MAD, BAD AND DANGEROUS TO KNOW

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INTRODUCTION

Persons who suffer from mental illness are the subject of stigma and are perceived by the community to suffer from all the characteristics by which Lady Caroline Lamb described Lord Byron notwithstanding the developments of the 20th and 21st century developments in psychiatry and psychology. Even doctors and health workers so perceive the mentally ill. In the report that I prepared for the State Government in August 2007, I referred to this and to the various human rights conventions.[1] As that report and many others have made clear, the position is much worse for those who have mental illness or mental condition who are involved in the criminal justice system – an amalgam of mad and bad becomes thoroughly dangerous to know.

However, the problem with being 'dangerous to know' is that it presents an obstacle to rational understanding and humane responses. Those who work at the interface between the mental health and criminal justice systems will recognize a familiar list of unsolved challenges. Mental health problems are over-represented in offender populations, but resources are relatively limited. Mental health and offending behaviour intersect in complex ways. Satisfactory case management requires the coordinated action of multiple agencies and disciplines, which is often difficult to accomplish in practice. Good data is hard to find; evidenced-based policy is even rarer.

Courts are continuously concerned with the realization that many people being incarcerated for criminal justice offences have some degree of mental condition which may be improved or assisted by appropriate treatment or rehabilitation (it has been estimated that over 60% of long term prisoners in NSW suffer some form of serious mental condition). Both the University of Southern Cross and the University of New South Wales have developed courses in an effort to attract mental health workers into this field, but there remains a paucity of services. Federal resources have been particularly aimed at rural and regional mental health.

It is the object of a competent humane health administration and correctional regime to ensure that the bad do not reoffend, the mad are treated and that neither should in the future be dangerous. Whilst no jurisdiction can claim to have all the answers, refinement of legal frameworks is central to shaping a rational response to these complex problems. This is not only relevant to the disposition of individual cases – the normative component of the law (as expressed through the objectives of the relevant Acts) can shape community attitudes and in turn the priorities of policymakers.

The past decade has seen many changes in NSW in perceptions of mental health and criminal justice interaction. The changes in perception have been

[1] Review of the NSW Forensic Mental Health Legislation dated 1 August 2007.

accompanied by changes in the legislation and to some extent, additional or reallocation of resources. Although health workers and hospital staff retain a distinct disquiet affecting their approach to persons with mental illness or mental conditions that have come in contact with the justice system, they are less reluctant to afford mental health care to persons being dealt with in that system than they were 10 years ago.

The new prison hospital, the new forensic hospital, the new ability to provide involuntary outpatient treatment in the gaol system and to give mental health treatment in community and hospital systems for persons on parole or on bonds are features of an increasingly favourable legislative and resource environment. It is however to be regretted that neither hospital has anything like sufficient beds and that there is simply no sufficient application of resources to enable treatment within the gaol system or in the community for the vast majority of people needing it.

It is not possible in this forum to address the myriad of issues and concerns that beset this jurisdiction. In light of the recent changes to the jurisdiction and powers of the Mental Health Review Tribunal, NSWLRC reports, the recent establishment of the Mental Health Commission, the increasing number of court decisions giving increased attention to mental health issues on sentencing and the publication of the second edition of Crime and Mental Health Law in NSW, much information is now available online and in the acknowledgments to this paper readers are referred to the relevant sites.

Since it is not possible to cover the breadth of the topic without sacrificing the necessary insight into the particular aspects which deserve attention, we have focused on the diversion provisions, the role of the Mental Health Review Tribunal with forensic patients, the recommendations of the NSW Law Reform Commission and current sentencing decisions concerning mental health issues.

Recent Developments in NSW

The history and practice both as to mental health and how questions of mental health are treated in the criminal justice system in NSW together with a practical guide to the impact of mental health matters on criminal justice is set out in some detail in *Crime and Mental Health Law in New South Wales*.[2] Following the 2007 report[3], the NSW Government abolished the old rule that persons found unfit for trial or not guilty by reason of mental illness should be detained indefinitely at the royal pleasure. Instead, legislation was amended to provide that the independent Mental Health Review Tribunal, already responsible for the involuntary treatment of civil patients, should be responsible to monitor forensic patients, as well as persons found to be mentally ill in gaol. It was now for the Tribunal to determine when forensic patients were to be released.

[2] Howard D, Westmore B, *Crime and Mental Health Law in New South Wales* (LexisNexis Butterworths, 2nd Edition, 2010).
[3] Review of the NSW Forensic Mental Health Legislation dated 1 August 2007.

A new hospital with 135 beds for Forensic Patients has been built at Malabar adjacent to but outside gaol precincts. In subsequent legislation provision has been made for the involuntary treatment of prisoners who do not require hospitalization in their gaols.[4]

In 2007, the NSW Law Reform Commission embarked on an external enquiry of people with cognitive and mental health impairments in the criminal justice system. Report 135 on *Diversion* was tabled in June 2012; Report 138 on *Criminal Responsibility and Consequences* was tabled in May 2013. Both can be found at http://www.lawreform.lawlink.nsw.gov.au. The main findings are summarized in the discussions below.

In July 2012, the NSW Mental Health Commission was established under the *Mental Health Commission Act* 2012 (NSW). It is an independent statutory body whose purpose is to monitor, review and improve the NSW mental health system. Its mandate is to drive reform across the mental health sector, including where this intersects with the justice system.

THE GOAL HOSPITAL AND THE FORENSIC HOSPITAL

Within the NSW prison system there is only one psychiatric hospital it consists of a small number of beds and is intended for treatment of acutely psychotic inmates who are dangerous to themselves and others who simply cannot be permitted to remain within the correctional system.

Inmates whose problems are less intense, even if acute, are placed on a waiting list. They can receive treatment if well enough to be voluntary patients and if the resources are available. Many are treated within a screening unit which is not a hospital and seriously short of resources.

Persons found unfit for trial or acquitted by reason of mental illness are accommodated and treated in a separate establishment.

DIVERSION

It has been noted internationally in many jurisdictions that in the wake of deinstitutionalization of civil mental health care, individuals with mental health problems have come into increasing contact with the criminal justice system, which has been ill-equipped to cope with this development.[5] The purpose of diversion schemes is to redirect these people away from the criminal justice system into treatment/rehabilitation, where appropriate. This has potential benefits both for the offender and the wider community, in reducing re-offending behaviour and improving the mental health status of the offender.

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[4] See *Mental Health (Forensic Provisions) Act 1990* (NSW). Section 67 deals with 'forensic' community treatment orders.
[5] Howard at 712-713

Diversion can occur pre-court (e.g. cautions; conferencing); as a result of referral from a court to treatment/rehabilitation services, or via 'problem solving courts' that combine access to rehabilitative services with monitoring of compliance and progress.[6]

In NSW Local Courts, diversion for summary offences (or indictable offences triable summarily) is available under s 32 *Mental Health (Forensic Provisions) Act 1990* (NSW) (MHFPA).[7]

Section 32 requires the magistrate to decide at least 3 questions.

The magistrate must first determine the jurisdictional question; that is whether the defendant is eligible to be dealt with under s32:

In accordance with s32(1)(a) this involves making a finding of fact, that the defendant is (or was at the time of the alleged commission of the offence to which the proceedings relate):

(i) developmentally disabled, or
(ii) suffering from a mental illness, or
(iii) suffering from a mental condition[8] for which treatment is available in a mental health facility[9], and
(iv) not a mentally ill person[10]

If this pre-condition is met, then pursuant to s32(1)(b) the magistrate must then, having regard to the alleged facts or such other evidence as the magistrate thinks relevant, determine whether it is more appropriate to deal with the defendant under s32 or otherwise in accordance with law.[11]

Once a Magistrate has determined that it is more appropriate to deal with the defendant in accordance with s 32 the Magistrate must then determine which of the actions set out in subs 2 or subs 3 should be taken.[12]

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[6] NSWLRC Report 135 3.3-3.6
[7] The legislative history of these provisions is outlined in Karen Weeks, *To Section 32 Or Not? Applications under s.32 Mental Health (Forensic Provisions) Act 1990 in the Local Court.* Law Society Journal, May 2010.
[8] A mental condition is defined under the Act as 'a condition of disability of the mind not including either mental illness or developmental disability of the mind': s3 *MHFPA*.
[9] A mental health facility is defined under s4 *Mental Health Act* 2007 (NSW) as a declared mental health facility or a private mental health facility (premises subject to a licence under Div 2 Pt 2 Ch 5 MHA).
[10] There is no (iv) in the Act itself. Mentally ill here has the same meaning as in s14(1) *Mental Health Act* 2007 (NSW).
[11] As the court pointed out in the leading case *Director of Public Prosecutions v El Mawas* [2006] NSWCA 154 at [71] – 'the magistrate is permitted latitude as to the decision which might be made, a latitude confined only by the subject matter and object of the Act. However, the court qualified this by stated that the discretion could not be exercised properly without due regard to the seriousness of the offending conduct and whether proceeding in accordance with s 32 would produce a better outcome both for the individual and the community
[12] See *Director of Public Prosecutions v El Mawas* [2006] NSWCA 154 at [71], cited in *Edwards v DPP* [2012] NSWSC 105 at [10].

Under s 32(3A) the defendant can be called to re-appear within 6 months if the magistrate suspects there has been failure to comply with a condition.

The main advantages of s 32 are that it offers magistrates wide discretion to deal with matters in a flexible manner, the application can be raised at any time during proceedings, and there is no requirement regarding a finding of guilt.[13] However, despite this the rates of court-initiated diversion under s 32 are extremely low – around 1% of Local Court and Children's Court hearings – suggesting that the existing scheme is greatly underutilized.[14]

There are several inter-related reasons that s 32 has not been used more widely. Firstly, the categories used to define the eligible conditions are confusing and outmoded. There is ongoing uncertainty regarding which conditions may be eligible – for example, whilst transient self-induced intoxication is usually excluded, the status of personality disorder or addiction is less clear-cut.[15]

Secondly, without resources to identify those with eligible conditions who may benefit from s 32 diversion, the application may never be made in the first place. Thirdly, the treatment plan is an important factor to be considered; if the plan is inadequate or the relevant treatment resources do not exist, then the magistrate will have difficulty making the order.[16] Finally, magistrates will be reluctant to make s32 orders where it is difficult to monitor compliance or act on breach of a condition, particularly where the offence is more serious or raises concerns regarding risk.[17] This assumes greater significance in the context of a growing trend to increase the number of indictable offences triable summarily.

NSW Law Reform Commission Recommendations (Report 135)

The NSWLRC has made a range of recommendations to address these difficulties.

The first is to replace the variety of terms used to identify the relevant conditions with the same simplified scheme being recommended for other relevant legislation:

> (a) **Cognitive impairment** is an ongoing impairment in comprehension, reason, adaptive functioning, judgement, learning or memory that is the result of any damage to, dysfunction, developmental delay, or deterioration of the brain or mind.
> (b) Such cognitive impairment may arise from, but is not limited to, the following:
> (i) intellectual disability
> (ii) borderline intellectual functioning

[13] Howard at 718
[14] NSWLRC Report 135 9.41-9.44
[15] Howard at 723: *R v Lawrence* [2005] NSWCCA 91
[16] ibid at 736: *DPP v El Mawas* [2006] NSWCA 154; *DPP v Albon* [2000] NSWSC 896; also see *Edwards v DPP* [2012] NSWSC 105 at [16]-[20] where a s32 application was dismissed on the basis of failure to address whether treatment could be provided in a mental health facility.
[17] ibid at 726: *Confos v DPP* [2004] NSWSC 1159

(iii) dementias
(iv) acquired brain injury
(v) drug or alcohol related brain damage
(vi) autism spectrum disorders.

(a) **Mental health impairment** means a temporary or continuing disturbance of thought, mood, volition, perception, or memory that impairs emotional wellbeing, judgement or behaviour, so as to affect functioning in daily life to a material extent.
(b) Such mental health impairment may arise from but is not limited to the following:
(i) anxiety disorders
(ii) affective disorders
(iii) psychoses
(iv) severe personality disorders
(v) substance induced mental disorders.
(c) "Substance induced mental disorders" should include ongoing mental health impairments such as drug-induced psychoses, but exclude substance abuse disorders (addiction to substances) or the temporary effects of ingesting substances.

The two definitions – cognitive impairment and mental health impairment – should also be adopted in the context of bail and pre-court diversion.[18]

In order for court-initiated diversion to take place, suitable cases need to be identified and assessed. NSW has the Statewide Community Court Liaison Service (SCCLS) but this is currently only available in 20 out of 148 Local Court locations. The NSWLRC recommends expansion of this capacity to all courts, and additional training for police, lawyers, magistrates and other court staff who may be initiating referrals.[19]

Whilst the present framework requires the submission of a 'treatment plan', there are often great difficulties in coordinating relevant resources and ensuring that defendant remains connected with services. As it stands, courts are only rarely notified if there has been non-compliance with s 32 orders, particularly as treatment providers generally do not see this as their role.[20] A case management system can address some of these problems, and NSW currently has a pilot program operating in two courts – Court Referral of Eligible Defendants into Treatment (CREDIT) – which has received positive evaluations. The NSWLRC recommends expansion of this program into a state-wide system.[21]

As noted earlier, s 32 confers wide discretionary powers to the Magistrate, but no guidelines as to how this discretion is to be exercised. Further there has been little judicial consideration of s 32. In the leading authority *DPP v El Mawas*, the court stated that a magistrate is required to:

> *balance the public interest in those charged with a criminal offence facing the full weight of the law against the public*

[18] NSWLRC Report 135 Recommendations 5.1-5.2; 9.1
[19] Recommendations 7.1-7.7
[20] In one study breach proceedings only comprised 1.4% of s 32 hearings – see Howard at 741
[21] Recommendation 7.4

> *interest in treating, or regulating to the greatest extent practical, the conduct of individuals suffering from any of the mental conditions referred to in s.32(1) or mental illness (s.33) with the object of ensuring that the community is protected from the conduct of such persons* [22]

The NSWLRC recommended that s 32 should include a non-exhaustive list of factors to be considered in the decision to divert:[23]

> (a) the nature of the defendant's cognitive or mental health impairment
> (b) the nature, seriousness and circumstances of the alleged offence
> (c) any relevant change in the circumstances of the defendant since the alleged offence
> (d) the defendant's history of offending, if any
> (e) the defendant's history of diversionary orders, if any, including the nature and quality of the support received during those orders, and the defendant's response to those orders
> (f) the likelihood that proposed orders will reduce the likelihood, frequency and/or seriousness of offending
> (g) whether or not it is appropriate to deal with the defendant according to law in all the circumstances of the case including:
> (i) the options that are available to the court if the defendant is dealt with according to law, and
> (ii) any additional impact of the criminal justice system on the defendant as a result of their cognitive or mental health impairment
> (h) the defendant's views about any proposed course of action, taking into account the defendant's degree of understanding
> (i) the availability of services appropriate to the defendant's needs
> (j) the family and community supports available to the defendant
> (k) the benefits of diversion to the defendant and/or the community
> (l) the desirability of making the order that has the least restrictive effect on the defendant that is appropriate in the circumstances of the case.

It also recommended increasing the range of diversionary options available to the magistrate, including referral to a specialist court list (see below), and the ability to extend diversion plans for up to 12 months (currently 6 months).[24]

It is recognized that not all offenders will be able to be dealt with in the ordinary Local Court, either because of their difficulty in complying with a treatment plan, or the greater seriousness of their offending behaviour, or both. In these situations the NSWLRC suggests a specialist court may be of value, as there is an opportunity to marshall the relevant legal and treatment/rehabilitative expertise, whilst providing a tighter framework to ensure compliance. An existing successful example in NSW is the *Magistrates Early Referral into Treatment* (MERIT) drug and alcohol treatment scheme, which operates under s 36A of the *Bail Act 1978 (NSW).*

The NSWLRC recommended the introduction of a specialist list to deal with these more complex s 32 cases, the *Court Referral for Integrated Service Provision* (CRISP). This list would operate in the Local and District Courts. The proposed eligibility criteria are that the defendant:

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[22] *DPP v El Mawas* [2006] NSWCA 154; McColl JA at 71; discussed in Weeks at 53.
[23] Recommendation 9.2
[24] Recommendation 9.4

- has a cognitive or mental health impairment;
- faces a serious prospect of imprisonment [but indictable-only offences probably excluded];
- is not contesting the facts that form the basis of the alleged offence;
- has a CRISP list geographically accessible.

The list would operate as a problem-solving court, using a dedicated team to develop diversion plans, provide case management and report back to the court. Successful completion of the plan would not entitle the defendant to discharge, but it would be a favourable factor in sentencing.[25]

Other recommendations include the police being able to make direct referrals to CREDIT or SCCLS, and that the police be given clear power to discontinue proceedings in appropriate cases in favour of referral to services.[26] Diversionary powers under s 32 and s 33 MHFPA should be extended to the District and Supreme Courts.[27]

Under s 33(1) MHFPA, a defendant who comes before a magistrate who appears to be a "mentally ill person" (i.e. suffering from a mental illness and in acute need for care, treatment or control to protect themselves or others from serious harm, as defined in the MHA 2007) can be ordered to be taken to a mental health facility for assessment. The magistrate has the option whether to require the defendant to be returned to court, if they are not assessed to be a mentally ill person or mentally disordered person. The charge that gave rise to the proceedings deemed to be dismissed if after 6 months the defendant has not been returned before the court.

Appeals against refusal to treat

Both under current and proposed NSW bail legislation and as a condition of parole or a bond rehabilitation and treatment regimes which can include hospitalization in state hospitals for mental health treatment and rehabilitation may be ordered. The perception referred to in the introduction however often means that there are difficulties for the patient since the court under present legislation cannot order the hospitals to take the patients

Difficulties can arise when the mental health facility declines to admit the defendant in these circumstances, with the risk of the person "bouncing" between the criminal justice and health systems (a parallel situation is when police take an individual to a mental health facility under s 22 of the MHA but they are not admitted).

Whilst the main response to these problems should be to improve interagency communication and cooperation, the NSWLRC has considered whether MHRT appeal rights could be extended to those that are *refused admission* to a mental

[25] Recommendation 12.1-12.9
[26] Recommendation 8.5
[27] Recommendation 13.1 – 13.3

health facility. In the situations outlined above, a request for review of the decision could be initiated by the magistrate or the police.[28] However, it is unclear when and how such reviews would take place (a 24/7 mobile MHRT?), or what orders the MHRT should be able to make in these circumstances.

ROLE OF MHRT - FORENSIC JURISDICTION

The Mental Health Review Tribunal is an independent specialist quasi-judicial body constituted under the *Mental Health Act 2007* (MHA). It has responsibilities under this Act and also the *Mental Health (Forensic Provisions) Act 1990* (MHFPA). The details of the MHRT's activities can be found on its website – www.mhrt.nsw.gov.au.

In terms of its forensic jurisdiction, the *Mental Health Legislation Amendment (Forensic Provisions) Act 2008* abolished the system of determinations previously made by the Minister for Health and the Governor for the treatment, care, detention and release of persons found not guilty by reason of mental illness (NGMI) or unfit for trial under the *Mental Health (Criminal Procedure) Act 1990*. All such determinations are now made by the MHRT, constituted by a special Forensic Panel. The Amendment Act also created the new category "correctional patient" for those persons who develop mental illness whilst in custody on remand or whilst serving sentence. Thus the term "forensic patient" only refers to NGMI who are either detained or released subject to conditions, or persons found unfit to stand trial who are detained.

The Tribunal has the following powers:

- To make orders in relation to the care, detention and treatment of forensic and correctional patients.
- To make orders for conditional or unconditional release of forensic patients.
- To make Community Treatment Orders for forensic patients; correctional patients ordered to be transferred to a correctional centre; persons subject to an order to be transferred to a mental health facility from a correctional centre, but who have not been transferred; inmates of correctional centres.
- To determine if a person is fit to plead to a criminal charge within 12 months of a court's finding that the person is unfit to be tried.

Procedure for determination of fitness

Once the court has found the defendant unfit (and if the court orders that the defendant be detained), it must refer the case to the MHRT. The MHRT must review the case as soon as practicable and make a determination:

- Whether the person is likely or unlikely to become fit within 12 months, and
- Whether the person suffers from a mental illness or a mental condition for which treatment is available in a hospital (s16).

[28] Recommendation 8.1, 10.7

If the person is likely to become fit within 12 months, the MHRT must notify the court and make recommendations as to care and treatment. The court has 3 options under s17 MHFPA – grant bail for a period not exceeding 12 months; order detention in a mental health facility (if mentally ill, or having a mental condition and not objecting); order detention in another facility (if not mentally ill/mental condition, or having a mental condition but objecting to detention in a mental health facility), for a period not exceeding 12 months.

If the court receives notification from the tribunal that the person is unlikely to become fit within 12 months, the court is to conduct a special hearing as soon as practicable, unless the Director of Public Prosecutions advises that no further proceedings will be taken. A special hearing can lead to one of four outcomes (s22):

- Acquittal
- Found NGMI
- Found guilty of another offence
- Where the court decides on the limited evidence available the accused committed the offence charged (or some other offence) the court nominates a limiting term (that is, the best estimate of the sentence the court would have imposed had it been a normal criminal trial) (s23).

If the court nominates a limiting term they must refer the person to the tribunal. The tribunal determines if the person is suffering from a mental illness or a mental condition for which treatment is available in a mental health facility, and whether or not the person objects to being detained in a mental health facility (s24). The court must then decide whether the person will be detained in a mental health facility or another facility and make orders accordingly (s27).

If the accused is found NGMI, the MHRT must review the case as soon as practicable.

Orders for forensic patients

The Tribunal's orders may stipulate where the patient is to be detained, under what level of security, leave provisions (if any) and, if on conditional release, conditions on the patient's continuing presence in the community, including geographical restrictions and non-association orders. The Tribunal is required to consider the matters set out in s 74 when determining what order to make in relation to forensic patients and correctional patients:

> (a) whether the person is suffering from a mental illness or other mental condition,
> (b) whether there are reasonable grounds for believing that care, treatment or control of the person is necessary for the person's own protection from serious harm or the protection of others from serious harm,
> (c) the continuing condition of the person, including any likely deterioration in the person's condition, and the likely effects of any such deterioration,
> (d) in the case of a proposed release, a report by a forensic psychiatrist or other person of a class prescribed by the regulations, who is not currently involved in treating the person, as to the condition of the person and

whether the safety of the person or any member of the public will be seriously endangered by the person's release,
(e) in the case of the proposed release of a forensic patient subject to a limiting term, whether or not the patient has spent sufficient time in custody.

The Tribunal must not make an order for the leave of a patient unless it is satisfied that the safety of the patient or any member of the public will not be seriously endangered (s49). In ordering release, the Tribunal must be satisfied regarding the same safety requirements, but also that suitable care of a less restrictive kind is available to the patient (or the patient does not need care) (s43).

The Tribunal may release a person unconditionally, or with conditions in accordance with ss 75 and 76 (which cover issues such as treatment, rehabilitation, accommodation, drug testing, conduct, non association with victims and families, travel/geographical restrictions).

NSW Law Reform Commission Recommendations (Report 138)

The NSWLRC made various recommendations regarding criminal responsibility of mentally ill offenders that were unlikely to impact directly on the operations of the MHRT, including:

- Updating the standards of the *Presser* test and incorporating them into statute, as is the case in most other Australian jurisdictions.[29]

- Redefining the *M'Naghten* test in terms of mental health impairment and cognitive impairment, consistent with the terminology proposed for other legislation.[30]

- Renaming the special verdict "not criminally responsible by reason of mental health or cognitive impairment".[31]

- Retaining the partial defences of substantial impairment and infanticide, but updating the terminology.[32]

The NSWLRC also recommended streamlining the procedures following a finding of unfitness, to reduce complexity and delays. It recommended the court (at the point of finding the defendant unfit) should also determine whether the defendant is likely to become fit to stand trial within 12 months. If not, it should proceed directly to a special hearing. Only those cases that are likely to become fit will be referred to the MHRT for a maximum of 12 months, who will review fitness periodically. If the person becomes fit during this period, the ordinary

[29] NSWLRC Report 138, Recommendation 2.1
[30] Recommendation 3.1, 3.2
[31] Recommendation 3.6
[32] Recommendation 4.1, 5.1

trial process will resume, otherwise the matter will be referred back to court for a special hearing.[33]

Once a finding of NGMI or UNA (unfit and not acquitted following a special hearing) is made, the court should nominate a limiting term (if imprisonment would have occurred at a normal trial). The court should then refer the defendant to the MHRT for ongoing determination regarding detention and treatment. However, the person ceases to be a forensic patient at the end of the limiting term. [34]

This means that those found NGMI will no longer be at risk of being detained indefinitely.[35] It was felt that this was an important protection for forensic patients, and would address the reluctance to raise NGMI in appropriate cases because of concerns about indeterminate outcomes. This would also make it feasible to extend NGMI to the Local Courts,[36] avoiding the anomaly that release is the only order available to the magistrate if a defendant successfully raises a common law mental illness defence.[37] The NSWLR also recommended that the fitness provisions of the MHFPA should also be available at Local Court.[38]

It was acknowledged that regarding forensic patients, there remained concerns regarding risk and community safety at the end of the limiting term; it was thought most cases could be dealt with through the civil mental health and guardianship systems.[39]

However, there are likely to be a few patients who require either continued detention or supervision in the community beyond the expiry of their limiting term. The recommendation is that the existing regime for continued detention of high risk sex offenders and violent offenders[40] be adapted to apply to forensic patients who present an unacceptable risk of serious psychological or physical harm to others if released. The application for extension of forensic patient status would be made to the Supreme Court, with orders limited to a maximum of 5 years, with provision for second and subsequent orders.[41]

SENTENCING

The sentencing principles outlined below relate to offenders with mental or cognitive impairments. As the language is that of the specific cases, without this warning, that fact may not be immediately obvious.

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[33] Recommendation 6.1
[34] Recommendation 7.1, 7.2
[35] At least not under the *Mental Health (Forensic Provisions) Act 1990 (NSW)*.
[36] Recommendation 12.3. If either fitness or the defence of mental illness is to be raised, the court should first consider diversion under s 32 or s 33.
[37] *R v McMahon* [2006] NSWDC 81.
[38] Recommendation 12.1 – see note above regarding diversion.
[39] Report 138, at 7.86 – 7.87
[40] See *Crimes (High Risk Offenders) Act 2006* (NSW).
[41] Recommendation 11.1

It should also be noted that the NSW Law Reform Commission conducted a concurrent review of sentencing. The final report was sent to the Attorney General on 19 July 2013.

In a preliminary outline the Commission made clear that regard would be had to:

> *…the scope and role of alternatives to prison, the ways in which those sentences could be used more widely to reduce re-offending, as well as appropriate options for particular categories of offenders where there are concerns in relation to the safety of the community*.[42]

General Principles

The purposes of sentencing are outlined in s3A(c) *Crimes (Sentencing Procedure) Act 1999 (NSW).* As at common law,[43] they include protection of society, deterrence of the offender and others who might be tempted to offend, retribution and reform.[44] The purposes cannot be considered in isolation. They are frequently overlapping and at times conflicting.

Pursuant to s21A(1) *Crimes (Sentencing Procedure) Act* 1999 (NSW*)* the sentencing court is also to take into account any relevant aggravating or mitigating factors. Mitigating factors include 'the offender was not fully aware of the consequences of his or her actions because of the offenders age or any disability'. [45]

The sentencing court is also required to take into account 'any other objective or subjective factors that affect the relative seriousness of the offence' and 'any other matters required or permitted to be taken into account by the court under any Act or rule of law'.[46]

How then is 'mental abnormality'[47] relevant to the sentencing process?

Before this question can be answered, it would seem prudent to define what falls within its rubric. Serious 'psychiatric disorder' is not essential.[48] Mental abnormality would appear to encompass temporary or permanent abnormalities[49] variously described as mental illness, mental disorders or conditions, mental impairment, psychiatric or intellectual disability.

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[42] NSW Law Reform Commission, Sentencing, Preliminary Outline of Review, Sept 2011.
[43] *Veen v The Queen* [No 2](1988) 164 CLR 465 at 476-477.
[44] *Crimes (Sentencing Procedure) Act 1999* (NSW) s21A(3)(e) and (g) add 2 purposes to those at common law – to make the offender accountable and to make the offender recognize the harm done to the victim and the community. The prevailing view is that they add 'nothing of substance'. See See Stephen J Odgers, *Sentence* (Longueville Publishing, 2012), 63 at [3.15].
[45] *Crimes (Sentencing Procedure) Act 1999* (NSW) s21A(3)(j).
[46] *Crimes (Sentencing Procedure) Act 1999* (NSW) s21A(1).
[47] The term used in *Veen [No 2].*
[48] Depending on the circumstances, mental disorders of moderate severity may influence the need for deterrence of the individual or others: see *DPP (Cth) v De La Rosa* [2010] NSWCCA 194 at [178].
[49] *Carlton v The Queen* [2008] NSWCCA 244 at [101].

The term also appears capable of extending to 'psychological factors that impair judgment or capacity to control behaviour to a degree not commonly experienced by other offenders'[50], or even to 'gross irrationality and highly unusual motivation',[51] but not to self-induced states of intoxication or addiction (at least where the addiction arose independently of any underlying disorder).[52]

Broad indeed but not particularly illuminating. It is hardly surprising that sentencing courts have responded in a pragmatic fashion. In *R v Verdins* Maxwell P Buchanan and Vincent JJA stated:

> *The sentencing court should not have to concern itself with how a particular condition is to be classified. Difficulties of definition and classification in this field are notorious. There may be differences of expert opinion and diagnosis in relation to the offender. It may be that no specific condition can be identified. What matters is what the evidence shows about the nature, extent and effect of the mental impairment experienced by the offender at the relevant time.*[53]

Similarly in *R v Sebalj*[54] Maxwell P cautioned against focusing on whether or not the abnormality amounted to a recognized psychiatric illness:

> *… What matters in any given case is not the label to be applied to the psychiatric condition but whether and to what extent the condition can be shown to have affected the offender's mental capacity at the time of the offence and/or at the time of sentence.*

It is suggested that the provision of workable definitions such as those recommended by the NSW Law Reform Commission will relieve much of the confusion that pervades this area.[55] Definitions that focus on function and observable criteria will hopefully enable experts to provide reports of greater utility and some certainty for the court. However the courts have already adopted a pragmatic approach to psychiatric evidence so this without more is unlikely to translate into better outcomes for the cognitively and mentally impaired.

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[50] See Stephen J Odgers, *Sentence* (Longueville Publishing, 2012), 230 at [4.73].
[51] *Sun v R* [2011] NSWCCA 99 at [46]
[52] *R v Henry* (1999) 46 NSWLR 346 at [252]-[254]; *MDZ v R [*2011] NSWCCA 243 at [74]-[76] In *MDZ* Hall J (Tobias AJA and Johnson J agreeing) held that the applicant's borderline personality disorder preceded and contributed to the applicant's long term addiction problems.
[53] *R v Verdins* [2007] VSCA 102 at [8].
[54] *R v Sebalj* [2006] VSCA 106 at [21].
[55] www.lawlink.nsw.gov.au/lrc : NSW Law Reform Commission, *People with cognitive and mental health impairments in the criminal justice system: criminal responsibility and consequences* Report No 135, (2012), recommendations 5.1 and 5.2.

How then is mental abnormality relevant to the sentencing process?

The fact that an offender was or is suffering from a mental disorder either at the time of the commission of the offence or at the time of sentencing may be taken into account at sentencing.[56]

The fact that an offender is mentally ill, does not necessarily mean that the sentence imposed must be less than that imposed on a person who commits the same criminal act without any mental abnormality.[57]

This is the case even if there is a causal relationship between the mental abnormality and the commission of the offence.[58]

In short, its relevance will depend on the circumstances of the case.

Gleeson CJ's observations in *R v Engert* are apposite:

> *'It is … erroneous in principle to approach the law of sentencing as though automatic consequences follow from the presence or absence of particular factual circumstances. In every case, what is called for is the making of a discretionary decision in the light of the circumstances of the individual case, and in the light of the purposes to be served by the sentencing exercise'.*[59]

What then are the relevant principles or considerations?

Whether a mental condition is relevant to assessment of the objective seriousness is not clear

In *Muldrock v R,* the High Court held that the objective seriousness of an standard non-parole period offence[60] is to be determined wholly by reference to the nature of the offending; matters personal to the offender are not to be taken into account even if they are causally related to the commission of the offence.[61]

Whilst the High Court did not specifically address the relevance of a mental condition to the assessment of the objective seriousness, it made clear that an offender's mental condition is relevant to the assessment of moral culpability.[62,63]

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[56] *R v Anderson* (1980) 2 A Crim R 379.
[57] *Courtney v R* [2007] NSWCCA 195 at [83].
[58] *R v Engert* (1995) 84 A Crim R 67 at 71.
[59] *R v Engert* (1995) 84 A Crim R 67 at 69.
[60] *Crimes (Sentencing Procedure) Act 1999* (NSW) s54A(2).
[61] *Muldrock v R* (2011) 244 CLR 120 at [27].
[62] See *Muldrock v R* at [54]-[55].
[63] Moral culpability is a factor that bears on the seriousness of the offence; the latter referring to all aspects of the offence - its causes, circumstances and consequences.See Stephen J Odgers, *Sentence* (Longueville Publishing, 2012), 72 -73, [3.32]-[3.33].

Before turning to moral culpability, it should be noted that post *Muldrock* contrasting approaches have emerged as to the relevance of an offender's mental condition to the determination of the objective seriousness of an offence.[64] An offender's mental condition has been rejected as a factor to be considered in the assessment of objective seriousness,[65] said to be a factor that bears upon such assessment,[66] been referred to but not decided,[67] been simultaneously rejected and included as a factor for consideration,[68] and considered as factor relevant to, and likely to produce the same sentence, irrespective of how it is taken into account.[69]

Indeed in *Williams v R,*[70] Price J (Allsop and Campbell agreeing) indicated that he construed the nature of offending referred to in *Muldrock* to mean the fundamental qualities of the offence. His Honour viewing provocation (as a mitigating factor under s21A(3)(c)CPSA) as a fundamental quality, added:

> *Notwithstanding this discussion, I am far from certain that, after Muldrock, whether proven provocation is taken into account in assessing the objective seriousness of the offence or as a matter personal to a particular offender, that there will be any practical impact upon the ultimate sentence.*

His Honour's sentiments and indeed his pragmatic approach was echoed by Button J (McClellan CJ and Price J agreeing) in *Stewart v R*:

> *…. I proceed on the basis that features personal to the offender should not be taken into account in assessing the objective seriousness of the offence. That approach accords with sentencing practice before the statutory system of standard non-parole periods began in 2003. Furthermore so long as sentencing is founded on instinctive synthesis whereby all relevant objective and subjective features will be accorded appropriate weight that approach disadvantages neither the Crown nor the offender*
>
> *It may be that with regard to some features the dividing line between classification of them as subjective and objective cannot be sharply drawn….*[71]

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[64] *Yang* [2012] NSWCCA 49 at [28]; *GN v R* [2012] NSWCCA 96 at [12] and [18].
[65] *Stewart v R* [2012] NSWCCA 183 at [37]; *Badans v R* [2012] NSWCCA 97 at [53]; *R v Biddle* [2011] NSWSC 1262 at [88].
[66] *MDZ v R* [2011] NSWCCA 243 at [67]; *Cotterill* [2012] NSWSC 89 at [30].
[67] *Ayshow v R* [2011] NSWCCA 240 at [39].
[68] *R v Fahda* [2012] NSWSC 114 at [50] and [38]. Here, His Honour found the offenders' mental illness mitigated the 'objective criminality' of the offence; however, whilst it remained 'particularly relevant' to sentence, it had no bearing on the objective seriousness of the offence. It is unclear exactly what His Honour means here.
[69] *Williams v R* [2012] NSWCCA 172 at [42] –[43]; *Stewart v R* [2012] NSWCCA 183 at [37] –[38].
[70] *Williams v R* [2012] NSWCCA 172 at [43];
[71] *Stewart v R* [2012] NSWCCA 183 at [37] –[38].

Both Price J and Button J's approach clearly reflect the judicial pragmatism of *Markarian.*[72] Whilst the issue awaits clarification it is my submission that their Honours' are correct in their assessment of the ultimate sentence remaining the same.

An offender's mental condition is relevant to moral culpability

Culpability involves an assessment of the offender's moral responsibility for the offence. It focuses attention on aspects of the offender's conduct and his or her subjective circumstances.[73] Culpability will depend on all the circumstances of the case including the nature and severity of the mental abnormality and the extent of its contribution to the offence.[74]

Where the mental condition contributes in a material way to the commission of the offence moral culpability will be reduced, thereby reducing the need for denunciation. This may ultimately lead to a reduction in sentence.[75]

If an offender asserts his or her mental condition materially contributed to the offending, he or she bears the burden of proof and must bring sufficient evidence to establish the causal link.[76]

The significance of any mental abnormality (with respect to seriousness of the offence) will be reduced where the offender's own voluntary conduct played a role in the commission of the offence such as where the abnormality was caused to a significant degree by the offender's drug addiction (except where the abnormality contributed to the development of the addiction) or where the offender deliberately chose not to take the prescribed medication.

A diagnosis of a mental condition per se does not mean that general or specific deterrence does not apply to the particular offender

Lush J in *R v Mooney* linked the significance of general deterrence in a particular case to the kindred concept of retribution[77] – 'a sentence imposed with deterrence in view will not be acceptable if its retributive effect on the offender is felt to be inappropriate to the situation and to the needs of the community'.[78]

In *Ryan v The Queen*, McHugh J observed:

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[72] In *Markarian v R* (2005) 228 CLR 357 at [51] McHugh J discussed what he meant by instinctive synthesis – 'the judge identifies all the factors that are relevant to the sentence, discusses their significance and then makes a value judgment as to what is the appropriate sentence given all the factors of the case. Only at the end of the process does the judge determine the sentence'.
[73] *KR v R* [2012] NSWCCA 32 at [22].
[74] *Carney v R* [2008] NSWCCA 277 at [59].
[75] *R v Israil* [2002] NSWCCA 255 at [23]: *R v Pearson* [2004] NSWCCA 129 at [43].
[76] *Wilmot v R* [2007] NSWCCA 278 at [26].
[77] *BP v R* [2010] NSWCCA 159 at [4] per Hodgson JA – 'considerations of retribution direct attention to what the offender deserves'.
[78] *R v Mooney* (unreported, Victorian Court of Criminal Appeal, 21 June 1978) at 8, cited in *Muldrock v R* (2011) 244 CLR 120 at [53].

> *…a proper purpose of the criminal law is not to give effect to the irrational prejudices of ill-informed public opinion. The urge for retribution is, or should be, treated as diminished in the case of the mentally ill.*[79]

However a diagnosis of mental illness per se does not mean that deterrence (specific or general) will not apply to a particular offender.[80]

An excellent exposition of principle is found in *R v Wright* (1997) 93 A Crim 4 at 48 Hunt CJ (Gleeson CJ and Hidden J agreeing) stating:

> *It is an accepted principle of sentencing that general deterrence should often be given very little weight in the case of an offender suffering from a mental disorder or abnormality because such an offender is not an appropriate medium for making an example to others. In most of the cases in which that principle is applied, the offender has suffered from a significant mental illness or retardation, but such a condition is not a necessary condition for the principle to be applied. Considerations of general (or even personal) deterrence are not rendered completely irrelevant, and the significance of the offender's mental incapacity is to be weighed and evaluated in the light of the particular facts and circumstances of the individual case.*
>
> *The reason for the principle is that the interests of society do not require such persons to be punished as severely as persons without that disability because such severity is inappropriate to their circumstances. The full understanding of the authority and requirements of the law which is attributed to the ordinary individual of adult intellectual capacities cannot be expected of a person whose intellectual function is insufficient to have that understanding. The means by which the courts give effect to that principle (as an instrument of social administration) is to moderate the consideration of general deterrence to the circumstances of the particular case.* ***But, if the offender acts with knowledge of what he is doing and with knowledge of the gravity of his actions, the moderation need not be great.***[81]

Thus where an offender makes a choice impacting upon the inherent condition (such as in *Wright* by failing to take prescribed medication and abusing substances which he knew made his illness worse),[82] general deterrence is likely to remain an important sentencing objective. Similarly specific deterrence may

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[79] *Ryan v The Queen* (2001) 206 CLR 267, cited in *R v Windle* [2012] NSWCCA 222 at [37].
[80] *R v Bugmy* [2012] NSWCCA 223 at [45].
[81] *Wright* has been applied in a number of subsequent cases including *Benitz v R* (2006) 160 A Crim R 166 at [41]-[42] and *Taylor v R* [2006] NSWCCA 7 at [30].
[82] *R v Wright* (1997) 93 A Crim 4 at 52.

be given more weight where an offender has chosen to disregard medical advice,[83] or where it is considered there is a need to reinforce strict adherence to treatment.[84] However, where a mental condition is ongoing, there is very little need for specific deterrence.[85]

In contrast to the question of substance abuse, there is a dearth of judicial exposition on the issue of choice in the context of mental illness. Decisions regarding treatment will obviously be affected if the defendant lacks insight into their illness or the need for treatment. It would be erroneous to give significant weight to deterrence in such situations. They are to be contrasted with situations where an individual in a normal mental state makes a decision to stop medication in circumstances where they were fully aware of the potential negative consequences of their actions.

Sentence length and the conditions under which it is served may be modified for offenders with mental abnormality

Ill health will only mitigate punishment when it appears that imprisonment will be more onerous than for other offenders or when there is a serious risk of imprisonment having a gravely adverse effect on the offender's health.[86] Even where the illness is relevant to the determination of sentence, its weight must be assessed in light of all of the circumstances of the case.[87]

A custodial sentence may weigh more heavily on a mentally unwell offender.[88] Thus the offender's mental illness or disorder may have a bearing on the kind or the length of the sentence that is imposed[89] and the conditions under which it is served.[90] Where the facts show that custody would pose a greater burden than for the average offender it may establish special circumstances warranting a longer period on parole.[91]

Even where there is an absence of a causal connection between the mental condition and the offence the mental disorder may be important as a factor relevant to rehabilitation

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[83] *Clay v R* [2007] NSWCCA 106 at [25]-[26] cf *Carroll v R v* [2012] NSWCCA 118 at [62] where there may have been good reasons for the offender to stop medication.
[84] *Carney v R* [2008] NSWCCA 277 at [66]
[85] *Windle v R* [2012] NSWCCA 222 at [41]
[86] *R v Smith* (1987) 44 SASR 587 at 317.
[87] *R v BJW* (2000) 112 A Crim R at [31]; *R v Achurch* [2011] NSWCCA 186 at [163]. In effect, there will be very little discount where the condition can be effectively managed by prison health services.
[88] This applies even if the person did not suffer from the mental abnormality at the time of the offence and has only a foreseeable risk of recurrence at the time of sentencing. See *De La Rosa* [2010] NSWCCA 194 at [177]
[89] *R v Israil* [2002] NSWCCA 255 at [26].
[90] *Muldrock v R* [2012] NSWCCA 108 at [6] In the case of an offender with severe intellectual disability personnel deterrence may be satisfied by requiring them to undergo appropriately tailored treatment in a secure facility.
[91] *R v Elkassir* [2013] NSWCCA 181at 37; *Subramaniam v R* [2013] NSWCCA 159 at 66.

In determining the appropriate sentence for an offence the court is to take into account whether the offender has good prospects of rehabilitation.[92] The better the prospects of rehabilitation at the time of sentencing the less the need for a sentence giving weight to specific deterrence or one containing an element of preventative detention, thereby allowing more weight to be given to rehabilitation as a sentencing goal.[93]

A sentencing court will be more persuaded the prospects of rehabilitation are good if significant rehabilitation has already occurred at the time of sentencing.[94] The reasons why an offender is unlikely to re-offend again are not material.[95]

Rehabilitation may also be found to be a special circumstance under ss 44(2) or 44(2B) of *Crimes (Sentencing Procedure) Act 1999* (NSW). However to amount to special circumstances there must be 'significant positive signs which show that if allowed a longer period on parole rehabilitation is likely to be successful and not merely a possibility'.[96]

Mental abnormality, dangerousness and protection of the community

An offender's ongoing mental illness may mean they present more of a danger to the community. In those cases, specific deterrence may result in an increased sentence.[97] The sentence cannot be increased beyond that which is proportionate to the crime.[98] However, the distinction between 'extending a sentence to protect society and taking into account society's protection' is not always clear-cut.[99]

In some instances conflicting considerations will produce a sentence 'no less severe than would have been imposed if the offender had not been suffering from a mental abnormality'.[100] As the majority in *Veen v The Queen [No 2]* pointed out:

> *… a mental abnormality which makes an offender a danger to society when he is at large but which diminishes his moral culpability for a particular crime is a factor which has 2 countervailing effects: one which tends towards a longer custodial sentence; one towards a shorter* [101]

[92] *Crimes (Sentencing Procedure) Act 1999* (NSW) s21A(3)(h).
[93] See Stephen J Odgers, *Sentence* (Longueville Publishing, 2012), 230 at [4.106].
[94] *R v JW* [2010] NSWCCA 49 at [210]; *R v Darby* [2011] NSWCCA 52 at [53].
[95] *R v Roberts* [2003] NSWCCA at [15].
[96] *R v Carter* [2003] NSWCCA 243 at [20].
[97] *Henry* at [28]; *Israil* at [24]; *De La Rosa* [2010] NSWCCA 194 at [177].
[98] Put alternatively a sentence may not exceed that which is warranted by the objective seriousness of the offence.
[99] *Muldrock* (2011) 244 CLR 120 at [59].
[100] *FD v R* [2013] NSWCCA 139 provides an excellent illustration of this.
[101] *Veen v The Queen* [No 2](1988) 164 CLR 465 at 476.

A recent NSWCCA decision *R v Potts* reaffirmed that the trial judge was correct in taking account of future dangerousness.[102] Referring to the appellant's violent propensities despite intensive attempts at treatment, the court citing *R v Garforth*[103] held there was no error in having regard to future dangerousness:

> *It is now well settled that the protection of society — and hence the potential dangerousness of the offender — is a relevant matter on sentence… This factor cannot be given such weight as to lead to a penalty which is disproportionate to the gravity of the offence. But it can be used to offset a potentially mitigating feature of the case, such as the offender's mental condition, which might otherwise have led to a reduction of penalty.*

The sentencing court must be satisfied that the offender is 'likely'[104] to re-offend, or at least there is a 'serious or substantial' *risk* of re-offending.[105]

In *R v Windle*, Basten JA expressed several concerns regarding the sentencing of violent and dangerous mentally ill offenders.[106] His Honour emphasized the difficulties in assessing the need for protection of society (alternatively put, dangerousness), the potential for 'unprincipled sentencing' and the risk of imposing excessive sentences on the mentally ill:

> *The ambiguity lies in the failure to identify whether the yardstick within which an element of preventative detention can operate (identified as the legitimate purpose of protection of the public), namely the greatest sentence which can be imposed proportionate to the gravity of the offence, includes the element of mental illness.*
>
> *If it does, and it is difficult to see how it cannot in a case where the mental illness constitutes an element of the offence, it would be difficult to take the mental illness (now described as a propensity to commit crime) into account in a manner which is set off against the diminished moral culpability, without the sentence being increased beyond the limit imposed by the yardstick of proportionality. On the other hand if mental illness is removed from the calculation of proportionality, a critical*

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[102] *Potts v R* [2012] NSWCCA 229; the danger of re-offending need not arise from any particular cause.
[103] *R v Garforth (*NSWCCA, 23 May 1994, unreported*),* cited in *Potts v R* [2012] NSWCCA 229 at [168].
[104] In *R v SLD* (2003) 58 NSWLR 589 at [37]-[39] Handley JA (Sully and Buddin JJ agreeing) held that a finding that a prisoner is likely to re-offend does not require a finding that it is more probable than not that he will do so.
[105] *R v McNamara* [2004] NSWCCA 42 at [23]-[30]. Grove J noting at [25] that the decision in *Olbrich v R* (1998) 45 NSWLR 538 is limited to facts and does not apply to 'future probabilities or possibilities'.
[106] *R v Windle* [2012] NSWCCA 222.

> *element central to the assessment of moral culpability is ignored. When re-introduced it is offset by the protective element.* [107]

His Honour at [57] articulated his preference for a system of preventative detention for dangerous mentally ill offenders:

> *The appropriate mechanism for protecting society cannot be found in the criminal law; the need for protection arises from mental illness and it is through mental health legislation that such protection as may be available must be sought.*[108]

His Honour's remarks are timely and in concordance with the recommendations made in Report 138.

[107] Ibid at [44]-[47]

[108] Although it is a sobering thought that clinician predictions of dangerousness have only a 33-50% success rate and are central to continuing detention orders: see Kirby J in *Fardo v A-G for Qld* (2004) 223 CLR 575 at [124].

CONCLUDING REMARKS

The MHRT has extensive relevant experience in managing the risk posed to the community by mentally ill offenders. However, the effect of the expiry of a limiting term is that the patient ceases to be a forensic patient. It is by no means clear that the civil mental health system has the resources or the expertise to manage a larger cohort of such patients. Nor is this patient group a priority for community mental health planners – for example, the intersection with the criminal justice system does not rate a mention in a recent tender for a pilot program of "mental health hubs".[109]

Similar to the requirements of diversion programs, the management of at-risk individuals in the community requires the concentration and integration of resources, in a manner that is to some extent geographically specific. The results from pilot programs may not be replicable on a wider scale, partly because of resource limitations, but also because of local variations.

In an era that aspires to evidence-based practice and policy, there are a small number of case-controlled short-term studies of diversion programs and court-mandated treatment that show positive results.[110] There is a complete absence of long-term investigations, or studies that can illuminate what are the most effective program components. High-risk individuals who come into contact with the criminal justice system often have multiple diagnoses across mental and cognitive domains, complicated by substance use, in the context of major psychosocial adversity and structural issues such as homelessness. These risk factors coalesce differently in individuals, demanding a bespoke response. Given the need for multi-agency involvement, which service takes ultimate responsibility for these individuals, and how are the costs to be borne?

Whilst the investment required now to provide comprehensive services is high, in the long run a systemic failure to address the needs of this offender group could be catastrophic. Perhaps the last words should be left to Lady Caroline Lamb:[111]

> Some poor men's tales I've heard upon my journies,
> Would make a bishop long to roast attornies.

[109] *Pilot – New Integrated Service Model for People with Mental Health Needs.* NSW Government tender HAC 13/51 published online 2 August 2013.
[110] Reviewed in NSWLRC Report 135 at 3.17-3.20
[111] A New Canto, 1819

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