

Chapter Three

Mental Impairment Court Intervention Programs



Contents

Introduction	91
Types of Mental Impairment	91
Mental illness or disorder	91
Personality disorder	91
Intellectual disability	92
Acquired brain injury	92
Terminology	92
Mental Impairment and the Criminal Justice System	94
Mental Impairment and the Law: An Historical Perspective	94
Deinstitutionalisation and criminalisation of the mentally ill	94
Mental Impairment and Offending Behaviour	94
Serious and violent offending	94
Minor offending and frequency of arrest	95
Combination of problems presenting in most offenders	96
Mental Impairment and Prison	97
Is prison the right place for the mentally impaired?	97
Mental Impairment Court Intervention Programs	99
South Australia – Magistrates Court Diversion Program	99
Program operation	99
Eligibility criteria	100
Referral and court process	100
Powers of the court and program outcomes	101
Tasmania – Mental Health Diversion List	101
Program operation	101
Eligibility criteria	102
Referral and court process	102
Powers of the court and program outcomes	103
Queensland – Special Circumstances List (Homeless Persons Court Diversion Program)	103
Program operation	104
Eligibility criteria	104
Referral and court process	104
Powers of the court and program outcomes	105
Western Australia – Intellectual Disability Diversion Program	105
Program operation	105
Eligibility criteria	105
Referral and court process	106
Powers of the court and program outcomes	107
Consultation Issues	108
Benefits of Mental Impairment Court Intervention Programs	108
Addressing underlying causes of offending behaviour	108
Improving outcomes	108
Improving efficiency of the court process	109
Operation of Mental Impairment Court Intervention Programs	110
Eligibility criteria	110
Should offenders with personality disorders be excluded?	110
Seriousness of the offence	110
Voluntariness	111
Need for affiliated services and appropriate resourcing	112
The Commission's Preliminary Proposals for Western Australia	112
Establish a Mental Impairment Court Intervention Program	113
Expansion of the Intellectual Disability Diversion Program	115
Addressing offender mental health issues in regional areas	116

Introduction

Mental health relates to emotions, thoughts and behaviours. A person with good mental health is generally able to handle day-to-day events and obstacles, work towards important goals, and function effectively in society. However, even minor mental health problems may affect everyday activities to the extent that individuals cannot function as they would wish, or are expected to, within their family and community.¹

It is estimated that one in five Australian adults will experience a mental illness at some time in their life,² while long-term cognitive impairments (such as intellectual disability and acquired brain injury) affect approximately 5% of the adult population.³ Mental health problems represent a significant burden on social and economic resources and are 'one of the leading causes of non-fatal ... disease and injury in Australia'.⁴ Mental impairment is also associated with increased exposure to health risk factors (such as suicide, substance abuse and decline in physical health)⁵ and social risk factors (such as homelessness, unemployment, family breakdown and social exclusion). These problems can combine to bring the mentally impaired into contact with the criminal justice system and to place them at a disadvantage within that system.⁶ This chapter will explore the ways in which court intervention programs have developed to assist this group of offenders in their dealings with the criminal justice system and to address the underlying causes of their offending behaviour.

TYPES OF MENTAL IMPAIRMENT

Mental illness or disorder

Mental disorders can range from short-term anxiety or depression to long-term psychotic disorders such as schizophrenia. The 1997 *National Survey of Mental Health and Wellbeing of Adults* found that the most prevalent (professionally diagnosed) mental disorders are anxiety disorders (eg, agoraphobia, social phobias, obsessive-compulsive disorder and post-traumatic stress disorder), followed by affective disorders (eg, depression, dysthymia, bipolar affective disorder and hypomania).⁷ Psychotic and delusional disorders, such as schizophrenia and substance-induced psychoses, are considered to be 'low prevalence' disorders.⁸ Psychotic illnesses cause sufferers to perceive the world differently from reality; typically sufferers will experience delusions, hallucinations, disorganised thought processes, irrational fear and confusion.

Personality disorder

Personality disorders refer to enduring patterns of maladaptive or harmful behaviour in an individual, which generally impair social, occupational and emotional functioning, as well as impulse control.⁹ Onset of a personality disorder can usually be traced back to childhood or adolescence and is often in consequence of a devastating experience.¹⁰ People with personality disorders exhibit behaviour that cannot otherwise be explained as manifestations or symptoms of a mental illness or brain injury.¹¹ Their behaviour is generally ego-syntonic; that is, they do

1. Australian Bureau of Statistics (ABS), *Mental Health and Wellbeing: Profile of adults 1997* (Canberra: ABS, 1998) 1.
2. Ibid.
3. According to the most recent national statistics, intellectual disability affects 2.7% of the adult population, while acquired brain injury affects 2.6% of the adult population. It should be noted that because of similarities in cognitive dysfunction in some instances there is some potential for these statistics to overlap making the combined statistic less than 5%; however, there is also potential for brain injuries acquired through stroke and other non-traumatic means to be counted under a different disability category. ABS, *Disability, Ageing and Carers: Disability and long term health conditions* (Canberra: ABS, 2004) table 6; Australian Institute of Health and Welfare (AIHW), *Disability in Australia: Acquired brain injury*, Bulletin No. 55, (Canberra: Australian Institute of Health and Welfare 2007) table 1.
4. AIHW, *Australia's Health 2006: The tenth biennial health report* (Canberra: AIHW, 2006) 97.
5. Ibid.
6. Bernstein R & Seltzer T, 'Criminalization of People with Mental Illnesses: The role of mental health courts in system reform (2003) 7 *University of District Columbia Law Review* 143, 143; Karras M et al, *On the Edge of Justice: The legal needs of people with a mental illness in NSW* (Sydney: Law and Justice Foundation of New South Wales, 2006) xvi.

7. ABS, *Mental Health and Wellbeing: Profile of adults 1997* (Canberra: ABS, 1998) 18. These results were mirrored in the 2004–2005 National Health Survey; however, respondents to that survey were not required to have been diagnosed by a health professional. It should be noted that the ABS survey counted substance use disorders—that is, harmful use of, or dependence on, drugs or alcohol—as a relevant mental health problem. Substance use disorders ranked third-most prevalent behind anxiety and affective disorders.
8. Jablensky A et al, *People Living with Psychotic Illness: An Australian study 1997–1998* (Canberra: National Survey of Mental Health and Wellbeing, 1999).
9. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th text revised ed., 2000) ('DSM-IV'), reproduced in Sadock J & Sadock V, *Kaplan and Sadock's Synopsis of Psychiatry* (Philadelphia: Lippincott Williams & Wilkins, 9th ed., 2003) table 27-1.
10. Though it is noted that there are some people who have a genetic predisposition to personality disorders, particularly antisocial, borderline, narcissistic and histrionic personality disorders. Sadock & Sadock, *ibid* 800.
11. Ibid, table 27-1.

not perceive a problem with their behaviour or feel anxiety about how their behaviour affects others.¹²

There are a number of different types of personality disorder,¹³ but borderline and antisocial personality disorders are those most often associated with offending behaviour.¹⁴ People with borderline personality disorder have frequent and severe mood swings (including short-lived psychotic breaks) and their behaviour can be highly unpredictable.¹⁵ They often have difficulty maintaining relationships and controlling their anger, and they frequently exhibit impulsive self-harming behaviour (including suicidal ideation, self-mutilation, substance abuse, binge eating, promiscuity and reckless driving).¹⁶ Antisocial personality disorder is characterised by a history of antisocial, non-conformist and criminal behaviour beginning in childhood.¹⁷ Previously referred to as sociopaths or psychopaths (for those with severe forms of the disorder), these people often present as articulate and charming while masking deceitful behaviour, rage and anxiety.¹⁸ Sufferers of antisocial personality disorder do not adhere to moral codes and have a notable lack of either conscience or remorse.¹⁹

Intellectual disability

Intellectual disability (sometimes known as mental retardation) describes a condition of 'arrested or incomplete development of the mind, which is especially characterised by impairment of skills manifested during the developmental period, which contribute to the overall level of intelligence, ie cognitive, language, motor and social abilities'.²⁰ Generally, this is understood to refer to an individual with below average cognitive functioning (indicated by an intelligence quotient (IQ) of 70 or less) and associated deficits in adaptive behaviour (the practical, conceptual and social skills of daily

living).²¹ It is important to stress that clinical definitions of intellectual disability require the onset of the disability to have occurred during the developmental period – that is, before the age of 18 years.²² This is a primary distinction between developmental intellectual disabilities and acquired intellectual disabilities, which are usually caused by brain injury.

Acquired brain injury

Acquired brain injury is a term used to describe an injury caused by severe head trauma, substance abuse, stroke, brain infections, brain tumours or other causes that lead to deterioration of the brain or reduced oxygen supply to the brain.²³ Acquired brain injury 'may lead to intellectual and adaptive deficits such that the person would be classified by a psychologist as having an intellectual disability'.²⁴ However, as the New South Wales Law Reform Commission (NSWLRC) point out, there is a distinction in many health and human services areas between intellectual disability and brain injury 'because their needs and the best management approach of each group are considered to be different'.²⁵ In Western Australia this difference has significance for funding avenues for specialist support services which can impact upon court intervention program delivery.²⁶

TERMINOLOGY

Although mental illness, personality disorder, intellectual disability and acquired brain injury are quite different (both in nature and aetiology), they are often grouped together for criminal justice purposes. For example, the *Criminal Code* (WA) defines 'mental impairment' broadly as intellectual disability, brain damage, senility or mental illness for the purposes of the 'insanity' defence.²⁷ Throughout this Paper the

12. Ibid.

13. Personality disorders are organised into three clusters by DSM-IV – Cluster A: paranoid and schizoid personality disorder; Cluster B: borderline, antisocial, histrionic and depressive personality disorders; and Cluster C: avoidant, dependent and obsessive-compulsive personality disorder.

14. Antisocial personality disorder is sometimes known as 'Dangerous and Severe Personality Disorder' because of the severity of the disorder (usually in the psychopathic range) and the high risk the sufferer poses to society by virtue of his or her serious antisocial behaviour. See Office of the Chief Psychiatrist (WA), *Report for the Minister for Health and Attorney General on Alternative Detaining Powers in Relation to Persons Diagnosed with Dangerous and Severe Personality Disorder* (24 December 2004) 8.

15. Sadock J & Sadock V, *Kaplan and Sadock's Synopsis of Psychiatry* (Philadelphia: Lippincott Williams & Wilkins, 9th ed., 2003) 809.

16. DSM-IV, reproduced in Sadock & Sadock, *ibid*, table 27-6.

17. Sadock & Sadock, *ibid* 807.

18. Ibid; Ruffles J, 'Diagnosing Evil in Australian Courts: Psychopathy and antisocial personality disorder as legal synonyms of evil' (2004) 11 *Psychiatry, Psychology and Law* 113, 114.

19. Sadock & Sadock, *ibid* 808.

20. World Health Organisation, *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines* (Geneva: World Health Organisation, 1992) 226.

21. DSM-IV, 39.

22. Ibid.

23. New South Wales Law Reform Commission (NSWLRC), *People with an Intellectual Disability and the Criminal Justice System*, Report No. 80 (December 1996) 57–58.

24. Ibid 58.

25. Ibid.

26. For example, some people with acquired brain injury are managed through the health department and others are provided with services funded through the state head injury unit or HeadWest. If a person with an acquired brain injury has severe functional needs (profound or severe core activity limitation) or has a brain injury with intellectual and adaptive deficits acquired prior to age 18, then he or she may also apply for funding (or provision of services) through the Disability Services Commission (DSC). The Intellectual Disability Diversion Program (IDDP) in the Perth Central Law Courts is somewhat restricted by its funding association with the DSC so cannot generally service offenders who have acquired a brain injury in adulthood, despite accompanying intellectual and adaptive deficits. See discussion below under 'Mental Impairment Court Intervention Programs Western Australia – Intellectual Disability Diversion Program'.

27. See *Criminal Code* (WA) s 27. The Commission has previously recommended that the defence be renamed 'mental impairment' (among various other relevant recommendations): LRCWA, *Review of the Law of Homicide*, Final Report, Project No. 97 (September 2007) ch 5.

Commission will use the term 'mentally impaired' to describe the general group of offenders to which mental impairment court intervention programs may usefully apply. However, it is worth noting that some existing court intervention programs discussed in this chapter are limited to certain classes of offenders that make up this broader group (for example, intellectually disabled or mentally ill offenders).²⁸ When discussing these programs, the Commission will refer to the relevant class of offender where it is necessary to make the distinction clear.

28. These limitations are often reflective of policy decisions and are generally based on the source of funding for support services aligned with the relevant program.

Mental impairment and the criminal justice system

MENTAL IMPAIRMENT AND THE LAW: AN HISTORICAL PERSPECTIVE

The civil laws that govern the management of the mentally ill in our communities have not always been treatment-oriented or cognisant of individual rights. According to Alfred Allan, the sole aim of early mental health laws was protection of the family estate. Mentally ill people (and their property) were routinely placed under the control of 'curators' (usually close male relatives) and cared for in the family home or community.¹ Renaissance societies were less tolerant and those afflicted with mental illness or incurable disease were generally sent to isolated places of confinement.² Over time, institutions became dedicated to the detention of the mentally ill with some 18th century laws beginning to regulate certain aspects of detention.³ The celebration of individual rights and scientific method born of the Enlightenment saw mental health problems reconceptualised as treatable illnesses.⁴ In consequence the profession of psychiatry emerged and institutions for the detention of the mentally ill became therapeutic hospitals or 'asylums'.⁵

Deinstitutionalisation and criminalisation of the mentally ill

Deinstitutionalisation describes the 20th century shift away from hospital-based treatment to community-based treatment. The policy of deinstitutionalisation was underpinned by a greater emphasis on patients' human rights and by the development of psychotropic drugs, which could aid the treatment of patients in the community.⁶ The requirements for civil commitment became restrictive and hospitalisation was a last resort, often limited to those considered dangerous.⁷ This led to a significant reduction in psychiatric beds during the late 20th century, but facilities for the management of mentally ill persons in the community were not correspondingly improved.⁸

1. Allan A, 'The Past, Present and Future of Mental Health Law: A therapeutic jurisprudence analysis' (2002) 20(2) *Law in Context* 24, 25.
2. Ibid 26.
3. Ibid. Allan notes that English legislation such as the *Act for Regulating Madhouses 1774* gave low priority to patients' rights; however, inspectors appointed under the Act were tasked with ensuring that no 'sane' people were held in these private institutions.
4. Ibid.
5. Ibid.
6. Ibid 28.
7. Ibid.
8. Ibid. Winick BJ & Wexler DB, *Judging in a Therapeutic Key: Therapeutic jurisprudence and the courts* (Durham: Carolina

These so-called 'criminalisation' of mental illness is widely attributed to the policy of deinstitutionalisation.⁹ Bruce Winick and David Wexler describe the impact that deinstitutionalisation has had on the mentally ill:

The tightening of civil commitment standards and the policy of deinstitutionalization has led to thousands of people with mental illness living in the community. Many of these, released to communities ill-prepared to deal with their continued clinical, social and housing needs, have become homeless. Many refuse to take needed medication in the community, and suffer a re-emergence of their symptoms, often requiring rehospitalisation. Many get into trouble with the police, and are charged with minor offenses like trespassing, urinating in public and petty theft. They are brought to jail, which typically has extremely limited mental health clinical resources. Subjected to the extreme stress of jail detention, they suffer further [deterioration].¹⁰

Mental impairment court intervention programs have emerged in response to the problem of prisons becoming de facto psychiatric institutions.¹¹ They recognise that many mentally ill offenders simply require attention to their treatment and practical needs to arrest the cycle of their offending behaviour.¹²

MENTAL IMPAIRMENT AND OFFENDING BEHAVIOUR

Serious and violent offending

Whether there is any connection between mental disorder and violent offending behaviour has been the subject of longstanding debate and numerous

Academic Press, 2003) 60.

9. See eg, Bernstein R & Seltzer T, 'Criminalization of People with Mental Illnesses: The role of mental health courts in system reform (2003) 7 *University of District Columbia Law Review* 143; Laberge D & Morin D, 'The Overuse of Criminal Justice Dispositions: Failure of diversionary policies in the management of mental health problems (1995) 18 *International Journal of Law and Psychiatry* 389; Luskin ML, 'Who is Diverted? Case selection for court-monitored mental health treatment (2001) 23 *Law and Policy* 217, 218 (and further studies cited therein).
10. Winick BJ & Wexler DB, *Judging in a Therapeutic Key: Therapeutic jurisprudence and the courts* (Durham: Carolina Academic Press, 2003) 59.
11. Commonwealth Parliament, Senate Select Committee on Mental Health, *A National Approach to Mental Health: From crisis to community*, First Report (March 2006) [13.98]. As discussed below under 'Mental Impairment and Prison', some 80% of Australian prisoners are believed to suffer from a mental disorder.
12. Winick BJ & Wexler DB, *Judging in a Therapeutic Key: Therapeutic jurisprudence and the courts* (Durham: Carolina Academic Press, 2003) 59.

studies.¹³ In 2001 Paul Mullen reviewed the existing research with the aim of sustaining 'some broad conclusions about correlations between different forms of mental disorders and a range of offending behaviours'.¹⁴ He found that there was enough evidence to suggest an association between major psychotic and affective disorders and increased rates of offending behaviours.¹⁵ Studies have also associated acquired brain injury or degenerative brain disease (especially when affecting the frontal lobe) with increased risk of violent and aggressive behaviours.¹⁶

However, as Mullen himself warns, it is impossible to rely entirely on many studies undertaken in this area because each is limited, whether by the ideological commitments of researchers, restrictive samples, varying methodologies or narrow investigations.¹⁷ For example, few studies take into account other traditional criminological variables such as social class, employment status, relationship status, age, gender and offending history. Indeed, one New Zealand study found that when social class is included as a factor 'the only specific groups of mental disorders which remained significantly associated with their measures of violent behaviour were the schizophrenias, alcohol dependence and marijuana dependence'.¹⁸

One factor that remains constant in all studies is that drug and alcohol abuse among mentally impaired individuals is the greatest risk factor for violent and aggressive behaviour.¹⁹ Mullen's review found that people with a severe mental disorder (whether psychotic, affective or personality disorders) were significantly more prone to violent types of offending when these disorders coexisted with substance abuse.²⁰

Minor offending and frequency of arrest

The most prevalent offences committed by mentally impaired people appear to be minor offences such as trespass, public transport offences, property damage, shoplifting, disorderly conduct and nuisance offences.²¹ Offending behaviour such as offensive language or conduct and resisting arrest is often a direct manifestation of an individual's mental illness or cognitive impairment, while trespass, theft and transport offences may be manifestations of coexisting problems such as homelessness, indigence or dependence on drugs or alcohol.²²

North American studies have consistently shown that mentally ill individuals are frequently arrested and jailed for 'minor offences for which others are not usually subject to arrest'.²³ Mental disorder has therefore been exposed as a 'critical situational variable' that can influence the decision of police officers to make an arrest.²⁴ An example given by an American mental health court judge is that while a drunk student caught urinating in a public place might simply be told to move along by police, a mentally impaired person who is also exhibiting bizarre or irrational behaviour (such as talking to himself) would usually be arrested.²⁵

So far as intellectually disabled individuals are concerned, a recent Western Australian study found that 'while people with an intellectual disability were no more likely to be arrested than individuals in the general population, after first arrest they were subsequently rearrested at nearly double

13. Mullen PE, *A Review of the Relationship Between Mental Disorders and Offending Behaviours and on the Management of Mentally Abnormal Offenders in the Health and Criminal Justice Services* (Canberra: Criminology Research Council, 2001) 3.
14. Ibid 4.
15. Ibid 44.
16. Mullen PE, *A Review of the Relationship Between Mental Disorders and Offending Behaviours and on the Management of Mentally Abnormal Offenders in the Health and Criminal Justice Services* (Canberra: Criminology Research Council, 2001) 16.
17. Ibid 3 & 17ff.
18. Arsenault L et al, 'Mental Disorders and Violence in a Total Birth Cohort' (2000) 57 *Archives of General Psychiatry* 979, as cited in ibid 18. It should be noted that substance use and dependence disorders are recognised as a mental illness by the DSM-IV, but are not widely viewed as a mental illness in Australia and are excluded from legislative definitions of mental illness.
19. Mullen PE, *A Review of the Relationship Between Mental Disorders and Offending Behaviours and on the Management of Mentally Abnormal Offenders in the Health and Criminal Justice Services* (Canberra: Criminology Research Council, 2001) 17.
20. Ibid 7–8, 11.

21. Magistrates Court Tasmania, *Mental Health Diversion List Procedural Manual* (April 2007) 3; Skrzypiec G, Wundersitz J & McRostie H, *Magistrates Court Diversion Program: An analysis of post-program offending* (Adelaide: Office of Crime Statistics and Research, 2004); Zappelli R & Mellor A, *Evaluation of the Intellectual Disability Diversion Program* (August 2004); NSWLRC, *People with an Intellectual Disability and the Criminal Justice System*, Report No. 80 (December 1996) 32–33.
22. Karras M et al, *On the Edge of Justice: The legal needs of people with a mental illness in NSW* (Sydney: Law and Justice Foundation of New South Wales, 2006) 58–60.
23. Bernstein R & Seltzer T, 'Criminalization of People with Mental Illnesses: The role of mental health courts in system reform' (2003) 7 *University of District Columbia Law Review* 143, 143. See discussion of arrest studies in Lurigio AJ & Swartz JA, 'Changing the Contours of the Criminal Justice System to Meet the Needs of Persons with Serious Mental Illness' (2000) 3 *Criminal Justice* 45, 61ff. The most frequently cited study in this area is Teplin LA, 'Criminalizing Mental Disorder: The comparative arrest rate of the mentally ill' (1984) 39 *American Psychologist* 794.
24. Lurigio & Swartz, ibid. Linda Teplin's study of police-citizen interaction in the United States found that police were acutely aware of non-arrest options for mentally ill or impaired people who had come to their attention because of a manifestation of their mental state. However, they were also aware of the limitations of these options, including the unwillingness of hospitals to deal with comorbid or potentially dangerous individuals: Teplin, ibid 800.
25. The example was offered by Judge Lerner-Wren who presided over the first mental health court in the United States, see Marini RA, *San Antonio Express-News*, 6 May 2002 as cited in Winick BJ & Wexler DB, *Judging in a Therapeutic Key: Therapeutic jurisprudence and the courts* (Durham: Carolina Academic Press, 2003) 60.

the rate compared to non-disabled offenders'.²⁶ Further studies have concluded that intellectually disabled offenders are more than twice as likely to be imprisoned following their first arrest than non-disabled offenders.²⁷

Combination of problems presenting in most offenders

Mentally impaired people commonly present to court with coexisting problems such as homelessness,²⁸ lack of employment,²⁹ poor social or interpersonal skills (leading to behaviour which may be perceived as socially deviant) and social exclusion.³⁰ These problems can compound to make arrest and imprisonment of mentally impaired individuals for minor offences more likely. For instance, if in the earlier example the mentally ill person was homeless, that person may have no option other than to urinate in public. More serious offences committed by mentally ill people, such as burglary, trespass or theft, may also be motivated by homelessness (to find shelter) or poverty (to find food). Homelessness may not only be the underlying cause of the offence, but it may also lead to further disadvantage within the criminal justice system: a lack of accommodation may mean that the offender will not be considered suitable to be released on bail and the offender may end up being remanded in custody.³¹

Comorbidity—that is, the presence of more than one disorder at the same time—is also common among people with mental health problems.³² Comorbidity

can involve a dual diagnosis of mental disorder and cognitive impairment or a combination of mental illnesses. The existence of certain conditions can also predispose a person to other comorbid health problems. For example, post-traumatic depression may lead to alcohol or substance abuse which may, in turn, cause severe physical health problems.³³ In the same way, long-term abuse of psychoactive substances or the psychological stress of serious ill health can cause the onset of certain mental disorders.³⁴

Comorbidity of mental disorders and substance-related disorders is particularly widespread.³⁵ The National Drug and Alcohol Research Centre reports that people suffering comorbid mental illnesses and substance disorders have higher rates of 'severe mental illness and relapse; violence, suicidal behaviour and suicide; infections and physical health problems; social isolation and family/carer distress; homelessness; antisocial behaviour; and imprisonment'.³⁶ Further, it has been observed that:

Treatment of substance abuse and mental health disorders is complicated by the fact that alcohol or drugs are often used by mental health consumers to alleviate the stresses of their mental illness, including psychotic systems, depression or to deal with the side effects of medication or the stigma of being mentally ill.³⁷

Because drug courts (including the Perth Drug Court)³⁸ do not usually accept offenders who also have a serious mental health problem,³⁹ mental

26. Cockram J & Underwood R, 'People with an Intellectual Disability and the Arrest Process' (2000) 17(1) *Law in Context* 101, as cited in Cockram J, *Equal Justice?: The experiences and needs of repeat offenders with intellectual disability in Western Australia* (Perth: Activ Foundation Inc, 2005) 7.

27. See discussion in Cockram, *ibid*.

28. In America, homelessness is seen as a symptom of the chronically mentally ill: see Lamb HR, 'Will We Save the Homeless Mentally Ill?' (1990) 147 *The American Journal of Psychiatry* 649; Winick BJ & Wexler DB, *Judging in a Therapeutic Key: Therapeutic jurisprudence and the courts* (Durham: Carolina Academic Press, 2003) 59. In Australia the prevalence of severe mental illness among marginally accommodated people has increased significantly in the past two decades. This has led to the establishment of a special list in Queensland dealing with homeless mentally ill people. See further discussion below under 'Mental Impairment Court Intervention Programs: Queensland – Special Circumstances List'.

29. Mental illness also impacts upon the ability to find and maintain employment. The debilitating effects of some mental illnesses (and the effect of some psychotropic drugs upon the system) can make employment difficult, but there are also issues of stigma and ignorance within a workplace that can make it hard for mentally ill people to get jobs: ABS, *Mental Health and Wellbeing: Profile of adults 1997* (Canberra: ABS, 1998) 9.

30. Many mentally ill people experience difficulty in forming or maintaining personal relationships and this can lead to a breakdown of interpersonal skills and ultimately to isolation from their community. A 1997 study by the ABS found that living arrangements were an important factor in the prevalence of mental disorders and that these were highest for adults living alone: ABS, *ibid* 8.

31. See discussion below under 'Consultation Issues: Improving outcomes'.

32. The ABS study found that 'nearly one in three of those who had an anxiety disorder also had an affective disorder while one in five also had a substance use disorder'. ABS, *Mental*

Health and Wellbeing: Profile of adults 1997 (Canberra: ABS, 1998) 10.

33. A Western Australian study has found that the physical health status of psychiatric patients and the mentally ill is markedly worse overall than that of the general population. Holman D et al, *A Duty to Care: Preventable physical illness in people with mental health problems* (Perth: Centre for Health Services Research, 2001).

34. Gregory RL (ed), *The Oxford Companion to the Mind* (Oxford: Oxford University Press, 1987) 187.

35. Victorian Government Department of Human Services, *Dual Diagnosis: Key directions for service development* (2007) 10.

36. National Drug and Alcohol Research Centre, *Comorbid Mental Disorders and Substance Use Disorders: Epidemiology, prevention and treatment* (Canberra: Commonwealth Department of Health and Ageing, 2003) as cited in *ibid* 11.

37. Commonwealth Parliament, Senate Select Committee on Mental Health, *A National Approach to Mental Health: From crisis to community*, First Report (March 2006) [14.8]. It was also observed that substance abuse can 'alleviate the discomfort of deprivation and homelessness, making it difficult to determine whether mental illness is the cause or the consequence of the substance abuse' [14.10].

38. For example, the *Perth Drug Court Draft Manual* (2007) states: 'An offender who has serious psychopathology or very serious personality problems and psychiatric issues that require ongoing intensive psychiatric or psychological intervention will not be admitted' (27). The definition of 'serious' in this context appears to be left to the court's discretion. Further, the eligibility criteria for drug courts in New South Wales and Queensland preclude offenders who have a 'mental condition which could prevent or restrict the person's active participation in the program': see *Drug Court Act 1998* (NSW) s 5 and *Drug Court Act 2000* (Qld) s 19.

39. There is good reason for this: drug court regimes are extremely demanding and place a high degree of responsibility on the individual. A seriously mentally ill or intellectually impaired person may not be able to respond appropriately to such a regime and the program staff or service providers may not be equipped to manage such an offender.

impairment court intervention programs are typically required to address a mentally impaired offender's substance issues as part of his or her individual intervention plan.⁴⁰

MENTAL IMPAIRMENT AND PRISON

It is now well accepted that the rate of mental health problems in prisoners is disproportionate to the rest of the community. Research published in 2006 using New South Wales prison and community data showed that 80% of prisoners suffered from some form of mental disorder⁴¹ as compared to 31% of the general community.⁴² A 2007 national study found that 'rates of the major mental illnesses, such as schizophrenia and depression, are between three and five times higher in offender populations than those expected in the general community'⁴³ with up to 8% of males and 14% of females in Australian prisons having a 'major mental disorder with psychotic features'.⁴⁴ So far as other mental impairments are concerned, the NSWLRC reported in 1996 that the prevalence of intellectually disabled offenders in prisons was six times greater than that in the broader community.⁴⁵

The proportion of mentally impaired people in prisons is seemingly too high to be solely attributable to any perceived association with significant offending behaviour. As discussed earlier, some mentally impaired people are arrested and imprisoned for relatively minor offences for which a non-mentally impaired person may not be subject to the same treatment. The addition of coexisting problems such as homelessness and substance abuse only increases a person's risk of arrest. Because community residential facilities for mentally impaired people are in very high demand and civil commitment requirements are extremely onerous, there are limited non-custodial pre-trial options for a homeless mentally impaired offender.⁴⁶ As discussed later in

this chapter, magistrates are also confronted with a dilemma when sentencing such offenders because non-custodial dispositions, such as fines and good behaviour bonds, are meaningless where an offender is clearly unable to pay or where the offender will continue to come before the court for fine default or breach of orders.⁴⁷

Is prison the right place for the mentally impaired?

Prison can have a significant detrimental effect on mentally ill and intellectually disabled prisoners. These prisoners are often vulnerable to assault and intimidation by other prisoners⁴⁸ and studies show that they will typically be held for much longer than other prisoners.⁴⁹ Management of the mentally impaired within prison generally follows the dominant correctional culture, with prisoners who are perceived to be difficult isolated from the mainstream population regardless of whether their behaviour is simply 'bad' or stems from a mental illness or intellectual impairment.⁵⁰ There is currently only one hospital unit with 30 secure inpatient beds⁵¹ for mentally ill prisoners in Western Australia and many of these beds are taken by people placed on indefinite custody orders, those declared unfit to stand trial and those referred by courts for psychiatric assessment.⁵² There is therefore no guarantee that a prisoner who is floridly psychotic or manifesting severe symptoms of a mental illness will be able to access a hospital bed – even if he or she is made

as emergency psychiatric detention, were available. With no other community-based options, arrest was found to be only available disposition to address public nuisance behaviour.

40. Data for South Australia's MCDP also confirm a small percentage of participants each year with a *primary* diagnosis of substance-related mental disorder. See discussion Hunter N & McRostie H, *Magistrates Court Diversion Program: Overview of key data findings*, Information Bulletin No. 20 (Adelaide: Office of Crime Statistics and Research, 2001); Courts Administration Authority (SA), *Annual Report 2006–2007* (2007) 23.
41. Including psychotic, personality, anxiety, affective and substance use disorders.
42. Butler T et al, 'Mental Disorders in Australian Prisoners: A comparison with a community sample' (2006) 40 *Australian and New Zealand Journal of Psychiatry* 272, 272.
43. Ogloff JR et al, 'The Identification of Mental Disorders in the Criminal Justice System', *Trends and Issues in Crime and Criminal Justice* No. 334 (Canberra: Australian Institute of Criminology, 2007) 1.
44. Ibid 2. Further, the research showed 'alarming proportions of prisoners with psychotic illnesses who were not being treated prior to committing offences'.
45. NSWLRC, *People with an Intellectual Disability and the Criminal Justice System*, Report No. 80 (December 1996) 25.
46. Teplin LA, 'Criminalizing Mental Disorder: The comparative arrest rate of the mentally ill' (1984) 39 *American Psychologist* 794, 800. Teplin found that police were acutely aware of the onerous requirements for hospitalisation of a mentally ill person and the circumstances in which other dispositions, such

47. See discussion below under 'Consultation Issues: Improving outcomes'.
48. Cockram J, *Equal Justice?: The experiences and needs of repeat offenders with intellectual disability in Western Australia* (Perth: Activ Foundation Inc, 2005) 76.
49. The Western Australian Parole Board reports that mental health issues and the lack of appropriate support services in the community for the mentally impaired are significant factors in determining a prisoner's suitability for release on parole: Western Australian Parole Board, *Annual Report* (2006) 8. Studies in the United States confirm similar problems as the reason for typically longer sentences for mentally impaired individuals. See studies cited in Bernstein R & Seltzer T, 'Criminalization of People with Mental Illnesses: The role of mental health courts in system reform' (2003) 7 *University of District Columbia Law Review* 143, 144; and Luskin ML, 'Who is Diverted? Case selection for court-monitored mental health treatment' (2001) 23 *Law and Policy* 217, 218.
50. Mullen PE, *A Review of the Relationship Between Mental Disorders and Offending Behaviours and on the Management of Mentally Abnormal Offenders in the Health and Criminal Justice Services* (Canberra: Criminology Research Council, 2001) 36. See also evidence given to the Commonwealth Parliament, Senate Select Committee on Mental Health, *A National Approach to Mental Health: From crisis to community*, First Report (March 2006) [13.107]–[13.111].
51. The Frankland Centre at Graylands Hospital.
52. Mahoney D, *Inquiry into the Management of Offenders in Custody and the Community* (Perth: Western Australian Government, 2005) [12.23]. Further, given the amount of mentally disordered offenders in prison, there is a clear need for rehabilitative strategies to reintegrate mentally ill offenders back into the community. Currently there are only 10 minimum-security beds in the Plaistowe Ward at Graylands Hospital designated for this purpose for offenders on custody orders or prisoners on parole.

an involuntary patient under the *Mental Health Act 1996* (WA).⁵³

Australian correctional facilities have been criticised for failure to properly assess mental disorders in offenders upon admission to prison and failure to adequately treat mental disorders while in prison.⁵⁴ The flow-on effects of poor treatment and management of mental disorders in prisons are confirmed by surveys of prisoners post-release. A study of 13,667 released Western Australian prisoners spanning the period 1995–2003 showed mental disorder to be the highest cause of post-release hospital admission among males⁵⁵ and a significant cause of hospital admission among females.⁵⁶ Clearly the detention of mentally ill offenders, especially for minor offences, is not economically sustainable. There is not only the high cost of imprisonment (and complex needs management while in prison), but there is also a significantly higher impact on publicly funded health resources following release. Such impact also logically extends to unemployment benefits since people (and particularly mentally ill people)⁵⁷ can find it extremely difficult to secure employment with any form of prison record. These issues support the need for justice initiatives that enable the diversion of some mentally impaired offenders from the prison system and that enable the underlying causes of offending by mentally impaired offenders to be more effectively addressed.⁵⁸

53. The Inspector of Custodial Services in Western Australia reports that there is 'a distinct element of musical chairs in the occupancy patterns [at the Frankland Centre], with one prisoner often being moved back to prison to make way for another prisoner': Office of the Inspector of Custodial Services, *Thematic Review of Offender Health Services*, Report No. 35 (2006) 26.

54. Ogloff JR et al, 'The Identification of Mental Disorders in the Criminal Justice System', *Trends and Issues in Crime and Criminal Justice* No. 334 (Canberra: Australian Institute of Criminology, 2007) 2. The same criticism has been specifically levelled at Western Australian prisons: Mahoney D, *Inquiry into the Management of Offenders in Custody and the Community* (Perth: Western Australian Government, 2005) [12.31]; Office of the Inspector of Custodial Services, *ibid* 25.

55. This was more prevalent in non-Indigenous males than Indigenous males (whose hospital admissions for mental disorder ranked equally with admissions for injury and poisoning). See Australian Institute of Criminology, 'Crime and Criminal Justice Statistics: Prisoner Health – Morbidity after release from prison' <<http://www.aic.gov.au/stats/cjs/corrections/health.html>> accessed 30 April 2008.

56. For Indigenous females the highest cause of hospitalisation was injury and poisoning, followed by skin diseases and mental disorder. For non-Indigenous females injury and poisoning again ranked highest followed by mental disorder. *Ibid*.

57. As noted by the Law and Justice Foundation (NSW), discrimination in employment is the most common type of discrimination for mentally impaired people: Karras M et al, *On the Edge of Justice: The legal needs of people with a mental illness in NSW* (Sydney: Law and Justice Foundation of New South Wales, 2006) 53–55.

58. As the Commonwealth Parliament's Senate Select Committee on Mental Health has observed, '[t]he need for diversion programs and mental health liaison services becomes clear when the prevalence of mental illness among people who come into contact with the criminal justice system is considered': Commonwealth Parliament, Senate Select Committee on Mental Health, *A National Approach to Mental Health: From crisis to community*, First Report (March 2006) [13.19].

Mental impairment court intervention programs

[P]eople with a mental illness have been identified as among the most vulnerable and disadvantaged in our community. The relationship between mental illness and other forms of social and economic disadvantage make this group of particular interest for [justice initiatives].¹

Mental illness, intellectual disability and acquired brain injury are major public health issues and coexisting problems—such as homelessness, poor physical health, substance abuse and associated crime—can have a high cost on the public purse, as well as a high personal cost for the mentally impaired and their families.² While services are available in the community to assist people to overcome these problems and to receive treatment or support for their mental impairment, access to these services is often inhibited.³ This may be because of lack of knowledge of the existence of, or eligibility for, a service; mistrust of service providers; lack of capacity to seek assistance because of a chronic mental or physical condition; inability to cope with daily interactions or communicate effectively; embarrassment or shame about a mental health problem or intellectual disability; or denial of an underlying mental impairment or substance abuse problem. Court intervention programs are an important means of introducing offenders to services to help them cope with their mental impairment and address other matters that contribute to their offending behaviour.

There are court intervention programs specifically designed for mentally impaired offenders currently operating in South Australia, Western Australia, Tasmania and Queensland. Each of these programs has different features; however, the primary objectives of diverting mentally impaired offenders from prison, linking them with existing community services and seeking to address the problems underlying their offending behaviour are common to each. The characteristics and limitations of each of these programs are discussed below.

SOUTH AUSTRALIA – MAGISTRATES COURT DIVERSION PROGRAM

South Australia's Magistrates Court Diversion Program (MCDP) is the longest-running and most comprehensive Australian program dedicated to diversion of mentally impaired offenders. The aims of the program are to prevent further offending behaviour by providing access to early assessment and interventions that address the particular offender's mental health or disability needs; to assist the court to identify and appropriately manage offenders with mental impairment; and to provide an alternative option for mentally impaired offenders who would otherwise seek to plead the complete defence of 'insanity'.⁴

The MCDP began as a pilot program in the Adelaide Magistrates Court in 1999 and secured recurrent funding in 2001 following an independent evaluation by the Office of Crime Statistics and Research.⁵ Since that time it has undergone another full evaluation showing a marked reduction in post-program offending.⁶ The program is now available in five metropolitan and four regional magistrates courts.⁷ For the year ending 30 June 2007, 269 offenders were accepted onto the program (from a total of 401 referrals) with 228 offenders successfully completing the program.⁸

Program operation

The MCDP operates weekly in the Adelaide Magistrates Court and monthly in four other metropolitan courts. It operates bi-monthly in four regional courts. The program has a manager, an administrative officer

1. Karras M et al, *On the Edge of Justice: The legal needs of people with a mental illness in NSW* (Sydney: Law and Justice Foundation of New South Wales, 2006) 21 (footnotes omitted).
2. Ibid 26.
3. The ABS study found that only 38% of those with mental disorders had used a mental health service in the prior 12 months. Those with a combination of mental disorders were the most likely to access services. ABS, *Mental Health and Wellbeing: Profile of adults 1997* (Canberra: ABS, 1998) 14.

4. See <<http://www.courts.sa.gov.au/courts/magistrates/>> accessed 30 April 2008. The defence of mental impairment is found in the *Criminal Law Consolidation Act 1935* (SA) s 296. The equivalent defence in Western Australia (known as the 'insanity defence') is found in the *Criminal Code* (WA) s 27. The Commission has made a series of recommendations for structural change of the defence in Western Australia and for dispositions consequent upon a successful defence: see LRCWA, *Review of the Law of Homicide*, Final Report, Project No. 97 (September 2007) ch 5.
5. Hunter N & McRostie H, *Magistrates Court Diversion Program: Overview of key data findings*, Information Bulletin No. 20 (Adelaide: Office of Crime Statistics and Research, 2001).
6. Skrzypiec G et al, *Magistrates Court Diversion Program: An analysis of post-program offending* (Adelaide: Office of Crime Statistics and Research, 2004).
7. See <<http://www.courts.sa.gov.au/courts/magistrates/>> accessed 30 April 2008.
8. Courts Administration Authority (SA), *Annual Report 2006–2007* (2007) 23.

and a number of specialist staff including four clinical advisors (psychologists with expertise in forensic and general psychological assessment); and five clinical liaison officers (with backgrounds in social work or human services).⁹ Courts are serviced by teams constituted by a psychologist and (generally) two clinical liaison officers. The program staff are centrally located in Adelaide and travel to courts as required.

Eligibility criteria

The MCDP applies to summary offences and some indictable offences dealt with in the magistrates' jurisdiction. These offences include assault, threatening behaviour, non-aggravated sexual assault, robbery, retail theft, fraud, property damage, drug offences, driving offences and public order offences.¹⁰ There is no formal requirement to plead guilty to an offence to be accepted onto the program; however, the objective facts of the offence should not be under dispute or contested.¹¹ There must be a causal link between the impairment and the offence and the offender must consent to participation in the program.¹² There is no limit to how many times an offender may participate in the program.

The MCDP's psychiatric diagnostic criteria enable it to capture the largest offender population of all like programs in Australia. To be considered for the program an offender must be an adult suffering from impaired intellectual or mental functioning arising from a mental illness, personality disorder, acquired brain injury, intellectual disability or neurological disorder including dementia.¹³ Substance related disorders (including a primary diagnosis substance related disorder) are accepted when diagnosed in conjunction with another form of impaired mental or intellectual functioning.¹⁴ The program's 2006–2007 figures show that the majority of offenders accepted into the program had a primary diagnosis of mental illness (74%) followed by personality disorder (11.5%), intellectual disability (9.7%), acquired or organic brain injury (4.1%) and substance-related disorder (0.4%). The principal mental illnesses were major depressive disorder and schizophrenia.¹⁵

Referral and court process

A person may self-refer to the program or be referred by another person including a police officer, prosecutor, magistrate, lawyer, guardian, service provider or a person known to the offender. The referral is formally activated by the magistrate at the first hearing of the offence. At this time, the program procedures and available justice options are explained to the offender and the offender must consent to participation in the program and to the exchange of information between the court and relevant service providers. If consent is withheld, the person is returned to the normal court process and may pursue a defence under the South Australian equivalent of s 27 of the *Criminal Code* (WA).¹⁶

A preliminary assessment is undertaken by one of the program's psychologists to determine whether the offender has a mental impairment, what his or her treatment needs are and whether participation in the program would be considered beneficial. The assessment involves an examination of relevant hospital case notes, psychiatric assessments, reports from any previous court intervention program contacts, the offender's criminal record and an interview with the offender.¹⁷ Offenders are also generally assessed against the Violent Offender Risk Assessment Scale in order to inform program staff's clinical judgement with regard to risk of acute violence to service providers.¹⁸ A program plan is then drafted in collaboration with service providers. This plan and accompanying reports are presented to the magistrate at the next hearing date at which time the magistrate assesses the legal criteria of the program and determines whether the offender should be accepted onto the program. If accepted, the court proceedings are adjourned for a period of approximately six months¹⁹ to allow the offender to obtain treatment in accordance with the prescribed plan. Participation in the program is a condition of bail.²⁰

The offender is brought back before the magistrate approximately every two months²¹ to monitor compliance with the program and to make any other orders that are required. As with many other court intervention programs the offender sits with his or her legal representative and is addressed directly by the magistrate in a relatively informal fashion. At each review, program staff provide a written report to the court outlining the offender's progress

9. See 'Magistrates Court Diversion Program' <<http://www.courts.sa.gov.au/courts/magistrates/>> accessed 12 March 2008.

10. Skrzypiec G et al, *Magistrates Court Diversion Program: An analysis of post-program offending* (Adelaide: Office of Crime Statistics and Research, 2004) 29.

11. 'Magistrates Court Diversion Program' <<http://www.courts.sa.gov.au/courts/magistrates/>> accessed 12 March 2008.

12. Ibid.

13. This is also reflected in the definition of 'mental impairment' in s 19C of the *Criminal Law (Sentencing) Act 1988* (SA) which provides for particular sentencing outcomes for program participants.

14. Hunter N & McRostie H, *Magistrates Court Diversion Program: Overview of key data findings*, Information Bulletin No. 20 (Adelaide: Office of Crime Statistics and Research, 2001) 9.

15. Courts Administration Authority (SA), *Annual Report 2006–2007* (2007) 23–24.

16. 'Magistrates Court Diversion Program' <<http://www.courts.sa.gov.au/courts/magistrates/>> accessed 12 March 2008.

17. Sue King, Manager Specialist Sentencing Courts (SA), email communication (26 March 2008).

18. Ibid.

19. Deferral of sentence for rehabilitation and other purposes is permitted for up to 12 months (or more in certain circumstances): *Criminal Law (Sentencing) Act 1988* (SA) s 19B(2).

20. *Bail Act 1985* (SA) s 21B.

21. However, a magistrate may order more frequent court appearances if necessary.

on the program. The report is compiled by the program's clinical liaison officers who are responsible for implementing the program plan and gathering information from the service providers regarding the offender's compliance with the program.²² During the review the magistrate invites the offender to comment on his or her progress and whether he or she is experiencing any problems on the program.²³ The clinical adviser (psychologist) is present in court to assist the magistrate if required.

At the second review (approximately four months into the program) the magistrate will indicate when the offender must return to court for finalisation of the matters. This is usually set at a period of six months from commencement on the program.²⁴ At the finalisation stage, program staff provide a final written report to the court summarising the offender's progress and any issues relevant to the final determination of the matter (including the need for ongoing support or treatment). At this stage the offender is required to plead guilty to the offences (if he or she has not already done so) and the magistrate makes a determination taking into account the offender's successful participation in the program. However, failure to satisfactorily complete the program is not relevant to sentencing.²⁵

Powers of the court and program outcomes

In 2005, South Australia enacted provisions giving magistrates special powers for dealing with a mentally impaired offender who has participated in the program.²⁶ Under s 19C of the *Criminal Law (Sentencing) Act 1988* (SA):

A court that finds a defendant guilty of a summary or minor indictable offence may release the defendant without conviction or penalty if satisfied—

- (a) that the defendant—
 - (i) suffers from a mental impairment that explains and extenuates, at least to some extent, the conduct that forms the subject matter of the offence; and
 - (ii) has completed, or is participating to a satisfactory extent in, an intervention program; and
 - (iii) recognises that he or she suffers from the mental impairment and is making a conscientious attempt to overcome behavioural problems associated with it; and
- (b) that the release of the defendant under this subsection would not involve an unacceptable

risk to the safety of a particular person or the community.²⁷

The court may also dismiss the charge 'at any time before the matter has been finally determined' if satisfied to the same extent and if there would be no compensation payable if a finding of guilt were made.²⁸ In deciding whether to exercise its powers under s 19C, the court 'may act on the basis of information that it considers reliable without regard to the rules of evidence'.²⁹ It may also consider information about the interests of any victims or possible victims.

When the Commission attended the MCDP in Port Adelaide in November 2007, it saw a number of different court outcomes for offenders who had successfully completed the program. These ranged from dismissal of charges under s 19C to suspended sentences with lengthy good behaviour bonds and supervision orders with treatment, program attendance³⁰ and counselling conditions. Statistics for 2006–2007 show that dismissal was the most common outcome for an offender who had completed the MCDP (28.1%) followed by supervised bond (20.6%), suspended sentence (18%) and other orders. A term of imprisonment was imposed in 1.8% of cases and 6.6% were returned to the general magistrates court for sentencing.³¹

TASMANIA – MENTAL HEALTH DIVERSION LIST

The Mental Health Diversion List (MHDL) in the Tasmanian Magistrates Court is the newest mental impairment court intervention program in Australia. It was established as a 12-month pilot program in late May 2007 in an effort to improve the efficiency of court processes and reduce reoffending in the mentally impaired offender group.

Program operation

The MHDL is heard once per month in the Hobart registry of the Tasmanian Magistrates Court. It is staffed by a Forensic Mental Health Court Liaison Officer³² and has a dedicated magistrate. Police prosecutions and Legal Aid also play an important role in the running of the program. Approximately 65 offenders have participated in the program over the 10 months since its inception.³³ Because the program is still in its 12-month pilot stage there has not been

22. Clinical liaison officers generally only meet face-to-face with the offender on the day of each review hearing, at which time they are available to discuss any concerns and provide any further advice to the court.

23. 'Magistrates Court Diversion Program' <<http://www.courts.sa.gov.au/courts/magistrates/>> accessed 12 March 2008.

24. Ibid.

25. *Criminal Law (Sentencing) Act 1988* (SA) s 10(6).

26. *Statutes Amendment (Intervention Programs and Sentencing Procedures) Act 2005* (SA). Prior to this time many matters were dealt with by withdrawal of charges after successful completion of the program.

27. *Criminal Law (Sentencing) Act 1988* (SA) s 19C(1).

28. *Criminal Law (Sentencing) Act 1988* (SA) s 19C(2).

29. *Criminal Law (Sentencing) Act 1988* (SA) s 19C(4).

30. Such as victim awareness and drug rehabilitation programs.

31. Courts Administration Authority (SA), *Annual Report 2006–2007* (2007) 25.

32. This position is currently staffed on a job-share basis. The officers have backgrounds in psychiatric nursing and occupational therapy.

33. Marita O'Connell, Forensic Mental Health Court Liaison Officer, Hobart Magistrates Court, telephone consultation (17 March 2008).

any formal evaluation of its operation; however, staff report only one instance of (very minor) reoffending whilst on the program.³⁴

Eligibility criteria

When compared to the South Australian program, the MHDL appears to have quite restrictive psychiatric diagnostic criteria. To be eligible for the program an offender must be an adult with impaired intellectual or mental functioning arising from a 'mental illness' as defined in s 4 of the *Mental Health Act 1996* (Tas):

Meaning of 'mental illness'

- (1) A mental illness is a mental condition resulting in –
 - (a) serious distortion of perception or thought; or
 - (b) serious impairment or disturbance of the capacity for rational thought; or
 - (c) serious mood disorder; or
 - (d) involuntary behaviour or serious impairment of the capacity to control behaviour.
- (2) A diagnosis of mental illness may not be based solely on –
 - (a) antisocial behaviour; or
 - (b) intellectual or behavioural nonconformity; or
 - (c) intellectual disability; or
 - (d) intoxication by reason of alcohol or a drug.

The program therefore excludes intellectually impaired and acquired brain injured offenders if they do not have a coexisting mental illness as defined by the Act. The position of offenders with a primary diagnosis personality disorder is unclear, though a severe personality disorder or dual diagnosis offender would probably fall within the meaning of mental illness for the purposes of the program.³⁵ The majority of offenders accepted on the program are schizophrenic with psychotic features.³⁶

The legal criteria of the MHDL restrict the program's operation to summary offences, but exclude sexual offences, offences that attract mandatory disqualification of a drivers licence, and family violence offences.³⁷ Like the South Australian program, there is no formal requirement that the offender plead guilty; however, the 'court needs to know that the matter is not under dispute nor likely to be contested'.³⁸ Contrary to the information in the MHDL procedure manual, the Commission is informed that the program does divert offenders who might otherwise seek to rely on the complete defence of insanity under s 16 of the *Criminal Code*

(Tas).³⁹ Because indeterminate detention remains an option in Tasmania (as in Western Australia) for an offender found not guilty on account of unsoundness of mind, the MHDL would appear to be an attractive alternative for minor offences.⁴⁰

Referral and court process

Applications for referral to the MHDL may be made by various sources including the offender, police, prosecution, defence lawyer, service providers and those with 'a genuine interest in the welfare of the [offender]'.⁴¹ Applications are encouraged at the first appearance, but may be made at any time prior to finalisation of a matter. When considering an application for referral to the program a magistrate may take into account the nature of the charges, the wishes of the complainant and the opinion of court-based service providers.⁴² Before an offender is referred to the list the court must obtain the offender's written consent.⁴³

An offender is usually assessed by the court's Forensic Mental Health Court Liaison Officer⁴⁴ before the date of the offender's first appearance before the MHDL magistrate.⁴⁵ The assessment involves determination of the offender's suitability for the program and the drafting of a proposed treatment plan in consultation with the offender and relevant service providers.⁴⁶ If the offender is accepted by the court he or she will be bailed on conditions which reflect the agreed program plan.⁴⁷ All offenders accepted onto the program are represented under an agreement with Legal Aid.

Stakeholders including the offender, defence lawyer and police/prosecutor are involved from the outset to establish a goal, in the form of a desired court outcome, for the offender to work towards.⁴⁸ For

34. Ibid.

35. Indeed, the program has included a small number of personality disordered dual diagnosis offenders and has achieved some success in linking these offenders to services and addressing offending behaviour. Ibid.

36. Ibid.

37. Magistrates Court Tasmania, *Mental Health Diversion List Procedural Manual* (April 2007) 5.

38. Ibid 7.

39. Marita O'Connell, Forensic Mental Health Court Liaison Officer, Hobart Magistrates Court, telephone consultation (17 March 2008).

40. *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 21.

41. Ibid 6.

42. Such as Forensic Mental Health Services. Ibid 6–7.

43. If necessary, the court will adjourn to allow the Forensic Mental Health Court Liaison Officer to consult with the offender for this purpose.

44. The Court Liaison Officer is a trained psychiatric nurse or occupational therapist experienced in the provision of forensic mental health services. An offender will not be independently assessed by a psychiatrist or psychologist unless hospitalisation is deemed necessary as part of the program or a psychiatric report is required by the court. Many offenders have a pre-existing relationship with Forensic Mental Health Services and have been previously diagnosed with a mental illness.

45. If the offender has not been fully assessed prior to his or her first appearance before the MHDL magistrate, proceedings are adjourned to allow a preliminary assessment to be made and verbally communicated to the court.

46. Magistrates Court Tasmania, *Mental Health Diversion List Procedural Manual* (April 2007) 9–10.

47. Treatment plans are tailored to each individual and their offending behaviours but will typically require attendance at mental health services appointments, taking of prescribed medication, attending rehabilitation or undertaking volunteer work or training programs.

48. Marita O'Connell, Forensic Mental Health Court Liaison Officer, Hobart Magistrates Court, telephone consultation (17 March 2008).

more serious offences or for offenders with an established offending history the focus will usually be avoiding imprisonment or a fine; for first offenders or those whose offending is aberrant it will be avoiding a criminal conviction. The prosecutor plays an important part in this process and is sufficiently senior to approve projected outcomes on behalf of the state. The magistrate is usually advised of the reasons for the offender's participation and his or her expectations of the program at the first appearance.⁴⁹ This may form the basis of a sentence indication given to the offender in court.

Over the course of the program the Court Liaison Officer monitors the offender's progress through liaison with service providers and meetings or telephone contacts with the offender. Case conferences attended by the prosecutor, defence and the Court Liaison Officer are held the week prior to the list date to discuss each appearing offender's participation in the program.⁵⁰ Offenders attend court for judicial monitoring as deemed appropriate, with most being reviewed on a monthly basis. Verbal reports detailing the offender's progress on the treatment plan are provided to the court at each court review and any necessary adjustments to the program are made at this time. During the review the offender receives verbal encouragement from the magistrate or, if the offender is non-compliant, verbal sanctions may be given.⁵¹ An offender who is non-compliant or not suitably progressing in the program can be excluded from further participation and returned to the general list.⁵²

Powers of the court and program outcomes

The matter is usually finalised at a court review held four to six months after the offender commences the program.⁵³ If the offender has complied with the treatment plan and has participated well the magistrate will generally impose an order on the basis of the agreed outcome. This can involve inviting the prosecution to consider withdrawing the charges. However, the court also has access to a broad range of sentencing options available under s 7 of the *Sentencing Act 1997* (Tas). Apart from fines and imprisonment these include a conditional bond of up to five years duration, dismissal of the charges and a variety of non-conviction orders.

49. Complainants are also informed of the offender's participation in the program and the projected outcome. According to the Court Liaison Officer, complainants appreciate this contact and understand the offender's behaviour and the diversion process better as a result. Ibid.

50. Service providers treating the offender will usually provide a written report to the Mental Health Court Liaison Officer detailing how the offender is progressing with treatment and whether any changes to treatment conditions are required.

51. Magistrates Court Tasmania, *Mental Health Diversion List Procedural Manual* (April 2007) 12–13.

52. Ibid.

53. Ibid.

QUEENSLAND – SPECIAL CIRCUMSTANCES LIST (HOMELESS PERSONS COURT DIVERSION PROGRAM)

Homelessness is a serious problem in Australia and several studies have confirmed that a high proportion of Australia's homeless suffer mental health problems or severe cognitive impairment.⁵⁴ As discussed earlier, homelessness is a significant context for public order or nuisance type offending, and homeless mentally ill people are more vulnerable to arrest for behaviour associated with their illness because such behaviour is necessarily public.⁵⁵ Justice initiatives have developed in Melbourne⁵⁶ and Queensland to address the problem of mounting fines (and consequent imprisonment) for public order offences given to homeless, mentally ill offenders.

The Special Circumstances List ('the list') began in May 2006 as an offshoot of the Homeless Persons Court Diversion Program in the Brisbane Magistrates Court.⁵⁷ This program provides a diversionary option for homeless people charged with public order or nuisance type offences, while the list caters for homeless offenders with coexisting mental health problems or substantial intellectual impairment. The list began in May 2006 as a 12-month pilot program funded from within the court's budget. The program was evaluated in 2007 (although this evaluation has not yet been publicly released) and it has been extended to June 2008. As of March 2008 there had been a total of 621 referrals to the program⁵⁸ with 348 offenders participating in the program. Of these offenders 20% were intellectually disabled, 44% had mental health issues and 3% had acquired brain injury.⁵⁹ Over half the participants had substance

54. See eg, Herrman H et al, 'Prevalence of Severe Mental Disorders in Disaffiliated and Homeless People in Inner Melbourne (1989) 146 *American Journal of Psychiatry* 1179; Teeson M et al, 'Psychiatric disorders in Homeless Men and Women in Inner Sydney' (2004) 38 *Australian and New Zealand Journal of Psychiatry* 162; Herman H et al, 'Disability and Service Use Amongst Homeless People Living with Psychiatric Disorders' (2004) 38 *Australian and New Zealand Journal of Psychiatry* 965.

55. Walsh T, 'The Queensland Special Circumstances Court' (2007) 16 *Journal of Judicial Administration* 223, 224. For further discussion of homelessness and the criminal justice system, see 'Homelessness', Introduction.

56. Melbourne Magistrates Court's Enforcement Review Program is not discussed in this chapter because it is a sentence-based program which does not feature judicial monitoring of the type included in the Commission's terms of reference and defined in the Introduction to this Paper.

57. The Homeless Persons Court Diversion Program began as a six-month Legal Aid funded pilot program in early 2005. It was given limited departmental funding for continuation on a weekly basis in June 2005. In May 2006 it began daily operation in the Roma Street Arrest Courts with a dedicated court liaison officer funded through the Department of Justice and the Attorney General: Magistrates Court (Qld), *Annual Report 2005–2006* (2006) 75.

58. At a rate of approximately 30 referrals per month.

59. Philip Macey, Homeless Persons Court Liaison Officer, Brisbane Magistrates Court, telephone consultation (25 March 2008).

use issues including some with a dual diagnosis of mental and drug and alcohol disorders.⁶⁰

Program operation

The list runs on a weekly basis out of the Roma Street Arrest Court in Brisbane. It has a dedicated magistrate and uses the coordination and assessment services of the Homeless Persons Court Liaison Officer.⁶¹ A special prosecutor is assigned to the court and offenders are generally represented by Legal Aid or the Aboriginal and Torres Strait Islander Legal Services.⁶² The program is a bail-based (pre-plea) and sentence-based (post-plea) program.

Eligibility criteria

The list has quite strict eligibility criteria. Firstly the person must be an adult who is homeless within the Chamberlain and Mackenzie definition of primary homelessness (sleeping rough or squatting), secondary homelessness (emergency, hostel or other temporary accommodation) or tertiary homelessness (boarding house residents).⁶³ Secondly, the person must be charged with an 'eligible summary offence' arising from or connected to his or her homelessness. These offences include public order offences (such as public nuisance, begging, wilful exposure, assault police and public drunkenness), procedural offences (such as failure to appear and breach of bail conditions) and minor theft, drug and property offences.⁶⁴ Serious personal violence offences and offences of a sexual nature (except prostitution) are excluded. Thirdly, the offence must have been committed or connected to the Central Division of the Brisbane Magistrates Court District, disqualifying those offenders from the outer-metropolitan area. And finally, the person must *appear* to suffer from 'impaired decision-making capacity as a result of mental health issues, intellectual disability or brain/neurological disorders'.⁶⁵

Offenders must plead guilty or indicate that there is no contest with the charges. They must also consent to assessment for and participation in the program.⁶⁶

Referral and court process

The list takes approximately five referrals per week from various sources including magistrates, police, lawyers, the Mental Health Court Liaison Officer or

the Homeless Persons Court Liaison Officer. Offenders may also self-refer to the program.⁶⁷ Proceedings are adjourned while the Homeless Persons Court Liaison Officer undertakes an assessment against the eligibility criteria. For successful applicants⁶⁸ a report is prepared for the court recommending entry to the program and outlining a diversion plan for the offender. A plan typically includes referral to an accommodation service, participation in a support program and treatment for any mental health or substance abuse problems.⁶⁹

For offenders who have pleaded guilty the program will become a condition of sentence, usually through the means of a recognisance or probation order. These orders are monitored by a community corrections officer and offenders are not returned to court unless the order is breached or periodic court appearances are made a condition of the order.⁷⁰ For those who have indicated no contest, the program becomes a condition of bail. The Court Liaison Officer is responsible for monitoring the offender's compliance with the program conditions and liaising with service providers to assess the offender's progress on the program. The offender is returned to court periodically (usually monthly) at the discretion of the magistrate or at the recommendation of the Court Liaison Officer.⁷¹ The Court Liaison Officer provides a report to the court which outlines the offender's progress in relation to the diversion plan and includes comment on his or her financial and housing situation, drug use, general health and family or relationship issues.⁷² Case conferencing is usually done in open court with all parties (offender, magistrate, prosecutor and defence lawyer) participating.⁷³ Representatives of relevant service providers and the Court Liaison Officer are also present to provide advice or information to the court.⁷⁴ The court emphasises a 'relationship building' approach encouraging communication between offenders, service providers and the court.⁷⁵

Offenders are generally given a number of opportunities to comply with the program and minor breaches are not usually formally actioned (though they are noted in the final report and are taken into account in finalisation of the matter).⁷⁶ An offender who is substantially non-compliant with the program will generally be returned to the normal court process. Bail cannot be revoked simply because of

60. Ibid.

61. The program also has administrative support. Ibid.

62. Some offenders have private representation. Ibid.

63. The Chamberlain and Mackenzie definition is a 'cultural definition' of homelessness adopted by the ABS. It reflects an interpretation of cultural standards in Australia about what is deemed adequate housing. See Chamberlain C & Mackenzie D, *Counting the Homeless 2001* (Canberra: ABS, 2003) 1.

64. Homeless Persons Court Diversion Program and Special Circumstances List Protocol (Queensland: Magistrates Court, October 2006) 2–3.

65. Ibid 4. There is no psychological assessment of offenders.

66. Ibid.

67. Ibid 2.

68. Applicants who are deemed ineligible for the program are returned to the normal court process. Ibid 5.

69. Ibid.

70. Ibid 7.

71. Ibid.

72. Philip Macey, Homeless Persons Court Liaison Officer, Brisbane Magistrates Court, telephone consultation (25 March 2008).

73. Ibid.

74. Ibid.

75. Ibid.

76. Homeless Persons Court Diversion Program and Special Circumstances List Protocol (Queensland: Magistrates Court, October 2006) 2–3.

breach of a program bail condition;⁷⁷ however, it may be varied by rescinding the condition and therefore terminating participation in the program.⁷⁸

Powers of the court and program outcomes

An offender will usually return to court for finalisation of his or her matter after a period of between four and six months.⁷⁹ The Court Liaison Officer will present a final report to the court setting out the achievements of the offender whilst on the program. The aim of the program is to avoid imprisonment for offences (generally offences relating to fine default) and so a successful participant will typically be given a penalty reflecting this aim. Short period good behaviour bonds with a condition of monthly return to court for continued monitoring are often used.⁸⁰ As with other court intervention programs, non-successful participation in the program does not affect sentencing.

WESTERN AUSTRALIA – INTELLECTUAL DISABILITY DIVERSION PROGRAM

The Intellectual Disability Diversion Program (IDDP) was established in the Perth Magistrates Court in July 2003 as a joint initiative by the Department of Corrective Services and the Disability Services Commission (WA). The specific objectives of the program are to reduce recidivism among the intellectually disabled offender group, to reduce the rate of imprisonment by diversion and appropriate dispositions and to generally improve the ways in which the justice system deals with intellectually disabled offenders.⁸¹

Program operation

The IDDP sits each Tuesday afternoon at the Perth Magistrates Court. It has a dedicated magistrate and is staffed by a coordinator (who has extensive experience in the disability and justice area) and a support officer (who is a qualified social trainer). The coordinator is responsible for case management, assessment and reporting⁸² and the support officer

(a new position) is primarily responsible for assisting the coordinator with monitoring the participants. Both positions are funded by the Department of Corrective Services. A 'specialist' mental impairment lawyer was initially provided by Legal Aid; however representation is now generally provided by the Legal Aid duty lawyer, the Aboriginal Legal Service or private defence counsel.

Since its inception in 2003, a total of 112 offenders have been through the program. Almost half of the offenders have coexisting drug or alcohol problems and approximately one-quarter have comorbid mental health problems.⁸³ Currently there are 30 offenders who are either participating in the program or awaiting assessment. Because of the complex needs of the intellectually disabled offender group and the hands-on management style required, this amount of participants is significantly stretching the human resources of the program.⁸⁴ The program was independently evaluated in 2004 after its first 12 months of operation and has secured recurrent funding for program staff through the Department of Corrective Services.

Eligibility criteria

The program's 'target group' is adult offenders with an intellectual disability who are eligible for 'level 3' services with the Disability Services Commission (DSC).⁸⁵ These offenders must meet the strict psychiatric diagnostic criteria for intellectual disability adopted by the DSC.⁸⁶ This includes that

information sessions to external agencies including the police, community corrections, Legal Aid and the Aboriginal Legal Service.

83. Perlinski A & Holder F, 'Small but Beautiful – The Intellectual Disability Diversion Program', presentation to the Disability and Justice Conference, Perth, 13 November 2007. These figures were based on the 83 offenders who had been through the program by November 2007.

84. Amanda Perlinski, IDDP Coordinator, email communication (22 March 2008).

85. The DSC has recently abandoned the 'level 3' description for its services; however, the Commission has found that most service providers still reference DSC provided/funded services for people with an intellectual disability using this term. Services provided by the DSC include individual and family support services and accommodation support. The DSC also funds non-government organisations to provide a range of services to people with intellectual and other disabilities. Each organisation has access criteria specific to the services and programs that they provide. People apply directly to the organisations for services or directly to the DSC for individual funding to purchase services. Francine Holder, A/Principal Policy Officer, Strategic Policy Branch, Disability Services Commission, email communication (11 March 2008).

86. The Commission is advised that the criteria is adopted from the American Association of Mental Retardation (AAMA) and is considered widely accepted: *ibid*. However commentators have observed that the AAMA has 'continuously changed the criterion for the intelligence level over a number of years. It has variously been specified in terms of standard deviations below the mean (either 1 or 2), or in terms of a particular score (either 70 or 75)': Hudson A & Radler G, 'Psychologists and Intellectual Disability' (2005) *InPsych: Journal of the Australian Psychological Society* available at <<http://www.psychology.org.au/publications/inpsych/disability/>> accessed 30 April 2008. For detailed discussion of these concerns, see Macmillan D et al, 'Conceptual and Psychometric Concerns About the 1992 AAMR Definition of Mental Retardation' (1993) 98 *American Journal on Mental Retardation* 325.

77. See *Bail Act 1980* (Qld) s 29(2)(c); s 30(6).

78. Homeless Persons Court Diversion program and Special Circumstances List Protocol (Queensland: Magistrates Court, October 2006) 2–3. For a detailed discussion of the Commission's approach to bail conditions, see 'Bail', Chapter Six.

79. There have, however, been instances of offenders (especially intellectually disabled offenders with complex needs) remaining on the program for up to 12 months: Philip Macey, Homeless Persons Court Liaison Officer, Brisbane Magistrates Court, telephone consultation (25 March 2008).

80. Philip Macey, Homeless Persons Court Liaison Officer, Brisbane Magistrates Court, telephone consultation (25 March 2008).

81. Zapelli R & Mellor A, *Evaluation of the IDDP Project* (2004) 14.

82. The Coordinator is also responsible for running intellectual disability awareness training and providing program

the person has an IQ less than 70, has deficits in adaptive behaviour and that the disability occurred before the age of 18 years. This funding association with the DSC significantly limits the type of offenders that can be accepted onto the program. For example, a person who has a brain injury acquired in adulthood is not eligible for DSC services, despite accompanying intellectual and adaptive deficits. The IDDP coordinator has advised the Commission that with the recent addition of an extra staff member to the IDDP team there is more capacity to include some people with cognitive impairment who do not fit the DSC criteria for intellectual disability.⁸⁷ These people are generally already receiving services from the key community service providers to which the program refers offenders.⁸⁸ However, those with borderline range IQ remain excluded from the program because there are no existing offender support services in the community to deal with these people.⁸⁹ A number of Indigenous offenders have participated in the program, many with brain injury acquired in their youth from petrol or solvent abuse. These offenders also have cultural needs that are difficult to meet with existing funding and services in the community⁹⁰ and some are unable to establish that they acquired the brain injury before the age of 18 and so are judged ineligible for DSC services.⁹¹

The legal criteria for eligibility require that the charges be of a nature that can be dealt with in the Magistrates Court; however, there have been exceptional cases where offenders with more serious charges have been dealt with under the program.⁹² The offender must be willing to plead guilty (or indicate no contest to the charges) and must voluntarily consent to participation in the program and sharing of information with service providers.

Referral and court process

Referral to the IDDP may be made by anyone including family members and the offender; however, most referrals come from the DSC, community corrections and defence lawyers. The program does accept referrals from outer metropolitan courts, but the offender must be able to appear in the Central Law Courts. Once a person is referred he or she is assessed by the IDDP Coordinator. Many offenders

are already clients of DSC services and have undertaken psychological assessment and testing for adaptive behaviour deficits. In these situations the offender is assessed on the legal criteria only by the IDDP coordinator who decides whether the offender is eligible for the program. If an offender has no previous assessment of intellectual disability, he or she is assessed by a psychologist (usually from corrective services). If the person is in custody and IQ testing gives a score indicative of intellectual disability, arrangements must be made to release the offender for the purposes of adaptive behaviour testing by the DSC.⁹³ This is because adaptive behaviour testing targets the skills used in daily living and cannot be adequately assessed in a prison environment.⁹⁴

Once accepted onto the program the coordinator devises a program plan in collaboration with the offender, his or her family and relevant service providers. The program is specifically addressed to the problem or problems that underpinned the offending behaviour.⁹⁵ The program is presented to the court in an initial report and the offender is bailed with a condition that he or she comply with all lawful directions of the IDDP coordinator.⁹⁶ The coordinator generally meets with an offender on a weekly basis⁹⁷ to monitor their progress and is in constant contact with community service providers who are also dealing with the offender. The offender is brought back before court for judicial monitoring when required, usually every two months. The IDDP coordinator supplies a written report to the court detailing the offender's participation in the program and making any necessary recommendations to the court.

At each court review the magistrate interacts directly with the offender, gaining insight into the offender's progress and ensuring that the requirements of the program are understood. Non-compliant offenders are returned to court for encouragement from the magistrate. If they remain non-compliant they can be transferred back to the general list for sentencing.⁹⁸

87. Amanda Perlinski, IDDP Coordinator, email communication (22 March 2008).

88. Funding for these offenders may be achieved through the service provider's discretionary funds (block funding) or from private sources such as accident compensation.

89. Amanda Perlinski, IDDP Coordinator, email communication (22 March 2008). See also, Cockram J, *Equal Justice?: The experiences and needs of repeat offenders with intellectual disability in Western Australia* (Perth: Activ Foundation Inc, 2005) 81.

90. Commonwealth Parliament, Senate Select Committee on Mental Health, *A National Approach to Mental Health: From crisis to community*, First Report (March 2006) [16.61]–[16.83].

91. Cockram J, *Equal Justice?: The experiences and needs of repeat offenders with intellectual disability in Western Australia* (Perth: Activ Foundation Inc, 2005) 81.

92. See discussion below under 'Consultation Issues: Seriousness of the Offence'.

93. Amanda Perlinski, IDDP Coordinator, email communication (22 March 2008).

94. The Adaptive Behaviour Assessment Scale assesses an individual in all 10 specific adaptive skills areas specified in the DSM-IV: communication; community use; functional academics; home living; health and safety; leisure; self-care; self-direction; social skills; and work.

95. Perlinski A & Holder F, 'Small but Beautiful – The Intellectual Disability Diversion Program' (Presentation to the Disability and Justice Conference, Perth, 13 November 2007).

96. Other conditions, such as residential conditions, are also often placed on bail.

97. Less frequently if the offender has strong supports in place and if the offences are minor: Amanda Perlinski, IDDP Coordinator, email communication (22 March 2008).

98. Perlinski A & Holder F, 'Small but Beautiful – The Intellectual Disability Diversion Program' (Presentation to the Disability and Justice Conference, Perth, 13 November 2007).

Powers of the court and program outcomes

Finalisation of the matter is usually taken approximately six months after the offender commenced the program.⁹⁹ In the event that an offender performs very well on the program and completes his or her program plan in less than six months, the coordinator can refer the person for sentencing at an earlier date. At sentencing the magistrate presents the offender with a certificate and congratulates the offender on his or her successful completion of the program. The magistrate then hears the defence and prosecution submissions regarding appropriate sentence and makes an order under the *Sentencing Act 1995* (WA). Where the court believes the offender would benefit from further supervision, support or a longer-term intervention, a Conditional Release Order or Community Based Order may be made with conditions that the offender continues working with the service providers he or she has been introduced to via the program. Offenders can expect a discount on the sentence they would have received had they not participated in the program.¹⁰⁰

99. Under s 16(2) of the *Sentencing Act 1995* (WA) sentencing must take place no later than six months after conviction. The Commission has proposed that this period be extended to 12 months: see Proposal 6.8, Chapter Six.

100. Perlinski A & Holder F, 'Small but Beautiful – the Intellectual Disability Diversion Program', presentation to the Disability and Justice Conference, Perth, 13 November 2007.

Consultation issues

The following section provides some general commentary on mental impairment court intervention programs with specific reference to their potential for operation in Western Australia. The Commission invites submissions and comments on any aspect of mental impairment court intervention programs, but especially seeks submissions on the areas covered in this section.

BENEFITS OF MENTAL IMPAIRMENT COURT INTERVENTION PROGRAMS

Addressing underlying causes of offending behaviour

Court intervention programs recognise that a person has reached a crisis point when appearing in court charged with an offence. They take advantage of this crisis to address the issues that underpin the offending behaviour in order to reduce the likelihood of reoffending.¹ With mental impairment court intervention programs the focus is placed on securing treatment of an offender's mental condition,² including regular counselling and medication checks. However, programs also seek to address practical issues by facilitating connections with government and community service providers who can assist an offender to find housing or supported accommodation; address coexisting substance abuse problems; enable assessment for the disability support pension or resolve issues with Centrelink; reconnect with his or her family; become involved in community activities to improve interpersonal skills; enrol in education or cognitive skills programs; or find suitable employment.

Often these seemingly tangential issues can underpin a person's offending behaviour and addressing these may be more important than mental health treatment to achieving the desired outcome of preventing reoffending. For example, a mentally impaired person who constantly offends by making nuisance calls to emergency services may respond better to a program that involves activities to take up the person's time and so limiting the time in which

he or she can offend.³ So too, a mentally ill homeless person who is frequently arrested for public order offences may respond well to a program that targets his or her housing crisis and introduces the person to social networks or activities that reinforce acceptable social behaviour.⁴

Improving outcomes

Victorian Deputy Chief Magistrate Jelena Popovic has observed that the sentencing role of magistrates has become more challenging in the past decade in line with an apparently 'increasing complexity' in offenders' personal circumstances.⁵ She highlights the sentencing dilemma faced by magistrates where offenders who are homeless, indigent or mentally impaired are brought to court for offences that do not warrant a term of imprisonment. It is difficult, Popovic states, to determine an appropriate sentencing outcome where offenders 'are not able to pay a fine or have lives which are too chaotic to enable them to comply with community corrections orders and suspended sentences, or to undertake to be of good behaviour'.⁶ She argues that court intervention programs provide judicial officers with an essential and more meaningful alternative to the imposition of dispositions that an offender simply cannot comply with.⁷

The role of the judicial officer is key to the success of court intervention programs, but this is especially so with regard to programs servicing mentally impaired offenders. Many such offenders have difficulty coping with new situations and do not have the cognitive ability to understand the normal court process. It is important in these circumstances that magistrates ensure that the procedure of the court and the

1. See further discussion under 'Maximising the Opportunity of a Crisis Point', Chapter One.
2. Or, in the case of intellectual disability or acquired brain injury, necessary support for the person's functional disabilities and cognitive skills training.

3. This example is a real life case from the Tasmanian program. The offender, who was schizophrenic with a low IQ responded successfully to an intervention involving volunteer work and enrolment in a literacy course: Marita O'Connell, Forensic Mental Health Court Liaison Officer, Hobart Magistrates Court, telephone consultation (17 March 2008).

4. The Human Rights and Equal Opportunity Commission has reported that the 'absence of suitable supported accommodation is one of the major obstacles to recovery and effective rehabilitation' of individuals with a mental illness: Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness* (1993) ('The Burdekin Report') as discussed in Karras M et al, *On the Edge of Justice: The legal needs of people with a mental illness in NSW* (Sydney, Law and Justice Foundation of New South Wales, 2006) 27.

5. Popovic J, 'Meaningless vs Meaningful Sentences: Sentencing the unsentencable', paper delivered to the Sentencing: Principles, perspectives, possibilities conference, Canberra, 10 February 2006, 1.

6. Ibid.

7. Ibid.

court's expectations of the offender are carefully explained. The Commission's review of Australian mental impairment court intervention programs showed a clear commitment among program staff and judicial officers to making court proceedings as transparent and accessible to the offender as possible. Programs are generally designed in collaboration with the offender, the content of progress reports is openly discussed and the offender is encouraged to speak directly with the magistrate about his or her experiences on the program. Some mentally impaired offenders also have limited appreciation of what triggers their offending behaviour or why their behaviour is unacceptable. The verbal feedback (whether encouragement or sanction) given by the magistrate during the court intervention process assists these offenders to learn to associate their behaviour directly with the court experience in the shorter term and the final outcome in the longer term.⁸

Improving efficiency of the court process

The Tasmanian Magistrates Court Mental Health Diversion List (currently in pilot stage) was explicitly established to improve the efficiency of the court process for mentally ill offenders charged with minor offences.⁹ The court noted that:

Defendants with mental health issues present 'challenges' to the court process due to their complex needs. They often present as unreliable and have difficulty attending and remembering appointments. Streamlining the process through a separate list and a dedicated Magistrate reduces the uncertainty in this process for defendants and for support staff that provide expert advice to the Court. This has the potential of reducing the number of listings that have to be rescheduled in general court lists, thereby improving listing potential for all Magistrates.¹⁰

Improving efficiency of court process was also a reason behind the establishment of the South Australian program.¹¹ In that jurisdiction, amendments to the procedure of courts dealing with fitness to plead issues and the defence of mental impairment (insanity)¹² removed the potential of indeterminate detention for offences and required the court to set a maximum

term for detention pegged to the penalty that would have been given in the absence of the defence. This encouraged more defendants to access the defence for minor matters, whereas before, with the prospect of indeterminate detention, only those who had committed very serious offences would generally argue the defence of mental impairment.¹³ A review of the operational implications of the amendments found significant 'clogging' of the system in lower courts and recommended that an intervention program be established to provide a diversion option for mentally impaired offenders charged with minor offences.¹⁴

The experience of South Australia is of particular significance for our own state as the Western Australian Government prepares to implement the recommendations of the 2003 Holman Review of the *Criminal Law (Mentally Impaired Accused) Act 1996* and the Commission's 2007 *Review of the Law of Homicide*.¹⁵ Both reviews recommended that the length of any custodial detention for those who satisfy the defence of mental impairment (insanity) in s 27 of the *Criminal Code* (WA) be capped (effectively abolishing indeterminate detention).¹⁶ Further, they each recommended a more flexible regime for dealing with mentally impaired offenders including a greater range of non-custodial dispositions.¹⁷ If these recommendations are implemented there will likely be a greater amount of mentally ill or intellectually disabled offenders willing to argue the complete defence of mental impairment, particularly for less serious offences. An alternative avenue of a mental health court intervention program will encourage and allow these offenders to address the problems underlying their offending behaviour while also improving the efficiency of court processes.

8. Marita O'Connell, Forensic Mental Health Court Liaison Officer, Hobart Magistrates Court, telephone consultation (17 March 2008). This has been particularly observed in relation to cognitively impaired offenders. Service providers to the South Australian program have commented that immediate responses to behaviour were essential to enable this offender group to learn that certain behaviour has certain consequences. Skrzypiec G et al, *Magistrates Court Diversion Program: An analysis of post-program offending* (Adelaide: Office of Crime Statistics and Research, 2004) 117.
9. Magistrates Court Tasmania, *Mental Health Diversion List Procedural Manual* (April 2007) 4.
10. Ibid 4.
11. Skrzypiec G et al, *Magistrates Court Diversion Program: An analysis of post-program offending* (Adelaide: Office of Crime Statistics and Research, 2004) 13.
12. See *Criminal Law Consolidation Act 1935* (SA) Part 8A.

13. Burvill M et al, 'The Management of Mentally Impaired Offenders within the South Australian Criminal Justice System (2003) 26 *International Journal of Law and Psychiatry* 13, 15.
14. Attorney General's Department (SA), *Review of the Operational Implications of the Criminal Law Consolidation (Mental Impairment Provisions) Act 1995* (Adelaide: Justice Strategy Unit, 2000).
15. Holman CDJ, *The Way Forward: Recommendations of the Review of the Criminal Law (Mentally Impaired Defendants) Act 1996* (WA) (2003); LRCWA, *Review of the Law of Homicide*, Final Report, Project No. 97 (September 2007).
16. LRCWA, *ibid* recommendation 36; Holman, *ibid* recommendations 4.2 & 5.3A. The Commission also recommended that compulsory custody orders be replaced by presumptive custody for all relevant offences (including homicide), while the Holman review recommended that the offences for which compulsory custody currently applies should be reviewed to reduce the number of less serious offences. LRCWA, *ibid*, recommendation 35; Holman, *ibid* recommendation 4.1.
17. LRCWA, *ibid* recommendation 37; Holman, *ibid* recommendation 4.2.

OPERATION OF MENTAL IMPAIRMENT COURT INTERVENTION PROGRAMS

Eligibility criteria

Mental impairment court intervention programs consider a mixture of psychiatric diagnostic criteria and legal criteria when assessing eligibility to participate in a program. Psychiatric diagnostic criteria may include the diagnosis of a specified mental illness or level of cognitive impairment (sometimes defined by legislation), and consideration of whether the offender is likely to respond to an appropriate treatment plan. Legal criteria include the seriousness of the offence, the offender's willingness to plead guilty or indicate no contest to the objective facts of an offence, and his or her offending history. The capacity of the program to service an offender's practical needs, such as finding accommodation with adequate support or enabling treatment for substance abuse or behavioural modification, will also influence assessment of eligibility for a mental impairment court intervention program. All these matters will be taken into account by a judicial officer in determining whether it is appropriate to allow the offender to participate in a court intervention program.

Should offenders with personality disorders be excluded?

There is some debate in legal circles about whether a personality disordered individual is 'mad' or just 'bad'.¹⁸ There is also some debate whether personality disorder is considered a mental illness, both at law and in the discipline of psychiatry.¹⁹ Though this debate is deeply relevant to the question whether the insanity defence under s 27 of the *Criminal Code* can apply to an individual with personality disorder²⁰ it should not, in the Commission's opinion, be used as the basis of exclusion from participation in a

mental impairment court intervention program. It is important that the psychiatric diagnostic eligibility criteria for such programs be as inclusive as possible²¹ and given that deterrent forms of punishment, such as imprisonment, do not usually modify the behaviour of persons suffering from personality disorder,²² alternative avenues to address offending behaviour in this group should not be ignored.

Although dangerous and severe forms of personality disorder (in particular, antisocial personality disorder) are generally considered to be untreatable,²³ less severe forms may be managed by a combination of pharmacotherapy (to assist in controlling symptoms of rage, irritability, depression and anxiety)²⁴ and psychotherapeutic support or training (to encourage control of particular behaviours).²⁵ Successful treatment of a personality disorder requires patient recognition of habitual behavioural problems and motivation to change those behaviours.²⁶ These preconditions are shared by court intervention programs which generally require that participants accept responsibility for their offending behaviour and are willing to work to address that behaviour.

Seriousness of the offence

Although existing mental impairment court intervention programs in Australia limit legal eligibility for participation to less serious offences in the magistrates' jurisdiction,²⁷ there is no reason to believe that a program would not be effective for mentally impaired offenders who commit more serious offences. The benefits of these programs

18. Ruffles J, 'Diagnosing Evil in Australian Courts: Psychopathy and antisocial personality disorder as legal synonyms of evil' (2004) 11 *Psychiatry, Psychology and Law* 113.

19. As CR Williams has noted: 'The word "personality" refers to an individual's characteristic way of functioning psychologically. Some persons have traits of character that are abnormal or socially undesirable. At an extreme level such persons are described as having a personality disorder. The position of such persons is, however, quite different from that of a person suffering from a disturbance of mental functioning, which is what mental illness is. The fact that a person's behaviour is deviant, maladapted or non-conformist does not necessarily mean that it is the product of any disturbance of mental functioning': Williams CR, 'Development and Change in Insanity and Related Defences' (2000) 24 *Melbourne University Law Review* 711, 729. This view is supported by the American Psychiatric Association in its 'Statement on the Insanity Defense' (1983) *American Journal of Psychiatry* 681, 685. See also Office of the Chief Psychiatrist (WA), *Report for the Minister for Health and Attorney General on Alternative Detaining Powers in relation to Persons Diagnosed with Dangerous and Severe Personality Disorder* (24 December 2004) 9.

20. The Commission has discussed this debate at length in its *Review of the Law of Homicide*, Project No. 97 (2007) 229–30.

21. Skrzypiec G et al, *Magistrates Court Diversion Program: An analysis of post-program offending* (Adelaide: Office of Crime Statistics and Research, 2004) 15.

22. Office of the Chief Psychiatrist (WA), *Report for the Minister for Health and Attorney General on Alternative Detaining Powers in relation to Persons Diagnosed with Dangerous and Severe Personality Disorder* (24 December 2004) 7.

23. Office of the Chief Psychiatrist (WA), *Report for the Minister for Health and Attorney General on Alternative Detaining Powers in relation to Persons Diagnosed with Dangerous and Severe Personality Disorder* (24 December 2004) 10.

24. Medications such as mood stabilisers, anxiolytics, antipsychotics and antidepressants may assist in reducing the various symptoms of personality disorders.

25. The CHANGES (Challenging Habitual Attitudes by Nurturing Growth, Education and Self-Responsibility) program at Royal Perth Hospital has had success in treating the symptoms of borderline personality disorder with voluntary group therapy in an outpatient setting. Affiliation with existing community programs such as these is crucial to the success of court intervention strategies and programs should be sufficiently funded to enable participants to secure placements in these external programs.

26. Submission to the Victorian Parliamentary Social Development Committee Inquiry into Mental Disturbance and Community Safety (1989) as cited in Williams CR, 'Development and Change in Insanity and Related Defences' (2000) 24 *Melbourne University Law Review* 711, 730. See also Office of the Chief Psychiatrist (WA), *Report for the Minister for Health and Attorney General on Alternative Detaining Powers in relation to Persons Diagnosed with Dangerous and Severe Personality Disorder* (24 December 2004) 10.

27. It should be remembered that the types of offences dealt with in magistrates' jurisdictions in different states varies greatly and that, as discussed in Chapter One, the jurisdiction in Western Australia appears to deal with much less serious offences than its interstate counterparts.

extend beyond treating offenders and addressing non-conformist personal behaviours: they provide tangible benefits to the community by reducing reoffending. These benefits do not diminish as an offence becomes more serious.

In fact, the seriousness of some offences dealt with in superior courts may be perceived differently when committed in the context of mental impairment. One example offered by the IDDP coordinator in Western Australia involved a man charged with armed robbery who suffered from a significant intellectual disability in combination with an anxiety disorder and a serious addiction to tobacco. He had run out of money and cigarettes and had gone to his local newsagency where he asked for cigarettes and left without paying. He returned the following day, but believing they would be unlikely to give him another packet of cigarettes, this time he showed a knife. The newsagent gave him the packet of cigarettes and he left the store without hurting anyone. Convinced that the offender would not fare well in custody, the magistrate who took the plea of guilty granted bail on the condition that the offender abide by the lawful directions of the IDDP coordinator. While waiting several months for his appearance in the Supreme Court, the offender participated in the program and was monitored by the IDDP magistrate. His behaviour improved on the program and he was ultimately sentenced by the Supreme Court to an intensive supervision order.²⁸

Without such intervention, this offender would have been remanded to prison while awaiting disposition of the charges by the Supreme Court and may well have been sentenced to a term of imprisonment.²⁹ The Commission has already set out the reasons why prison is not always the most appropriate place for a mentally impaired offender.³⁰ These include the peculiar vulnerability of mentally impaired offenders, the difficult challenges prisons face in managing these offenders and the fact that adequate treatment for mental illness is not available in prison. In respect of offence seriousness, it is important also to note that punishment by way of imprisonment (which is a typical outcome for serious offences like armed robbery) does little to deter mentally impaired offenders and nor does it assist them to manage their mental health problems or address their offending behaviour. As Dixon J said in *Porter*:

The purpose of punishing people is to prevent others from committing a like crime or crimes. Its prime purpose is to deter people from committing offences. ... it is perfectly useless for the law to attempt, by threatening punishment, to deter people from committing crimes if their mental condition is such that they cannot be in the least influenced by the possibility or probability of subsequent punishment;

28. Amanda Perlinski, IDDP Coordinator, email communication (22 March 2008).

29. Ibid.

30. See discussion above under 'Is Prison the Right Place for the Mentally Impaired'.

if they cannot understand the ground upon which the law proceeds.³¹

As discussed earlier in Chapter One, it is the Commission's opinion that court intervention programs should, in principle, be available to offenders in all jurisdictions irrespective of the seriousness of the offence category. Whether a court intervention program is in fact considered for a particular offender for a particular offence will depend upon satisfaction of the eligibility criteria, the capacity for community service providers to manage the offender, the perceived dangerousness of the offender, whether a custodial sentence is required and, ultimately, a determination by the judicial officer in all the circumstances.

Voluntariness

As discussed in Chapter One, it is important that participation in court intervention programs is voluntary³² and for programs which involve treatment of a mental illness or disorder this is particularly so. The United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care³³ provides that treatment (including diagnosis or assessment) cannot be given without a person's informed consent, voluntarily given.³⁴ In the circumstances of a mentally impaired offender this may require that the court intervention program's processes and consequences of involvement be explained to the offender in the presence of a legal representative or guardian.

Another important aspect of voluntary participation is that offenders must consent to sharing information about their medical status, offending history and any substance abuse with government departments, relevant non-government service providers and the court. Although privacy laws protect this information from being accessed by parties to whom no consent has been given, offenders should be advised that their mental health or disability status may form part of the public record and that this information may be used by government department or agencies to determine their eligibility for other benefits. Procedures should be developed to balance the needs of the program with the right to privacy and confidentiality of information provided by or about the offender.³⁵

31. *Porter* (1933) 55 CLR 182, 186.

32. Court intervention programs would be unlikely to be effective without the voluntary participation of the offender and the motivation to succeed in addressing the problems underlying their offending behaviour. Court intervention programs are onerous and intensive and for some offenders a term of imprisonment may be preferable to participation.

33. Adopted by the United Nations General Assembly, resolution 46/119 (17 December 1991).

34. Ibid, principle 11. Except in circumstances of involuntary commitment meeting certain criteria. In Western Australia this criteria is specified in the *Mental Health Act 1996* (WA).

35. Zammit A, 'Disability and the Courts – An Analysis of Problem Solving Courts and Existing Dispositional Options: The search for improved methods of processing defendants with a mental

Need for affiliated services and appropriate resourcing

Like most court intervention programs, the effectiveness of mental impairment programs is reliant on the availability of appropriate support services in the community.³⁶ Existing programs in Australia use a mix of government and non-government community support services. Under the *Commonwealth-State/Territory Disability Agreement (2002–2007)*³⁷ the Commonwealth is responsible for funding and managing employment programs for people with disabilities, while the states fund and administer accommodation and community support services, respite care, information provision and non-vocational daytime activity.³⁸ Advocacy and research and development are joint Commonwealth-state responsibilities. Under the agreement, the term 'people with disabilities' means:

[P]eople with disabilities attributable to an intellectual, psychiatric, sensory, physical or neurological impairment or acquired brain injury (or some combination of these) which is likely to be permanent and results in substantially reduced capacity in at least one of the following:

- self care/management
- mobility
- communication

requiring significant ongoing and/or long-term episodic support and which manifests itself before the age of 65.³⁹

While narrow in some respects, this definition is likely to cover many individuals to whom a mental impairment court intervention program might apply.⁴⁰ However, agencies administering disability funding generally have further eligibility criteria that must be met and the competition for funding is fierce. Understandably, individuals with the most severe disabilities or those considered to be especially vulnerable (eg, children) are resourced as a priority.

In these circumstances, the role of block government-funded⁴¹ or alternatively funded⁴² non-government organisations (NGOs) is important for the effective operation of mental impairment court intervention programs. These organisations ensure that people with mental impairments who meet the court intervention program eligibility criteria, but may not fit precisely within the government's criteria for specific disability funding can still participate in the program and address the issues that contribute to or cause their offending behaviour.

But despite the crucial role that NGOs are required to play in the delivery of mental health and other community services to people that do not meet the exacting criteria for individual disability funding, these organisations remain significantly under-resourced.⁴³ As discussed in Chapter One, court intervention programs should be sufficiently independently resourced as justice initiatives to enable the purchase from NGOs of essential services for program participants.

THE COMMISSION'S PRELIMINARY PROPOSALS FOR WESTERN AUSTRALIA

The Commission's research has demonstrated that mental impairment court intervention programs are extremely useful tools for managing mentally impaired offenders through the court process, diverting offenders from unnecessary imprisonment and addressing the underlying causes of offending behaviour. Taking into account the benefits to the community (in reducing reoffending and welfare dependence), to offenders (in addressing underlying disadvantage) and to the efficiency of court process, it is the Commission's opinion that Western Australia would benefit from the establishment of a mental impairment court intervention program.

The Commission has carefully considered the different models of mental impairment court intervention programs currently operating in Australian jurisdictions. As will be evident from the discussion in the preceding section, Australian court intervention programs have varying eligibility criteria and target different groups of mentally

impairment through the criminal courts' (Melbourne: Office of the Public Advocate, 2004) 39–40.

36. Bernstein R & Seltzer T, 'Criminalization of People with Mental Illnesses: The role of mental health courts in system reform (2003) 7 *University of District Columbia Law Review* 143, 147.

37. The agreement expires on 30 June 2007; however, all parties have agreed to extend the current agreement to the end of the year. Negotiations for the next agreement may well see changes to current funding and responsibility models. See <<http://www.facsia.gov.au/internet/facsinternet.nsf/disabilities/policy-cstda.htm>> accessed 30 April 2008.

38. The Commonwealth funds approximately one-sixth of the total budget available to service the needs of Western Australians with disabilities, with the remaining funded by the state government: *Commonwealth-State/Territory Disability Agreement (2002–2007)* sch A1.

39. *Commonwealth-State/Territory Disability Agreement (2002–2007)* 9.

40. The Commission is not, however, suggesting that mental impairment court intervention programs be limited by legislative definitions of disability or impairment

41. Block funding is government funding that is able to be applied at the service provider's discretion and may not, therefore, require individual recipients of services to meet strict eligibility criteria or legislative definitions.

42. NGOs often rely on a complex mix of funding sources including Commonwealth or state government grants, specifically funded activities, and private donations and bequests. So far as mental health is concerned, certain services such as medical and medication services and some psychological counselling are funded by Medicare on an individual basis.

43. As highlighted by the Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness* (1993) ('The Burdekin Report') and more recently by the Commonwealth Parliament, Senate Select Committee on Mental Health, *A National Approach to Mental Health: From crisis to community*, First Report (March 2006) [9.26]–[9.30].

impaired offenders. For example, the IDDP program in Western Australia only deals with intellectually disabled offenders, the MHDL program in Tasmania only deals with mentally ill offenders and the Special Circumstances List in Queensland only deals with homeless, mentally impaired offenders. The MCDP program in South Australia is the only program to embrace all offenders with mental impairment, including those with primary diagnoses of personality disorder or substance use disorder.

The Commission is impressed by the inclusivity of the South Australian model which services metropolitan and regional areas and applies to all people with a mental impairment⁴⁴ who meet the relevant legal, diagnostic and other eligibility criteria. However, in view of the existence of the IDDP, which has been successful over a substantial period in managing the intellectual disability offender group, the Commission has considered whether a new 'one-size-fits-all' program would provide the best outcome for Western Australia.

The only apparent reason for separation of mentally ill and intellectually impaired offenders in current Australian court intervention programs is the source of initial funding and the specialist experience of staff leading the pilot initiative.⁴⁵ However, the Commission's review of programs and relevant literature suggests that there is a significant difference between the management needs of mentally ill offenders as opposed to cognitively impaired offenders. For example, cognitively impaired offenders appear to require much more intensive hands-on case management and often longer-term supervision or support than mentally ill offenders.⁴⁶ While many mentally ill offenders may be dealt with effectively in the short-term by medication and counselling, cognitively impaired offenders must learn skills to manage a lifelong disability. Cognitively impaired offenders also

present more often with severe functional disabilities (especially those people who have degenerative brain injury or acquired brain injury) and sometimes require supported accommodation with assistance in all aspects of daily living from toileting to decision-making.

The difference between the mentally ill and cognitively impaired offender groups is highlighted by the post-program offending of participants in the South Australian program. As mentioned earlier, the MCDP has inclusive eligibility criteria which embrace all mentally impaired offenders; however, the management needs of different offender groups are not necessarily reflected in the court-based aspects of the program. An evaluation of the program found that while it did facilitate the linking of cognitively impaired offenders with relevant support services and assist them to gain some improvement in day-to-day functioning, there was a relatively high rate of post-program offending in this offender group.⁴⁷ Service providers and program staff highlighted that cognitively impaired offenders required more immediate responses to their offending behaviour in order to learn that consequences are associated with the behaviour.⁴⁸ While the IDDP and MCDP have similar levels of judicial monitoring, the case management of offenders by program staff appears to be far more intensive with the IDDP.

With these points in mind, the Commission has determined its preliminary proposals based on a split model featuring an expanded and enhanced Intellectual Disability Diversion Program to deal with cognitively impaired offenders and a new mental impairment court intervention program to deal with mentally ill and personality disordered offenders. With the establishment of the Court Intervention Programs Unit, proposed in Chapter Six, staff from both programs will be co-located with combined administrative, managerial and policy development support. This, and the potential for government and non-government service providers to also be co-located with program staff, will assist in ensuring that there are no resource disadvantages to splitting the programs and that program staff can rely upon the expertise of others in a collegial environment.⁴⁹

Establish a Mental Impairment Court Intervention Program

The Commission believes that a mental impairment court intervention program should be established, preferably as a justice initiative with joint resource responsibility from the Departments of the Attorney

44. Including intellectual disability, mental illness, acquired brain injury, dementia, degenerative frontal lobe conditions and personality disorders.

45. For example, the IDDP program in Western Australia was limited to dealing with intellectually impaired offenders because the program grew from a joint initiative with the DSC, which only provided the services necessary for managing offenders to a certain group of intellectually disabled people. Similarly, the Tasmanian program was a collaborative effort between the court and the forensic mental health services which had no experience in providing services to intellectually disabled people or funding for those offenders. The MCDP in South Australia appears to be the only program that began as a dedicated program with central funding and a commitment to inclusivity.

46. This is supported by the frequency of offender-court liaison contact in each of the programs. Western Australia's IDDP coordinator reported that she requires weekly contact with most offenders to ensure that they continue on the program and comply with its conditions. The Queensland Special Circumstances List court liaison officer reported that intellectually disabled offenders required more intensive management and often spent longer on the program than other offenders: Amanda Perlinski, IDDP Coordinator, email communication (22 March 2008); Philip Macey, Homeless Persons Court Liaison Officer, Brisbane Magistrates Court, telephone consultation (25 March 2008).

47. Skrzypiec G et al, *Magistrates Court Diversion Program: An analysis of post-program offending* (Adelaide: Office of Crime Statistics and Research, 2004) 112–13.

48. Ibid 117.

49. See further, Chapter Six, Proposal 6.2.

General, Health⁵⁰ and Corrective Services. The program should be sufficiently resourced to purchase services from non-government organisations to enable those who might 'fall between the funding cracks' to be adequately catered for in the justice system.⁵¹

For the reasons set out above under the heading 'Operation of Mental Impairment Court Intervention Programs', the Commission proposes that the program should have inclusive psychiatric diagnostic criteria which include personality disorders and dual diagnosis substance abuse. However, the Commission proposes that cognitively disabled offenders be dealt with under an expanded version of the existing Intellectual Disability Diversion Program and therefore should not be specified in the diagnostic criteria of the proposed mental impairment court intervention program.

Also for the reasons discussed above, the Commission proposes that the mental impairment court intervention program be available to offenders in all adult courts, but managed by judicial monitoring through the Magistrates Court.⁵² The seriousness of the offence should not necessarily be a barrier to an offender's participation in the program, but the offender must be able to be managed in the community. In some cases this may not be possible because of the perceived dangerousness of the offender or because relevant service providers are unwilling to take the offender. All these matters can be taken into account in determining whether a particular offender can participate in the program.

An offender who has been referred to the program, but is assessed as ineligible to participate should be returned to the general court list to be dealt with at the earliest opportunity. These offenders—and any offender who withdraws from the program before completion—should retain the option to plead the defence of insanity under s 27 of the *Criminal Code* (WA). The proposed mental impairment court intervention program only requires an indication of willingness to plead guilty or a declaration of no contest to the objective facts of the offence. Offenders with a relevant mental impairment,⁵³ for the purposes of the

s 27, defence are in a unique category as compared to other offenders because they may admit to the objective facts of the offence (that is, the offending behaviour and its consequences) and still have a valid and complete defence.

PROPOSAL 3.1

Establish a mental impairment court intervention program

That there should be a mental impairment court intervention program established in Western Australia at the earliest opportunity to service all metropolitan courts dealing with adults, with the following features:

- The program should have psychiatric diagnostic criteria that includes mental illness, personality disorder and dual diagnosis substance use disorder, but excludes intellectually disabled and cognitively impaired offenders (who may apply for referral to the Intellectual Disability Diversion Program).
- The program should be available, in principle, to offenders in all of the state's adult court jurisdictions, but be monitored by the Magistrates Court pursuant to Proposals 6.4 and 6.12.
- There should be no formal requirement to plead guilty to an offence to be accepted onto the program; however, the objective facts of the offence should not be in dispute or contested.
- An offender should not be barred from participating in the program for a particular offence simply because he or she has pleaded not guilty to, or disputes the facts of, another offence, whether related or unrelated.⁵⁴
- An applicant that has been referred to, but is assessed as ineligible to participate in, the program should be returned to the general court list to be dealt with at the earliest opportunity.
- An offender who has been returned to the general court list or who withdraws from the program before completion and who has simply indicated no contest to the objective facts of the offence should retain the option to plead the defence of insanity under s 27 of the *Criminal Code* (WA).

50. In particular the State Forensic Mental Health Service and Court Liaison Service.

51. See discussion above under 'Need for Affiliated Services and Appropriate Resourcing'.

52. The Commission has made proposals for legislative reform to enable this to occur: see Proposals 6.4 & 6.12. The Commission has separately examined the need for court intervention programs in the Children's Court and because of the limited number of potential participants seeks submissions about the viability of a general court intervention program in the Children's Court for a variety of different problems including mental impairment: see Consultation Question 6.6

53. Under s 1 of the *Criminal Code* (WA), 'mental impairment' is defined as intellectual disability, brain damage, senility or mental illness. The term 'mental illness' is separately defined in s 1 of the Code 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 stimuli'. The Commission has considered this definition in its recent review of the laws of homicide and determined that it was adequate for the purposes of the defence in s 27 and did not require

amendment: see LRCWA, *Review of the Law of Homicide*, Final Report, Project No. 97 (September 2007) 228–29.

54. The Commission notes that the IDDP allows participation of an offender in these circumstances and supports this flexibility.

- Participation in the program must be on a voluntary basis and the offender's written consent to sharing of information among the court, relevant government departments and external service providers should be obtained.
- Anything done by the offender in compliance with the program should be taken into account during sentencing and all sentencing options (including the option to impose no sentence) after successful completion of a program should be available to the magistrate. Unsuccessful participation in the program should not be taken into account during sentencing.⁵⁵
- The program should be established as a justice initiative with joint resource responsibility from the Departments of the Attorney General, Health and Corrective Services.
- The program should be sufficiently resourced to purchase services from relevant non-government service providers on behalf of participants.
- The program should begin as a two-year pilot program in the Perth Magistrates Court taking referrals from all metropolitan courts with the aim of extending its operation, subject to independent evaluation, to as many metropolitan courts as possible.
- The program should be assigned a designated magistrate who has an appropriate understanding of issues faced by mentally impaired offenders and an interest in improving outcomes for mentally impaired offenders. Other magistrates should be appropriately trained as relief magistrates.

Expansion of the Intellectual Disability Diversion Program

The Commission acknowledges that the Intellectual Disability Diversion Program is improving court outcomes for its target offender group and helping these offenders to engage (or re-engage) with crucial community services. Because of this success, as well as the differences in the management needs of this offender group discussed above, the Commission is persuaded that the program should be retained rather than subsumed within an all-encompassing mental impairment court intervention program. However, the Commission is concerned that the eligibility criteria (born of its initial funding association with the Disability Services Commission) unnecessarily denies the participation of many cognitively impaired offenders who would benefit from the program.

55. See Proposals 6.6 & 6.15.

In particular those offenders with a brain injury acquired after age 18,⁵⁶ offenders with borderline IQ and offenders with organic or degenerative brain disorders. These concerns are not new: they were raised by stakeholders in the 2004 evaluation of the program where it was observed that many cognitively impaired offenders who are deserving of assistance to navigate their way through the criminal justice system were simply 'falling through the gaps'.⁵⁷

It is the Commission's opinion that the IDDP should be retained, but that its eligibility criteria should be broadened to include offenders with all types of cognitive impairment (including acquired and organic brain injury, intellectual disability, dementia and other degenerative brain disorders) and that it should be expanded to service the outer metropolitan courts. The Commission understands that the IDDP currently accepts some referrals from courts in the outer metropolitan area; however, these offenders must be able to travel to Perth for court appearances and for case management by the IDDP coordinator. There is clearly a need for a program presence in outer-metropolitan courts; this has been a long-standing goal of the program, but has been thwarted by limited resources.

PROPOSAL 3.2

Expand Intellectual Disability Diversion Program

- That the Intellectual Disability Diversion Program remain a specialist list, but that it be expanded and adequately resourced to service the outer-metropolitan courts and to include offenders with all types of cognitive impairment including acquired or organic brain injury, intellectual disability, dementia and other degenerative brain disorders.
- That the program should formally be made available, in principle, to offenders in all of the state's adult court jurisdictions, but be monitored by the Magistrates Court pursuant to Proposals 6.4 and 6.12.
- That an offender who has been returned to the general court list or who withdraws from the program before completion and who has simply indicated no contest to the objective facts of the offence should retain the option to plead the defence of insanity under s 27 of the *Criminal Code* (WA).

56. As discussed earlier these offenders are excluded regardless of whether they have similar cognitive and adaptive deficits to an intellectually impaired individual: see discussion above under 'Mental Impairment Court Intervention Programs: Western Australia – Intellectual Disability Diversion Program'.

57. Zapelli R & Mellor A, *Evaluation of the IDDP Project* (2004) 40–41. See also Cockram J, *Equal Justice?: The experiences and needs of repeat offenders with intellectual disability in Western Australia* (Perth: Activ Foundation Inc, 2005) 19.

Addressing offender mental health issues in regional areas

The Commission recognises the need for court intervention programs to address mental health issues in regional areas and the unique impact that regional magistrates can have in facilitating court intervention programs.⁵⁸ Because there is limited access to early intervention, rehabilitation and counselling opportunities in remote and regional areas, the court becomes an important catchment point for disadvantaged offenders and court processes can be an effective tool for encouraging rehabilitation and reducing reoffending.⁵⁹ Having separately constituted court intervention programs addressing different issues in each regional court is clearly unrealistic. There may be exceptional needs in some regional areas for which a specialist and separately staffed program is established,⁶⁰ but the Commission acknowledges that resources will never extend to establishing a regional presence for each of the specialist programs that are available in, or proposed for, the metropolitan area.

One way to address the needs of mentally impaired offenders in the regions is by a type of 'travelling' program. This is the model employed in South Australia where specialist teams based in Adelaide (and also servicing metropolitan courts) travel to regional courts on a bi-monthly basis. Offenders are assessed on site by the Clinical Advisor (a forensic psychologist) and provided with counselling sessions with Clinical Liaison Officers or the Clinical Adviser at each court appearance. The offender's participation is monitored remotely through liaison with service providers.

Another way is to provide for general court intervention programs that assist offenders to engage with relevant services as part of a judicially monitored plan. These programs, discussed in detail in Chapter Five, are a cost-effective way of servicing courts in regional areas and in closing the gaps between specialist court intervention programs. The Commission considers that general programs that can deal with mental impairment as well as other offender rehabilitation and community reparation needs are likely to be more effective than a specialist program that travels to the regions on a periodic basis. Experience with programs such as the Geraldton Alternative Sentencing Regime shows that there is invaluable rapport built between the court

and service providers when they are reporting to the magistrate or court liaison officer at the local level. This same rapport would be unlikely to develop with remote reporting to a liaison officer based in Perth.

Recognising that court liaison officers or general program coordinators in regional courts may not necessarily be expert in dealing with mentally impaired offenders, it is important that sufficient training be given to enable them to effectively case manage participants and to design appropriate intervention plans. In the Commission's opinion, responsibility for training of regional court officers involved in coordinating general court intervention programs should fall to the coordinators of specialist programs in the metropolitan area.⁶¹ A collegial relationship should also be encouraged whereby regional court officers can call upon the expertise of coordinators of specialist programs and local mental health professionals to advise on appropriate program or treatment plans for offenders. This will be enabled by the development of a Court Intervention Programs Unit as proposed in Chapter Six.⁶²

PROPOSAL 3.3

Establish general court intervention programs to service mentally impaired offenders in regional areas

- That mentally impaired offenders be eligible for referral to general court intervention programs in regional areas pursuant to Proposal 5.1.
- That regional courts running general court intervention programs be trained by and, where necessary, take advice from coordinators of specialist programs including the proposed mental impairment court intervention program and the Intellectual Disability Diversion Program.

The Commission invites comments and submissions on the above proposals. Responses are encouraged from mental health professionals, judicial and court officers, lawyers, service providers and non-government organisations, relevant government departments, court intervention program participants and other interested parties.

See Chapter Six for the Commission's proposals regarding the legislative and policy framework for all proposed court intervention programs, including the proposed mental impairment court intervention program and the Intellectual Disability Diversion Program.

58. This is recognised by regional magistrates in Western Australia who have signed a resolution supporting the use of therapeutic jurisprudence in their courts: King MS & Auty K, 'Therapeutic Jurisprudence: An emerging trend in courts of summary jurisdiction' (2005) 30(2) *Alternative Law Journal* 69, 72.

59. King MS, 'Applying Therapeutic jurisprudence in Regional Areas – The Western Australian Experience' (2003) 10(2) *ELaw: Murdoch University Electronic Journal of Law* [11].

60. For example, the Barndimalgu Court (an Indigenous family violence court based in Geraldton) or the Kalgoorlie Community Court (an Indigenous general court).

61. See 'The Operation of General Programs: Training', Chapter Five and Consultation Question 5.1.

62. See Proposal 6.2.