 17 of the United Nations 'Principles for the protection of persons with mental illness and the improvement of mental health care'; United Nations High Commissioner for Human Rights, Adopted by the First United National Congress on the Prevention of Crime and the Treatment of Offenders, Geneva 1955.

[3] Human Rights and Equal Opportunity Commission, (1993). Human Rights and Mental Illness. Report of the National Inquiry into the Human Rights of People with a Mental Illness, the Commission, Australian Government Canberra.

[4] Ibid. Reference 2.

Section 5
The Executive Discretion

Option 1
Retain the current system of executive discretion-making in relation to forensic patients.

> Sector consultations and surveys collected strongly confirmed that this is a completely unacceptable option. MHCC endorse this point of view.

Option 2
Amend the legislation to transfer all decision-making in relation to forensic patients to a court, such as the Supreme Court.

> No jurisdiction in Australia has adopted this model. The closest to it is in Victoria and South Australia, neither of which is identical. We suggest that this model is somewhat cumbersome, expensively time consuming and legalistic since the Supreme Court is not necessarily well equipped to handle these hearings.
>
> However, we understand that there is considerable public satisfaction with this model on account of the fact that senior judicial officers are making decisions and that Executive Discretion no longer plays a part in the process.

Option 3
Amend the legislation to transfer decision-making regarding the release of forensic patients to a court, and all other decision making to the Mental Health Review Tribunal (subject to appeal to the Supreme Court).

> No jurisdiction utilises this model which we suggest would result in similar disadvantages as experienced in Option 2 with regard to delays in conducting hearings.

Option 4
Amend the legislation to transfer decision-making regarding the release of forensic patients to the Tribunal (subject to appeal to the Supreme Court).

> No jurisdiction has this exact model, the closest match is in Qld. Most stakeholders felt that with some amendment that this was the most appropriate model option. MHCC endorse the following comments expressed, which were:
>
> - That the MHRT has the experience and expertise across the appropriate disciplines: legal, clinical and community mental health to determine forensic patient treatment and release reviews;
>
> - That the process is less formal and intimidating for consumers and their carers, more flexible and provides the safety net of judicial review;

- That the MHRT can better facilitate ongoing monitoring of forensic patients' progress than the court;

- That the MHRT must have the authority and access to all the relevant information.

Recommendation

MHCC recommend that Option 4 with suggested amendments would provide the most appropriate reform alternative to Executive Discretion. As a caveat to proposing Option 4 as the preferred model, MHCC propose the following additions to the option:

- That a Mental Health Court (MHC) be established (as per the Qld model), as a division of the Supreme Court. The presiding judge to have expertise in mental health issues in consultation with two psychiatric assessors.

- In order for the process to be transparent, forensic hearings could include relevant information presented in person from the treating team, carers and other stakeholders.

- That the MHC should have the power to determine: fitness to be tried; eligibility for a not guilty by virtue of mental illness (NGMI) plea; diminished responsibility; special hearings; allocation and termination of forensic status; limiting terms and orders.

- That the President of the MHRT establish a forensic division of the Tribunal (FMHRT), headed by a senior judicial officer with knowledge and experience of forensic matters with expanded powers to determine treatment; detention; leave and release; as well as hear cases of breaches leave or release conditions.

- That incorporated into the MHC model, the legislation provide that, once a person has been detained for five years (for offences with indeterminate sentences) or three years (for other lesser offences with indeterminate sentences) that criminal proceedings must be discontinued. Furthermore, the MHC must request that the FMHRT determine discharge or involuntary admission under the civil provisions of the *Mental Health Act,* as proposed in the Newcastle Model for a Mental Health Legislation.

- That there must be an avenue for participation by the Crown (The Executive and Attorney General, etc.) who may appeal to the Supreme Court. This would provide balance and satisfy community concerns regarding risk and 'victim' [5] input.

[5] The term 'victim' used in inverted commas is presented as such because some stakeholders question the language used in this context. Since no sentence has been handed down, and no crime committed some view the 'victim' is one of several interested stakeholders in the event's outcome, as opposed to 'victim' of crime.

- That the appeal process be heard by the full bench headed by a Supreme Court Judge with access to all relevant information and presentations from the FMHRT, the MHC, the treating team, carers and other stakeholders.

MHCC expect that there is little likelihood that a new model might incorporate the establishment of a Mental Health Court. On that basis we endorse Option 4 as presented in the consultation paper as a compromise.

Option 5
Amend the legislation to transfer all decision making to the Tribunal, but establish a right of veto for the Executive, through the Minister for Health.

We suggest that this is Executive Discretion under another guise and therefore reject it completely.

Section 4

Categories of a forensic patient

The definition of forensic patient

Option 1
Retain the current definition of a forensic patient in the *Mental Health Act 1990 (NSW).*

Option 2
Amend the legislation to provide a simplified definition of a 'forensic patient', and consistency in the references to them.

MHCC believe it is necessary to retain the definition of a forensic patient, as it is important to define the various contexts in which a person is classified as such. However, there is no reason why the definition 'forensic patient' should not also be used consistently, and that the alternative references 'person,' or 'party', should be avoided.

Recommendation
That Option 1 is used retaining the current definition of 'forensic patient,' but that it should be used consistently.

Detention

Option 1
Retain the current system.

Option 2
Amend the forensic mental health legislation to define expressly:

i. The power to detain
ii. The power to release
iii. Commencement and termination of forensic status.

MHCC believe that it is necessary to provide greater clarity surrounding provisions for detention and their implementation.

Recommendation
That the legislation be amended to define detention as per Option 2

Intellectual Disability

There is a 10% overrepresentation of people with intellectual disability (PWID) in the criminal justice system as against representation in the general population. Whether intellectual disability (ID) is present as a result of developmental disability, brain damage, illness or genetic disorder, ID is not a mental illness (MI) which can be managed by medication or therapeutic practices from which there can be 'recovery.' Mental illness may be episodic and with treatment consumers may ultimately achieve recovery and rehabilitation.

People with intellectual disability may be classified as 'forensic' patients. The absence of a consistent definition of ID throughout the several Acts that deal with PWID has led to considerable confusion, particularly where co-morbidity of ID and MI occur.

Frequently forensic patients with ID are detained in gaol while subject to 'limiting terms' or after a special verdict. As a consequence of the assumption that characteristics of ID can be assessed by the same criteria as mental illness, PWID may be subject not only to difficulties with current legislation, but as a result of the inadequate capacity of community services to provide alternatives to incarceration, they may suffer indefinite detention in corrective services.

Existing rights and obligations for PWID are affected by ratified federal, state and international instruments and therefore automatically incorporated into Australian law. At this point in time, acknowledgement of these obligations, rights and principles is inconsistent in the legislation. These instruments must be made manifest in the amended Act.

Option 1
Retain the current framework for dealing with intellectual disability among forensic patients.

MHCC totally reject Option 1.

Option 2
Amend the legislation to make specific provision in relation to people with an intellectual disability within the forensic mental health system.

MHCC reject Option 2.

Option 3
The NSW Government should conduct a further inquiry into the need for specific provision for people with an intellectual disability within the forensic mental health system.

MHCC suggest that Options 2 and 3 are inappropriate because even where co-morbidity is present, identification of ID should override a presentation of MI. We agree that an inquiry should be undertaken, but not into the ***need*** for specific provision for people with ID, as need is clearly evident from the Burdekin Report (1993), the Australian Law Reform Commission Discussion Papers 35 (1994) and 80 (1996), and a plethora of literature on the subject.

The need lies in the development of provisions for PWID within the forensic provisions of the Act, to establish a special Intellectual Disability Review Tribunal (as a division of the MHRT) with expert knowledge and experience in the field, and powers to divert PWID and PWID and MI into the most appropriate long-term housing and supportive alternatives.

It will inevitably be necessary to maintain some security facilities within the forensic system for PWID and MI subject to limiting terms. MHCC assume that the special unit to be provided within the confines of the proposed new Long Bay Forensic Hospital will protect these patients from harassment, assault, rape and HIV.

The DADHC Criminal Justice Program must be expanded to include PWID and MI who present with challenging behaviours but are reviewed as appropriate for ongoing conditional release. Nevertheless, The Intellectual Disability Council has alerted us to the risk that accommodation options in the program will tend towards a more institutional accommodation model if an option is created for people with an ID, to be detained in Criminal Justice Program accommodation.

Recommendation
That the legislation be amended to make special provision for PWID within the forensic system, and that a special Intellectual Disability Review Tribunal (IDMHRT) be established as a division of the MHRT with the same extended powers as suggested in Recommendations (Executive Discretion, pg. 6) to release (conditionally or otherwise) and divert PWID into the most appropriate alternative community service.

Children

There are nine juvenile justice centres in NSW. Eight are run by the Department of Juvenile Justice. In November 2004, management of the ninth centre, Kariong Juvenile Justice Centre for serious male offenders over 16 years of age was transferred from the Department of Juvenile Justice to the Department of Corrective Services. In December 2004, it was renamed the Kariong Juvenile Correctional Centre and became a medium security facility.

In July 2005 the NSW Select Committee on Juvenile Offenders Report recommended that the NSW government consider returning the management of Kariong to the Department of Juvenile Justice (Recommendation #24).

> ***Recommendation 24***
> *That the NSW Government continue to develop a long-term strategy for the accommodation of serious young offenders, and in particular:*
>
> > *• to further consider returning the responsibility for management of all juvenile offenders to the Department of Juvenile Justice in the longer term.*

MHCC note in the NSW Government Response to the Inquiry, that the recommendation was interpreted as follows:

> *The Report of the Inquiry into Juvenile Offenders generally endorses the Government's juvenile justice policies, in particular the decision by the Government to place responsibility for NSW's most serious young offenders with the Department of Corrective Services.*

Nothing in the Government's Response indicates that the Government will consider returning the responsibility of Kariong back to Juvenile Justice in the future.

The 2005 Inquiry suggested that the government consider the *"practicality and appropriateness of establishing specialist mental health units within juvenile justice centres or a purpose – built facility for young people with mental illness,"* (Recommendation #7). We understand from the Government's response to the Inquiry that a 15 bed male adolescent unit will be incorporated into the new Long Bay forensic hospital, and that this unit will be physically separate from adult units. It is unclear where and how many adolescent females will be accommodated.

Despite the fact that the new forensic hospital will no longer be under DCS jurisdiction, MHCC advocate that all juvenile offenders with a mental illness receive treatment, care necessary programs and services in secure adolescent mental health facilities in the community in collaboration with Juvenile Justice and Justice Health rather than in the new Long Bay hospital facility.

The 2005 Inquiry also recommended collaboration between departments ensuring continuity of services whilst in custody (Recommendation #9). MHCC note that there is no reference to continuity of care after release. We assume that case management plans are initiated.

Despite the Select Committee's report and the subsequent Government response, MHCC suggest that neither adequately address the complex needs of juveniles with mental illness, who according to the two research surveys conducted by Justice Health on Young Offenders comprise a high percentage of juveniles in custody.[6]

Using the Psychological Distress instrument, The Kessler-10 (K-10) which is a ten-item questionnaire yielding a global measure of psychosocial distress, the questions examine the level of anxiety and depressive symptoms in the previous four weeks. Based on the data collected, 30% of young people in custody had high or very high psychological distress, consistent with a greater than fifty percent chance of an anxiety or depressive disorder; 8% of the sample had an almost eighty percent chance of having an anxiety or depressive disorder.

Population norms suggest that between 11% and 12% of the general population had high to very high scores on the K-10. In terms of risk behaviours, nineteen percent (16% of young men and 53% of young women) had injected drugs in the twelve months prior to custody. Almost 90% had used cannabis, nineteen percent of males and 24% of females had seriously considered attempting suicide at some time in the past. The reports also identified evidence of a high instance of childhood abuse and neglect, suggesting that the presence of complex pathology requires particular training and skills on the part of professionals working in the field, which may be more appropriately accessed in adolescent mental health units than a forensic hospital.

Option 1
Retain the current framework for dealing with children within the NSW forensic mental health system.

> MHCC are opposed to maintaining the current system.

Option 2
Amend the legislation to make specific provision for children within the forensic mental health system.

> Insufficient inquiry has been undertaken into the complex needs of juveniles in the forensic system. Our concern is how a satisfactory inquiry can be undertaken between the present time and the deadline for introduction of the amended forensic provisions to be inserted into the *Mental Health Bill 2006*. We assume that conclusions reached as a result of inquiries will subsequently be introduced as amendments to the Act tabled as and when.

---

[6] NSW Department of Juvenile Justice. (2003). NSW Young People in Custody Health Survey. Kenny, D. T., Nelson, P., Butler, T., Lennings, C., Allerton, M. & Champion, U. (2006) NSW Young People on Community Orders Health Survey 2003-2006: Key Findings Report. University of Sydney

Option 3
The NSW Government should conduct a further inquiry into the need for specific provision for children within the forensic mental health legislation.

> MHCC propose that further extensive inquiry and community consultation is undertaken.

Recommendation
That Option 3 is supported.

Federal Offenders

Option 1
Retain the current framework for dealing with federal offenders within the NSW forensic mental health system.

Option 2
Amend the legislation to make specific provision for people detained under federal legislation.

Recommendation
MHCC endorse Option 2, if the evidence collected in other jurisdictions can be appropriately utilised in the NSW context.

Option 3
The NSW Government should conduct a further inquiry into the need for specific provision for people detained under federal legislation within the NSW forensic mental health system.

Recommendation
If the evidence collected is insufficient or inappropriate in a NSW context, MHCC would support Option 3.

References to mental illness and mental condition

MHCC consider the current terminology problematic. It has not kept abreast of the latest scientific thinking and frequently leads to inappropriate determinations.

Option 1
Retain the existing terminology in forensic mental health legislation in relation to ‘mental illness’ and ‘mental condition’.

Option 2
Review the terminology used in forensic mental health legislation including the terms ‘mental illness,’ and ‘mental condition’.

Recommendation
That Option 2 is supported.

Section 5.

Practical matters arising from any change in decision-making

Review of decisions

If the current system of decision making is reformed so as to remove Executive Discretion, we comment as follows:

Option 1
A forensic patient has the right of appeal in relation to any decision of the determining body.

Option 2
A forensic patient has the right of appeal in relation to any decision of the determining body, and the Minister for Health and the Attorney General have the right of appearance before a determining body, and a right of appeal on public interest grounds.

Recommendation
MHCC propose that Option 2 is an appropriate amendment to the legislation.

The Tribunal's Constitution

MHCC understand that *The NSW Mental Health Bill 2006*, tabled in parliament in November 2006 has amended the administrative framework of the MHRT so that the composition of the Tribunal is as follows:

150 Composition of the Tribunal (cf 1990 Act, ss 264, 265)

> *(1) The Tribunal is to be constituted by one or more members nominated by the President for the exercise of its functions.*
> *(2) For the purpose of exercising any of its functions (other than in relation to forensic patients), the Tribunal must consist of at least 1 member who is to be the President, a Deputy President or a member who is an Australian legal practitioner.*
> *(3) The President may nominate other members of the following kinds:*
> > *(a) a member who is a psychiatrist,*
> > *(b) a member who (not being an Australian legal practitioner) has other suitable qualifications or experience.*
>
> *(4) For the purpose of exercising its functions in relation to forensic patients, the Tribunal must consist of the President or a Deputy President, a member who is a psychiatrist and a member who (not being an Australian legal practitioner) has other suitable qualifications or experience.*
> *(5) The regulations may make provision for or with respect to the members who are to constitute the Tribunal for the exercise of any of its functions.*

MHCC did not endorse this amendment and expressed their strongest objections to the MHRT being represented in any circumstances other than by three tribunal members with legal, clinical and community mental health expertise.

> We have already proposed in this submission under Executive Discretion Options our 'best practice' option, which includes the President establishing forensic and intellectual disability divisions of the MHRT. We are concerned as to how the new Tribunal framework in the *NSW Mental Health Bill 2006,* would impact on the composition of the Tribunal if the President so determined that a review could be heard by one legal member only.
>
> We strongly oppose any other than the tripartite model and suggest that no one member of the FMHRT should have the deciding vote on a determination involving the release of a forensic patient.

Option 1
Retain the current administrative framework of the Tribunal.

Option 2
Amend the legislation to provide that the President may establish a division of the Tribunal for matters relating to forensic patients.

Recommendation
Provided that the MHRT and the newly formed forensic division (FMHRT) are given expanded powers as outlined in the Recommendation (pg.6:7), and that the tripartite model is maintained, MHCC propose Option 2 as an appropriate amendment to the legislation.

We propose that appointment of the MHRT President and members is independent of political influence, and the responsibility of an independent interview panel comprising a retired Supreme Court Judge, senior clinical and forensic professionals and (for example) the Chief Executive, NSW Centre for Mental Health.

MHCC also propose that the Tribunal's authoritative powers be stipulated in legislation, making them less easy to tamper with than when powers are merely present in regulations which may result in less transparency and greater individual discretion.

Despite the recommendation that the MHRT and its newly formed divisions are to have expanded determining powers, we support the continuation of informality. The MHRT must remain free to inform itself as it sees fit, and not bound by the rules of evidence.

Notice of hearings

Option 1
Retain the current framework, which does not make statutory provision for hearings.

Option 2
Amend the legislation to provide that the MHRT and the determining body must give a specified amount of notice of any hearing in relation to:

- The forensic patient (and his or her legal representative)
- The person responsible for the detention, care and treatment of the patient
- The Attorney General and Minister for Health
- Registered victims and family members of the patient who have given notice of their desire to be informed.

MHCC understand that currently a hearing is an open process unless a forensic patient has requested otherwise. MHCC see no reason any persons listed above should not be informed. However, we express the view that interested stakeholders wishing to make submissions to the Tribunal, should be able to do so only in writing.

Recommendation
That legislation reflects Option 2, giving adequate time for those who wish to make representations to do so. That registered victims may only make representations in writing.

Production of reports

Option 1
Retain the current framework, which does not make statutory provision for the production of information for reviews or decisions in relation to forensic patients.

MHCC support Option 1, subject to the establishment of a Forensic Mental Health Review Tribunal, with the proviso that it be stated in the legislation that the Tribunal may request any documentation they deem appropriate in order to make determinations.

Option 2
Amend the legislation to provide that the review and determining body may only make a recommendation or determination after considering certain prescribed information, and may require the production of reports and other information from any relevant person or public official involved in the detention, care, treatment, or supervision of a forensic patient.

MHCC propose that although Option 2 appears to be an appropriate amendment to the legislation that this may result in unnecessary red tape.

Recommendation
That Option 1 is supported with the suggested clarification.

Reason for decisions

The MHRT provide extensive detail on its determinations, informed by documentation from all involved in the care, treatment and detention of a forensic patient, carers, family and victims. In contrast, current legislation provides a loophole through which the Executive remains unaccountable for its decisions on release, not only to the Tribunal but to the forensic patients under review. We submit that this represents a denial of natural justice.

MHCC suggest that the Tribunal's current role is to offer the Minister the benefit of its expertise. The fact that recommendations are frequently rejected outright is a measure of Tribunal's powerlessness in matters of release.

Option 1
Retain the current framework, which does not make statutory provision for giving reasons for decisions regarding the detention, care, treatment, or supervision of a forensic patient.

Option 2
Amend the legislation to provide that the determining body must provide a copy of any decision (and reasons for it) to the forensic patient concerned or his or her representative and may provide a copy to any other person with interest in the proceedings.

Recommendation
MHCC strongly support Option 2 as an amendment to the legislation.

Compliance with orders

Option 1
Retain the current provisions.

Option 2
Amend the legislation to provide a duty to comply with the orders of the determining body, and provide a sanction for non-compliance without reasonable excuse.

> Whilst in theory MHCC would like the legislation to provide a duty of compliance, our sense is that this would prove impossible to implement. A sanction for non-compliance without reasonable excuse is likely to result in ever more bureaucratic paper trails creating further delays in the system and work of the determining body.
> If the inability to provide appropriate post-release support options is a valid reason for non-compliance (which will in most instances be the case), any other reason would constitute negligence under the NSW Health Guidelines, and should be dealt with under a policy framework.

Recommendation
Retain the current provisions in Option 1. However, MHCC ask policy makers to take note that when drafting amendments to the NSW Health Guidelines that embody the new legislation, to take care that appropriate quality management systems are in place to ensure compliance with the determining body's orders and accountability for non-compliance.

Section 6

Fitness to be tried

The current law

Option 1
Retain the current system.

Option 2
Amend the legislation to declare that the forensic status continues after the Tribunal has made its determination and until the Court has made its order.

Recommendation
MHCC support Option 2.

The fitness framework

As the current legislation stands, Sections 32 and 33 *Mental Health (Criminal Procedure) Act 1990* (NSW) are the means by which 'unfit' defendants may be dealt with. These are diversionary provisions for defendants appearing in summary matters who fit within certain categories.

However, they are inadequate in dealing with the issue of unfitness because fitness is not a specific consideration in the legislation. For example, a defendant with an intellectual disability or mental illness may still be fit to be tried; or may have an intellectual disability assessed as mental illness. Alternately, a defendant who does not necessarily suffer from any of the conditions referred to may still be unfit to be tried.[7]

A magistrate may also decline to exercise discretion under Section 32 because of the nature of an offence, such as a prior criminal record, or the offending behaviour being coupled with abuse of alcohol or drugs. None of these reasons would be considered in relation to the determination of fitness to be tried. This emphasises the fact that the present legislation exists for a different purpose to that of determining fitness to be tried.[8]

---

[7] Wilcock, P. (2002). The Fitness to Plead Procedure - An Adequate Protection? New Law Journal 439. Craigie, C. (2002). Fitness to be Tried in Superior Courts*:* Public Defenders Office. Quoted in NSW Young Lawyers Criminal Law Committee. (2003). Submission: Determination of fitness to be tried in the local court and children's court.

[8] Ibid.

If a matter is not dealt with under Section 32 or Section 33: *Mental Health (Criminal Procedure) Act 1990* (NSW), the only way that a defendant can raise an issue of fitness to be tried is to elect to have the charges to be dealt with on indictment in the District Court, where the issue of fitness can then be determined. This is unsatisfactory, because there is real difficulty in committing a defendant who is unfit to be tried for trial.[9]

In addition, a defendant will be disadvantaged because the opportunity of having matters finalised in the Local Court (which would have otherwise been the case) would be lost.[10]

Option 1
Retain the current framework for determining a person's 'fitness to be tried' for an offence.

Option 2
Amend the legislation to provide that the court is responsible for making all determinations regarding an accused's fitness to be tried and mental condition, holding special hearings, imposing limiting terms, and (where detained) determining whether the person should be detained in a hospital or other place.

Option 3
Amend the legislation to provide that the Mental Health Review Tribunal is responsible for making all determinations regarding an accused's fitness to be tried and mental condition, holding special hearings, imposing limiting terms, and (where detained) determining whether the person should be detained in a hospital or other place.

> In order to maintain consistency with recommendations outlined in this submission, Executive Discretion (Option 4, pg.7) MHCC favour Option 3. However, were the model to include a MHC, this Option would need to be appropriately revised.

Recommendation
That Option 3 is supported if the chosen empowered determining body is the Mental Health Review Tribunal.

Power to order an examination

Option 1
Retain the current procedures for determining fitness to be tried.

[9] Ebatarinja v Deland (1998) 157 ALR 385 at 392 per the Court.

[10] Young Lawyers Criminal Law Committee. (2003). Submission: Determination of fitness to be tried in the local court and children's court.

Option 2
Amend the legislation to provide that the body responsible for determining fitness may order the conduct of a medical or other assessment to assist in determining the person's fitness to be tried for an offence.

Recommendation
That the legislation be amended to reflect Option 2.

Alternative orders

Option 1
Retain the current provisions that state that the court may impose any other penalty or make any other order that it might have made if the person had been convicted of the offence.

Option 2
Amend the legislation to provide a non-exhaustive list of sentencing alternatives available to the court where a special hearing has resulted in a qualified finding that the person committed an offence.

Recommendation
That the legislation re amended to reflect Option 2.

Limiting terms

Most people found unfit to be tried rather that NGMI are given a limiting term. Many of them are PWID, not a mental illness. They are seldom released prior to the expiration of limiting terms, because of their security classification and the absence of post - release options. In determining limiting terms, one could ameliorate the problem by deducting non-parole periods and consider mitigating factors. Alternatively, if expanded post-release options were available, using guardianship orders, a forensic patient with a low risk determination could be released into the community.

Forensic patients should have the benefit of sentencing legislation such as receiving a suspended sentence, non-parole period or community treatment order. The Victoria system has introduced a maximum term for a forensic order. It also has a leave committee which makes decisions about leave from hospital. It would be useful to inquire into how this model is working in practice.

Option 1
Retain the current provisions for setting limiting terms.

MHCC propose that such an option would be completely unacceptable.

Option 2
Amend the legislation to provide that a limiting term represents the minimum sentence the court would have imposed if the person had been convicted of the offence.

In the absence of a more enlightened diversionary and release framework to deal with PWID being implemented. We propose that Option 2 is the least draconian alternative.

Option 3
Amend the legislation to provide that, in setting a limiting term, the court must presume that the accused would have pleaded guilty if he or she had been fit to be tried, and give a discount accordingly.

MHCC do not support this option.

Option 4
Amend the legislation to provide that a limiting term represents the average term of imprisonment for which a person convicted of the offence would be liable.

MHCC do not support this option.

Option 5
Amend the legislation to provide that the limiting term for a person found to have committed an offence at a special hearing is the term specified in legislation.

MHCC do not support this option.

Recommendation
MHCC support Option 2 as the 'least unacceptable' option, in the absence of a more appropriate alternative.

Section 7

Special verdicts

The mental illness defence

When a defence of MI is applied to a PWID, this may and often does cause a PWID to be detained in the mental health system. In this setting, their support and care needs may not be met. There is need for the legislation to reflect the difficulty a PWID may have in understanding the judicial process and comprehending the significance of their behaviour in terms of community values.

Disability services such as the DADHC funded Criminal Justice Support Network are now providing support for people with intellectual disabilities in court and police interviews. Disability services have also shown that they have great difficulty appropriately supporting Indigenous and CALD PWID.

MHCC stress the need for Government to take into consideration when conducting reform of the defence of mental illness, the issues highlighted in The Law Reform Commission, *People with Intellectual Disabilities and the Criminal Justice System and Sentencing Issues:* Discussion Paper 35 (1994) and Discussion Paper 80 (1996).

We refer back to comments in this submission (pp.6:7) suggesting that the MHRT President be empowered to establish a special division with responsibility for reviewing PWID, and PWID with a MI.

Option 1
Retain the existing defence of mental illness.

Option 2
The NSW Government should conduct a further inquiry into the need to reform the defence of mental illness to better address intellectual disability.

> Option 2 proposes that the NSW Government conduct an inquiry into the **need** for reform. The need is well documented, as are proposals for best models for reform.

Recommendation
MHCC advocate that the Government apply reform as outlined in the NSW Law Reform Discussion Papers 35 (1994) and 80 (1996) and seek advice from disability legal services as to further evidence and recommendations gathered in the subsequent decade. Our understanding is that the evidence is readily available from those representing and supporting PWID through legal processes.

Alternatives to detention

Option 1
Retain the current provisions stating that, where a person is subject to a special verdict, the court may order the person's detention or make such other order as it considers appropriate.

Option 2
Amend the legislation to provide a non-exhaustive list of alternative orders available to the court where a person is subject to a special verdict of not guilty due to mental illness.

Recommendation
That the amended legislation provide the determining authority a non exhaustive list of alternative orders that serve as indicative options, enabling the development of alternatives specifically appropriate to the individual under review.

Length of detention

Our sense is that that the issue discussed in this section embody the concept of culpability, and the need for a NGMI to serve some period of incarceration that represents a sentence similar to what they would have received under 'normal' circumstances.

As discussed elsewhere in this submission, we believe attention should centre on human rights of people with a mental illness, essentially a recovery model that removes itself from detention and punishment. With this in mind, we alert those reviewing submissions to the human rights principles as stated in the National Mental Health Strategy: National Mental Health Plan 2003 – 2008.

Option 1
Retain the current system of indeterminate detention in relation to persons subject to a special verdict of not guilty due to mental illness.

> MHCC strongly object to the current system of indeterminate detention.

Option 2
Amend the legislation to provide that the person must be released at the end of a specified period unless it is satisfied that the release criteria have not been met; provide that reasonable efforts be made to progress the person toward release at that time; and set a maximum period of detention if the person is not released at this time.

> MHCC support Option 2 in the absence of more appropriate alternatives. At the very least it will enable a forensic patient to know how long they will be incarcerated. There will of course, be need for experts to determine the preconditions necessary for release.

Option 3
Amend the legislation to provide for the imposition of a limiting term in relation to persons subject to a special verdict.

Recommendation
MHCC support Option 2.

Section 8

Offenders and inmates

Discussion

MHCC support the belief that people with a mental illness irrespective of their status when entering the criminal justice system should be treated as a forensic patient, neither discriminated against nor subject to punitive practices whilst receiving care and treatment.

Option 1
Retain the existing provisions that include transferees within the definition of a ‘forensic patient’.

> MHCC consider it entirely appropriate that transferees are included in the definition of a forensic patient.

Option 2
Amend the legislation to provide for 'security patients', being convicted offenders who are transferred from a correctional centre to a hospital for treatment, and make provision for their treatment, security, leave, release and inter-jurisdictional transfer.

Recommendation
MHCC propose that Option 1 is appropriate. We also suggest that an inquiry be instigated into the needs of convicted offenders with serious mental health diagnoses who require ongoing management and for whom a corrective environment is seriously detrimental to their health and safety. We suggest that such cases should be subject to a status review despite fitness to plead at the time of sentencing. A different status may result in early transfer back into prison which might well prove to be detrimental.

Expiry of non parole period

It is our strong belief that the Act should reflect 'world best practice' supporting the concept of *"the best treatment in the least restrictive environment,"* [11] - the most effective treatment with an emphasis on recovery and appropriate support in the community for all individuals with a mental illness.
This is no less applicable to forensic patients for whom gaol is an unsuitable environment in which 'management' and 'medication' rather than 'recovery' and 'rehabilitation' are the main focus.

We have long held the view that no forensic patient should be held in a correctional facility whether their non-parole period has expired or not. We support Option 2.ii., and assume that when the new hospital at Long Bay comes becomes operational (technically operating as a civil hospital under NSW Health) this may confuse the issue. We would welcome further clarity on this matter.

Option 1
Retain the existing provisions.

Option 2
Amend the legislation to expressly provide in relation to a forensic patient whose non-parole period has expired:

> i. That if they are mentally ill they may be detained in an appropriate correctional facility (whether a gaol or hospital) notwithstanding that their non-parole period has expired or
>
> ii. That they may be transferred to and detained in a suitable hospital or other facility outside the corrections system or treated as would be a civil patient.

[11] Article 9(1) and (4) International Covenant on Civil and Political Rights United Nations 'Principles for the protection of persons with mental illness and the improvement of mental health care'; United Nations High Commissioner for Human Rights, Adopted by the First United National Congress on the Prevention of Crime and the Treatment of Offenders, Geneva 1955.

Recommendation
MHCC strongly advocate that the legislation be amended to reflect Option 2.ii.

Grounds for transfer

Option 1
Retain the existing provisions for transferring prison inmates from a correctional centre to hospital for mental health treatment.

Option 2
Amend the legislation to provide an additional ground of transfer from a correctional centre to a hospital, being where the person is a 'mentally disordered person' as defined in the *Act.*

Option 3
Amend the legislation to provide for the transfer of a person from a correctional centre to a hospital on the same grounds as apply under the civil provisions of the *Mental Health Act.*

Recommendation
MHCC support Option 3 as an amendment to the legislation.

Transferees and continued treatment orders

Option 1
Retain the present system.

Option 2
Amend the legislation to provide that a transferee may also be classified as a continuing treatment patient immediately before or at the expiry of the non-parole period.

Recommendation
MHCC support Option 2 as an amendment to the legislation.

Community treatment orders for prison inmates

Option 1
Retain the current framework for providing mental health treatment to prison inmates.

Option 2
Amend the legislation to provide a framework for the making, implementing and monitoring of community treatment orders in the correctional context.

Recommendation
MHCC support Option 2 as an amendment to the legislation.

Section 9

Review of forensic patients

Notifying the Tribunal

Option 1
Retain the existing administrative framework for notifying the Mental Health Review Tribunal that it has acquired jurisdiction over a forensic patient.

Option 2
The Attorney General, Minister for Health, Minister for Justice and the Tribunal should develop a protocol to ensure that the Tribunal is notified that it has acquired jurisdiction over a forensic patient within a specified period.

Recommendation
That Option 2 is reflected in the amended provisions of the legislation.

The review provisions

Option 1
Retain the existing separate provisions regarding the Mental Health Review Tribunal's responsibility for conducting initial and ongoing reviews of forensic patients.

Option 2
Amend the legislation to simplify and consolidate the provisions for initial and ongoing reviews of forensic patients.

> MHCC suggest that the question of review provisions can only be discussed in relation to changes that may occur in the event of the MHRT Tribunal being granted expanded power. We suggest that only in the event of removal of Executive Discretion and MHRT expanded power may Option 2 be possible.

Recommendation
MHCC support any amendments to the legislation that would give the MHRT jurisdiction over forensic patients that would make Option 2 viable.

Timing of reviews

Option 1
Retain the current provisions regarding frequency of reviews of forensic patients.

Option 2
Amend the legislation to provide that the Mental Health Review Tribunal must:

- conduct a review at least once every 12 months, but may do so at any time (and must do so if requested by the forensic patient [or his or her representative] on reasonable grounds, or by the Minister for Health,

the Attorney General, the Minister for Corrective Services, the Chief Health Officer or a medical superintendent).

- monitor the detention, care and treatment of each forensic patient on an ongoing basis.

Option 3
Adopt Option 2 providing that the Tribunal obtain and consider reports from the forensic patient's treating team for review on a six monthly basis.

Recommendation
MHCC support Option 3 and strongly advocate the proviso that reviews must be conducted every 6 months.

Review of conditions of detention, care and treatment

The use of solitary confinement for people with a mental illness within the correctional system has been the subject of considerable alarm. Where abuses of human rights occur, service providers must be accountable to the determining body.

Option 1
Retain the current provisions regarding the Mental Health Review Tribunal's jurisdiction to review the detention, care and treatment of a forensic patient.

Option 2
Amend the legislation to provide that the Tribunal may review, and the determining body may make orders, in relation to any matter it considers appropriate in relation to the detention, care or treatment of a forensic patient, including the conditions of a patient's detention, care or treatment.

Recommendation
MHCC support Option 2, and propose that complaints unresolved by internal complaints mechanisms regarding inadequate and/or inhumane care or treatment could be reviewed by the MHRT.

Informal reviews

For the purposes of those reading this submission, the following options refer to legislation dealing with delayed transfers to hospital of inmates or persons on remand, found unfit but have not had a special hearing.

Option 1
Retain the existing provisions requiring the Mental Health Review Tribunal to conduct informal reviews.

Option 2
Amend the legislation to provide the Tribunal with greater powers to address these concerns.

Option 3
Amend the legislation to remove the requirement that the Tribunal conduct informal reviews of these matters.

Recommendations
MHCC support Option 2.

Section 10

Release of forensic patients

Leaves of absence

Since leave provisions apply only to forensic patients in the hospital, those held in a correctional centre with forensic status by virtue of the fact they are PWID, are subject to leave arrangements applying to inmates in general. This is an example of discriminatory practices against one of the most vulnerable and marginalised groups in the criminal justice system. Leaves of absence would provide a step down process through which PWID could be skilled up and assessed for re-integration into the community.

MHCC would like to pick up on the statement made in the consultation paper (p.44, para. 2) that, *"If NSW continues to accommodate forensic patients within the prison system, there does not appear to be any justification for punishing or detaining them further or more intensively than those who have been found wholly responsible for the offences they have committed."* This is an acknowledgement that forensic 'patients,' are in fact another category of inmate, subject to punitive practices contrary to Human Rights Principles, the NSW Mental Health Strategy and all the standards and guidelines which the Government profess to uphold with regard to forensic patients.

Option 1
Retain the current framework for the grant of leaves of absence by the medical superintendent, the Minister or the Governor in relation to forensic patients.

Option 2
Amend the legislation to provide for leaves of absence for forensic patients, to be granted by the Tribunal in lieu of the Minister or the Governor and to provide criteria for such grants.

Option 3
Adopt Option 2 and establish a new security classification category for forensic patients held in correctional centres that better facilitates access to leave and release arrangements.

Recommendation
MHCC are strongly supportive of an amendment the legislation that incorporates both Option 2 and 3.

Broader criteria for decision making

MHCC urge the Task Force, when focusing on broader criteria for decision making to consider the Submission from the New South Wales Consumer Advisory Group (CAG) to the NSW Legislative Council Select Committee on Mental Health (2002). We quote verbatim.

> *"The Australian Health system works primarily with the medical model. Other jurisdictions focus on recovery. The following extract is from Recovery Competencies (Mental Health Commission 2001) published by the Mental Health Commission of New Zealand: 'Recovery' is defined as the ability to live well in the presence or absence of one's mental illness (or whatever people choose to name their experience). Each person with mental illness needs to define for themselves what 'living well' means to them.*
>
> *The definition is purposefully a broad one, because the experience of recovery is different for everyone and a range of service models could potentially support recovery. The recovery approach requires mental health services to develop and draw on their own resources, but it also requires that they develop and draw on the resources of people with mental illness and their communities.*
> *Recovery happens when people with mental illness take an active role in improving their lives, when communities include people with mental illness, and when mental health services can enable people with mental illness and their communities and families to interact with each other.*
>
> *The recovery approach is more compatible with community-based models of service provision than institutionally-based ones, but it is not a model of service delivery. It is an approach which can be applied to any models that draw on the resources of service users, their communities as well as mental health services."* [12]

Option 1
Amend the legislation to provide that the determining body must order the leave or release of a forensic patient at any time if it is satisfied, on the available evidence, that the safety of the patient or any members of the public will not be seriously endangered by the patient's leave or release.

Option 2
Amend the legislation to provide that the determining body must order the leave or release of a forensic patient at any time if it is satisfied, on the available evidence, that:

- care or treatment of a less restrictive kind (where necessary) is reasonably available to the patient within the community

[12] New South Wales Consumer Advisory Group. (2002). Submission to the NSW Legislative Council Select Committee on Mental Health, pp. 5, 15

- reasonable arrangements have been made to ensure the person's continued care or treatment (where necessary) within the community

- the safety of the patient, or members of the public, will not be seriously endangered by the person's release.

MHCC support Option 2, as it represents a better balance that the two alternative options.

Option 3
Adopt Option 2, and amend the legislation to provide that, when making such decisions, the determining body must consider criteria such as the following:

- The need to ensure that persons who are mentally ill or mentally disordered receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given.

- The need to ensure that any restriction on the liberty of persons who are mentally ill or mentally disordered and any interference with their rights, dignity and self-respect are kept to the minimum necessary in the circumstances.

- The nature of the person's condition.

- The prospect of a relapse or deterioration in the person's condition once released into the community.

- The potential safety concerns arising from such relapse or deterioration in the person's condition.

- The availability of care and treatment in the community.

- The availability of relevant social factors mitigating against a future relapse or deterioration in the person's condition.

MHCC suggest that the list of evidence to be provided in Options 3, are issues that the MHRT already consider. It is unnecessary to devise specific lists that are likely to lead to bureaucratic, protracted release delays as a result of overzealous caution.

Recommendation
MHCC support Option 2 as an amendment to the legislation.

Conditions placed on release

Option 1
Retain the current framework that does not specify the conditions that may be placed on a forensic patient's conditional release.

Option 2
Amend the legislation to provide a non-exhaustive list of conditions that the determining body may place on a forensic patient's conditional release.

Recommendation
That Option 2 is reflected in the amended legislation.

Notification of release

Option 1
Retain the current framework for notification of the possible release of a forensic patient.

Option 2
Amend the legislation to provide that only the Minister for Police should be notified of the proposed release of a forensic patient.

Option 3
Amend the legislation to remove all of the notification requirements regarding the possible or proposed release of a forensic patient.

Recommendation
MHCC take the view that the only persons who should be notified of proposed release of a forensic patient are registered victims who have identified their wish to be notified, and that non-contact orders be issued prior to release. No such option is offered in the consultation paper that we can support.

Supervision of released patients

Option 1
Retain the current framework for supervision of forensic patients within the community.

Option 2
The Mental Health Review Tribunal should enter into a formal agreement with relevant government agencies to ensure that there is a consistent and complementary framework for the supervision, treatment and care of forensic patients who are subject to conditional release from detention.

Option 3
Amend the legislation to require relevant government agencies to cooperate with each other for the supervision, treatment and care of forensic patients who are subject to conditional release from detention.

Recommendation
MHCC do not support such matters entrenched in the legislation. We would like to support Option 2, but sense that it will be very difficult to comply with formal agreements when there is an absence of appropriate care in the community. A duty of care is part of the object and aims of the Government's mental health strategy and should be manifest in policy and procedures, standards and guidelines.

Breach of conditional release

The Mental Health Tribunal should be empowered to review a breach of conditional release, however case management to monitor need must be provided to ensure that a forensic patient can uphold conditions set once back in the community and do not breach their release conditions. This may involve the establishment of specific case management services. MHCC propose that development of collaboration with NGO agencies to support these patients be initiated.

Breach provisions should be revised to allow for alternate processes for less serious breaches. Determination of what constitutes 'less serious' should be made in consultation with people with a mental illness and other relevant services. MHCC are concerned that harsh penalties are meted out for seemingly minor infractions.

Option 1
Retain the current framework for responding to these matters.

Option 2
Amend the legislation to provide a hierarchy of responses according to the seriousness of an alleged breach of conditional release, and a clear mechanism for responding to deterioration in a person's condition.

> A treatment order is handed down as part of a conditional release, this should be included as an appendix so that all stakeholders involved in the management plan are aware of their responsibilities should the patient deteriorate.

Option 3
Adopt Option 2, and amend the legislation to provide a framework for the determining body to: order the apprehension and detention, care or treatment of a forensic patient if satisfied, on the balance of probabilities, that he or she has breached a condition of release; conduct a review of the person's case as soon as reasonably practicable after the person is apprehended; and make a determination as to the person's detention or release.

Recommendation
MHCC recommend Option 2 which provides clear mechanisms and represents a tempered response.

Termination of forensic patient status

Option 1
Retain the current provisions for termination of forensic patient status.

Option 2
Amend the legislation to consolidate the provisions dealing with termination of forensic patient status, and provide that it terminates upon the earlier of:

a. the expiry of a limiting term
b. unconditional release
c. the expiry of any conditions of release
d. in the case of transferees, release on parole or the expiry of the term of imprisonment.

Recommendation
MHCC support Option 2 as an amendment to the legislation.

A related issue: bail

Option 1
Retain the current provisions.

Option 2
Amend the legislation to clarify the powers to make recommendations and orders concerning a person who is granted bail after being found unfit.

Recommendation
That Option 2 is reflected in the amended legislation.

Section 11

Victims of crime

Discussion

During consultations, 'victim'[13] interests were undoubtedly the area in which there was most disagreement. Many of those consulted prefer to refer to 'victims' as 'aggrieved stakeholders' who have experienced extreme grief and loss, who have been impacted by an incident during which an offence was committed without malicious intent or understanding of wrongdoing.

Much of the argument centres around the participation of an 'aggrieved stakeholder' in a process where an acquittee with NGMI status; persons found unfit to be tried and those set a limiting term of imprisonment following an unfitness ruling under the the *Mental Health Act 1990,* and the *Mental Health (Criminal Procedure) Act 1990).*

It was felt by many that 'victim' advocacy and support organisations fail to promote de-stigmatising education and understanding of mental health issues. In response to supporting victims (who frequently feel, with good reason, frustrated and unheard) they encourage clients to use the judicial process to vent their anger and grief.

Whilst the law states that judges' determinations should not be affected by victim impact statements, we understand that the court process is frequently 'high-jacked' by lengthy vilifications and protracted emotional outpourings. The emotive nature of these statements often renders expert evaluation worthless and can hardly fail to impact on a final judgement.

The principles of victim participation were developed outside of the forensic context, and we suggest that attention be paid to these unique circumstances. It is entirely inappropriate that aggrieved stakeholders' judgement on culpability or assessment of evidence regarding recovery and rehabilitation involving people under the Act be considered as relevant to evidence presented at hearings.

The view expressed during consultations was that court was not a suitable environment in which to address victims' needs or provide a place for 'catharsis.' More enlightened and expanded support and counselling services must be offered to victims in the community on a basis that enables them to feel that their needs are being appropriately addressed.

[13] The term 'victim' used in inverted commas is presented as such because some stakeholders question the language used in this context. Since no sentence has been handed down, and no crime committed some view the 'victim' is one of several interested stakeholders in the event's outcome, as opposed to 'victim' of crime.

However, MHCC feel that registered victims must have an opportunity to be heard. In the context of legislative reform to the model, processes must be formalised. We suggest that rather than in person presentations, victims may provide written submissions to the MHRT or to the Attorney general on appeals.

It is particularly important that during the Tribunal process confidentiality is maintained. The media take great interest in hearings involving victims and frequently display few scruples in publishing identifying details. We understand that to date the Attorney General has done little to respond to complaints about such breaches.

MHCC are unclear as to whether the following options relate to pre-tribunal processes or are intended to cover all hearings and reviews. The MHRT have done much to balance the process and provide an opportunity for victims to be heard. In view of the different models under discussion as alternatives to Executive Discretion, we feel it is necessary to provide much more detail as to how the administrative framework would differ under the various models. Nevertheless, we attempt to comment on the following:

Option 1
Retain the current administrative framework for dealing with victims of crime within the forensic mental health system.

> We assume that in the event of the removal of Executive Discretion that the current framework will have to be amended in the legislation.

Option 2
Amend the legislation to provide for the courts to receive victim impact statements when considering the imposition of a limiting term or release, and at any hearing of the determining body which might result in an order for leave or release of the patient.

> MHCC assume that this relates to the pre-Tribunal process and understand that these arrangements are fundamentally in place. These arrangements may need to be formalised.

Option 3
Amend legislation to provide that registered victims may apply to the determining body for notification and non-contact orders in relation to a forensic patient.

> MHCC suggest that this option be incorporated into Option 2.
> When this legislation is enacted policy writers need to note that the MHRT needs to work with these groups to offer education and training packages.

Option 4
Adopt Option 2 but extend to family victims, as defined in the *Crimes (Sentencing Procedure) Act 1999 (NSW).*

> For the purposes of MHCC members reading this submission to make our comment clear we explain that the identification of persons who are victims for the purposes of this Act, include:

(i) the determination of the persons who are family representatives of victims, and
(ii) the provision, by persons claiming to be victims, of evidence of their identity and of the circumstances by which they claim to be victims.

MHCC suggest that this option be included together with Option 2 and 3. As advocates

Option 5
Adopt Option 3 but extend to victims as defined in the *Crimes (Sentencing Procedure) Act 1999 (NSW).*

We explain that under the above Act, "victim" of a serious offender means a person whose name is recorded in the Victims Register as a victim of that offender.
"Victims Register" means the register kept under section 256 of the names of victims of offenders who have requested that they be given notice of the possible parole of the offender concerned.
"Victim submission" means a submission made to the Review Council or the Parole Authority, for the purposes of this Act, by a victim of a serious offender.

MHCC suggest that this option be included together with Option 2, 3, and 4.

Recommendation
MHCC support Option 2, 3, 4 and 5 be included in the legislation.

Section 12

Other issues

Inter-judicial arrangements

Option 1
The Minister for Health should take the legislative and administrative action necessary to ensure an effective framework for the inter-jurisdictional transfer of forensic patients, and the inter-jurisdictional application of the legislative provisions.

Option 2
Adopt Option 1 and consider the need for arrangements in relation to forensic patients who may wish to move overseas.

Recommendation
That Option 2 is reflected in the amended provisions of the Act.

Interaction between the legislation

Option 1
Retain the current legislative framework.

> MHCC support Option 1.

Option 2
Consolidate forensic mental health legislation into a new stand-alone piece of legislation.

> MHCC do not want to see a stand-alone piece of legislation, but for forensic matters to continue to operate within the mental health provisions.

Option 3
Consolidate forensic mental health legislation by transferring the provisions of Chapter 5 of the *Mental Health Act 1990 (NSW)* into the *Mental Health (Criminal Procedure) Act 1990 (NSW).*

> MHCC strongly recommend that the forensic provisions remain within the *Mental Health Act 2006,* so that the legislation supported by the Human Rights, Objects and Principles of the Act, service delivery standards and guidelines remain focused on mental health service provision and distanced from criminal procedures, except when absolutely necessary.

Recommendation
MHCC support Option 1 to keep forensic provisions within the *Mental Health Act 2006.*

Conclusion

MHCC would like to commend the NSW Government for undertaking a review of the forensic provisions of the *Mental Health Act 2006,* and particularly for acknowledging the need to review Executive Discretion. We also congratulate the Hon Greg James QC for the objectively and clarity with which the paper was presented.

However, we comment that that the consultation paper review did not attempt to look comparatively at jurisdictions outside of Australia. Our understanding is that we have a lot to learn form forensic reforms in Canada or Scotland for example, and would have welcomed a less parochial view of the matters under discussion. We also feel that in view of the momentous changes being contemplated to the model of a determining hierarchy, that on some issues, how a new system might interpret options presented was no longer clear.

There is no reference in the consultation paper as to how legislation will provide for families of forensic patients (in the context of the new forensic hospital to be built at Long Bay) who may be impacted by the forensic status of an acquittee.

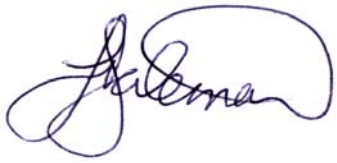
Provision needs to be developed that encourages normalcy of relationships in 'the least restrictive environment,' in which attachment to children and family may be maintained.

In the light of our understanding as to how the system works in practice, we suggest that the issue of victim participation was somewhat misrepresented or misunderstood. The consultation paper needed to discuss philosophical principals crucial to our thinking as a democratic and humane society with regard to people with a mental illness, PWID and the discriminatory and stigmatising practices entrenched in the current legislation.

.In conclusion, MHCC state the system as its stands precludes patients release even when it has been assessed as clinically appropriate that release be approved.[14] We propose that a review of criminal procedure and diversionary alternatives be undertaken that will lead to the establishment of appropriate services in the community that enable a forensic patient to be managed under a gradual 'step-down' process that provides care in the least restrictive environment.

MHCC thank the Hon Greg James QC and the Taskforce for their interest in the views of MHCC and its members and express our willingness to be involved in future consultations related to the forensic provisions.

Please address any further inquiries about this submission to Corinne Henderson, Senior Policy Officer, corinne@mhcc.org.au or telephone: 9555 8388 ext 101.



Jenna Bateman
Executive Officer

[14] Boyd-Caine, Tessa & Chappell, Duncan. (2005).'The Forensic Patient Population in New South Wales. Current Issues in Criminal Justice 17(1), p. 26.