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Foreword by the Chair of the Sentencing Advisory Council

The criminal justice system plays a vital role in keeping South Australians safe. Reports of crime and punishment are frequently in the news with sentencing in particular attracting more public interest than any other aspect of the criminal justice system. In January 2012, the Attorney General, the Hon. John Rau established the South Australian Sentencing Advisory Council (the Council). The Council was established to improve the quality and availability of information on sentencing in South Australia and assist in bridging the gap between the courts and the community.

The Council aims to strengthen public understanding of the sentencing process and by doing so enhance confidence in the criminal justice system. The Council aims to improve the quality and availability of information on sentencing in South Australia by:

- preparing research papers, advice and reports in connection with sentencing at the request of the Attorney-General;
- publishing information relating to sentencing;
- educating the public about sentencing matters; and
- obtaining the community’s views on sentencing matters.

The Council is an advisory body with a broad membership. It includes people with experience in the criminal justice system such as representatives from the Director of Public Prosecutions, the Parole Board, the Legal Services Commission, the South Australian Bar Association, the Commissioner for Victims’ Rights, the Law Society of South Australia, the Commissioner for Aboriginal Engagement and South Australian Police. However, one of the key components of the membership of the Council is that it includes community members from a diverse range of backgrounds. They play an integral part in ensuring that the views of the community are taken into account when formulating recommendations for the Government.

The current members of the Council are:

- Hon. Kevin Duggan AM, QC (Chair)
- Mr Peter Alexander
- Ms Liesl Chapman SC
- Mr Ian Leader-Elliott
- Ms Anne McLennan
- Mr Greg Mead SC
- Ms Caroline Mealer
- Ms Frances Nelson QC
- Mr Michael O’Connell
- Mr Ian Press SC
- Ms Khatija Thomas
- Assistant Commissioner Linda Williams
- Mr Michael Woods

One of the pressing issues for the Government and a matter of community concern is the review of the applicability and functionality of the ‘mental impairment defence’. The need for such a review is not unique to South Australia. Victoria, Western Australia, New South Wales,
New Zealand and Scotland have recently considered their mental impairment laws and the United Kingdom is in the process of undertaking a similar review.

The legislation regulating the defence is set out in Part 8A of the *Criminal Law Consolidation Act 1935* (SA) (*the CLCA*). The making of supervision orders and the fixing of limiting terms pursuant to Part 8A of the CLCA are matters closely related to the sentencing process. Although such orders are not imposed as punishment, they involve a deprivation of freedom and, when the Court fixes a limiting term, it must do so by reference to the period of imprisonment that would have been ordered if the defendant had been convicted of the relevant offence.

Accordingly the Attorney-General was of the view that the issue was one which would best be considered by the Council and in March 2012, he referred the following terms of reference to the Council for its consideration:

*To consider the operation of Part 8A of the Criminal Law Consolidation Act with particular reference to:*

- the test of mental incompetence in section 269C;
- the fixing of limiting terms; and
- the supervision of defendants released on licence pursuant to section 269O

The Attorney-General requested that the Council consider the terms of reference, identify any issues or challenges associated with it and, where appropriate, make recommendations to the Government.

The first task of the Council was to prepare a comprehensive Discussion Paper for circulation in the community. The Discussion Paper was released in July 2013 and the closing date for submissions was 11 October 2013. It posed a number of specific questions but also invited comment on all aspects relevant to the operation of Part 8A of the CLCA.

I would like to thank Dr Arlie Loughnan from the Institute of Criminology at the Faculty of Law, University of Sydney who was our principal writer of the Discussion Paper.

A list of organizations and persons who made submissions is set out at Appendix E of this Report. The Council is grateful for the assistance of these responders.

After receiving the submissions the Council embarked on the onerous task of considering the issues raised in the Discussion Paper. At one point it was considered appropriate to refer some of the issues to a sub-committee which then reported back to the Council. The Council is particularly grateful to persons with expertise in the area of our discussions who were co-opted to assist us. They were:

- Ms Pauline Barnett, managing prosecutor at the Office of the Director of Public Prosecutions;
- Judge Steven Millsteed, a South Australian District Court judge; and
- Ms Bronwen Waldron, a senior solicitor from the Legal Services Commission.

During the preparation of both the Discussion Paper and the Report the Council had discussions with professionals involved in various functions under Part 8A of the CLCA including:
• Chief Magistrate Elizabeth Bolton, Chief Magistrate of the Magistrates Court of South Australia;
• Ms Frances Nelson QC, Presiding Member of the Parole Board of South Australia;
• Dr Ken O’Brien, Clinical Director of the Forensic Mental Health Service (SA);
• Dr Craig Raeside, senior forensic psychiatrist; and
• Dr Harry Hustig, Director of the Rehabilitation Services at the Glenside Campus.

The Council secured the services of Mr Jamie Walvisch as the Principal writer of the Report. He is a graduate in Arts and Law from Monash University and has commenced work on a PhD. His thesis is titled “Sentencing Offenders With Mental Illnesses: A Principled Approach”. He is a lecturer at Monash University and has undertaken research work with the Victorian Law Reform Commission, the Australian Institute of Criminology and the Judicial College of Victoria.

At the request of the Council Mr Walvisch has incorporated significant excerpts from the Discussion Paper into the Report so as to provide background to the discussion, but he has also undertaken an extensive summary of the issues, the Council’s discussions, the recommendations of other reviews and the recommendations of the Council. We are grateful for his contribution.

The Council has also received extensive support from M/s Amy Ward, Legal Officer, Attorney-General’s Department who acted as an adviser and administrative officer to the Council from its inception to 25 July 2014 and her successor in these roles, M/s Emily Sims.

It is hoped that the recommendations now made by the Council to the Government, including any proposed legislative reforms, will enhance the operation of Part 8A of the CLCA and create a safer environment for all South Australians.

The Hon. Kevin Duggan AM, QC
Chair of the Sentencing Advisory Council
**Abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACAT</td>
<td>Civil and Administrative Tribunal</td>
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<tr>
<td>AGD</td>
<td>Attorney General’s Department (SA)</td>
</tr>
<tr>
<td>ALRC</td>
<td>Australian Law Reform Commission</td>
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<tr>
<td>ALRM</td>
<td>Aboriginal Legal Rights Movement</td>
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<td>AMA(SA)</td>
<td>Australian Medical Association (South Australia)</td>
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<td>APD</td>
<td>Antisocial Personality Disorder</td>
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<tr>
<td>Bar Association</td>
<td>South Australian Bar Association</td>
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<tr>
<td>CBO</td>
<td>Community Based Order</td>
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<tr>
<td>CFP</td>
<td>Australian Psychological Society College of Forensic Psychology</td>
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<tr>
<td>CLCA</td>
<td><em>Criminal Law Consolidation Act 1935</em> (SA)</td>
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<tr>
<td>Clinical Director</td>
<td>Clinical Director of the Forensic Mental Health Service (SA)</td>
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<tr>
<td>Council</td>
<td>South Australian Sentencing Advisory Council</td>
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<tr>
<td>CRO</td>
<td>Conditional Release Order</td>
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<tr>
<td>CTO</td>
<td>Community Treatment Order</td>
</tr>
<tr>
<td>CVR</td>
<td>Commissioner for Victims’ Rights</td>
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<tr>
<td>DCS</td>
<td>Department for Correctional Services (SA)</td>
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<tr>
<td>DCSI</td>
<td>Department for Communities and Social Inclusion (SA)</td>
</tr>
<tr>
<td>DFATS</td>
<td>Disability Forensic Assessment and Treatment Service (Vic)</td>
</tr>
<tr>
<td>DPP</td>
<td>Director of Public Prosecutions (SA)</td>
</tr>
<tr>
<td>DSM</td>
<td>The American Psychiatric Association’s <em>Diagnostic and Statistical Manual of Mental Disorders</em></td>
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<tr>
<td>ELC</td>
<td>English Law Commission</td>
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<tr>
<td>FMHS</td>
<td>Forensic Mental Health Service (SA)</td>
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<tr>
<td>ICD</td>
<td>The World Health Organisation’s <em>International Classification of Diseases</em></td>
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<tr>
<td>ISO</td>
<td>Intensive Supervision Order</td>
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<tr>
<td>Law Society</td>
<td>Law Society of South Australia</td>
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<tr>
<td>LRCWA</td>
<td>Law Reform Commission of Western Australia</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>LSC</td>
<td>Legal Services Commission of South Australia</td>
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<td>MHA</td>
<td>Mental Health Act 2009 (SA)</td>
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<tr>
<td>MHRT(NSW)</td>
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<td>MHRT(Qld)</td>
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<tr>
<td>MIARB</td>
<td>Mentally Impaired Accused Review Board (WA)</td>
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<tr>
<td>Minister for Health</td>
<td>Minister for Mental Health and Substance Abuse (SA)</td>
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<tr>
<td>NOK</td>
<td>Next of kin</td>
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<tr>
<td>NSWLRC</td>
<td>New South Wales Law Reform Commission</td>
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<td>NZLC</td>
<td>New Zealand Law Commission</td>
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<tr>
<td>OCEO</td>
<td>Office of the Commissioner for Equal Opportunity</td>
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<tr>
<td>OCPP</td>
<td>Office of the Chief Psychiatrist and Mental Health Policy (SA)</td>
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<td>ODPP</td>
<td>Office of the Director of Public Prosecutions (SA)</td>
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<tr>
<td>OPA</td>
<td>Office of the Public Advocate (SA)</td>
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<tr>
<td>RANZCP</td>
<td>Royal Australian and New Zealand College of Psychiatrists</td>
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<td>SACAT</td>
<td>South Australian Civil and Administrative Tribunal</td>
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<tr>
<td>SADHA</td>
<td>South Australia Department of Health and Ageing</td>
</tr>
<tr>
<td>SLC</td>
<td>Scottish Law Commission</td>
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<tr>
<td>VLRC</td>
<td>Victorian Law Reform Commission</td>
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Executive Summary

Part 1: Context of the Report

1. In January 2012, the Hon. John Rau MP, Attorney-General announced the establishment of the Sentencing Advisory Council in South Australia (the Council). The Council’s first terms of reference related to the operation of Part 8A of the Criminal Law Consolidation Act 1935 (SA) (CLCA). In July 2013, the Council released a Discussion Paper which asked 27 questions and called for submissions from the public. After consideration of the 21 submissions received, as well as consideration of the position in other Australian jurisdictions and recommendations made by other reviews of the relevant issues, the Council prepared this Recommendation Report.

2. This Report considers the law and practice relating to the defence of mental incompetence, and associated legal processes, under Part 8A of the CLCA. The defence of mental incompetence concerns those who are considered not responsible under the criminal law due to a mental impairment which has certain consequences referred to in Part 8A of the CLCA.

3. Currently, to be convicted of an offence in South Australia, the defendant must have possessed certain cognitive, volitional and moral capacities at the time he or she committed the criminal act. It is assumed that the defendant possesses the necessary capacities, unless the contrary is established. When a defendant is found not to have possessed the necessary capacities, he or she is found not guilty by reason of mental impairment and becomes subject to special powers of the court. These powers allow the court to release the defendant unconditionally, or to make a supervision order committing the defendant to detention or releasing him or her on licence. If the court makes a supervision order, it must specify the period for which the defendant may be subject to supervision. This is referred to in the Report as a limiting term.

4. This Report comprises of four parts. Part 1 provides the contextual background for the substantive issues associated with the terms of reference; Part 2 makes recommendations about the defence of mental incompetence; Part 3 makes recommendations about the fixing of limiting terms; and Part 4 makes recommendations concerning the supervision of defendants released on licence.

Part 2: The Defence of Mental Incompetence

5. Currently, section 269C of the CLCA provides that the defence of mental incompetence should be available to people who were suffering a ‘mental impairment’ at the time of the offence, and in consequence of that impairment did not know the ‘nature and quality’ of the conduct, did not know the conduct was wrong, or were unable to control the conduct. The definition of ‘mental impairment’ includes ‘a mental illness, or an intellectual disability or a disability or impairment of the mind resulting from senility’ but does not include intoxication.

6. The Council is of the view that there is still a need to provide a legal mechanism for excusing from criminal responsibility those offenders whose mental capacity was significantly impaired at the time of the alleged offending. The defence of mental
incompetence provides protection to the community and provides individuals with the opportunity for treatment.

7. Section 269C(a) of the CLCA provides the first way that the defence of mental incompetence can be proved, which is by establishing that due to the defendant’s mental impairment, he or she did not know the ‘nature and quality’ of his or her conduct, in other words did not know what he or she was doing. The wording of this test has been criticised for being unclear and for unjustly denying the defence to people who have an intellectual or ‘verbalistic’ knowledge of the nature and quality of the conduct but who do not properly understand that conduct’s significance due to their mental health condition. Despite these criticisms, the Council recommends that section 269C(a) of the CLCA should not be amended to define the phrase ‘nature and quality of the conduct’ or to replace the word ‘knowledge’ with the word ‘understanding’.

8. Section 269C(b) of the CLCA provides the second way in which the defence of mental incompetence can be proven, which is by establishing that, due to the defendant’s mental impairment, he or she did not know the conduct was wrong. The concept of wrongness has been interpreted as meaning “wrong having regard to the everyday standards of reasonable people”. This is the most common basis on which the defence of mental incompetence is proved. A Case File Review conducted by the Attorney-General’s Department for the purposes of the Report revealed that the wrongfulness component was the basis for the finding of mental incompetence in 87 per cent of all matters. The Council reached the view that the way in which the concept of “wrongness” has been interpreted has led to vagueness and difficulty, particularly in relation to a gloss which has been added to the test whereby the courts and juries are asked to decide whether the defendant is unable to reason about wrongness with a moderate degree of sense and composure. The Council recommends that section 269C(b) of the CLCA be amended by providing that a person would not know the conduct was wrong if, as a consequence of a mental impairment, the person could not reason about whether his or her conduct, as perceived by reasonable people, was wrong. The intention would be to provide a test which did not turn on the question whether the defendant was able to reason with a moderate degree of sense and composure about the wrongness of the conduct.

9. Section 269C(c) of the CLCA provides the third way in which the defence of mental incompetence can be proved, which is by establishing that due to the defendant’s mental impairment, he or she was unable to control the conduct. As section 269C(c) is rarely used by defendants, the Council considered whether it should be removed from the CLCA. The Council recognises the rarity with which this limb of the defence is used, the practical difficulties with its implementation and the opposition to its continued use. However, the Council is of the view that the limb should remain part of the defence as there are some cases where section 269C(c) is utilised and the defence should be available for those cases. Nonetheless, the Council recommends that the limb should only be able to be utilised by people who are completely unable to control their conduct.

The Definition of Mental Impairment

10. The Council considered the appropriate bounds of the definition of ‘mental impairment’. That phrase is currently defined in section 269A of the CLCA to mean “a pathological infirmity of the mind (including a temporary one of short duration)”. 
The Council recommends that the definition of ‘mental impairment’ should remain in its current form without any amendment.

**Intoxication by Drugs or Alcohol**

11. The Council considered the best way to approach the relationship between mental impairment and intoxication. The Council is of the view that the key question in this area is whether the illness caused the defendant to not know the nature and quality of the conduct, or to not know it was wrong, or to be unable to control the conduct. If it was the illness that was the cause of one of these effects, the defendant should be allowed to raise the defence of mental incompetence. If it was the intoxication that was the cause, the defence should not be available. As this reflects the current law under the CLCA, the Council recommends that the provisions on intoxication and mental impairment in the CLCA be retained without change.

**Part 3: The Fixing of Limiting Terms**

**Psychiatric and Psychological Reports**

12. Expert psychiatric and psychological reports provide important evidence for the court when determining whether a defendant was mentally incompetent to commit the offence, as well as in deciding how to deal with defendants found not guilty by reason of mental incompetence. Part 8A of the CLCA currently provides for the possibility of four different types of expert reports. In light of this, the Council considered whether there should be a reduction in the number of psychiatric reports required by Part 8A and whether judicial officers should be given a discretion regarding the type and number of expert reports that are required for a particular matter.

13. Where a court is considering whether to release a defendant or significantly reduce the level of the defendant’s supervision and where the supervision order arose from proceedings based on a charge of an indictable offence, section 269T of the CLCA requires the court to consider three reports prepared by different experts. The Council is of the view that it is no longer necessary to require three reports to be produced in these circumstances. The requirement to order several reports has the effect of creating significant delay in the finalisation of orders. It is also a costly process. The Council recommends that the default position (regardless of the nature of the offence committed) should be the production of just one section 269T report, to be provided by a psychiatrist (or other appropriate expert) who has personally examined the defendant. The Council further recommends that judges and magistrates should be provided with a broad discretion to order further reports where necessary. The Council does not recommend changes to any of the other reporting requirements within Part 8A of the CLCA.

**Options for Disposition**

14. When a defendant successfully raises the defence of mental incompetence, he or she is found ‘not guilty by reason of mental incompetence’, rather than being completely acquitted. Upon making this finding, the court has three options:

- Release the defendant unconditionally;
- Make a supervision order committing the defendant to detention; or
• Make a supervision order releasing the defendant on licence on specific conditions.

15. The Council recommends that additional disposition options should be introduced and suggests that particular consideration should be given to enacting a provision similar to section 20BQ of the *Crimes Act 1914* (Cth), so as to allow judicial officers to impose conditional bonds on defendants for less serious offences. The Council recommends that the maximum duration of such bonds should be capped.

**Limiting Terms**

16. In the event that the court makes a supervision order, either committing the defendant to detention or releasing the defendant on licence, the court is required to fix a limiting term. The limiting term is the period during which the supervision order remains in operation. When the limiting term expires, the person is no longer subject to the order and the conditions specified in it.

17. The CLCA currently provides that the limiting term should be equal to the length of the sentence that would have been imposed had the defendant been convicted of the offence charged. The general purpose of the supervision order is not to penalise, but to protect the public and to secure the defendant such supervision and treatment as is available and appropriate.

18. Having considered the models in other jurisdictions, the Council recommends that South Australia’s current limiting term system should be retained. Accordingly, the Council recommends that the court should continue to fix the limiting term by reference to the term of imprisonment that would have been imposed had the defendant been convicted of the offence and sentenced in the usual way.

19. The Council recommends that, when fixing a limiting term, the court should not be allowed to reduce the limiting term by taking into account a concession by a defendant that the facts which would otherwise constitute the commission of the offence charged were carried out by him or her.

**Part 4: Supervision of Individuals Released on Licence**

**Community Safety**

20. The Council considered whether South Australia should enact a model similar to that which currently exists in New South Wales, whereby neither the court nor the Mental Health Review Tribunal can order the release of a forensic patient unless they are satisfied, on the balance of probabilities, that the safety of the patient, or a member of the public, will not be seriously endangered by the patient’s release. The Council sees merit in enacting a model similar to that in New South Wales and recommends that the CLCA be amended to insert a provision which ensures that a defendant will not be released from custody unless, on the balance of probabilities, the safety of that person or any member of the public will not be seriously endangered by the person’s release.

**Victims and Interested Parties**

21. The court cannot release a defendant, or significantly reduce the degree of supervision to which he or she is subject, unless it has a report on the attitudes of victims and next of kin. The court must also be satisfied that the victims and next of kin have been
given reasonable notice of the proceedings. In the Discussion Paper, the Council noted that involvement in proceedings under Part 8A of the CLCA can be stressful for victims, particularly when information about the attitude of victims and next of kin is required each time changes are requested to a defendant’s supervision order. The Council sought submissions on whether judges and magistrates should have a discretion in requiring victim and next of kin reports at all stages of the Part 8A proceedings.

22. The Council does not support any changes to the CLCA which would deprive victims of the opportunity to express their views. The Council believes that victims should always be consulted and allowed to make their own decisions about whether or not to participate in the process. Currently, the Office of the Director of Public Prosecutions (ODPP) is responsible for providing the court with a report setting out, so far as is reasonably ascertainable, the views of the victim (if any) of the defendant’s conduct, and the views of the next of kin of a deceased victim. The Council recommends that the current legislative approach should be retained.

23. The Council supports the continued practice of the ODPP providing the victim and next of kin report orally in cases where the victim or next of kin does not wish to participate in the process. The Council also supports people other than the direct victim being consulted during the preparation of victim and next of kin reports in appropriate cases, such as where the victim has difficulty expressing his or her views due to an illness or disability.

24. The Council notes that at present there are only sufficient resources available to employ one person to prepare victim and next of kin reports. The Council believes this is inadequate and recommends that additional resources should be allocated.

Nominating a Lead Agency

25. Where a defendant is released on licence, supervisory responsibilities are divided between the Minister for Health and the Parole Board. The Minister for Health is responsible for matters relating to the treatment or monitoring of the licensee’s mental health. This is normally carried out by the Forensic Mental Health Service. The Parole Board is responsible for all other aspects of the licensee’s supervision. This is normally carried out by the Department for Correctional Services.

26. When a licensee contravenes, or is likely to contravene, a condition of his or her licence, the ODPP may make an application to review the order. In exercising this responsibility, the ODPP receives instructions from both the Forensic Mental Health Service and the Department for Correctional Services. In some circumstances, those instructions conflict. This led the Council to consider whether it would be beneficial for the court to nominate a ‘lead agency’ at the time it sets the licence conditions. The Council also considered an alternative whereby the supervisory agencies themselves would nominate a lead agency who would be primarily responsible for a particular licensee.

27. The Council does not support either the court or the supervisory agencies nominating a lead agency to have primary responsibility for the supervision of a particular licensee. The Council recommends that the current arrangement be retained. This allows the Parole Board to remain responsible for the licensee’s supervision and the Minister for Health to remain responsible for matters relating to the treatment or monitoring of the licensee’s mental health. However, the Council does support the
development of a formal protocol to facilitate consensus on individual cases where there are divided views between the agencies.

**Extending Supervisory Responsibilities to the Minister for Disabilities**

28. In South Australia, issues concerning individuals with mental illnesses generally fall within the domain of the Minister for Health, while issues concerning individuals with intellectual disabilities or brain injuries are the responsibility of the Minister for Disabilities. Even though a significant portion of people who successfully raise the defence of mental incompetence have an intellectual disability or brain injury, currently the Minister for Disabilities does not have any supervisory responsibilities in relation to defendants on supervision orders. The Council recommends amending the CLCA to extend supervisory responsibilities to the Minister for Disabilities.

**Housing Options for People with Cognitive Impairments**

29. The Council is of the view that there is a clear need for a dedicated secure facility for people with cognitive impairments who are found not guilty due to mental incompetence, or who are unfit to stand trial. However, in the absence of a purpose-built facility, the Council considered measures that could be put in place to address the needs of defendants who have been found not guilty of an offence due to mental incompetence (or found unfit to stand trial) on the basis of an intellectual disability or brain injury. The Council recommends that tailored options for housing and support should be provided for these individuals. They should not be housed in James Nash House, which is specifically designed for individuals with mental health issues.

**Breaches of Licence Conditions**

30. The Council considered the appropriate way to deal with breaches of licence. It is obvious that licence conditions are imposed by the court for a reason and that they should not simply be ignored by the licensee. Systems should be in place to ensure compliance with such conditions as far as practicable. However, the Council does not recommend amending the Mental Health Act 2009 (SA) to enable licensees to be assessed and treated as an alternative to revoking their licences and returning them to secure detention at James Nash House. Instead, the Council is in support of retaining the current arrangement which allows a patient to be treated under the Mental Health Act 2009 (SA) if he or she meets the ordinary requirements of that Act, but does not allow that Act to be used in other circumstances.

31. The Council recommends the use of home detention and electronic monitoring devices in appropriate cases. However, the Council does not recommend introducing a criminal sanction for licensees who breach the terms of their licences.

**Administrative Detention**

32. Prior to 2008, it was common practice for licences to include a condition that a licensee could be detained at James Nash House without a court order for up to 14 days, if it was felt that the licensee was contravening, or about to contravene, a licence condition and was a danger to themselves, or another. This practice ceased in 2008
due to the decision in *R v Draoui*\(^3\) where the Court of Criminal Appeal held that the provisions of the CLCA did not allow for administrative detention, even for a short period, and that only the court could revoke a licence.

33. Under the current law, the Clinical Director of the Forensic Mental Health Service can now only detain a licensee under the *Mental Health Act 2009 (SA)* if the relevant requirements have been met, or after a court order has been made revoking a licence under section 269U or 269P of the CLCA. The Council recommends that the CLCA should be amended to allow a licensee to be administratively detained for up to 14 days where future breaches of licence conditions are likely, or treatment is required in order to prevent future breaches.

**Cross-Border Issues**

34. There is currently no provision in the CLCA which allows for a licensee who has entered South Australia contrary to his or her conditions of licence to be returned to the State which granted the licence. The current procedure is for the interstate authorities to apply for a warrant for the arrest of the licensee which is then executed pursuant to the powers contained in the *Service and Execution of Process Act 1992* (Cth). This enables the authorities to return the licensee to the State which applied for the warrant. The Council does not recommend making any changes to the current legislative procedure. The Council does not recommend introducing a statutory provision which allows police officers or other authorised officers to take care and control of interstate forensic patients who are found in South Australia, and to return them to the jurisdiction that made the orders. The Council is of the view that the present practice of applying for warrants under the *Service and Execution of Process Act 1992* (Cth) should be retained. However, the Council supports the development of protocols for use in circumstances where forensic patients impermissibly cross State borders.

35. The Council also considered the best approach to take to co-operative interstate transfers (that is, where a person under supervision or a person who is detained wants to move interstate for proper reasons). The Council recommends the development of a mechanism that provides for the co-operative interstate transfer of people under supervision. The Council is of the view that the provisions of Part 7A of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) provide a suitable model.\(^4\) However, the Council believes it is preferable for a formal reciprocal arrangement between States to be established. The Council therefore recommends the implementation of any reciprocal arrangements agreed upon by national Mental Health Ministers as part of the Fourth National Mental Health Action Plan.

**Supervision by a Mental Health Review Board or Tribunal**

36. Under the present system, all matters relating to supervision orders and the enforcement thereof require formal hearings and the making of orders before the relevant court. Delays in processing these applications are common. In a number of jurisdictions, applications of this nature go before a tribunal. The Council considered


whether South Australia should consider introducing a Mental Health Review Tribunal, Board or equivalent to assist in the supervision of individuals released on licence. The Council is of the view that a specialist tribunal, board or equivalent would provide a more direct and effective method of supervising licensees. Members of the tribunal, board or equivalent would be able to utilise and develop expertise appropriate to such applications along with a familiarity with the history of particular matters. The Council recommends that the Government should consider establishing such a tribunal, board or equivalent. However, the Council is of the view that its powers should be limited to matters concerning the supervision of individuals released on licence. The tribunal, board or equivalent should not play a role in making the initial determination about whether an individual is mentally impaired, or whether the elements of the mental incompetence defence have been met. The court should retain this role.

37. The Council recommends that a working group should be developed to consider the powers, functions and operations of the South Australian tribunal, board or equivalent. The working group should closely examine the models used in other Australian jurisdictions.

**Forensic Mental Health Facilities in South Australia**

38. Step-up and step-down facilities are residential mental health facilities that operate to assist persons recovering from serious mental health episodes. Step-up facilities allow persons to ‘step-up’ from the community into the facility when they begin to suffer some form of relapse, preventing a worsening of the person’s condition. Step-down facilities enable a more gradual return to the community after a person leaves a hospital setting, often providing outreach and drop-in services as well as a residential program to offer further support to persons integrating back into the community.

39. The Council supports the use of step-up and step-down facilities. The Council recommends that a Mental Health Review Tribunal or Board, if established, should be empowered to assist with the efficient operation of the step-up and step-down process. The Council believes that it should be for the tribunal or board to determine the necessary level of court involvement in transitioning a licensee between James Nash House and a step-up or step-down facility.
1. Context of the Report
Terms of Reference

In March 2012, the Attorney-General (SA) referred the following terms of reference to the Sentencing Advisory Council (the Council) for its consideration:

To consider the operation of Part 8A of the Criminal Law Consolidation Act with particular reference to:

- the test of mental incompetence in section 269C;
- the fixing of limiting terms; and
- the supervision of defendants released on licence pursuant to section 269O.

The Attorney-General requested that the Council respond to the terms of reference and, where appropriate, make recommendations to the Government. This Report contains those recommendations.

Introduction

1.1 This Report examines the defence of mental incompetence, and associated legal processes, under Part 8A of the Criminal Law Consolidation Act 1935 (SA) (the CLCA). The purpose of the Report is to consider the appropriateness and effectiveness of the current law and associated practices in dealing with people under Part 8A.

1.2 The defence of mental incompetence concerns those who are considered not responsible under the criminal law due to a medical condition. This defence is largely based on the former ‘insanity’ defence, which continues to exist in some form in all Australian jurisdictions. Due to the stigma attached to the term ‘insanity’, it has now been replaced in many jurisdictions (including South Australia) by terms such as ‘mental impairment’, ‘mental incompetence’ or ‘mental illness’.

1.3 The defence of mental incompetence represents an important safeguard for vulnerable individuals charged with criminal offences. As individuals falling under the mental incompetence defence may be dangerous to themselves or others, practices have developed to deal with such individuals. These practices are analogous to sentencing, but are not the same as sentencing.

1.4 The issues that arise when individuals with mental health issues or cognitive impairments are charged with a criminal offence can be complex and difficult. On the one hand, criminal law principles and practices indicate that special treatment may be appropriate. On the other hand, the fact that such individuals may have caused harm by committing a criminal act must also be taken into account. Fairness to the accused, consideration due to any victims, and adherence to trial procedures all have a bearing on the law of mental incompetence.

Structure of the Report

1.5 The Report consists of four parts. Part 1 provides contextual background for the substantive issues associated with the terms of reference, and includes an overview of:
• The role of sentencing advisory bodies in Australia;
• The current legislative approach taken in South Australia;
• The terminology used in this Report;
• The approach taken by the Council to the terms of reference;
• The Council’s process in formulating its recommendations;
• Previous reviews of the law in the area; and
• A Case File Review undertaken by the Attorney General’s Department (AGD) to understand the way that Part 8A of the CLCA currently operates.

1.6 Part 2 makes recommendations about the defence of mental incompetence. It includes recommendations about the definition of ‘mental impairment’ that should be used, the way intoxication should be addressed, and the relevant legal criteria that should be enacted for establishing the defence. Part 3 makes recommendations about the fixing of limiting terms. Part 4 makes recommendations concerning the supervision of defendants released on licence.

1.7 When examining each issue, the following format is generally adopted:

1. Discussion of the current law, practice or procedures;
2. Issues to be addressed;
3. Approaches taken in other Australian jurisdictions;
4. Approaches taken in other recent reviews;
5. Analysis of submissions received by the Council;
6. Conclusions and Council’s recommendations.

The Role of Sentencing Advisory Bodies in Australia

1.8 Over the last few years, a number of sentencing advisory bodies have been created in various States and Territories in Australia. The New South Wales Sentencing Council was the first such body in Australia, established in 2003. This was soon followed by other States, with the Sentencing Advisory Council established in Victoria in 2004, and the Tasmanian Sentencing Advisory Council and the Queensland Sentencing Advisory Council created in 2010. To date, no sentencing advisory body has been

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established in the Northern Territory or Western Australia, or at the Commonwealth level.\textsuperscript{9}

1.9 While each of these sentencing advisory bodies has distinct aims and objectives, the Australian Law Reform Commission (\textsc{ALRC}) has identified three primary functions that sentencing advisory councils perform: research, advice and rule making regarding sentencing.\textsuperscript{10} In undertaking research, and providing advice, sentencing advisory bodies also inform the public on issues relating to sentencing.

1.10 As explained in the Foreword to the Report, in January 2012 the Hon. John Rau, Attorney-General, announced the establishment of a Sentencing Advisory Council in South Australia. The Council was established to improve the quality and availability of information on sentencing in South Australia, and to assist in bridging the gap between the courts and the community. This reference is the first to be given to the Council.

Overview of the Current Legislative Approach

1.11 The terms of reference require the Council to consider the law and practice relating to the defence of mental incompetence. As some readers will not be familiar with the nature and scope of this defence, and the consequences of its successful establishment, a brief overview is provided here. A full examination of the relevant law and practice is contained in Parts 2 to 4 of the Report.

1.12 To be convicted of a criminal offence in South Australia, the defendant must have possessed certain cognitive, volitional and moral capacities at the time he or she committed the criminal act. It is assumed that all adults who are charged with an offence possess these capacities. However, it is possible to prove that the defendant was ‘mentally incompetent’ at the relevant time, and so did not possess the necessary capacities. Consequently, he or she should not be found guilty.

1.13 Currently, the law provides that the defence of mental incompetence should be available to people who were suffering a ‘mental impairment’ at the time of the offence, and in consequence of that impairment did not know the ‘nature and quality’ of the conduct, did not know the conduct was wrong, or were unable to control the conduct (s 269C, CLCA). ‘Mental impairment’ is defined in the CLCA to include ‘a mental illness, or an intellectual disability or a disability or impairment of the mind resulting from senility’ but does not include intoxication (s 269A, CLCA).

1.14 Where a defendant successfully raises this defence, he or she is not completely acquitted. Instead, the defendant is found ‘not guilty by reason of mental incompetence’, and is subject to special powers of the court. These powers allow the court to release the defendant unconditionally, or to make a ‘supervision order’

\textsuperscript{9} The Northern Territory Government has announced that it will establish a sentencing advisory council (http://www.nt.gov.au/justice/documents/depart/annualreports/ANNUAL\_20REPORT\_202008\_20DOJ.pdf?search=\%22sentencing\%22) but no council has yet been established. It does not appear that the creation of a sentencing advisory body has been considered by the Western Australian government. The establishment of a federal sentencing advisory council was considered unnecessary by the \textsc{ALRC}: See \textit{Australian Law Reform Commission, Sentencing of Federal Offenders: Report 70} (\textsc{ALRC}, 2005) 19.34.

committing the defendant to detention or releasing him or her on licence (s 269O(1), CLCA). In this context, the purpose of detention is the protection of the community, not the punishment of the defendant.

1.15 If a court makes a supervision order, it must specify the period for which the defendant may be subject to supervision (a ‘limiting term’). Under the current law, the length of the limiting term must be equivalent to the period of imprisonment or supervision that would have been appropriate had the defendant been convicted of the offence(s) charged (s 269O(2), CLCA).

**Terminology**

1.16 Before proceeding further, it is appropriate to make a point about terminology. In the Report, the term ‘insanity defence’ denotes the defence in general (as implemented around Australia and internationally), while the term ‘defence of mental incompetence’ refers to the South Australian version of that defence.

1.17 The Report uses the terms ‘insanity’ and ‘mental incompetence’ to refer to an impairment in an individual’s cognitive, moral and volitional capacities that meets the requirements of the relevant legal defence. By contrast, the terms ‘mental illness’ and ‘mental disorder’ are used to refer to specific clinical conditions, such as schizophrenia or depression, that are recognised by expert medical professionals.

1.18 While a claim that an individual was mentally incompetent at the time he or she committed an offence is likely to be supported by one or more diagnoses of a particular clinical condition, this is not required. The current law focuses on the effects of the relevant conditions, rather than the conditions themselves. This is significant not just because of the potential for a disconnect between expert legal and medical understandings of impairment, but because not all mental illnesses will affect an individual in a way considered relevant to the criminal law.

**Approach Taken by the Council to the Terms of Reference**

1.19 The terms of reference require the Council to consider the substantive law concerning the defence of mental incompetence, as well as the practices of fixing limiting terms, and supervision of individuals on licence, attendant to the substantive law. As this might be considered a larger remit than that typically provided to sentencing advisory bodies, a brief explanation is appropriate.

1.20 As stated in the Foreword to the Report, the making of supervision orders and the fixing of limiting terms are closely related to the sentencing process. This is the case although, under Part 8A of the CLCA, detention is not equivalent to punishment because it is not intended to have a punitive effect. The connection arises from the role of the court in protecting the individual, and others, from further harm, and the relevance of incapacitation and rehabilitation in the sentencing process. These matters are discussed further in Parts 3 and 4 of the Report.

1.21 The Council recognises that the issues addressed in the Report have great significance for the community. The impact upon a defendant, the victim and the community more

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broadly may differ depending on the way in which the defendant is dealt with under Part 8A. The different options provided for in the CLCA will affect the availability of treatment, the prospects of rehabilitation, and may affect perceptions of justice and fairness to the victim and his or her family.

1.22 The Council also recognises that the issues addressed in the Report have great significance for the criminal justice system. The high prevalence of mental disorders among offenders nationally is now well-known, and the mental health of offenders is of key policy interest to health services, justice departments and others concerned with reducing the rate of re-offending.

1.23 As the terms of reference indicate, the Council has not been asked to examine the law and practice relating to the issue of unfitness to stand trial. That area of the law requires a determination of whether a person’s mental processes are so disordered or impaired that the person is unable to understand the nature of the proceedings or give rational instructions to Counsel. However it is important to note that if a court is satisfied that a defendant is mentally unfit to stand trial and the objective elements of the offence are established the court must record a finding to that effect and declare the defendant to be liable to supervision under Part 8A of the CLCA. The provisions in Division 4 of the CLCA dealing with the disposition of persons declared liable to supervision under Part 8A then come into operation. These provisions are common to both unfitness to stand trial cases and cases of persons found to be mentally incompetent to commit an offence. It follows that the recommendations made in the Report in respect of the procedures for supervision and detention of mental incompetence cases apply also to unfitness to stand trial cases.

1.24 Except as they concern the supervision of offenders, the availability of resources and the provision of services lie beyond the scope of the Report. However, the Council acknowledges that these considerations affect the number of individuals coming into contact with the criminal justice system, and the prospects of diagnosis and treatment of the impairments that may give rise to a mental incompetence defence.

The Council’s Process

1.25 Prior to publication of the Discussion Paper, the Council consulted with the following professionals, each of whom have experience with the operation of Part 8A:

- Chief Magistrate Elizabeth Bolton, Chief Magistrate of the Magistrates Court of South Australia;
- Ms Frances Nelson QC, Presiding Member of the Parole Board of South Australia;
- Dr Ken O’Brien, Clinical Director of the Forensic Mental Health Service (SA);

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13 Criminal Law Consolidation Act 1935 (SA) ss 269M-269N.
14 See Lubica Forsythe and Antonette Gaffney, Mental Disorder Prevalence at the Gateway to the Criminal Justice System (Australian Institute of Criminology, 2012).
15 Frances Nelson QC sits on the Sentencing Advisory Council as an Expert Member.
Dr Craig Raeside, senior forensic psychiatrist; and

Dr Harry Hustig, Director of the Rehabilitation Services at the Glenside Campus.

1.26 The Council also co-opted multiple persons with expertise in the area of its discussions to assist it. They were:

- Ms Pauline Barnett, managing prosecutor at the Office of the Director of Public Prosecutions (ODPP);
- Judge Steven Millsteed, a South Australian District Court judge; and
- Ms Bronwen Waldron, a senior solicitor from the Legal Services Commission of South Australia (LSC).

1.27 The Discussion Paper, which was published in July 2013, largely focused on the issues identified by the consultants as being of practical importance. It asked 27 questions, and called for submissions from the public. The Council received 21 submissions. The Council wishes to express its thanks to those who took the time to make a submission.

1.28 The Council met regularly to discuss the issues raised in the Discussion Paper. In formulating its recommendations, the Council considered all of the submissions received, the position in other Australian jurisdictions, and recommendations made by other reviews of the relevant issues. Unless otherwise noted, all recommendations were unanimous.

Previous Reviews of the Law

1.29 There have been two significant reviews of Part 8A of the CLCA in the past ten years. The first was an operational review of the CLCA mental impairment provisions, which was undertaken by the Justice Strategy Unit in 2000. This review examined the way the mental impairment provisions in the criminal justice system were working in practice, and considered how to achieve the best possible interface between justice and treatment support services. The report included a number of recommendations.

1.30 A subsequent review was carried out by the Department of Health in April 2005. It was entitled Paving the Way - Review of Mental Health Legislation in South Australia and examined the legislative framework regarding Part 8A of the CLCA. It noted the findings of the Operational Review and also made separate recommendations.

1.31 Most recently, in 2011 the Attorney-General issued a scoping paper which specifically considered Division 4 of Part 8A of the CLCA. This section of the Act deals primarily with licences. As such, the Scoping Paper is linked to the current work of the Council. Following the publication of the Scoping Paper, submissions were

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16 A list of submissions is included in Appendix E.
18 Ian Bidmeade, Paving the Way: Review of Mental Health Legislation in South Australia (Department of Health, 2005).
received from various stakeholders. However, as the Council was established shortly thereafter, and was asked to consider Part 8A more broadly, no proposals for legislative change were recommended to the Attorney-General at that time. Instead, the issues identified in the Scoping Paper and submissions received were referred to the Council in its overall consideration of Part 8A.

1.32 In order to build on the work that has been carried out previously, those issues or recommendations that were raised in previous reviews have been identified throughout this Report.

Summary of a Case File Review Undertaken by the Attorney General’s Department

1.33 The Council was determined to ensure that its recommendations were informed by current data. However, there were difficulties in obtaining relevant statistics. It has become apparent that this issue is not unique to South Australia, with other jurisdictions facing similar difficulties in relation to this issue.20

1.34 The relative absence of data in South Australia appears to be the result of the way in which data is captured and stored by the Courts Administration Authority, which has been designed with the traditional criminal justice system in mind. The data collection systems do not capture data for those individuals who plead not guilty on the basis of mental incompetence (or who are unfit to stand trial), and who are then dealt with under Part 8A of the CLCA.

1.35 In light of the difficulties in obtaining data, and in order to gain a clearer picture about how Part 8A of the CLCA is currently operating in South Australia, the Council requested the Attorney-General’s Department to undertake a Case File Review (the Case File Review) on its behalf.21 A summary of the data obtained is provided below. The full findings are set out in Appendix B.

1.36 The Case File Review included an analysis of approximately 90% of the total number of cases in which there had been a finding of not guilty on the basis of mental incompetence in the South Australian District and Supreme Courts between 2006 and 2012. This represents a total of 55 cases. In analysing the data, a number of factors were examined, including:

- the total number of individuals found not guilty on the basis of mental incompetence;
- the percentage of males and females found not guilty on the basis of mental incompetence;
- whether the individuals had any prior offences which had been dealt with through the traditional court process;

20 For example, when data was sought in this area in the United Kingdom, it was found that official statistics were not kept on the use of the insanity defence. Instead, the authors needed to rely on court and post-trial files that were tracked through the co-operation of the Home Office Statistical Service, The Home Office Mental Health Unit, and the Court Service: RD Mackay, BJ Mitchell and L Howe, 'Yet More Facts About the Insanity Defence' (2006) Criminal Law Review 399.

21 The Council is grateful to the ODPP for making a significant number of files available for the Case File Review.
- whether there was a pre-existing diagnosis of mental illness;
- which limb of section 269C of the CLCA applied;
- whether the judge identified the basis for the finding of mental incompetence;
- the number of individuals who had consumed drugs or alcohol in the weeks or days preceding the offending act(s);
- the classes of offences allegedly committed by the individuals;
- whether the individual was released unconditionally, detained or released on licence (upon a finding of not guilty and an order as to supervision);
- the length of limiting terms imposed;
- the number of individuals subject to a review of their licence before the court on the basis of a breach of licence; and
- the number of individuals who committed subsequent offences whilst on licence.

1.37 While every effort was made to ensure the accuracy of the data included in the Case File Review, the results of the data collection were not independently verified by a professional statistician, and so accuracy cannot be guaranteed. Nonetheless, this data was included in order to go some way towards remedying the shortage of empirical material available on the defence of mental incompetence and related procedural practices. Where appropriate, the Council has drawn on this evidence in addressing particular issues in the Report.
2. The Defence of Mental Incompetence
Introduction

2.1 As explained in Part 1 of the Report, to be convicted of a criminal offence in South Australia, the defendant must have possessed certain cognitive, volitional and moral capacities at the time he or she committed the criminal act. While it is assumed that all adults who are charged with an offence possess these capacities, it is possible that an individual may have been lacking the necessary capacities at the relevant time, and so should not be found guilty.

2.2 Traditionally, the legal defence that addressed this issue was known as the ‘insanity defence’. However, due to the stigma associated with the term ‘insanity’, several jurisdictions have altered the language of the law. In South Australia, the defence is now known as the defence of mental incompetence.

2.3 Currently, section 269C of the *Criminal Law Consolidation Act 1935* (SA) (the CLCA) provides that the defence of mental incompetence should be available to people who were suffering a ‘mental impairment’ at the time of the offence, and in consequence of that impairment did not know the ‘nature and quality’ of the conduct, did not know the conduct was wrong, or were unable to control the conduct. ‘Mental impairment’ is defined in the CLCA to include ‘a mental illness, or an intellectual disability or a disability or impairment of the mind resulting from senility’ but does not include intoxication (s 269A, CLCA).

2.4 Where a defendant successfully raises this defence, he or she is not completely acquitted. Instead, the defendant is found ‘not guilty by reason of mental incompetence’, and is subject to special powers of the court.22

2.5 The defence of mental incompetence represents a boundary around the criminal law. It marks out those who are not responsible for their conduct, as opposed to those who are not liable (such as those who are acquitted due to acting in self-defence). The underlying rationale of the defence is that due to their impairment, the affected individuals should be separated from the usual processes of the criminal law, and special processes should be put in place to ensure that the community is protected. This was highlighted by the New South Wales Law Reform Commission in its recent reference on *People with Cognitive and Mental Health Impairments in the Criminal Justice System*. They stated that the defence is grounded in ‘recognition of impaired mental functioning as an excuse from criminal responsibility’ and ‘protection of the community through detention of those, who, because of their mental illness, pose a threat to themselves or others’.23

2.6 The Council appreciates that there may be those in the community, or stakeholders in the criminal justice system, who consider the defence out-dated or flawed and who believe it should be entirely reconsidered. The Council does not take this view, and the Report proceeds on the basis that there is still a need to provide a legal mechanism for excusing from criminal responsibility those offenders whose mental capacity was significantly impaired at the time of their alleged offending. The Council views a defence of mental incompetence as necessary to protect the community and to provide individuals with the opportunity for treatment.

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22 These special powers are discussed in Parts 3 and 4 of the Report.

This Part of the Report examines the scope of the defence of mental incompetence. It is divided into the following sections:

- The history of the insanity defence;
- Examination of the current defence of mental incompetence;
- Discussion of CLCA section 269C(a): the defendant does not know the nature and quality of the conduct;
- Discussion of CLCA section 269C(b): the defendant does not know the conduct is wrong;
- Discussion of section 269C(c): the defendant is unable to control the conduct;
- Examination of the definition of ‘mental impairment’;
- Consideration of the interaction between mental impairment and intoxication by drugs or alcohol.

The History of the Insanity Defence

The law on insanity has a long history in the common law world. This history demonstrates a leniency in treating offenders with mental illnesses. While the absence of sources renders the early history of insanity somewhat opaque, it is generally accepted that the practice of excusing an insane defendant from trial long preceded the appearance of a formal insanity defence. It was usual practice for the insane individual’s family to provide compensation to the victim or his or her family and to look after the insane person. As ‘trial by ordeal’ was replaced with trial by jury in the medieval era, insane defendants who had committed serious offences (such as homicide) were likely to be tried and, if convicted, left to the royal prerogative of mercy.

At ‘some point’ during the early modern period, for reasons that are unclear, it became regular practice to acquit an insane defendant rather than leave him or her to be pardoned by the King. In his seminal historical work on this issue, Nigel Walker traces the earliest recorded acquittal on the basis of insanity (‘the felon was of unsound mind’) to 1505. At this time, there seems to have been no substantial elaboration of the meaning of phrases such as ‘unsound mind’ or any particular procedural structure for adjudicating claims of insanity.

The criminal process underwent significant changes associated with the rise of adversarial criminal procedure during the eighteenth century. The changes in

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28 Many features of the adversarial trial, such as the use of prosecution and defence counsel, the distinction between fact and law, and the rudiments of the laws of evidence and procedure, appeared before 1800 (although
prosecution and trial processes were accompanied by changes in punishment and sentencing practices. Despite these changes, the capacity of informal criminal processes to accommodate insane individuals remained at large. If an insane individual was acquitted, no particular disposal was mandated, and what happened to the defendant varied according to his or her personal circumstances.  

2.11 It was in this context that the first famous insanity case of Edward Arnold took place in 1724.  

In his directions to the jury in that case, Justice Tracy stated that 'when a man is guilty of a great offence, it must be very plain and clear before a man is allowed such an exemption [...] it must be a man that is totally deprived of his understanding and memory, and doth not know what he is doing, no more than an infant, than a brute, or a wild beast’ in order to avoid punishment. This direction, which has come to be called the ‘wild beast’ insanity test, reflects the attitudes to mental illness then prevailing. It is more of an informal standard than a ‘precise formula’ for assessing lack of intent. This reflects the fact that the notion of exculpatory insanity had not yet undergone any sustained conceptual elaboration in the criminal law. 

2.12 The next major development in this area was procedural rather than substantive. Following the high profile insanity trial of James Hadfield for high treason in 1800, the English parliament enacted the Criminal Lunatics Act 1800. This Act established the modern practice of using criminal law dispositions for people who successfully raise the insanity defence. This legislation is the origin of current disposal practices, and it is discussed further in Part 3 of the Report.  

2.13 The most significant development of the law of insanity occurred when Daniel McNaughtan was tried in London in 1843. McNaughtan was aiming to shoot the Prime Minister, but instead shot and killed his private secretary, Edward Drummond. McNaughtan was charged with wilful murder and pleaded not guilty. Defence counsel argued that, although McNaughtan had done the act, he should not be held responsible for it because the ‘fierce and fearful delusion’ that he was being persecuted subsisted at the time of the killing and meant that he was unable to

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defence counsel had a limited role until the nineteenth century): see generally J.H. Langbein, The Origins of the Adversary Criminal Trial (Oxford University Press, 2003).  


Edward Arnold (1724) 16 St. Tr. 695. Arnold was charged under the recently enacted Black Act (1723) 9 Geo. 1 c.22 with maliciously shooting at a prominent local member of the aristocracy. Arnold pleaded that he did not know what he was doing and did not intend any harm, but evidence given about the preparation for the offence suggested that Arnold could ‘form a steady and resolute design’: extracted in R Moran, 'The Origin of Insanity as a Special Verdict: The Trial for Treason of James Hadfield' (1985) 19(3) Law and Society Review 487, 502. See also J.M. Beattie, Crime and the Courts in England, 1660-1800 (Clarendon Press, 1986) 84.  


33 See further Arlie Loughnan, Manifest Madness: Mental Incapacity in the Criminal Law (Oxford University Press, 2012).  

34 R v Hadfield (1800) 27 St. Tr. 1281.  

35 39 & 40 Geo. III c. 94.  

control his actions.37 By contrast, the Solicitor-General argued that McNaughtan could not be excused on the grounds of insanity if he had ‘that degree of intellect which enabled him to know and distinguish between right and wrong’.38

2.14 The evidence was so strongly in McNaughtan’s favour that after hearing the medical witnesses, Chief Justice Tindal stopped the proceedings and remarked that ‘the whole of the medical evidence is on one side’.39 In accordance with the practice carried over from the previous era, the jury found McNaughtan ‘not guilty by reason of insanity’.

2.15 This outcome was controversial. Queen Victoria and others expressed concern that the verdict was unduly lenient. All fifteen judges of the Queen’s Bench were called to appear before the House of Lords to defend the decision. Their responses to the questions asked clarified the scope of the insanity defence, and produced what subsequently came to be known as the M’Naghten Rules.40 These Rules continue to inform the law on insanity in common law jurisdictions around the world, and are explained below in some detail.

The M’Naghten Rules

2.16 The elements of the insanity defence were set out by Lord Tindal CJ who stated that:

Every man is to be presumed to be sane, and possess a sufficient degree of reason to be responsible to his crimes, until the contrary be proved to their satisfaction; and to establish a defence on the ground of insanity, it must be clearly proven that at the time of committing the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know that what he was doing was wrong.41

2.17 From this passage it can be seen there are two aspects to the M’Naghten insanity defence. First, the defendant must have suffered from a specific type of mental health condition: a ‘defect of reason’ caused by a ‘disease of the mind’. Secondly, that condition must have had a particular effect on the defendant: it must have either caused him or her to not know the ‘nature and quality’ of his or her act, or to not know that it was ‘wrong’.

2.18 Under the M’Naghten Rules, where the defendant raises the defence of insanity, he or she must prove that fact on the balance of probabilities. When the contention that the defendant was insane is advanced by the prosecution, or is put by the judge of his or her own motion, the trier of fact (judge or jury) may only find that the defendant was insane if satisfied of that fact on the balance of probabilities.42

37 Extracted in R Moran, Knowing Right from Wrong: The Insanity Defense of Daniel McNaughtan (The Free Press, 1981) 1. Defence counsel was able to address the jury due to the passage of the Prisoners’ Counsel Act 1836.
38 Extracted in D.J. West and A Walk (eds), Daniel McNaughton: His Trial and the Aftermath (Gaskell Books, 1977) 16. The Solicitor-General was relying on earlier cases, such as R v Hadfield (1800) 27 St. Tr. 1281.
39 Extracted in ibid 72.
41 M’Naghten (1843) 10 Cl & Fin 200.
2.19 The result of a successful insanity defence was (and remains) a particular trial verdict: the ‘special verdict’. By contrast with a general verdict (‘guilty’ or ‘not guilty’), the special verdict includes a statement of the factual basis on which the verdict has been reached (‘not guilty by reason of insanity’). It is the returning of the special verdict that allows judges to impose the specific disposition options that are discussed in Part 3 of the Report.

2.20 While the main focus of the law of insanity has been the content of the Rules themselves, what has been at least as significant as the content of the M’Naghten Rules has been the way in which they were created. The unique character of the Rules – a judicial formulation, developed independently from a specific trial, and in a legislative context – has earned them the label of ‘judicial legislation’ and served to entrench them in common law countries around the world.

The Development of the Law in Australia

2.21 The Australian colonies inherited the M’Naghten Rules. The developing nature of Australian legal regimes, and the small number of cases, alongside other factors, meant that there was little change in the law until the twentieth century.

2.22 A significant development occurred when, in the case of Porter, Dixon J directed a jury on what it means to know that conduct is ‘wrong’ for the purposes of the insanity defence. This direction, which has come to be known as the ‘Porter gloss’, is discussed in detail below.

2.23 In the years since Porter’s case, each Australian jurisdiction has passed legislation codifying its own version of the insanity defence. They have also enacted a range of disposition options for those individuals who successfully raise the defence. In South Australia, these provisions are contained in Part 8A of the CLCA, which came into effect on 2 March 1996.

The Mental Incompetence Defence

2.24 The South Australian version of the insanity defence is known as the defence of mental incompetence. The requirements of that defence are set out in section 269C of the CLCA, which provides:

269C—Mental competence

A person is mentally incompetent to commit an offence if, at the time of the conduct alleged to give rise to the offence, the person is suffering from a mental impairment and, in consequence of the mental impairment—

a) does not know the nature and quality of the conduct; or

b) does not know that the conduct is wrong; or

c) is unable to control the conduct.


44 See further Arlie Loughnan, Manifest Madness: Mental Incapacity in the Criminal Law (Oxford University Press, 2012).

45 R v Porter (1933) 55 CLR 182.
In accordance with common law principles, a person’s mental competence to commit an offence is presumed unless the person is found to have been mentally incompetent to commit the offence (s 269D, CLCA). In order to displace this presumption, the burden of proving that the defendant was mentally incompetent lies on the party advancing that contention. Ordinarily this would be the defendant, but on occasion the defence is raised by the prosecution. This presumption remains intact unless it is proven on the balance of probabilities that the defendant was mentally incompetent at the time of the offence.

It can be seen that the defence of mental incompetence largely replicates the insanity defence. There are, however, two important differences:

- The scope of the qualifying mental health conditions differs: The defence of mental incompetence requires the defendant to have been suffering from a ‘mental impairment’ rather than a ‘defect of reason’ caused by a ‘disease of the mind’.

- The necessary effects of the relevant mental health condition also differ: Unlike the insanity defence, the defence of mental incompetence will succeed where it can be proven that the defendant was unable to control his or her conduct.

The sections below examine whether it is necessary to modify any of the three different ways in which the defence of mental incompetence may be proved. The Report then examines the meaning of the term ‘mental impairment’, and the appropriate scope of the qualifying mental health conditions.

Section 269C(a): Does Not Know the Nature and Quality of the Conduct

The first way in which the mental incompetence defence can be proved is by establishing that due to the defendant’s mental impairment, he or she did not know the ‘nature and quality’ of his or her conduct (s 269C(a), CLCA). Apart from using the word ‘conduit’ rather than ‘act’ (which is not seen to be of any significance), this is identical to the first limb of the *M’Naghten Rules*.

The judges in *M’Naghten* did not discuss the meaning of the phrase ‘the nature and quality of the act’, presumably because they regarded this phrase as ‘too clear to need explanation’. In subsequent cases, it has been interpreted to refer to knowledge of the physical nature of the act, rather than its moral or social nature. It includes knowledge of the physical consequences of the conduct. In *Porter*, Justice Dixon gave the following example:

In a case where a man intentionally destroys life he may have so little capacity for understanding the nature of life and the destruction of life, that to him it is no more than breaking a twig or destroying an inanimate object. In such a case he would not

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47 *R v Porter* (1933) 55 CLR 182.
49 *R v Codere* (1917) 12 Cr App R 21, 27.
50 *R v Porter* (1933) 55 CLR 182.
know the physical nature of what he was doing. He would not know the implications and what it really amounted to.  

2.30 To raise the defence successfully, it must be proved that the defendant did not ‘know’ the nature and quality of his or her conduct. It appears that ‘knowledge’ refers to a mere intellectual appreciation of the nature and quality of the conduct, rather than some deeper form of understanding.  

2.31 This component of the defence rarely seems to be the basis upon which the defence of mental incompetence is grounded. For example, in the Case File Review undertaken by the Attorney-General’s Department, it was relied upon in only two percent of the cases reviewed. In consultations it was suggested that the reason for this is that during the course of committing the alleged offence, defendants generally perform some purposeful act that indicates that they know the nature and quality of their conduct.

Issues to be Addressed

2.32 Two main criticisms have been made about the approach currently taken in section 269C(a) of the CLCA. First, it has been argued that the wording of the current test is unclear, and gives insufficient guidance to psychiatrists or psychologists working in the area, as well as to the jury. In particular, it was noted in consultations that some psychiatrists or psychologists misunderstand that it is restricted to knowledge of the physical nature and consequences of the conduct, and focus on the moral or social nature of the conduct as well. It has therefore been suggested that it may be desirable to legislatively define the meaning of the phrase ‘nature and quality of the conduct’.

2.33 Secondly, it is seen to be unjust to deny the defence to people who have an intellectual or ‘verbalistic’ knowledge of the nature and quality of the conduct, but who do not properly understand that conduct’s significance due to their mental health condition. For example, it is argued that it is wrong to exclude people who on the surface appear to ‘know’ the nature and quality of their conduct, but whose perception is distorted, whose reasoning processes are corrupted, or who suffer from an affective impairment that prevents them from truly appreciating the

51 R v Porter (1933) 55 CLR 182, 188.
52 Willgoss v R (1960) 105 CLR 295. In Willgoss the High Court was addressing the meaning of the word ‘knowledge’ in relation to the wrongness limb of the M’Naghten Rules. It is assumed that the same definition applies to this limb. See Simon Bronitt and Bernadette McSherry, Principles of Criminal Law (Thomson Reuters (Professional) Australia Ltd, 3rd ed, 2010) [4.50] for discussion of this issue.
53 See Appendix B.
54 To know something in a ‘verbalistic’ sense is akin to learning a mathematical formula by rote: Simon Bronitt and Bernadette McSherry, Principles of Criminal Law (Thomson Reuters (Professional) Australia Ltd, 3rd ed, 2010) [4.50].
55 It should be noted that there is some support in the case law for the idea that ‘knowledge of the nature and quality of the act’ includes understanding (to some extent) the significance of what was done: see Willgoss v R (1960) 105 CLR 295.
meaning of the conduct. It is argued that the defence should be available to people who lack a deep appreciation of the nature and quality of the conduct.

2.34 Consequently, in the Discussion Paper the Council asked the following questions:

Question 1: Should the CLCA be amended to replace reference to ‘knowledge’ with the word ‘understanding’? Should the CLCA be amended to define ‘nature and quality of the conduct’? If so, should the definition include ‘understanding the physical nature of the conduct and its physical consequences’?

**Approaches Taken in Other Australian Jurisdictions**

2.35 The majority of Australian jurisdictions take the same approach to this issue as taken in South Australia. However, a different approach is taken in Queensland, Tasmania and Western Australia. In each of these jurisdictions the word ‘knowledge’ has been replaced with the word ‘understanding’. In Queensland and Western Australia the relevant test is whether the defendant was deprived of the capacity to understand what he or she was doing. In Tasmania the test is whether the defendant was incapable of understanding the physical character of the act.

**Approaches Taken in Other Reviews**

2.36 The Scottish Law Commission (SLC) recommended adopting a test that focuses on the defendant’s ability to appreciate (rather than know) the nature of his or her conduct. In making this recommendation, they argued that such an interpretation complies with an intuitive view of what this aspect of the defence is seeking to achieve, as noted by McAuley:

>[I]f the Rules are construed from the point of view of their implicit logical form, the first limb of the knowledge test can be seen to be much wider than has traditionally been supposed. Contrary to the interpretation that comes down from Codère, it goes to the accused's ability to evaluate his actions, including his reasons or motives for committing them and the consequences normally associated with them, in the way that a sane person can. An accused who cannot do this may know what he is doing in a literal sense, but he does not know why he is doing it and cannot assess its true effects. He may be quite clear about the 'physical character' of his actions, ... or even about their immediate physical consequences, .... But since he cannot break out of the circle described by his insane delusions, he does not know what he is doing in any epistemologically significant sense. Unlike the sane person, he cannot measure the

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58 See *Criminal Code Act 2002* (ACT) s 28(1)(a); *Criminal Code Act 1995* (Cth) s 7.3(1)(a); *Mental Health (Forensic Provisions) Act 1990* (NSW) s 38; *Criminal Code Act (NT)* s 43C(1)(a); *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 20(1)(a).
59 *Criminal Code 1899* (Qld) s 27(1); *Criminal Code Act 1913* (WA) s 27(1).
60 *Criminal Code Act 1924* (Tas) s 16(1)(a)(i).
effects of his actions or assess the validity or propriety of his motives against the
criteria by which they are ordinarily judged.\textsuperscript{62}

2.37 The SLC provided the example of a woman who kills her children by smothering
them with a pillow, in the belief that in doing so she will drive out demons from
their souls. While in one sense she understands the physical nature of her actions
(she knows that putting a pillow over their faces will stop them breathing), ‘in a
wider sense the woman cannot be said to have ’true’ or ’complete’ knowledge of her
actions. Her mental disorder (schizophrenia…) has had the effect of distorting her
understanding of the exact nature of her acts. Her children’s souls are not possessed
by demons’…\textsuperscript{63} The SLC argued that a person who lacks knowledge in this broader
sense should be exculpated. In positing this view, they noted that the American Law
Institute’s Model Penal Code\textsuperscript{64} and the Criminal Code of Canada\textsuperscript{65} both incorporate
an ‘appreciation’ standard.

2.38 By contrast, the New Zealand Law Commission (NZLC) rejected a move towards
the broader concept of ‘appreciation’. They were concerned about the broad range
of mental functions that might be covered by an appreciation standard, stating that:

\begin{quote}
if the concept is … as broad as “errors in reasoning” and “affective impairments”, it is
not at all clear how the defence would then be applied in practice. All of us some of
the time, and some of us most of the time, are guilty of reasoning errors and mood
swings. It must refer to a more fundamental form of irrationality: thought patterns
which are alien to normal people. But the fact is that illogical and irrational thought
patterns, and the mental states that accompany them, are on a continuum.
‘Appreciation’ does no better job than the present defence of clarifying where on the
continuum the line between sanity and insanity ought to be drawn.\textsuperscript{66}
\end{quote}

2.39 The New South Wales Law Reform Commission (NSWLRC) also did not
recommend changing the law in this area in any way. They favoured retention of the
current approach because:

\begin{itemize}
  \item It is consistent with other Australian and cognate jurisdictions (such as New
    Zealand, the United Kingdom and Canada);
  \item It has existed since 1843, and has generally been retained despite numerous
    reviews being undertaken;
  \item Its meaning has been elaborated by substantial case law; and
  \item Stakeholders in the area are generally in favour of retaining it.\textsuperscript{67}
\end{itemize}

\textsuperscript{2.45}.
\textsuperscript{64} The American Law Institute Model Penal Code, Official Draft (1985), s.4.01(1).
\textsuperscript{65} RS 1985 c. C-46, s 16(1).
\textsuperscript{66} New Zealand Law Commission, \textit{Mental Impairment Decision-Making and the Insanity Defence: Report 120}
\textsuperscript{67} New South Wales Law Reform Commission, \textit{People with Cognitive and Mental Health Impairments in the
Criminal Justice System: Criminal Responsibility and Consequences: Report 138} (New South Wales Law
Reform Commission, 2013) 3.36-3.41.
2.40 The submissions addressed two separate (but interrelated) issues: whether the phrase ‘nature and quality of the conduct’ should be legislatively defined in any way, and whether the term ‘knowledge’ should be replaced with ‘understanding’. These issues are addressed in turn below.

Defining ‘Nature and Quality of the Conduct’

2.41 In the Discussion Paper, the following questions were asked: ‘Should the CLCA be amended to define ‘nature and quality of the conduct’? If so, should the definition include ‘understanding the physical nature of the conduct and its physical consequences’?

2.42 There were nine submissions that addressed these questions, of which only two were in favour. The only reason given in support of defining the phrase was that it ‘has the potential to promote clarity’.68

2.43 By contrast, seven submissions did not support the proposal to define the phrase. The main arguments against this proposal were summarised by the Law Society of South Australia (the Law Society) as follows:

The Society is concerned that an amendment to the CLCA to define the words ‘nature and quality of the conduct’ may limit this limb of the test. The Society takes the view that these words are currently interpreted appropriately and should continue to be interpreted in this way. In the Society’s view, a definition of these words would likely result in problems of statutory construction; the words are not amenable to attempts at codifying their meaning without causing practical difficulties.

The meaning of these words does not appear to have given rise to any particular difficulties in practice. The advice of forensic psychiatrists shows that there is not any difficulty with the application of this limb. The observation that other psychiatrists and psychologists who are not familiar with forensic issues may not apply the same test is unfortunate. However, that is an issue to do with the scope of the forensic psychiatry industry in South Australia…

Furthermore, if the state of the law in Australia is that the phrase ‘nature and quality’ is interpreted to refer to an individual’s appreciation of the physical nature of the act and its physical consequences (as indicated in paragraph 2.36 of the Discussion Paper) then there is not any apparent need to define the phrase as suggested. The question … refers to whether the definition should ‘include’ those physical matters. That suggests other definitions not identified but included and highlights that attempts at codifying the meaning of the words is likely to be problematic.

Furthermore, there would seem to be good reason to not include consideration of the defendant’s appreciation of the ‘moral social nature of his/her act’.69

2.44 It can be seen from this passage, and from the other submissions received by the Council, that there are a number of arguments against defining the phrase ‘nature and quality of the conduct’ in legislation:

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68 Director of Public Prosecutions, Submission to the Sentencing Advisory Council.

69 Law Society of South Australia, Submission to the Sentencing Advisory Council. The Law Society’s submission in this regard (and most others) was supported by the submission of the Aboriginal Legal Rights Movement.
• There is no need for the suggested change, given that the test is already defined in terms of its physical nature and consequences;

• Any definition may unintentionally alter the scope of the test, or create difficulties with interpretation;

• Expert witnesses, such as forensic psychiatrists, have little difficulty with the current test;

• Where witnesses do have difficulty, the problem is with their experience or training rather than the legislation. There would be ‘little benefit changing the act to compensate for a lack of training or experience in interpretation of medico-legal criteria or forensic report writing’;¹⁰ and

• Even if witnesses make mistakes, there is little evidence that this affects the ultimate judicial determination.

**Changing ‘Knowledge’ to ‘Understanding’**

2.45 In the Discussion Paper the Council asked the following question: ‘Should the CLCA be amended to replace reference to ‘knowledge’ with the word ‘understanding’?’

2.46 There were 12 submissions that addressed this question. Of these, seven were supportive of replacing the word ‘knowledge’ with a word such as ‘understanding’ or ‘appreciation’. These submissions argued that the current approach is overly narrow, and that it would be preferable for the test to reflect a deeper appreciation of the nature and quality of the conduct. For example, Jamie Walvisch argued that for people to properly be held criminally responsible:

> At the very least, they must have a proper appreciation of the physical nature of their conduct and its physical and moral consequences. Without such a deeper understanding, it cannot be said that they will have truly recognised the reasons for behaving differently, and so should be held responsible for failing to comply with the law.⁷¹

2.47 By contrast, the five submissions that opposed the change argued that:

• There is no reason to change the test, as it is well understood and is based on principles which have been ‘carefully developed over time’;⁷²

• Changing the test in this way is likely to ‘give rise to an uncertainty in understanding what it is that the change is to convey’;⁷³ and

• It is difficult to see that the test will make any difference in practice, especially given the rarity with which this aspect of the defence is relied upon.

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¹⁰ Australian Medical Association (South Australia), Submission to the Sentencing Advisory Council.

⁷¹ Jamie Walvisch, Submission to the Sentencing Advisory Council.

⁷² South Australian Bar Association, Submission to the Sentencing Advisory Council.

⁷³ Director of Public Prosecutions, Submission to the Sentencing Advisory Council.
Conclusions and Recommendations

2.48  The Council does not believe it is necessary to define the phrase ‘nature and quality of the conduct’, and does not recommend doing so. It appears that the phrase is already well understood by most practitioners and expert witnesses, and that it is not difficult to explain to the jury. While there may be some psychiatrists or psychologists who misunderstand the phrase, that is an issue that should be addressed by professional training rather than legislative modification.

2.49  The current approach is also consistent with the approach taken in most other Australian jurisdictions. The Council is of the view that, unless there is a strong reason for departing from the common position, harmonisation should be sought. Given the rarity with which this aspect of the defence is raised, and the lack of support for defining the phrase amongst legal practitioners and mental health professionals, the Council does not believe that this is an appropriate occasion for such departure.

2.50  In addition, any attempt to define the phrase faces difficulties, and may simply complicate the law. For example, if the term ‘nature’ is defined to mean the physical nature of the conduct and its physical consequences, how should ‘quality’ be defined? Does this term have a residual meaning that is not covered by the extended definition, or should it be removed? If it is removed, could there be unanticipated implications? In light of the lack of support for defining the phrase, the Council does not think it is worth taking the risk of unintentionally modifying the law in an undesirable way.

2.51  The Council also does not recommend replacing the word ‘knowledge’ with the word ‘understanding’. While it sees merit in the opposing view, it is concerned about the uncertainty that would be introduced into the law by making such a change. It also shares the concerns of the NZLC\textsuperscript{74} about the broad range of mental functions that might be covered by the new term.

2.52  Furthermore, it seems that trained mental health professionals and the judiciary have little difficulty with the current test. The Council is concerned that this could change if a new approach was taken. The difference between ‘knowledge’ and ‘understanding’ would need to be clearly explained to expert witnesses and jurors. This creates the possibility for confusion and misunderstandings.

2.53  Moreover, in light of the small number of cases which raise this aspect of the defence, it seems unlikely that such a change will make any substantive difference. This is especially the case given that the change would only affect defendants who know the nature and quality of their conduct, but do not appreciate it in a deeper sense, and are unable to rely on one of the other limbs of the defence.\textsuperscript{75} The number of people who fall within this class is likely to be exceptionally small.

2.54  The Council is conscious of the fact that its decision is contrary to the majority of submissions that addressed this issue. However, the Council notes that there was also significant opposition to the proposal. Taking into account the policy and

\textsuperscript{74} See ‘Approaches Taken in Other Reviews’ above.

\textsuperscript{75} It seems likely that many of the people who fall within this class of defendants would be able to successfully argue that they did not know that their conduct was wrong, or they could not control their conduct.
practical concerns outlined in all of the submissions, it is the Council’s view that the word ‘knowledge’ should be retained.

**Recommendation 1**

Section 269C(a) of the *Criminal Law Consolidation Act 1935* should not be amended to define the phrase ‘nature and quality of the conduct’ or to replace the word ‘knowledge’ with the word ‘understanding’.

**Section 269C(b): Does Not Know the Conduct is Wrong**

2.55 The second way in which the mental incompetence defence can be proven is by establishing that due to the defendant’s mental impairment, he or she did not know the conduct was wrong (s 269C(b), CLCA). This is identical to the second limb of the *M’Naghten Rules*.

2.56 This is the most common basis on which the defence of mental incompetence is proven. For example, in the Case File Review conducted by the Attorney-General’s Department, the ‘wrongfulness’ component of section 269C was identified as the basis for the finding of mental incompetence in 87 per cent of all matters.

2.57 In England, the ‘wrongfulness’ test has been defined narrowly, to refer to whether the defendant knew that what he or she was doing was against the law. By contrast, in Australia the test has been interpreted to mean ‘wrong having regard to the everyday standards of reasonable people’. In other words, knowledge of ‘wrongfulness’ is judged on moral, rather than legal, standards. The test is not whether the defendant knew the conduct was illegal (rather than legal), but whether he or she knew it was wrong (rather than right) or evil (rather than good).

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76 See Appendix B.

77 In its review of the defence in New South Wales, the NSWLRC also noted that this is the most frequently used element of the test: New South Wales Law Reform Commission, *People with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences: Report 138* (New South Wales Law Reform Commission, 2013) 3.102. Further, the Victorian Law Reform Commission’s report, *Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, made reference to the Case File Review conducted by the Attorney-General’s Department of South Australia. The Victorian Law Reform Commission then went on to observe that the figures obtained in that review are ‘supported by anecdotal information obtained during consultations and through an informal analysis of case data provided to the Commission. The Commission had information about the basis of the finding in 18 cases out of the 159 CMIA cases in the higher courts from 1 July 2000 to 30 June 2012. In none of these cases was the finding made solely on the grounds that the accused did not understand the nature and quality of the conduct. This is supported by anecdotal information obtained during consultations and suggests that the second limb of the test is far more common as a basis of a finding of not guilty because of mental impairment.’ (Footnote omitted): Victorian Law Reform Commission, *Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997: Report* (Victorian Law Reform Commission, 2014) [7.130].

78 *Windle* [1952] 2 QB 826.

79 *R v Porter* (1933) 55 CLR 182.

An illustration of the approach to ‘wrongfulness’ adopted by Australian jurisdictions is provided by the recent decision of *R v Ey (No 2).*[^1] In this decision, the defendant was charged with the manslaughter of her son in 2008, and raised the mental incompetence defence. In his reasons, the Judge held as follows:

In considering what is meant by ‘wrong’, the question to be asked is: Can I be satisfied, on the balance of probabilities, that the defendant, having regard to her mental impairment, did not know it was wrong to omit to render care or obtain assistance for the baby in the sense that an ordinary or reasonable person would understand right and wrong? Was she so disabled that she was unable to reason that, in leaving the baby exposed in the driveway, her failure to render assistance or obtain help was wrong? Wrongfulness in the context of section 269C(b) is judged by wrongfulness in the eyes of ordinary people having regard to the everyday standards of reasonable people.[^2]

**The ‘Porter gloss’**

An additional ‘gloss’ was added to the definition of ‘wrongfulness’ in *R v Porter.*[^3] In that case the defendant was accused of administering strychnine to his infant son with the intention of causing his death. He was charged with murder and raised the insanity defence. In directing the jury, Justice Dixon stated:

The question is whether the defendant’s ‘disease or disorder or disturbance of mind was of such a character that he was unable to appreciate that the act he was doing was wrong. It is supposed that he knew he was killing, knew how he was killing and knew why he was killing, but that he was quite incapable of appreciating the wrongness of the act. That is the issue, the real question in this case. Was his state of mind of that character? The question is whether he was able to appreciate the wrongness of the particular act he was doing at the particular time. Could this man be said to know in this sense whether his act was wrong if through a disease or defect or disorder of the mind he could not think rationally of the reasons which to ordinary people make that act right or wrong? If through the disordered condition of the mind he could not reason about the matter with a moderate degree of sense and composure it may be said that he could not know that what he was doing was wrong. What is meant by "wrong"? What is meant by wrong is wrong having regard to the everyday standards of reasonable people. If you think that at the time when he administered the poison to the child he had such a mental disorder or disturbance or derangement that he was incapable of reasoning about the right or wrongness, according to ordinary standards, then you should find him not guilty upon the ground that he was insane at the time he committed the acts charged.[^4]

Justice Dixon’s reference to whether the defendant could ‘reason with a moderate degree of sense and composure’ has been taken up in other decisions, and has become known as ‘the Porter gloss’.

In some cases, such as *Sodeman v R*[^5] and *Stapleton v R,*[^6] the High Court appears to have treated the Porter gloss as being synonymous with ‘wrongness’. For

[^2]: *R v Ey (No 2)* [2012] SASC 116, [33]-[34].
[^3]: (1933) 55 CLR 182.
[^4]: (1936) 55 CLR 192.
[^5]: (1936) 55 CLR 182, 189, 190.
[^6]: (1952) 86 CLR 358.
example, in *Stapleton* the High Court stated that the accused should not be convicted if their disease of the mind ‘so governed the faculties at the time of the commission of the act that the accused was incapable of reasoning with some moderate degree of calmness as to the wrongness of the act or of comprehending the nature or significance of the act of killing’.

2.62 However, in *Willgoss v R* the High Court made it clear that the *Porter* gloss is not of general application, and that its relevance will depend on the facts of the case. The court held that while such a direction ‘may be called for in cases where the acts which but for insanity would form the crime charged are committed in a state of frenzy, uncontrolled emotion or suspended reason, the product of mental disease or disorder’, there will be other cases in which the defendant’s incapacity to comprehend the wrongness of the act will depend ‘on other considerations than a capacity to reason about the matter with a moderate degree of sense and composure’. A judge will not need to direct the jury in terms of the *Porter* gloss in the latter cases.

2.63 Despite the High Court’s statements in *Willgoss v R*, the *Porter* gloss has become something of a default ‘test’ for knowledge of ‘wrongfulness’. For instance, in *R v Ey (No 2)*, referred to above, the judge concluded:

> I am not satisfied that the defendant due to her mental impairment was unable to reason about the moral quality of her omissions. I accept the evidence of Dr Tomasic that the defendant had the capacity to know that it was wrong not to seek help after giving birth, but was overborne by her desire to uphold the secrecy of her pregnancy. I accept that the defendant is mentally impaired, and is of low intelligence, at times exhibiting a child-like naivety. I accept that the defendant would have found herself in an overwhelming situation with various pressures affecting her decision to place the infant outside. It does not follow, however, that at that moment she was disabled from knowing that it was a wrong act to commit in the sense that an ordinary person understands right from wrong, and that she was disabled from considering with some degree of composure and reason the wrongfulness of her actions.

2.64 Reliance on the *Porter* gloss extends across jurisdictions. For example, in the New South Wales case of *R v Jones*, Justice Sperling stated that the more recent authorities on the *M’Naghten Rules* ‘throw the emphasis under the second limb of the Rules onto a capacity to reason calmly about the wrongfulness of the act’.

2.65 It is also clear that the *Porter* gloss has been taken up by expert medical professionals, and is often referred to in psychiatric and other reports adduced in court. For instance, in *R v Zilic* the defendant was charged with the murder of his son at Cooper Pedy. He was diagnosed with paranoid schizophrenia, and raised the mental incompetence defence. In providing her reasons for a finding of mental incompetence, Justice Nyland quoted the following expert testimony from Drs Raeside and O’Brien:

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87 *Stapleton v R* (1952) 86 CLR 358, 367.
88 (1960) 105 CLR 295.
89 *Willgoss v R* (1960) 105 CLR 295, 301.
90 *R v Ey (No 2)* [2012] SASC 116, [48].
92 [2010] SASC 70.
Dr Raeside: Whilst [the defendant] would appear to have known the nature and quality of his actions in killing his son by using a knife to cut his throat and then putting his body in a mineshaft, it is my opinion that Mr Zilic’s ability to reason with a moderate degree of sense and composure about the wrongfulness of his actions would have been severely impaired. There does not appear to be any non-psychotic motive for Mr Zilic’s alleged behaviour…

Dr O’Brien: [As a result of his active illness, although [the defendant] did know the nature and quality of his conduct (the killing of his son) he was not able at the material time to reason about the wrongfulness of his conduct “with a moderate degree of sense and composure”. It would seem to me that his behaviour was driven by the intensity of his psychotic and delusional belief system.

The Case File Review supports the view that the Porter gloss is used frequently by psychiatrists assessing whether, in their opinion, a defendant knew that their conduct was wrong in accordance with the legislation.

Issues to be Addressed

As can be seen from the discussion above, there is some confusion about the precise meaning of the word ‘wrong’ in section 269C(b) of the CLCA. In particular, it is unclear whether that term is synonymous with the phrase ‘unable to reason with a moderate degree of sense and composure’, or whether that definition is limited to cases of ‘frenzy, uncontrolled emotion or suspended reason’. It may be desirable to legislatively resolve this confusion, by specifying precisely what ‘wrong’ means in this context.

Consequently, in the Discussion Paper the Council asked the following questions:

Question 2: Should the CLCA provide for a definition of ‘wrongness’ based on whether the defendant was able to ‘reason with a moderate degree of sense and composure’?

Question 3: Alternatively, should the CLCA be amended so as to provide that a consideration of whether there was an ability to reason with a moderate degree of sense and composure be confined to cases of ‘frenzy, uncontrolled emotion or suspended reason’?

Approaches Taken in Other Australian Jurisdictions

Only New South Wales, which incorporates the common law in this area, takes the same approach to this issue as taken in South Australia. All other Australian jurisdictions have either enacted a version of the Porter gloss, or have taken a completely different approach to this aspect of the insanity defence.

Versions of the Porter gloss have been enacted in the ACT, the Commonwealth, Victoria and the NT. The wording of the relevant provisions is virtually...
identical, defining the ‘wrongfulness’ test to mean that ‘the person could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong’.

2.71 In Queensland and Tasmania the relevant Acts entirely avoid reference to the word ‘wrong’. In these jurisdictions people are not held criminally responsible if, by reason of their mental impairment, they are incapable of knowing that they ‘ought not to do’ the act. This phrase is not legislatively defined.

Approaches Taken in Other Reviews

2.72 The five reviews that have recently examined the scope of the ‘wrongfulness’ test in any detail reached different views about the appropriate scope of that test.

2.73 In its Consultation Paper, the NSWLRC appeared sceptical about defining ‘wrongness’ in the way Justice Dixon did in Porter, stating that:

A problem with this approach is that it is based on an assumption that, in ordinary circumstances, a person acts (or refrains from acting) only after a reasoned assessment of the rights and wrongs of behaving in a certain way. It is at least open to question whether human behaviour is planned at this conscious, rational level, or whether, in fact, it is largely regulated by the subconscious suppression of inappropriate impulses. An ordinary person may refrain from doing a wrongful act, not by a process of reasoning, but because doing the act would not occur to him or her or, if it did, a feeling of disapproval or revulsion would prevent that person from doing it. In many cases where the defence of mental illness is based on a claim that the person did not know that the act was wrong, it is the extinction or impairment of subconscious regulation, not an inability to reason calmly, which accounts for the act being done (or, more correctly, the person’s failure to refrain from doing it).

2.74 However, in its Final Report, the NSWLRC ultimately recommended the relevant Act be amended to define ‘wrongness’ as meaning that ‘the person could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong’. In reaching this conclusion, the NSWLRC argued that the test was functional, strongly supported, and understood by both juries and expert witnesses. It was also seen to be especially useful in cases where the defendant suffers from delusions:

Cases in which the defendant acts under a delusion have traditionally presented difficulties. For example, a person who kills believing that the victim is a danger to the safety of his or her family may not qualify under the first limb of the defence,

98 Criminal Code Act 1995 (Cth) s 7.3(1)(b).
99 Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) s 20(1)(b).
100 Criminal Code Act (NT) s 43C(1)(b).
101 Criminal Code 1899 (Qld) s 27(1); Criminal Code Act 1924 (Tas) s 16(1)(a)(ii).
102 These reviews were undertaken in New South Wales, New Zealand, Scotland and England.
105 Ibid 3.108.
because they know the nature and quality of their act (that they are killing a person) even though they believe that killing to be necessary. There may also be difficulty in bringing cases of delusional actions within the second limb of the test, because such people may also know that killing is wrong. However, the Porter approach enables proof that the person did not know the act to be wrong by inference from an inability to reason with sense and composure about whether the conduct was wrong.\textsuperscript{106}

As noted above, a form of the Porter gloss has been enacted in Victoria. In the Victorian Law Reform Commission’s (VLRC) recent review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997, the Commission decided that the focus in relation to the defence is on the defendant’s awareness of his/her own behaviour, either in assessing its physical nature and consequences and/or in assessing whether reasonable people would consider it wrong.\textsuperscript{107} The VLRC recommended that section 20(1)(b) of the Act be amended by removing the words ‘he or she could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong’ and inserting the words ‘he or she did not have the capacity to think rationally about whether the conduct, as perceived by reasonable people, was wrong’.\textsuperscript{108} In its discussion the VLRC noted the criticisms by clinicians of the phrase ‘moderate degree of sense and composure’ referring to it as vague, subjective and difficult to apply in situations in which most people would not be acting with calmness and composure.\textsuperscript{109} Although the VLRC recommended an amendment to the ‘wrongfulness’ test, the VLRC did not recommend any amendments to the essential elements of the two limbs of the mental impairment defence; namely, that he or she did not know the nature and quality of the conduct; or that he or she did not know that the conduct was wrong.\textsuperscript{110}

The NZLC saw little advantage to specifically including the Porter gloss in its legislation. It took the view that the gloss simply reflected the current law in New Zealand, and incorporating it in legislation would make no material difference.\textsuperscript{111}

Neither the English nor Scottish Law Commissions specifically examined the Porter gloss. The English Law Commission (ELC) was mostly concerned with the question of whether knowledge of ‘wrongfulness’ should extend beyond knowledge of illegality. They recommended adopting an approach similar to that taken in Queensland and Tasmania, focussing on whether the defendant could understand ‘that the conduct was something he or she ought not to do’.\textsuperscript{112} Under this approach, awareness of wrongfulness is not limited to awareness of illegality.

By contrast, the SLC was concerned with whether the test should focus simply on the defendant’s ‘knowledge’ of wrongfulness, or whether the defendant should be required to have a deeper ‘appreciation’ that the conduct was wrong. They

\textsuperscript{106} Ibid 3.102 (footnotes omitted).


\textsuperscript{108} Ibid 121, Recommendation 25.

\textsuperscript{109} Ibid 119.

\textsuperscript{110} Ibid [4.107].

\textsuperscript{111} New Zealand Law Commission, Mental Impairment Decision-Making and the Insanity Defence: Report 120 (Law Commission, 2010) 43-49. The current test in New Zealand simply requires proof that the defendant knew that the act or omission was morally wrong.

concluded that the latter was more appropriate, recommending that the test be defined in terms of the defendant’s inability at the time of the offence to appreciate the wrongfulness of his or her conduct.113

Submissions

2.79 The Council received thirteen submissions addressing different aspects of this issue. Six of those submissions opposed the enactment of the Porter gloss, largely on the basis that such a change is unnecessary. For example, the Office of the Public Advocate’s (OPA) submission stated:

We note from the discussion paper that the Porter definition of wrongness is widely used, and once again this suggested law reform would merely put into statute what is already common practice. Unless there have been problems reported by the Courts or participants in the process, we would see little point in incorporating this definition into the Act. Doing so could create an impression that something has changed, when in fact it has not.114

2.80 By contrast, four submissions supported enactment of the Porter gloss. It was noted that it would not change the law, and may enhance clarity. For example, the submission of the Legal Services Commission of South Australia (LSC) suggested that such a change ‘may be useful for less experienced expert witnesses, or a jury’.115

2.81 The submissions were divided on the question of whether the Porter gloss should be confined to cases involving ‘frenzy, uncontrolled emotion or suspended reason’, with three submissions in favour of this limitation and four against it. While some submitters were concerned that use of the phrase ‘frenzy, uncontrolled emotion or suspended reason’ may lead to problems of interpretation, the main reason for opposing the limitation was a concern that it would result in defendants who did not act in such a state being excluded from the scope of the defence, even if they did not know their conduct was wrong due to their mental impairment.116 This misunderstands the proposal suggested by the Council. It was not suggested that the wrongfulness test should be confined to cases involving ‘frenzy, uncontrolled emotion or suspended reason’, and that people who were not acting in such a state should be denied access to the defence. Rather, it was suggested that the Porter gloss be confined to such cases. That is, it would only be in cases involving ‘frenzy, uncontrolled emotion or suspended reason’ that ‘wrongfulness’ would be defined as meaning ‘unable to reason with a moderate degree of sense and composure’. In other cases, ‘wrongfulness’ would simply retain its ordinary meaning.

2.82 There were two submissions that recommended a more substantial revision to the test. The submission from criminal law academics at Adelaide Law School suggested adopting an approach similar to that taken in the United States Model Penal Code, whereby a person is held not criminally responsible if he or she lacked

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114 Office of the Public Advocate, Submission to the Sentencing Advisory Council.
115 Legal Services Commission of South Australia, Submission to the Sentencing Advisory Council.
116 One example that was suggested in the submissions was a person with a severe intellectual disability who acts spontaneously and unpredictably in response to an environmental stimulus, and hits a nearby person. Such an individual was arguably not acting in a state of frenzy, uncontrolled emotion or suspended reason, but may nevertheless not have known that his or her conduct was wrong.
substantial capacity ‘to appreciate the criminality [wrongfulness] of his or her conduct’. By contrast, the submission of Jamie Walvisch recommended focusing on the ability of the defendant to reason properly:

If a person is convicted of an offence, he or she will be punished in some way. In imposing punishment, society is expressing the view that the offender deserved to be punished – that his or her conduct was sufficiently wrongful to deserve blame and censure. However, if the accused was incapable of recognising or responding to the reasons for acting differently, then it seems inappropriate to censure him or her for his or her behaviour.

Conclusions and Recommendations

2.83 The Council is of the view that the law in this area is currently unclear. In particular, it is not clear whether the Porter gloss applies to all cases, or is limited to specific types of cases (such as those involving frenzy, uncontrolled emotion or suspended reason). The Council believes it is important to resolve these issues, to ensure that the law is applied consistently by judges, and to help guide practitioners and mental health practitioners working in the area.

2.84 The Council is also of the view that it would be useful to provide a clear legislative definition of what it means for a defendant to not know that his or her conduct was ‘wrong’. Such a definition would be particularly useful for mental health practitioners who are asked to write a report, but who do not or ordinarily practice in the area. In consultations with the Council it was noted that such practitioners have some difficulty understanding the current test.

2.85 The Council does not support adopting the position taken in Queensland or Tasmania, whereby the focus is on whether the defendant knew that they ‘ought not to do’ the act. The Council believes such a test would raise unnecessary complications, and prefers to retain a test that focuses on the defendant’s knowledge of the wrongfulness of their conduct.

2.86 The Council considered recommending that the test be amended to include the basic Porter gloss. Such a change would formalise what is currently widely considered to be the law, and would have the benefit of making the South Australian legislation consistent with the approach taken in a number of other Australian jurisdictions. As noted above, harmonisation of laws is considered to be an important goal.

2.87 However, the Council does not recommend adopting the complete wording of the Porter gloss for a number of reasons:

- The language of the gloss (that the defendant is ‘unable to reason with a moderate degree of sense and composure’) is archaic and complicated, and is likely to be difficult for juries and mental health professionals to properly understand. It would be preferable to have a test that was defined in simpler language;

- The meaning of the terms ‘sense’ and ‘composure’ is not clear, and no guidance has been provided about when a person should be considered to have reasoned

118 Jamie Walvisch, Submission to the Sentencing Advisory Council.
with a ‘moderate’ degree of these attributes. It would be preferable to enact terms that are more commonly used in the mental health field;

- While the gloss is routinely mentioned by mental health professionals in their reports, its meaning or application is rarely explained. It would be preferable to incorporate a definition that results in more focused analyses being presented;

- Requiring a person to reason with a moderate degree of sense and composure may be too much to expect of many sane people, particularly those committing crimes of violence. It would be preferable to set the threshold at a place that better reflected the boundary between mental competence and incompetence; and

- As noted in Willgoss v R, there will be some cases in which the defendant’s incapacity to comprehend the wrongness of the act will depend ‘on other considerations than a capacity to reason about the matter with a moderate degree of sense and composure’.  

2.88 The last point raised above could be addressed by limiting the definition to cases involving frenzy, uncontrolled emotion or suspended reason. However, it is the Council’s view that this will unnecessarily complicate the law. In addition, it would add a layer of complexity for mental health professionals and judges, who would need to grapple with the meaning of the newly enacted terms (such as ‘frenzy’).

2.89 The Council agrees with Mr Walvisch that the key issue to be addressed by the law in this area should be the impact the defendant’s mental impairment had on his or her reasoning processes. The question should not simply be whether the defendant knew that the conduct was wrong (as suggested by the current law), but whether the defendant was unable to reason that it was wrong. The defence should only be available where the defendant was unable to think rationally, in the same way as other people, in order to reason that the conduct was wrong.

2.90 The Council is of the view that the best way to enact this approach is to adopt wording similar to section 7.3(1)(b) of the Schedule to the Criminal Code Act 1995 (Cth), but to delete the words ‘with a moderate degree of sense and composure’. This would make the defence available to a person who, in consequence of his or her mental impairment, ‘does not know that the conduct is wrong (that is, the person cannot reason about whether the conduct, as perceived by reasonable people, is wrong)’.

2.91 The Council believes that this approach is consistent with the way the test is currently applied by psychiatrists. In consultations with the Council, it was noted that psychiatrists generally approach this issue by considering whether the defendant’s impairment resulted in a significant state of thought disorder or an internal state of disorganisation that meant they could not know their conduct was wrong. In other words, the focus is on the interruption the impairment causes to the defendant’s reasoning processes, rather than merely on their knowledge of the wrongness of their conduct.

119 Willgoss v R (1960) 105 CLR 295, 301.
120 Jamie Walvisch, Submission to the Sentencing Advisory Council.
121 See ‘Approaches Taken in Other Australian Jurisdictions’ above.
Recommendation 2

Section 269C(b) of the *Criminal Law Consolidation Act 1935* should be amended to reflect section 7.3(1)(b) of the Schedule to the *Criminal Code Act 1995* (Cth), leaving out the words ‘with a moderate degree of sense and composure’. This would mean that a person would not know the conduct was wrong if, as a consequence of a mental impairment, the person could not reason about whether his or her conduct, as perceived by reasonable people, was wrong.

Recommendation 3

The existing drafting of s 269C(b) should be amended as follows: does not know the conduct is wrong, that is, he or she could not reason about whether the conduct, as perceived by reasonable people, was wrong.

Section 269C(c): Is Unable to Control the Conduct

2.92 The third way in which the mental incompetence defence can be proved is by establishing that due to the defendant’s mental impairment, he or she was unable to control the conduct (s 269C(c), CLCA).

2.93 This volitional component of the defence is not drawn from the *M’Naghten Rules*, but represents an extension of the common law on insanity. It was added to address the perceived ‘cognitive bias’ of the Rules, which has been much lamented for almost as long as those Rules have been around. It has been long argued that people who are unable to control their conduct due to their mental health conditions are just as deserving of exculpation as people who do not know the nature and quality of their conduct, or who do not know that it is wrong.122

2.94 In order to rely on this part of the mental incompetence defence, the defendant must have been completely unable to control his or her conduct. If the defendant had any degree of control over the relevant conduct, he or she will be considered mentally competent.123

Issues to be Addressed

2.95 The defence of mental incompetence is rarely based on the volitional element. For example, in the Case File Review undertaken by the Attorney-General’s Department,124 it was relied upon in only two per cent of the cases reviewed. This appears to be due to two inter-related reasons:

- It is rare that a defendant will have been completely unable to control his or her conduct; and

- It is difficult (if not impossible) to distinguish between a desire or an impulse that is uncontrollable, and one that is simply not controlled by the defendant.

124 See Appendix B.
The difficulty of differentiating between an irresistible impulse and one that is simply not resisted has been commented on by mental health practitioners, academics and judges. For example, Bronnitt and McSherry have argued that it is ‘impossible to devise an objectively verifiable test to determine when an accused could not control his or her conduct and when he or she would not’\(^{125}\) while Lord Parker has stated that the distinction is ‘one which is incapable of scientific proof’\(^{126}\).

In addition, Bronnitt and McSherry argue that the test is based on an ‘abandoned system of faculty psychology’ which divides the mind into separate and unrelated compartments (such as cognition, emotion and will)\(^{127}\). By contrast, most modern psychological theories are based on a holistic model, which assumes that there cannot be serious impairment of one mental function without impairment of others:

The law relating to mental impairment stems from the notion that an individual must possess the ability to reason about the significance of conduct in order for the criminal law to apply. Loss of control tests assume that a person can know what he or she is doing is wrong, yet be unable to control his or her actions. In reality, such tests assume that cognition remains completely unaffected, and this contradicts not only the holistic standpoint of modern psychology but also the view that the ability to reason plays an essential part in controlling conduct.\(^{128}\)

On consultation with the Council, a number of the experts in this field, such as representatives from defence lawyers, the Office of the Director of Public Prosecutions (ODPP), the judiciary and forensic psychiatrists, concurred that not only was section 269C(c) rarely relied upon by individuals raising the defence of mental incompetence, but it was exceptionally difficult to prove.

Given the criticisms levelled against this aspect of the defence, and the rarity with which it is raised by defendants, the Council asked the following question in the Discussion Paper:

**Question 4: Should the CLCA be amended to remove the ‘unable to control conduct’ component of the defence?**

**Approaches Taken in Other Australian Jurisdictions**

The majority of Australian jurisdictions include a volitional element in their version of the insanity defence.\(^{129}\) The only two jurisdictions that do not have a volitional

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\(^{126}\) *R v Byrne* [1960] 2 QB 396, 404.

\(^{127}\) Ibid [4.65].

\(^{128}\) Criminal Code Act 2002 (ACT) s 28(1)(c); Criminal Code Act 1995 (Cth) s 7.3(1)(c); Criminal Code Act (NT) s 43C(1)(c); Criminal Code Act 1899 (Qld) s 27(1); Criminal Code Act 1924 (Tas) s 16(1)(b); Criminal Code Act 1913 (WA) s 27(1).
component to the defence are Victoria and New South Wales. However, the law in this area has recently been reviewed in both of those jurisdictions.\textsuperscript{130}

**Approaches Taken in Other Reviews**

2.101 Of the six reviews which have recently addressed this issue, three recommended incorporating a volitional element into the insanity defence (NSW, WA and England),\textsuperscript{131} and three opposed its adoption (Victoria, New Zealand and Scotland).\textsuperscript{132}

2.102 In its Final Report on *Defences to Homicide*, the VLRC gave two main reasons for rejecting a volitional element. First, it pointed to the difficulty of differentiating between irresistible impulses and non-resisted impulses. It noted that in its consultations, psychiatrists had argued that it would be very difficult to give expert evidence in this area.\textsuperscript{133} Secondly, it argued that the other two limbs of the defence ‘were sufficiently flexible to allow at least some cases where the accused was unable to control his or her actions to raise the defence’.\textsuperscript{134} For example, evidence that the defendant was unable to control his or her conduct may be used to prove that the defendant did not know his or her conduct was wrong.\textsuperscript{135} Consequently, the VLRC saw no compelling reason for introducing a volitional element.\textsuperscript{136}

2.103 In the VLRC’s recent report, *Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, they confirmed their earlier recommendation that a volitional element should not be included as an element of the mental impairment defence. The only change which the Commission recommended to the mental impairment defence was to the ‘wrongfulness’ definition in the second limb of the defence.\textsuperscript{137}

2.104 The SLC relied on the same two arguments as the VLRC in its Final Report on *Defences to Homicide* when also recommending that a volitional element not be adopted.\textsuperscript{138} In the Scottish context the second argument was seen to be even stronger, due to the Commission’s recommendation that the first two limbs of the

\textsuperscript{130} The NSWLRC has recently recommended that a volitional element be included in the NSW defence: see below.


\textsuperscript{134} Ibid [5.31].

\textsuperscript{135} See, eg, *Sodeman v R* (1936) 55 CLR 192.


defence use the term ‘appreciation’ rather than ‘knowledge’. Neither the SLC nor any of its consultees could identify an example where a person might fail the test for the defence on the appreciation criterion but satisfy it purely on a volitional one. The Commission also noted ‘the mental health experts whom we met were virtually unanimous in rejecting a category of mental disorder which was purely volitional in nature and which had no impact on cognitive functions’.

2.105 The NZLC was also strongly influenced by the difficulty of distinguishing between an irresistible and an impulse not resisted, quoting the American Psychiatric Association’s view that the line between them ‘is probably no sharper than that between twilight and dusk’. Ultimately, the Commission was not convinced that the arguments in favour of a volitional element were ‘sufficiently strong to outweigh reservations about whether it can be robustly applied in practice’.

2.106 The NSWLRC and the ELC were also both concerned about the difficulty differentiating between volitional and non-volitional conduct, but saw this to be an evidentiary matter, not a substantive reason for rejecting this aspect of the defence. In their view, it is possible for a person to genuinely be unable to control his or her actions, despite knowing the nature and quality of the conduct and knowing it was wrong. As a matter of principle, such a person should be exculpated. Consequently, they concluded that a volitional limb should be included in the defence.

2.107 In addition, the NSWLRC supported the inclusion of a volitional element on the basis that most other Australian jurisdictions have such an element. They were also influenced by the fact that the defence is raised very rarely in those jurisdictions, and so introducing it was unlikely to open the ‘floodgates’. This point was also raised by the Law Reform Commission of Western Australia (LRCWA), who saw its rarity of use as a reason for not recommending it be removed from the Western Australian legislation.

Submissions

2.108 The Council received 15 submissions addressing this issue. Of those, nine advocated the retention of the volitional element, while six showed support for its removal.

2.109 Four reasons were given in favour of removing the volitional element. First, concerns were raised about the difficulty differentiating ‘non-volitional actors from

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139 Ibid [2.54].
141 Ibid [5.43].
144 Law Reform Commission of Western Australia, Review of the Law of Homicide (Law Reform Commission of Western Australia, 2007) 231.
impulsive actors’. Secondly, the problem of identifying truly non-volitional conduct was seen to leave the test open to potential abuse. Thirdly, the test was argued to be obsolete, with it being ‘difficult to think of a medical condition in which this limb of the test would apply, without the person also being unable to reason about the wrongfulness of their conduct’. Finally, the test was considered to be ‘highly subjective and unsatisfactory’ and subject to misinterpretation. In this last regard, the Australian Medical Association (South Australia) (AMA(SA)) referred to data which shows that this is the most common area in which experts misinterpreted the legal standard.

2.110 Four reasons were also given in support of retaining the element. First, a number of submitters, including the South Australian Bar Association (Bar Association), the Law Society and the OPA, noted that the fact that this limb is rarely relied upon and difficult to prove does not provide a reason for its removal. These submissions noted that there are cases where the limb is relied upon, and that it should continue to be available for use by those few people who are genuinely unable to control their conduct.

2.111 Secondly, it was suggested that while the limb may rarely be used at present, ‘[d]evelopments in mental illness and advances in mental health research may see the current trend change in the future’. The limb should therefore be retained to properly address these future developments. Thirdly, it was noted that the provision has not been exploited, and so the potential for abuse does not provide a reason for the limb’s deletion. Finally, it was argued that some of the difficulties of differentiating between volitional and non-volitional conduct could be overcome by the greater use of standardised psychometric tests.

2.112 One additional issue that was raised in the submissions was the question of whether the test should require the defendant to have a total inability to control his or her conduct. The submission of the Law Society suggested that:

A more refined question may be whether the defendant was unable to control the particular conduct that is causative of the offence rather than being required to prove a complete inability to control all conduct at the relevant time. That may be an example of a better, reasonable and appropriate test rather than requiring proof of total inability to control conduct.

2.113 This suggestion was opposed by the AMA(SA), whose submission stated that it was not consistent with the way the brain works: ‘A person either has the capacity to

145 Jamie Walvisch, Submission to the Sentencing Advisory Council.
146 Ibid.
147 Australian Medical Association (South Australia), Submission to the Sentencing Advisory Council.
148 Forensic Mental Health Service, Submission to the Sentencing Advisory Council.
149 Australian Medical Association (South Australia), Submission to the Sentencing Advisory Council.
150 South Australian Bar Association, Submission to the Sentencing Advisory Council; Law Society of South Australia, Submission to the Sentencing Advisory Council; Office of the Public Advocate, Submission to the Sentencing Advisory Council.
151 Law Society of South Australia, Submission to the Sentencing Advisory Council.
152 Commissioner for Victims’ Rights, Submission to the Sentencing Advisory Council.
153 College of Forensic Psychologists (SA Section) Australian Psychological Society, Submission to the Sentencing Advisory Council.
154 Law Society of South Australia, Submission to the Sentencing Advisory Council.
resist impulses or not’.\textsuperscript{155} The Forensic Mental Health Service (FMHS) also opposed this idea. While their submission supported removal of the limb entirely, they said ‘in the event that it is retained, the Act should make explicit that inability to control means complete inability to control (a partial inability does not suffice)’.\textsuperscript{156}

Conclusions and Recommendations

2.114 The Council acknowledges that the practical implementation of the volitional element creates challenges. As noted by numerous past reviews, as well as in the submissions, it can be difficult to differentiate genuine cases of non-volitional action from cases where the defendant simply failed to resist his or her impulses.

2.115 The Council also accepts that there are likely to be very few occasions on which a person suffers from a mental impairment, knows the nature and quality of the conduct and that it is wrong, but is unable to control that conduct. In most cases where a person suffers from a volitional impairment, he or she will be able to rely on one of the other two limbs of the defence.

2.116 In light of the rarity with which this defence is used (and is likely to be used), the practical difficulties with its implementation, and the opposition to its continued use (especially by mental health practitioners), there are strong reasons in favour of its removal from the CLCA. It is unlikely that this would have a significant impact on the way the law is administered.

2.117 However, abolishing the volitional element would take South Australia out of step with most other Australian jurisdictions. In addition, the data in this area indicate that there are some cases where the volitional element is successfully relied upon, even if they are very rare. As a matter of principle, the Council believes that a defence should be available for those cases. If a person is genuinely unable to control his or her conduct due to a mental impairment, then the defence of mental incompetence should be open to him or her. The Council therefore does not recommend that section 269C(c) should be abolished.

2.118 The Council is concerned, however, that the limb is widely misinterpreted, and thinks it is important to clarify its precise scope. The Council agrees with the AMA(SA) and the FMHS that the test should be restricted to people who are completely unable to control their conduct.

Recommendation 4

Section 269C(c) of the Criminal Law Consolidation Act 1935 should be retained, but should be amended to require the defendant to be totally unable to control his or her conduct. It should be made clear that a partial inability to control conduct is not sufficient.

\textsuperscript{155} Australian Medical Association (South Australia), Submission to the Sentencing Advisory Council

\textsuperscript{156} Forensic Mental Health Service, Submission to the Sentencing Advisory Council.
The Definition of Mental Impairment

2.119 The defence of mental incompetence, like the insanity defence, has two main components: (i) the defendant must have suffered from a specific mental health condition; and (ii) that mental impairment must have affected the defendant in a certain way (s 269C, CLCA). So far this Report has focused on the necessary effects of the mental impairment (such as whether it caused the defendant to not know that the conduct was wrong). It is now time to examine the nature of the qualifying mental health conditions.

2.120 To successfully raise the defence of mental incompetence, it must be established that, at the time of the alleged offence, the defendant suffered from what is called a ‘mental impairment’. Section 269A(1) of the CLCA defines ‘mental impairment’ as follows:

mental impairment includes -

(a) a mental illness;

(b) an intellectual disability;

(c) a disability or impairment of the mind resulting from senility,

but does not include intoxication.

2.121 The question of whether a person is suffering from a ‘mental impairment’ is not answered by determining whether his or her condition has been accorded a psychiatric or medical label: it is a matter of law. Nonetheless, when courts are deciding whether an individual has a ‘mental impairment’, they are likely to be informed by medical classifications. Expert evidence is likely to be given by mental health professionals, using the diagnostic criteria set out in psychiatric manuals such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD). However, the mere fact that psychiatric or other medical classifications consider a condition to be a ‘mental illness’, an ‘intellectual disability’ or a ‘disability or impairment of the mind resulting from senility’ is not conclusive.

2.122 The decision about whether the defendant was mentally incompetent when he or she acted is always one for the trier of fact (judge or jury). This does not allow for what has been called ‘trial by psychiatrist’. The trier of fact is always entitled to make up its own mind about the quality and weight of the evidence. The mere fact that a rejection of the defence is inconsistent with the evidence of medical witnesses does not mean that the verdict is unreasonable.

2.123 The Case File Review conducted by the Attorney-General’s Department revealed that the disorder that most commonly grounded a successful defence of mental

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158 R v Rivett (1950) 34 Cr App R 87 (CA).

159 See Appendix B.
incompetence was schizophrenia. Other disorders commonly suffered by defendants included drug-induced psychosis, bipolar disorder, substance abuse and dependence, personality disorders and major depressive disorder. See Diagram A below for a summary.

Diagram A: Clinical Bases of the Defence of Mental Incompetence

2.124 The following sections examine the meaning of the terms ‘intellectual disability’, ‘disability or impairment of the mind resulting from senility’ and ‘mental illness’ in turn. Before doing so, however, it is important to once again emphasise the two-pronged nature of the mental incompetence defence. To successfully raise that defence it is not sufficient to simply prove that the defendant suffers from a mental illness, intellectual disability or a ‘disability or impairment of the mind resulting from senility’. Similarly, it is not enough to merely prove that, at the time of the offence, the defendant did not know the nature and quality of the conduct, did not know the conduct was wrong, or was unable to control the conduct. It must be established that, at the time of the offence, the defendant lacked the requisite knowledge or control as a consequence of the relevant mental health condition.

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160 It is important to note that personality disorders and substance abuse/dependence only formed the basis of the defence in conjunction with other psychological or psychiatric disorders.

161 While ‘mental illness’ is listed first in section 269A(1), intellectual disability and senility are discussed first as the definitions in these areas are relatively uncontentious.
Intellectual Disability

2.125 One type of ‘mental impairment’ specified in section 269A(1) is ‘intellectual disability’. This phrase is not defined in the CLCA.

2.126 The term has been defined in other legislation. For example, in section 4 of the Child Sex Offenders Registration Act 2006 (SA), intellectual disability is defined as ‘permanent or temporary loss or imperfect development of mental faculties resulting in reduced intellectual capacity’.

2.127 A more detailed definition is provided in the psychiatric manuals. For example, the DSM-5 defines ‘intellectual disability’ in the following way:

   Intellectual disability… is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. The following three criteria must be met:

   A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.

   B. Deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

   C. Onset of intellectual and adaptive deficits during the developmental period.\(^{162}\)

2.128 It can be seen from these definitions that an ‘intellectual disability’ is a form of cognitive impairment.\(^{163}\) It affects the way that an individual learns. The NSWLRC notes that a person with an intellectual disability may:

   - take longer to learn things
   - have difficulty reading and writing
   - have difficulty in communicating
   - have difficulty in understanding things and the world around them
   - find it difficult to maintain eye contact
   - have difficulty understanding abstract concepts
   - have difficulty in planning and problem solving and
   - have difficulty adapting to new or unfamiliar situations.\(^{164}\)


One important difference between an intellectual disability and a mental illness (the meaning of which is discussed below) is that an intellectual disability cannot be ‘treated’. This was noted by Simpson in his submission to the NZLC Inquiry into Community Safety: Mental Health and Criminal Justice Issues. He stated:

The nature of the care, containment and support that intellectually disabled people require…is very different from that of the mentally ill. While they require psychological and psychiatric understanding and appropriately structured care, to define such processes as treatment is to miss the difference between the onset of an illness which is largely treatable and reversible in the case of major mental illness [and a condition] which is simply managed by training, allowance of maturation and caring support in the case of an intellectual deficit. This difference rightly requires different legal mechanisms for each group.165

This raises issues about the general applicability of principles and practices set up around individuals with mental illnesses for those with intellectual disabilities. Some of these issues are considered in Part 4 of the Report, in relation to the supervision of individuals released on licence.

For present purposes, it has not been suggested that there is any difficulty with including ‘intellectual disability’ as one of the bases for proving the defence of mental incompetence, nor was it suggested that there was a need for a legislative definition. The Council does not recommend making any changes in this regard.

Senility

A second type of ‘mental impairment’ specified in section 269A(1) is ‘disability or impairment of the mind resulting from senility’. This phrase is also not defined in the CLCA.

Although not clear, it seems likely that ‘senility’ encompasses any impairment of the mind resulting from old age. This would include the loss of memory and confusion commonly associated with Alzheimer’s disease.

The terms ‘senility’ and ‘dementia’ are closely related. However, dementia is not necessarily age-related. The NSWLRC defines ‘dementia’ in the following way:

Dementia is a syndrome associated with a range of diseases which are characterized by the impairment of brain functions, including language, memory, perception, personality and cognitive skills. The impairments may include memory problems, communication difficulties, confusion, personality changes, depression, delusions, apathy and withdrawal. Many illnesses can cause dementia, but the most common are Alzheimer’s disease, vascular dementia, dementia with Lewy bodies, frontotemporal dementia and mixed dementia. Less common causes include Parkinson’s disease,

164 Ibid 123.
165 Ibid 124.
167 See J Millsteed, ‘Mental Competence’, Paper presented to the Law Society of South Australia, 21 March 2012, on file with the South Australian Attorney-General’s Department.
alcohol-induced dementia, drug related dementia, head injury dementia and Huntington’s disease.168

2.135 In its submission to the Council, the Office of the Chief Psychiatrist suggested replacing the term ‘senility’ with the term ‘dementia’. Similar suggestions have been made by academic commentators.169 In its report on the insanity defence, the NSWLRC recommended allowing the defence to be based on any ‘cognitive impairment’, which was defined to include ‘dementias’.170

Mental Illness

2.136 The third type of ‘mental impairment’ specified in section 269A(1) is ‘mental illness’, which is defined as follows:

**mental illness** means a pathological infirmity of the mind (including a temporary one of short duration)\(^1\);

Note

1 A condition that results from the reaction of a healthy mind to extraordinary external stimuli is not a mental illness, although such a condition may be evidence of mental illness if it involves some abnormality and is prone to recur (see R v Falconer (1990) 171 CLR 30).

2.137 This definition reflects the definition of ‘disease of the mind’ which formed the basis of the insanity defence at common law. The meaning of that phrase was explained by Chief Justice King in R v Radford as follows:

The expression ‘disease of the mind’ is synonymous...with ‘mental illness’. ...The essential notion appears to be that in order to constitute insanity in the eyes of the law, the malfunction of the mental faculties called ‘defect of reason’ in the M’Naghten Rules, must result from an underlying pathological infirmity of the mind, be it of long or short duration and be it permanent or temporary, which can be properly termed mental illness, as distinct from the reaction of a healthy mind to extraordinary stimuli.171

2.138 This statement of the law was approved by the High Court in R v Falconer,172 subject to the following qualification by Mason CJ, Brennan and McHugh JJ:173

[T]he dichotomy between mental illness and a healthy mind is correctly drawn. However, we would think that it is necessary that a temporary mental disorder or disturbance must not be prone to recur if it is to avoid classification as a disease of the

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mind. That is because a malfunction of the mind which is prone to recur reveals an underlying pathological infirmity of the mind.

2.139 While medical classifications may be used as evidence to support claims of the existence of mental illness, it must be emphasised that the ultimate decision about whether something is a mental illness for legal purposes is a matter of law. 174

2.140 Because the statutory definition of mental illness (pathological infirmity of the mind) draws on the common law concept of ‘disease of the mind’, common law principles can assist in determining its meaning. 175 In particular, the following principles derived from the common law are relevant.

2.141 First, a ‘disease of the mind’ is to be distinguished from the ‘mere excitability of a normal man, passion, even stupidity, obtuseness, lack of self control and impulsiveness’. 176 In other words, it does not encompass conduct that is simply part of the defendant’s personality or emotional state. 177

2.142 Secondly, a ‘disease of the mind’ involves a pathological infirmity of the mind not the brain. In this context ‘mind’ is used in its ordinary sense to mean ‘the mental faculties of reason, memory and understanding’. 178 While a ‘disease of the mind’ may be caused by physical changes to the constitution of the brain, as might occur with a brain tumour, such changes are not essential. A ‘disease of the mind’ may exist without any physical deficiency or deterioration of the brain. Conversely, the mere fact that the brain has been damaged is insufficient. The focus is on the disturbance of the mental faculties, not the cause of that disturbance. 179

2.143 Thirdly, a ‘disease of the mind’ may be curable or incurable, temporary or permanent. 180 However, in determining whether or not the defendant’s behaviour was due to a pathological infirmity of the mind, the potential for repetition is an important factor. 181 As earlier noted, the High Court stated in R v Falconer that a temporary mental disorder or disturbance must not be prone to recur if it is to avoid classification as a ‘disease of the mind’. The prospect of recurrence as a relevant consideration has been driven, at least in part, by reasons of policy. As Lord Denning said in Bratty v Attorney General (Northern Ireland): 182

It seems to me that any mental disorder which has manifested itself in violence and is prone to recur is a disease of the mind. At any rate it is the sort of disease for which a person should be detained in hospital rather than be given an unqualified acquittal.

2.144 Fourthly, a distinction is drawn between conditions with internal and external causes. A mental condition brought about by an internal cause amounts to a ‘disease of the mind’, whereas one brought about by external influences does not. Consistent

176 R v Porter (1933) 55 CLR 182, 188-189. This passage was cited with approval in R v Falconer (1990) 171 CLR 30, 53.
177 J Clough and C Mulhern, Criminal Law (LexisNexis Butterworths, 2nd ed, 2004) [15.19].
179 R v Kemp [1957] 1 QB 399, 407; R v Porter (1933) 55 CLR 182, 189.
180 R v Kemp [1957] 1 QB 399 at 407.
with this dichotomy, the following conditions have been characterised as ‘diseases of the mind’ (when they have affected the soundness of the mental faculties): major psychiatric disorders, such as schizophrenia; physical diseases such as cerebral arteriosclerosis (hardening of the arteries causing reduced blood flow to the brain); hyperglycaemia (high blood sugar); psychomotor epilepsy. Conversely, temporary disturbances of the mind caused by external factors such as the consumption of alcohol or drugs, taking too much insulin (hypoglycaemia), or a physical blow to the head have been held not to be ‘diseases of the mind’.

2.145 Fifthly, a distinction is drawn between cases in which an external factor caused a disturbance in a sound mind, and cases in which an external factor triggered an underlying pathological infirmity. In the former case, the defendant’s disturbed mental state is seen to be attributable to the external factor, and so is not considered to be a ‘disease of the mind’. By comparison, in the latter case it is the defendant’s pre-existing condition that is considered to be the cause of his or her disturbed mental state, and so he or she considered to be suffering from a ‘disease of the mind’. This distinction is of crucial importance to cases where the defendant is alleged to have acted in a dissociative state due to a ‘psychological blow’. This issue is addressed in detail below.

*Psychological Blow Automatism*

2.146 It is a fundamental principle of the criminal law that a person should not be held criminally responsible for an involuntary act (i.e. an act which was not performed by the person in the exercise of his or her conscious will). Thus, a person who hits another in the course of a spasm, or kicks a person as part of a reflex action, will generally not be convicted of an offence.

2.147 In some cases it may be alleged that the defendant acted in a state of impaired consciousness or ‘automatism’, and so was acting involuntarily. If that was the case, he or she should not be convicted of the alleged offence. However, the consequences of successfully raising a claim of ‘automatism’ will depend on the cause of the impaired consciousness:

- If it was caused by a mental illness (‘insane automatism’), the defendant should be found not guilty by reason of mental incompetence, and will be subject to the special dispositions discussed in Part 4 of this Report;

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184 R v Kemp [1957] 1 QB 399.
187 R v Meddings [1966] VR 306. Intoxication as a source of mental illness is now specifically excluded as mental illness: CLCA s 269A(1).
189 R v Carter [1959] VR 105; Cooper v McKenna; Ex parte McKenna [1960] Qd R 407.
191 Ryan v R (1967) 121 CLR 205, 214.
192 They may be convicted if they were somehow responsible for their involuntary action.
• If it was caused by something other than a mental illness (‘sane automatism’\(^{193}\)) the defendant should be acquitted.

2.148 In many cases it will be clear whether the state of automatism should be classified as ‘sane’ or ‘insane’. For example, automatism caused by a major mental illness (such as schizophrenia) or a brain tumour will be insane automatism.\(^{194}\) By contrast, automatism caused by concussion from a blow to the head will be sane automatism.\(^{195}\)

2.149 Particular difficulties arise in cases where the defendant claims to have been acting involuntarily due to being in a dissociative state at the time of the offence. In general terms, such a state involves a disruption of a person’s memories, sense of self, and awareness of his or her surroundings, so as to cause that person to feel dissociated from reality. For example, a person may feel as if he or she is watching him or herself perform the act.\(^{196}\) Dissociative disorders are frequently found in the aftermath of trauma.\(^{197}\)

2.150 The question of whether a dissociative disorder caused by a ‘psychological blow’ should be classified as ‘sane’ or ‘insane’ automatism was addressed in \(R v \) Radford.\(^{198}\) In that case Chief Justice King held that:

• There is no reason in principle for differentiating between disturbances of the mind caused by external psychological or physical factors. Both are capable of constituting either sane or insane automatism, depending on the circumstances;

• The key issue is whether the defendant had a sound mind that was reacting to extraordinary external stimuli (sane automatism), or whether he or she had an unsound mind that was reacting to its own delusions or external stimuli (insane automatism).

2.151 According to this test, sane automatism can only be caused by ‘extraordinary’ external stimuli. The ordinary stresses and disappointments of life are insufficient to induce a state of sane automatism.\(^{199}\)

2.152 This issue was addressed by the High Court in \(R v \) Falconer.\(^{200}\) While the Court was divided on the onus of proof that applies in respect of sane automatism,\(^{201}\) all of the

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\(^{193}\) This is sometimes referred to as ‘non-insane automatism’. For the sake of clarity, this Report uses the term ‘sane automatism’.

\(^{194}\) See, eg, \(R v \) Falconer (1990) 171 CLR 30; \(R v \) Hughes (1989) 42 A Crim R 270.

\(^{195}\) See, eg, \(R v \) Scott [1967] VR 276.


\(^{198}\) (1985) 42 SASR 266.

\(^{199}\) See Rabey v R (1977) 37 CCC (2d) 461, 482.

\(^{200}\) (1990) 171 CLR 30.

\(^{201}\) The minority (Mason CJ, Brennan and McHugh JJ) held that the persuasive burden rested with the defence to prove automatism on the balance of probabilities. The majority (Deane, Dawson, Toohey and Gaudron JJ) held that the persuasive burden rested with prosecution to disprove automatism beyond reasonable doubt.
members of the Court agreed that sane automatism could be caused by an extraordinary psychological blow, and approved of the sound/unsound mind test formulated by Chief Justice King for distinguishing between sane and insane automatism.\textsuperscript{202}

2.153 Chief Justice Mason and Justices Brennan and McHugh recognised, however, that it may be difficult to determine whether the defendant’s mind was sound or unsound. How can cases where a psychological blow \textit{causes} the automatism be distinguished from cases where the blow \textit{triggers} an underlying pathological infirmity in the defendant’s mind? To resolve this difficulty, they stipulated that the accused had to have the powers of self-control of an ‘ordinary person’.\textsuperscript{203} If the psychological blow would have produced a dissociative state in an ordinary person then the mind is sound (sane automatism). If the blow would not have produced a dissociative state in an ordinary person then the mind is unsound (insane automatism).

2.154 Their Honours said:

The problem of classification in a case of a transient malfunction of the mind precipitated by psychological trauma lies in the difficulty in choosing between the reciprocal factors – the trauma and the natural susceptibility of the mind to affection by psychological trauma – as the cause of the malfunction. Is one factor or the other the cause or are both to be treated as causes? To answer this problem, the law must postulate a standard of mental strength which, in the face of a given level of psychological trauma, is capable of protecting the mind from malfunction to the extent prescribed in the respective definitions of insanity. That standard must be the standard of the ordinary person: if the mind’s strength is below that standard, the mind is infirm; if it is of or above that standard, the mind is sound or sane. This is an objective standard which corresponds with the objective standard imported for the purpose of determining provocation.\textsuperscript{204}

2.155 Their Honours went on to hold that, when considering the powers of self-control of an ordinary person, the unusual temperaments of the defendant are to be ignored:

In determining whether the mind of an ordinary person would have malfunctioned in the face of the physical or psychological trauma to which the accused was subjected, the psychotic, neurotic or emotional state of the accused at the time is immaterial. The ordinary person is assumed to be a person of normal temperament and self-control.\textsuperscript{205}

2.156 It is not clear whether the ‘ordinary’ person test postulated by Chief Justice Mason and Justices Brennan and McHugh applies in South Australia. While it seems likely that it does, it has yet to be determined by the Court of Criminal Appeal.

**Personality Disorders**

2.157 Mental illnesses are often differentiated from personality disorders, which the DSM-5 defines as ‘an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and

\[\text{\textsuperscript{202}} (1990) \text{171 CLR 30, 55 (Mason CJ, Brennan and McHugh JJ), 59 (Deane and Dawson JJ), 76 (Toohey J), 85 (Gaudron J).}\]

\[\text{\textsuperscript{203}} \text{R v Falconer (1990) \text{171 CLR 30, 55. Gaudron J expressed a similar view but used the expression ‘normal person’ (84).}\]

\[\text{\textsuperscript{204}} \text{R v Falconer (1990) \text{171 CLR 30, 55.}\]

\[\text{\textsuperscript{205}} \text{R v Falconer (1990) \text{171 CLR 30, 58.}\]
inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.\textsuperscript{206} The DSM-5 lists 10 different types of personality disorder, including antisocial personality disorder, borderline personality disorder and obsessive-compulsive personality disorder.

2.158 Peay explains the difference between a mental illness and a personality disorder by using the analogy of raspberry ripple ice cream with a cherry on top. The cherry is a mental illness, ‘something added on to the person, which might be excised through treatment’.\textsuperscript{207} By contrast, the personality disorder resembles the ripples, being integral to the person rather than an optional extra.

In this sense, the personality disordered person’s current mental state cannot be defined as abnormal in relation to his or her own previous state, but rather only with reference to the population as a whole; and that deviation needs to be perceived as dysfunctional.\textsuperscript{208}

2.159 Because of the perceived differences between mental illnesses and personality disorders, previous versions of the DSM separated them. Mental illnesses were placed in Axis I and personality disorders were placed in Axis II. However, due to empirical and conceptual concerns about the nature of the distinction, the DSM-5 has shifted to a non-axial system, with all disorders being treated equally.\textsuperscript{209}

2.160 The term ‘personality disorder’ is not used or defined in section 269A or elsewhere in the CLCA. This was a deliberate decision. The definition of ‘mental impairment’ in section 269A is based on section 7.3 of the \textit{Criminal Code Act 1995} (Cth), which includes ‘severe personality disorder’ within its scope. However, the inclusion of severe personality disorders was controversial, and after lobbying from psychiatrists and others it was omitted in South Australia.\textsuperscript{210}

2.161 By contrast, personality disorders are included in the definition of ‘mental impairment’ for the purposes of sentencing. In the \textit{Criminal Law (Sentencing) Act 1988} (SA) ‘mental impairment’ is defined as ‘impaired intellectual or mental function resulting from a mental illness, an intellectual disability, a personality disorder, or a brain injury or neurological disorder (including dementia)’.\textsuperscript{211}

2.162 It is not clear whether personality disorders can provide the basis for the mental incompetence defence. On the one hand, the intentional omission of severe personality disorders from the definition of ‘mental impairment’ would seem to indicate that they cannot. In addition, in preliminary consultations the Council received feedback from forensic psychiatrists that there is an unofficial agreement between forensic practitioners in South Australia that psychopathic and personality disorders do not and should not come within the scope of the defence.


\textsuperscript{208} Ibid 23.


\textsuperscript{211} \textit{Criminal Law (Sentencing) Act 1988} (SA) s 19C.
2.163 On the other hand, it has been argued that there is no reason in principle to conclude that a diagnosed severe personality disorder could never constitute a mental impairment. The key question should be whether that disorder caused the defendant to not know the nature and quality of the conduct, to not know that it was wrong, or to be unable to control the conduct. \(^{212}\)

2.164 There are some cases in which personality disorders have been treated as a type of ‘mental illness’, and thus as a category of ‘mental impairment’. For example, in *R v Bini*\(^{213}\) District Court Judge David (as he then was) accepted psychiatric evidence to the effect that manifestations of the defendant’s borderline personality disorder\(^{214}\) amounted to a mental illness, and that by virtue of his condition he was unable to control his conduct (and so was mentally incompetent). In a subsequent case involving the same defendant, District Court Judge Muecke also found that Mr Bini suffered from a mental illness, but concluded that he was mentally competent because he was able to control his conduct.\(^{215}\) The issue has not been considered by the Court of Criminal Appeal.

2.165 Although not clear, it seems that at common law a personality disorder could provide the basis for the insanity defence. This seems to be the implication of cases such as *Willgoss v R*,\(^{216}\) *R v Jeffrey*\(^{217}\) and *R v Hodges*,\(^{218}\) in which the courts were called upon to consider whether the defence of insanity was available to a person suffering from an antisocial personality disorder (formerly called ‘psychopathy’).\(^{219}\) In each case the defence failed not because the courts held that an anti-social personality can never amount to a mental illness, but because the evidence relied upon by the defendant failed to establish that his condition deprived him of the capacity to know that his conduct was wrong.

2.166 In *McDermott v Director of Mental Health; Ex parte A-G (Qld)*\(^{220}\) the Queensland Court of Appeal held that it was not the law that a personality disorder could never constitute ‘an abnormality of the mind’ (disease of the mind) for the purposes of the Queensland *Criminal Code*. The Court held that it must always be a question of fact whether a particular disorder either alone, or in combination with other facts, gives rise to that state of mind. The Court stated that the question is necessarily one of degree and the finder of fact, whether a judge or jury, is entitled to approach it in a broad common sense way, and not necessarily in accordance with medical evidence. The New Zealand Court of Appeal has also held that a recognised and severe

\(^{212}\) See, eg, J.B. Robertson, *Adam’s on Criminal Law* (Brookers, 1992) CA23.09.
\(^{213}\) *R v Bini* [2000] SADC 137.
\(^{214}\) Borderline personality disorder is a ‘pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts’: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (American Psychiatric Association, 5th ed, 2013) 663.
\(^{215}\) *R v Bini* [2003] SADC 35.
\(^{216}\) (1960) 105 CLR 295.
\(^{217}\) (1992) 7A Crim R 55.
\(^{218}\) (1985) 19 A Crim R 129.
\(^{219}\) Antisocial personality disorder is ‘a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood’: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* (American Psychiatric Association, 5th ed, 2013) 659.
personality disorder could be an ‘abnormal state of mind’ and, by extension, could constitute a mental disorder.\textsuperscript{221}

**Issues to be Addressed**

2.167 The Discussion Paper raised three inter-related issues concerning the definition of ‘mental impairment’. First, it noted that the external factors test has been criticised because of the anomalous results it may produce in respect of complex medical conditions.\textsuperscript{222} For example, in *R v Hennessy*,\textsuperscript{223} the condition hyperglycaemia (high blood sugar), caused by a diabetic failing to take insulin, was held to be a ‘disease of the mind’ because the cause was internal to the defendant. By contrast, in *R v Quick*,\textsuperscript{224} the condition hypoglycaemia (low blood sugar), caused by a diabetic taking too much insulin, was held not to be a ‘disease of the mind’ as the cause was external to the accused. It may be desirable to legislatively resolve this anomaly, or other similar anomalies, in some way.

2.168 The Council therefore asked the following questions in the Discussion Paper:

Question 5: Should the definition of mental illness in s269A of the CLCA be amended to specifically include hypoglycaemia or exclude hyperglycaemia? Should the definition of mental illness in s269A of the CLCA be amended to specifically include or exclude any other problematic medical conditions?

2.169 Secondly, the Discussion Paper noted the difficulties surrounding the soundness of mind test that is used in cases of psychological blow automatism (as outlined above), and the lack of clarity concerning the current law in South Australia. Consequently, the Council asked the following question:

Question 6: Should the definition of mental illness in s269A of the CLCA be amended to expressly declare that the objective test formulated by Mason CJ, Brennan and McHugh JJ in *Falconer* must be applied for the purposes of distinguishing between sane and insane automatism in cases involving dissociation?

2.170 Finally, the Discussion Paper highlighted the confusion concerning the current state of the law with regard to personality disorders, and asked:

Question 7: Should the definition of mental impairment under the CLCA be amended to specifically exclude personality disorder including psychopathy?

2.171 Underlying each of these questions is a concern to determine the appropriate bounds of the definition of ‘mental impairment’ in the CLCA.

**Approaches Taken in Other Australian Jurisdictions**

2.172 Three main approaches are taken to defining the qualifying mental health conditions required for the purpose of the various insanity defences:

\textsuperscript{221} *Waitemato Health v A-G* (2001) 21 FRNZ 216.


\textsuperscript{223} [1989] 2 All ER 9.

\textsuperscript{224} [1973] QB 910.
Some jurisdictions (Vic and NSW) do not define the relevant conditions at all, instead relying on the common law;\textsuperscript{225}

Some jurisdictions (Tas and Qld) slightly expand or clarify the common law position, by stating that it covers both ‘mental diseases’ and ‘natural imbecility’;\textsuperscript{226} or ‘natural mental infirmity’;\textsuperscript{227}

Some jurisdictions (ACT, Cth, NT and WA) provide a more comprehensive definition of ‘mental impairment’, in terms similar to the CLCA.\textsuperscript{228}

Of the latter jurisdictions, each Act includes mental illness, intellectual disability and senility within the scope of ‘mental impairment’. The definition of ‘mental illness’ that is used largely replicates the definition in section 269A of the CLCA.

Unlike the CLCA, the ACT, Cth, NT and WA Acts also include ‘brain damage’ in their definition of ‘mental impairment’.\textsuperscript{229} The ACT and Cth Acts also include ‘severe personality disorder’.

No Australian legislation seeks to explicitly address the anomalies raised by the hyperglycaemia/hypoglycaemia situation, nor does any legislation expressly declare that the objective test from \textit{R v Falconer} must be applied for the purposes of distinguishing between sane and insane automatism in cases involving dissociation.

\textbf{Approaches Taken in Other Reviews}

The appropriate scope of the qualifying mental health conditions for the insanity defence has recently been considered by reviews undertaken in New South Wales, Victoria, Western Australia, New Zealand, England and Scotland. Their views on the general definition of ‘mental impairment’ are considered below. Following that, their views on automatism and personality disorders are examined in turn.

\textbf{The Definition of ‘Mental Impairment’}

At the time of conducting their reviews, five of the six jurisdictions lacked a legislative definition of ‘mental impairment’ (or its jurisdictional equivalent). They each considered whether such a definition should be introduced. One jurisdiction (New Zealand) recommended that no definition be introduced, one jurisdiction (Scotland) recommended the enactment of a brief definition, and three jurisdictions (New South Wales, Victoria and England) recommended a comprehensive change.

The NZLC rejected the enactment of a definition for the following reasons:

\begin{itemize}
  \item The lack of definition provides the defence with flexibility; and
\end{itemize}

\begin{footnotesize}
\footnotesubscript{225} In Victoria, the term ‘mental impairment’ has been interpreted to mean the same as ‘disease of the mind’: \textit{R v Sebalj} [2003] VSC 181; \textit{R v Martin (No 1)} (2005) 159 A Crim R 314.
\footnotesubscript{226} \textit{Criminal Code Act} 1924 (Tas) s 16(4).
\footnotesubscript{227} \textit{Criminal Code Act} 1899 (Qld) s 27(1).
\footnotesubscript{228} \textit{Criminal Code Act} 2002 (ACT) s 27(1)-(2); \textit{Criminal Code Act} 1995 (Cth) s 7.3(8)-(9); \textit{Criminal Code Act} (NT) s 43A; \textit{Criminal Code Act} 1913 (WA) s 1.
\footnotesubscript{229} \textit{Criminal Code Act} 2002 (ACT) s 27(1)-(2); \textit{Criminal Code Act} 1995 (Cth) s 7.3(8)-(9); \textit{Criminal Code Act} (NT) s 43A; \textit{Criminal Code Act} 1913 (WA) s 1.
\end{footnotesize}
• It is not possible to define the scope of the qualifying conditions with any clarity.\textsuperscript{230}

2.179 In taking this stance, the NZLC was aware that the current ‘open-ended, flexible, case-based approach invariably carries the risk of anomalous results such as hyperglycaemia and hypoglycaemia’.\textsuperscript{231} However, they argued that any new definition ‘would in the end produce similar, and perhaps new, anomalies and that its novelty would cause more uncertainty than presently arises from the well-understood (if imperfect) case law’.\textsuperscript{232}

2.180 The same approach was taken by the LRCWA when considering whether the phrase ‘underlying pathological infirmity of the mind’ should be defined for the purposes of section 1 of the \textit{Criminal Code Act 1913} (WA). It noted that the absence of a definition allowed the defence a degree of flexibility to adapt to modern diagnostic practices. However, it also led to uncertainty about whether certain conditions, such as hyperglycaemia and epilepsy, would be covered.\textsuperscript{233} The LRCWA ultimately concluded that the current definition was adequate, and should not be amended.

2.181 While the SLC also initially favoured not defining the term ‘mental disorder’ for the purposes of their legislation, they were ultimately persuaded that a definition was desirable. They recommended that the term should be defined as meaning ‘(a) mental illness; (b) personality disorder; or (c) learning disability’.\textsuperscript{234} This approach leaves the definition of ‘mental illness’ at large, and does not address the anomalies discussed above.

2.182 By contrast, the ELC suggested a radical change to the qualifying conditions for the defence, recommending that it should be available to anyone who suffers from a ‘recognised medical condition’.\textsuperscript{235} This definition does not differentiate between physical and mental conditions, or between internal and external causes, thus avoiding the problems of ambiguity plaguing the current law.

2.183 A very different approach was taken by the NSWLRC. They gave significant consideration to the scope of the qualifying mental health conditions, seeking a definition that ‘captures the appropriate people, reflects contemporary psychological and psychiatric understandings, and is respectful of people with such impairments’.\textsuperscript{236}

\textsuperscript{231} Ibid 4.5.
\textsuperscript{232} Ibid 4.8.
\textsuperscript{233} Law Reform Commission of Western Australia, \textit{Review of the Law of Homicide} (Law Reform Commission of Western Australia, 2007) 229. Additional uncertainty about these matters arises in the WA context, due to the fact that their definition of ‘mental illness’ only refers to ‘extraordinary stimuli’, not ‘external extraordinary stimuli’. The fact that the definition leaves out the word ‘external’ has caused some commentators to suggest that conditions resulting from a healthy mind’s reaction to internal extraordinary stimuli (such as hyperglycaemia) are excluded from the defence.
The NSWLRC favoured a broad definition of the qualifying mental health conditions. They argued that it was not necessary to restrict the scope of the definition too much, because:

the function of the definition of the person’s mental state in the defence is to provide a preliminary ‘gate’ through which a defendant must pass. In order to succeed in the defence of NGMI, defendants must also pass through a second, and much narrower, ‘gate’ by demonstrating the required nexus between their impairment and the offence. They must show that their impairment is so serious that when they offended they did not know what they were doing, did not know it was wrong, or that they were unable to control their conduct. It is the second part of this test, rather than the definition, which operates to limit the defence to those people who are so affected by their impairment that they should not be held criminally responsible.\(^{237}\)

The NSWLRC drew a distinction between ‘mental health impairments’ and ‘cognitive impairments’, recommending that the defence be available on the basis of either condition. They recommended that these terms be defined as follows:

(1) Mental health impairment:

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

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

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

(2) Cognitive impairment

(a) Cognitive impairment is an ongoing impairment in comprehension, reason, adaptive functioning, judgement, learning or memory that is the result of any damage to, dysfunction, developmental delay, or deterioration of the brain or mind.

(b) Such cognitive impairment may arise from, but is not limited to, the following:

   (i) intellectual disability

\(^{237}\) Ibid 3.48.
(ii) borderline intellectual functioning

(iii) dementias

(iv) acquired brain injury

(v) drug or alcohol related brain damage

(vi) autism spectrum disorders.\textsuperscript{238}

2.186 Neither this definition, nor the NSWLRC Report, specifically discuss the anomalous results caused by cases of hyperglycaemia or hypoglycaemia. It would appear, however, that such anomalies would not arise under the recommended definition, which no longer contains the same internal/external focus as the CLCA or the common law. The definition seems sufficiently broad to capture all such conditions, with the success of the defence depending on proof of the nexus between the impairment and the offence.

2.187 The VLRC favours the introduction of a broad statutory definition of ‘mental impairment’.\textsuperscript{239} This recommendation differs greatly from the VLRC’s recommendation in their 2004 report on Defences to Homicide where they took the view that a statutory definition of ‘mental impairment’ should not be introduced.\textsuperscript{240} The VLRC supported their most recent recommendation by reasoning that the introduction of a statutory definition is the best way to clarify the law on the meaning of the that term.\textsuperscript{241} The VLRC recommended that for the purposes of the defence, the term ‘mental impairment’ should be defined as a condition that ‘includes, but is not limited to, mental illness, intellectual disability and cognitive impairment’.\textsuperscript{242} The Commission also recommended that:

The proposed definition of mental impairment should not include any self-induced temporary conditions resulting from the effects of ingesting substances.

The proposed definition should include self-induced conditions that exist independently of the effect of ingesting substances.\textsuperscript{243}

2.188 The VLRC decided that the above definition would ‘provide flexibility to include any mental condition (subject to specific exclusions) that has the effect of the accused not knowing the nature and quality of their conduct and/or not knowing their conduct is wrong’.\textsuperscript{244} The VLRC was not concerned about the broadness of its proposed definition because the scope of the mental impairment defence would be limited by the standards required to satisfy the operational elements of the defence;

\textsuperscript{238} Ibid Recommendation 3.2.


\textsuperscript{240} Victorian Law Reform Commission, Defences to Homicide: Final Report (Victorian Law Reform Commission, 2004) [5.18], [5.29].


\textsuperscript{242} Ibid 115, Recommendation 24.

\textsuperscript{243} Ibid 115, Recommendation 24.

\textsuperscript{244} Ibid [4.67].
and the serious consequence of the imposition of an indefinite supervision order if the defence is established.  

**Automatism**

2.189 None of the reviews considered incorporating the objective test from *R v Falconer* into their legislative schemes. In their 2004 report on *Defences to Homicide*, the VLRC did, however, consider excluding dissociative states from the scope of automatism, or bringing such states within a broader defence of mental impairment. However, they concluded that such reform was unnecessary and unlikely to achieve the desired outcome. They therefore did not recommend making any changes to the law of automatism. Automatism was beyond the scope of the VLRC’s recent report, *Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*. Nonetheless, the VLRC commented that their proposed statutory definition of ‘mental impairment’ may impact upon the doctrine of automatism as the distinction between sane and insane automatism in Victoria is dependent upon the current meaning of ‘mental impairment’ which is ‘disease of the mind’. The VLRC noted that their recommendations about jury directions may also impact upon the doctrine of automatism.

2.190 The LRCWA did not recommend any amendments in relation to the law in this area. By comparison, the ELC recommended widespread reforms to the defence of automatism, limiting it to cases where the defendant acted involuntarily due to a cause other than a recognised medical condition. Where the involuntary action was due to a recognised medical condition, the defendant should be found ‘not criminally responsible by reason of a recognised medical condition’ (the new equivalent to the ‘not guilty by reason of insanity’ special verdict). This approach avoids the problems of differentiating between ‘sound’ and ‘unsound’ minds, and thus the need to implement the objective test from *R v Falconer*. Instead, the focus of the trier of fact will be on whether the defendant suffered from a recognised medical condition, such as post-traumatic stress disorder, that caused the involuntary conduct.

**Personality Disorders**

2.191 The reviews adopted differing positions on the issue of personality disorders. Two jurisdictions (WA and NZ) argued against their legislative exclusion. For the NZLC, this was a consequence of their general view that particular conditions should not be singled out in legislation. They argued that specifically excluding any disorders, including psychopathic and personality disorders, ‘might create injustices and it

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245 Ibid 4.66.
248 Ibid [4.14], [4.81].
249 Ibid [7.156].
would inevitably arbitrarily distinguish the excluded conditions from a range of other conditions involving similar degrees of mental impairment’.  

2.192 The LRCWA noted that neither the psychiatric profession nor case law in WA consider such disorders to be a mental illness. They stated that:

> according to the Oxford Textbook of Psychiatry, ‘most psychiatrists begin by separating mental handicap and personality disorder from mental illness’. The common element of all mental illnesses is said to be a ‘pervasive inability to engage reality’, and it is here that personality disorders differ from mental illness. People suffering from a personality disorder generally appreciate what they are doing and, although there may be some difficulty in controlling their actions, ‘it cannot be said that [they are] completely lacking in volitional capacity’. Even if such a disorder was accepted by a Western Australian court as a relevant mental illness for the purpose of the defence of insanity, it would be a rare case where one or more of the three relevant capacities was completely (as opposed to substantially) impaired.

2.193 Consequently, the LRCWA did not believe that personality disorder should automatically qualify as a mental impairment for the purposes of the insanity defence. However, they also did not think that it should be specifically excluded. They noted that diagnostic practices can change over time, and suggested that there may be some types of personality disorder that come to be considered mental illnesses in the future. There may also be cases where ‘a personality disorder derives from an underlying pathological infirmity of the mind or where it coexists with such an infirmity. Whether a particular mental illness will activate consideration of the defence of insanity is a question of law for the judge.’

2.194 The ELC noted two additional arguments that have been raised against the automatic exclusion of personality disorders from the definition. First, it is difficult to reliably differentiate personality disorders from other mental illnesses. If there is no valid difference between them, there is no scientific basis for excluding them. Secondly, what is important for a determination of criminal responsibility is not the cause of the defendant’s incapacity, but the fact of the incapacity. Where a person suffers from a relevant incapacity (such as a total loss of control) due to a personality disorder, it would be unjust to exclude him or her from the scope of the defence.

2.195 The ELC accepted both of these arguments, but took the provisional view that:

> there comes a point at which they lose all force. That point is where the evidence of the recognised medical condition (of a personality disorder) is no more than evidence of what would ordinarily be regarded as serious criminal behaviour. We would therefore say that there is a particular kind of personality disorder which should not

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254 Ibid 230.

255 Ibid 230.
qualify as a recognised medical condition which might provide the foundation for the defence.\textsuperscript{256}

2.196 Rather than specify particular types of personality disorder that should be excluded, the ELC focused on the nature of the excluded conditions. They recommended that ‘any condition which is manifested solely or principally by abnormally aggressive or seriously irresponsible behaviour’ should be excluded.\textsuperscript{257}

2.197 While the SLC recommended specifically \textit{including} ‘personality disorder’ within its definition of ‘mental disorder’, it also recommended the exclusion of a specific type of personality disorder: psychopathic personality disorder. It gave the following reasons for this recommendation:

We take the view that the condition of psychopathy does not, and should not, fall within the set of circumstances which we have argued forms the basis of the defence, namely inability to appreciate conduct as a result of mental disorder... Psychopathy does not have the effect that the person's reasons for acting as he did are in any way 'abnormal' or 'crazy' or 'disordered.' Rather, psychopathic personality disorder has the effect that because of the psychological make-up of the accused he has difficulties, not shared by the ordinary person, in complying with the requirements of the law. But such difficulties do not remove the person completely from responsibility for his actings. He appreciates what he is doing. At most such a person has difficulties in controlling his conduct but it cannot be said that a psychopath is completely lacking in volitional capacity. We have already recommended that the test for the defence should not contain any volitional element. In any event, if a person could have controlled his conduct at the time but did not do so, he is hardly relieved from responsibility, even if he was suffering from a condition which made it difficult for him to refrain from acting as he did. Any such condition might be an extenuating circumstance but not an excusing one. But psychopathy does not have the effect that a person cannot control his conduct. Its effect is to make it more difficult, but not impossible, for the person concerned to behave in a way that he knows is correct.\textsuperscript{258}

2.198 By contrast, the NSWLRC recommended specifically excluding \textit{all} personality disorders from the scope of the definition. The NSWLRC made this recommendation for the following three reasons:

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

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

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


\textsuperscript{257} Ibid Proposal 4.

have concluded in favour of exclusion, preferring to review the issue further as knowledge develops and there is a better evidence base for policy development.  

Submissions

2.199 The Council received a wide range of submissions on the definition of ‘mental impairment’. The sections below examine the submissions concerning the general scope of the definition, its specific application in relation to automatism, and the potential exclusion of personality disorders in turn.

The Definition of ‘Mental Impairment’

2.200 The Council received 11 submissions addressing the way in which ‘mental impairment’ should be defined. Only the submission of the LSC recommended specifically mentioning hypoglycaemia in the legislation, on the basis that the conditions covered should be as open as possible, with it left to the trier of fact to decide if the rest of the defence is met. The rest of the submissions opposed this proposal, but were split in their reasons for rejecting it, with some favouring retention of the current approach and others arguing that the definition should be broadened.

2.201 There was general agreement that it would be undesirable to specifically list any conditions for inclusion or exclusion, with all submitters favouring approaching the issue on a case-by-case basis according to principle. Concern was raised that ‘[n]arrowing or prescribing the definition can potentially result in unforeseen or undesirable consequences’. In addition, it was argued that it made little sense to specifically target hypoglycaemia, as there are many other conditions that could give rise to similar anomalies:

There is a long list of causes for organic mental disorders, both internal and external. It could ultimately be pointless to only definitively mention one metabolic disturbance, in this case hypoglycaemia, as there are so many different other causes of confusion. These include changes in serum electrolytes (for example caused by dehydration), oxygen, carbon dioxide, calcium, endocrine conditions (hypo or hyperthyroidism), infections and the side effects of many drugs.

2.202 Some submissions argued that the current law provides an appropriate basis for making such a determination. For example, the submission of the Law Society stated:

The Society considers that the relationship between internal organic or mental processes factors, mental disorder and disease or illness of the mind and the particular conduct resulting therefrom are necessary criteria for a mental impairment defence. If complex medical conditions do not satisfy that causative chain then that must be the

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260 Legal Services Commission of South Australia, Submission to the Sentencing Advisory Council.

261 South Australian Bar Association, Submission to the Sentencing Advisory Council.

262 Office of the Public Advocate, Submission to the Sentencing Advisory Council.
limits of the definition of mental illness for the purposes of the mental impairment
defence. 263

2.203 Similarly, the submission from the Bar Association suggested that:

The real question is whether the person relying on the defence suffered a pathological
infirmity of the mind at the time of committing the offence. Answering that question
generally requires the assistance of an expert. It may be that, depending on the facts, a
Court’s findings may either include or exclude hypo- or hyper-glycaemia. It is
important to be able to rely on the finder of fact using the well established definition
with the assistance of expert opinion.264

2.204 By contrast, submissions from the OPA, the LSC and Mr Walvisch favoured the
adoption of a broader test that would include both hyperglycaemia and
hypoglycaemia. For example, the submission of the LSC argued that:

As a matter of principle, it is preferable that the legal definition of a ‘mental illness’,
which is capable of amounting to a ‘mental impairment’ under s 269A(1), be as open
as possible by way of inclusion of other problematic medical condition [sic]. Medical
knowledge, diagnostic tools and medical understanding of the workings of the mind
are subject to change and development over time and it is important that the court has
the flexibility to keep up with and interpret medical developments.265

2.205 A similar approach was taken by Mr Walvisch, who suggested that any type of
‘abnormality’ or impairment should be sufficient to ground the defence. While
acknowledging this would significantly broaden the definition, he noted that:

it must be borne in mind that the existence of an ‘abnormality’ is only the first matter
that must be proved. It must also be established that the abnormality affected the
accused in one of the relevant ways. It is these other requirements that act to severely
limit the scope of the defence.266

2.206 By comparison, the submission of the OPA focussed on the problems caused by the
internal/external factors test, suggesting that it be abolished:

Our observation is that the problem described in the discussion paper would appear to
be the historical artificial division between disorders created by an internal cause and
those created by external causes, which creates an anomaly and potential injustice.
There does not seem to be any valid scientific, or moral reason to separate such
internal and external factors, in considering whether or not a person has a mental
illness. For example one person might have mania precipitated by a hyperthyroid state
caused by an overactive thyroid gland, while another person has a similar mental state
caused by thyroid hormone prescribed by their doctor at too high a dose. If offences
are committed in such a state, in both situations a mental impairment defence should
be available if the definitions in s269C are met.

For this reason, rather than definitively naming individual metabolic disorders, if there
is a need to eliminate this anomaly, a note could be made in the legislation that a
mental illness can be caused or precipitated by internal or external causes, and if it is

263 Law Society of South Australia, Submission to the Sentencing Advisory Council.
264 South Australian Bar Association, Submission to the Sentencing Advisory Council.
265 Legal Services Commission of South Australia, Submission to the Sentencing Advisory Council
266 Jamie Walvisch, Submission to the Sentencing Advisory Council.
necessary to name a condition such as hypoglycaemia it could be given as an example.\textsuperscript{267}

\textbf{Automatism}

2.207 The Council received 11 submission addressing the possible enactment of the objective test from \textit{R v Falconer}. Four of those submissions supported the proposal, with a fifth offering qualified support. Five opposed the proposal, with a sixth also leaning towards its rejection.

2.208 Those who supported the proposal, such as the Law Society and the AMA(SA),\textsuperscript{268} did so on the basis that it would help clarify the law, and would not substantively change it. The strongest support was given by the criminal law academics from Adelaide Law School, whose submission argued that non-insane automatism should be included in Part 8A of the CLCA to avoid confusion. The submission suggested the following wording:

\begin{quote}
Non-insane automatism refers to the reaction of a sound mind to extraordinary external stimuli, including stress producing factors or an extraordinary psychological blow. It is excluded where an underlying pathological infirmity of the mind preceded the malfunction of the mind.

Sound mind refers to a standard of mental strength which, in the face of a given level of psychological trauma, is capable of protecting the mind from malfunction. That standard is measured objectively according to the ordinary person of normal temperament and self-control.\textsuperscript{269}
\end{quote}

2.209 Those who opposed the proposal, such as the OPA, the Director of Public Prosecutions (DPP), and the LSC, largely did so on the basis that the change was unnecessary. For example, the submission of the OPA stated:

\begin{quote}
The objective test for sane automatism put forward by the High Court – how the ordinary person of normal temperament and self control might respond to such a psychological trauma – has been a part of case law for over 20 years, and we understand is now routinely followed in South Australia. In the absence of controversy about this provision, and with the understanding that the test is currently being used, it is not clear what benefit, if any, there would be in putting this test in the statute.
\end{quote}

\textbf{Personality Disorders}

2.210 The Council received 15 submissions on the issue of personality disorders. Eight favoured specifically providing that the defence of mental incompetence could not be based on such disorders, while six did not support a change to the current law. One submission argued that personality disorders should be specifically included in the CLCA.

2.211 The exclusion of personality disorders was supported by a number of bodies working in the field of mental health, such as the FMHS, the Office of the Chief

\textsuperscript{267} Office of the Public Advocate, \textit{Submission to the Sentencing Advisory Council}.

\textsuperscript{268} Given the lack of controversy surrounding the issue, the AMA(SA) only gave qualified support to the proposal.

\textsuperscript{269} Kellie Toole, et al., \textit{Submission to the Sentencing Advisory Council}.
Psychiatrist (OCPP) and the AMA(SA). It was also supported by correctional organisations, such as the Department for Correctional Services (DCS) and the Parole Board. Five reasons were given for excluding personality disorders from the scope of the definition.

2.212 First, it was contended that people with personality disorders do not suffer from the type of condition that should qualify them for the defence. This point was made pointedly by the Parole Board, whose submission stated:

[T]he Parole Board is strongly of the view that including “personality disorder” in the definition is inappropriate because the majority of prisoners suffer from a type of personality disorder. It is the Board’s experience that persons with a personality disorder are not mentally incompetent. They may be impulsive, they may make poor choices and they may have poor problem solving skills but they are able to make decisions and should be responsible for the consequences of their actions.\(^{270}\)

2.213 Secondly, it was suggested that including personality disorders within the definition would open the defence too broadly, given that ‘[a]n extremely high proportion of people who come into contact with the criminal justice system have a previously diagnosed personality disorder of some type’.\(^{271}\)

2.214 Thirdly, it was argued that ‘the regime established by Part 8A is a therapeutic one. It has at its core that if a person was mentally incompetent to commit the offence, then they will receive treatment.’\(^{272}\) As personality disorders are generally not considered to be amenable to meaningful treatment, they should not be considered under that regime.\(^{273}\)

2.215 Fourthly, it was put that, by definition, a person with a personality disorder should never meet the other requirements of the defence: ‘if the sufferer meets criteria under one of the sub-limbs of s 269C, then they warrant a different diagnosis’.\(^{274}\) While this makes the specific exclusion of personality disorders technically unnecessary (as a person with such a disorder should never be able to successfully raise the defence), it was nevertheless considered to be worthwhile in order to remove confusion.

2.216 Finally, it was suggested that ‘from a therapeutic point of view, excusing a person for their behaviour on the basis of [a personality disorder] is counter-therapeutic. The mainstay of treatment is to force patients to take responsibility for their own actions and choices, and assist them to make better choices in [the] future.’\(^{275}\)

2.217 The retention of the current law was supported by a number of legal organisations, such as the Bar Association, the Law Society and the LSC. It was also supported by the Australian Psychological Society College of Forensic Psychology (CFP) and the OPA. Seven reasons were offered in support of this position.

\(^{270}\) Parole Board of South Australia, Submission to the Sentencing Advisory Council.

\(^{271}\) Department for Correctional Services, Submission to the Sentencing Advisory Council.

\(^{272}\) Director of Public Prosecutions, Submission to the Sentencing Advisory Council.

\(^{273}\) Commissioner for Victims' Rights, Submission to the Sentencing Advisory Council.

\(^{274}\) Australian Medical Association (South Australia), Submission to the Sentencing Advisory Council.

\(^{275}\) Ibid.
First, it was noted that the ‘critical issue in mental incompetence assessments is in regards to the defendant’s cognitive, moral and volitional capacities, rather than any specific diagnosis attributed to the individual in question’. Consequently, the mere inclusion of personality disorders in the definition of mental impairment does not mean that antisocial individuals will be exempted from criminal responsibility.

Secondly, it was pointed out (as discussed above) that a person with a personality disorder is unlikely to meet the requirements of the defence, as they are likely to know the nature and quality of the conduct, know that it is wrong, and be able to control their conduct. Consequently, specifically excluding the disorders form the definition is unnecessary.

Thirdly, it was argued that it is wrong in principle to exclude specific disorders, and that the definition ‘should be left open-ended as it is and be allowed to develop on a case by case basis’. Each case ‘must be assessed on its individual facts and circumstances’. While most people with personality disorders are unlikely to meet the requirements of the defence, it is possible that a particular individual may suffer from some type of rare and severe personality disorder that does meet the requirements. ‘An individual in this category should not be excluded from consideration under Part 8A of the CLCA’.

In this regard, concern was raised about the current agreement between forensic practitioners that personality disorders do not, and should not, come within the scope of the defence. It was suggested that this ‘may be due to resource implications rather than a proper application of the legal criteria’. It was argued that there have been cases where personality disorders have properly been recognised as mental impairments, and have allowed the defence to be successfully raised.

Fourthly, it was noted that psychiatric diagnosis can be uncertain, and that often a condition which is originally considered to be a personality disorder will later be reclassified as a mental illness. For example, ‘[s]evere mental illness such as schizophrenia and bipolar disorder can evolve over time, sometimes years, and it is not uncommon for personality disorder diagnoses to be made that are subsequently abandoned when a fully developed syndrome of psychosis or manic depression becomes evident’. It would be unjust to deny such individuals access to the mental incompetence defence.

Fifthly, it was suggested that excluding personality disorders could create problems where defendants also suffer from a mental illness. For example, the submission of the OPA stated:

Our concern is that a specific exclusion related to personality disorders, could disadvantage such people. In court it might lead to debates as to whether or not co-morbid episodes of psychotic decompensation, dissociation or mood disorder should

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276 College of Forensic Psychologists (SA Section) Australian Psychological Society, Submission to the Sentencing Advisory Council.
277 South Australian Bar Association, Submission to the Sentencing Advisory Council.
278 Law Society of South Australia, Submission to the Sentencing Advisory Council.
279 Ibid.
280 Ibid.
281 Office of the Public Advocate, Submission to the Sentencing Advisory Council.
be considered as additional to the Borderline Personality Disorder diagnosis, and therefore acceptable for a mental impairment defence, or part of the overall presentation; in the latter case an impairment defence would be excluded under this proposal.  

2.224 Sixthly, it was argued that personality disorders are no different from other type of mental disorder, and should not be treated differently. This argument was raised strongly by the CFP, who suggested that the call for exclusion may stem from the structure of the DSM, which previously listed personality disorders on a separate axis from other mental disorders:

This separation may have influenced a perception that clinical disorders and PDs are distinct and separate in nature from other clinical disorders. However, current research suggests that this perception may be misguided and the current edition of the DSM no longer lists PDs on a separate axis. PDs should not be understood to be conditions distinct from other mental disorders, and as such, excluding them from the mental incompetence defence would be arbitrary.  

2.225 Finally, it was suggested that much of the concern about personality disorders stems from antisocial personality disorder (APD). There is seen to be a ‘paradox of excusing people from criminal responsibility on the basis of previous antisocial behaviour’. There are, however, many other types of personality disorder, which it was contended should not be excluded simply because of APD:

For example, Borderline Personality Disorder (BPD) is characterised by disturbances in self-image, relationships with others, affective instability (including difficulties controlling anger), marked impulsivity and severe dissociative symptoms in times of stress. These features, where they occur, may impact on an individual’s ability to appropriately understand or control their conduct, and thus, ought to impact on whether they are considered criminally responsible for their conduct in such instances.  

2.226 Mr Walvisch was the only submitter to argue that personality disorders should be specifically included in the definition of ‘mental impairment’. As noted above, it was his view that the focus of the defence should be on the effects caused by an ‘abnormality’, not the nature of that ‘abnormality’. Consequently, he argued that ‘impairment’ should be defined broadly, and should specifically include personality disorders (in order to avoid any confusion).  

Conclusions and Recommendations

2.227 The Council has considered the many different arguments raised by the submissions and past reviews concerning the appropriate scope of the definition of ‘mental impairment’. While the Council is concerned about the anomalies created by the current approach, it agrees with the view held by the majority of submitters that it would be undesirable to specifically list any conditions for inclusion or exclusion

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282 Ibid.
283 College of Forensic Psychologists (SA Section) Australian Psychological Society, Submission to the Sentencing Advisory Council (citations omitted).
284 Ibid.
285 Ibid (citations omitted).
286 A similar view was strongly put in the submission of the Office of the Public Advocate.
287 Jamie Walvisch, Submission to the Sentencing Advisory Council.
from the definition. The Council favours approaching the issue on a case-by-case basis according to principle.

2.228 Although the Council sees merit in adopting a broad approach to the definition of mental impairment, and relying on the other aspects of the defence to filter out inappropriate cases, it is concerned about the unintended consequences that may flow from such a change. Moreover, it does not believe that such a change is necessary, given the limited number of cases affected by the current anomalies. It is the Council’s view that the current definition in section 269A is sufficiently flexible to appropriately address the vast majority of cases, and that that flexibility should be retained. The Council therefore recommends that section 269A should not be modified.

2.229 This includes not amending section 269A to expressly incorporate the objective test from *R v Falconer*. The Council notes that there was little substantive support for any amendment in this area, and agrees that a change is unnecessary. The common law is capable of adequately handling the few cases of psychological blow automatism that arise.

2.230 The recommendation that section 269A not be amended also extends to personality disorders. It is the Council’s view that such disorders should not be expressly excluded from the definition of ‘mental impairment’. Such a change is unnecessary, given that the vast majority of defendants who solely suffer from a personality disorder will already be excluded from the defence, by virtue of their inability to prove that they did not know the nature and quality of the conduct, did not know it was wrong, or could not control the conduct. In this regard, it is important to emphasise the Council’s earlier recommendation that the volitional element of the defence should only cover cases where the defendant lacked *complete* control over his or her actions. A partial lack of control will be insufficient. If there is an exceptional case in which a personality disorder has one of the requisite effects, it is the Council’s view that the individual should be exculpated.

2.231 Furthermore, the Council is concerned about the feasibility of defining precisely which conditions would be excluded, given the uncertainty surrounding the precise meaning of ‘personality disorders’ and changing scientific knowledge about the distinction between such disorders and mental illnesses. It is also of the view that such an exclusion could have an undesirable impact on cases in which the defendant also suffers from a mental illness or intellectual disability. In the Council’s view the preferred approach is to retain a flexible definition of mental impairment, and rely on the other aspects of the defence to filter out undeserving cases.
Recommendation 5

The definition of mental illness in section 269A of the Criminal Law Consolidation Act 1935 should not be amended to specifically include or exclude any medical condition, including hypoglycaemia or hyperglycaemia.

Recommendation 6

The definition of mental illness in section 269A of the Criminal Law Consolidation Act 1935 should not be amended to expressly declare that the objective test formulated by Chief Justice Mason and Justices Brennan and McHugh in R v Falconer (1990) 171 CLR 30 must be applied to distinguish between sane and insane automatism in cases involving dissociation.

Recommendation 7

The definition of mental impairment in section 269A of the Criminal Law Consolidation Act 1935 should not be amended to specifically include or exclude personality disorders. The wording of section 269A should remain in its current form.

Intoxication by Drugs or Alcohol

2.232 The use of drugs and alcohol by individuals suffering from a mental illness is common, and data indicates that there is an increased likelihood of offending by individuals who suffer from a comorbid mental illness and a substance abuse disorder. That is not to say that mental illnesses, substance abuse disorders or their combination cause criminal conduct. The relationships between these matters are complex and the subject of continuing investigation. Nevertheless, the correlations between mental illnesses, drug and alcohol abuse and criminal conduct are a significant cause for concern, and make it necessary to consider the interaction between the mental incompetence defence and the law relating to intoxication.

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288 For the sake of simplicity, this section of the Report focuses on mental illnesses. However, the issues raised also apply to intellectual disabilities and disabilities or impairments of the mind resulting from senility.

289 ‘Comorbidity’ refers to the co-existence of two or more psychiatric conditions, including substance abuse disorders. For more information on co-morbidity, see: National Comorbidity Project, National Drug Strategy and National Mental Health Strategy (Commonwealth Department of Health and Aged Care, 2001).


291 For example, Wallace and colleagues concluded that ‘The strong relationship between co-morbid substance abuse and offending in schizophrenia is confirmed, but the data on convictions over a 25-year period during which co-morbid substance abuse escalated dramatically cast doubt on the role of substance abuse alone in accounting for the higher rates of offending. .....The association between schizophrenia and a higher rate of criminal convictions is likely to reflect the concatenation of a range of deleterious influences’: C Wallace, P Mullen and P Burgess, ‘Criminal Offending in Schizophrenia over a 25-year Period Sparked by Deinstitutionalization and Increasing Prevalence of Comorbid Substance Use Disorders’ (2004) 161 American Journal of Psychiatry 716.
The need to carefully consider this interaction was highlighted by the Case File Review undertaken by the Attorney-General’s Department, which found that:

- 80% of all individuals indicated that drugs and/or alcohol had been a problem for them in the past;
- 73% of all individuals had ingested drugs and/or significant amounts of alcohol in the weeks or days leading up to the commission of the offence;
- 15% of individuals suffered from a drug-induced psychosis; and
- 9% of individuals suffered from substance abuse and dependence.

In addressing the relationship between intoxication and mental illness, separate consideration needs to be given to the following types of cases:

- Cases in which an individual who is clearly already suffering from a mental illness becomes intoxicated (for example, where a person suffering from major depressive disorder drinks alcohol);
- Cases in which an individual has a latent mental illness which is triggered by the intoxication (for example, where a person with a pre-disposition to schizophrenia suffers from a first psychotic episode after smoking cannabis); and
- Cases in which an individual’s mental illness is caused by the intoxication. The resulting illness may be temporary (for example, where a person without a pre-disposition to schizophrenia suffers from a short-lived drug-induced psychotic episode) or permanent (for example, where a person suffers organic brain damage due to petrol sniffing).

A distinction can also be drawn between cases in which an individual is still under the influence of drugs or alcohol at the time of the alleged offence, and those in which the drugs or alcohol have been completely metabolised by the time of the offence, but the mental illness (which had been triggered or induced by the intoxication) remains.

**Common Law Approach**

At common law, an individual cannot rely on the insanity defence where the relevant impairment is caused solely by a temporary state of intoxication. This is because such a state of intoxication does not constitute a ‘disease of the mind’. However, the insanity defence may be relied upon if:

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292 See Appendix B.
293 *R v Davis* (1881) 14 Cox CC 563; *R v O’Connor* (1979) 146 CLR 64.
294 See Judicial College of Victoria, *Victorian Criminal Charge Book* (Judicial College of Victoria, 2014) 8.6.1 – Bench Notes: Common Law Intoxication, [58].
• The consumption of drugs or alcohol caused the accused to suffer from a condition which is considered to be a ‘disease of the mind’ (eg, permanent brain damage);\(^{295}\)

• The consumption of drugs or alcohol triggered or exacerbated a pre-existing condition which is considered to be a ‘disease of the mind’ (eg, schizophrenia);\(^{296}\) or

• The accused’s mental impairment caused him or her to become intoxicated.\(^{297}\)

2.237 An individual may rely on the mere fact of intoxication to show either that he or she acted involuntarily,\(^{298}\) or did not have the necessary intention to commit the crime.\(^{299}\) If this was the case, the individual must be acquitted.\(^{300}\) This is sometimes known as the ‘drunks’ defence’.

**Current South Australian Approach**

2.238 In South Australia, the laws concerning intoxication and the mental incompetence defence are currently contained in different parts of the CLCA. Intoxication is addressed in Part 8, which was enacted in 1999 in order to eliminate the so-called ‘drunks’ defence’.\(^{301}\) The mental incompetence defence is addressed in Part 8A, which was enacted in 1995 in order to modernise the procedure and consequences of a finding that an individual was either unfit to stand trial or not guilty on the ground of mental impairment.\(^{302}\)

2.239 The definition of ‘mental impairment’ in Part 8A specifically excludes intoxication, which is defined as ‘a temporary disorder, abnormality or impairment of the mind that results from the consumption or administration of intoxicants and will pass on metabolism or elimination of intoxicants from the body’.\(^{303}\) This means that intoxication alone, no matter how severe or disorienting its effects, cannot provide the basis for the defence of mental incompetence. This will be the case even if the intoxication is involuntary. Questions relating to the criminal responsibility of a merely drunken or drug-affected offender must instead be dealt with under Part 8 of the CLCA.\(^{304}\)

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\(^{298}\) Such a level of intoxication is rare, as it requires the individual to have completely lacked control over his or her actions. In most cases, the individual’s intoxication will be relevant to the issue of intention.

\(^{299}\) For example, the individual may not have intended to commit the act charged (‘basic intent’), or he or she may not have intended to attain the result required by the offence (‘specific intent’).

\(^{300}\) *R v O’Connor* (1979) 146 CLR 64.

\(^{301}\) Criminal Law Consolidation (Intoxication) Amendment Act 1999 (SA).

\(^{302}\) Criminal Law Consolidation (Mental Impairment) Amendment Act 1995 (SA).

\(^{303}\) Criminal Law Consolidation Act 1935 (SA) s 269A(1).

\(^{304}\) Evidence of mental impairment from whatever cause, whether resulting from intoxication, mental illness or their combined effects, is admissible after conviction, when sentence is determined, to mitigate the penalty for the offence: see Jamie Walvisch, ‘Sentencing Offenders with Impaired Mental Functioning: Developing Australia’s ‘Most Sophisticated and Subtle’ Analysis’ (2010) 17(02) Psychiatry, Psychology and Law 187; Michelle Edgely, ‘Common Law Sentencing of Mentally Impaired Offenders in Australian Courts: A Call for Coherence and Consistency’ (2009) 16(2) Psychiatry, Psychology and Law 240.
Part 8 of the CLCA abrogates the common law on intoxication. It provides that a person may be convicted of an offence, even if his or her consciousness was (or may have been) impaired by intoxication to the point of criminal irresponsibility. ‘Consciousness’ is defined to include volition, intention, knowledge or any other mental state or function relevant to criminal liability. ‘Intoxication’ is not defined for the purposes of Part 8.

For a person to be held criminally responsible despite his or her consciousness being impaired by drugs or alcohol, the person must have either:

- Formed an intention to commit the offence before becoming intoxicated, and consumed intoxicants in order to strengthen his or her resolve to commit the offence;
- Engaged in ‘recreational use’ of drugs or alcohol. Any consumption of drugs or alcohol is regarded as ‘recreational’ (and thus ‘self-induced’), unless: the substance is administered against the will or without the knowledge of the person; consumption occurs accidentally; the substance is taken under duress, or as a result of fraud or reasonable mistake; or the substance is taken for a therapeutic purpose in accordance with directions for medical use.

However, a person whose consciousness was (or may have been) impaired by intoxication to the point of criminal irresponsibility cannot be convicted of an offence which requires proof that he or she:

- Foresaw the consequences of his or her conduct; or
- Was aware of the circumstances surrounding his or her conduct.

There are no provisions in the CLCA specifically addressing the issue of comorbid mental impairment and substance use. Thus, while it is clear that a person cannot raise the mental incompetence defence solely on the basis of intoxication, it is unclear how Parts 8 and 8A interact in the three situations listed in paragraph 2.234 above (concurrent, triggered or induced mental impairments).

On the basis of case law, it appears that a person may not rely on the defence of mental incompetence where a temporary impairment was triggered or induced by

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305 Criminal Law Consolidation Act 1935 (SA) s 268.
306 Criminal Law Consolidation Act 1935 (SA) s 267A.
307 Criminal Law Consolidation Act 1935 (SA) s 268(1).
308 Criminal Law Consolidation Act 1935 (SA) s 268(2).
309 Criminal Law Consolidation Act 1935 (SA) s 267A.
310 Criminal Law Consolidation Act 1935 (SA) s 268(3). The one stated exception is rape, which may be proved despite the fact that, due to the intoxication, the defendant was unaware of the circumstances surrounding his or her conduct.
311 The absence of an integrated approach to intoxication and mental impairment is apparent from the fact that the definition of ‘intoxication’ in Part 8A has no application to Part 8 (which leaves the concept of ‘intoxication’ undefined). Similarly, while Part 8 differentiates between voluntary and involuntary intoxication, Part 8A does not. This is in contrast to the Queensland and Western Australian Criminal Codes, in which the mental impairment defence extends to impairments of mental capacity resulting from involuntary or accidental intoxication.
drug or alcohol use. For example, in *Police v Hellyer* the defendant committed a burglary under the combined effects of alcohol, cannabis and LSD. Medical evidence suggested that he was either suffering from a drug-induced psychosis, or an evolving schizophrenic disorder which was triggered by his substance use. Justice Perry held that regardless of the nature of the mental disorder, it was either directly induced or precipitated by drug use. As it was a condition which would pass on metabolism or elimination of the intoxicants from the body, it fell within the scope of the definition of ‘intoxication’ in Part 8A, and could not ground the defence.

**Issues to be Addressed**

2.245 A moral distinction can be drawn between a mental impairment that is caused by a mental illness or intellectual disability, and one that is caused solely by voluntary intoxication. In the former case, the affected individual is generally not seen to be responsible for the impairment, and so it is usually considered to be unfair to hold him or her criminally responsible for his or her actions. By contrast, in the latter case the individual has chosen to drink or take drugs, and so should arguably be held responsible for his or her consequent behaviour. This distinction underlies the current separation between Parts 8 and 8A of the CLCA, and the exclusion of ‘intoxication’ from the definition of ‘mental impairment’ in Part 8A.

2.246 Unfortunately, this moral distinction becomes blurry in cases involving comorbid mental illness/intellectual disability and substance use. In such cases it is often difficult to know:

- Whether the intoxication caused the mental impairment, or the mental impairment preceded (or even caused) the intoxication; and

- Whether the intoxication or the mental impairment was the cause of the offending behaviour.

2.247 The law in this area is complex and uncertain. In the Discussion Paper, the Council asked a number of questions aimed at determining the best way to approach the relationship between mental impairment and intoxication. It proposed four possible options for reform, each of which is outlined below.

*Option 1: A Broad Approach to ‘Mental Impairment’*

2.248 The first option for reform raised in the Discussion Paper involved defining ‘mental impairment’ broadly, to include any impairment that affects the defendant’s
cognitive capacities to the extent that he or she does not know the nature and quality of the conduct, does not know it was wrong, or is unable to control the conduct.

This approach was advocated by the VLRC in their report on *Defences to Homicide*. The VLRC argued that this approach complied with the underlying purpose of the mental impairment defence:

If the purpose of the defence is to ensure that people are excused from criminal responsibility when their cognitive functions are so affected that they are unable to understand what they are doing or that it is wrong, then it should not matter what the cause of the particular impairment was.  

While it is possible that this approach would open the floodgates to acquittal based on evidence of intoxication, the VLRC did not believe this would be the case due to the potential severity of the consequences of an acquittal on the ground of mental impairment. They considered it to be unlikely that defendants would choose to rely on the defence in cases where the criminal conduct occurred as a consequence of an isolated and adverse reaction to an intoxicant.

The VLRC’s proposal for an extended statutory definition of ‘mental impairment’ was not adopted by the Victorian Government in its response to the report.

However, the VLRC has again supported the inclusion of a statutory definition of ‘mental impairment’ in their more recent report, *Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*. This report was published in June 2014 and recommended that ‘mental impairment’ should be defined to mean ‘a condition that includes but is not limited to mental illness, intellectual disability and cognitive impairment’.

The Council sought views on this option for reform, asking the following question:

Question 8: Should the CLCA be amended so that a person charged with an offence would be able to rely on a defence of mental incompetence when, from whatever cause, he or she was unable to understand the nature and quality of their conduct or understand that it was wrong?

**Option 2: Exclude Cases of Comorbid Mental Illness and Substance Use**

The second option for reform raised in the Discussion Paper involved preventing individuals from relying on the defence of mental incompetence if the criminal conduct occurred during a period of self-induced intoxication.

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317 Victorian Law Reform Commission, *Defences to Homicide: Final Report* (Victorian Law Reform Commission, 2004) [5.38]. In Victoria, a person found not guilty because of mental impairment may be detained or placed under supervision for a period that extends beyond the maximum period of imprisonment for the offence.

318 The VLRC recommended that a provision should be added to the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) which would specify that the term ‘mental impairment’ includes but is not limited to the common law notion of a ‘disease of the mind’: ibid Recommendation 38.

2.255 Under this proposal, defendants who seek to rely on the defence would be required to prove, on the balance of probabilities, that their ignorance of the nature and quality of their conduct, inability to appreciate that it was wrong, or inability to control their conduct was not a consequence of the combined effect of their mental illness and a state of self-induced intoxication. If they could not prove this, then they would be prevented from relying on Part 8A of the CLCA. Instead, their case would need to be addressed in accordance with the intoxication provisions in Part 8.

2.256 A similar provision currently exists in Part 8 to address cases in which an individual consumes drugs for both recreational and therapeutic purposes. Section 267A(3) states:

If a person becomes intoxicated as a result of the combined effect of the therapeutic consumption of a drug and the recreational use of the same or another drug, the intoxication is to be regarded as self induced even though in part attributable to therapeutic consumption.

2.257 The purpose of this provision is to require individuals who use drugs for lawful therapeutic purposes to take particular care, when consuming recreational drugs, to avoid impairing their consciousness. By analogy, it is arguable that individuals who suffer from mental illnesses should be required to take particular care, when taking drugs or alcohol, to avoid becoming mentally impaired.

2.258 The Council sought views on this option for reform, asking the following question:

Question 9: Should the CLCA be amended so that a person charged with an offence would be barred from reliance on a defence of mental incompetence if their inability to understand the nature and quality of their conduct or inability to understand that it was wrong or incapacity for self control was a consequence of the combined effects of mental illness and a state of self induced intoxication?

Option 3: Exclude Short-termed Impairments

2.259 The third option for reform raised in the Discussion Paper would prevent individuals from relying on the defence of mental incompetence where their mental illness resulted from the use of intoxicants, unless that illness was permanent, prolonged, persistent, protracted or enduring.

2.260 This option would only apply to cases where the mental illness is induced by the intoxication. It seeks to draw a distinction between cases in which the resulting illness is permanent (such as where drugs or alcohol have caused organic brain damage), and those in which the illness is temporary (such as where a drug-induced psychotic episode is short-lived).

2.261 At present, this distinction is not drawn by the CLCA. The focus of the current law is simply on whether or not the illness persists after the intoxicants have been metabolised. If it does not, then the case is treated as one of intoxication (to be addressed under Part 8 of the CLCA). If it does, then it is treated as a case of mental incompetence (to be addressed under Part 8A of the CLCA), regardless of whether the illness is temporary or permanent.  

See the definitions of ‘intoxication’, ‘mental illness’ and ‘mental impairment’ in section 269A of the Criminal Law Consolidation Act 1935 (SA).
By contrast, it appears that such a distinction is drawn by the United States Model Penal Code, which requires the defence of mental disease or defect to be based on evidence of a ‘fixed and settled’ mental disease resulting from alcohol or drug use.\(^{321}\)

The Discussion Paper noted three possible reasons for differentiating between permanent and temporary impairments:

- Individuals with significant and continuing impairments may have a better moral entitlement to the defence than individuals whose impairments are temporary and unlikely to return unless induced by resumption of drug use;

- The effects of long term alcoholism, habitual solvent abuse or petrol sniffing are similar to the effects of physical trauma causing brain injury, and there is little reason for differentiating between them; and

- When an individual has suffered permanent damage, the origin of the disability is likely to be too remote in time to have any relevant bearing on the individual’s current blameworthiness.

The Council sought views on this option for reform, asking the following question:

Question 10: Should the CLCA be amended so that a person charged with an offence would be barred from reliance on a defence of mental incompetence based on evidence of a mental illness resulting from the use of intoxicants unless the illness is permanent/prolonged/persistent/protracted/enduring?

**Option 4: Do Not Reform the CLCA Provisions**

The fourth option raised in the Discussion Paper was to retain the current legislative scheme, and make no reforms addressing the interaction of Parts 8 and 8A of the CLCA.

In proposing this option, it was noted that cases involving questions of comorbidity are likely to show considerable variation in practice. It was suggested that this may be an area in which attempts to guide courts, lawyers and expert witnesses by statutory refinement will either lack effect, or result in unpredictable and unwanted consequences. Consequently, it may be preferable to allow courts to exercise their interpretive discretion within the existing framework of rules.

The Council sought views on this option, asking the following question:

Question 11: Should the existing provisions on intoxication and mental impairments in the CLCA be retained without change?

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\(^{321}\) The interpretation of this provision is unresolved. While some cases have adopted a liberal approach, allowing the defence to be raised where the illness persists after cessation of the use of drugs (see, eg, *People v Kelly* 10 Cal. 3d 565 (1973)), other cases have taken a more restrictive approach requiring the illness to be permanent (see, eg, *State v Sexton* (2003-331); 180 Vt. 25; 904 A.2d 1133). The vigorous dissent in *Sexton* provides an informative account of the absence of consensus on the issue in American criminal jurisprudence.
Approaches Taken in Other Australian Jurisdictions

2.268 Australian jurisdictions take three different approaches to the relationship between the insanity defence and intoxication. Three jurisdictions (Qld, WA and NT) draw a distinction between voluntary and involuntary intoxication. They provide that the insanity provisions apply to cases of involuntary intoxication.\(^{322}\) The legislation in Queensland and Western Australia goes on to specifically exclude the insanity provisions from applying where the defendant has ‘intentionally caused himself to become intoxicated or stupefied’.\(^{323}\) The Queensland Act further states that, where the defendant has become intentionally intoxicated, the insanity provisions do not apply regardless of whether his or her mind ‘is disordered by the intoxication alone or in combination with some other agent’.\(^{324}\)

2.269 By contrast, the Tasmanian legislation draws no distinction between voluntary and involuntary intoxication. It simply provides that the insanity provisions ‘shall apply to a person suffering from disease of the mind caused by intoxication’.\(^{325}\)

2.270 The third approach, taken by four jurisdictions (the ACT, the Cth, NSW and Vic), is to not address the relationship at all. In each of these jurisdictions no mention of intoxication is made in relation to their insanity provisions, with the issues of intoxication and insanity treated in separate sections of the relevant legislation.

2.271 With the exception of Victoria (which largely retains the common law),\(^{326}\) the law concerning intoxication is very similar in all Australian jurisdictions. The relevant legislation generally provides that:\(^{327}\)

- A person will not be criminally responsible if their conduct was the result of involuntary intoxication;
- Evidence of self-induced intoxication should not be considered in relation to the issues of voluntariness or basic intent; and
- Evidence of self-induced intoxication may be considered in relation to the issue of specific intent.

2.272 In New South Wales and the Northern Territory, the issue of intoxication is addressed in relation to the defence of diminished responsibility. In that context it is provided that if the defendant's impairment is attributable in part to an underlying condition, and in part to self-induced intoxication, then the impairment must be ignored insofar as it was attributable to the self-induced intoxication.\(^{328}\)

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322 Criminal Code 1899 (Qld) s 28(1); Criminal Code Act 1913 (WA) s 28(1); Criminal Code Act (NT) s 43AS.
323 Criminal Code 1899 (Qld) s 28(2); Criminal Code Act 1913 (WA) s 28(2).
324 Criminal Code 1899 (Qld) s 28(2).
325 Criminal Code Act 1924 (Tas) s 17(1).
326 The common law has been abrogated in relation to homicide offences only; see Crimes Act 1958 (Vic) s 9AJ.
327 See Criminal Code Act 2002 (ACT) s 15, 30-1, 34; Criminal Code Act 1995 (Cth) s 4.2, 8.1, 8.2; Crimes Act 1900 (NSW) s 428A, 428C, 428D, 428G; Criminal Code Act (NT) s 43AF, 43AR, 43AS; Criminal Code 1899 (Qld) s 28; Criminal Code Act 1924 (Tas) s 17; Criminal Code Act 1913 (WA) s 28.
328 Criminal Code Act (NT) s 159(3); Crimes Act 1900 (NSW) s 23A.
Approaches Taken in Other Reviews

2.273 The VLRC’s recent report, Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997, addressed the availability of the defence of mental impairment to a person who was intoxicated. As noted above, the VLRC recommended that ‘mental impairment’ should be defined as ‘a condition that includes but is not limited to mental illness, intellectual disability and cognitive impairment’. The Commission was of the opinion that this definition should encompass conditions that result from the ingestion of substances, but only if those conditions exist independently of the effect of the substance on the person. Further, the Commission recommended that where a person is suffering from an ongoing mental condition which meets the requirements of the test, the original source of that condition should not prevent the person from relying on the defence. However, the VLRC formed the view that conditions resulting from the temporary effects of the ingestion of substances (including intoxication) should not be included within those conditions captured by the definition of ‘mental impairment’.

2.274 The NSWLRC also considered the relationship between intoxication and mental impairment. They did so in some detail when determining how to define the phrase ‘mental health impairment’. They held that it is important to emphasise the distinction between:

- Casual substance use or temporary intoxication;
- Substance use disorders or addiction; and
- Substance-induced mental disorders (ongoing cognitive or mental health impairments caused by the use of drugs or alcohol).

2.275 The Commission recommended that ongoing ‘substance induced mental disorders’, such as drug induced psychoses, should be included in the definition of ‘mental health impairments’. However, substance use disorders (including addiction to substances) and the temporary effects of ingesting substances should be excluded. In making this recommendation, the Commission stated:

We exclude from the definition of mental health impairment people who have taken a drug or other substance, and who offend when under its influence. We also exclude those people who are addicted to a drug, without more. There are provisions and programs in the criminal justice system for this group and they should be dealt with in that context rather than being defined as having mental health impairments.

2.276 This approach was seen to be consistent with the New South Wales law concerning diminished responsibility, which denies the defence to a person who is simply

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330 Ibid xxvii, [4.71], [4.73], Recommendation 24.
333 Ibid Recommendation 5.2.
334 Ibid 5.139.
suffering the short-term effects of intoxication, but allows it if the defendant can prove that it was the underlying condition (such as brain damage caused by prolonged alcohol use) that caused the substantial impairment of mental capacity.\(^{335}\) The NSWLRC did not recommend any changes to the law in that area.

2.277 The SLC also examined the issue of intoxication in relation to the diminished responsibility defence.\(^{336}\) Their conclusion was similar to that of the NSWLRC insofar as they recommended that the defence be denied to a person on the basis of intoxication alone. However, they diverged from the NSWLRC in that they recommended that a substance use disorder should be allowed to ground the defence. Moreover, they recommended that the defence should be available where the disorder (including addiction) caused the defendant to become intoxicated. They stated that the focus should be:

> the contribution made to the killing by the underlying condition (the state of dependency). The peculiarity of this situation is that that contribution might lie in the fact that the dependency itself caused the state of intoxication, which in turn led to the killing. In such a situation it could not be said that the accused's intoxication was voluntary. Much would therefore depend on the facts and circumstances of each case to determine whether or not the acute intoxication was brought on by the underlying condition and thus bring diminished responsibility into play.\(^{337}\)

2.278 Consequently, the SLC recommended that a ‘state of acute intoxication at the time of an unlawful killing should not by itself constitute diminished responsibility. However, a state of acute intoxication by itself should not prevent diminished responsibility from being established if the intoxication co-existed with, or was the consequence of, some underlying condition which meets the general criteria for the plea.’\(^{338}\)

2.279 A similar conclusion was reached by the ELC, who recommended that the defence of diminished responsibility should be able to be based on a ‘recognised medical condition’, including drug or alcohol dependency, but it should not be available simply on the basis of ‘acute intoxication’.\(^{339}\) This reflects the ‘well established principle of criminal law that a defendant cannot rely on excuses arising from his own prior fault’.\(^{340}\)

2.280 The principle of ‘prior fault’ also provided the basis for the Law Commission’s approach to the relationship between intoxication and the new defence of ‘not criminally responsible by reason of a recognised medical condition’ (the proposed replacement for the ‘insanity’ defence).\(^{341}\) This was explained by the Commission in the following passage:

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\(^{337}\) Ibid 3.39.

\(^{338}\) Ibid Recommendation 15.


\(^{340}\) Ibid 6.1.

\(^{341}\) See above.
The fundamental question underlying the reforms in this paper … is when it is unfair to hold someone criminally responsible for what they have done. The answer is that a person who is incapable of conforming his or her behaviour to the criminal law should be exempted from criminal responsibility. The problem is that this simple statement does not go far enough; it would, for example, put someone whose mental faculties are impaired by voluntary drunkenness in the same category as one whose mental faculties are damaged by disease. Most people would find this unacceptable because, where a defendant commits a crime having voluntarily drunk him or herself into an incapacitated state, there is a degree of prior fault on the defendant’s part for which he or she should be held responsible. Thus a defendant should only be entitled to rely on a defence based upon a lack of capacity if he or she had not been culpable in bringing about that lack of capacity.

2.281 It was the Commission’s view that the principle of prior fault should apply to all situations in which the defendant was at fault in inducing his or her lack of capacity, and then seeks to rely on that lack of capacity to deny criminal responsibility:

The same rules should apply where the defendant was at fault for ingesting a substance, for failing to ingest a substance, or for doing or failing to do anything else which caused the loss of capacity. In our view there is no logical distinction between, for example, a diabetic who culpably misuses his insulin knowing that this is likely to make him lose capacity, and one who culpably fails to take insulin knowing that this is likely to have the same effect.  

2.282 Thus, under the ELC’s proposal, the court’s focus should be on the defendant’s culpability in inducing the incapacitated state, not on the existence of an underlying medical condition. If the defendant has been culpable in bringing about his or her ‘recognised medical condition’ (for example, by voluntarily becoming intoxicated), the special verdict of ‘not criminally responsible by reason of a recognised medical condition’ should not be available.

2.283 In the Commission’s view, a person whose medical condition develops as a result of involuntary intoxication is not at fault, and so should not be precluded from the defence. This includes a person who ‘ingests a substance deliberately, but that substance is not commonly known to cause aggression or unpredictability, the defendant did not personally know that it might produce such effects, and it was reasonable for him or her to take it in the circumstances’. Such intoxication should properly be considered involuntary. The Commission also argued that a person whose intoxication was caused by an medical condition is not at fault, and so should be able to rely on the defence.  

2.284 The Commission proposed a ‘predominant cause’ test for cases where the defendant committed a crime while both intoxicated and suffering from a recognised medical condition. If the medical condition was the predominant cause of the individual’s actions, then the defendant should be found ‘not criminally responsible by reason of a recognised medical condition’. If the intoxication was the predominant cause, then

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343 Ibid 6.78.
344 Ibid 6.41.
345 Ibid 6.41.
346 Ibid 6.37, 6.80.
the normal principles governing intoxication should apply.\textsuperscript{348} The Commission acknowledged that in some cases it will be difficult to discern the predominant cause, but argued that ‘[m]ixed causes are simply a fact of life’.\textsuperscript{349}

\textbf{Submissions}

2.285 The Council received 17 submissions addressing the interaction between intoxication and the mental incompetence defence. Of these, one argued in favour of Option 1, none completely supported Option 2, three showed support for Option 3, and eight supported Option 4. The arguments for and against each Option are presented below.

\textit{Submissions on Option 1}

2.286 Only one submission (Mr Walvisch) argued in favour of Option 1 (taking a broad approach to ‘mental impairment’). He stated:

Questions 5-11 each focus on the difficult question of which impairments should be included within the scope of the mental incompetence defence. In answering this question, I believe it is essential to focus on the purpose the defence serves. At heart, the defence aims to exculpate people who suffer from some kind of ‘abnormality’ which undermines their responsibility for their behaviour. The precise nature of that ‘abnormality’ is not as important as the fact that there was some kind of ‘abnormality’, and the effects that ‘abnormality’ had on them. Consequently, ideally the requirements for the defence would mark out the need for an ‘abnormality’, but provide flexibility about the specific ‘abnormalities’ that qualify. In my view, Option 1… is best suited to achieve this aim. It requires some kind of an ‘impairment’ (i.e., an ‘abnormality’), without being specific about the precise impairment required.\textsuperscript{350}

2.287 Mr Walvisch acknowledged that many people would consider this approach to be too broad, but argued that ‘it must be borne in mind that the existence of an ‘abnormality’ is only the first matter that must be proved. It must also be established that the abnormality affected the accused in one of the relevant ways. It is these other requirements that act to severely limit the scope of the defence.’\textsuperscript{351} He also suggested that concerns about opening the floodgates to acquittals based on evidence of intoxication could be addressed by introducing a specific offence of ‘culpable intoxication’.

2.288 By contrast, eight submitters specifically opposed Option 1. Some submissions focussed on matters of principle. For example, the submission of the DPP noted that the current distinction between mental impairment and intoxication ‘has served the community well in terms of the different ways that the moral blameworthiness of each is approached’.\textsuperscript{352} Other submissions were concerned about the practical implications of such a proposal. For example, the Law Society’s submission argued that such an approach ‘is too broad and has the potential to create uncertainty and

\textsuperscript{348} In the UK, the person would be convicted of a crime of basic intent, but acquitted of a crime of specific intent: \textit{DPP v Majewski} [1977] AC 443.


\textsuperscript{350} Jamie Walvisch, \textit{Submission to the Sentencing Advisory Council} (footnotes omitted).

\textsuperscript{351} Ibid.

\textsuperscript{352} Director of Public Prosecutions, \textit{Submission to the Sentencing Advisory Council}. 89
confusion as to what is its reach’. Yet other submissions were concerned about the message such an approach would send. For example, the submission of the Commissioner for Victims’ Rights (CVR) stated:

If the suggestion became law, the distinction between mental illness and drug/alcohol intoxication would be blurred. The voluntariness of a state of intoxication adds to the complexity of this issue. It seems to me to treat them the same results in the moral (and legal) blameworthiness of each being confused. The public are more likely to condemn a perpetrator who chose to consume a drug/alcohol as there is an element of choice, thus culpability. I suspect, given the debate on drunkenness as a defence, that it will be more difficult for the public at large and victims in particular to comprehend self-intoxication as a defence equivalent to mental illness. The law on mental impairment must not be, or be seen to be, a ‘to readily available pathway’ by which those suffering mental illness or drug induced psychosis avoid being called to account for their criminal acts or omissions. I have not noted anything in the operation of the current law to suggest that law is not working as intended.

Submissions on Option 2

2.289 No submissions clearly supported Option 2. The strongest level of support came from the Parole Board, whose submission noted that drugs and alcohol have played a significant part in the lives of many defendants leading up to the commission of the crime. It argued that ‘[i]ncompetence due to drug ingestion or substance abuse generally should not be a defence in circumstances where there is a voluntary decision to use drugs or to abuse alcohol’. The use of the term ‘generally’ suggests that the Parole Board may not support a blanket ban on raising the mental impairment defence in cases involving intoxication, but it is not clear.

2.290 The submission of the Aboriginal Legal Rights Movement (ALRM) provided qualified support for Option 2, due to the difficulty medical practitioners face when determining whether a mental illness was caused by intoxication or vice versa:

Which came first; the chicken or the egg? Was the section 269C mental illness due to self induced intoxication or was it pre-existing and exacerbated by intoxication at the time of the crime? Was uncontrolled intoxication a symptom of the illness? Is expert opinion possible?

2.291 Given these difficulties, the ALRM was of that view that a proposal such as Option 2 may be desirable, ‘but only so as to cure the ambiguity and resolve the dilemma which is built around the difficulty of medical opinion distinguishing the bifurcation of mental illness and intoxication in some circumstances’. As a matter of principle, however, they preferred Option 4.

2.292 The OCPP supported a modified version of this proposal, which would prevent a person from relying on the mental incompetence defence ‘if the incapacity was a combination of mental illness and intoxication, unless it is clear that the mental illness was the major contributing factor to the committal of the offending

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353 Law Society of South Australia, Submission to the Sentencing Advisory Council.
354 Commissioner for Victims’ Rights, Submission to the Sentencing Advisory Council.
355 Parole Board of South Australia, Submission to the Sentencing Advisory Council [emphasis added].
356 Aboriginal Legal Rights Movement, Submission to the Sentencing Advisory Council.
behaviour’. A similar approach was suggested by Emeritus Fellow Ian Leader-Elliott, who argued that:

reliance on the mental impairment defence should be barred for mentally ill, intellectually disabled and senile defendants unless they can establish that their disability was the predominant cause of their state of impairment at the time of the offending conduct. If they cannot exclude the likelihood that their state of impairment was a consequence of recreational drug use, reliance on the defence is barred and their liability will fall to be determined by ordinary principles, including the provisions of Part 8 Intoxication.

2.293 An alternative modification to this Option was suggested by the criminal law academics from Adelaide Law School. Their submission contended that, when there is evidence of intoxication, the defendant should be precluded from relying on the defence of mental incompetence unless they can establish, on the balance of probabilities:

- the existence of a mental illness or impairment; and
- that they did not know at the time of the offence that they were suffering from a mental illness, or
- the intoxication was not self-induced, or
- they were taking their medication as prescribed, and were not aware of the effect of the interaction between their prescribed medication and the intoxicant, or
- the mental health episode occurred in spite of the intoxication not because of it, or
- exceptional circumstances exist that make it appropriate for them to rely on the mental health provisions (e.g. a mental health episode that made it difficult for them to comply with their medication regime).

2.294 In proposing this test, they argued that ‘the mental impairment regime of the criminal law must not be or be seen to be a mechanism by which those suffering mental impairment avoid criminal sanction on account of irresponsible behaviour’, and that people suffering from mental impairments must, presumptively, ‘be treated and considered responsible members of the community as any other member of the community. To do otherwise undermines people with mental illness in society.’

2.295 By contrast, nine submissions explicitly opposed Option 2. This included submissions from the DCS, the DPP and the Bar Association. This opposition was largely based on four arguments.

2.296 First, it was argued that it is unjust to exclude from the defence people whose mental illness or intellectual disability significantly contributed to their behaviour, simply because they happened to be intoxicated at the time of the offending. For example, the submission of the Law Society stated that:

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357 Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.
358 Ian Leader-Elliott, Submission to the Sentencing Advisory Council.
360 Ibid.
The Society does not support a definition of mental impairment that would exclude mental illness in combination with a state of voluntary intoxication at the time of the criminal conduct. The overriding consideration is that a person should not be guilty of an offence if he/she is not mentally competent to commit the offence. Issues such as voluntariness of a state of intoxication add a layer of complexity which inappropriately and unfairly detract from the principal issue of mental incompetence as a consequence of a mental illness. A person who is mentally incompetent to commit an offence should not be precluded from such a finding just because of voluntary intoxication. To do so would expose the citizen to the grave injustice of a guilty verdict when they are mentally incompetent to commit the offence.\textsuperscript{361}

2.297 Secondly, it was noted that it is sometimes the case that a defendant’s mental illness is the underlying cause of the intoxication, and so they are not at fault for becoming intoxicated and should not be excluded from the defence. These first two points were succinctly raised in the AMA(SA) submission, which stated that:

Between 50 and 80\% of schizophrenics have a substance abuse disorder. To amend the act in this way would exclude many genuinely mentally ill people from an appropriate defence solely on the basis of co-morbid intoxication. If they are psychotic or have chronic impairment in their capacity to make decisions, this would include the decision to refrain from the use of drugs and alcohol in case they commit an offence.

2.298 Similar points were made by the ALRM, who noted that consumption of drugs or alcohol can be a symptom of mental illness or acquired brain injury, and should not be a cause for condemnation. They further submitted that ‘regardless of the moral culpability of foolish drug and alcohol abusers; if there is a genuine issue of mental impairment, such that Part 8A is properly invoked, that should be the end of the matter and it should continue to apply’.\textsuperscript{362}

2.299 Thirdly, a number of submissions argued that rather than creating special provisions, this issue should properly be dealt with as an ordinary matter of causation, as it is under the current law. For example, the submission of the LSC stated that:

Whether, on the balance of probabilities, the conduct was the consequence of mental illness, on the one hand or intoxication on the other, is a question of causation, and should not be determined by reference to an arbitrary and unquantified ‘combination’ of those two states.

It should be noted, in any event, that it is normally the case that where there is evidence that both mental illness and self-induced intoxication were present at the time of the defendant’s conduct, the defence of mental incompetence will almost certainly be unsuccessful. This is because, firstly, the onus is on the defendant to rebut the presumption of mental competence and, secondly, because the defendant must satisfy the court that it was the mental illness, not some other cause such as intoxication that caused the conduct.

Intoxication in the current legislation is already specifically excluded from being the basis of a mental impairment. In a scenario where the defendant is both mentally ill and intoxicated, it will not be possible in any but the clearest case for expert witnesses to say clinically - even on the balance of probabilities - that the conduct was a

\textsuperscript{361} Law Society of South Australia, \textit{Submission to the Sentencing Advisory Council}.

\textsuperscript{362} Aboriginal Legal Rights Movement, \textit{Submission to the Sentencing Advisory Council}.
consequence of the illness rather than of intoxication, and therefore is not possible for
the finder of fact to be satisfied that the presumption is rebutted.

Questions of causation must be subject to determination by the court, rather than
decided by an artificially ‘deemed’ combination of mental illness and self-induced
intoxication, particularly where the onus of proof of the causation is already placed on
the defendant by the presumption of mental competence.

2.300 Fourthly, some submissions noted that the courts are not experiencing any
difficulties in relation to this issue, and argued there is insufficient justification for
making any statutory changes.\textsuperscript{363} This is especially the case given that such changes
could lead to ‘unfair arbitrary results’.\textsuperscript{364}

\textit{Submissions on Option 3}

2.301 Three submissions supported Option 3 (excluding short-termed impairments),
although little argument was provided to back up this position. The submission of
the OCPP merely stated that they supported the proposal, while the Parole Board
simply argued that ‘Incompetence due to drug ingestion or substance abuse
generally should not be a defence in circumstances where there is a voluntary
decision to use drugs or to abuse alcohol’. Emeritus Fellow Leader-Elliott supported
the proposal for the reasons ‘outlined in the Discussion Paper’.

2.302 By contrast, 10 submissions explicitly opposed Option 3. The reasons given were
similar to those given for opposing Option 2: people should be entitled to the
defence if there is a genuine mental impairment;\textsuperscript{365} there is insufficient reason for
changing the current law;\textsuperscript{366} and changing the law could lead to unfair results.\textsuperscript{367} In
addition, there were seen to be practical difficulties with implementing this
approach, as was highlighted by the submission of the OPA:

By way of context a presumption in all of this is that it is possible with some accuracy
to say that a psychotic episode has been drug induced. In practice this is often not the
case. As part of early psychosis protocols, it is expected that all young people with
first episode psychosis be followed up, because it is often not possible to determine
what might be a drug induced psychotic episode compared to the first episode of a
developing psychotic illness. Because drug use is prevalent in the community it is not
an easy proposition to link a person’s psychosis with their drug use – there may be
causality but there may also be a coincidental association.

Sometimes psychiatrists have only been able to confidently determine that person has
had a drug induced psychosis following a period of prolonged hospitalisation away
from illicit drugs, and after antipsychotic medication has been stopped. So apart from
an in principle lack of support for this proposition, there would also be practical
difficulties in implementation.

\textsuperscript{363} See, eg, Office of the Public Advocate, \textit{Submission to the Sentencing Advisory Council}.
\textsuperscript{364} South Australian Bar Association, \textit{Submission to the Sentencing Advisory Council}.
\textsuperscript{365} See, eg, Aboriginal Legal Rights Movement, \textit{Submission to the Sentencing Advisory Council}; Ombudsman
SA, \textit{Submission to the Sentencing Advisory Council}.
\textsuperscript{366} See, eg, Director of Public Prosecutions, \textit{Submission to the Sentencing Advisory Council}.
\textsuperscript{367} See, eg, South Australian Bar Association, \textit{Submission to the Sentencing Advisory Council}. 

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Submissions on Option 4

2.303 As can be seen from the discussion above, there was little enthusiasm for any of the suggested options for reform. Consequently, eight of the submissions supported retaining the law in its current form. For example, the submission of the LSC saw the current scheme to be appropriate, stating that:

The existing provisions require the court to consider whether intoxication was a main cause of the conduct and, if so, the court is required to reject the defence of mental incompetence. Similarly, if there is evidence that intoxication was present at the same time as a mental impairment, but expert evidence cannot assist the court in concluding which was the causal factor, the defendant would not be able to prove on the balance of probabilities that the conduct was the consequence of the mental impairment rather than the intoxication, and the defence is likely to fail. However, and properly, the existing provisions do not exclude cases where there is expert evidence that recent consumption of drugs or alcohol would not have had any contributing or causal effect on the conduct.\footnote{Legal Services Commission of South Australia, \textit{Submission to the Sentencing Advisory Council}.}

2.304 The submission of the OPA made similar points, and also noted that:

There is a risk that any requirement in law to separate out conditions precipitated by drug use, will be beyond the ability of psychiatry and psychology to accurately distinguish between conditions. Furthermore it is our impression, that much of the controversy about drug use has come about because of instances where people who have been found not guilty of mental impairment, and have used drugs while under community supervision. If this is the problem, then stricter provisions should apply to those people in their limiting who with full capacity use drugs, rather than limit access to the mental impairment defence in the first place to a potentially large group of people, because of the non-compliance of this smaller group.\footnote{Office of the Public Advocate, \textit{Submission to the Sentencing Advisory Council}.}

2.305 By contrast, the Bar Association was mostly concerned about the potential problems that could be caused by adopting another approach: ‘By attempting to prescribe the approach to much, there is risk of unpredictable and unwarranted consequences’.\footnote{South Australian Bar Association, \textit{Submission to the Sentencing Advisory Council}.}

Conclusions and Recommendations

2.306 The Council does not support amending the CLCA to allow people charged with an offence to be able to rely on the defence of mental incompetence when, from whatever cause, they are unable to understand the nature and quality of their conduct, or to understand that it was wrong (Option 1). The Council believes that this option is too broad, has the potential to create uncertainty, and sends an inappropriate message to the community.

2.307 The Council also does not support amending the CLCA to prevent people from relying on the defence of mental incompetence if their impairment was a consequence of the combined effects of mental illness and a state of self-induced intoxication (Option 2). The Council believes that it would be unjust to exclude people whose mental illness significantly contributed to their behaviour from the
defence, simply because they happened to be intoxicated at the time of the offending.

2.308 The Council has similar concerns about preventing people from relying on the defence of mental incompetence where their mental illness has resulted from the use of intoxicants, but is not permanent, prolonged, persistent, protracted or enduring (Option 3). The Council does not believe it is appropriate to exclude a person who suffers from an illness that persists after the effects of the intoxicants have worn off, but which is not permanent (such as a drug-induced psychosis), from relying on the defence.

2.309 It is the Council’s view that the key question in this area should not be whether the illness is long-lasting, but rather whether the illness caused the defendant to not know the nature and quality of the conduct, to not know it was wrong, or to be unable to control the conduct. If it was the illness that was the cause of one of these effects, the defendant should be allowed to raise the defence of mental incompetence. If it was the intoxication that was the cause, the defence should not be available.

2.310 The Council notes that this is currently the law under the CLCA, due to two requirements. First, there is the requirement that the defendant suffer from a ‘mental impairment’. As this is defined to exclude intoxication, the defendant must prove that he or she suffered from a mental illness, intellectual disability, or impairment resulting from senility that was not simply a temporary disorder resulting from the consumption of intoxicants. If he or she cannot do this, then the defence of mental incompetence will fail.

Secondly, there is the requirement that the defendant’s lack of knowledge about the nature and quality of the conduct or its wrongness, or his or her inability to control the conduct, arise ‘in consequence of the mental impairment’. This means that the defendant must prove that it was his or her mental illness, intellectual disability, or impairment resulting from senility – rather than intoxication – that caused the requisite effects. If he or she is unable to do so, the defence will fail.

2.311 The defendant must prove both of these matters on the balance of probabilities. This means that if there is any doubt about either of the requirements the defence of mental incompetence will fail. For example, if it is unclear whether the defendant’s lack of control was due to illness or intoxication, he or she must not be acquitted on the grounds of mental incompetence.

2.312 Unfortunately, little guidance has been provided about precisely when the requisite effects should be seen to have arisen in consequence of a mental impairment. While phrases such as ‘effective cause’ or ‘operating cause’ have occasionally been used in the cases, these phrases have not been clearly explained. The Council therefore gave some consideration to whether the causal test should be legislatively defined in some way, in order to provide clarity.

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371 CLCA s 269A(1).
373 _Criminal Law Consolidation Act 1935_ (SA) s 269C.
374 The defendant will fail where the intoxication was seen to be the cause of the relevant effects, or where it is unclear whether the relevant effects were caused by the illness or disability.
In particular, the Council considered the possibility of introducing a ‘predominant cause’ test, such as that recommended by Emeritus Fellow Leader-Elliott in his submission to the Council.\footnote{Ian Leader-Elliott, Submission to the Sentencing Advisory Council.} According to such a test, individuals should be precluded from relying on the defence of mental incompetence unless they can establish that their illness or disability was the predominant cause of their state of impairment at the time of the offending conduct.\footnote{A similar recommendation was made by the ELC: see ‘Approaches Taken in Other Reviews’ above.}

While the Council can see the appeal of such an approach, it is concerned about the consequences of tampering with the general causation test. Given that a ‘predominant cause’ test does not currently exist elsewhere in the criminal law, it is likely to lead to significant debate concerning its meaning and scope. In addition, it may result in injustice where the defendant’s illness played a significant causal role in their behaviour, but cannot be shown to have been the predominant cause. The Council does not believe that it is appropriate to prevent such individuals from relying on the defence of mental incompetence. Consequently, the Council does not support the introduction of such a test.

The Council believes that the current ‘in consequence of’ test is sufficiently clear, and is capable of adequately achieving its purpose. The Council is therefore of the view that issues relating to causation should be left within the framework of the existing legislation. The Council recommends that the provisions on intoxication and mental impairments in the CLCA be retained without change (Option 4).

In reaching this view, the Council has been partly influenced by its concern about the likely consequences of restricting the application of the defence in any of the ways suggested. In particular, it is concerned about the effects of diverting people with comorbid mental illnesses and substance abuse disorders out of mental health facilities and into prison, given the lack of adequate services to deal with such people in the corrections system. Were such amendments to be made, they would need to be put in place alongside significant institutional changes.
Recommendation 8
The *Criminal Law Consolidation Act 1935* should not be amended to allow people to rely on the defence of mental incompetence when, from whatever cause, they are unable to understand the nature and quality of their conduct or to understand that it is wrong.

Recommendation 9
The *Criminal Law Consolidation Act 1935* should not be amended to prevent people from relying on the defence of mental incompetence when their inability to understand the nature and quality of their conduct, inability to understand that it was wrong, or incapacity for self-control was a consequence of the combined effects of mental illness and a state of self-induced intoxication.

Recommendation 10
The *Criminal Law Consolidation Act 1935* should not be amended to prevent people from relying on the defence of mental incompetence when their mental illness was caused by the use of intoxicants, but is not permanent, prolonged, persistent, protracted or enduring.

Recommendation 11
The existing provisions on intoxication and mental impairment in the *Criminal Law Consolidation Act 1935* should be retained without change.
3. The Fixing of Limiting Terms
Introduction

3.1 Where a defendant successfully raises the defence of mental incompetence he or she is not completely acquitted. Instead, the defendant is found ‘not guilty by reason of mental incompetence’, and is subject to special powers of the court. These powers allow the court to release the defendant unconditionally, or to make a ‘supervision order’ committing the defendant to detention or releasing him or her on licence. In this context, the purpose of detention is the protection of the community, not the punishment of the defendant.

3.2 If a court makes a supervision order, it must specify the period for which the defendant may be subject to supervision (a ‘limiting term’). Under the current law, the length of the limiting term must be equivalent to the period of imprisonment or supervision that would have been appropriate had the defendant been convicted of the offence(s) charged.

3.3 This Part of the Report examines the process that follows a finding of ‘not guilty by reason of mental incompetence’ (known as the ‘disposal’ process). It focuses in particular on the practice of fixing limiting terms. Together with Part 4, which addresses the supervision of individuals released on licence, it provides the procedural framework for the defence of mental incompetence.

3.4 This Part is divided into the following sections:

- Historical development of the law and practice in this area;
- Overview of current South Australian procedures;
- Issues concerning expert reports;
- Dispositions for people found not guilty by reason of mental incompetence;
- Setting of limiting terms.

3.5 The Council acknowledges that there are concerns with the use of the term ‘disposal’ due to its negative connotations. In its submission the Office of the Public Advocate (OPA) suggested that an alternative word be used:

We appreciate here that it is used in the context of disposition, however in common use it has other connotations. People with mental illness and disability have been highly stigmatised over the years, and they or the public may not appreciate the subtlety of the legal use of this term. The historical use of the term ‘bin’ to describe specialist psychiatric hospitals is an example of this stigma.

3.6 The Council shares these concerns, and has endeavoured to avoid using the term as much as possible. However, due to its longstanding use in this area, it has been impossible to avoid it entirely.

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377 Criminal Law Consolidation Act 1935 (SA) s 269O(1).
378 Criminal Law Consolidation Act 1935 (SA) s 269O(2).
379 Office of the Public Advocate, Submission to the Sentencing Advisory Council.
Historical Development of Law and Practice

3.7 The origins of the modern law in this area can be traced back to that the trial of James Hadfield for high treason in 1800. As with the trial of Daniel McNaughtan (see Part 2), the significance of this case is such that it warrants discussion in some detail.

3.8 Hadfield attempted to shoot King George III, believing that this act would ensure that he himself would be killed but the world would be saved. As special privileges accompanied treason trials, Hadfield was entitled to assistance from counsel in the preparation of evidence and the examination and cross-examination of witnesses. His counsel, Thomas Erskine, argued that he was insane due to his delusions. The Attorney-General did not challenge the evidence. Hadfield was acquitted and, in accordance with the practice from the previous era, the jury gave both their verdict and its factual basis: ‘[w]e find the prisoner Not Guilty; he being under the influence of insanity at the time the act was committed’.

3.9 There was some uncertainty about what powers the court had following such a verdict, and in particular whether they could detain Hadfield. This led the English Parliament to pass the Criminal Lunatics Act 1800, which provided for the indefinite detention of people acquitted on the basis of insanity:

That in all cases … of any person charged with treason, murder, or felony, that such person was insane at the time of the commission of such offence, and such person shall be acquitted, the jury shall be required to find specially whether such person was insane at the time of the commission of such offence… if they shall find that such person was insane at the time of the committing such offence…. the court shall order such person to be kept in strict custody until his Majesty’s pleasure shall be known.

3.10 The Criminal Lunatics Act 1800 marked the beginning of the formalisation of the defence of insanity (and ‘insanity on arraignment’ or unfitness to plead). Although the Act did not define insanity for legal purposes, it fundamentally altered the procedural context in which claims to exculpation on the basis of insanity were made.

3.11 As a result of the 1800 Act, it was no longer possible for juries to simply acquit insane defendants: they were required to return a special verdict. The Act also brought the detention of insane defendants into the criminal law, by enabling the defendant to be acquitted, but at the same time providing the court with the power to keep the insane defendant in custody. The effect of the passage of the 1800 Act was that a defendant did not have to be convicted of a crime in order to be confined.

380 R v Hadfield (1800) 27 St. Tr. 1281.
385 This Act was subtitled ‘An Act for the Safe Custody of Insane Persons Charged with Offences’ (39 & 40 Geo. III c. 94).
under the criminal law. Although it had been possible to detain insane defendants before 1800, the Act introduced a ‘more systematic means of containing them within a voluntarist legal system’. While in theory defendants such as Hadfield could be released if they were no longer a danger to themselves or others, in practice the period of confinement was life.

3.12 The combined effect of the statutory provisions was to connect a successful insanity defence with a particular verdict (the special verdict) and indefinite detention. This link proved to be an enduring feature of the insanity defence. As discussed below, even after indefinite detention fell away, and other options for dealing with insane defendants were made available to courts, the link between a successful mental impairment plea and the special verdict has remained, conjoining the issue of no criminal responsibility and disposition in a way that is unique in criminal law.

3.13 The practice of indefinitely detaining individuals found ‘not guilty by reason of insanity’ was implemented in the Australian States and Territories. This meant that an individual who successfully raised the insanity defence would be detained until such a time as the State or Territory granted an application for release. Consequently, most individuals were detained for long periods of time (in some cases, longer than had they been convicted and sentenced to a term of imprisonment). This reflected the long-standing nature of concerns with dangerousness that marked the development of the insanity defence itself. As a result, only those charged with the most serious crimes (such as murder) usually raised the insanity defence, even after the abolition of capital punishment.

3.14 Over the last few decades, jurisdictions within Australia came to recognise that indeterminate detention for individuals found not guilty on the basis of insanity was no longer consistent with developments in expert medical knowledge of mental illness, nor with the human rights of those individuals. As a result, laws in some jurisdictions, including South Australia, were amended to provide alternatives to indefinite detention. More nuanced dispositions were introduced, which were intended to be closely targeted to particular individuals and their circumstances. There is some evidence from overseas jurisdictions that providing alternatives to indefinite detention has resulted in increased use of the insanity defence.

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391 Prior to the amendments introduced in 1995, section 292(2) of the CLCA provided that ‘the Court shall order any person found not guilty on the ground of insanity, to be kept in strict custody in such place and in such manner as it thinks fit, until the Governor’s pleasure be known’.
392 See, for discussion, R.D. Mackay, Mental Condition Defences in the Criminal Law (Clarendon Press, 1995); Arlie Loughnan, Manifest Madness: Mental Incapacity in the Criminal Law (Oxford University Press, 2012).
394 In South Australia, the law was amended by the Criminal Law Consolidation (Mental Impairment) Amendment Act 1995, which came into operation in March 1996.
Current Procedure

3.15 The current procedures for finding a defendant not guilty by reason of mental incompetence, and for determining an appropriate disposition, are contained in Part 8A of the *Criminal Law Consolidation Act 1935* (SA) (*‘CLCA’*). This section sets out those procedures. Throughout this Part of the Report, all section numbers refer to the CLCA unless otherwise stated.

3.16 If the defence of mental incompetence is raised, an investigation into the defendant’s mental competence must be undertaken. That investigation must be separated from the remainder of the trial (s 269E(1)). It must be conducted before a jury, unless the defendant has elected to have the matter dealt with by a judge sitting alone (s 269B(1)). In practice, defendants usually elect to have the issue considered by judge alone.

3.17 The Act draws an important distinction between the ‘subjective’ and ‘objective’ elements of an offence. The following elements are defined as ‘subjective elements’: ‘voluntariness, intention, knowledge or some other mental state that is an element of the offence’. All other elements of an offence are considered to be ‘objective elements’ (s 269A).

3.18 To find the defendant ‘not guilty by reason of mental incompetence’, the judge or jury must be satisfied (i) that the defendant was mentally incompetent;\(^{396}\) and (ii) that the objective elements of the offence have been proven beyond reasonable doubt. If the objective elements cannot be proven, the defendant must be acquitted (ss 269F-G). There is no need to prove the subjective elements of the offence.

3.19 The judge has a discretion about the best way to proceed with the investigation. He or she can choose to first focus on either the objective elements or the defendant’s mental competence (s 269E(2)). The procedure varies slightly, depending on which path the judge chooses. The procedures are summarised in Diagrams B and C below.\(^{397}\)

Trial of Defendant’s Mental Competence First

3.20 If the judge decides to first determine the defendant’s mental competence, the court must hear relevant evidence and representations on this issue first. The court may also require the defendant to undergo an examination by a psychiatrist or other appropriate expert, and require the results of the examination to be reported to the court (s 269FA(1)(a), (b)).

3.21 At the conclusion of the trial of the defendant’s mental competence, the court must decide whether it has been established, on the balance of probabilities, that at the time of the alleged offence the defendant was mentally incompetent to commit the offence. If so, the court must record a finding to that effect. If not, the court must

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\(^{396}\) The requirements for mental incompetence were outlined in Part 2 of the Report. In brief, the judge or jury must be satisfied, on the balance of probabilities, that due to a mental impairment, the defendant did not know the nature and quality of the conduct, did not know the conduct was wrong, or was unable to control the conduct.

\(^{397}\) The flow charts in Diagrams A and B have been taken from *Question of Law Reserved (No 1 of 1997)* 70 SASR 251.

*with Cognitive and Mental Health Impairments in the Criminal Justice System: Criminal Responsibility and Consequences* (New South Wales Law Reform Commission, 2010) [3.6].
record a finding that the presumption of mental competence has not been displaced and proceed with the trial in the normal way (s 269FA(3)(a), (b)).

3.22 In some cases, the prosecution and defence will agree that the defendant was mentally incompetent to commit the offence. In such cases, the court may dispense with, or terminate, the investigation into the defendant’s mental competence, and simply record a finding that the defendant was mentally incompetent (s 269FA(5)(a), (b)).

3.23 If the court records a finding that the defendant was mentally incompetent to commit the offence, the court must then hear evidence and representations relevant to the question of whether the objective elements have been established (s 269FB(1)). If the court is satisfied that the objective elements of the offence have been established beyond reasonable doubt, the court must record a finding to that effect, and declare the defendant to be liable to supervision under Part 8A. If the court is not satisfied that the objective elements have been proven beyond reasonable doubt, the court must acquit the defendant and discharge him or her (s 269FB(2)-(3)).

**Trial of Objective Elements First**

3.24 If the judge decides to proceed first with the trial of the objective elements, he or she must first hear evidence and representations about that issue (s 269GA(1)). If the court is satisfied that the objective elements of the offence have been established beyond reasonable doubt, the court must record a finding to that effect; but otherwise the court must find the defendant not guilty of the offence and discharge him or her (s 269GA(2)).

3.25 If the court records a finding that the objective elements of the offence have been established, the court must then hear evidence and representations relevant to the question of whether the defendant was mentally competent. The court may also require the defendant to undergo an examination by a psychiatrist or other appropriate expert, and require the results of the examination to be reported to the court (s 269GB(1)(a),(b)).

3.26 At the conclusion of the trial of the defendant’s mental competence, the court must decide whether it has been established, on the balance of probabilities, that at the time of the alleged offence the defendant was mentally incompetent to commit the offence. If so, the court must declare that the defendant was mentally incompetent to commit the offence, find the defendant not guilty of the offence and declare him or her to be liable to supervision under Part 8A. If not, the court must record a finding that the presumption of mental competence has not been displaced and proceed with the trial in the normal way (s 269GB(3)). In any trial that follows, the objective elements are to be accepted as established (s 269GB(4)).

3.27 Where the prosecution and defence agree that the defendant was mentally incompetent to commit the offence, the court may dispense with, or terminate, the investigation into the defendant’s mental competence, and declare that the defendant was mentally incompetent to commit the offence, find him or her not guilty of the offence, and declare him or her to be liable to supervision under Part 8A (s 269GB(5)).
Diagram B: Trial of Mental Competence First

The court hears evidence and representations on the issue of mental competence (s 269FA(1))

If not satisfied of mental incompetence the trial of the offence proceeds in the normal way. (s 269FA(3))

If satisfied of mental incompetence court determines whether objective events of offence are established. (s 269FB(1))

If satisfied that objective elements are established the accused is found not guilty of the offence but declared to be liable to supervision. (s 269FB(3))

If not satisfied that objective elements are established the accused is found not guilty of the offence and discharged. (s 269FB(3))
Diagram C: Trial of Objective Elements First

The court hears evidence and representations on the issue of the objective elements (s 269GA(1))

If objective elements not established the accused is found not guilty and discharged. (s 269GA(2))

If objective elements are established court hears evidence and representations on the issue of mental competence. (s 269GB(1))

If satisfied of mental incompetence the accused is found not guilty but declared to be liable to supervision. (s 269GB(3))

If not satisfied of mental incompetence court determines whether subjective elements of offence are established. (s 269GB(4))

If satisfied that subjective elements are established the accused is found guilty of the offence. (s 269GB(4))

If not satisfied that subjective elements are established the accused is not found guilty of the offence. (s 269GB(4))

Procedure Following a Declaration of Mental Incompetence

3.28 Where a defendant is declared liable to supervision under Part 8A (due to being found mentally incompetent to commit the offence), the court may either release him or her unconditionally, or make a ‘supervision order’. A supervision order will either commit the defendant to detention under Part 8A, or release him or her on licence on specific conditions (s 269O).

3.29 If the court makes a supervision order, it must fix the period of time for which the defendant will be liable to supervision (the ‘limiting term’) (s 269O(2)). Limiting terms are discussed in more detail below.
Psychiatric and Psychological Reports

3.30 Expert psychiatric and psychological reports provide important evidence for the court when determining whether the defendant was mentally incompetent to commit the offence, as well as in deciding how to deal with defendants found not guilty by reason of mental incompetence.

3.31 At present, the CLCA provides for the possibility of four different types of expert reports:

- Prior to a trial, the court may require the defendant to undergo an examination by a psychiatrist or other appropriate expert, if it appears that this might expedite the trial (s 269WA(1));

- During an investigation into the defendant’s mental incompetence, the court may order a report from a psychiatrist or other appropriate expert to help determine whether, on the balance of probabilities, the defendant was mentally incompetent at the time of the alleged criminal conduct. Such a report may be ordered upon request from the defendant, the prosecution or at the initiative of the judge (ss 269FA(1)(b), 269FA(2), 269GB(1)(b), 269GB(2));

- If a defendant is declared to be liable to supervision under Part 8A, the Minister for Mental Health and Substance Abuse (Minister for Health) must, within 30 days, submit to the court a report prepared by a psychiatrist or other appropriate expert on the defendant's mental condition. The report must contain a diagnosis and prognosis of the defendant's condition, and a suggested treatment plan (s 269Q(1)).

- If the court is considering releasing a defendant, or significantly reducing the level of supervision, it must first consider reports by psychiatrists (or other appropriate experts) who have personally examined the defendant. The reports must examine the defendant’s mental condition and the possible effects of the proposed action on his or her behaviour. For indictable offences, the court must consider reports prepared by three different experts. For summary offences, the court may act on the basis of one or two expert reports, if satisfied that, in the circumstances of the case, the reports adequately cover the matters on which the court needs expert advice (s 269T).  

Issues to be Addressed

3.32 In preliminary consultations, the number and range of expert reports required by the CLCA in relation to the defence of mental incompetence was seen to be a matter of concern, due to its impact on resources and potential delays. It was suggested that the number of reports required in such cases should be reduced.

3.33 Particular concern was expressed about the requirement to produce three different reports when considering releasing a defendant or significantly reducing the level of supervision (s 269T). This requirement was introduced at a time when the insanity defence was mainly relied on by people charged with murder (due to the system of indefinite detention). Given the gravity of the acts committed, one report was seen

398 Under section 269Q(2), the Minister must also arrange for a yearly report to be made to the court regarding the treatment and condition of the defendant. However, this report does not need to be made by a psychiatrist.
to be insufficient, and two reports created the possibility for conflicting opinions. To provide for the likelihood of a majority viewpoint, three reports were required.

3.34 As noted above, however, the use of the mental incompetence defence is no longer confined to cases of murder. Due to the application of the defence to all offences (including summary offences), and the range of dispositional options available, there has been a significant increase in the number of defendants raising the defence of mental incompetence. Defendants are now successfully relying on the defence in response to a range of charges, at all levels of the court. The Council’s preliminary enquiries in the Magistrates Court indicate that a number of defendants are raising the defence of mental incompetence for minor offences in that jurisdiction.\(^{399}\)

3.35 Given that the majority of cases are no longer murder cases, it has been suggested that it is no longer necessary to require three reports to be produced for all indictable offences. This is especially seen to be the case in light of the significant increase in cost to the court and taxpayer caused by the current requirement, given the expanded use of the defence. In addition, the requirement is seen to cause extended time delays in obtaining reports, due to the relatively small pool of experts available to provide such reports.

3.36 Furthermore, it has been suggested that the number of reports is excessive and repetitious in some instances, particularly in uncontested matters. For instance, where the defendant has had a psychotic episode during a prescribed period of time, it is not uncommon for him or her to face multiple charges in different jurisdictions. At present, different reports would be required for each jurisdiction. It was suggested that in such cases it would be preferable for courts to be able to rely on the same reports, as the offences arose out of same period of time/psychotic episode.

3.37 Consequently, in the Discussion Paper the Council asked the following questions:

- Question 12: Should there be a reduction in the number of psychiatric reports required under Part 8A?
- Question 13: Should Magistrates and Judges have a discretion regarding the type and/or number of reports to be ordered? If so, what factors should guide the exercise of that discretion?

Approaches Taken in Other Australian Jurisdictions

3.38 When considering the reporting requirements, it is useful to differentiate between the reports that are required when a defendant is first found to be not guilty on the basis of insanity (or its jurisdictional equivalent), and those which are required as part of the review process. These issues are examined in turn.\(^{400}\)

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\(^{399}\) See, for example, \textit{Schwark v Police} [2011] SASC 212.

\(^{400}\) In Queensland, matters concerning mental health issues are addressed by a specially established court, the Mental Health Court. As the system and procedures in that State differ so significantly from those in place in South Australia, it is excluded from the following analysis.
Victoria has similar reporting requirements to South Australia in relation to defendants who are found not guilty by reason of mental impairment, and so liable to supervision. The relevant legislation requires the appropriate person to arrange for a registered medical practitioner or registered psychologist to prepare and file a report within 30 days of the person being declared to be liable to supervision (or such longer period as the court allows), containing a diagnosis and prognosis of the defendant’s condition, details of the defendant’s response to any treatment, therapy or counselling, and a suggested treatment plan. However, the Victorian Law Reform Commission’s (VLRC) recent report, Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997, recommended that the Act be amended to allow the report to be filed prior to making a declaration that the person is liable to supervision.

The Northern Territory and Western Australia also have similar initial reporting requirements. However, their Acts do not specify that the report must be prepared by a particular type of expert. In the Northern Territory, the Act simply states that the report must be prepared and submitted by the ‘appropriate person’ (who is likely to be the CEO of the Agency administering the Medical Services Act), while in Western Australia it must be provided by the Mentally Impaired Accused Review Board.

In the Australian Capital Territory, a report does not need to be provided in all cases where the defendant is declared insane. However, before making a ‘mental health order’, the ACT Civil and Administrative Tribunal (ACAT) must consider an assessment ordered by the ACAT and conducted at a mental health facility, as well as another assessment of the person that the ACAT considers appropriate.

There are no initial reporting requirements in New South Wales, Tasmania or at the Commonwealth level.

**Review Reports**

No other Australian jurisdiction requires the consideration of three different reports when considering releasing a defendant, or significantly reducing the level of supervision. Two jurisdictions (Tas and the Cth) require consideration of two expert reports, two jurisdictions (NSW and Vic) require consideration of one expert report, and three jurisdictions (ACT, WA and NT) do not require consideration of any expert reports.

At the Commonwealth level, where a person is ordered to be detained in a prison or a hospital, the Attorney-General must, as soon as practicable after the person is so

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401 Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) s 41.
403 Criminal Code Act (NT) s 43ZJ; Criminal Law (Mentally Impaired Accused) Act 1966 (WA) s 33(2).
404 In the ACT, the ACAT can make three different kinds of ‘mental health orders’: a psychiatric treatment order, a community care order and a restriction order. See Mental Health (Treatment and Care) Act 1994 (ACT) Part 4.
405 See Mental Health (Treatment and Care) Act 1994 (ACT) ss 15-22E for information concerning ‘assessment orders’.
406 Mental Health (Treatment and Care) Act 1994 (ACT) s 23.
detained, consider whether or not the person should be released from detention. In making this determination, the Attorney-General must obtain and consider a report from a psychiatrist or psychologist, as well as a report from another duly qualified medical practitioner. The Attorney-General may also consider any other reports he or she considers necessary. While the person is in detention, his or her release must continue to be reconsidered every 6 months.407

3.45 In Tasmania, a court may not discharge a restriction order, release a defendant, or significantly reduce the degree of supervision to which a defendant is subject, unless the court has considered the reports of the Chief Forensic Psychiatrist, or a medical practitioner nominated by the Chief Forensic Psychiatrist, and one other psychiatrist, each of whom has personally examined the defendant.408

3.46 In NSW, where the Mental Health Review Tribunal (MHRT(NSW)) is determining whether or not to release the defendant from custody, it must consider a report by a forensic psychiatrist (or other appropriate expert) who is not currently involved in treating the defendant. The report must address the condition of the defendant, and whether their safety or that of any member of the public would be seriously endangered by the defendant’s release.409

3.47 In Victoria, a court cannot order the defendant to be released from custody, or significantly reduce the degree of supervision to which the defendant is subject, unless it has obtained and considered the report of at least one registered medical practitioner or registered psychologist, who has personally examined the defendant. Such a report is also required before an additional grant of extended leave is ordered. Where the defendant is subject to a supervision order, the court must also obtain and consider a report from a person who has supervision of them. The court must also consider the report obtained when the defendant was first declared liable to supervision (see above), and may consider any other reports it considers necessary.410

3.48 In the ACT, the ACAT has responsibility for reviewing orders for detention and licence conditions.411 While the ACAT must consider a number of different matters, such as the nature and extent of the person’s mental dysfunction and the likely consequences of their release, there is no specific requirement to consider expert reports. However, if, as part of this process, the ACAT wishes to make a ‘mental health order’, it will need to consider the assessments outlined in the previous section.

3.49 In the NT and WA the bodies responsible for the management or supervision of the defendant are required to produce annual reports on matters such as their treatment

407 Crimes Act 1914 (Cth) s 20BK.
408 Criminal Justice (Mental Impairment) Act 1999 (Tas) s 34(2)(a).
409 Mental Health (Forensic Provisions) Act 1990 (NSW) s 74.
410 Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) s 40; It is to be noted that the Victorian Law Reform Commission recently recommended amendments to the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 to simplify the reporting requirements by allowing the court to consider one report instead of two: Victorian Law Reform Commission, Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997: Report (Victorian Law Reform Commission, 2014) [9.68], Recommendation 72.
411 Mental Health (Treatment and Care) Act 1994 (ACT) ss 72-73.
and management, and recommendations concerning their release. However, there is no requirement for these reports to be prepared by a particular type of expert.\textsuperscript{412}

**Approaches Taken in Other Reviews**

3.50 The provision of expert reports is not an issue that has been considered in detail in many of the recent reviews in this area. For example, it was not specifically considered by the New South Wales Law Reform Commission (NSWLRC) in its comprehensive review of *People with Cognitive Mental Health Impairments in the Criminal Justice System*. While the Commission recommended broad-ranging changes in many related areas, it made no recommendations with regard to the nature or number of reports required.

3.51 The issue was briefly considered by the English Law Commission (ELC) in two contexts: in relation to supporting a plea of ‘not criminally responsible by reason of recognised medical condition’, \textsuperscript{413} and in relation to the disposition of those who successfully raise the defence.\textsuperscript{414} While the Commission acknowledged that reducing the number of reports could save public money, it recommended that at least two reports from registered medical practitioners should be provided in both situations. In reaching this view, the Commission noted that:

- Some diagnoses are more problematic than others, so require a multiplicity of views. As it is not practical to require different numbers of reports for different medical conditions, as a general rule at least two reports should be required;
- It is inappropriate to require only one report, given the adversarial nature of criminal proceedings;
- The decisions being made are significant for the defendant, who should have the benefit of two reports; and
- Article 5(1)(e) of the *European Convention on Human Rights* requires the court to be satisfied that the defendant has a mental disorder which warrants compulsory detention in a hospital before ordering his or her detention. This requires consideration of at least two expert reports.

3.52 This issue has been previously considered in three reviews undertaken in South Australia. Two of those reviews recommended removing the requirement for three expert reports, and replacing it with a discretionary power in the court.\textsuperscript{415} The third review recommended only requiring one report for summary offences, but maintaining the requirement for three reports for indictable offences.\textsuperscript{416}

\textsuperscript{412} [Criminal Code Act (NT) s 43ZK; Criminal Law (Mentally Impaired Accused) Act 1966 (WA) s 33.]

\textsuperscript{413} [Law Commission, *Criminal Liability: Insanity and Automatism* (Law Commission, 2013) 7.36-7.53.]

\textsuperscript{414} [Ibid 4.146-147.]


The Council received 13 submissions addressing the issue of expert reports, all of which supported a reduction in the number of reports required.

Arguments in Favour of Reducing the Number of Reports

Multiple arguments for reducing the number of reports were summarised by the Legal Services Commission of South Australia (LSC) as follows:

In SA, there is a relatively small pool of suitably qualified experts available to compile these reports, all of whom are also engaged in clinical practice which provides limited time for preparing reports. The statutory requirement of three s 269T reports, in addition to a further s 269Q report (the 30-day Minister’s report, which in practice is almost never done within 30 days) is causing:

- Delays of 2 to 3 months or more in finalizing a matter waiting for the reports to become available. There have been many cases where defendants have had to remain in custody awaiting the provision of reports even though the defendant’s treating psychiatrist has indicated that an order for release on licence would be appropriate.

- Duplication and repetition of historical information within the three s 269T reports which is of no assistance to the court.

- Unnecessary and considerable financial burden on the court, which until recently continued to pay for s 269T reports. The Chief Justice has recently commented that the court should no longer bear this cost from the Courts Administration Authority budget, which is under severe pressure. Should the CAA decline to continue servicing this cost, the Commission would find it very difficult to pay for s 269T reports due to its funding constrains.

- Pointless cost of statutorily-required s 269Q, R and T reports for very minor Magistrates Court matters where it is clear that the only appropriate order must eventually be one for unconditional release rather than a supervision order… In these cases, there is normally ample information about the defendant’s current mental state and proposed plans for his or her future treatment already before the court from the report(s) which defence tenders initially under s 269O to establish the defence.

- Unnecessary and costly replication of the same expert opinion in cases where there are already in existence recent s 269Q and T reports ordered in another jurisdiction but which cannot be re-used. This is due to the wording that requires that those reports be ordered at the time the defendant is declared liable to supervision, if the defendant is later dealt with for a charge from the same period of time.

The Department for Correctional Services (DCS) highlighted two additional reasons for reducing the number of reports required:

Often individuals offend repeatedly so re-doing reports on the same information is not the best use of resources. In addition, for many individuals their presentation and prognosis will not change nor will their fitness to plead (for example, those with an acquired brain injury or intellectual disability). Repeated reports and assessments likely do not achieve much benefit.
Reducing the number of reports required might also assist in the time taken for the Court to declare an individual under Section 269. At this point in time, it is understood that it can take over 12 months. During this time, the individual is in the prison system often managed in management cells due to their unstable mental state; or due to vulnerability (this is especially so if the individual has an intellectual disability). Reducing the number of reports required should assist in expediting this process resulting in individuals being placed in a mental health facility (which is much more appropriate) than in a prison.417

3.56 A similar point was raised by the Chief Magistrate, who noted that:

this Court sees instances where, when fresh charges are brought, police insist on a fresh report as to fitness to plead where in the recent past the same defendant has been found unfit to plead and the report at that time stated that he/she was never going to be fit to plead. In such circumstances, it would be helpful to have a provision enabling the Court to have regard to such reports and only order a fresh one or indeed an addendum report when it was considered essential to do so.

3.57 The financial burden and delays caused by the current system were of particular concern to the Office of the Commissioner for Equal Opportunity (OCEO), whose submission stated that:

If the effect of the current number of reports is to unreasonably create procedural barriers - including unnecessary financial detriment, and delays in accessing justice for those persons relying on the defence of mental incompetence then a breach of that person’s human rights may exist, and the number of reports should be reduced. However, reductions to the number of reports should only occur where it serves to remove procedural barriers, and not diminish a person’s human rights.418

Suggested Reforms

3.58 Four different approaches were taken to this issue. First, some submissions suggested that the default position should be the provision of just one report. For example, the submission of the Forensic Mental Health Service (FMHS) stated:

The current system is quite rigid with respect to the number of psychiatric reports required. More discretion with respect to their ordering, and the number of reports, is required. It is recommended that the standard or basic requirement should be one report only but this number can be increased, depending on the complexity and particular circumstances of a case.419

3.59 Similarly, the Office of the Chief Psychiatrist’s (OCP) submission suggested:

that the Court should request 1 comprehensive report only from an appropriate multidisciplinary mental health or disability source. That report may recommend further (specialist) examination(s) and report(s) for complex cases but otherwise 1 comprehensive multidisciplinary report should suffice.420

3.60 To ensure that the Court was provided with sufficient information in this report, the OCP recommended:

417 Department for Correctional Services, Submission to the Sentencing Advisory Council.
419 Forensic Mental Health Service, Submission to the Sentencing Advisory Council.
420 Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.
1) That a list of suitable agencies or sources (to provide reports regarding a person’s incompetence) should be listed to assist the court in sourcing that information. These would include: Community Corrections, Community Mental Health Services, Disability SA, Drug and Alcohol Services SA, Forensic Mental Health Services, the Office of the Public Advocate and the Parole Board.

2) For current or recent clients of mental health services that the court could request a comprehensive report from the current or recent multidisciplinary team for historical and current symptoms, treatment and prognoses.

3) For people unknown to mental health services it may be more helpful to the Court to get 1 report from a psychiatrist (or an experienced disability clinician if possible incompetence is likely due to disability) and 1 report from an experienced psychologist or mental health nurse (or an experienced disability rehabilitation clinician), to enable the Court to examine information from a multidisciplinary perspective.

4) It is assumed that a history of a person’s offending behaviour will be made available to the Court by the Police, so the court can make a determination using a balance of information about offending behaviour over time and mental incompetence over time.\textsuperscript{421}

3.61 By contrast, two submissions suggested that two reports should generally be produced, with the option for ordering a third if there is disagreement between them.\textsuperscript{422} Concern was expressed that reducing the requirement to one report would ‘insufficiently protect the interests of the defendant and would be open to abuse’.\textsuperscript{423}

3.62 A third approach recommended that different numbers of reports may be required in different circumstances. For example, the submission of the Director of Public Prosecutions (DPP) contended that the number of reports should depend on the nature of the decision to be made. It argued that:

the number of reports required in relation to a decision to release a detainee on licence, or to significantly reduce the level of supervision, could be reduced to two provided there was the capacity for a Court to order a third report if the interests of justice required it.

For changes to licence conditions which were less significant in nature I would support there only being one formal report from the treating psychiatrist provided there was a covering letter from the Director of Forensic Mental Health or his nominee agreeing with the treating psychiatrist’s recommendation. The Director of Forensic Mental Health may be able to provide such a letter without necessarily seeing the licensee but on the basis of reviewing the licensee’s case notes. If there was any doubts in either the report or supporting letter then the Court could ask for a further report.

In relation to the situation where a defendant had a psychotic episode during a prescribed period of time and as a consequence is facing multiple charges in different jurisdictions, one report may suffice for each of the different jurisdiction court appearances. However, it would be necessary to ensure that the psychiatrist was aware of the entire range of alleged offending and any relevant information about the

\textsuperscript{421} Ibid.

\textsuperscript{422} Jamie Walvisch, Submission to the Sentencing Advisory Council; Director of Public Prosecutions, Submission to the Sentencing Advisory Council (for decisions to release on licence or significantly reduce supervision).

\textsuperscript{423} Jamie Walvisch, Submission to the Sentencing Advisory Council.
defendant’s behaviour at the time of the alleged offending, to ensure that the defendant’s mental state was assessed in relation to each offence... It would be for each Court to reach a view as to whether the report provided was sufficient for its purposes.424

3.63 By contrast, the Chief Magistrate’s submission suggested differentiating matters on the basis of the underlying offence:

One approach would be to reduce the number of Section 269T reports required for non violent minor indictable offences to one as is currently the position in relation to summary offences. Alternatively, it would be possible to reduce the number of Section 269T reports for all minor indictable offences to one with a discretion to order more than one report where the matter was complex, high risk or where there was concern about prognosis and/or treatment.425

3.64 The Chief Magistrates’ submission also recommended expanding the scope of reports produced pre-trial or during the trial, to cover matters that may be relevant to disposition. This would reduce the number of reports that need to be produced:

In addition, it would be worth considering whether 269F and K reports could also include advice on prognosis and treatment. No further reports will then be required although a discretion to order further reports could be retained if the circumstances required them. The requirement for a s 269R report in every case would need to be amended. It may be that this suggestion would only relate to categories of offences where there is no victim or alternatively, to non violent offences.426

3.65 The submission of the Law Society of South Australia (Law Society) argued that the number of reports required ‘should be dictated by the jurisdiction in which the matter is heard rather than the categorisation of the offence’.427 Strong support was given for reducing the number of reports required in the Magistrates’ Court, including by the Chief Magistrate.428 The Australian Medical Association (South Australia) (AMA(SA)) suggested that magistrates ‘should be able to order a single report that addresses fitness, mental competence and recommendations for treatment (a) if the person was declared liable to supervision, or (b) if the defendant was not declared liable to supervision’.429

3.66 Fourthly, a number of submissions, including those of the South Australian Bar Association (Bar Association), the DCS and the LSC, supported the court having discretion in the nature and number of reports to order.430 For example, the submission of the Bar Association stated:

424 Director of Public Prosecutions, Submission to the Sentencing Advisory Council.
425 Chief Magistrate Judge Elizabeth Bolton, Submission to the Sentencing Advisory Council. Section 269T reports are those which the court must consider prior to releasing a defendant or significantly reducing the degree of supervision.
426 Ibid.
427 Law Society of South Australia, Submission to the Sentencing Advisory Council.
428 Chief Magistrate Judge Elizabeth Bolton, Submission to the Sentencing Advisory Council.
429 Australian Medical Association (South Australia), Submission to the Sentencing Advisory Council.
430 Department for Correctional Services, Submission to the Sentencing Advisory Council; Office of the Public Advocate, Submission to the Sentencing Advisory Council; Legal Services Commission of South Australia, Submission to the Sentencing Advisory Council; Australian Medical Association (South Australia), Submission to the Sentencing Advisory Council.
The number of reports can be reduced depending on the jurisdiction, complexity and potentially the matters in dispute. If the matter in question is a summary or minor indictable matter being heard in a summary court, there is a strong case for fewer reports. Most desirable, of course, is ensuring that the Court is properly assisted in any given case. For that reason, the final number of reports ordered in any given case, ought to remain at the discretion of the Court hearing the matter.

3.67 While the Bar Association recommended leaving the discretion wide,\textsuperscript{431} the Law Society argued that the factors that should guide the exercise of that discretion include ‘the need to establish the treatment and care of an accused as well as the safety and protection of the community’.\textsuperscript{432} By contrast, the DCS submitted that the court’s discretion ‘should be based on matters including the consideration of previous reports in existence that are available to the Court; and the chronicity of the impairment (for example, if intellectual disability or acquired brain injury) as these are static factors and will not change between reports / assessments’.\textsuperscript{433}

3.68 The LSC suggested that factors guiding the exercise of discretion might include:

- The gravity of the subject offence(s).
- The information already available to the court in previously-prepared expert reports.
- Whether there is any substantial disagreement of opinion between experts who have prepared previous reports.\textsuperscript{434}

Conclusions and Recommendations

3.69 The Council agrees with the submitters that the number of reports required under section 269T should be reduced. In the Council’s view, it is no longer necessary to require three reports to be produced for indictable offences, or for the court to be actively satisfied that fewer reports are sufficient for a summary matter. This system creates unnecessary expense and causes unjustifiable delays.

3.70 In the Council’s view, the default position (for both summary and indictable offences) should be the production of just one section 269T report, to be provided by a psychiatrist (or other appropriate expert) who has personally examined the defendant. However, judges and magistrates should be provided with a broad discretion to order further reports where necessary. Factors relevant to that discretion being exercised should include:

- Whether there is a dispute over the defendant’s diagnosis;
- The nature of the defendant’s impairment, and whether it is likely to have changed; and
- Whether the information already available to the court from previous reports is sufficient to address the matters in issue.

\begin{footnotesize}
\textsuperscript{431} South Australian Bar Association, \textit{Submission to the Sentencing Advisory Council}.

\textsuperscript{432} Law Society of South Australia, \textit{Submission to the Sentencing Advisory Council}.

\textsuperscript{433} Department for Correctional Services, \textit{Submission to the Sentencing Advisory Council}.

\textsuperscript{434} Legal Services Commission of South Australia, \textit{Submission to the Sentencing Advisory Council}.
\end{footnotesize}
The Council does not believe that the other reporting requirements in the CLCA need to be amended.

Recommendation 12
There should be a reduction in the number of psychiatric reports required under section 269T of the Criminal Law Consolidation Act 1935. Regardless of the nature of the offence committed, the default position should be the production of just one report, to be provided by a psychiatrist (or other appropriate expert) who has personally examined the defendant.

Recommendation 13
Judicial officers should be provided with a broad discretion to order further reports under section 269T of the Criminal Law Consolidation Act 1935 where necessary.

Options for Disposition

The dispositions that are available to a judge when a person is declared mentally incompetent to commit an offence, and thus liable to supervision, are set out in Division 4 of Part 8A of the CLCA. As mentioned in Part 1 of the Report, these dispositions are not intended to be punitive. Rather, they are oriented to the treatment and care of the defendant, and the protection of the community.

This difference was highlighted by Justice Bleby in R v Tzeegankoff. He stated that:

there has never been and cannot be any suggestion of punishment being due to the applicant, or any suggestion that he must remain in secure custody for that reason. The only justification for a person being detained after a finding of not guilty on the ground of insanity is for the protection of himself and of the community – to ensure that the disease of the mind from which he suffers cannot adversely affect others. It must also be clearly understood that a person who has been subject to a detention order … is entitled to ... enjoy a regime that is the least restrictive of his freedom and personal autonomy as is consistent with the safety of the community. That relaxation is not dependent upon his having served an appropriate period of ‘punishment’. That is just not a relevant consideration.

Section 269O of the CLCA provides three dispositional options for a defendant who is found not guilty by reason of mental incompetence. A judge may:

- Release the defendant unconditionally;
- Make a supervision order committing the defendant to detention; or
- Make a supervision order releasing the defendant on licence on specific conditions.

In determining the appropriate disposition, the court must have regard to the following matters (s 269T(1)):

- The nature of the defendant’s mental impairment;
- Whether the defendant is, or would if released, be likely to endanger another person, or other persons generally;
- Whether there are adequate resources available for the treatment and support of the defendant in the community;
- Whether the defendant is likely to comply with the conditions of the licence; and
- Other matters the court thinks relevant.

Unconditional release is likely to be the most appropriate option in cases where a fine or other non-custodial sentence would have been imposed had the defendant been convicted of the offence, and the court is satisfied that the defendant does not pose an ongoing risk to him or herself or the community. In other cases, a supervision order is likely to be appropriate.

In determining whether to commit a defendant to detention or to release a defendant on licence, as well as the conditions of the licence, the court must apply the principle that the restrictions on the defendant’s freedom of personal autonomy should be kept to the minimum consistent with the safety of the community (s 269S).

All licences are subject to the following conditions (s 269O(1a)):

- The defendant must not possess a firearm or ammunition;
- The defendant must submit to reasonable testing for gunshot residue.

Other conditions may also be included as terms of a licence. Conditions that commonly form part of a licence include: that the defendant be housed in a certain location; that the defendant refrain from consuming drugs or non-prescribed medication; and that the defendant receive psychiatric treatment. Licence conditions are considered in Part 4 of the Report.

Where the defendant is released on licence, supervisory responsibilities are divided between the Minister for Health and the Parole Board (s 269V(3)):

- The Minister for Health is responsible for matters relating to the treatment or monitoring of the defendant’s mental health. This is normally carried out by the FMHS;
- The Parole Board is responsible for all other aspects of the defendant’s supervision. This is normally carried out by the DCS.

Where a supervision order is made committing the defendant to detention, he or she is placed in the custody of the Minister for Health (s 269V). The Minister may:

- Give directions as to the appropriate custody, supervision and care of the defendant;
• Place the defendant under the custody, supervision and care of another person; or

• Direct that a defendant be kept in custody in a prison (if there is no practicable alternative).

3.82 In most cases individuals will be detained at the forensic mental health facility, James Nash House. However, the Council is aware that given the shortage of hospital beds, either in acute mental health wards or James Nash House, individuals are often detained in prison on the basis that there is ‘no practical alternative’. There are a number of difficulties with this. First, the individual is unlikely to be given adequate mental health treatment whilst in prison. Secondly, as they have been found not guilty on the basis of mental incompetence, prison is an inappropriate place for them to be detained. The Council is of the view that steps should be taken to avoid this situation as far as possible.

Approaches Taken in Other Australian Jurisdictions

3.83 The dispositions that are available for a defendant who is found not guilty by reason of insanity vary widely according to jurisdiction. The sections below briefly outline the options available in each Australian jurisdiction.

ACT

3.84 In the Australian Capital Territory, the dispositions available for a person found not guilty because of mental impairment depend on whether the relevant offence is classified as a ‘serious offence’ or not:

• If it is a ‘serious offence’, the Supreme Court or Magistrates’ Court should usually order that the defendant be detained in custody until the ACAT orders otherwise. However, the court can order that the defendant submit to the jurisdiction of the ACAT, to enable them to make a ‘mental health order’ (see below).436

• If it is not a serious offence, the Supreme Court or Magistrates’ Court may make an order requiring the defendant to submit to the jurisdiction of the ACAT, to enable the ACAT to make recommendations about how he or she should be dealt with. Alternatively, the court may make any other orders it considers appropriate, including ordering that the defendant be detained in custody until the ACAT orders otherwise.437

3.85 The ACAT can make a ‘mental health order’, which can include:

• A ‘psychiatric treatment order’: This is an order requiring the defendant to attend a specific health facility, to undergo certain forms of psychiatric treatment, or to limit communication with certain people.438

436 Crimes Act 1900 (ACT) ss 324, 329.
437 Crimes Act 1900 (ACT) ss 323, 328.
438 See Mental Health (Treatment and Care) Act 1994 (ACT) s 29.
• A ‘community care order’: This is an order requiring the defendant to be given treatment care or support, to be given medication, to undertake a counselling, training, therapeutic or rehabilitation program, or to limit communication with certain people.439

• A ‘restriction order’: This is an order requiring the defendant to live or be detained at a stated place, to not approach a stated person or place, or to not undertake stated activities.440

New South Wales

3.86 In NSW, where the defendant is found not guilty by reason of mental illness, the court may:

• Order that he or she be detained in such place and in such manner as the court thinks fit; or

• Make any other order the court considers appropriate, including releasing the defendant from custody with or without conditions.441

3.87 In addition, in cases in the Magistrates Court in which it appears that the defendant is suffering from a developmental disability or mental illness, or was suffering from such a condition at the time of the alleged commission of the offence, the Magistrate may:

• Adjourn the proceeding;

• Grant the defendant bail;

• Dismiss the charge and discharge the defendant conditionally442 or unconditionally; or

• Make any other order that the Magistrate considers appropriate.443

Northern Territory

3.88 In the NT, if the defendant is found not guilty because of mental impairment, the court must either declare that he or she is liable to supervision, or order that he or she be released unconditionally.444 Supervision orders may be custodial (with the defendant committed to a prison or other appropriate place) or non-custodial, and may contain whatever conditions the court considers appropriate.445

439 See Mental Health (Treatment and Care) Act 1994 (ACT) s 36A.
440 See Mental Health (Treatment and Care) Act 1994 (ACT) ss 31, 36C.
441 Mental Health (Forensic Provisions) Act 1990 (NSW) s 39.
442 If a Magistrate discharges a defendant subject to a condition, and the defendant fails to comply with the condition within six months of the discharge, the Magistrate may deal with the charge as if the defendant had not been discharged.
443 Mental Health (Forensic Provisions) Act 1990 (NSW) s 32.
444 Criminal Code Act (NT) s 43I(2).
445 Criminal Code Act (NT) s 43ZA.
Queensland

3.89 In Queensland, matters relating to mental impairment and the criminal law are generally addressed by the Mental Health Court. That Court was established under the Mental Health Act 2000 (Qld), and is constituted by a Supreme Court judge, who may seek advice from two assisting psychiatrists. It determines whether, when an offence was allegedly committed, a person was of unsound mind; of diminished responsibility (where the charge is murder); and if the person was not of unsound mind, whether he or she is fit for trial.

3.90 If the Mental Health Court decides the defendant was of unsound mind when the alleged offence was committed, it may make a ‘forensic order’ requiring him or her to be detained for involuntary treatment or care.\(^{446}\) If the unsoundness of mind was a consequence of an intellectual disability, the court must determine whether the defendant should be detained in the forensic disability service or an authorised mental health service. If it is not a consequence of such a disability, the defendant must be detained in an authorised mental health service.\(^{447}\) As part of the forensic order, the Court may order limited community treatment, which allows the defendant to reside in the community with active monitoring by a mental health service.\(^{448}\)

3.91 In some cases, the issue of insanity will be determined by a jury rather than the Mental Health Court.\(^{449}\) If the jury finds the defendant not guilty on the basis of insanity, the court must order the defendant to be kept in strict custody, in such place and manner as the court thinks fit, until he or she is dealt with under the Mental Health Act 2000 (Qld).\(^{450}\) If the court orders the defendant to be detained somewhere other than an authorised mental health service, the Minister may direct that he or she be detained in a stated high security unit or authorised mental health service.\(^{451}\)

Tasmania

3.92 In Tasmania, where the defendant is found not guilty on the ground of insanity, the court may:\(^{452}\)

- Make a restriction order, requiring the defendant to be detained in a secure mental health unit;\(^{453}\)

- Make a supervision order, releasing the defendant to the supervision of the Chief Forensic Psychiatrist, on such conditions as the court considers appropriate;\(^{454}\)

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\(^{446}\) Mental Health Act 2000 (Qld) s 288(2).
\(^{447}\) Mental Health Act 2000 (Qld) s 288(5)-(9).
\(^{448}\) Mental Health Act 2000 (Qld) s 289.
\(^{449}\) For the circumstances in which a matter can be referred to the Mental Health Court, see Mental Health Act 2000 (Qld) ss 256-263.
\(^{450}\) Criminal Code Act 1899 (Qld) s 647.
\(^{451}\) Mental Health Act 2000 (Qld) s 302.
\(^{452}\) Criminal Justice (Mental Impairment) Act 1999 s 21.
\(^{453}\) Criminal Justice (Mental Impairment) Act 1999 s 22.
\(^{454}\) Criminal Justice (Mental Impairment) Act 1999 s 29A.
• Make a treatment order, requiring the defendant to be given specific treatment; or
• Release the defendant conditionally or unconditionally.

**Victoria**

3.93 In Victoria, if the defendant is found not guilty because of mental impairment by the Magistrates’ Court, he or she must be discharged. If that same verdict is returned in another court, the court must make a supervision order or release the defendant unconditionally. A supervision order may either be custodial (committing the person to custody in an approved mental health facility, residential treatment facility, prison or other appropriate place) or non-custodial (releasing the person on conditions decided by the court).

**Western Australia**

3.94 In Western Australia, if a court of summary jurisdiction finds the defendant not guilty on account of unsoundness of mind, it may release the defendant unconditionally, or make one of the following orders:

• A custody order, detaining the defendant in an authorised hospital, a declared place, a detention centre or a prison, as determined by the Mentally Impaired Accused Review Board (MIARB);
• Make a conditional release order (CRO), requiring the defendant to comply with any requirements the court decides are necessary to secure his or her good behaviour;
• Make a community based order (CBO), requiring the defendant to comply with the standard obligations set out in section 63 of the *Sentencing Act 1995 (WA)*, as well as any primary obligations imposed under section 64 of that Act;
• Make an intensive supervision order (ISO), requiring the defendant to comply with the supervision requirements set out in section 71 of the *Sentencing Act 1995 (WA)*, the standard obligations set out in section 70 of that Act, and any primary requirements imposed under section 72;
• Release the defendant unconditionally.

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455 See *Mental Health Act 2013* (Tas) Division 2 for more information concerning treatment orders.
456 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 5.
457 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) ss 23, 26.
458 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 26.
459 *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) ss 20, 22. The court must not make a CRO, CBO or ISO unless such an order could have been made had the defendant been found guilty of the offence.
461 See *Sentencing Act 1995 (WA)* Part 7 for information concerning CROs.
462 See *Sentencing Act 1995 (WA)* Part 9 for information concerning CBOs.
463 See *Sentencing Act 1995 (WA)* Part 10 for information concerning ISOs.
If the court imposes a CRO, CBO or ISO, the relevant parts of the *Sentencing Act 1995* (WA) apply, despite the fact that the defendant is not an offender. However, if the court finds it necessary to cancel that order (for example, because the conditions have been breached), the court must make a custody order.\(^{464}\)

The options listed above are also available to superior courts.\(^{465}\) However, if the offence is one that is listed in Schedule One of the Act,\(^{466}\) the court must make a custody order.

### Commonwealth

At the Commonwealth level, where the defendant is acquitted of an indictable offence because of mental illness, the court may order that he or she be:

- Detained in safe custody in prison or in a hospital for a period specified in the order;
- Released from custody unconditionally; or
- Released from custody subject to specified conditions.\(^{467}\)

The conditions for release may include a condition that the defendant remain in the care of a nominated person, or a condition that the defendant attend a certain place for assessment or treatment.\(^{468}\)

Different options are provided to courts of summary jurisdiction. If it appears to the court that the defendant is suffering from a mental illness or intellectual disability, or that it would be more appropriate to deal with the person otherwise than in accordance with the law,\(^{469}\) the court may:

- Dismiss the charge and discharge the person conditionally or unconditionally;
- Adjourn the proceedings;
- Remand the person on bail; or
- Make any other order that the court considers appropriate.\(^{470}\)

### Issues to be Addressed

In the Discussion Paper, the Council sought comment on whether any other dispositions, such as those outlined above, should be adopted in South Australia. The following question was asked:

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\(^{464}\) *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 22.


\(^{466}\) A wide number of offences are listed in Schedule One. They are largely offences of a sexual or violent nature.

\(^{467}\) *Crimes Act 1914* (Cth) s 20BJ.

\(^{468}\) *Crimes Act 1914* (Cth) s 20BJ(5).

\(^{469}\) This determination may be based on an outline of the facts alleged in the proceeding, or such other evidence as the court considers relevant.

\(^{470}\) *Crimes Act 1914* (Cth) s 20BQ.
Question 14: Should the court be provided with additional disposal options to apply to persons found not guilty by reason of mental incompetence? If so, what options should be available to the court?

Approaches Taken in Other Reviews

3.101 The NSWLRC recently considered the dispositions that should be made available after a defendant is found not guilty because of mental impairment. It was their recommendation that such defendants should be referred to the MHRT(NSW) for disposition as soon as possible after the verdict is returned:

The MHRT has expertise and an ongoing monitoring role in relation to forensic patients. This approach has the advantages of consistency, simplicity and informed decision making. It will save the costs of providing the court with the information and expertise required to make an informed decision which, as we have already noted, is inevitably only a temporary one. It will deal with the risks to public safety, and the welfare of forensic patients and concerns regarding inappropriate release and inappropriate orders.  

3.102 Upon referral to the MHRT(NSW), the defendant would become a ‘forensic patient’. The Tribunal should be required to conduct an initial review as soon as practicable (at least within two months), and make decisions regarding the defendant’s detention, care or treatment in a mental health facility or other place, or his or her release (either unconditionally or subject to conditions). Where the defendant would not have been sentenced to imprisonment if found guilty at trial, the MHRT(NSW) must not order that he or she be detained, unless he or she poses a significant risk of serious physical or psychological harm to others.

3.103 By contrast, the Law Reform Commission of Western Australia (LRCWA) recommended retaining court-ordered dispositions. However, it was concerned with two aspects of the current Western Australian system (as outlined above):

- It did not believe that a custody order should be mandatory for Schedule 1 offences. It recommended that custody orders should be presumptive only;

- It did not believe it was appropriate to impose conditional release orders, community based orders or intensive supervision orders on people found not guilty by reason of mental impairment, due to the potential need for specialist supervision (rather than the more general supervision normally available for people on these orders), and the emphasis these orders place on punishment rather than treatment and reintegration. It recommended the introduction of a new ‘Supervised Release Order’. This order would have conditions set by the MIARB, which address compliance, treatment, residential and training


472 Ibid Recommendation 7.3.

473 Ibid Recommendation 7.4.

conditions. The court could make recommendations about appropriate conditions to incorporate.475

3.104 The ELC recommended that following a verdict of ‘not criminally responsible by reason of a recognised medical condition’, the court should be able to make a hospital order (with or without a restriction order), a supervision order, or an absolute discharge.476

Submissions

3.105 The Council received 12 submissions addressing options for disposition. These were largely supportive of the introduction of additional options, with a number of submissions emphasising the desirability of a flexible system.477 Only the DPP argued that the current regime was appropriate for major indictable matters, given their seriousness. However, even he saw possible merit in creating additional options for defendants who appear on less serious matters in the Magistrates Court.478 The need for additional options at the lower end of the scale was expressed by a number of submitters, including the Chief Magistrate.479

3.106 While there was general support for the introduction of additional options, there was concern to ensure that relevant interests and principles were properly taken into account. For example, the submission of the Commissioner for Victims’ Rights (CVR) stated that ‘it is important that whatever options are available the harm done to the victim is validated’,480 and the submission of the OPA argued that:

It would be important that, the option chosen be the least restrictive compatible with the safety of those involved. For example, it would be unfortunate, if a person, say, having committed a minor offence, was then subject to coercive and directed mental health treatment, that would not be applied to a person with such an illness and risk of harm to self or others, under the civil provisions, of the Mental Health Act 2009.481

3.107 Nine specific options for reform were proposed in the submissions. These are addressed in turn below.

Summary Dismissal by Magistrates

3.108 It was suggested that consideration be given to enacting a provision similar to section 20BQ of the Crimes Act 1914 (Cth).482 As noted above, this provision allows magistrates to deal with the defendant otherwise than in accordance with the law, where the defendant suffers from a mental illness or intellectual disability, or the magistrate considers it appropriate to do so. In such circumstances the magistrate can summarily dismiss the charge and discharge the person conditionally or unconditionally, adjourn the proceedings, remand the defendant on bail, or make

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475 Ibid 245-6.
477 See, eg, Ombudsman SA, Submission to the Sentencing Advisory Council; Jamie Walvisch, Submission to the Sentencing Advisory Council; Office of the Public Advocate, Submission to the Sentencing Advisory Council.
478 Director of Public Prosecutions, Submission to the Sentencing Advisory Council.
479 Chief Magistrate Judge Elizabeth Bolton, Submission to the Sentencing Advisory Council.
480 Commissioner for Victims’ Rights, Submission to the Sentencing Advisory Council.
481 Office of the Public Advocate, Submission to the Sentencing Advisory Council.
482 Chief Magistrate Judge Elizabeth Bolton, Submission to the Sentencing Advisory Council.
any other orders he or she considers appropriate. In proposing such a reform, the Chief Magistrate stated:

Such a provision might be restricted to certain classes of offences. I raise this issue because in many cases where a defendant is awaiting finalisation of his/her matters during the months needed for the reports to be obtained, he/she will commit breaches of bail or other minor offences which will have no impact on a limiting term ultimately to be set. When it occurs, further section 269QR and T reports become necessary unless police withdraw the fresh charges which they are often unwilling to do. The capacity to summarily dismiss such matters would ease the pressure on the justice system as a whole and also reduce costs.483

3.109 A similar reform appears to be supported by the Law Society, whose submission suggested that:

There should perhaps be a threshold whereby a matter that would ordinarily call for imprisonment of less than six months should not require any particular sanction pursuant to Part 8A where a person has been found not guilty by reason of mental impairment. Usually by that stage the Court should be well informed about the treatment issues concerning the individual and in particular whether there exists a community treatment order or other treatment regimes. The use of Diversion Court practices or Diversion Court programs should also be considered and interrelated to the options available.484

3.110 One submission contended that the law should be amended to remove the link between the court’s ability to unconditionally release a defendant and the danger the defendant poses to him or herself:

In para 3.46 [of the Discussion Paper] it is stated that the court’s ability to unconditionally release a defendant is linked not only to an assessment of the risk he or she poses to the community, but also to the risk posed to him or herself… I do not believe it is appropriate to use this mechanism of the criminal law to protect individuals from themselves, or to provide them with an opportunity for treatment. In my view, if the only reason for detaining a person relates to the danger they pose to themselves, it is more appropriate to use civil dispositions rather than criminal ones. The law in relation to unconditional release should be amended to reflect this.485

3.111 It was submitted that if the court is satisfied that the offending behaviour is minor, but that the defendant appears to have a mental illness and to be at risk of harm, the court should have the ability to dismiss the offence and make a Community Treatment Order Level 1 (CTO1) or Inpatient Treatment Order Level 1 (ITO1) under the Mental Health Act 2009 (SA).486 These are civil mental health treatment orders, that allow a medical practitioner or authorised health professional to order a

483 Ibid.
484 Law Society of South Australia, Submission to the Sentencing Advisory Council.
485 Jamie Walvisch, Submission to the Sentencing Advisory Council.
486 Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.
person’s treatment either in the community or in a treatment centre. In proposing this option, the submission of the OCPP noted:

This option would be similar to that of s 69 of the Mental Health Act, where the Chief Psychiatrist can make a CTO1 for a person on an interstate CTO, but the CTO1 is then handled as per usual [i.e. it is handled as if the order had been made by a health professional]. This option allows the Court to dismiss the offending behaviour and hand the health aspects over to SA Health to deal with through their usual processes.

3.112 A similar option also appears to be supported by the Law Society, which ‘takes the view that there should be an option for referral to the appropriate authority for a Community Treatment Order or something similar. The Court should have a discretion to release someone with conditions that it deems appropriate in accordance with material supplied by expert(s) without the necessity of providing for a supervision order’. Similarly, the Bar Association’s submission suggested that the ‘Tasmanian option of a community based treatment order would be a worthwhile option to consider along with the types of conditions listed in paragraph 3.57 of the Discussion Paper’. The conditions referred to are that the defendant remain in the care of a responsible person nominated in the order, and that the defendant attend a certain person or place for assessment or treatment where required.

Bonds

3.113 A number of submissions recommended that there be an option for some kind of bond. For example, the OCPP proposed the option of a good behaviour bond, with ‘the penalty for non-compliance being community supervision (release on license) or detention depending on the nature of the offence’. The Bar Association also supported a ‘bond with conditions’. The submission of the Chief Magistrate recommended ‘an intermediate option of release on a supervised bond with the Department for Correctional Services being responsible for that supervision’. However, the Law Society queried the utility of a supervised bond:

The Society takes the view that... an application of a supervision condition on licence, is too restrictive for those that would normally be the subject of a Bond if the matter was too serious for an unconditional release. For those matters where a short term of imprisonment would normally be imposed (for example, driving disqualified which often attracts 7 — 21 days imprisonment) a licence condition for supervision of that short a duration would be of little use.

487 See Mental Health Act 2009 (SA) ss 10, 21.
488 Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.
489 Law Society of South Australia, Submission to the Sentencing Advisory Council.
490 South Australian Bar Association, Submission to the Sentencing Advisory Council.
491 Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.
492 South Australian Bar Association, Submission to the Sentencing Advisory Council.
493 Chief Magistrate Judge Elizabeth Bolton, Submission to the Sentencing Advisory Council.
494 Law Society of South Australia, Submission to the Sentencing Advisory Council.
Leave from Detention for Trial of Community Supervision on License

3.114 Another option that was recommended was ‘leave from detention for trial of community supervision on license’.495 This would be an intermediate option for use in relation to serious offences. It would allow the defendant to have an extended trial of leave from detention, as a precursor to the Court considering ordering supervision in the community.

Change of Custodial Arrangements

3.115 Some submissions recommended that the custodial arrangements ordered by the court be amended. As noted above, under the current system the defendant is placed in the custody of the Minister for Health, who may give directions as to the appropriate custody, supervision and care of the defendant. In most cases individuals are detained at the forensic mental health facility, James Nash House. The submission of the AMA(SA) suggested that the defendants with intellectual disabilities or brain injuries should be placed under the care of the Minister for Disabilities, and housed in secure disability units if too dangerous to be released into the community.496 They argued that it is inappropriate to house such defendants in James Nash House or other psychiatric units.

3.116 The OCPP also recommended the involvement of the Minister for Disabilities.497 The FMHS suggested that James Nash House should not be the default position for custody: ‘Factors to be taken into account should reflect a requirement for an open versus a closed ward, geographical considerations, the benefits likely to be gained for placement at a mental health facility etc.’498 Custodial arrangements for defendants with intellectual disabilities are considered in more detail in Part 4.

Restitution and Compensation

3.117 The CVR recommended that consideration be given to restitution as an option. He argued that ‘[s]ome mentally ill perpetrators have the means to pay for the damage done or harm caused, and they should’.499

3.118 On a related issue, the OCPP recommended that:

any determinations or options available to the Court regarding the disposal of people to whom s 269 may or does apply should not preclude the objective elements of a case being decided upon, so that a victim and/or victim next of kin can still be availed of legal and service options, regardless of whatever incompetence or unfitness finding is made, or disposal option used. This may require some change to current provisions and practice where some victims are excluded from applying for compensation and/or support because of how the CLCA is worded. It is recommended that the objective elements of the case should always be determined so that victims are not penalised by the use of the s 269 defence.500

495 Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.
496 Australian Medical Association (South Australia), Submission to the Sentencing Advisory Council.
497 Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.
498 Forensic Mental Health Service, Submission to the Sentencing Advisory Council.
499 Commissioner for Victims' Rights, Submission to the Sentencing Advisory Council.
500 Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.
The issue of compensation was also raised by the CVR, who noted that victims have ‘complained that their applications for state-funded victim compensation are processed slower because they must wait until criminal proceedings are complete before finalising such applications’.

Non-Involvement of Courts in Clinical Decisions

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) argued that there should be no capacity for courts to order someone to be detained in any mental health facility. Decisions to admit the defendant to a facility such as James Nash House should only be made by doctors, based on the same health-based criteria as any inpatient admission.

Consequently, their submission recommended that a person who was found not guilty by reason of mental impairment ‘should either be discharged to the community, if indicated on health grounds, or detained in a non-hospital correctional facility, if it is felt appropriate to incarcerate them for other reasons (such as community safety)’. The court’s role should cease after this point, with all future decisions ‘about where the person is housed and treated [being] made on clinical grounds (which includes clinical risk) without involvement of the courts’.

Referral to Specialist Tribunal

The submission of the OPA strongly supported the creation of a specialist court or tribunal ‘that is well versed on care and treatment options, and balancing least restrictive options with the prevention of harm’. It argued that such a tribunal ‘would deliver better outcomes to patients and victims’. The submission suggests that this tribunal would be the appropriate body for determining the defendant’s disposition. The creation of a specialist tribunal is discussed in more detail in Part 4 of the Report.

Conclusions and Recommendations

The Council agrees with the majority of submitters that additional disposition options should be introduced. In particular, the Council believes that serious consideration should be given to introducing a provision similar to section 20BQ of the Crimes Act 1914 (Cth). As noted above, this section applies to courts of summary jurisdiction, and applies where it appears to the court that the defendant is suffering from a mental illness or intellectual disability, or that it would be more appropriate to deal with the person otherwise than in accordance with the law. In such circumstances, the court may:

- Dismiss the charge and discharge the person conditionally or unconditionally;
- Adjourn the proceedings;

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501 Commissioner for Victims' Rights, Submission to the Sentencing Advisory Council.
502 Royal Australian and New Zealand College of Psychiatrists (South Australian Branch), Submission to the Sentencing Advisory Council.
503 Ibid.
504 Ibid.
505 Office of the Public Advocate, Submission to the Sentencing Advisory Council.
- Remand the person on bail; or
- Make any other order that the court considers appropriate.

3.124 Alternatively, consideration should be given to allowing judicial officers to impose a bond for less serious offences, as was recommended by the OCPP, the Bar Association and the Chief Magistrate. Such a bond could have conditions attached to it, such as requiring the defendant to be of good behaviour or to reside in a certain facility (such as a half-way house). The penalty for non-compliance could be the imposition of a supervision order.

3.125 In the Council’s view, such an option may be useful where the defendant has committed an offence which would not attract a term of imprisonment even if he or she were found guilty. Under the current scheme, such an offender must be released unconditionally. This intermediate option would allow a judge or magistrate to impose limited conditions on the defendant. A bond may also be useful for cases where a short term of imprisonment may have been appropriate, but the judge or magistrate is reluctant to impose a supervision order with a limiting term. It provides a less onerous avenue for disposition.

3.126 The Council is aware that introducing this option could potentially result in defendants being under court supervision for longer than if a supervision order were made. For example, it would be possible for a magistrate to impose a 3 year good behaviour bond on a defendant, where the limiting term for a supervision order would have been set at 12 months. To reduce this possibility, and make it clear that this should be considered an intermediate option between unconditional release and a supervision order with conditions, the Council recommends that the maximum duration of any bond be capped (for example at 12 months).

Recommendation 14

The Government should consider enacting additional dispositions for people found not guilty because of mental incompetence. Particular consideration should be given to the following two options:

- Enacting a provision similar to section 20BQ of the Crimes Act 1914 (Cth); and
- Allowing judicial officers to impose conditional bonds on defendants for less serious offences. The maximum duration of such bonds should be capped.

Limiting Terms

3.127 In the event that the court makes a supervision order, either committing the defendant to detention or releasing the defendant on licence, the court is required to fix a limiting term (s 269O(2)). The limiting term is the period during which the supervision order remains in operation. When the limiting term expires, the person is no longer subject to the order and the conditions specified in it.

3.128 The limiting term should be equal to the length of the sentence that would have been imposed had the defendant been convicted of the offence charged (s 269O(2)).
This requires the court to engage in a hypothetical sentencing exercise, assuming the defendant was fit for trial and was found guilty. The length of the limiting term must be the same length as the sentence that would have been imposed in the circumstances.

3.129 It is important to emphasise that when a court fixes a limiting term it is not imposing a penalty. The general purpose of the supervision order is not to penalise, but to protect the public and to secure the defendant such supervision and treatment as is available and appropriate.\(^{506}\)

3.130 As the length of the limiting term is determined by the sentence that would have been imposed in the circumstances, it is necessary to consider how a sentence is ordinarily determined. In South Australia, sentencing is largely governed by the *Criminal Law (Sentencing Act) 1988*. The main sentencing considerations are set out in section 10, which states:

> (1) In determining the sentence for an offence, a court should have regard to such of the following factors and principles as may be relevant:

a) the circumstances of the offence;

b) other offences (if any) that are to be taken into account;

c) if the offence forms part of a course of conduct consisting of a series of criminal acts of the same or a similar character—that course of conduct;

d) the personal circumstances of any victim of the offence;

e) any injury, loss or damage resulting from the offence;

f) if the offence was committed by an adult in circumstances where the offending conduct was seen or heard by a child (other than the victim (if any) of the offence or another offender)—those circumstances;

g) the degree to which the defendant has shown contrition for the offence (including by taking action to make reparation for any injury, loss or damage resulting from the offence);

h) the degree to which the defendant has cooperated in the investigation of the offence;

i) the deterrent effect any sentence under consideration may have on the defendant or other persons;

j) the need to ensure that the defendant is adequately punished for the offence;

k) if a forfeiture of property (other than a forfeiture that merely neutralises a benefit that has been obtained through the commission of the offence) is, or is to be imposed, as a result of the commission of the offence—the nature and extent of the forfeiture;

l) the character, antecedents, age, means and physical or mental condition of the defendant;

\(^{506}\) *Question of Law Reserved (No 1 of 1997)* 70 SASR 251, 266; *R v Draoui* (2008) 101 SASR 267, 281.
m) any other relevant matter.

(2) In determining the sentence for an offence, a court must give proper effect to the following:

a) the need to protect the safety of the community;

b) the need to protect the security of the lawful occupants of their home from intruders;

c) in the case of an offence involving the sexual exploitation of a child—the need to protect children by ensuring that paramount consideration is given to the need for general and personal deterrence;

d) in the case of an offence involving arson or causing a bushfire—
   
i. the need to protect the community from offending of such extreme gravity by ensuring that paramount consideration is given to the need for general and personal deterrence; and
   
ii. the fact that the offender should, to the maximum extent possible, make reparation for the harm done to the community by his or her offending;

e) in the case of an offence involving a firearm—the need to protect the safety of the community by ensuring that paramount consideration is given to the need for general and personal deterrence.

3.131 It is for the court to consider all of these factors and principles, and determine a proportionate sentence. It is a fundamental principle of sentencing law that a sentence may not be extended beyond what is proportionate to the crime in order to protect the community.\(^{507}\) Thus, even if the offender is considered to be dangerous due to his or her mental impairment, a disproportionate sentence may not be imposed.\(^{508}\) This principle also applies to limiting terms, which must remain proportionate to the offence charged.\(^{509}\)

3.132 Ordinarily, a mental illness or intellectual disability may be taken into account in sentencing an offender who is not mentally incompetent. For example, it may reduce his or her culpability, or the need for general deterrence, leading to a lighter sentence.\(^{510}\) Such factors may not, however, be taken into account in setting the limiting term.\(^{511}\) In determining the appropriate length of the limiting term, the judge must not take into account the defendant’s mental impairment (s 269O(2) Note 1). In \(R v\) \(Behari\)\(^{512}\) Justice Kourakis, as he was then, commented on the way in which a limiting term is fixed without reference to the mental state of the defendant (as would usually occur when sentencing in the usual way):

\(^{507}\) \textit{Veen v The Queen (No 2) (1987-1988) 164 CLR 465, 472.} It is possible to create statutory exceptions to this principle.

\(^{508}\) There are some specified circumstances in which a sentence of indeterminate duration may be imposed: see, eg, Division 3 of Part 2 of the \textit{Criminal Law (Sentencing Act) 1988.}

\(^{509}\) \textit{R v T, JA [2013] SADC 12;}


\(^{511}\) \textit{R v Draoui (2008) 101 SASR 267.}

\(^{512}\) \textit{(2011) 110 SASR 147.}
It is a consequence of the conditions for making supervision orders and limiting terms that they will commonly, although not necessarily, be made with respect to persons who, by reason of their mental state, are either unlikely to have formed a guilty intention or, if an intention were formed, are likely to have acted in a state which the common law may have accepted as one of diminished responsibility for the purpose of sentencing. In those circumstances it would be problematic to take into account the mental state which accompanied the objective elements as part of the required hypothetical sentencing exercise. The very mental impairment which renders the accused unfit to stand trial would make a determination of the mental state very difficult. Indeed, it may be self-contradictory to do so, because the mental state may not be a culpable one. They are prophylactic and remedial in nature.

The tension which arises when sentencing persons with mental impairments under the criminal law between the mitigating effect of their diminished responsibility on the one hand and the increased need for community protection on the other is ameliorated by fixing a limiting term because the Act allows for release into the community on licence and ultimately discharge when there is no longer any risk to the community. Those options are not available under criminal sentencing regimes.

It follows, in my view, that in fixing a limiting term the court must proceed as if it is sentencing for an offence constituted by the objective elements it has found but where it has been left in ignorance of the mental state of the accused. It can neither reduce the limiting term by reason of diminished responsibility nor increase it by reason of callous premeditation or disregard for the suffering of the victims. In that way, fixing a limiting term will not be plagued by the difficulty of ascertaining the relevant guilty mental state to which I have referred nor will the period during which the psychiatric care is provided be reduced on account of diminished responsibility arising out of the very mental condition which requires treatment.513

Approaches Taken in Other Australian Jurisdictions

3.133 Only two other Australian jurisdictions (the ACT and the Cth) require the court to set a limiting term, beyond which the defendant’s detention or supervision may not extend.

3.134 The system in the ACT is similar to that in South Australia. If the Supreme Court or Magistrates’ Court makes an order that the defendant be detained in custody until the ACAT orders otherwise (see above), the court must indicate whether, if the defendant had not been acquitted, it would have imposed a sentence of imprisonment. If so, it must provide the ‘best estimate of the sentence it would have considered appropriate’ if the defendant had been found guilty of that offence. 514 The defendant must not be detained for a period longer than this ‘limiting period’. 515 In estimating the sentence it would have imposed, the court ‘may inform itself and consider the evidence and submissions that it would were the court determining the sentence to be imposed in normal criminal proceedings’. 516

3.135 By contrast, in the Commonwealth, where the defendant is acquitted because of mental illness, the court may order that he or she be:

513 R v Behari (2011) 110 SASR 147, [14].
514 Crimes Act 1900 (ACT) s 302, 304.
515 Crimes Act 1900 (ACT) s 303, 306; Mental Health (Treatment and Care) Act 1994 (ACT) s 75.
516 Crimes Act 1900 (ACT) s 307.
• Detained in safe custody in prison or in a hospital for a period ‘not exceeding the maximum period of imprisonment that could have been imposed’ if he or she had been convicted of the offence charged; or

• Released from custody unconditionally or subject to conditions that apply for such period as the court specifies, but not exceeding three years.\(^{517}\)

### 3.136

In all other jurisdictions, the period for which the defendant may be detained or supervised is potentially indefinite. However, each jurisdiction sets out a mechanism for ending the orders made in relation to the defendant. There are three main types of mechanism:

• Setting a date for a major review of the defendant’s situation, where it is presumed (in the absence of evidence to the contrary) that the level of supervision will be reduced (Vic and NT);

• Providing for periodic reviews of the defendant’s situation, which may result in the orders being varied or revoked (Qld, Tas and WA);

• Providing that the defendant may only be released when it is considered safe to do so (NSW).

### 3.137

The mechanisms established in each of these jurisdictions are outlined below.

#### Victoria

### 3.138

In Victoria, a supervision order is for an indefinite term.\(^{518}\) However, when making the order the court may direct that the matter be brought back to court for review at the end of a specified period.\(^{519}\) In addition, the court must set a ‘nominal term’ for the supervision order.\(^{520}\) At least three months before the end of that term the court must undertake a major review, to determine whether the defendant is able to be released from the order.\(^{521}\) If the defendant is on a custodial supervision order, the court must vary it to a non-custodial order unless satisfied, on the evidence available, that the safety of the defendant or members of the public will be seriously endangered as a result of his or her release. If the defendant is on a non-custodial supervision order, the court may confirm it, vary its conditions or revoke it.

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\(^{517}\) *Crimes Act 1914* (Cth) ss 20BJ; 20BQ.

\(^{518}\) *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 27.

\(^{519}\) *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 27.

\(^{520}\) *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 28.

\(^{521}\) *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 35.
3.139 The ‘nominal term’ is fixed in accordance with the following table:522

<table>
<thead>
<tr>
<th>Person found not guilty of offence because of mental impairment or found at special hearing to have committed</th>
<th>Nominal term</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) murder or treason</td>
<td>25 years</td>
</tr>
<tr>
<td>(b) a serious offence (within the meaning of the Sentencing Act 1991) other than:</td>
<td></td>
</tr>
<tr>
<td>(i) murder</td>
<td>a period equivalent to the maximum term of imprisonment available for the offence</td>
</tr>
<tr>
<td>(ii) an offence against section 20 of the Crimes Act 1958 (threats to kill)</td>
<td></td>
</tr>
<tr>
<td>(c) any other offence for which there is a statutory maximum term of imprisonment</td>
<td>a period equivalent to half the maximum term of imprisonment available for the offence</td>
</tr>
<tr>
<td>(d) any other offence punishable by imprisonment but for which there is no statutory maximum term</td>
<td>a period specified by the court</td>
</tr>
</tbody>
</table>

3.140 A number of different people, including the defendant, can apply to the court to vary a custodial supervision order, or to vary or revoke a non-custodial supervision order.523 The court must not vary a custodial supervision order to a non-custodial supervision order during the defendant’s nominal term unless satisfied, on the evidence available, that the safety of the defendant or members of the public will not be seriously endangered as a result of the release.524 If the court makes the variation, the nominal term continues to run.525 If the court refuses the application to vary or revoke the supervision order, a new application cannot be made for another three years (unless the court directs otherwise).526

522 Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) s 28. If the defendant is found not guilty because of mental impairment of more than one offence, the nominal term must be calculated by reference to the offence that carries the longest maximum term of imprisonment.
523 Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) s 31.
524 Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) s 32.
525 Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) s 32.
526 Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) s 31.
Northern Territory

3.141 In the Northern Territory, supervision orders are also for an indefinite term.\textsuperscript{527} Like in Victoria, when the court makes a supervision order it must specify a nominal term for that order.\textsuperscript{528} However, unlike Victoria, the length of that term must be equivalent to the period of imprisonment or supervision that would, in the court's opinion, have been the appropriate sentence to impose on the defendant if he or she had been found guilty of the offence charged.\textsuperscript{529}

3.142 At least 3 months (but not more than 6 months) before the expiry of that term, the court must conduct a major review to determine whether to release the defendant from the supervision order.\textsuperscript{530} At the completion of the major review, the court must release the defendant unconditionally, unless it considers that his or her safety, or the safety of the public, is likely to be seriously at risk if he or she is released. In such circumstances the court must either confirm the supervision order, or vary its conditions.\textsuperscript{531}

3.143 In addition, every 12 months a report must be submitted to the court on the treatment and management of the defendant's condition.\textsuperscript{532} After considering this report the court may conduct a periodic review to determine whether the defendant may be released from the supervision order. The consequences of undertaking a periodic review vary, depending on whether the defendant is on a custodial or non-custodial supervision order:

- If the defendant is on a custodial supervision order, the court must vary it to a non-custodial supervision order, unless satisfied on the evidence available that the safety of the defendant or the public will be seriously at risk if the person is released on such an order.

- If the defendant is on a non-custodial supervision order, the court may confirm the order, vary its conditions, change it to a custodial supervision order, or revoke the order and release the defendant unconditionally.

3.144 A range of people, including the defendant and the people who care for him or her, can apply to have the supervision order varied or revoked. Applications are usually limited to once per year, but this can be altered by the court.\textsuperscript{533}

Queensland

3.145 Queensland does not use a ‘limiting term’ device. Instead, a forensic order made by the Mental Health Court remains in force indefinitely until it is revoked by a review

\textsuperscript{527} Criminal Code Act (NT) s 43ZC.

\textsuperscript{528} While this is not called a ‘nominal term’ in the NT legislation, it has the same effect as a ‘nominal term’ in Victoria. For the sake of simplicity, this Report uses the same terminology.

\textsuperscript{529} If the defendant was charged with the commission of multiple offences, the term must be fixed by reference to the offence carrying the longest maximum period of imprisonment. If the appropriate penalty would have been life imprisonment, the court must specify the period it would have set as the non-parole period for the offence.

\textsuperscript{530} Criminal Code Act (NT) s 43ZG. The court can adjourn the review to after the expiry of the nominated term if it considers it appropriate to do so.

\textsuperscript{531} Criminal Code Act (NT) s 43ZG.

\textsuperscript{532} Criminal Code Act (NT) s 43ZK.

\textsuperscript{533} Criminal Code Act (NT) s 43ZD.
of the Mental Health Review Tribunal (MHRT(Qld)). The Tribunal must conduct such reviews every 6 months, or on application. The Tribunal may also conduct a review on its own initiative.

3.146 On review, the MHRT(Qld) must confirm or revoke the forensic order. If it confirms the order, it may vary its terms. For example, it may approve or revoke an order for limited community treatment, change the monitoring conditions, order the patient’s transfer to another approved mental health service, or order a transfer to the forensic disability service. The Tribunal is required to take into account factors such as the patient’s treatment and security needs and the safety of the community when conducting such a review. 535

3.147 The Tribunal must not revoke the order, approve community treatment or amend a monitoring condition unless it is satisfied that the defendant does not represent an unacceptable risk to his or her safety, or the safety of others, having regard to the defendant’s mental illness or intellectual disability. 536

Tasmania

3.148 In Tasmania, if the defendant is given a restriction or supervision order (collectively known as a ‘forensic order’), he or she must be detained until the relevant order is discharged. All forensic orders must be reviewed by the Mental Health Tribunal within 12 months after the order is made, and at least once in each period of 12 months afterwards. 538

3.149 If the Tribunal determines that the order is no longer warranted, or that the conditions of the order are inappropriate, it must issue a certificate to that effect. The certificate may contain recommendations about the appropriate course to take (for example, replacement of a restriction order with a supervision order). The defendant may then apply to the Supreme Court for discharge, revocation or variation of the forensic order. 539

3.150 Alternatively, the defendant, the Secretary of the responsible Department, or the Chief Forensic Psychiatrist may apply to the Supreme Court for a restriction order to be discharged two years after it has been made, and every two years thereafter. An application for revocation or variation of a supervision order can be made by the defendant (or a number of other parties) every 6 months (unless the court directs otherwise). If it is discharged, the court may instead impose a supervision order or treatment order, or release the defendant conditionally or unconditionally. 542

534 Mental Health Act 2000 (Qld) s 200. The court can dismiss an application for a review if satisfied that it is frivolous or vexatious.
535 Mental Health Act 2000 (Qld) s 203
536 Mental Health Act 2000 (Qld) s 204.
537 Criminal Justice (Mental Impairment) Act 1999 (Tas) ss 22, 30.
538 Reviews are undertaken in accordance with the provisions of the Mental Health Act 2013 (Tas).
539 Criminal Justice (Mental Impairment) Act 1999 (Tas) s 37.
540 Criminal Justice (Mental Impairment) Act 1999 (Tas) s 26.
541 Criminal Justice (Mental Impairment) Act 1999 (Tas) s 30.
542 Criminal Justice (Mental Impairment) Act 1999 (Tas) s 27.
In reviewing a forensic order, the Supreme Court and the Mental Health Tribunal must have regard to the principle that restrictions on the defendant's freedom and personal autonomy should be kept to the minimum consistent with the safety of the community.\(^{543}\)

**Western Australia**

In Western Australia, a person who is detained under a custody order must remain in detention until released by an order of the Governor.\(^{544}\) At least once a year the MIARB must give the relevant Minister a report which, amongst other things, must recommend whether or not the Governor should be advised to release the defendant.\(^{545}\) The Act specifies a number of factors that the MIARB must take into account in making this recommendation, such as the degree of risk the defendant appears to present to the community, and the likelihood that he or she would comply with any conditions imposed.

The Governor may order that a mentally impaired defendant be released, conditionally or unconditionally, at any time.\(^{546}\) Any conditions set apply indefinitely, or for a period determined by the Governor. The Governor may amend or cancel those conditions at any time.

**New South Wales**

There is currently no limiting term mechanism in place in NSW for people found not guilty because of mental illness.\(^{547}\) Under the current law, the court may order that the defendant be detained in such place and in such manner as the court thinks fit, until released by due process of law.\(^{548}\)

Where the court orders the defendant to be detained, it may not order his or her release unless it is satisfied, on the balance of probabilities, that the defendant’s safety, or the safety of any member of the public, will not be seriously endangered by his or her release.\(^{549}\) The MHRT(NSW) also may not order the defendant’s release unless it is satisfied of those matters, as well as being satisfied that other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the defendant, or that the defendant does not require care.\(^{550}\)

**Issues to be Addressed**

In the Discussion Paper, the Council noted that other jurisdictions have taken different approaches to the way in which the length of a supervision order should be

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\(^{543}\) *Criminal Justice (Mental Impairment) Act 1999* (Tas) ss 34, 37.

\(^{544}\) *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 24.

\(^{545}\) *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 33.

\(^{546}\) *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 35.

\(^{547}\) There is a limiting term mechanism for people found unfit to stand trial: see *Mental Health (Forensic Provisions) Act 1990* (NSW) s 23.

\(^{548}\) *Mental Health (Forensic Provisions) Act 1990* (NSW) s 39(1).

\(^{549}\) *Mental Health (Forensic Provisions) Act 1990* (NSW) s 39(2).

\(^{550}\) *Mental Health (Forensic Provisions) Act 1990* (NSW) s 43.
regulated. The Council sought views on whether any of these approaches should be adopted in South Australia.

3.157 In the event that a decision was made to retain limiting terms, the Council sought views on the best way to set the length of the term. In particular, the Council queried whether it was appropriate to do so by reference to the term of imprisonment that would have been imposed in the circumstances, or whether some other formulation (such as by reference to the maximum penalty for the offence) would be preferable.

3.158 In addition, the Council noted that under sections 10A to C of the Criminal Law (Sentencing Act) 1988 (SA), sentencing reductions are made available where the defendant pleads guilty to an offence. However, it has been held that no similar reduction should be made available to a defendant who pleads not guilty by reason of mental incompetence, but admits the objective elements of the offence (thereby avoiding the need for the prosecution to raise evidence proving those elements beyond reasonable doubt). In R v Draoui Vanstone J said:

The reference in s 269O(2) to ‘the period of imprisonment ... that would ... have been appropriate if the defendant had been convicted of the offence ...’ must be taken to attract the factors enumerated in s10 Criminal Law (Sentencing) Act 1988, so far as they ‘are relevant and known to the court’: s 10(1) Sentencing Act. For the reasons which follow I consider that the factor found in s 10(1)(g) – the fact of a plea of guilty – cannot be relevant to the task contemplated by s 269O(2) CLCA.

In my opinion the words ‘... a term ... equivalent to the period of imprisonment ... that would ... have been appropriate if the defendant had been convicted ...’ in s 269O(2) cannot accommodate the reduction in sentence which would have been given to a defendant who had pleaded guilty. What the section requires is an exercise or calculation which is hypothetical. It is hypothetical first, because in determining what sentence would otherwise have been imposed no account is to be taken of the defendant’s mental impairment and second, because it is based on the premise that the defendant had been found guilty of the offence. He has not been. Under the legislative framework he has either been found mentally incompetent and therefore not guilty, or mentally unfit to stand trial.

It would be contrary to the thrust of the legislation to assume those two false premises as required, but then have regard to the way the trial of the objective elements was conducted and use that conduct to reduce the figure otherwise reached. I say that because to do so would be to go behind one of the false premises which the judge is required to act upon and to build into it an antecedent step.

3.159 The Council sought views on whether this was an appropriate position, or whether in setting the length of the limiting term, the court should be allowed to take into account a concession by the defence that the objective facts have been admitted.

3.160 The Council therefore asked the following questions:

Question 15: The following options are suggested for consideration:

a) Should any of the procedures in the interstate models discussed above be adopted in South Australia?

b) If the court is to retain the power of fixing a limiting term should it be fixed in a way other than by reference ‘to the term of imprisonment that would have been imposed’ had the accused been convicted of an offence and sentenced in the usual way?

c) If the court is to retain the power of fixing a limiting term should the court be allowed to take into account a concession by the defence that the objective facts are admitted?

Approaches Taken in Other Reviews

3.161 The NSWLRC canvassed the issue of limiting terms in some detail. They summarised the arguments for and against limiting terms in the following way:\textsuperscript{552}

7.45 Arguments in favour of a time limit:

1) The absence of a time limit may mean that a person who is … NGMI is detained or subjected to restrictions for longer than if he or she were convicted of the relevant offence at an ordinary trial.

2) Indeterminate orders deter people with cognitive and mental health impairments from relying on the defence of mental illness… even though this option is open to them, may be the most appropriate course of action, and may be in the interests of community safety.

3) Indeterminate orders may affect a forensic patient’s self esteem, confidence and hope for the future.

7.46 Arguments against imposing a time limit:

1) Time-limited orders lead to the result in some cases that the person must be released, unconditionally, at the end of the time limit in circumstances where he or she is at risk of causing harm to the public. However, many cases may be appropriate for management within the civil mental health system or through the guardianship system…

2) The forensic system has quite different objectives to sentencing, it focuses on treatment and safety, has support arrangements, and a person can be released at any point provided he or she no longer presents a risk of harm to the public (taking into account individual patient needs and other factors such as diagnosis, responsiveness to treatment and rehabilitation). Release should be determined by these factors, not a time limit set at the point the person enters the forensic system.

3) The length of the time limit is set at the time of disposition, when the progress of the defendant’s treatment and rehabilitation is hard to predict.

4) The imposition of a time limit, which is generally set by reference to a hypothetical sentence, may create the expectation that the time limit is a sentence.

3.162 After carefully weighing these arguments, and the numerous submissions that were made both in support of and against limiting terms, the Commission concluded that limiting terms should be introduced in New South Wales. They stated:

On balance, we are of the view that a time limit should apply to people who are … NGMI. A time limit provides an important protection for forensic patients. It can help ensure fairness, so that forensic patients are not detained or managed within the forensic system for longer than they would have been following conviction. In particular, we were told repeatedly by stakeholders that indeterminate outcomes deter people from raising NGMI. This is likely to result in people being dealt with through the correctional system who should more appropriately be in the forensic system.553

The NSWLRC considered a number of different ways in which the limiting term could be set, including by reference to the hypothetical sentence that would have been imposed had the person been convicted in the ordinary way, using a fixed statutory formula, or adopting a risk management approach focusing on matters such as the defendant’s prospects for rehabilitation and future risk.554 It concluded that the ‘least arbitrary’ approach was the one which requires the court to estimate the sentence that would apply had the defendant been held criminally responsible at a normal trial.555

While this kind of hypothetical sentencing exercise is currently undertaken in South Australia, the NSWLRC’s final recommendation varied from the South Australian approach in two ways:

- It recommended that the defendant’s cognitive or mental health impairment be taken into account in determining the appropriate sentence. This could act to mitigate or lengthen the sentence, depending on the circumstances;556

- The court should be required to take into account that, due to the nature of the proceedings, it may not be possible to demonstrate particular mitigating or discounting factors, such as a guilty plea or an expression of remorse. The court should be given a broad discretion to discount the sentence (and thus the limiting term), to make it fair in comparison to those who are convicted at normal trial.557

The NSWLRC recommended that a limiting term should only be set where a sentence of imprisonment would have been imposed if the defendant was found guilty at a normal trial. In other cases, the defendant should become a forensic patient, under the supervision of the MHRT(NSW), for a period of two years (unless unconditionally released earlier by order of the Tribunal).558

The LRCWA also recommended the use of limiting terms, which should be determined by reference to the term of imprisonment the court would have imposed had the defendant been found guilty of the offence.559 They agreed that in determining the length of the limiting term, the court should take into account the effects of the defendant’s mental impairment. In making this recommendation, the Commission noted that:

553 Ibid 7.86.
554 Ibid 7.59-7.81.
555 Ibid 7.90.
556 Ibid 7.91.
557 Ibid 7.91.
558 Ibid Recommendation 7.4.
559 Law Reform Commission of Western Australia, *Review of the Law of Homicide* (Law Reform Commission of Western Australia, 2007) 244.
the South Australian legislation precludes the accused’s mental impairment from being taken into account by the court in nominating a limiting term. However, given that the court must consider aspects of the accused’s mental impairment, including potential dangerousness, when determining whether or not to impose a custody order, the Commission does not believe that it is appropriate for the court to artificially exclude these considerations when setting the limiting term. The court should, however, be required to set the limiting term with the relevant sentencing principles and precedent in mind. While the continuing dangerousness of the accused and the protection of society is an important consideration, it should be remembered that, if at the expiry of a limited term the mentally impaired accused remains dangerous or is assessed as a threat to himself or the community, that person can be managed under the *Mental Health Act 1996* (WA) as an involuntary patient.  

3.167 By contrast, the Victorian Law Reform Commission recently recommended that supervision orders should continue to be for an indefinite term. However, the VLRC made recommendations which sought to ensure that ‘the decision-making framework in place once an order is made is rigorous and ensures that the period a person is supervised closely reflects the minimum period necessary to address the person’s risk to the community’.  

3.168 The VLRC recommended replacing the nominal term system with a system involving progress reviews every five years. They recommended that the progress reviews apply to both custodial supervision orders and non-custodial supervision orders. In relation to variation and revocation of supervision orders, the VLRC recommended that the Act be amended to ‘introduce the following presumptions to apply at progress reviews of supervision orders:

- the court must not vary a custodial supervision order to a non-custodial supervision order before the first progress review unless satisfied on the evidence available that the person would not pose an unacceptable risk of causing physical or psychological harm to another person or other people generally as a result of the variation

- at the second progress review of a custodial supervision order and progress reviews thereafter, the court must vary the custodial supervision order to a non-custodial supervision order unless satisfied on the evidence available that the person would pose an unacceptable risk of causing physical or psychological harm to another person or other people generally as a result of the variation, and

- at the second progress review of a non-custodial supervision order and progress reviews thereafter, the court must revoke the non-custodial supervision order unless satisfied on the evidence available that the person would pose an unacceptable risk of causing physical or psychological harm to another person or other people generally as a result of the revocation of the order.’  

3.169 The VLRC further recommended that at a progress review, a custodial supervision order should not be varied to a non-custodial supervision order except if the person

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560 Ibid (footnotes omitted).
562 Ibid [10.113].
563 Ibid [10.149], [10.154]-[10.155], Recommendation 84.
564 Ibid [10.155].
565 Ibid Recommendation 85.
has completed a period of at least 12 months extended leave. In addition, the VLRC recommended that the current three year restriction on applying for a variation of a custodial supervision order be lifted.

Submissions

3.170 The Council received 12 submissions addressing the issue of limiting terms. Of these, four opposed the continued use of limiting terms and eight supported their retention.

Submissions Opposing the Continued Use of Limiting Terms

3.171 Many of the arguments against the use of limiting terms were succinctly summarised in the submission of the Law Society, which stated: ‘A limiting term is variable, arbitrary, and not related to the core issue concerned with a person’s treatment of their behaviour, conduct, mental illness and risk of re-offending.’ The Law Society recommended thoroughly considering the options available in other jurisdictions, with an eye to national harmonisation.

3.172 Similar concerns motivated the opposition to limiting terms expressed by academics from Adelaide Law School, Gawler Legal and Mr Walvisch. They each argued that the amount of time the defendant spends in custody should be determined by the defendant’s treatment needs and the protection of the community, rather than the nature of the offence committed. While acknowledging that this could create the possibility of lengthy or indefinite supervision or detention, they thought this could be appropriately managed through a regular review process. For example, Mr Walvisch suggested an annual review to determine whether or not the defendant continues to pose a danger to the community, and thus whether or not the supervision order should be maintained or varied:

The review process should incorporate a presumption in favour of reducing the level of supervision, unless there is evidence that members of the public will be seriously endangered as a result of reducing the supervision status of the person. Such a presumption strikes an appropriate balance between achieving the purpose of supervision (protection of the community) and ensuring that a person’s liberty is not deprived for any longer than absolutely necessary. The likelihood of the person endangering themselves should not be a relevant factor in this determination.

3.173 Another argument presented against the current system is that by maintaining a link between the limiting term and the hypothetical sentence, it implicitly suggests that the defendant bears some responsibility for the offence, thereby partially undermining the purpose of the qualified acquittal:

For example, the fact that a person who is found not guilty of murder by reason of mental incompetence is subject to a longer limiting term than a person found not guilty of rape by reason of mental incompetence, suggests that the former person is

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566 Ibid [10.175], Recommendation 86.
567 Ibid [10.316], Recommendation 97.
568 Law Society of South Australia, Submission to the Sentencing Advisory Council.
569 Kellie Toole, et al., Submission to the Sentencing Advisory Council; Gawler Legal, Submission to the Sentencing Advisory Council; Jamie Walvisch, Submission to the Sentencing Advisory Council.
570 Jamie Walvisch, Submission to the Sentencing Advisory Council.
more culpable than the latter. Whilst this may be the popular perception of the issue (with the public perhaps thinking that a person receiving a qualified acquittal for murder should serve a longer time under supervision), it is not the purpose of the order. The length of supervision should solely be related to the question of whether or not the person continues to pose a risk to the community.\footnote{Ibid. The submission of the OPA also acknowledged this problem, but argued that the solution rests ‘in having an effective method of overseeing key decisions such as hospital discharge during the limiting term’: Office of the Public Advocate, Submission to the Sentencing Advisory Council.}

**Submissions in Favour of Retaining Limiting Terms**

3.174 Eight submissions favoured the retention of the limiting term system. While for some this appeared to be due to the lack of a better alternative, for others the current system was seen to be appropriate and functioning well. For example, the DPP stated:

The current approach is well understood by the Courts and it provides a procedure which is flexible enough to provide a suitable period of supervision if the licensee’s illness is slower to resolve than at first thought. If, on the other hand, a person becomes well sooner than anticipated it provides a mechanism for revoking the order.\footnote{Director of Public Prosecutions, Submission to the Sentencing Advisory Council.}

3.175 A system of limiting terms was seen to be preferable to a system which allowed for the possibility of indefinite detention.\footnote{See, eg, Office of the Commissioner for Equal Opportunity, Submission to the Sentencing Advisory Council; Office of the Public Advocate, Submission to the Sentencing Advisory Council.} It was argued that a system which allows for a longer period of supervision than the defendant would have received had he or she been found guilty ‘unfairly discriminates against defendants found not guilty by reason of mental incompetence’.\footnote{Legal Services Commission of South Australia, Submission to the Sentencing Advisory Council. See also Office of the Public Advocate, Submission to the Sentencing Advisory Council.} It was also seen to be likely to deter people from pursuing the defence, with the consequence being ‘that they may well not receive treatment that is appropriate and necessary and thus pose an increased risk to the community’.\footnote{Director of Public Prosecutions, Submission to the Sentencing Advisory Council. See also Office of the Public Advocate, Submission to the Sentencing Advisory Council.}

3.176 One potential problem with the limiting term system is that a defendant may still require supervision at the end of the limiting term, and could pose a danger to the community if simply released. This was not, however, seen to require the system to be overhauled. Instead, it was suggested that this problem should be addressed by the treating team seeking orders under the Mental Health Act 2009 and the Guardianship and Administration Act 1993.\footnote{Office of the Public Advocate, Submission to the Sentencing Advisory Council.}

**Submissions Regarding the Length of Limiting Terms**

3.177 It was widely acknowledged that the current system for determining the length of the limiting term was ‘problematic’,\footnote{Ibid.} especially given that an ordinary sentence ‘must have regard to principles of punishment and specific and general deterrence which [are not] appropriate to have regard to for the mentally incompetent
defendant’. This point was made in the submission from Gawler Legal, which argued that setting the limiting term by reference to the term of imprisonment which would otherwise be imposed ignores a number of factors:

- It ignores the fact that imprisonment is imposed taking into account inter alia, remorse demonstrated by an accused, prospects for rehabilitation, personal and general deterrence and public protection.

- An accused suffering mental incompetence will frequently not show any remorse because he/she believes he/she has done nothing wrong. The prospects for rehabilitation will be dependent upon the mental incapacity and the illness causing the incapacity being properly diagnosed and treated. In the absence of diagnosis and treatment, the personal deterrence and general deterrence will be zero and the accused will most likely re-offend upon his release back into the community.

3.178 It was suggested that the judge’s task in such circumstances is ‘absurd’, for it requires him or her to determine the defendant’s ‘blameworthiness’ for an offence for which he or she has not been convicted, and for which he or she is not considered to be culpable.

3.179 Despite such criticisms, most submissions on the issue accepted that it was the best available option. For example, the Bar Association argued that it was ‘the least worst of the options available. The danger of other tests is that a person risks being detained longer than the equivalent prison sentence under normal conditions. That is undesirable.’ The LSC saw it to be ‘the fairest and most objective rule-of-thumb for setting reasonably equivalent periods of time during which a person under supervision is to remain accountable’.

3.180 The only alternative mechanism that was proposed (other than replacing limiting terms with indefinite sentencing, as discussed above) was to introduce ‘fixed limiting terms of whatever the non-parole period for that offence would be. For offences without parole opportunities the limiting term could be half the maximum term of imprisonment provided for the offence’.

Submissions Regarding Concessions by the Defence about the Objective Facts

3.181 One of the questions asked in the Discussion Paper was whether, if the court is to retain the power of fixing a limiting term, it should be allowed to take into account a concession by the defence that the objective facts are admitted. Of the six submissions that addressed this issue, four supported taking the concession into account, one opposed it, and one was equivocal.

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578 Law Society of South Australia, Submission to the Sentencing Advisory Council.
579 Gawler Legal, Submission to the Sentencing Advisory Council.
580 Jamie Walvisch, Submission to the Sentencing Advisory Council.
581 South Australian Bar Association, Submission to the Sentencing Advisory Council.
582 Legal Services Commission of South Australia, Submission to the Sentencing Advisory Council.
583 Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.
The main concern of those in favour of taking the concession into account was that the defendant not be disadvantaged on the basis of his or her mental impairment.\textsuperscript{584} For example, the submission of the Law Society stated:

The Society notes that the purported purpose of the early guilty plea legislation is to reduce a backlog in criminal cases reaching trial and to encourage offenders who are minded to plead guilty to do so in a timely fashion. In the circumstances, the Society supports an amendment that would allow the Court to take into account a concession by the defence that the objective facts are admitted. A defendant should not be disadvantaged on the basis of their mental impairment despite the reasoning in Draoui.\textsuperscript{585}

The Law Society also recommended that credit should be given on the basis of the defendant’s conduct whilst participating in the proceedings, especially if he or she is subject to bail conditions:

If a person adheres to bail conditions for a substantial period of time, that is tantamount to a bond or a licence. The time on which a person has adhered to such bail conditions, especially as to treatment and good behaviour should be reflected and credited in full in any ultimate sanction when having been found not guilty by reason of mental impairment.\textsuperscript{586}

The sole objector to the proposal that the concession be taken into account was the DPP, who argued that:

There is no place for making an allowance for taking into account a concession by defence that the objective facts are admitted. Mental impairment defences mean that there is no guilty state of mind. Concepts such as remorse and contrition are then irrelevant. While this means that the limiting term is equivalent to a sentence where these concepts were not present and thus a longer term, the legislation provides for the limiting term to be revoked at any point if the Court is satisfied that it is appropriate to do so. This trade off works to the benefit of a person subject to a supervision order, while at the same time protecting the community in circumstances where the detainee remains unwell.\textsuperscript{587}

Conclusions and Recommendations

The Council is of the view that the limiting term system should be retained. It is concerned that a system of indefinite detention may improperly deter people with relevant mental impairments from relying on the defence of mental incompetence, even though it may be appropriate in the circumstances. It also does not believe it is just to allow a person to be detained by the criminal justice system for a longer period than he or she would have been if convicted of the relevant offence. If an individual continues to pose a danger at the end of a limiting term, it is appropriate to use the civil mental health system to determine whether his or her continued to detention is required.

The Council acknowledges that the current system, whereby the length of the limiting term is set by reference to the sentence that would have been imposed had

\textsuperscript{584} See, eg, Office of the Public Advocate, Submission to the Sentencing Advisory Council; South Australian Bar Association, Submission to the Sentencing Advisory Council.

\textsuperscript{585} Law Society of South Australia, Submission to the Sentencing Advisory Council.

\textsuperscript{586} Ibid.

\textsuperscript{587} Director of Public Prosecutions, Submission to the Sentencing Advisory Council.
the defendant been convicted of the offence charged, is not perfect. However, it agrees with the Bar Association that it is ‘the least worst of the options available’. In the Council’s opinion, none of the interstate models offer a superior procedure for fixing a limiting term.

3.187 The Council accepts that a judge will face inevitable difficulties in engaging in a hypothetical sentencing exercise in relation to an individual who has not been convicted of an offence, and who may not have been culpable for his or her actions. However, it sees merit in a system which allows the judge to comment on the nature of the offence, and the impact it had on the victim, their family and the community. By making the length of the limiting term equivalent to the term of imprisonment that would have been imposed, the court clearly denounces the crime, sending a message to the community that the conduct was unacceptable, even though the defendant should not be held criminally responsible for his or her actions.

3.188 There was division amongst Council members about whether the court should be allowed to take into account a concession by the defence about the objective facts. A strong minority recommended adopting such an approach, on the basis that to do otherwise unfairly discriminates against people with mental impairments. However, the majority recommended retaining the status quo, agreeing with the DPP that the current approach is sufficiently flexible to achieve its intended purposes. In the Council’s view it would be undesirable to reduce this flexibility by specifying additional matters the court must take into account in setting a limiting term.

Recommendation 15

(a) The limiting term system should be retained.

(b) The court should continue to fix the limiting term by reference to the term of imprisonment that would have been imposed had the defendant been convicted of the offence and sentenced in the usual way.

(c) The court should not be allowed to take into account the fact that the objective facts have been admitted when fixing a limiting term.
4. Supervision of Individuals Released on Licence
4.1 In Part 3 of the Report it was noted that where a defendant is found ‘not guilty by reason of mental incompetence’, he or she becomes subject to special powers of the court. These powers allow the court to release the defendant unconditionally, or to make a ‘supervision order’ committing the defendant to detention or releasing him or her on licence. In this context, the purpose of supervision is the protection of the community, not the punishment of the defendant.

4.2 This Part of the Report examines the supervision of individuals released on licence. It is divided into the following sections:

- Overview of current South Australian procedures;
- Issues concerning community safety;
- The need for reports from victims and interested parties;
- The desirability of nominating a lead agency to be responsible for the supervision of licensees;
- Extending supervisory responsibilities to the Minister for Disabilities;
- Housing options for people with cognitive impairments;
- Breaches of licence conditions;
- Cross-border issues;
- Forensic mental health facilities in South Australia; and
- Options for a Mental Health Review Tribunal or Board in South Australia.

Current Procedures

4.3 The legal regime governing the supervision of individuals released on licence following a successful defence of mental incompetence is set out in Division 4 of Part 8A of the Criminal Law Consolidation Act 1935 (SA) (CLCA). This section sets out those procedures. Throughout this Part of the Report, all section numbers refer to the CLCA unless otherwise stated.

4.4 As discussed in Part 3, section 269O provides three dispositional options for a defendant who is found not guilty by reason of mental incompetence. A judge may:

- Release the defendant unconditionally;
- Make a supervision order committing the defendant to detention; or
- Make a supervision order releasing the defendant on licence on specific conditions.

588 Criminal Law Consolidation Act 1935 (SA) s 269O(1).
4.5 The Case File Review undertaken by the Attorney-General’s Department\textsuperscript{589} found that, upon a finding of not guilty by reason of mental incompetence, 64 percent of individuals were released on licence, 32 percent were detained, and 2 percent were released unconditionally.

4.6 If the court makes a supervision order, it must fix a limiting term equivalent to the period of imprisonment or supervision that would, in the court’s opinion, have been appropriate if the defendant had been convicted of the offence. The supervision order automatically lapses at the end of the limiting term (s 269O). Limiting terms are discussed in detail in Part 3 of the Report.

4.7 At any time during the limiting term, the defendant, the Crown, the Parole Board, the Public Advocate or any other person with a proper interest\textsuperscript{590} may apply to the court to vary or revoke the supervision order (s 269P(1)). The applicant may seek to reduce the supervisory requirements (for example, ordering that the defendant be released from detention and placed on a conditional licence) or increase them (for example, ordering that a conditional licence be revoked and the defendant returned to detention).

4.8 If the defendant applies to have his or her supervision order varied or revoked, and the court refuses the application, he or she cannot reapply for at least six months (unless the court directs otherwise) (s 269P(2)).

4.9 The court cannot release the defendant, or significantly reduce the degree of supervision to which he or she is subject, unless it has considered at least three expert reports (or at least one report if the offence is summary),\textsuperscript{591} a recent report on the defendant’s mental condition provided by the Minister for Mental Health and Substance Abuse (\textit{Minister for Health}), and a report on the attitudes of victims and next of kin (s 269T(2)).

\textbf{Relevant Factors for the Court’s Determination}

4.10 In determining proceedings in relation to a defendant found not guilty by reason of mental incompetence, the court must have regard to the following matters (s 269T(1)):

- The nature of the defendant’s mental impairment;
- Whether the defendant is, or would if released, be likely to endanger another person, or other persons generally;
- Whether there are adequate resources available for the treatment and support of the defendant in the community;
- Whether the defendant is likely to comply with the conditions of the licence; and
- Other matters the court thinks relevant.

\textsuperscript{589} See Appendix B.

\textsuperscript{590} In \textit{R v Steele (No 2)} [2012] SASC 162 Gray J allowed the victim to be represented by Counsel on the basis that they were an ‘interested party’; see also, \textit{R v Bowen} [2014] SASC 81 where the victim and next of kin were represented by Counsel.

\textsuperscript{591} The issue of expert reports is considered in detail in Part 3 of the Report.
In deciding whether to commit a defendant to detention or to release a defendant on licence, as well as the conditions of the licence, the court must apply the principle that the restrictions on the defendant’s freedom of personal autonomy should be kept to the minimum consistent with the safety of the community (s 269S).

The principle contained in section 269S has been described as the ‘cornerstone to the operation of the statutory scheme’. In *R v Ridings* Justice White stated that the section intends that:

the court should have regard, as a fundamental matter, to the safety of the community but otherwise should ensure that restrictions on the defendant’s freedom and personal autonomy are kept to the minimum consistent with that safety. Continuing a person in custody for the purposes of retribution or punishment is not an appropriate consideration when determining an application for the variation of a supervision order.592

**Community Safety**

In the recent case of *R v Wagner*, Justice Kelly noted (with some concern) that community safety is not the dominant consideration for the court to take into account in determining an appropriate disposition – it is simply one factor amongst many. She stated:

The legislative scheme set out in Part 8A of the Act is in marked contrast to the provisions in Division 3 of the *Criminal Law (Sentencing) Act 1988* (SA) (“the Sentencing Act”) concerning applications for release on licence by recidivist sexual offenders. Section 24(1b) of the *Sentencing Act* provides that the community’s safety is the paramount consideration for the Court in determining applications. The emphasis in the Part 8A scheme is on rehabilitation of the applicant and the fundamental consideration for the Court in determining the application is that interference with the applicant’s freedom and personal autonomy is to be kept at a minimum consistent only with the safety of the community.593

In the later case of *R v Bowen*594 Justice Vanstone commented on Justice Kelly’s statement, noting that while community safety is not the paramount consideration in determining an appropriate disposition, it can nevertheless be a critical consideration for the court. Consequently, if the judge is of the view that community safety will be threatened by the proposed course of action, he or she can refuse to grant the order sought (as Justice Vanstone did in *Bowen*).

**Conclusions and Recommendations**

This issue was not addressed in the Discussion Paper, but was considered by the Council after the decisions in *Wagner* and *Bowen* were handed down. In particular, the Council considered whether South Australia should enact a model similar to that which currently exists in NSW, whereby neither the court nor the Mental Health Review Tribunal (MHRT(NSW)) can order the release of a forensic patient unless they are satisfied, on the balance of probabilities, that the safety of the patient, or

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any member of the public, will not be seriously endangered by the patient's release.  

4.16 In the Council’s view, such an approach is appropriate. While the current law is likely to achieve the same outcome (as judges are unlikely to make a disposition that will threaten public safety), it would be beneficial to make the position clear by enacting a provision that explicitly addresses the issue. This will help to ensure that the community is kept safe, as well as helping to alleviate public concerns about this matter.

4.17 While it would be possible to address this issue by providing that community safety should be the ‘paramount consideration’ of those listed in section 269T, the Council believes it is clearer and simpler to enact a stand-alone provision such as that which exists in NSW. Such a test also has the advantage of explicitly setting out the burden of proof which must be met before a defendant can be released from custody.

Recommendation 16
The Criminal Law Consolidation Act 1935 should be amended by adopting a provision similar to section 39(2) of the Mental Health (Forensic Provisions) Act 1990 (NSW), which ensures that a defendant will not be released from custody unless, on the balance of probabilities, the safety of that person or any member of the public will not be seriously endangered by the person’s release.

Victims and Interested Parties

4.18 As noted above, at present the court cannot release the defendant, or significantly reduce the degree of supervision to which he or she is subject, unless it has a report on the attitudes of victims and next of kin (s 269T(2)). In addition, the court needs to be satisfied that the victims and next of kin have been given reasonable notice of the proceedings (s 269T(3)).

4.19 To assist with this process, section 269R provides that the Office of the Director of Public Prosecutions (ODPP) must provide the court with a report setting out, so far as reasonably ascertainable, the views of (a) the defendant’s next of kin; (b) the victim (if any) of the defendant's conduct; and (c) if a victim was killed as a result of the defendant's conduct, the next of kin of the victim.  

4.20 In the Discussion Paper it was noted that involvement in Part 8A proceedings can be stressful for victims, particularly when information about victim/next of kin attitudes is required each time changes to a defendant’s supervision order are requested. The Council invited comment on whether judges and magistrates should have a discretion in requiring these reports, asking the following questions:


596 Such a report is not required if the purpose of the proceeding is to increase the level of the defendant’s supervision, or vary the licence conditions in minor respects: s 269R(2).
Question 16: Should Judges and Magistrates have a discretion in requiring Victim/Next of Kin reports at all stages of the Part 8A proceedings? If so, what factors should guide the exercise of that discretion?

Approaches Taken in Other Australian Jurisdictions

4.21 Tasmania is the only other jurisdiction that requires the production of victim and next of kin reports. Under section 33 of the Criminal Justice (Mental Impairment) Act 1999 (Tas), the Attorney-General must provide the court with a report in substantively the same terms (and circumstances) as is required in South Australia.

4.22 In Victoria, the Director of Public Prosecutions is generally required to notify victims and family members of the defendant about any court hearings that are going to take place, and provide them with certain information about the hearing. This includes reviews of the terms of the defendant’s supervision order, hearings to determine whether the order should be varied or revoked, and applications for extended leave. Victims and family members are then free to make a report to the court, which must be taken into account.

4.23 However, in Victoria victims and family members can notify the Director that they do not wish to receive any notification of court hearings, in which case they must not be notified. The court may also order (on application by the Director, the Attorney-General or the Secretary of the Departments of Health or Human Services) that notice need not be given, if it is satisfied that giving such notice would be detrimental to the individuals’ mental or physical health.

4.24 In Queensland, the Mental Health Court and the Mental Health Review Tribunal (MHRT(Qld)) may take into account material submitted by the victim or any other concerned person when making their decisions. However, neither the victim nor any other concerned person are generally required to submit material to the Court or Tribunal. The one exception is where the Court or Tribunal is considering making a non-contact order preventing the defendant from contacting them. In such circumstances, the Court or Tribunal must consider the views of the affected people, and so must receive evidence about those views.

4.25 In the Northern Territory, the court must consider any reports made to it by the victim or the next of kin of the victim or defendant. Specific provision is made for the victim or the victim’s next of kin to make a report about the defendant’s conduct, the impact it had on him or her, and the likely impact of the proposed variation to the supervision order. Making such a report is discretionary. The court can, however, request a report setting out the views of the defendant’s next of kin, if it considers it will assist in making its determination. In Western Australia,
the Mentally Impaired Accused Review Board (MIARB) must also take into account any statement received from the victim in determining whether to recommend the defendant’s release to the Governor.\textsuperscript{606} However, there is no obligation to obtain such a statement.

4.26 The \textit{Mental Health (Forensic Provisions) Act 1990} (NSW) addresses the issue of contact between defendants and victims, providing that victims may apply for an order imposing or varying a non-association or place-restriction condition on a supervision order.\textsuperscript{607} However, this is the only role given to victims in the Act (other than providing them with a right to appeal certain decisions). Victims also play a limited role in the ACT and Commonwealth legislation. While the courts in these jurisdictions can receive victim impact statements when setting limiting terms,\textsuperscript{608} there is no explicit mention of victims in the context of varying or revoking supervision orders.

4.27 Although the legislation in these jurisdictions does not explicitly provide for the involvement of victims, it is likely that they are catered for to some extent. For example, in New South Wales the MHRT(NSW), in conjunction with the Statewide Forensic Mental Health Directorate, has released a Forensic Procedural Note which deals with the role of victims in MHRT(NSW) proceedings. It provides that:

Victims may subscribe to a ‘victim register’, and elect to be notified about any or all of: upcoming hearings; the making of a decision by the MHRT; or that the forensic patient has absconded. Registered victims may also provide a written statement to the MHRT to be included in the papers to be considered at the forensic patient’s hearing. The statement should address the ‘care, treatment, detention and release’ of the forensic patient, and any relevant information about the risk of serious danger to individuals or the community if the forensic patient was to be released. Additionally, victims may attend the hearing by telephone, videolink or in person, if they choose to do so. Victims, however, are not entitled to be legally represented before the MHRT and do not have the right to cross-examine witnesses or obtain access to relevant documents.

In practice, it appears that the MHRT will advise the victim if the forensic patient is seeking release or a leave of absence at an upcoming hearing, given that these are usually the hearings with which victims are most concerned and where they may wish to attend or participate.\textsuperscript{609}

Approaches Taken in Other Reviews

4.28 The Victorian Law Reform Commission (VLRC) decided in their recent report, \textit{Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997}, that

\textsuperscript{606} \textit{Criminal Law (Mentally Impaired Accused) Act 1996} (WA) s 33.
\textsuperscript{607} \textit{Mental Health (Forensic Provisions) Act 1990} (NSW) s 76.
\textsuperscript{608} As noted in Part 3, limiting terms in these jurisdictions are set by reference to general sentencing principles, which include considering the impact the offence had on the victim.
the victim notification procedure should continue, but that it should be modified to provide for greater flexibility.\textsuperscript{610}

4.29 The New South Wales Law Reform Commission (NSWLRC) considered the issue of victim reports in its Report on \textit{People with Cognitive and Mental Health Impairments in the Criminal Justice System}.\textsuperscript{611} It noted that the victim’s perspective is particularly relevant to issues of leave and release, as they may have legitimate concerns about their safety or the safety of family members. They stated that it was important that these perspectives be taken into account when making decisions about leave and release.

4.30 However, they noted that the MHRT(NSW) has ‘reported situations in which victim participation [in hearings] may result in revictimisation, impact upon the privacy of rights of forensic patients, and may in some circumstances be detrimental to the forensic patient’s recovery. The MHRT also noted inappropriate behaviour in hearings on the part of some victims.’\textsuperscript{612} Consequently, the Commission was of the view that the issue was most appropriately dealt with by the MHRT(NSW) on a case by case basis, without the need for any specific legislative guidance.

4.31 By contrast, the New Zealand Law Commission (NZLC) favoured a very limited role for victims in leave and release decisions. They stated:

\begin{quote}
This is a controversial and difficult area. We acknowledge the view that allowing victims to speak in such a forum, on their own terms, can be cathartic for them, and an important part of the restorative process. But in terms of the legislation, the primary considerations that the decision-maker should be concerned with are community safety and treatment. In many cases, perhaps the vast majority of cases, victims are unlikely to be in a position to comment on either of those matters. Allowing them free rein in their submissions may create unreasonable expectations and something of a misleading impression, because the decision-maker must then either disregard or fail to place a great deal of weight on a submission that is heartfelt on the part of the victim, but not relevant from the narrowly-focused statutory perspective...
\end{quote}

Almost everyone we spoke to had concerns about whether victims should be involved at all in mental health decision-making... They noted that, unlike parole, decisions in this context are not the end point of a punitive process; and the Tribunal is dealing with people not responsible for their actions.\textsuperscript{613}

4.32 The NZLC agreed with these concerns. Consequently, they recommended retaining the status quo in New Zealand, whereby the only formal role victims have is a right to be kept informed of the progress of proceedings.\textsuperscript{614}

\begin{footnotes}
\item[611] Ibid [8.109]-[8.149].
\item[612] Ibid [8.147].
\item[614] Ibid Recommendation 35.
\end{footnotes}
Submissions

4.33 The Council received 11 submissions addressing the issue of victim and next of kin reports. All of these submissions supported reforming the law in this area in some way.

4.34 It was generally accepted that victims’ views were relevant and should be considered by the court when dealing with applications for release or changes of licence conditions. For example, the Director of Public Prosecutions (DPP) said:

   In my view given the proximity of the applications for release on licence etc to the index offence, the victim’s views remain extremely important. Even minor changes to conditions of licence may impact on victims in ways unknown to the Court. For example a change of residence may place the defendant close to a victim’s place of work, church, usual shopping centre.

4.35 However, there was also general agreement that the current system does not meet the needs of victims, next of kin (NOK) or defendants. Requiring reports each time changes to a supervision order are requested was seen to be repetitive and unnecessary. It was seen to be particularly undesirable for property offences, where the victims frequently do not wish to be consulted.

4.36 In relation to violent offences, there was a concern that requiring such reports ‘every time an order goes before the Court may be overly traumatic for the victim/NOK without the opinion or options available to the victim/NOK changing’. This process was seen to have ‘the potential for re-traumatising victims (the potential for which should be minimised)’.

4.37 In addition, it was noted that under the current system, there are frequently 3 month delays in the preparation of the necessary reports. This can have a detrimental impact on defendants, who have to remain in custody pending those reports.

4.38 A number of different proposals were put forward by the submitters. The Chief Magistrate suggested that:

   police could ask the victim at the time of investigating the matter, whether he/she wishes to be involved in the sentencing process and whether he/she wishes to be consulted should mental health issues arise. A Section 269R report would only be ordered then if an indication had been given that the victim wished to be consulted.

4.39 In a similar vein, the Office of the Chief Psychiatrist (OCPP) suggested that ‘[p]erhaps the best way forward would be for victims/NOK to nominate when, in

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615 Director of Public Prosecutions, Submission to the Sentencing Advisory Council.
616 See, eg, Office of the Public Advocate, Submission to the Sentencing Advisory Council; Australian Medical Association (South Australia), Submission to the Sentencing Advisory Council.
617 See, eg, Forensic Mental Health Service, Submission to the Sentencing Advisory Council.
618 Chief Magistrate Judge Elizabeth Bolton, Submission to the Sentencing Advisory Council.
619 Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.
620 Forensic Mental Health Service, Submission to the Sentencing Advisory Council.
621 Legal Services Commission of South Australia, Submission to the Sentencing Advisory Council.
622 Chief Magistrate Judge Elizabeth Bolton, Submission to the Sentencing Advisory Council.
the usual schedule of limiting term processes, they want to participate through reports’. 623

4.40 The DPP, the Legal Services Commission of South Australia (LSC) and the Commissioner for Victims’ Rights (CVR) each suggested the implementation of an opt-out scheme, according to which victims or next of kin could choose not to participate in the system. 624 For example, the submission of the CVR stated:

There should be no discretion on consulting victims and victims next-of-kin; rather the courts should be tasked to enquire whether the right to participate has been offered to victims and next-of-kin. This is often their ‘only day in court’, they should choose whether to be involved or not. Although the defendant might be mentally impaired, the effects are likely the same as had that perpetrator been mentally competent.

As Commissioner, my staff and I interview all registered and some non-registered victims (for example, immediate family members) regarding murderers’ applications for release on parole. It is exceptional for these people not to want input, even if that input is simply to say they will leave the decision in the hands of the Parole Board.

With the establishment of a Victim Register in Forensic Mental Health Services, it might in the future be possible to identify those victims who do not want to be kept informed and/or exercise their right to make a report to the court. 625

4.41 The Forensic Mental Health Service (FMHS) argued that ‘certain essential alterations in circumstances details (such as a change of residence) should automatically require victim notification and comment’. 626 However, in other circumstances the court should be provided with discretion over the reports required. In particular, they should be given the ability to avoid requiring excessive numbers of repetitive reports.

4.42 The LSC also recommended the court be provided with a limited discretion in relation to next of kin reports. They suggested that where the defendant ‘has no contact with, or support from, any existing next of kin, the court should have discretion not to require a Next of Kin report at any stage of Part 8A proceedings’. 627

4.43 By contrast, the Law Society of South Australia (Law Society), the Parole Board and the South Australian Bar Association (Bar Association) recommended that the court should be given general discretion over the reports that must be produced. 628 For example, the Bar Association argued that:

The purpose of Part 8A is not punishment but rehabilitation and the projection of the community. The views of the victims and the next of kin reports are important but

623 Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.
624 Director of Public Prosecutions, Submission to the Sentencing Advisory Council; Legal Services Commission of South Australia, Submission to the Sentencing Advisory Council; Commissioner for Victims’ Rights, Submission to the Sentencing Advisory Council.
625 Commissioner for Victims' Rights, Submission to the Sentencing Advisory Council.
626 Forensic Mental Health Service, Submission to the Sentencing Advisory Council.
627 Legal Services Commission of South Australia, Submission to the Sentencing Advisory Council.
628 Law Society of South Australia, Submission to the Sentencing Advisory Council; Parole Board of South Australia, Submission to the Sentencing Advisory Council; South Australian Bar Association, Submission to the Sentencing Advisory Council.
arguably play a different role from those reports in “normal” sentencing proceedings. The discretion should be broad and unfettered.\textsuperscript{629}

\section*{4.44} While the Office of the Public Advocate (OPA) also favoured judges and magistrates being given discretion in relation to reports, they were concerned that some victims and next of kin currently feel like their views are not being heard. Consequently, there has recently ‘been a trend for victims and next of kin to seek to be heard directly in court hearings to review supervision arrangements’.\textsuperscript{630} They suggested that this problem:

\begin{quote}
could be explored further with victims and next of kin. Should a victim support agency have a role in preparing these reports? Would this specialist victim support involvement reduce the stress of victims and next of kin, and increase a sense of being heard. Improved support to victims would also assist the experience of forensic patients returning to court as the environment might then be less adversarial.
\end{quote}

Ultimately we suggest a tribunal or specialist court, overseeing supervision would better be able to meet the needs of all parties.\textsuperscript{631}

\section*{Conclusions and Recommendations}

\section*{4.45} The Council believes that victims play an important role in this process, and is concerned to ensure their continued involvement. The Council would therefore not be supportive of any measures which may result in victims being deprived of the opportunity to express their views. It is the Council’s opinion that victims should always be consulted, and allowed to make their own decisions about whether or not to participate in the process.

\section*{4.46} To this end, it is the Council’s view that the current legislative approach should not be amended, and that the ODPP should retain the responsibility for providing the court with a report setting out, so far as is reasonably ascertainable, the views of the victim (if any) of the defendant's conduct, and the views of the next of kin of a deceased victim. The Council believes that such a process ensures that victims are given the opportunity to express their views on a matter which may be of significant concern to them.

\section*{4.47} The Council notes that, at present, it is possible for the ODPP to provide an oral report to the court about the victim’s views. This is generally done where the victim has indicated that he or she has no particular views about the matter, or does not wish to be consulted. It is the Council’s view that this is an appropriate way of proceeding. It ensures that the victim is consulted, but does not create onerous administrative burdens on the ODPP in cases where the victim does not wish to participate.

\section*{4.48} The Council is aware that in some circumstances the victim may have difficulty expressing his or her views (for example, due to an illness or a disability). In such circumstances, it is important to ensure that the victim be provided with the support necessary to ascertain his or her views. Where this is not possible, the court should be allowed to receive evidence from appropriate other people, such as the victim’s

\begin{flushleft}\textsuperscript{629} South Australian Bar Association, \textit{Submission to the Sentencing Advisory Council}.\textsuperscript{630} Office of the Public Advocate, \textit{Submission to the Sentencing Advisory Council}.\textsuperscript{631} Ibid.\end{flushleft}
family. People other than the direct victim should also be allowed to provide their views in other suitable circumstances.

4.49 The Council is concerned to note that, at present, there are only sufficient resources available to employ one person to prepare victim and next of kin reports. This is inadequate, and needs to be increased.

**Recommendation 17**

The requirements for the production of victim and next of kin reports contained in the *Criminal Law Consolidation Act 1935* should not be amended.

The ODPP should continue to be allowed to make oral reports in cases where the victim or next of kin does not wish to participate in the process.

In appropriate circumstances people other than the direct victim should be consulted when preparing victim and next of kin reports.

Additional resources should be allocated to the preparation of victim and next of kin reports.

**Nominating a Lead Agency**

4.50 Where the defendant is released on licence, supervisory responsibilities are divided between the Parole Board and the Minister for Health (s 269V(3)):

- The Minister for Health is responsible for matters relating to the treatment or monitoring of the licensee’s mental health. This is normally carried out by the FMHS;

- The Parole Board is responsible for all other aspects of the licensee’s supervision. This is normally carried out by the Department for Correctional Services (DCS).  \(^{632}\)

4.51 Where a licensee contravenes, or is likely to contravene, a condition of his or her licence, the ODPP may make an application to review the order (s 269U). The court must provide the ODPP and the licensee an opportunity to be heard on the matter, after which it may confirm the terms of the supervision order, amend the conditions of the licence, or revoke the licence and order the defendant’s detention.  \(^{633}\)

4.52 In the Discussion Paper, it was noted that in exercising its responsibility under this section, the ODPP receives instructions from both the FMHS and the DCS. In some cases these instructions will conflict. For example, if a licensee has used illicit drugs contrary to the conditions of the licence, the DCS may ask that breach proceedings be instituted and the defendant be returned to detention. However, upon consulting with the FMHS, the ODPP may find that the treating clinicians consider the person’s mental condition to be stable, and that they do not consider that there

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\(^{632}\) As at 30 September 2013, there were 201 offenders being supervised in the community by the DCS: Department for Correctional Services, *Submission to the Sentencing Advisory Council*.

\(^{633}\) The issue of breach of licence conditions is discussed in more detail below.
would be any benefit in instituting breach proceedings and admitting the defendant to James Nash House.

4.53 These diverging instructions can cause difficulty for the ODPP, which may be unsure whether or not it is appropriate to institute breach proceedings. If they do institute such proceedings, they will be required to put the conflicting views before the court, limiting their ability to provide the court with meaningful assistance about the best way to proceed.

4.54 One possible way to address this problem, as well as other problems that may arise due to the current division of supervisory responsibilities between agencies, would be for the court to nominate a ‘lead agency’ at the time licence conditions are set. This has been recommended by previous South Australian reviews of this issue.634 These reviews also recommended developing cross agency protocols, and implementing training aimed at improving collaboration between agencies.

4.55 Alternatively, instead of the court nominating a lead agency, it would be possible to implement a system whereby the supervisory agencies themselves nominated a lead agency to be primarily responsible for a particular licensee. That agency could be empowered to obtain a consensus on the agencies’ position prior to a court appearance.

4.56 The Council invited comment on whether a lead agency should be nominated, and if so whether it should be nominated by the court or by the agencies themselves. It asked the following question:

Question 17: Should the court or supervisory agencies nominate a lead agency to be primarily responsible for supervision of an individual licensee?

4.57 The Council also sought comment on whether the lead agency should be able to direct the ODPP to determine whether breach proceedings should be instituted. It asked the following question:

Question 18: If a lead agency is nominated to be primarily responsible should it instruct the ODPP to determine whether breach proceedings should be instituted?

Approaches Taken in Other Australian Jurisdictions

4.58 Victoria and Queensland are the only jurisdictions that differentiate between the different supervisory responsibilities of the relevant agencies. All other jurisdictions either have only one body that is responsible for an individual’s supervision (avoiding the need to address the issue of lead agencies), or do not specify how the responsibilities are to be shared between the agencies involved.

4.59 In Victoria, supervisory responsibility is shared between the Secretary to the Department of Health, and the Secretary to the Department of Human Services. The former is responsible for people who are held in custody in an approved mental

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health service. The latter is responsible for people who are held in custody in a residential treatment facility or a residential institution.  

4.60 In Queensland, a clear distinction is drawn between individuals whose impairment is a result of a cognitive or intellectual disability, and those whose impairment is the result of a mental illness. The former are the responsibility of the Director of Forensic Disabilities, and will be dealt with under the provisions of the Forensic Disability Act 2011 (Qld). The latter are the responsibility of the Director of Mental Health, and will be dealt with under the provisions of the Mental Health Act 2000 (Qld).

Approaches Taken in Other Reviews

4.61 None of the reviews recently undertaken specifically addressed the issue of a lead agency. However, the NSWLRC did discuss the relationship between the MHRT(NSW) and other agencies.  

It noted that the MHRT(NSW) sometimes had difficulty securing the information required from other agencies to make appropriate decisions, or achieving timely compliance with its requests and orders. In addition, it highlighted gaps in available services, and difficulties identifying responsible agencies for forensic patients with cognitive impairments. Forensic patients with complex needs, such as a mental illness together with substance abuse issues, were also seen to pose particular challenges.

4.62 While the NSWLRC suggested that the availability of resources was the most serious cause of these difficulties, it contended that an additional cause was ‘the unwillingness of agencies to accept responsibility for forensic patients or doubts and concerns about who is the appropriate responsible agency’.  

Although the Commission thought it was ‘highly desirable that there be agreement about roles, and collaboration and integration in the delivery of services’, it did not believe that specific roles should be specified in legislation. Instead, it suggested that arrangements be put in place to support coordinated management of forensic patients. Those arrangements should ‘allow for flexibility and collaboration between services where forensic patients do not fit within existing service paradigms’. To this end, the Commission recommended:

The establishment of a Forensic Working Group, to consist of representatives from key bodies involved in the supervision of forensic patients. The group should develop and facilitate the implementation and maintenance of a framework of protocols providing for agency responsibilities in relation to forensic patients. The framework should include agency responsibilities, agency response arrangements to MHRT requests and strategies to deal with cognitive impairment and complex needs. The Forensic Working Group should also identify barriers to effective management and

635 Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) s 26. Residential treatment facilities and institutions provide for the custody, care and treatment of people with intellectual disabilities, and are governed by the provisions of the Disability Act 2006 (Vic).


637 Ibid 9.93.

638 Ibid 9.100.

639 Ibid.
supervision of forensic patients and develop priority actions to deal with these barriers.

Submissions

4.63 The Council received 11 submissions addressing the issue of a lead agency. Of these, seven supported the idea of a lead agency, three opposed it and one was equivocal. Those that offered support included the Law Society, the Bar Association, the FMHS and the Parole Board. The main concern with the current system appeared to be the inappropriateness of requiring the FMHS to be responsible for supervising patients who do not have a mental illness or whose mental illness is not the cause of their difficulties. For example, the submission of the Parole Board argued that:

Current arrangements of shared responsibility between agencies for managing a licensee reflect the complex problems with which licensees present but there should be a lead agency and that entity must have relevant or clearly defined authority.

It is inappropriate to be seeking the view of mental health professionals as to drug and alcohol abuse in the circumstance of licence breaches...

The current legislation is inadequate and prescriptive and the lack of lead agency can at time lead to a lack of communication to the detriment of both the licensee and the broader community.

4.64 Opinions were divided about who should be responsible for determining which agency should be the lead agency. On the one hand, the Chief Magistrate suggested that ‘the supervisory agency should nominate a lead agency as they are best placed to make this decision’. A similar position was proposed by the Bar Association, who contended that:

A supervising agency should be able to nominate a lead agency and be empowered to obtain consensus on their position prior to orders being made. That does not mean that the decision should be taken away from the Court but the Court ought to be guided by the consensus position given that it is the agencies that will be responsible for supervision ultimately.

4.65 On the other hand, the submission of the OCPP suggested that the lead agency ‘should be determined by the Court, the Parole Board and the Minister of Health’s representative (at this point FMHS) at the time the order is made’. It went on to note that, if a Mental Health Review Tribunal is created to deal with supervision issues (see below), they should be the lead agency for all licenses.

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641 See South Australian Bar Association, Submission to the Sentencing Advisory Council; Law Society of South Australia, Submission to the Sentencing Advisory Council; Forensic Mental Health Service, Submission to the Sentencing Advisory Council; Parole Board of South Australia, Submission to the Sentencing Advisory Council.
642 See, eg, Australian Medical Association (South Australia), Submission to the Sentencing Advisory Council.
643 South Australian Bar Association, Submission to the Sentencing Advisory Council.
644 Chief Magistrate Judge Elizabeth Bolton, Submission to the Sentencing Advisory Council. The submission suggested that it should be possible to change the lead agency during the licence period, if the defendant’s mental health changes.
645 Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.
4.66 The OCPP also supported the proposal to give the lead agency the power to instruct the ODPP to determine whether breach proceedings should be instituted, as did the FMHS, the Bar Association and the Law Society. The Parole Board went further, arguing that the lead agency should be able to require the ODPP to institute breach proceedings:

If the DPP and/or Police Prosecution are to appear on behalf of the lead agency then their respective response to the instructions need to be immediate and the DPP or prosecution should act on those instructions rather than form a view as to whether or not to proceed.

4.67 By contrast, the LSC opposed the proposal to give the lead agency the power to instruct the ODPP to determine whether breach proceedings should be instituted. They noted that currently the ODPP does not ‘take instructions’ from any agency, and contended that ‘this independence should be maintained’.

4.68 The three submissions that opposed the development of a lead agency argued that the different agencies play different roles in the treatment of the defendant and the protection of the community, and should each continue to do so. They therefore saw the development of inter-agency protocols to be a preferable solution. For example, the submission of the CVR stated that:

It is not feasible in the current regime to have one agency or institution responsible for the supervision of mentally impaired perpetrators. If the regime is intended to treat the perpetrator and also protect the community, then no one agency or institution has such responsibility.

Perhaps a Code of Practice or Protocols to enhance cross-agency co-operation, such as exists in child protection, might provide a framework for decision-making. The Family Safety Framework is another example where collaboration and co-operation via joint case-management has proven better than relying on one agency or institution.

4.69 In addition, it was suggested that the development of a lead agency would not solve the current problems, and may disadvantage some defendants. For example, the OPA argued that:

While the nomination of a lead agency is superficially attractive, as a strategy in itself, it will not solve the fundamental problems that arise when there is a disagreement between the Department of Correctional Services and Forensic Mental Health Services.

In particular the Parole Board will have expertise in setting limits and responding to breaches by individuals who have regained their capacity following treatment, but for

647 Ibid; Forensic Mental Health Service, Submission to the Sentencing Advisory Council; South Australian Bar Association, Submission to the Sentencing Advisory Council; Law Society of South Australia, Submission to the Sentencing Advisory Council; Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.
648 Parole Board of South Australia, Submission to the Sentencing Advisory Council.
649 Legal Services Commission of South Australia, Submission to the Sentencing Advisory Council.
650 See Commissioner for Victims' Rights, Submission to the Sentencing Advisory Council; Director of Public Prosecutions, Submission to the Sentencing Advisory Council; Office of the Public Advocate, Submission to the Sentencing Advisory Council.
651 Commissioner for Victims' Rights, Submission to the Sentencing Advisory Council.
personality and other reasons choose not to comply with their conditions. The Mental Health Services of course will have expertise in assisting a person who relapses or breaches because they are unwell…

Our Office is very concerned that people who have a mental illness or a disability are not disadvantaged in any realignment of roles to create a lead agency for each client. The purpose of a limiting term is to provide therapy and rehabilitation, and the professional judgement and decision making of health and disability staff should not be undermined if another agency is given a ‘lead’ role.

On the other hand the particular skills of the Parole Board are needed to supervise people who have mental capacity and need limits set on behaviour driven by non-illness or non-disability related factors.

For this reason we think that there is benefit in each agency continuing to have its defined role, and that one agency’s judgement is not given precedence over the other by arbitrarily assigning a lead role. There can be benefit in these conflicts being heard, not by the ODPP, but by a decision making body - for example a specialist tribunal or Court, could consider the different perspectives before making a determination.652

### Conclusions and Recommendations

4.70 While the DCS thought that it was ‘reasonable’ for a lead agency to be nominated, it was concerned about resource implications if one agency was ‘over-nominated’. Furthermore, it suggested that if a lead agency other than the Parole Board was nominated, it was important to ensure that the Parole Board retain ‘the ability to issue a warrant for a licensee’s arrest to be brought before the Court in every case. The main point here is that the breach process is imperative and should be timely and clear regardless of who is deemed responsible.’653

4.71 It is the Council’s view that a lead agency should not be nominated to be primarily responsible for the supervision of an individual licensee. This proposal is impractical, and is unlikely to resolve the issues outlined above. In the Council’s opinion, the Minister for Health/FMHS and the Parole Board/DCS should continue to play different roles in the treatment of the defendant and the protection of the community. The Parole Board should remain responsible for the licensee’s supervision, and the Minister for Health should remain responsible for matters relating to the treatment or monitoring of the licensee’s mental health.

4.72 However, the Council believes that a formal protocol should be developed to try and reach consensus on individual cases where there are divided views between the agencies. This could involve a case conference between relevant agencies, or a mediation as part of Mental Health Review Tribunal proceedings (if such a tribunal is formed: see below). The Council is of the view that the development and implementation of such a protocol will be assisted by the reintroduction of administrative detention (see below), as well as by the formation of a tribunal.


653 Department for Correctional Services, *Submission to the Sentencing Advisory Council*. 
Recommendation 18
A lead agency should not be nominated to be primarily responsible for the supervision of an individual licensee.

Extending Supervisory Responsibilities to the Minister for Disabilities

4.73 In South Australia, issues concerning individuals with mental illnesses generally fall within the domain of the Minister for Health, while issues concerning individuals with intellectual disabilities or brain injuries are the responsibility of the Minister for Disabilities. However, at present only the Minister for Health and the Parole Board have any supervisory responsibilities in relation to defendants on supervision orders. This is despite the fact that a significant proportion of people who successfully raise the defence of mental incompetence have an intellectual disability or a brain injury.654

4.74 In the Discussion Paper it was noted that individuals with mental illnesses and individuals with intellectual disabilities or brain injuries are likely to have different treatment needs.655 It was suggested that channelling all people with intellectual disabilities or brain injuries into the mental health system was therefore likely to be inappropriate. To address this issue, a number of past reviews have suggested that the Minister for Disabilities be given a supervisory role for detainees and licensees whose primary diagnosis is a cognitive disability rather than mental illness.656 The Council sought comment on this proposal, asking the following question:

Question 19: Should the shared supervisory role of the Minister for Health and the Parole Board be extended to include the Minister for Disabilities?

Approaches Taken in Other Australian Jurisdictions

4.75 As noted above, Queensland and Victoria are the only jurisdictions that differentiate between the different supervisory responsibilities of the relevant agencies. In Queensland, the distinction is based on the nature of the defendant’s impairment. If the impairment is seen to be a result of a cognitive or intellectual disability, the defendant will be classified as a ‘forensic disability client’, and will be the responsibility of the Director of Forensic Disabilities. All other defendants will be the responsibility of the Director of Mental Health.657

654 For example, in information provided to the Council it was noted that, on 18 August 2014, there were 11 patients at James Nash House with an intellectual disability or acquired brain injury.
656 Margaret Bonesmo, Part 8A Criminal Law Consolidation Act Magistrates Court Diversion Program: Mental Impairment Joint Stakeholder Survey (Department of Health, Department of Justice and Attorney-General’s Department, 2005); Ian Bidmeade, Paving the Way: Review of Mental Health Legislation in South Australia (Department of Health, 2005). A similar proposal was put to the Attorney-General’s Department by SA Health.
657 Mental Health Act 2000 (Qld) s 288.
4.76 By contrast, in Victoria supervisory responsibilities are determined by the place in which the defendant is held in custody. The Secretary to the Department of Health is responsible for defendants who are held in custody in mental health services, and the Secretary to the Department of Human Services is responsible for defendants who are held in custody in a residential treatment facility or a residential institution.

4.77 All other jurisdictions either have only one body that is responsible for an individual’s supervision, or do not specify how the responsibilities are to be shared between the agencies involved. Consequently, their legislative schemes do not specifically mention the Minister for Disabilities (or the jurisdictional equivalent).

Submissions

4.78 The Council received 12 submissions on this issue. Eleven were in favour of extending supervisory responsibilities to the Minister for Disabilities. The sole (and qualified) opposition came from the Law Society, who stated:

We do not believe an amendment to include the Minister for Disabilities is required at this time but should be considered at future reviews dependent on the workings of the Memorandum of Understanding between the Department for Correctional Services, the Department for Communities and Social Inclusion and the South Australia Department of Health and Ageing.

4.79 Many of the submissions in favour of this proposal were emphatic in their support, and saw it as being of great significance. For example, the submission of the Australian Medical Association (SA) (AMA(SA)) noted that:

The AMA(SA) has received feedback to indicate a very strong and vehement ‘yes’. We received feedback that this would be one of the single most important improvements in the care of the mentally disabled for some time. At present, persons with an intellectual disability detained under part 8A receive almost no input at all from Disability SA. It has been put to the AMA(SA) that successive Ministers have shown no interest in caring for this vulnerable group.

4.80 The main argument that was put in favour of this proposal was that it is inappropriate for individuals with cognitive impairments to be under the care of the

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658 While this scheme technically differs from that in Queensland, it is unlikely to be significantly different in practice (as the place of custody will largely be determined by the nature of the impairment).

659 Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) s 26. Residential treatment facilities and institutions provide for the custody, care and treatment of people with intellectual disabilities, and are governed by the provisions of the Disability Act 2006 (Vic).

660 The NSW legislation does note that the Director-General of the Department of Health, the Commissioner of Corrective Services, the Director-General of the Department of Human Services, or another government Department or agency may become responsible for the detention, care or treatment of people found not guilty by reason of mental illness, and must use their best endeavours to comply with any subsequent requests made to them by the MHRT(NSW): Mental Health (Forensic Provisions) Act 1990 (NSW) s 76K.

661 Law Society of South Australia, Submission to the Sentencing Advisory Council.

662 See, eg, Forensic Mental Health Service, Submission to the Sentencing Advisory Council; Office of the Public Advocate, Submission to the Sentencing Advisory Council.

663 Australian Medical Association (South Australia), Submission to the Sentencing Advisory Council.
The Minister for Disabilities was seen to be ‘better suited to match individuals with appropriate accommodation and living options and provide the most appropriate support and supervision of these persons’.

These arguments were stated clearly by the LSC, whose submission also focussed on funding issues:

Under s 269V(3) the Forensic Mental Health Service, which is primarily a psychiatric service, is responsible for the treatment and mental health management of all persons found liable to supervision, whether they be mentally incompetent or mentally unfit to stand trial. However, many such defendants, particularly those who are unfit to stand trial, do not have any psychiatric disorder but rather come under Part 8A because of intellectual disability, various forms of brain damage, dementia or other non-psychiatric conditions.

FMHS is not designed or funded for intensive case management of those conditions, which more properly should come under the supervision of the Minister responsible for Disability SA.

Funding which should come through the Disability portfolio is currently being spent under the Health portfolio on patients who do not have a psychiatric condition, at the expense of patients who do need secure psychiatric housing. At the same time, disability patients are not receiving the benefit of funding for housing and case management which should be available to them, with many spending long periods in effective custody as a result.

In addition to supporting the proposal, the OCPP’s submission addressed procedural issues. It suggested that it should be for the court to nominate the appropriate Minister when making its determination. In cases where the individual suffers from both a mental illness and a cognitive impairment, the court should consider the balance of evidence before making a decision.

The DCS also addressed procedural and consequential issues, arguing that:

the roles and responsibilities of each agency would need to be clearly documented. It would be suggested that, should these delegations be given to the Minister for Disabilities, a specialist and targeted forensic disability response would need to be established in South Australia, similar to what has been developed in other Australian jurisdictions.

Conclusions and Recommendations

The Council is in favour of extending supervisory responsibilities to the Minister for Disabilities. It agrees with the extensive submission made by the OPA on this issue, which argued that:

Currently people with a primary disability who come under Part 8A, are assigned to be supervised by the wrong Minister, the wrong department, the wrong service with the wrong training. Everyone loses out: people with disability who could otherwise receive care, supervision and rehabilitation from a disability organisation; people with

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664 See, eg, Chief Magistrate Judge Elizabeth Bolton, Submission to the Sentencing Advisory Council; Commissioner for Victims’ Rights, Submission to the Sentencing Advisory Council.

665 Department for Correctional Services, Submission to the Sentencing Advisory Council.

666 Legal Services Commission of South Australia, Submission to the Sentencing Advisory Council.

667 Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.

668 Department for Correctional Services, Submission to the Sentencing Advisory Council.
a primary mental illness who have reduced access to mental health services shared with disability clients without any adjustment for bed numbers; and mental health staff who are expected to manage behaviours of concern secondary to disability without the specialist positive behaviour support programs used in that sector.

There is a strong argument that the legislation sets the parameters that then lead the services to operate the way they do. Changing these legislative parameters – in this case creating a role for the Minister for Disability, may not initially create changes in practice, but over time systems would realign the provision of services into distinct forensic mental health and forensic disability services that each undertake custodial, community and prison in reach services.

For people with a disability, it means that the same Minister would be responsible for care and supervision in custody, as well as in the community. This would provide continuity of care and supervision, and better planning.

For people with disability in custody they could be managed in a Disability run low stimulus environment that meets their needs. Staff would have training in positive behaviour support to prevent and respond to potentially violent behaviour. The care would be cheaper to deliver than hospital care because of the different cost structure. Disability services use disability workers, disability educators and psychologists to deliver a program, and can also efficiently deliver services to smaller cohorts…

For people with disability in the community, these changes would allow Disability services to develop specialist expertise in managing risk. This expertise would be available not just to forensic disability clients serving a limiting term in the community, but to other general disability services with behaviours of concern, with the aim to prevent future offending.

With respect to costs, a forensic disability community service would also be more efficient in delivering services to people at risk, compared to the current system of developing one off solutions for individuals though an exceptional needs process. A program response would allow skills to develop and deal with predictable need…

A change to legislation now, could lead to positive changes to services in coming years, assisting individuals, and would contribute to community safety.669

4.84 In making this recommendation, the Council notes that the current division of supervisory responsibilities was not created intentionally. When Part 8A of the CLCA was introduced, the Department of Human Services was responsible for both mental health and disability issues. It was only upon a restructuring of ministries that the responsible ministers came to be different.670 The Act was never amended to reflect the new political landscape.

4.85 The Council is concerned that similar recommendations have been made in previous reviews, which have not been implemented.671 It urges the government to rectify this situation, and amend the legislation accordingly.

669 Office of the Public Advocate, Submission to the Sentencing Advisory Council
670 See Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.
671 Margaret Bonesmo, Part 8A Criminal Law Consolidation Act Magistrates Court Diversion Program: Mental Impairment Joint Stakeholder Survey (Department of Health, Department of Justice and Attorney-General’s Department, 2005); Ian Bidmeade, Paving the Way: Review of Mental Health Legislation in South Australia (Department of Health, 2005). A similar proposal was put to the Attorney-General’s Department by SA Health.
Recommendation 19

The Criminal Law Consolidation Act 1935 should be amended to extend the shared supervisory role of the Minister for Health and the Parole Board to the Minister for Disabilities.

Housing Options for People with Cognitive Impairments

4.86 It has long been recognised that defendants with cognitive disabilities fall through ‘service gaps’, and that facilities and services designed primarily for people with mental illnesses are not appropriate for this group. This problem has been identified in a number of past reviews undertaken in South Australia, including the Gaps in Secure Services Project Report.\(^672\)

4.87 The Gaps in Secure Services Project was a 12-month project established in December 2011 to examine the service needs of individuals with cognitive disabilities who are either under a custodial supervision order and detained in a forensic mental health facility (James Nash House) or a Youth Justice Centre, or who are under a non-custodial supervision order and monitored by the FMHS. It identified that 30 percent of people under a forensic order between 1 January 2011 and 1 January 2012 were found to have a primary diagnosis of cognitive disability. Its findings suggested that rehabilitation and support services were struggling to cater for the intensive cognitive and behavioural needs of this cohort, with some individuals defaulting into the criminal justice system.\(^673\)

4.88 These findings coincide with information anecdotally provided to the Council by Dr Ken O’Brien, Clinical Director of the Forensic Mental Health Service (Clinical Director). He advised the Council that approximately 30 percent of the patients at James Nash House have an intellectual disability or brain injury, rather than an acute mental illness. He noted that it cost approximately $300,000 per year to keep these individuals in forensic mental health facilities, and that doing so diverts crucial resources from individuals with mental illnesses.

4.89 One of the difficulties in this area is the lack of suitable purpose-built facilities or accommodation for licensees with cognitive impairments. This makes it difficult for such individuals to secure a release from James Nash House, especially if their condition is such that they would require extensive (and expensive) supervision to ensure the safety of the community. Consequently, they tend to remain in James Nash House, despite the fact that they do not suffer from a mental illness, and are unlikely to receive treatment appropriate to their needs (as James Nash House has been set up to deal with individuals with mental illnesses, not individuals with cognitive impairments). This is clearly unsatisfactory.

\(^672\) The Gaps in Secure Services Project was led by the South Australian Department for Health and Ageing (SADHA) (Mental Health and Substance Abuse) in conjunction with a Steering Committee comprising SADHA, Department for Communities and Social Inclusion (DCSI) and DCS.

\(^673\) To help address this problem, the Gaps in Secure Services Project Steering Committee has agreed to develop a Memorandum of Understanding between DCS, DCSI and SADHA that improves the coordinated delivery of services to forensic disability consumers.
In the Council’s view, it is clear that there is a need for a dedicated secure facility for people with cognitive impairments who are found not guilty due to mental incompetence, or who are unfit to stand trial. This was recommended in the Operational Review of the CLCA undertaken in 2000, and a similar proposal has recently been made to the Attorney-General’s Department by SA Health. The Council strongly endorses the construction of such a facility.

However, at present there is no such facility, and it is unclear whether (or when) one will be constructed. One issue raised by the Council in the Discussion Paper was what measures could be put in place to address the needs of defendants with cognitive impairments, in the absence of a purpose-built facility. The following question was asked:

Question 20: In the absence of a purpose built facility for individuals found not guilty of an offence due to mental incompetence (or being found unfit to stand trial) on the basis of an intellectual disability or brain injury, what options are available for housing and supporting these individuals whilst on a licence pursuant to s 269?

Approaches Taken in Other Australian Jurisdictions

The only jurisdictions that have enacted specific legislative dispositions for defendants with cognitive impairments are Victoria and Queensland. In Victoria, the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 draws a distinction between mental health services, residential treatment facilities and residential institutions. Mental health services are used for the custody, care and treatment of people with mental illnesses, and are governed by the provisions of the Mental Health Act 2014 (Vic). Residential treatment facilities and institutions provide for the custody, care and treatment of people with intellectual disabilities, and are governed by the provisions of the Disability Act 2006 (Vic).

As noted above, the Secretary to the Department of Human Services is responsible for defendants who are held in custody in a residential treatment facility or a residential institution. To assist with this task, the Department of Human Services funds the Disability Forensic Assessment and Treatment Service (DFATS), which it describes as follows:

DFATS is a state-wide disability forensic service that delivers time-limited treatment, support and residential services for people with a disability who display high-risk anti-social behaviour and are involved, or at risk of being involved, in the criminal justice system…

The framework has been developed by the department to ensure delivery of timely and quality services, and to support effective monitoring and accountability of
services. The framework defines service requirements, and presents a service description and background information about the service.\textsuperscript{678}

4.94 The Queensland legislation differentiates between ‘mental health services’ and ‘forensic disability services’. A defendant whose impairment is the consequence of an intellectual disability may be detained in either, at the discretion of the Mental Health Court. By contrast, a defendant whose impairment is not the consequence of an intellectual disability must be detained in an approved mental health service (if he or she is to be detained for involuntary treatment or care).\textsuperscript{679}

\textbf{Approaches Taken in Other Reviews}

4.95 The NSWLRC was very concerned about the plight of defendants with cognitive impairments, stating that ‘the criminal justice and forensic systems do not deal effectively’ with such individuals.\textsuperscript{680} They summarised the problems as follows:

- cognitive impairment may not be perceived, diagnosed or responded to, especially where it co-exists with mental health impairment, drug and alcohol abuse and other factors
- cognitive impairment is frequently confused with mental illness
- people with cognitive impairment are dealt with, inappropriately, in the mental health system, and
- services responding to the needs of people with cognitive impairment may be absent, hard to locate or not coordinated with each other.\textsuperscript{681}

4.96 The NSWLRC contended that these problems ‘are primarily operational rather than legal’, and highlighted the need for a ‘coordinated cross agency solution to deal with issues that arise in relation to cognitive impairment’.\textsuperscript{682} They recommended creating a Forensic Working Group of representatives from a range of agencies involved in supervising and supporting forensic patients, to develop an action plan to provide for additional and improved options for the detention, care, and community support of forensic patients with cognitive impairments.\textsuperscript{683} The Working Group were also urged, as a matter of priority, to consider the provision of secure facilities for people with cognitive impairments.\textsuperscript{684}

4.97 The Law Reform Commission of Western Australia (\textbf{LRCWA}) was also concerned about defendants with intellectual disabilities, dementia or acquired brain injuries. As such defendants lack a ‘treatable’ mental illness, they are unable to be detained in an authorised hospital in Western Australia. While they could instead be detained


\textsuperscript{679} \textit{Mental Health Act 2000} (Qld) s 288(5)-(9).


\textsuperscript{681} Ibid 1.41.

\textsuperscript{682} Ibid 1.47.

\textsuperscript{683} Ibid Recommendation 1.1.

\textsuperscript{684} Ibid 10.55, Recommendation 10.2.
in a ‘declared place’, no such places currently exist in Western Australia. Consequently, such defendants are generally held in prison. The LRCWA stated that:

Clearly prison is not always the most appropriate place for the detention of such people, and programs or services required by these accused are not always available in prison. Further, it is possible that some ‘untreatable’ mentally impaired accused are not able to be conditionally released because of the lack of facilities in the community to accommodate their special needs. Under the present regime, the potential exists for a brain-damaged person who has been found not guilty under s 27 of a relatively minor offence (such as criminal damage or indecent assault) to be kept in prison indefinitely.

The failure of government to provide appropriate facilities in the community should never be the rationale behind keeping such people incarcerated in prisons. These are welfare issues, not criminal issues.  

The VLRC expressed similar concerns regarding the facilities provided for people with an intellectual disability or other cognitive impairment who are subject to a supervision order. They recommended that:

The Department of Human Services should commission a review of current forensic disability services to identify appropriate models of care and the accommodation needs of people with an intellectual disability or other cognitive impairment who are subject to supervision orders under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic).

**Submissions**

The Council received 11 submissions addressing housing options for people with cognitive impairments. These submissions were virtually unanimous in their support for a purpose-built facility for such individuals, stressing the inappropriateness of housing them in forensic mental health facilities. For example, the DPP stated:

It is not in the interests of a defendant with an intellectual impairment or acquired brain injury, or for the long term protection of the community, to simply detain such a defendant in an acute care psychiatric bed for the balance of their limiting term. The defendant is not receiving any of the training or behavioural modifications they need to successfully remain in the community and the supervision comes at an enormous cost. There is also the potential for the denial of a place for a person who would benefit from treatment at James Nash House.

The FMHS saw the construction of a dedicated forensic disability unit to be ‘absolutely essential’, arguing that it:

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is the only logical and coherent solution to the increasing number of disability clients who require security and are occupying valuable Forensic Mental Health beds. It is iniquitous that Forensic Mental Health has to bear this responsibility to the detriment of its own patient/client group. Given the courts’ increasing expectation that close supervision and security is required for some of the disabled forensic population, no other solution is workable. South Australia stands isolated with respect to the lack of provision of such a facility compared to interstate jurisdictions and overseas. There is an urgent need for interagency and government agreement on this urgent need, notwithstanding budgetary pressures and constraints.  

4.101 In the absence of a purpose built facility, there was widespread support for options tailored to the needs of individuals with cognitive impairments. For example, the submission from the Office of the Commissioner for Equal Opportunity (OCEO) suggested that:

age appropriate adjustments, supports and programs should be provided to allow people with a disability to participate in and benefit from suitable access to appropriate health, housing and rehabilitation programs whilst in prison or other purpose built facilities. Where possible, specialist support, accommodation and programs should be provided to people with a disability when they are deemed mentally incompetent under Part 8A of the CLCA.  

4.102 The DCS highlighted the lack of clinicians and services specialising in the area, and thought that ‘it would be advantageous … to build the skills and expertise in this area within South Australia’. In addition, they made four suggestions for reform in their submission:

- Develop suitable community accommodation options that can cater for the needs of defendants with cognitive impairments. In this regard, they pointed to interstate models that service the needs of people with disabilities who come into contact with the criminal justice system, such as Wintringham Specialist Aged Care in Victoria, and accommodation and support services run by the Office of the Senior Practitioner in New South Wales for people with intellectual disabilities who are exiting the criminal justice system.

- Include an area in James Nash House or the proposed step-down facility (discussed below) to address the needs of this group.

- Establish a diversion program within the court context, such as The Court Integrated Services Program (CISP) operating in Victoria. That program is ‘designed to assist people coming into the courts with offending associated with homelessness, poverty, substance abuse, or disability. It facilitates diversion rather than sentencing. Its stated role is to “offer a coordinated, team-based approach to the assessment and treatment of defendants at the pre-trial or bail stage”’.  

- Provide specific training for people working with individuals with intellectual disabilities and acquired brain injuries, in light of the particular challenges they can pose. They suggested that ‘workers charged with providing support to these

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688 Forensic Mental Health Service, Submission to the Sentencing Advisory Council.
690 Department for Correctional Services, Submission to the Sentencing Advisory Council.
691 Ibid.
people need to be well trained, skilled and supported in developing and reviewing strategies in behaviour intervention, and in having access to clinical debriefing and review when behaviour escalates and appears unmanageable.\footnote{692}

The OCPP and the OPA raised the possibility of converting some existing facilities into forensic disability facilities. For example, the OCPP suggested that:

Disability SA, with bed-equivalents of 2500 places in single-person dwellings and group homes…has the capacity to take on the co-supervisory responsibility of disabled people subject to s 269 orders released on license to the community in a reasonably straight forward manner, within existing single-person or group homes resources, some of which already provide for residents with complex needs and behaviours. Several of these could be designated for forensic disability clients on license and could be run similarly to existing disability facilities for men who are physically active but who are impulsive, have poor mood control and/or have drug or alcohol issues etc.

OCPP suggests that the transition for the Minister of Disabilities to take on the custody of people with disability detained under s 269 will be more involved, however a couple of group and single homes could be made more secure and a model of care and supervision developed that incorporated what Disability SA already do with active men (as above) and people who need around the clock supervision.\footnote{693}

Similarly, the OPA recommended that:

For people in custody a 10 person secure residential unit could be established now. Appreciating the limits of funding at the present time, an existing residential setting could be modified. For example at the Oakden sites wards previously occupied by Mental Health Services for Older People could be renovated to become accommodation for a forensic disability service.

The design and ambience of the unit should be as close as possible to a community disability setting. The modern approach to security is to not build prison like buildings as the principal means of security, but rely on a high tech perimeter fence. Inside the ambience should be residential, therapeutic and rehabilitative, rather than custodial. It is likely that such a facility could be operated by an existing non-government organisation working in the disability area.\footnote{694}

The OPA’s submission also focussed on funding issues, noting that:

There would be a cost in operating such a new facility, as the current mental health beds occupied by people with a primary disability would not close and the existing operating costs would not be transferred. When the existing residents moved to a purpose built disability facility, there would be mental health patients currently waiting for these existing beds, who would then use this freed up mental health capacity.

While this is a cost, there would also be savings as the Health and Correctional system would not need to pay for the extra marginal costs of looking after clients in the wrong environment (ie the ward or prison cell) which has traditionally created risk and the need for extra staff presence.

\footnote{692}{Ibid.}
\footnote{693}{Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.}
\footnote{694}{Office of the Public Advocate, Submission to the Sentencing Advisory Council.}
The costs could be funded directly by the Government but there are other financing options. Over recent years our Office has put forward the idea of using social impact bonds – an innovative financing method used in the UK and the US – to fund a forensic disability service.

For those in the community, existing resources funded through the disability and exceptional needs unit budget could be pooled to create a specialist forensic disability team. The Senior Practitioner in Disability could oversee the programs and standards of this service. As funds are already spent on these clients through one-off packages of care, it is likely that existing financial resources could be redirected to support this community work, and that this approach would be more efficient.

Finally it is worth commenting on the interrelationship between forensic disability services and the NDIS, because this is relevant to the planning of long term options for this group. It is our view that a forensic disability client should still be eligible for NDIS funding, at least to the level that would be funded if the client was living in the community. It could be reasonable for the State to fund the added care costs due to the security requirements of a CLCA order. This is different to the current situation where all costs are funded by the State.\textsuperscript{695}

Conclusions and Recommendations

4.106 As noted above, it is the Council’s view that a dedicated secure facility for people with cognitive impairments who are found not guilty due to mental incompetence, or who are unfit to stand trial, should be developed. These individuals have specific treatment and management needs which cannot be properly addressed in a facility such as James Nash House, which is designed for individuals with mental health issues. In addition, it is inappropriate to require staff who are trained to deal with forensic mental health patients to also have to treat and manage forensic disability patients.

4.107 The Council wishes to again highlight its concern that similar recommendations have previously been made in the South Australian context\textsuperscript{696} but have not been implemented. It urges the government to implement these recommendations as a matter of priority.

4.108 In the absence of a purpose-built facility, it is essential that supported accommodation tailored to the needs of individuals with cognitive impairments be developed. Such accommodation should encourage independent living skills and deliver appropriate programmes (such as those dealing with substance abuse). In developing appropriate housing and support options, particular consideration should be given to the recommendations of the OPA, the OCPP and the DCS outlined above.

\textsuperscript{695} Ibid.

Recommendation 20
Tailored options for housing and support should be provided for individuals with cognitive impairments who are found not guilty of an offence due to mental incompetence, or who are unfit to stand trial. Such individuals should not be housed in James Nash House, which is specifically designed for individuals with mental health issues.

Breaches of Licence Conditions

4.109 When a judge orders a defendant to be released on licence, he or she can attach specific conditions (s 269O). Examples of conditions that are commonly imposed are:

- That the licensee is under the care of a psychiatrist and must comply with the treatment recommended by that psychiatrist;
- That the licensee is under the care of a mental health team;
- That the licensee must take the medication he or she has been prescribed;
- That the licensee must not take other drugs;
- That the licensee must ensure that his or her blood alcohol concentration does not exceed 0.08%;
- That the licensee must undergo drug and alcohol testing;
- That the licensee will be supervised by a community corrections officer;
- That the licensee will be assessed for fitness to hold a driver’s licence.  

4.110 Data generated by the Case File Review indicated that half of the individuals released on licence have breached the conditions of that licence; in 86 percent of cases where there was evidence of a breach, there was also evidence of multiple breaches associated with the consumption of drugs and/or alcohol.  

4.111 As noted above, if a licensee breaches, or appears likely to breach, the conditions of their licence, the ODPP can apply to the court (by telephone if necessary) to review the supervision order. The licensee can be arrested and detained while the application is dealt with. The court can vary the conditions or revoke the licence. If the licence is revoked, the defendant will be detained (s 269U).

4.112 If the action committed by the licensee is a criminal offence, such as using an illegal drug or drink-driving, the licensee can also be charged with that offence in the ordinary way, and can be arrested if necessary. This applies whether or not the licensee is suffering from a mental illness at the time. However, if the licensee

697 Attorney-General’s Department (South Australia), Review of Division 4, Part 8A, Criminal Law Consolidation Act 1935: Scoping Paper (Attorney-General’s Department, 2011). The content of this section has been largely adapted from this Scoping Paper.

698 See Appendix B.
committed the offence while mentally impaired, he or she can raise the defence of mental incompetence at the trial for the new offence.

4.113 Alternatively, if the licensee is suffering from a mental illness and needs medical treatment to avert danger to him or herself or others, the normal civil procedures set out in the Mental Health Act 2009 (SA) (MHA) can be used. Under these procedures, a person can be examined by a doctor or authorised mental health professional, who can certify that he or she is mentally ill and needs to be detained (s 21). This authorises the police to take the person to an approved treatment centre where he or she can be held and treated, subject to rights of appeal. If a police officer suspects that a person may be in need of detention in this way, the officer can apprehend the person and take them for medical examination (s 57).

4.114 If a person is not currently suffering from a mental illness, and the breach of licence condition is not an offence in itself (for instance, the person has failed to keep a compulsory medical appointment), only section 269U of the CLCA can be used to deal with the breach.

Options for Dealing with Breaches of Licence Conditions

4.115 It is important that breaches of licence conditions are not ignored. This is not only because the conditions have been imposed by a court and have the force of law, but also because breaches can lead to a deterioration in the person’s mental health (for example, if they stop taking their medication), and can increase the risk that the person will become dangerous to others (for example, if they use illegal drugs or drink to excess) or will commit an offence. Licence conditions should therefore be readily enforceable both in the public interest and in the interests of the person concerned.

4.116 In the Discussion Paper, the Council raised three possible options for dealing with breaches of licence conditions. The first option raised was to provide the court with the ability to order the licensee to be detained as if under the MHA, if it appears to the court that he or she is in need of inpatient medical treatment. This would result in the licensee’s admission to an approved treatment centre, where he or she could be assessed and treated as necessary. By operation of the MHA, the licensee would be released once medically assessed to be recovered. It was suggested that this might be preferable to the current system, under which the only option is to revoke the licence and return the person to secure detention at James Nash House. This is likely to result in a lengthier stay in detention, as even if the licensee recovers, he or she cannot be released until the necessary psychiatric reports have been obtained.

4.117 The second option raised was to provide the court with the ability to detain the licensee at home for a period of time. This option would be made available in cases where the breach suggests that the licensee is unable or unwilling to comply with the conditions of the licence (justifying a higher level of restraint on his or her liberty), but the court is not of the view that he or she requires inpatient medical treatment. The purported benefits of this option are that it attaches a consequence to the breach, and protects the public against any danger posed by the licensee while he or she is confined to his or her home. As home detention requires the licensee to have a ‘home’, this option would not be applicable where the licensee is homeless or drifting from one short-stay accommodation to another.

699 As home detention requires the licensee to have a ‘home’, this option would not be applicable where the licensee is homeless or drifting from one short-stay accommodation to another.
4.118 The third option raised in the Discussion Paper was to create a criminal offence for breaching a licence condition, as is currently the case for breaches of bail conditions and bond conditions. If detected, a breach of these conditions can result in arrest and prosecution. In proposing this option, it was noted that a licensee’s limiting term may be of a lengthy duration, and in some cases the licensee may not be suffering from a mental impairment at the time of the breach. In such circumstances, it was suggested that ordinary criminal sanctions might be more appropriate than mental-health related sanctions.

4.119 The Council sought views on the appropriate way to deal with breaches of licence. It asked the following questions:

Question 21: Should breaches of licence particularly, persistent breaches, be dealt with by way of:

(a) an amendment to the Mental Health Act 2009 to enable a licensee to be assessed and treated as an alternative to revocation of the licence and returning the person to secure detention at James Nash House; and/or

(b) amending the CLCA (and any other ancillary legislation) to provide for home detention where a licensee is either unable or unwilling to comply with the conditions of licence, justifying a higher level of restraint on their liberty, but not requiring inpatient medical treatment; and/or

(c) where there is evidence that a breach or persistent breach of licence conditions is not as a result of a mental impairment at the time of the breach, should a breach of licence conditions constitute a criminal offence and attract a criminal sanction?

Approaches Taken in Other Australian Jurisdictions

4.120 No Australian jurisdiction specifically provides for any of the options outlined in the Discussion Paper. While the approaches taken in other jurisdictions differ slightly, in general they allow the relevant court, tribunal or Minister to revoke or amend the terms of the supervision order if it has been breached. For example, at the Commonwealth level, the Attorney-General may revoke a licence at any time, if the licensee has failed to comply with a condition, or there are reasonable grounds for suspecting a failure to comply. Similarly, in Western Australia, if a licensee breaches a condition of a release order, the MIARB may cancel the order. This will result in the previous custody order being reinstated. In the ACT, if a licensee breaches a condition of an order, the ACT Civil and Administrative Tribunal (ACAT) may order the licensee to be detained in custody until they order otherwise.

4.121 In the Northern Territory, if it appears to the Director of Public Prosecutions that a licensee is not complying, or is not likely to comply, with the supervision order and, because of that, the supervision order should be varied urgently, the Director may make an urgent application to the court for an order varying the supervision order.

700 Crime Act 1914 (Cth) s 20BM.
701 Criminal Law (Mentally Impaired Accused) Act 1996 (WA) s 37.
702 Mental Health (Treatment and Care) Act 1994 (ACT) s 74.
On hearing the application, the court may confirm the order, vary its conditions, or change it to a custodial supervision order.\textsuperscript{703}

4.122 A similar system exists in Victoria.\textsuperscript{704} However, Victorian legislation also provides that a licensee may be apprehended by an appropriate person\textsuperscript{705} if that person reasonably believes that the licensee has failed to comply with the order, and that the safety of the licensee or members of the public will be seriously endangered if he or she is not apprehended. The licensee must be detained in an appropriate place, and treated for his or her condition if necessary. He or she must be released from detention within 48 hours, unless an application is made to the court to vary the supervision order. Any such application must be heard as soon as possible.\textsuperscript{706}

4.123 In Tasmania, a prescribed person\textsuperscript{707} may apprehend a licensee if the prescribed person believes on reasonable grounds that:

- The licensee has contravened, or is likely to contravene, the supervision order; or there has been, or is likely to be, a serious deterioration in the licensee’s mental health; and

- Because of the breach or likely breach of the supervision order, or the deterioration or likely deterioration in the licensee’s mental health, there is a risk that the licensee will harm himself, herself or another person.\textsuperscript{708}

4.124 As soon as practicable after apprehending a licensee the prescribed person is to notify the Chief Forensic Psychiatrist of the apprehension, and take the licensee to a secure mental health unit. He or she may initially be detained for no longer than 24 hours. The Chief Forensic Psychiatrist can extend the detention by an additional 72 hours. The Mental Health Tribunal may order further extensions. The supervision order is suspended while the licensee is being detained.\textsuperscript{709}

4.125 In New South Wales, the President of the MHRT(NSW) may make an order for the apprehension of a person if it appears to the President that the person has breached a condition of an order, or has suffered a deterioration of mental condition and is at risk of causing serious harm to himself or herself or to any member of the public because of his or her mental condition. The MHRT(NSW) must then review that person’s case, and either confirm their release or order their detention, care or treatment in a mental health facility, correctional centre or other place.\textsuperscript{710}

\textsuperscript{703} Criminal Code Act (NT) s 43ZE.
\textsuperscript{704} Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) s 29. In Victoria, an application may be made by a person having the supervision of the licensee (the supervisor), the Secretary to the Department of Human Services or the Secretary to the Department of Health.
\textsuperscript{705} For the purposes of this section, an ‘appropriate person’ is defined to mean: the supervisor, a member of the police force, and ambulance officer, or a person who is prescribed to be appropriate for the purposes of this section: Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) s 30.
\textsuperscript{706} Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) s 30.
\textsuperscript{707} The people prescribed for the purposes of this section are: the Chief Forensic Psychiatrist; a person who administers, or assists in the administration of, medical treatment to the defendant under a supervision order; a person who is authorised by the Chief Forensic Psychiatrist to supervise, wholly or partly, the administration of a supervision order in respect of the defendant; an authorised person; a mental health officer; or a police officer.
\textsuperscript{708} Criminal Justice (Mental Impairment) Act 1999 (Tas) s 31.
\textsuperscript{709} Criminal Justice (Mental Impairment) Act 1999 (Tas) s 31.
\textsuperscript{710} Mental Health (Forensic Provisions) Act 1990 (NSW) s 68.
4.126 One of the disposition options available to the MHRT(NSW) is a community treatment order (CTO).\textsuperscript{711} The \textit{Mental Health Act 2007} (NSW) has a specific provision relating to breach of such orders.\textsuperscript{712} It provides that if the licensee in any way refuses or fails to comply with a CTO, and the director of the relevant facility is of the opinion that there is a significant risk of deterioration in the licensee’s mental or physical condition, the director must document the matter and inform the licensee that if he or she further refuses to comply, he or she will be taken to a mental health facility and treated. If the licensee continues to fail to comply, the director may issue a ‘breach notice’ requiring him or her to accompany a staff member of the NSW Health Service to the relevant facility for treatment. If he or she fails to comply with that notice, the director may make a ‘breach order’, ordering the person to be taken by police to the facility.\textsuperscript{713}

4.127 A person who is at a mental health facility as the result of being given a breach notice or breach order may be given treatment in accordance with the CTO, or assessed for involuntary admission to a mental health facility. If treatment is accepted, they may be released.\textsuperscript{714} If treatment is refused, an authorised medical officer may require the licensee to be treated involuntarily, or to be detained for further observation, treatment or both.\textsuperscript{715}

\textit{Approaches Taken in Other Reviews}

4.128 The NSWLRC briefly examined the issue of breaches in its review of \textit{People with Cognitive and Mental Health Impairments in the Criminal Justice System}. It noted that the MHRT(NSW) had requested the Ministry of Health Legal Branch to explore amending the \textit{Mental Health (Forensic Provisions) Act 1990} (NSW) to allow for breaches of supervision orders to be managed in a similar way to breaches of a CTO.\textsuperscript{716} The MHRT(NSW) also sought the power to adjourn proceedings when required, to assess a forensic patient’s response to treatment before making a final decision regarding revocation of the supervision order.\textsuperscript{717}

4.129 The NSWLRC did not comment on the suggestion to allow for breaches of supervision orders to be managed in a similar way to breaches of a CTO. Instead, they focussed on the need to ensure that forensic patients can be detained and treated while awaiting review of their breach by the MHRT(NSW). In this regard, they made the following recommendation:

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

\textsuperscript{711} \textit{Mental Health (Forensic Provisions) Act 1990} (NSW) s 67.
\textsuperscript{712} \textit{Mental Health Act 2007} (NSW) s 58.
\textsuperscript{713} Police are given specific powers for apprehending such individuals: \textit{Mental Health Act 2007} (NSW) s 59.
\textsuperscript{714} \textit{Mental Health Act 2007} (NSW) s 60.
\textsuperscript{715} \textit{Mental Health Act 2007} (NSW) s 61. A similar scheme exists in relation to non-compliance with community involuntary treatment orders in Queensland: see \textit{Mental Health Act 2000} (Qld) s 117.
\textsuperscript{717} Ibid 9.146. The NSWLRC noted that the MHRT already have a general power to adjourn proceedings.
(a) the forensic patient may continue to be given treatment in accordance with the
terms of conditional release imposed by the Tribunal

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

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

4.130 The English Law Commission (ELC) also gave brief consideration to the issue of
breaches. They noted that, under current English law, there is no sanction available
for a person who breaches a supervision order. They stated that:

On the one hand, this seems unsatisfactory: it should be possible for an order of the
court to be enforced, as in, for example, contempt proceedings. On the other hand, it is
questionable whether a person should receive a criminal sanction for breaching a non-
penal order made in circumstances where the individual was found not to be
responsible for his or her actions.

4.131 The ELC was particularly concerned about the possible human rights violations that
could arise if sanctions were introduced in relation to supervision orders that
include a requirement to undergo medical treatment. They noted that:

Article 25(2) of the United Nations Convention on the Rights of Persons with
Disabilities requires that health care be provided to persons with disabilities “on the
basis of free and informed consent”. Consent is unlikely to be free and informed
where a person feels they have no choice – because of the threat of sanction – but to
acquiesce to the treatment required.

4.132 They were also concerned about the likely effectiveness of such sanctions, pointing
out that:

The rate of breach for other types of orders to which criminal sanctions attach is
relatively high. Research into orders which provide for non-criminal sanctions in the
event of breach (such as readmission to hospital for failing to comply with the
requirements of a community treatment order) similarly fails to show that the threat of
sanction increases compliance. However, differences between these types of orders
and supervision orders … makes it difficult to draw conclusions about the likely
effectiveness of attaching sanctions to the latter type of order.

4.133 The ELC ultimately made no recommendations in this regard, promising to return
to this ‘difficult issue’ in their work on unfitness to plead.

Submissions

4.134 The Council received 12 submissions on the three proposals relating to breach of
licence conditions. These proposals are discussed in turn below.

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718 Ibid Recommendation 9.11.
722 Ibid.
4.135 Opinions were split in relation to the first option raised by the Council, with five submissions supporting the proposal to give the court the power to order a licensee to be detained as if under the MHA,723 and two submissions opposing that proposal.724 One submission was neutral, seeking further information about the efficacy of the proposed change.725

4.136 The OPA supported this proposal, which it thought would work more effectively if a Mental Health Review Tribunal supervised the licensee rather than a court.726 Its submission suggested that:

a Tribunal could make decisions about community supervision and at the same time consider an application from the mental health service for a Level II Community Treatment Order, if such an order was required. The patients would then have access to a right of appeal over such an order… In addition to CTOs, It would also be appropriate for a specialist tribunal or a Court to have power to grant a level III Inpatient Treatment Order (ITO) by application or on its own initiative, consistent with the expert evidence before it…

In the South Australian setting, two advantages could be foreseen in giving the Courts this option. First for forensic patients it would allow inpatient care to be delivered in a wider range of settings in instances where treatment is needed but security is not an issue. Where a forensic patient on a CLCA order can be admitted is tightly defined. Forensic patients in custody are admitted to secure settings only, such as James Nash House, Grove Closed, the Cedars Psychiatric Intensive Care Unit and the Margaret Tobin Centre’s Psychiatric Intensive Care Unit. This is irrespective of the clinical need for these secure intensive care settings. There may be situations where a person needs detention but does not require these secure settings. A Mental Health Act order would permit this option when the principal purpose of detention is the delivery of treatment, rather than placing the person in a secure environment.

Second if the court had these powers they could be used to assist people convicted of an offence as well as forensic patients. This situation would be analogous to the use of the UK Mental Health Act 1983 by the courts in that country. A person could receive psychiatric care as an alternative to imprisonment. The court or tribunal should only overturn such orders, once made.727

4.137 While the OPA supported this proposal, it was concerned to ensure that treatment orders should not be made in situations where an order would not normally be used in general psychiatric settings. Similar concerns were expressed by the LSC.728

4.138 The OCPP’s submission suggested a slight variation to the proposal, arguing that:

723 Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council; Commissioner for Victims’ Rights, Submission to the Sentencing Advisory Council; Office of the Public Advocate, Submission to the Sentencing Advisory Council; South Australian Bar Association, Submission to the Sentencing Advisory Council.

724 Commissioner for Victims’ Rights, Submission to the Sentencing Advisory Council; Director of Public Prosecutions, Submission to the Sentencing Advisory Council; Legal Services Commission of South Australia, Submission to the Sentencing Advisory Council.

725 Law Society of South Australia, Submission to the Sentencing Advisory Council.

726 The possible establishment of a Mental Health Review Tribunal is discussed in detail below.

727 Office of the Public Advocate, Submission to the Sentencing Advisory Council.

728 Legal Services Commission of South Australia, Submission to the Sentencing Advisory Council.
an amendment to the CLCA could be made detailing what can happen if someone breaches or is at risk of breaching their license conditions. This new breach section would describe that if someone has breached/is at risk of breaching that the community corrections and (mental health or disability) treating team supervising the license (see question 27) can either apply to the Court for a full review/change (as per s 269P) or may make a ‘CLCA Temporary Treatment Order’ for up to 4 weeks for the person to receive mental health or disability inpatient (or community) treatment, with similar provisions to Inpatient Treatment Orders (MHA2009) and s 32 powers (GAA1993). The agency supervising the person’s license would also have the power to revoke the ‘CLCA Temporary Treatment Order’. The OCPP suggests that an option for 1 additional 4 week order would be useful.729

4.139 The OCPP was concerned to ensure, however, that licensees whose mental impairments were due to intellectual disabilities or acquired brain injuries should not be subject to the provisions of the MHA. Those provisions should only apply to licensees whose mental impairment was found by the court to be caused by a mental illness.730

4.140 The CVR and the DPP opposed this proposal on the grounds that it would increase the complexity of managing licensees.731 For example, the DPP argued that ‘[t]rying to manage a licensee under two different legislative provisions will lead to confusion and inconsistencies of approach. If the licensee is detainable under the Mental Health Act then it should be that Forensic Mental Health assume the control and treatment pursuant to the licence conditions’.732

Amend the CLCA to Provide for the Possibility of Home Detention

4.141 The nine submissions the Council received about home detention were unanimously in support of allowing it as an alternative to detention in James Nash House. It was argued that ‘[i]n many cases, this would be preferable to the blunt instrument of revoking a licence’.735 Such an option was seen to be appropriate ‘where a licensee is either unable or unwilling to comply with the conditions of licence justifying a higher level of restraint on their liberty but not requiring inpatient medical treatment’.734 There would, however, be resource and cost implications which would need to be considered.735

4.142 The LSC, CVR and DPP suggested that the court already has the power to impose home detention in relation to a licensee, and that this option had been used in the past.736 Consequently, the DPP queried whether it was necessary to amend the CLCA to implement this proposal, unless there was some doubt over the legislative base to do what has previously been done.

729 Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.
730 Ibid.
731 Director of Public Prosecutions, Submission to the Sentencing Advisory Council; Commissioner for Victims’ Rights, Submission to the Sentencing Advisory Council.
732 Director of Public Prosecutions, Submission to the Sentencing Advisory Council
733 South Australian Bar Association, Submission to the Sentencing Advisory Council.
734 Parole Board of South Australia, Submission to the Sentencing Advisory Council. See also Office of the Public Advocate, Submission to the Sentencing Advisory Council.
735 Department for Correctional Services, Submission to the Sentencing Advisory Council.
736 Legal Services Commission of South Australia, Submission to the Sentencing Advisory Council; Director of Public Prosecutions, Submission to the Sentencing Advisory Council; Commissioner for Victims’ Rights, Submission to the Sentencing Advisory Council.
Create Criminal Sanctions for Breach of Licence Conditions

4.143 Of the 12 submissions the Council received on the issue of criminal sanctions, seven argued in their favour and five opposed them. Those who supported the proposal tended to see criminal sanctions as appropriate in cases where the breach was not the result of the licensee’s mental impairment.\(^{737}\) To this end, a number of submissions were concerned to ensure that individuals charged with this new offence be able to raise the defence of mental incompetence.\(^{738}\) This would help ensure that individuals were not inappropriately convicted.

4.144 The Parole Board argued that a criminal offence was necessary to ensure the supervision system operated effectively. It stated that:

> The … supervision of a licensee needs to reflect:

> 1. the seriousness of the offence;
> 2. community expectations that further offending will be prevented, as would have occurred had the offender been imprisoned and subsequently paroled;
> 3. community expectations of the level of supervision and management had the offender been released on parole; and
> 4. community expectations that the offender will be effectively treated towards rehabilitation and reintegration.

In order to meet those supervision requirements there needs to be a sanction for breaches of licence.\(^{739}\)

4.145 The CVR saw the situation to be analogous to that governing suspended sentences:

> That is, the Court should release an ‘appropriate’ person on licence or bond / community service and the threat of imprisonment should be attached to the breaching of the licence or bond. This approach is especially pertinent if a once mentally impaired/incompetent perpetrator is stabilised by treatment and able to assume a ‘normal’ life style. In such circumstances, a breach should be criminal.\(^{740}\)

4.146 By contrast, the DPP highlighted a fundamental difference between supervision orders and suspended sentences (and similar bonds): ‘Breaches of bail, suspended sentence bonds and restraining orders are all attached to criminal offending. Here the index offence has not been characterised as criminal. It would criminalise what has been imposed to assist in the treatment and rehabilitation of a person when the person has been found not guilty’.\(^{741}\) The Bar Association also saw supervision orders as being fundamentally different from other kinds of bonds, arguing that the suggestion to impose a criminal sanction seems contradictory:

\(^{737}\) See, eg, Department for Correctional Services, Submission to the Sentencing Advisory Council; Parole Board of South Australia, Submission to the Sentencing Advisory Council.

\(^{738}\) See, eg, Forensic Mental Health Service, Submission to the Sentencing Advisory Council; Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.

\(^{739}\) Parole Board of South Australia, Submission to the Sentencing Advisory Council.

\(^{740}\) Commissioner for Victims' Rights, Submission to the Sentencing Advisory Council.

\(^{741}\) Director of Public Prosecutions, Submission to the Sentencing Advisory Council.
The purpose of licensing conditions primarily is to ensure that a mental health patient is properly rehabilitated. It does not seem appropriate to treat a breach as a criminal offence. Either the licence condition deals with mental health or it does not. If there is no mental impairment and the breach is simply treated as if it were a breach of bond, it begs the question of whether there is a need in that instance for Part 8A supervision at all. \(^{742}\)

However, the Bar Association went on to suggest that a breach might appropriately be treated with a criminal sanction where current treatment is ensuring the licensee is stable, that treatment must continue, and it is clear that the person knows the wrongness of the breach. \(^{743}\) The OPA also supported the possibility of a severely circumscribed sanction, to be available to respond to ‘persistent breaches by persons who have decision making capacity, who show antisocial disregard for the safety of others in their decision to breach licence requirements’. \(^{744}\) However, this will only be a very small group of people. In most other cases, a breach should be dealt with in other ways:

- If the breach is due to illness, then a return to hospital is needed.
- If a breach is due to behaviours secondary to a disability, then a person could be transferred for a period of time to a closed disability setting that offers positive behaviour support and other specific disability interventions.
- If a person has an underlying drug and alcohol problem which is driving this behaviour then a specific drug and alcohol therapeutic response might be more appropriate. For example an order to undertake, and stay at a residential ‘inpatient’ program run by the Drug and Alcohol Services at its Glenside Hospital Campus, followed by closer home supervision until it is clear that the person will no longer seek and use the drugs of concern.
- For other people who have capacity, some other form of non-criminal detention, not at James Nash House, may be needed for a period of time until the risk to the community has been lowered. This could be analogous to the non-prison administrative detention used under the Public Health Act 2011 for people who create a risk of spreading infectious disease. A person could receive in reach drug and alcohol, and mental health interventions if detained in this way.

While the OPA was open to the possibility of introducing criminal sanctions for that small group of people who, with full capacity, ‘do not comply with their conditions, and repeatedly and wilfully take actions in defiance of their supervision conditions with disregard to the potential consequences to others’, it was concerned to ensure that any new offence not ‘inadvertently penalise the broader group; people who are seeking to comply with their orders, who may need tolerance and support, and from time to time have set backs’. \(^{745}\) In addition, it sought further information about the issue:

[We] would wish to better know how other jurisdictions perform, particularly if the creation of a new offence for such breaches is a ‘first’ in South Australia. In particular are other jurisdictions managing such situations more effectively, and what options do they use?

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\(^{742}\) South Australian Bar Association, Submission to the Sentencing Advisory Council.

\(^{743}\) Ibid.

\(^{744}\) Office of the Public Advocate, Submission to the Sentencing Advisory Council.

\(^{745}\) Ibid.
If an offence is created, how can this be done in a way that does not disadvantage people with a mental illness or a disability, who may be competent before the law, but are driven in their behaviours by the combined effects of their illness, co-morbid history of substance use (which is more likely to be present than not), and possible financial impoverishment. History of brain injury can also be common. Arguably these are the constellation of problems that lead to people with mental illness to be overrepresented in prisons following convictions for minor offences. A new law should not contribute to this.

4.149 Four main arguments were posited in opposition to the proposal to impose criminal sanctions on those who breach their license conditions. First, as noted above, such a proposal is seen to be philosophically unsound, insofar as it attaches criminal sanctions to what is fundamentally a health issue. In this regard, the Law Society noted:

The nature of the breach is not ordinarily criminal. If it is criminal then they will be subject to criminal proceedings. If the nature of the breach is concerned with adherence to conditions as to residence or treatment given the particular philosophies and concerns associated with the treatment of mentally ill people, they should not be exposed to criminal sanctions for such conduct.

4.150 Secondly, the LSC argued that such a proposal was unjust and discriminates against people found not guilty by reason of mental incompetence:

[C]onvicted persons who breach parole conditions are not subject to criminal charges on the grounds of parole breaches; they simply face the possibility of serving out the remainder of the head sentence that was originally ordered as being appropriate to the circumstances of the original offending, i.e. they simply forgo the benefit of the non-parole period originally fixed. It would be inequitable and discriminatory if licensees were to face the prospect of additional detention and/or incarceration over and above the length of the original limiting term for breach(es) of licence conditions, where convicted prisoners do not.

4.151 Thirdly, the DPP highlighted the practical difficulties involved in implementing this proposal: ‘For example, would this apply to any breach, even relatively minor ones? If not, who would determine which breaches criminal sanctions did apply to? What enquiries would have to be made to determine the licensee’s mental state in terms of capacity to commit the offence?’

4.152 Finally, the AMA(SA) were concerned about the possible consequences of such a reform, suggesting that a ‘criminal sanction for a breach of licence would see many intellectually impaired offenders found unfit to stand trial for the charge of breach of licence, only adding to further burden on the court system’.

Conclusions and Recommendations

4.153 In the Council’s view, it is important that breaches of licence conditions be dealt with expeditiously and appropriately. Licence conditions are imposed by the court for a reason, and should not simply be ignored by the licensee. Doing so can
increase the risks to the public, as well as to the licensee. Systems need to be in place to ensure compliance with such conditions as far as is practicable.

4.154 However, the Council does not believe that it is appropriate for courts to specifically use the MHA for this purpose. That Act is designed to address the treatment needs of people with mental illnesses, and not to deal with breaches of licence conditions. The mere fact that a licensee breaches his or her licence conditions does not mean that he or she requires medical treatment. There may be many reasons why a breach occurs. To that end, the Council is in favour of retaining the status quo, which allows a licensee to be treated under the MHA if he or she meets the ordinary requirements of that Act, but does not allow that Act to be used in other circumstances.

4.155 The Council is supportive of the use of home detention in appropriate cases. It believes that it may offer a suitable alternative to detention in James Nash House. However, the Council does not believe it is necessary to amend the CLCA to provide for this possibility. It is the Council’s view that home detention can already be ordered under section 269O(1)(b)(ii)(B) of that Act, and this has been done in a number of cases. There has been no suggestion that this practice lacks a legal basis, and so legislative amendment is not required.

4.156 The Council notes that in 2013 the *Statutes Amendment (Electronic Monitoring) Act 2013* was passed. This Act will amend section 269O(1)(b)(ii)(B) of the CLCA to make it clear that a supervision order can include a condition that the defendant be monitored by use of an electronic device approved under section 4 of the *Correctional Services Act 1982*. The Council supports the use of electronic monitoring devices for licensees in appropriate cases.

4.157 The Council does not believe a specific criminal sanction should be introduced for breaching licence conditions. While it is appropriate for a person who breaches his or her licence conditions by committing a criminal offence (such as theft) to be charged with that new offence, it is not appropriate to also charge him or her with the additional offence of breaching his or her licence conditions. Licensees have not been convicted of a criminal offence, and it would be unjust to place them in a situation where they may be convicted of a failure to comply with a condition that has been largely imposed for medical purposes.

4.158 In addition, the Council does not believe that such sanctions are likely to be particularly effective at preventing breaches. There is no evidence to suggest that deterrence works in such circumstances. Instead, such an option would likely result in additional people with mental illnesses or intellectual disabilities being placed in prison, which is an undesirable outcome.

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750 This section allows the court to release the defendant on ‘any other conditions decided by the court and specified in the licence’.

751 This Act will commence operation on a day to be proclaimed.

752 Such an individual would be able to raise the defence of mental incompetence in relation to this charge.
Recommendation 21
The Council does not recommend amending the Mental Health Act 2009 to enable licensees to be assessed and treated as an alternative to revoking their licences and returning them to secure detention at James Nash House.

The Council supports the appropriate use of home detention and electronic monitoring for licensees.

Recommendation 22
The Council does not recommend introducing a criminal sanction for licensees who breach the terms of their licenses.

Powers of the Parole Board

4.159 As noted above, under the current system the only option generally available to a court in the case of a licence breach is to revoke the licence and return the individual to James Nash House. This creates a dilemma:

- If the ODPP generally seeks a review when a licence is breached, James Nash House will quickly fill up with people who are stable in terms of their mental health, but who have breached their licence conditions;

- If the ODPP does not generally seek licence reviews, licensees may ignore their licence conditions and become dangerous.

4.160 The Case File Review indicates that, where a breach of licence was evident, the ODPP brought an application to review the licence before the court in 30 percent of cases.753

4.161 In the Discussion Paper, the Council expressed concern at the possibility that licensees may be aware that the ODPP is currently unlikely to seek an application to review a licence unless there is an indication of a decline in mental health. Given the lack of external incentive to comply with their licence conditions, licensees may be choosing to disregard them.

4.162 The Council invited comment on whether additional means of empowering particular agencies (such as the Parole Board) were required to deal with non-compliance by licensees. It was suggested, for example, that licence conditions that include the threat of a short prison term for non-compliance with Parole Board directions might enhance compliance by licensees. The Council asked the following question:

Question 22: Are additional means of empowering particular agencies (such as the Parole Board) required to deal with non-compliance by licensees?

753 See Appendix B.
The Council received 10 submissions on this issue. The Parole Board argued strongly in favour of being given extra powers to deal with non-compliance:

When a licensee breaches his or her licence in a way that may impact on community safety someone needs to be accountable for effective and timely intervention. Those events are the result of drug and alcohol abuse rather than a relapse of psychosis. The Parole Board is not currently equipped with the legislative framework nor the resources to meet its obligations. The Board needs to be able to:

1. issue a warrant for the apprehension and detention of a licensee. That detention may be for a specified period of time sufficient either:
   (a) to have the licensee forensically examined; or
   (b) to determine the nature of the breach.

2. the Board needs the capacity to deal with breaches rather than the present cumbersome administrative approach of referring the licensee back to the sentencing court, which not only takes time but which has proved to be ineffective.\(^{754}\)

The DCS made a similar recommendation, stating:

Having to take the person back before the Court for action delays the Board’s ability to act quickly on a presenting risk. Whilst a matter for the Board, it would assist in the supervision of the person, if the Parole Board were empowered to deal with non-compliance by licensees and also empowered to issue a warrant for the person’s arrest in order to be brought before the Board for a determination about the breach/heightened risk. It would also serve as an immediate consequence/action for a breach or non-compliant behaviour.\(^{755}\)

The OCPP also recommended giving the Parole Board the power to take action directly on breaches.\(^{756}\) However, this suggestion was opposed by the FMHS: ‘The reasons for this include opposition to further criminalisation of the mentally ill and the potential confusion/conflict of too many agencies being involved with respect to licence management.’\(^{757}\)

Several submissions focused on the need for additional resources and facilities. For example:

- The CVR argued that the Parole Board could ‘do its job better if there were more places in the community to house offenders/perpetrators’;\(^{758}\)
- The DPP suggested that the Parole Board could deal with non-compliance more effectively if a supervised hostel or step-up facility was available;\(^{759}\)

\(^{754}\) Parole Board of South Australia, *Submission to the Sentencing Advisory Council*.
\(^{755}\) Department for Correctional Services, *Submission to the Sentencing Advisory Council*.
\(^{756}\) Office of the Chief Psychiatrist and Mental Health Policy, *Submission to the Sentencing Advisory Council*.
\(^{757}\) Forensic Mental Health Service, *Submission to the Sentencing Advisory Council*.
\(^{758}\) Commissioner for Victims’ Rights, *Submission to the Sentencing Advisory Council*.
• The LSC recommended that the Parole Board be given ‘funding for specialist case managers experienced in dealing with persons with psychiatric/intellectual disability disorders’.  

4.167 For the Law Society, it is important to retain court involvement in the process, given that the liberty of an individual is involved. However, they suggested that the practices and procedures for enforcement of license conditions could be streamlined:

Dedicated Rules of Court need to be devised. Dedicated procedures of the Courts need to be implemented. Court staff and judicial officers need to be specialised in these areas and so specialised training should be developed. Fast response to enable urgent and ex parte applications could be considered.  

Conclusions

4.168 The Council does not believe it is always necessary to deal with a breach of licence by taking the matter to court. For example, in some circumstances it will be appropriate to address the breach by providing short-term treatment to the licensee, at the discretion of relevant medical practitioners. However, it is the Council’s view that this situation is best dealt with by the reintroduction of a system of administrative detention (as discussed below), rather than by further empowering particular agencies. Consequently, the Council has made no specific recommendations in relation to Question 22.

Administrative Detention

4.169 Prior to 2008, it was common for the following condition to be included in licences: that a licensee could be detained at James Nash House, without court interference, for up to 14 days, if it was felt that the licensee was contravening, or about to contravene, a licence condition and was a danger to themselves, or another. This allowed the Clinical Director of the FMHS to administratively detain licensees who breached the terms of their licences, without the need to seek a court order.

4.170 The Council understands that the Clinical Director’s practice was based on the belief that, during the short period of detention, a licensee’s mental condition might stabilise, avoiding the need for the matter to return to the court. If this was not the case, and it was clear that a period of detention of longer than 14 days would be required, a formal application for a review of licence was made and the matter was listed for hearing before the court.

4.171 This system was ended in 2008, due to the decision in R v Draoui. In that case the Court of Criminal Appeal held that the provisions of the CLCA did not allow for administrative detention, even for a short period, and that only the court could revoke a licence. As a consequence, a licensee can only be detained under the MHA (if the relevant requirements have been met), or after a court order has been made revoking a licence under section 269P or 269U of the CLCA.

759 Director of Public Prosecutions, Submission to the Sentencing Advisory Council. Step-up facilities are discussed in more detail below.
760 Legal Services Commission of South Australia, Submission to the Sentencing Advisory Council.
761 Law Society of South Australia, Submission to the Sentencing Advisory Council.
In the Discussion Paper, the Council noted that the practical difficulty with this situation is that, unless a licensee is acutely unwell at the time and the ODPP has serious concerns about the licensee, detention under the MHA is not an option. By the time an application is made under section 269P or 269U and the relevant order obtained, the licensee may have become dangerous to himself or herself, or others.\(^{763}\) It suggested the possibility of reintroducing a system of administrative detention.

This could be done by once again allowing a condition such as that outlined above to be inserted into licences. Alternatively, it could be made a standard condition of release on licence that the Clinical Director can order a licensee to be admitted to James Nash House (or another appropriate treatment facility) for no more than 14 days, if the Clinical Director forms the view that the licensee is mentally unwell and requires medical treatment, but is unwilling to receive such treatment voluntarily. An ‘appropriate treatment facility’ could be defined to include the step–up facilities (‘halfway houses’) which are discussed below.

The Council is aware that a system of administrative detention raises issues about the rights of an individual to the minimum restrictions on his or her freedom and personal autonomy as is consistent with the safety of the community (as is currently required by CLCA s 269S). However, in the Discussion Paper the Council stated that it understood that it was the experience of the ODPP that under the previous system decisions were made infrequently and usually assisted in stabilising the licensee quickly. A formal court process was avoided with consequent savings on court time and cost. The period of detention was never longer than 14 days without review by the court, and there was the ability to act quickly when the need arose.

The Discussion Paper noted that if a system of administrative detention was introduced, there would need to be further amendments to provide police with the power to apprehend relevant licensees, without the need for a court warrant.

The Council invited comment on the desirability of an administrative detention option, or on other possible alternatives. The following questions were asked:

**Question 23:** Should the CLCA be amended to allow for administrative detention in the circumstances discussed in *R v Draoui*? Are there any alternatives to administrative detention in these circumstances?

**Approaches Taken in Other Australian Jurisdictions**

Most Australian jurisdictions do not specifically provide for any form of administrative detention of forensic licensees. The only limited exceptions are:

- **Tasmania:** A prescribed person\(^{764}\) may apprehend a licensee if the prescribed person believes on reasonable grounds that the licensee has contravened, or is

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\(^{763}\) It is possible to seek an urgent review of a supervision order. Currently, the court, SA Police and the ODPP have agreed to an interim process whereby a warrant sought urgently after hours may be processed. This process is necessary if there is any doubt about the danger the licensee may represent to himself or herself, victims or members of the community.

\(^{764}\) The people prescribed for the purposes of this section are: the Chief Forensic Psychiatrist; a person who administers, or assists in the administration of, medical treatment to the defendant under a supervision order; a person who is authorised by the Chief Forensic Psychiatrist to supervise, wholly or partly, the administration of a supervision order in respect of the defendant; an authorised person; a mental health officer; or a police officer.
likely to contravene, the supervision order, or there has been, or is likely to be, a serious deterioration in the licensee’s mental health; and because of the breach or likely breach of the supervision order, or the deterioration or likely deterioration in the licensee’s mental health, there is a risk that the licensee will harm himself, herself or another person. As soon as practicable after apprehending a licensee the prescribed person is to notify the Chief Forensic Psychiatrist of the apprehension, and take the licensee to a secure mental health unit. He or she may initially be detained for no longer than 24 hours. The Chief Forensic Psychiatrist can extend the detention by an additional 72 hours. The Mental Health Tribunal may order further extensions.

- Victoria: If an appropriate person reasonably believes that the licensee has failed to comply with his or her supervision order, and that the safety of the licensee or members of the public will be seriously endangered if the licensee is not apprehended, they may apprehend him or her. The licensee must be detained in an appropriate place, and treated for his or her condition if necessary. He or she must be released from detention within 48 hours, unless an application is made to the court to vary his or her supervision order.

- NSW: If a licensee fails to comply with a CTO, and the director of the relevant facility is of the opinion that there is a significant risk of deterioration in the person’s mental or physical condition, the director must inform the licensee that if he or she further refuses to comply, he or she will be taken to a mental health facility and treated. If the licensee continues to fail to comply, the director may issue a ‘breach notice’ requiring him or her to accompany a staff member of the NSW Health Service to the relevant facility for treatment. If he or she fails to comply with that notice, the director may make a ‘breach order’, ordering the licensee to be taken by police to the facility. A person who is at a mental health facility as the result of being given a breach notice or breach order may be given treatment in accordance with the CTO, or assessed for involuntary admission to a mental health facility. If treatment is accepted, they may be released. If treatment is refused, an authorised medical officer may require the licensee to be treated involuntarily, or to be detained for further observation, treatment or both.

Approaches Taken in Other Reviews

4.178 The NSWLRC did not specifically address the issue of administrative detention in its review of *People with Cognitive and Mental Health Impairments in the Criminal
However, as noted above, they were concerned to ensure that forensic patients could be detained and treated while awaiting review of their breach by the MHRT(NSW). In this regard, they made Recommendation 9.11 (quoted above), which allows for licensees to be assessed, detained and treated prior to having the matter finally determined by the MHRT(NSW).

Submissions

4.179 The Council received 10 submissions on the issue of administrative detention, all of which were largely supportive of the option. Administrative detention was seen to work very well in the past, allowing the FMHS to monitor a person who was beginning to show signs of being unwell for a short period and, if necessary, to adjust his or her medication. Suggested benefits of this option include:

- It can allow the licensee to be treated quickly. This may prevent their mental state from deteriorating, and their behaviour from becoming dangerous to themselves or others;
- It can allow the licensee to be treated in circumstances where the strict requirements of the MHA have not been met;
- It will not result in acute care beds being occupied for longer than necessary;
- It will reduce matters being taken to court, saving public resources.

4.180 In advocating for the reintroduction of this system, the FMHS noted that:

there is evidence that the ease with which it is possible to re-admit forensic patients to an inpatient bed is therapeutic and reduces risk when the threshold for admitting this group does not depend on their meeting criteria for civil commitment (i.e. The Mental Health Act); ‘There has been increasing evidence from several jurisdictions that well-implemented conditional release systems, with the capacity to readmit at the first sign

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773 It is unclear whether or not the Law Society support administrative detention. In one part of their submission they express support for the option, while in another they oppose it.


775 Director of Public Prosecutions, *Submission to the Sentencing Advisory Council*; Legal Services Commission of South Australia, *Submission to the Sentencing Advisory Council*.

776 Department for Correctional Services, *Submission to the Sentencing Advisory Council*; Australian Medical Association (South Australia), *Submission to the Sentencing Advisory Council*; Forensic Mental Health Service, *Submission to the Sentencing Advisory Council*.

777 Department for Correctional Services, *Submission to the Sentencing Advisory Council*; Australian Medical Association (South Australia), *Submission to the Sentencing Advisory Council*; Forensic Mental Health Service, *Submission to the Sentencing Advisory Council*.

778 Director of Public Prosecutions, *Submission to the Sentencing Advisory Council*; Legal Services Commission of South Australia, *Submission to the Sentencing Advisory Council*. The LSC noted that, under the current system, a licensee would be detained for at least two to three months while the court obtains updated reports.

of increased risk, are indeed effective at reducing the risk of recidivism, thereby protecting the public’. 780

4.181 Although the LSC was supportive of the option, they limited their support to cases ‘where there is a well-grounded concern that the licensee is becoming dangerously unwell’. They argued that ‘a mere positive cannabis test or a missed appointment should not be sufficient’ to result in administrative detention. 781

4.182 The OPA and the Bar Association suggested that if this option were reintroduced, some kind of review mechanism should be implemented. The OPA suggested that the licensee could seek court or tribunal review of the Clinical Director’s decision if he or she disagreed with it. That review should be resolved within one or two days. 782 The Bar Association suggested that it may be desirable to always require the matter to be brought before the Court within a short specified period, as is the case in relation to the emergency removal of children under section 16(5) of the Children’s Protection Act 1993. 783

4.183 While the OCPP supported this option, it was of the view that it would be preferable to instead introduce a ‘CLCA Temporary Treatment Order’, which would ‘enable the agencies supervising a person (community corrections, parole board, mental health or disability) to mandate a short period of treatment in the community or in a facility because a person is becoming unwell, is unwell, is likely to breach or has breached’. 784

4.184 The DPP suggested that, if administrative detention were not to be reintroduced, then there ‘should be a provision which enables a period of release on licence to be suspended for a set period. This would enable Forensic Mental Health to apply to the Court and bring the person back to James Nash House for assessment and treatment without that licence being cancelled and the defendant being back in detention on an ongoing basis’. 785

4.185 The sole opposition to administrative detention came from the Law Society, who preferred instead to develop an inter-relationship between the MHA and Part 8A of the CLCA: ‘Detention is more readily able to be affected pursuant to the Mental Health Act and would not necessarily involve much change to Part 8A’. 786

Conclusions and Recommendations

4.186 It is the Council’s view that a system of administrative detention should be reintroduced. It appears that such a system operated effectively in the past, providing a useful mechanism to enable the treatment of licensees whose mental

781 Legal Services Commission of South Australia, Submission to the Sentencing Advisory Council.
782 Office of the Public Advocate, Submission to the Sentencing Advisory Council.
783 South Australian Bar Association, Submission to the Sentencing Advisory Council.
784 Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.
785 Director of Public Prosecutions, Submission to the Sentencing Advisory Council.
786 Law Society of South Australia, Submission to the Sentencing Advisory Council. Note, however, that earlier in its submission the Law Society stated that it supported an amendment to allow for a form of administrative detention.
health appeared to be deteriorating, and were in need of some assistance. It allowed
them to be treated quickly, preventing future problems from arising. The system
also has the benefit of ensuring that the limited number of acute care beds in
facilities such as James Nash House are not occupied inappropriately, and that court
resources are not wasted by hearing matters which can be quickly and efficiently
dealt with as health issues.

4.187 The Council appreciates that it is a very serious matter to deprive a person of their
liberty without court intervention. However, it believes that a short, 14-day time
period spent in a mental health facility, when the Clinical Director of that facility
believes that treatment is required to prevent future breaches of licence conditions,
is not unduly restrictive. This is especially the case given the limited number of
beds available at James Nash House, which makes it highly unlikely that the
Clinical Director would order a licensee’s detention lightly.

Recommendation 23

The Criminal Law Consolidation Act 1935 should be amended to allow for a licensee to be
administratively detained for up to 14 days where future breaches of licence conditions are
likely, or treatment is required in order to prevent future breaches.

Cross-Border Issues

4.188 The Discussion Paper raised two issues concerning the movement of licensees
across State borders:

- How should the law deal with licensees who have crossed into South Australia
  contrary to the conditions of their licence?
- How should the law respond to requests by licensees to move interstate?

4.189 These issues are addressed in turn below.

Licensees who Abscond Interstate

4.190 Sometimes licensees from interstate will enter South Australia, contrary to the
conditions of their licence. Currently, there is no provision that allows them to be
returned to the State which granted the licence. The only way to arrange for their
return is if grounds for a warrant exist. In such circumstances a warrant may be able
to be enforced by authorities in the other State under the Service and Execution of
Process Act 1992 (Cth), to bring the person before the court of the jurisdiction
where the licence was granted.

4.191 By contrast, Part 10 of the MHA provides for civil mental health detainees who
abscond to be returned to detention, including those from interstate. It was

787 The content of this section of the Report has been adapted from Attorney-General’s Department (South
Australia), Review of Division 4, Part 8A, Criminal Law Consolidation Act 1935: Scoping Paper (Attorney-
General’s Department, 2011).
suggested in the Discussion Paper that a similar model could be introduced for licensees. This would allow an authorised officer or police officer who reasonably believes that a person in South Australia is a forensic patient from interstate, who has not been lawfully transferred here, to exercise powers necessary to return the patient to an authorised officer of that State. Conversely, officers could be authorised, to the extent permitted by a corresponding law, to take care and control of a South Australian forensic patient who has been apprehended by authorities interstate.

4.192 Another option raised in the Discussion Paper was to provide for a warrant to be issued in South Australia for the apprehension of a forensic patient who has absconded to South Australia from interstate. Victoria has enacted such a provision in Part 7B of its Crimes (Mental Impairment and Unfitness to be Tried) Act 1997. That provision allows the Secretary of the Health Department to apply for a warrant to apprehend a person who has arrived in Victoria in breach of supervision or detention conditions applying in another State. The execution of that warrant enables the person to be returned to the State they have left. This is useful if no warrant has been issued in the other State, or if a warrant issued in the other State cannot, for some reason, be executed. Such a provision would assist other jurisdictions if an interstate licensee entered South Australia contrary to licence conditions.

4.193 A third option raised in the Discussion Paper was to enact a provision allowing a person who may be apprehended under a corresponding law in another State to be apprehended and returned to that State (or detained in a forensic mental health facility). This includes cases where a warrant has been issued in another State. This is the approach taken in Queensland and the Australian Capital Territory.

4.194 The Discussion Paper noted that there may be a danger in providing for a warrant from one State to be treated as applying in another State. This is because of the risk of inconsistency with the Service and Execution of Process Act 1992 (Cth), which covers the field as to the execution of a warrant from one State in another State. Whether this is problematic for the above approach has not been tested.

4.195 The Council sought comments on the best approach to take in relation to licensees who enter South Australia contrary to their licence conditions. The following questions were asked:

Question 24: (a) Should there be statutory provision for police officers or authorised officers in South Australia to take care and control of interstate forensic patients who are found in South Australia and to return them to the jurisdiction that made the orders?

(b) Further, should provisions similar to those in Part 7B of the Victorian Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 be enacted in South Australia?

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788 Mental Health Act 2000 (Qld) s 184; Mental Health (Treatment and Care) Act 1994 (ACT) ss 48P, 48Q.
Approaches Taken in Other Australian Jurisdictions

4.196 The Victorian, Queensland and New South Wales approaches to licensees who abscond interstate have been outlined above. The other Australian jurisdictions do not specifically address this issue in their legislation.

Approaches Taken in Other Reviews

4.197 The issue of licensees who abscond interstate has not been addressed in recent reviews.

Submissions

4.198 Nine submissions addressed the issue of licensees who abscond interstate. Of these, four (the DPP, FMHS, CVR and AMA(SA)) were clearly in favour of implementing a procedure analogous to that currently contained in Part 10 of the MHA (allowing an authorised officer or police officer who reasonably believes that a person in South Australia is a forensic patient from interstate who has not been lawfully transferred here to exercise powers necessary to return the patient to an authorised officer of that State). The Bar Association also thought the suggestion appeared sensible, but stated that ideally ‘there should be a uniform approach adopted in all States and Territories’.

4.199 The OPA was supportive of ‘the process of examining… procedures currently used in mental health legislation to develop a suitable system’, but was concerned to ensure that a person ‘affected by such provision, irrespective of their State of origin, should be able to challenge a decision about interstate movement in a South Australian Court or a tribunal’.

4.200 The OCPP offered conditional support for the proposal, arguing that:

The cross border arrangements in part 10 of the MHA2009 are a great step forward BUT are overly complicated, cumbersome and do not consistently provide for actions by SA and interstate officers in SA or in other states.

The CLCA should contain provisions that allow an SA authorised office or police office to take a person, subject to an interstate forensic order who is in SA, into care and control (with similar provisions to s 56 of the MHA2009) and return them to the other State (or to the custody of police officers or authorised officers of that State) or, if that is not practicable or safe, temporarily to a SA facility (police cells, prison, mental health facility, disability facility) while arrangements are made for transport to the other State. (If someone on an interstate forensic order is taken to a SA facility they can be made subject to a “CLCA Temporary Treatment Order”. Those orders could include a criterion (in addition to those about becoming or being unwell, or liable to breach etc) along the lines of “the person is subject to the equivalent of a s 269 order from another jurisdiction and requires temporary involuntary

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789 Australian Medical Association (South Australia), Submission to the Sentencing Advisory Council;
Commissioner for Victims’ Rights, Submission to the Sentencing Advisory Council; Director of Public Prosecutions, Submission to the Sentencing Advisory Council; Forensic Mental Health Service, Submission to the Sentencing Advisory Council.

790 South Australian Bar Association, Submission to the Sentencing Advisory Council.

791 Office of the Public Advocate, Submission to the Sentencing Advisory Council.
treatment/accommodation while transport arrangements to the other jurisdiction are made.”)

The CLCA should also contain provisions that enable an interstate authorised officer or police officer to take a person, on a SA forensic order who is interstate, into care and control and to return the person to SA or to the custody of a SA police officer or authorised officer. And, if that is not practicable or safe, temporarily to an Interstate facility (police cells, prison, mental health facility, disability facility) while arrangements are made for transport to SA.

Officers authorised under this new section of the CLCA could include police officers, community corrections, and authorised officers as per s 3 of the MHA2009 (police, ambulance, flying doctors and classes of people classified as mental health clinicians by the Chief Psychiatrist). 792

4.201 By contrast, the Law Society and the LSC opposed the implementation of a procedure analogous to that contained in the MHA. The Law Society was concerned to ensure that licensees retained “the usual types of protections available under the Commonwealth Execution of Process Act” 793. The LSC argued that:

The ‘reasonable belief’ that a person is an interstate forensic patient by a police officer is too low a threshold to activate such a serious step in the absence of an existing court warrant for that person’s apprehension. The potential for errors in record-keeping and break-downs in communication between police agencies, and the lack of understanding of mental health law by all but specialist police officers, presents too great a risk of an unjust apprehension and could even, on a worst-case scenario, precipitate a fatal incident. 794

4.202 The Law Society and the LSC were more supportive of adopting a warrant system similar to that which currently exists in Victoria. The Law Society suggested that such a process ‘should be investigated further’, 795 while the LSC stated that it ‘could be more workable than 24(a) above, but any such provision should specify that there must already be in existence a court warrant for that person in the original jurisdiction’. 796 General support for this option was also given by the DPP, FMHS, CVR and the Bar Association. 797 While the OCPP also thought this option was ‘worth exploring’, they were concerned that warrants ‘require the involvement of the Courts, which can be more difficult after hours. The provision of powers directly to coal-face police officers and authorised officers is more immediate’. 798

Conclusions and Recommendations

4.203 In the Council’s view, the primary responsibility for identifying absconders should lie with the jurisdiction from which the individual absconds. The relevant agency in that State should apply for a warrant for the absconding individual’s arrest, which

792 Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.
793 Law Society of South Australia, Submission to the Sentencing Advisory Council.
794 Legal Services Commission of South Australia, Submission to the Sentencing Advisory Council.
795 Law Society of South Australia, Submission to the Sentencing Advisory Council.
796 Legal Services Commission of South Australia, Submission to the Sentencing Advisory Council.
797 Director of Public Prosecutions, Submission to the Sentencing Advisory Council; Commissioner for Victims’ Rights, Submission to the Sentencing Advisory Council; Forensic Mental Health Service, Submission to the Sentencing Advisory Council; South Australian Bar Association, Submission to the Sentencing Advisory Council.
798 Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.
can then be enforced by authorities in other States under the *Service and Execution of Process Act 1992* (Cth). This will allow the person to be returned to their jurisdiction, while also ensuring that their legal rights are adequately protected.

4.204 The Council does not believe it is appropriate to give police officers (or other authorised officers) the power to detain interstate absconders without a warrant. It shares the concerns expressed by the LSC about the potential for errors and the risk of unjust apprehension. Moreover, police officers should not be placed in the position of having to ascertain whether an individual is an absconder. It should be the institution with the care of that person who has the responsibility of identifying them and seeking their return.

4.205 Consequently, the Council does not recommend making any changes to the current legislative procedure. However, in the Council’s opinion it would be worthwhile to develop an inter-agency protocol that sets out the best way to approach this issue. The protocol should address issues such as the appropriate place in which to detain such individuals prior to their return to their home jurisdiction.

**Recommendation 24**

The Council does not recommend introducing a statutory provision allowing police officers or other authorised officers to take care and control of interstate forensic patients who are found in South Australia, and to return them to the jurisdiction that made the orders. The Council is of the view that the present practice of applying for warrants under the *Service and Execution of Process Act 1992* (Cth) should be retained.

The Council does not recommend enacting statutory provisions similar to those in Part 7B of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic).

Protocols should be developed for use in circumstances where forensic patients impermissibly cross State borders.

**Co-operative Interstate Transfers**

4.206 It can also happen that a person under supervision or a person who is detained may wish to move interstate for proper reasons, such as to be with family.799 Section 70 of the MHA makes provision for people under detention and treatment orders to be transferred interstate where there is an arrangement permitting this and it would be in their best interests to do so. Likewise, in the case of a person detained interstate, the director of a South Australian treatment centre may approve their admission to the centre, whereupon the patient is treated as if under a South Australian order.

4.207 One possibility would be to make similar provision for forensic patients. The law could provide, in the case of an interstate forensic patient being transferred to South Australia, that the interstate detention or supervision order and licence conditions apply as if they were orders of a South Australian court, and that they can be

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799 The content of this section of the Report has been adapted from Attorney-General's Department (South Australia), *Review of Division 4, Part 8A, Criminal Law Consolidation Act 1935: Scoping Paper* (Attorney-General's Department, 2011).
reviewed by a South Australian court in the same way. The law could also provide for arrangements to be made under a Ministerial agreement for the transfer of South Australian forensic patients to reside interstate.

4.208 Victoria has enacted provisions that enable the Victorian courts to set conditions of supervision if a person who has been under supervision in another State moves to Victoria.\textsuperscript{800} The Minister must be satisfied that the transfer is for the person’s benefit and that there are facilities available in Victoria for their custody, treatment or care. The transfer must also be necessary for the maintenance or re-establishment of family relationships or of relationships with support persons. Part 7A of the Victorian Act also deals with the conditions under which the Minister may consent to the transfer of a Victorian forensic patient to another State. Broadly, the Minister must be satisfied that the person has given informed consent, that the transfer is in their best interests and that the law of the receiving State permits the transfer.

4.209 In the Discussion Paper the Council sought comments on the best approach to take in relation to co-operative interstate transfers. The following question was asked:

Question 25: Are the provisions of Part 7A of the \textit{Victorian Crimes (Mental Impairment and Unfitness to be Tried) Act 1997} a suitable model for amendments to the South Australian law to enable transfer of persons under supervision to and from South Australia?

\textbf{Approaches Taken in Other Australian Jurisdictions}

4.210 The only jurisdictions that specifically provide for co-operative interstate transfers of forensic patients are Victoria, the Australian Capital Territory and Queensland. The Victorian approach is outlined above.

4.211 In the Australian Capital Territory, interstate custodial patients may be transferred to mental health facilities in the Australian Capital Territory, although the facility can only accept them if they could reasonably have been detained under the Australian Capital Territory Act.\textsuperscript{801} A person who is being detained at an approved mental health facility in the Australian Capital Territory may be transferred to a health facility in another State, if the transfer is permitted by or under a provision of a corresponding law of the other State and is in accordance with the regulations.\textsuperscript{802}

4.212 In Queensland, when the Mental Health Court is making a forensic order for a patient, it may approve that the patient move out of the State.\textsuperscript{803} However, the court may only give such approval if it is satisfied that appropriate arrangements exist for the patient’s treatment or care at the place where the patient is to move. The court may impose reasonable conditions on the approval.

\textbf{Approaches Taken in Other Reviews}

4.213 The review by the VLRC is the only recent review which has made recommendations concerning co-operative interstate transfers. In their \textit{Consultation Paper}, the VLRC highlighted some of the difficulties with the current situation:

\textsuperscript{800} \textit{Crimes (Mental Impairment and Unfitness to be Tried) Act 1997} (Vic) Part 7A.
\textsuperscript{801} \textit{Mental Health (Treatment and Care) Act 1994} (ACT) s 48K.
\textsuperscript{802} \textit{Mental Health (Treatment and Care) Act 1994} (ACT) s 48G.
\textsuperscript{803} \textit{Mental Health Act 2000} (Qld) s 288B.
Throughout Australia, the laws governing the supervision of people who are unfit to stand trial or found not guilty because of mental impairment are different. This can create complexity when a person subject to a supervision order in one state, moves to another state. There is no uniform legislation governing the interstate transfer of people subject to supervision orders in Australia and therefore interstate agreements govern the process. Limited progress has been made in finalising these agreements, ‘notwithstanding the existence of legislation enabling their development’.

When compared with the powers to apprehend a person who has left Victoria, Carroll et al argue that the situation regarding interstate transfer orders is less ‘clear cut’ and is largely a legal problem:

It was accepted that there was a ‘conflict of laws’, of the kind that frequently arises in the Australian system of federalism. While there are often compelling arguments for interstate transfers consistent with good clinical practice, such as optimising relationships with families and other support networks, the issue unfortunately remains low on the political agenda and attendant with a high degree of political sensitivity.

Interstate transfers can be beneficial for the person subject to the supervision order and their family members. However, there may be a range of reasons the transfers are difficult to effect, including the lack of complementary provisions across jurisdictions, a lack of motivation on the part of the people who are able to initiate these transfers and possibly a lack of straightforward mechanisms in the legislation to enable the transfers to occur.804

In their subsequent report, the VLRC recommended amendments to Part 7A of the Victorian Act to remove Ministerial involvement.805 The Commission formed the view that it should not be a political decision as to whether a patient is transferred interstate.806 The Commission recommended that it should be the Secretary of the Department of Health or the Secretary of the Department of Human Services (whoever is relevant for the particular patient) who should be the decision-maker in respect of an interstate transfer of the patient.807 The Commission also recommended that either the Chief Psychiatrist or the Secretary of the Department of Human Services should be able to certify that the transfer is of benefit to the person and that facilities and services are available.808 Under the current Victorian Act, only the Chief Psychiatrist has the power to make this certification.809

Submissions

The Council received eight submissions on the issue of co-operative interstate transfers. These submissions were unanimously in support of implementing a mechanism to deal with this issue, such as that in Part 7A of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic). For example, the LSC stated that:

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807 Ibid [11.234].
808 Ibid Recommendation 107.
809 See, Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) ss 73D, 73E.
There have been a number of SA cases where a person declared liable to supervision has been separated from family and social supports interstate, which is detrimental to rehabilitation. Provision definitely needs to be made for their supervision to be delegated and transferred to appropriate interstate authorities.  

4.216 The Bar Association was also supportive of this proposal, but noted that there ‘may need to be a protocol developed between the participating States and Territories for dealing with transfers. For example, there may be questions about what must be established in the receiving State before a transfer can be effected; that is, things such as treatment in place, accommodation and so on.  

4.217 While the DCS also supported the development of a procedure for co-operative transfer, they suggested that it may be desirable to implement a national approach. In this regard, they noted that:

South Australia has legislation to enable the transfer of prisoners interstate for welfare purposes and also for the transfer of parole orders interstate. This is national uniform legislation and the Department processes hundreds of applications of these kind each year.

There is also in progress (in various stages nationally) a commitment to progress uniform legislation to enable the transfer of community based orders across States and Territories.

Perhaps it may be worthwhile considering and progressing national uniform legislation for the transfer of persons under supervision to and from all States and Territories as the schemes currently in operation in relation to prisoners and offenders work extremely well.

Conclusions and Recommendations

4.218 The Council agrees with the submitters that it is important to develop a clear mechanism that provides for the co-operative interstate transfer of people under supervision. In the Council’s view, Part 7A of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) provides an appropriate model.

4.219 However, the Council also agrees with the DCS that a uniform approach to this issue would be preferable. In this regard, the Council notes that, as part of the Fourth National Mental Health Action Plan, Mental Health Ministers nationally have agreed that provisions should be enacted around Australia to enable co-operative transfers in the interest of people under supervision. The Council is supportive of this approach, and urges the government to implement any reciprocal arrangements agreed upon.

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810 Legal Services Commission of South Australia, *Submission to the Sentencing Advisory Council.*

811 South Australian Bar Association, *Submission to the Sentencing Advisory Council.*

812 Department for Correctional Services, *Submission to the Sentencing Advisory Council.*
Recommendation 25
The Council recommends developing a mechanism that provides for the co-operative interstate transfer of people under supervision.

While the provisions of Part 7A of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) provide a suitable model, it would be preferable for a formal reciprocal arrangement between States to be established. The Council therefore recommends the implementation of any reciprocal arrangements agreed upon by national Mental Health Ministers as part of the Fourth National Mental Health Action Plan.

Forensic Mental Health Facilities in South Australia

4.220 Patients utilising the FMHS in South Australia primarily consist of two groups:

- People found mentally incompetent to commit an offence or unfit to stand trial;
- Prisoners who require acute mental health care as inpatients before returning to prison, where their ongoing mental health care is managed by Forensic Prison In-Reach Services at the prison in conjunction with Prison Health Services.

4.221 In South Australia, the FMHS is currently undergoing a period of development. Given this dynamic situation, a description of what exists currently and what is planned for the future is provided below.

Current Services

4.222 The South Australian FMHS consists of the following component parts:

- **Inpatient Services (High Security):** inpatient services available to prisoners and individuals on remand who are in need of acute mental health care, and the provision of secure care to those people found not guilty by reason of mental impairment (forensic patients) and deemed by the court to require care within a secure facility. There are currently 40 beds in James Nash House: 30 at Oakden and 10 at Glenside. At the time of writing the Report these beds were filled by 34 forensic patients, four patients from the prison system, and two patients who were detained under s 269X of the CLCA.

- **Forensic Step Down Rehabilitation Services:** rehabilitation services provided to suitable forensic patients who require intensive rehabilitation prior to a planned return to the community. There are currently 10 beds in Ashton House, located outside the secure perimeter at the Oakden site of James Nash House.

- **Forensic Community Mental Health Service:** this service consists of a multidisciplinary team located at Oakden, mandated to provide supervision of all forensic patients on licence in the community.


814 At the time of writing the Report these beds were filled by 34 forensic patients, four patients from the prison system, and two patients who were detained under s 269X of the CLCA.
• **Correctional Mental Health Service**: this service includes prison in-reach, which is provided by forensic consultant psychiatrists and registrars to all prisons in South Australia. Limited prison in-reach is also provided by the Forensic Community Mental Health Service to assist the DCS in the management of offenders with mental disorders.

• **Court Assessment Service**: this service provides coordination and provision of expert reports required by the courts to investigate mental competence to commit offences and mental unfitness to stand trial, applications to vary supervision orders and release on licence conditions. It also comments on mental health considerations at the point of sentencing.

• **Court Liaison Service**: this service is attached to courts to provide mental health advice to the judiciary and courts more broadly. It also provides a mental health assessment for individuals referred by the courts who appear to have a mental illness and are awaiting sentencing, and a referral and liaison service to assist in ensuring that individuals are linked into appropriate services.

• **Owenia House**: Sex offender treatment for adult offenders who have committed sexual offences against children.

### Pressures on Forensic Services

4.223 There are current, well-publicised pressures on forensic inpatient services. The shortage of beds is of particular concern, and has impacted on wider mental health inpatient services.

4.224 Some forensic patients being held in metropolitan hospital acute wards are those that have breached licence conditions, who the courts have directed be detained in a secure mental health facility. A number of these do not require intensive psychiatric care, and their detention in mental health facilities can result in beds not being available for other patients who need acute or intensive psychiatric care. This also impacts on emergency department wait times, as patients may be held for a long time in the emergency department while awaiting an inpatient bed.

4.225 With limited access to forensic inpatient beds, there is also increased pressure on SA Police resources. The police are required to transport forensic clients to hospital when a breach of licence has occurred and, notably, they have to remain with the patient until a secure bed becomes available.

4.226 The lack of capacity in forensic inpatient mental health services has drawn criticism from a number of areas. These include comments in the OPA’s Annual Report. The Public Advocate has called for an increase in capacity to 60 beds.\(^\text{815}\)

James Nash House

4.227 James Nash House was the first institution of its type in Australia to provide forensic mental health treatment in a dedicated facility. It has been operating since 1987 and currently has 40 beds.

4.228 James Nash House provides varying levels of security and independence so that mentally disordered offenders and forensic patients are subjected to the level of security they require so they can gradually be prepared for less restrictive living. Over 50 percent of James Nash House patients have been there between 1 and 10 years.\footnote{Information provided to the Attorney-General’s Department by SA Health.}

4.229 Given the significance of James Nash House in the mental health and prison system in South Australia, the James Nash House Redevelopment Project has been approved by the Government. This project will add a new 20-bed forensic mental health facility adjacent to the existing 30-bed facility at Oakden. Upon completion, the 10-bed Glenside site of James Nash House will close.

4.230 When all works are finished, South Australia will have a total of 60 forensic mental health beds: 50 at James Nash House and 10 at Ashton House.

Patient Numbers

4.231 During the 2010-11 financial year, there were 58 discharges from the 40 forensic beds in existence at the time. These patients, depending on their treatment needs, had average lengths of stay of between 40 and 1200 days. Patient turnover is low due to the nature of the patient’s illness or conditions imposed by the courts.\footnote{Information provided to the Attorney-General’s Department by SA Health.}

4.232 On average there are 25 individuals on the waiting list for admission to James Nash House. The number can fluctuate, and recently there were 35 individuals on the waiting list. Of the 25 individuals usually on the forensic waiting list, an average of 16 (65%) are in the prison system and nine (35%) are held in adult mental health acute wards across the metropolitan hospital system.\footnote{Information provided to the Attorney-General’s Department by SA Health.}

4.233 At the time the Report was drafted, 11 of the 40 patients being held in James Nash House or at Grove Closed Ward had an intellectual disability or an acquired brain injury.\footnote{Information provided to the Attorney-General’s Department by SA Health.} As mentioned above, these individuals may have different treatment and care needs from individuals with mental impairments. Ideally, these patients would be treated in a different environment to James Nash House; however, an alternate location is not available at present.

Step-up and Step-down Facilities

4.234 While James Nash House provides an important service in forensic mental health in South Australia, there is a recognised need for an intermediate step between James Nash House and being released – either conditionally or unconditionally – into the community.
4.235 Step-up and step-down facilities are residential mental health facilities that operate to assist persons recovering from serious mental health episodes. Step-up facilities allow persons to ‘step-up’ from the community into the facility when they begin to suffer some form of relapse, preventing a worsening of the person’s condition. Step-down facilities enable a more gradual return to the community after a person leaves a hospital setting, often providing outreach and drop-in services as well as a residential program to offer further support to persons integrating back into the community.

4.236 Some facilities, such as one that is currently running in the Australian Capital Territory, act as both ‘step-up’ and ‘step-down’ facilities in one. This is a residential mental health program known as The Adult Step Up Step Down Program. The aim of the program is to prevent relapse and to assist individuals recovering from acute episodes of mental illness. The step-up component is available to individuals in the community who are displaying signs of a deterioration in their mental health. It is hoped that the highly supportive environment will prevent them from further deterioration. The Step Down component of the program provides a graduated return to the community for those exiting a hospital setting. As those individuals graduate into the community, the program continues to provide outreach services.820

4.237 At the time of writing the Discussion Paper, a step-down unit (Ashton House) was proposed as part of the development of James Nash House. This unit is now operating. It has been ‘resourced and designed to operate as a Step Down Unit from James Nash House, where patients are stable in terms of mental state, risk factors have been well assessed and any deterioration will be identified early’.821 It does not operate as a step-up unit, and is unable to do so because ‘it cannot stop a patient leaving the unit and does not have access to facilities for acute treatment’.822

4.238 When the Discussion Paper was drafted, it was anticipated that the Clinical Director would have the ability to move licensees between James Nash House and Ashton House, depending on clinical need. Under such a system, forensic staff would monitor patients in Ashton House on a daily basis, and would alert the Clinical Director if a licensee’s mental health was beginning to deteriorate. The patient could then be moved to the more secure James Nash House.

4.239 This system has not eventuated.823 Instead, a discharge from James Nash House to Ashton House is considered to be a significant reduction in supervision, and so requires the court’s approval in accordance with section 269T(2) of the CLCA.824 Once in Ashton House, the patient is considered to have been discharged to the community. In order to return him or her to James Nash House, the ODPP needs to apply to the court to suspend or revoke his or her licence. If the Clinical Director simply tries to return a patient to James Nash House without undergoing this process, it would be considered to be administrative detention, which is currently prohibited.825

821 Forensic Mental Health Service, Submission to the Sentencing Advisory Council.
822 Ibid.
823 Ibid.
824 Section 269T(2) is discussed in Part 3 of this Report.
825 Administrative detention is discussed above.
The Discussion Paper also mentioned a proposal for the creation of a ‘transitional team’, who would be used to move licensees from Ashton House into a non-forensic facility or community housing. In Dr Brereton's words:

If we were able to set up a transition team from James Nash House, the purpose would be to provide community based rehabilitation for our inpatients and facilitate accurate assessment of their progress and risk. Ideally the team would be multidisciplinary and consist of 4 staff, including Occupational Therapy, Social Work, and Nursing. These staff members would work under the existing discipline departments but would be identified as specifically available for transition. They would work with patients on the ward prior to transition, draw up leave programs and rehab goals and help provide detailed information to the courts when considering licence applications. They would be available to provide escorts for leaves, liaise with police, and link patients in with Drug and Alcohol counselling, TAFE courses etc. They would also provide detailed information regarding a patient's progress on leaves and risk assessments. With this in place we could have a number of patients on leave at the same time and facilitate a number of different types of leave - from patients who only require a few weeks to settle into a new placement, to patients who require leave for years before we could reassure the court we were comfortable they were ready to be discharged.\[826\]

A transitional team has not yet been created. It appears that there are currently no plans, or resources available, to implement this proposal.\[827\]

In the Discussion Paper, the Council asked the following question:

**Question 26: Are there comments with respect to the Step-Up and Step-Down proposal outlined and being investigated by the Director of James Nash House?**

**Submissions**

The Council received 10 submissions in relation to step-up and step-down facilities. They were all very supportive of the notion, suggesting that such facilities would provide individuals with the support necessary to transition defendants back into the community.\[828\]

Ashton House is seen to be operating successfully, and is seen to provide an ‘important opportunity to reintegrate mentally impaired offenders back into the community in a safe, supervised and graded manner’.\[829\] Some concerns were raised about the continued funding of Ashton House, with it being suggested that Commonwealth Funding may be time limited. A renewed commitment to funding was urged, so that the unit can continue to operate.\[830\]

A number of submissions raised concerns about the inability of the Clinical Director to move licensees between Ashton House and James Nash House without court intervention. For example, the LSC suggested that:

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\[826\] Information provided to the Attorney-General’s Department by SA Health.

\[827\] Forensic Mental Health Service, *Submission to the Sentencing Advisory Council*.


\[829\] Australian Medical Association (South Australia), *Submission to the Sentencing Advisory Council*.

\[830\] Office of the Public Advocate, *Submission to the Sentencing Advisory Council*; Australian Medical Association (South Australia), *Submission to the Sentencing Advisory Council*. 

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There should be provision for the Director of James Nash House to transfer forensic detainees from James Nash House itself to the Step-down unit at Ashton House without the need for the licencee to apply to the court for a formal order for release on licence. Under such a scheme the person would remain detained under s 269O(1)(b)(i) and, should any concerns arise regarding the person’s progress or state of mental health, the Director could transfer the person back to James Nash House without the need for an application to the court by ODPP to suspend or revoke an order for release on licence.\(^{831}\)

4.246 In this regard, the OPA drew a comparison between the management of prisoners by the DCS, and the management of forensic patients by the FMHS, noting that:

After a court has handed a prisoner to Corrections, the Corrections department does not have to go back to the Court to seek permission when it moves a prisoner to a low security prison, or allows a prisoner accompanied leave with staff to attend to some task in the community. In contrast the Forensic Mental Health service cannot make even small changes to a patients regime without Court agreement. The value of this involvement should be questioned. There is an argument that there should be a greater reliance on Forensic Mental Health practitioners to responsibly administer a robust and transparent risk management system. Changes could be reported to the Court, and subject to review if parties disagreed.

We appreciate that Ashton House is new, and its performance is yet to be evaluated. However after this has been done, and it is clear that the model is effective and working, it would be reasonable to give forensic mental health services the discretion for patients to be moved from the medium security environment of James Nash House to the lower security setting of Ashton House, and then notify the Court. This would be different to the current need to seek Court approval.\(^{832}\)

4.247 The OCPP contended that the best solution to this issue would be ‘for people detained under s 269 for mental illness to be ordered into the custody of the Minister only, letting SA Health determine where and how it will deliver custody and/or treatment to the person… SA Health would then have the responsibility for moving people to the step down facility or more secure facilities as clinical and safety needs change over time.’\(^{833}\)

4.248 The FMHS noted that efforts ‘have been made to try and obtain more flexible licence conditions by the forensic service. It has been proposed that Ashton House and James Nash House should be considered part of a forensic mental health campus which together make up the forensic residential service, thus allowing movement based on clinical need.’\(^{834}\) However, to date the courts have rejected this proposal. The submission of the FMHS also supported the creation of a transition team, arguing that it ‘would significantly improve existing services in terms of rehabilitation and risk reduction’.\(^{835}\)

4.249 The DCS addressed two additional issues. First, they suggested that a step down facility may be beneficial for people detained in their custody.\(^{836}\) Secondly, they thought that it would be ‘advantageous if the proposed step down facility included a

\(^{831}\) Legal Services Commission of South Australia, *Submission to the Sentencing Advisory Council*.
\(^{832}\) Office of the Public Advocate, *Submission to the Sentencing Advisory Council*.
\(^{833}\) Office of the Chief Psychiatrist and Mental Health Policy, *Submission to the Sentencing Advisory Council*.
\(^{834}\) Forensic Mental Health Service, *Submission to the Sentencing Advisory Council*.
\(^{835}\) Ibid.
\(^{836}\) Department for Correctional Services, *Submission to the Sentencing Advisory Council*.

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specialist component specifically dedicated to addressing the needs of people with
cognitive disability, with disability support and clinical staff specifically trained for
the role and to undertake consistent, day to day behavioural intervention”. 837

Conclusions and Recommendations

4.250  The Council strongly supports the use of step-up and step-down facilities. It
believes the use of such facilities can help transition licensees back into the
community by providing appropriate supports and safeguards. The Council believes
that facilities such as Ashton House play a crucial role in the licence system, and
their continued operation should be encouraged.

4.251  The Council understands the desire to have a flexible system that allows
licensees to be easily transferred between James Nash House and Ashton House according to
clinical need. However, it also appreciates the need for some kind of oversight of
this process, in light of the lower levels of supervision available at Ashton House.
As noted above, victims and next of kin play an important role in this system, and it
may be appropriate for them to be notified or consulted prior to a licensee’s level of
supervision being significantly reduced.

4.252  In the Council’s view, this balance could be best addressed by the involvement of a
Mental Health Tribunal or Board in the process (as discussed below). Such a body
should be empowered to assist the step-up and step-down process to operate in an
efficient manner, that safeguards the needs of the licensee, victims, next of kin and
the community. In some cases it may be appropriate to require the licensee to apply
to have his or her level of supervision amended, while in other cases it may be
appropriate for decisions to be made by the Clinical Director without court
intervention. This should be determined by the tribunal or board on a case-by-case
basis.

Recommendation 26

The Council supports the use of step-up and step-down facilities.

A Mental Health Tribunal or Board should be empowered to assist with the efficient operation
of the step-up and step-down process. It should be for the Tribunal or Board to determine the
necessary level of court involvement in transitioning a licensee between James Nash House
and a step-up or step-down facility.

Supervision by a Mental Health Review Board or Tribunal

4.253  Every Australian jurisdiction, other than the Commonwealth and the Northern
Territory, has established some kind of specialist body to assist in the supervision of
individuals released on licence.

4.254  Four jurisdictions (the ACT, NSW, Qld and Tas) have established specialist
tribunals (or lists in generalist tribunals). While the models differ,838 the tribunals

837 Ibid.
can generally make orders for detention or release of licensees, impose conditions on licences, oversee licensees’ supervision and conduct reviews.\textsuperscript{839}

4.255 By contrast, Victoria has created the Forensic Leave Panel, an independent statutory body with jurisdiction to consider applications for certain types of leave for forensic patients and forensic residents.\textsuperscript{840} Leaves of absence which can be granted by the Forensic Leave Panel include on-ground leave, limited off-ground leave and special leave.\textsuperscript{841}

4.256 In Western Australia, the MIARB reports and makes recommendations to the Attorney-General on matters relating to people who are either unfit to stand trial or acquitted on account of unsoundness of mind and detained under custody orders issued under the Act.\textsuperscript{842} The MIARB also decides where a mentally impaired accused should be detained, and in certain circumstances may make or cancel leave of absence orders. It is for the MIARB to appoint and oversee the licensees’ supervising officers.

4.257 In the Discussion Paper, the Council sought comments on the establishment of such a body in South Australia. It noted that if this were to be done, a wide range of issues would need to be carefully considered, including:

- Whether it should be an existing body or a new body established for the purpose of supervision;
- Who its membership should include. For example, should it have representation from organisations such as the Parole Board or DCS?
- What areas it should address. For example, should it monitor conduct, grant leave, be able to vary security or terminate orders?
- Whether it should be able to make orders in all of the relevant areas, or whether there should be areas where it should simply make recommendations to the relevant Minister or the court. For example, should the Tribunal be allowed to revoke a non-custodial order?
- Whether the Minister for Health and the Parole Board would retain their supervisory roles; and
- What part, if any, the court should continue to play. For example, should the court’s function cease once orders have been made under s 269O, with the


\textsuperscript{839} The relevant tribunals are: the ACT Civil and Administrative Tribunal (ACAT), the Mental Health Review Tribunal (NSW), the Mental Health Review Tribunal (Qld) and the Mental Health Tribunal (Tas).

\textsuperscript{840} See \textit{Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)} ss 59-73.

\textsuperscript{841} The Victorian Law Reform Commission’s \textit{Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997: Report} did not recommend any change to the types of decisions made by the Forensic Leave Panel. However, the Commission did recommend changes to provide the Forensic Leave Panel with more guidance in relation to its decision-making: Victorian Law Reform Commission, \textit{Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997: Report} (Victorian Law Reform Commission, 2014) xxxiv, [10.279]-[10.283].

person thereafter being subject to supervision and management by experts in the mental health sector? Should the Tribunal be required to report back to the court at any stage?

4.258 If established, a Mental Health Review Board or Tribunal would need to fit into the existing structures and frameworks, particularly in the Magistrates Court, that are designed to assist offenders who have a mental illness and/or co-morbid issues.

4.259 The Council raised the question of whether the recently established South Australian Civil and Administrative Tribunal (SACAT) may provide a suitable framework within which to institute a Mental Health Review Board or Tribunal. It noted that one possible drawback to this approach could be the relatively small pool of experts with the relevant expertise to sit on such a Tribunal.

4.260 The following questions were asked in the Discussion Paper:

Question 27: Should South Australia consider introducing a Mental Health Review Tribunal, Board or equivalent to assist in the supervision of individuals released on licence? If so, what functions and powers would such a Tribunal, Board or equivalent perform?

Approaches Taken in Other Reviews

4.261 In its Report on Mental Impairment Decision-Making and the Insanity Defence the NZLC recommended the establishment of a specialised independent tribunal. In making this recommendation, the Commission noted that:

An independent Tribunal or Board is the most commonly observed model in the overseas jurisdictions surveyed and, in our view, is the preferred model for the present purposes, for all three classes of patient including special care recipients.

On review of the New South Wales forensic mental health legislation, which has recently been implemented, the overwhelming majority of submissions supported transferring all such decision-making to a Tribunal, for reasons that included:

- The Tribunal’s membership (including both legal and medical experts) would ensure that it has specialist expertise in the areas of mental health and dangerousness, as well as the advantages of legal expertise.

- The system would provide transparency in decision-making – no less transparency than a court, and a great deal more than either an Executive or a clinical decision.

- Because a Tribunal is generally quicker and less formal than the courts, it could be clinically advantageous, because clinical recommendations could be acted on speedily, and the forum would be likely to lend itself better to ongoing monitoring of forensic patients’ progress. The relative informality and non-adversarial nature of proceedings would make the review process more user friendly for patients and their victims.

843 The establishment of the SACAT was announced by the Premier in June 2013. It is an independent statutory body, charged with the review of a number of administrative decisions made by the government that are currently reviewed by a variety of different bodies.

Similar factors were raised by the VLRC which recently examined the issue of whether Victoria should introduce a tribunal. In their *Consultation Paper*, the VLRC suggested that the introduction of a specialist tribunal may have the following benefits:  

- It may allow for judges to develop a higher level of expertise in forensic mental health;
- It may provide for greater involvement of clinicians;
- It may be in a better position than a court to explore the dangerousness of people with mental illnesses;
- It may ameliorate the perceived over-cautiousness of courts in making decisions relating to people subject to supervision orders;
- It may be more therapeutic for the individuals involved (as the adversarial nature of courts may be counter-therapeutic);
- Its informal nature may make the proceedings more accessible to the licensees, victims and family members;
- It would have a greater capacity than a court to schedule matters and to monitor a person’s progress; and
- It would free up resources in other courts.

However, the Commission noted that there are also a number of benefits in maintaining a judicial model of decision making:

- Courts have an established procedural framework and safeguards, including mechanisms for appeal;
- Courts are able to develop valuable jurisprudence in the area;
- Courts provide continuity in approach, with the judge responsible for the supervision order generally also being responsible for review and revocation of that order;
- Courts provide a forum that is more open to public scrutiny; and
- Courts confer a degree of authority which may be more effective at reassuring victims that their interests are important and being meaningfully represented.

In their *Report*, the VLRC recommended that the existing judicial model of decision-making should be retained as there was insufficient support in Victoria to sustain a recommendation for a mental health court or tribunal. The VLRC also

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846 Ibid [9.68]-[9.70].

concluded that the benefits of the judicial model outweigh those of an alternative model.\textsuperscript{848}

**Submissions**

4.265 The Council received 10 submissions addressing the possible establishment of a specialist tribunal or board. Of these, four argued in favour of creating such a body, four were equivocal, and one argued against it.

4.266 Strong support for the proposal came from the OPA, who referred to the establishment of such a body throughout their submission. In their view, the current review process ‘does not adequately look after either the rights and welfare of forensic patients, or the rights and welfare of victims and their families. A move to transfer the current role of the Courts, to a suitably qualified tribunal or specialist Court, should create a more satisfactory system for all participants’.\textsuperscript{849}

4.267 The OPA’s submission suggested that the tribunal ‘could make initial determinations of mental competence, and then routinely supervise patients, taking over the existing role of the Courts’.\textsuperscript{850} It queried whether the tribunal should take over Parole Board functions so that all decisions would be made by a single panel. If this were to be the case, ‘members of the Parole Board would need to be coopted to sit on the tribunal to provide this expertise’.\textsuperscript{851}

4.268 Similarly strong support for this proposal was offered by the OCPP, whose detailed submission on this issue is worth quoting at length:

1. There should be a Mental Impairment Review Board as part of the SACAT. The MIRB would deal with matters relating to s 269 impairment because of mental illness and with mental health orders and appeals under the MHA2009 currently heard by the Guardianship Board. The MIRB would also deal with matters relating to s 269 impairment because of intellectual disability and acquired brain injury, and with guardianship orders, administration orders and s 32 orders currently handled by the Guardianship Board.

2. The MIRB would draw on existing mental health expertise in the Parole Board, community corrections, FMHS, GSB at its inception and would draw membership from these bodies, as well as mental health services in general, legal professionals and community members as time went on.

3. The MIRB would manage all aspects of a person released on license by the Court.

4. The MIRB should have the power to make “CLCA Temporary Treatment Orders” as described … above.

5. S 269 people who are detained should continue to be supervised by the appropriate Minister but s 269 people released on license should be supervised by the MIRB.

6. Options for release from detention to on license in the community similar to WA could be explored, including having an extended trial of leave from detention/Minister

\textsuperscript{848} Ibid [10.31].  
\textsuperscript{849} Office of the Public Advocate, *Submission to the Sentencing Advisory Council*.  
\textsuperscript{850} Ibid.  
\textsuperscript{851} Ibid.
supervision to on license/MIRB supervision, as a precursor to the Court considering changing an order for detention to on license supervision in the community.

7. The MIRB should provide an annual report to the Minister (and to SACAT).

The AMA(SA) argued that the establishment of a tribunal could help streamline the processes concerning licensees. It would also help ensure that decision-makers were familiar with mental illness, and the options for supervision and rehabilitation. The OCEP suggested that, if developed within a human rights framework, such a tribunal could “provide another layer of necessary safeguards to protect both the human rights of the individual as well as to ensure the continued safety of the broader community.”

While the FMHS supported the proposal, they were concerned to ensure that the powers of the tribunal were carefully defined and operationalised, to avoid ‘unnecessary administrative and clinical obstacles with respect to patient movement’. Similar concerns were raised by the DCS, who neither supported nor opposed the proposal. They simply stated that:

If a Mental Health Review Board or Tribunal or equivalent was established the (new) role (if any) of the Parole Board would need to clearly defined and stated. The suggestion of having a Parole Board and Corrections membership on such a Tribunal has merit given the current involvement of these Agencies in the supervision of licensees, However, the roles of Corrections and the Parole Board may alter significantly dependent upon the powers granted to a Tribunal if progressed. Corrections may not be allocated responsibility to supervise licensees at all, for example.

It appears to make sense to have a group of multidisciplinary experts to sit on such matters, but the day-to-day supervision or monitoring probably not practical to be able to be assigned to the Board.

The South Australian Civil and Administrative Tribunal Bill 2013 is currently before the Parliament and the Paper suggested that this may provide a suitable framework within which to institute a Mental Health Review Board or Tribunal.

The Law Society, the DPP and the CVR were not opposed to the establishment of a board or tribunal, but each expressed some concerns. The Law Society and the DPP were concerned about whether, in a state as small as South Australia, there was sufficient expertise to sit on such a tribunal whenever access to it was needed. The DPP was also worried about the level of resources that would be required to set up such a body.

The CVR was concerned that removing court oversight of the process might undermine the symbolic message that the offending is taken seriously. He also

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852 Office of the Chief Psychiatrist and Mental Health Policy, Submission to the Sentencing Advisory Council.
853 Australian Medical Association (South Australia), Submission to the Sentencing Advisory Council.
855 Forensic Mental Health Service, Submission to the Sentencing Advisory Council.
856 Department for Correctional Services, Submission to the Sentencing Advisory Council.
857 Law Society of South Australia, Submission to the Sentencing Advisory Council; Director of Public Prosecutions, Submission to the Sentencing Advisory Council.
wanted to make sure that the presiding authority was independent, impartial, and was required to ‘weigh and protect the rights of all involved, including victims’. 858

4.273 The sole objector to the establishment of a specialist tribunal was the LSC, who argued that:

Reviews of licence condition and licensees’ progress should remain the responsibility of the court rather than consideration by a tribunal which is not bound by rules of evidence. In addition, the level of funding currently available is insufficient to make such a body genuinely effective. If additional funding was made available in the future, it would be better spent on supervised housing for intellectually disabled detainees. 859

Conclusions and Recommendations

4.274 It is the Council’s view that a specialist mental health tribunal or board should be established to assist in the supervision of licensees. Such a body has a great number of benefits. It allows members of the tribunal to develop a high level of expertise in the area. It can involve clinicians in the decision making process, ensuring that licensees’ needs are appropriately addressed. Its informality is likely to encourage greater involvement of licensees and victims in the process, and lead to better outcomes. It can also provide continuity of case management that may not be possible under the current court system.

4.275 The fact that most other jurisdictions have established specialist tribunals, which have functioned effectively, provides further support for such an approach. It is the Council’s recommendation that a working party should be developed to closely examine the different models used in other Australian jurisdictions, to determine which aspects should be incorporated into the South Australian model. The relevant powers, functions and operations of the tribunal will need to be clearly outlined.

4.276 The Council believes that the powers of the tribunal should be limited to matters concerning the supervision of individuals released on licence. The tribunal should not play a role in making the initial determination about whether an individual is mentally impaired, or whether the elements of the mental incompetence defence have been met. That is a role that should stay with the courts.

Recommendation 27

The Government should consider introducing a Mental Health Review Tribunal, Board or equivalent to assist in the supervision of individuals released on licence.

A working party should be established to consider the powers, functions and operations of such a Tribunal, Board or equivalent.

If a Tribunal, Board or equivalent is introduced, the court should retain its current role as the body which determines whether the person was mentally incompetent to commit the offence.

858 Commissioner for Victims' Rights, Submission to the Sentencing Advisory Council.

859 Legal Services Commission of South Australia, Submission to the Sentencing Advisory Council.
Summary of Recommendations
The Defence of Mental Incompetence

Recommendation 1

Section 269C(a) of the Criminal Law Consolidation Act 1935 should not be amended to define the phrase ‘nature and quality of the conduct’ or to replace the word ‘knowledge’ with the word ‘understanding’.

Recommendation 2

Section 269C(b) of the Criminal Law Consolidation Act 1935 should be amended to reflect section 7.3(1)(b) of the Schedule to the Criminal Code Act 1995 (Cth), leaving out the words ‘with a moderate degree of sense and composure’. This would mean that a person would not know the conduct was wrong if, as a consequence of a mental impairment, the person could not reason about whether his or her conduct, as perceived by reasonable people, was wrong.

Recommendation 3

The existing drafting of s 269C(b) should be amended as follows: does not know the conduct is wrong, that is, he or she could not reason about whether the conduct, as perceived by reasonable people, was wrong.

Recommendation 4

Section 269C(c) of the Criminal Law Consolidation Act 1935 should be retained, but should be amended to require the defendant to be totally unable to control his or her conduct. It should be made clear that a partial inability to control conduct is not sufficient.

Recommendation 5

The definition of mental illness in section 269A of the Criminal Law Consolidation Act 1935 should not be amended to specifically include or exclude any medical condition, including hypoglycaemia or hyperglycaemia.

Recommendation 6

The definition of mental illness in section 269A of the Criminal Law Consolidation Act 1935 should not be amended to expressly declare that the objective test formulated by Chief Justice Mason and Justices Brennan and McHugh in R v Falconer (1990) 171 CLR 30 must be applied to distinguish between sane and insane automatism in cases involving dissociation.

Recommendation 7

The definition of mental impairment in section 269A of the Criminal Law Consolidation Act 1935 should not be amended to specifically include or exclude personality disorders. The wording of section 269A should remain in its current form.
Recommendation 8

The Criminal Law Consolidation Act 1935 should not be amended to allow people to rely on the defence of mental incompetence when, from whatever cause, they are unable to understand the nature and quality of their conduct or to understand that it is wrong.

Recommendation 9

The Criminal Law Consolidation Act 1935 should not be amended to prevent people from relying on the defence of mental incompetence when their inability to understand the nature and quality of their conduct, inability to understand that it was wrong, or incapacity for self-control was a consequence of the combined effects of mental illness and a state of self-induced intoxication.

Recommendation 10

The Criminal Law Consolidation Act 1935 should not be amended to prevent people from relying on the defence of mental incompetence when their mental illness was caused by the use of intoxicants, but is not permanent, prolonged, persistent, protracted or enduring.

Recommendation 11

The existing provisions on intoxication and mental impairment in the Criminal Law Consolidation Act 1935 should be retained without change.

The Fixing of Limiting Terms

Recommendation 12

There should be a reduction in the number of psychiatric reports required under section 269T of the Criminal Law Consolidation Act 1935. Regardless of the nature of the offence committed, the default position should be the production of just one report, to be provided by a psychiatrist (or other appropriate expert) who has personally examined the defendant.

Recommendation 13

Judicial officers should be provided with a broad discretion to order further reports under section 269T of the Criminal Law Consolidation Act 1935 where necessary.

Recommendation 14

The Government should consider enacting additional dispositions for people found not guilty because of mental incompetence. Particular consideration should be given to the following two options:

- Enacting a provision similar to section 20BQ of the Crimes Act 1914 (Cth); and
- Allowing judicial officers to impose conditional bonds on defendants for less serious offences. The maximum duration of such bonds should be capped.
Recommendation 15

The limiting term system should be retained.

The court should continue to fix the limiting term by reference to the term of imprisonment that would have been imposed had the defendant been convicted of the offence and sentenced in the usual way.

The court should not be allowed to take into account the fact that the objective facts have been admitted when fixing a limiting term.

Supervision of Individuals Released on Licence

Recommendation 16

The Criminal Law Consolidation Act 1935 should be amended by adopting a provision similar to section 39(2) of the Mental Health (Forensic Provisions) Act 1990 (NSW), which ensures that a defendant will not be released from custody unless, on the balance of probabilities, the safety of that person or any member of the public will not be seriously endangered by the person’s release.

Recommendation 17

The requirements for the production of victim and next of kin reports contained in the Criminal Law Consolidation Act 1935 should not be amended.

The ODPP should continue to be allowed to make oral reports in cases where the victim or next of kin does not wish to participate in the process.

In appropriate circumstances people other than the direct victim should be consulted when preparing victim and next of kin reports.

Additional resources should be allocated to the preparation of victim and next of kin reports.

Recommendation 18

A lead agency should not be nominated to be primarily responsible for the supervision of an individual licensee.

Recommendation 19

The Criminal Law Consolidation Act 1935 should be amended to extend the shared supervisory role of the Minister for Health and the Parole Board to the Minister for Disabilities.

Recommendation 20

Tailored options for housing and support should be provided for individuals with cognitive impairments who are found not guilty of an offence due to mental incompetence, or who are unfit to stand trial. Such individuals should not be housed in James Nash House, which is specifically designed for individuals with mental health issues.
Recommendation 21

The Council does not recommend amending the Mental Health Act 2009 to enable licensees to be assessed and treated as an alternative to revoking their licences and returning them to secure detention at James Nash House.

The Council supports the appropriate use of home detention and electronic monitoring for licensees.

Recommendation 22

The Council does not recommend introducing a criminal sanction for licensees who breach the terms of their licenses.

Recommendation 23

The Criminal Law Consolidation Act 1935 should be amended to allow for a licensee to be administratively detained for up to 14 days where future breaches of licence conditions are likely, or treatment is required in order to prevent future breaches.

Recommendation 24

The Council does not recommend introducing a statutory provision allowing police officers or other authorised officers to take care and control of interstate forensic patients who are found in South Australia, and to return them to the jurisdiction that made the orders. The Council is of the view that the present practice of applying for warrants under the Service and Execution of Process Act 1992 (Cth) should be retained.

The Council does not recommend enacting statutory provisions similar to those in Part 7B of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic).

Protocols should be developed for use in circumstances where forensic patients impermissibly cross State borders.

Recommendation 25

The Council recommends developing a mechanism that provides for the co-operative interstate transfer of people under supervision.

While the provisions of Part 7A of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) provide a suitable model, it would be preferable for a formal reciprocal arrangement between States to be established. The Council therefore recommends the implementation of any reciprocal arrangements agreed upon by national Mental Health Ministers as part of the Fourth National Mental Health Action Plan.

Recommendation 26

The Council supports the use of step-up and step-down facilities.

A Mental Health Tribunal or Board should be empowered to assist with the efficient operation of the step-up and step-down process. It should be for the Tribunal or Board to determine the necessary level of court involvement in transitioning a licensee between James Nash House and a step-up or step-down facility.

Recommendation 27

The Government should consider introducing a Mental Health Review Tribunal, Board or equivalent to assist in the supervision of individuals released on licence.

A working party should be established to consider the powers, functions and operations of such a Tribunal, Board or equivalent.

If a Tribunal, Board or equivalent is introduced, the court should retain its current role as the body which determines whether the person was mentally incompetent to commit the offence.
List of Cases and Legislation
Cases

Cooper v McKenna; Ex parte McKenna [1960] Qd R 407

DPP v Majewski [1977] AC 443

Edward Arnold (1724) 16 St. Tr. 695

M’Naghten (1843) 10 Cl & Fin 200

McDermott v Director of Mental Health; Ex parte A-G (Qld) (2007) 175 A Crim R 461

People v Kelly 10 Cal. 3d 565 (1973)

Police v Hellyer [2002] SASC 61

Question of Law Reserved (No. 1 of 1997) 70 SASR 251

R v Ayoub [1984] 2 NSWLR 511

R v Behari (2011) 110 SASR 147

R v Bini [2003] SADC 35

R v Bowen [2014] SASC 81

R v Byrne [1960] 2 QB 396

R v Carter [1959] VR 105

R v Codere (1917) 12 Cr App R 21

R v Connolly (1958) 76 WN (NSW) 184

R v Cox [2006] SASC 188

R v Davis (1881) 14 Cox CC 563

R v Draoui (2008) 101 SASR 267

R v Ey (No 2) [2012] SASC 116

R v Falconer (1990) 171 CLR 30

R v Hadfield (1800) 27 St. Tr. 1281


R v Hodges (1985) 19 A Crim R 129

R v Jeffrey (1992) 7A Crim R 55

R v Jones [1996] NSWSC 124

R v Kemp [1957] 1 QB 399

R v Martin (No 1) (2005) 159 A Crim R 314

R v Meddings [1966] VR 306
R v Milka [2010] SASC 250
R v O’Connor (1979) 146 CLR 64
R v Porter (1933) 55 CLR 182
R v Quick [1973] QB 910
R v Radford (1985) 42 SASR 266
R v Ridings [2008] SASC 366
R v Rivett (1950) 34 Cr App R 87 (CA)
R v Sebalj [2003] VSC 181
R v Shields [1967] VR 706
R v Steele (No 2) [2012] SASC 162
R v Stones (1955) 56 SR (NSW) 25
R v Sullivan [1984] AC 156
R v T, JA [2013] SADC 12
R v Tsiaras [1996] 1 VR 398
R v Tzeegankoff [1998] SASC 6639
R v Wagner [2014] SASC 70
R v Weeks (1993) 66 A Crim R 466
R v Zilic [2010] SASC 70
Rabey v R (1977) 37 CCC (2d) 461
Ryan v R (1967) 121 CLR 205
Schwark v Police [2011] SASC 212
Sodeman v R (1936) 55 CLR 192
Stapleton v R (1952) 86 CLR 358
State v Sexton (2003-331); 180 Vt 25
Veen v The Queen (No 2) (1987-1988) 164 CLR 46
Waitemato Health v A-G (2001) 21 FRNZ 216
Willgoss v R (1960) 105 CLR 295
Windle [1952] 2 QB 826
Youssef (1990) 50 A Crim R 1 (CCA NSW)
Legislation

Crimes Act 1900 (ACT)
Crimes Act 1914 (Cth)
Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)
Criminal Code 1899 (Qld)
Criminal Code Act (NT)
Criminal Code Act 1913 (WA)
Criminal Code Act 1924 (Tas)
Criminal Code Act 1995 (Cth)
Criminal Code Act 2002 (ACT)
Criminal Justice (Mental Impairment) Act 1999 (Tas)
Criminal Law (Mentally Impaired Accused) Act 1996 (WA)
Criminal Law (Sentencing) Act 1988 (SA)
Criminal Law Consolidation (Mental Impairment) Amendment Act 2000 (SA)
Criminal Law Consolidation Act 1935 (SA)
Criminal Lunatics Act 1800 (39 & 40 Geo. III c. 94)
Disability Act 2006 (Vic)
Forensic Disability Act 2011 (Qld)
Mental Health (Forensic Provisions) Act 1990 (NSW)
Mental Health (Treatment and Care) Act 1994 (ACT)
Mental Health Act 2000 (Qld)
Mental Health Act 2007 (NSW)
Mental Health Act 2009 (SA)
Mental Health Act 2013 (Tas)
Mental Health Act 2014 (Vic)
Prisoners’ Counsel Act 1836
Sentencing Act 1995 (WA)
Service and Execution of Process Act 1992 (Cth)
Mental Impairment Flow Chart

Flowchart provided by Witness Assistance Services, DPP, SA Attorney-General’s Department
Analysis of the Case File Review

In order to gain a clearer picture about how section 269C of the Criminal Law Consolidation Act 1935 is currently operating in South Australia, the Attorney-General’s Department undertook a file review on behalf of the Sentencing Advisory Council. The file review included an analysis of a high proportion of cases where there had been a finding of not guilty on the basis of mental incompetence in the South Australian District and Supreme Courts between 2006 - 2012. The percentage of cases reviewed was approximately 90% of the total number of cases where a finding of mental incompetence was made by the courts during the relevant period. In total, 55 individual cases were reviewed.

A number of factors were considered, including: the percentage of males and females found not guilty; whether there were any prior offences; whether there had been a prior diagnosis of mental illness; which limb of section 269C applied; whether the judge gave the basis for the finding of mental incompetence; the number of individuals that had consumed drugs or alcohol in the weeks or days preceding the offending act(s); the classes of offences committed by the individuals; whether the individual had been released unconditionally, detained or released on licence (upon a finding of not guilty and an order as to supervision); the limiting terms imposed; the number of individuals subject to a review of their licence before the court on the basis of a breach of licence; and the number of individuals that committed subsequent offences whilst on licence.

The outcomes of the review have been shown in graph form below.

A snapshot of the outcomes of the file review indicates the following:

- 78% of the individuals were male and 22% were female;
- 40% of the individuals committed offences against the person, including serious assault, creating risk of harm, endangering life and wounding with intent;
- 69% of the individuals had prior offences. Of those with a prior offence a high proportion had been dealt with in the traditional manner in the courts (82%), and not by way of the section 269 legislation (8%);
- 85% of individuals had been diagnosed with a mental illness prior to the commission of the offence. Of those diagnosed with a mental illness 64% had been prescribed medication;
- The primary psychiatric diagnosis was schizophrenia (47%), followed by drug-induced psychosis (15%) and bipolar disorder (10%) (keeping in mind that many individuals had co-morbid conditions which is the existence of two or more psychiatric conditions);
- Limb (b) of section 269C (that the defendant did not know that the conduct was wrong) was the basis for the finding of mental incompetence in 87% of all matters;
- 65% of judges did not give the basis of their finding that an individual was not guilty by reason of mental incompetence;
- 80% of all individuals indicated that drugs and/or alcohol had been a problem for them in the past;
- 73% of all individuals indicated they had ingested drugs and/or alcohol in the weeks or days leading up to the commission of the offence;

- Only 20% of individuals were tested for drugs and/or alcohol upon being arrested by police;

- Upon a finding of not guilty and an order as to supervision, 64% of individuals were released on licence, 32% were detained, and 2% were released unconditionally;

- Of those who have been detained half have since been released;

- There is evidence that half of the individuals released on licence have breached the conditions of that licence;

- In 86% of cases where there was evidence of a breach there was also evidence of multiple breaches associated with the consumption of drugs and/or alcohol; and

- Where a breach of licence was evident the DPP brought an application to review the licence before the court in 30% of cases.

- Whilst every effort was made to ensure the accuracy of the data, the results have not been independently verified and on that basis their accuracy cannot be guaranteed.
OUTCOMES OF THE REVIEW IN GRAPH FORMAT

1. Breakdown of individuals (male/female)

   - Male: 78%
   - Female: 22%

2. Individuals with prior offences

   - Had Priors: 69%
   - No Priors: 27%
   - Uncertain: 4%
3. For those individuals who had committed prior offences, the manner in which they were dealt with in the courts.

4. The number of individuals diagnosed with a mental illness prior to committing the offence.
5. Of the individuals diagnosed with a mental illness, the percentage which had been prescribed medication.

6. The limb of s269(C) which was used as the basis for the finding of mental incompetence.
7. Whether the judge presiding over the matter gave the basis for the finding of mental incompetence (i.e. the nature of the mental impairment and the limb that applied)

8. The percentage of individuals where drugs and/or alcohol had presented a problem for the individual in the past.
9. The percentage of individuals who reported as having consumed (or tested positive for) drugs and/or alcohol in the weeks or days leading up to the commission of the offence.

![Graph showing percentages of Yes, No, and Unable To Determine.](image)

73% Yes
25% No
2% Unable To Determine

10. The number of matters where testing for drugs and/or alcohol was carried out by police or medical staff following the arrest of an individual.

![Graph showing percentages of No, Yes Positive, Yes Negative, and Uncertain.](image)

76% No
15% Yes Positive
5% Yes Negative
4% Uncertain
11. The limiting terms imposed.

12. Where a finding of not guilty was made and an order as to supervision - the level of supervision imposed (ROL = release on licence)
13. If detained, the number of individuals that have since been released.

14. If released on licence, the number of individuals where a breach of licence conditions was evident.
15. Where a breach had been indicated was there evidence of multiple breaches?

16. Where there was evidence of multiple breaches to what extent did the breaches relate to the consumption of drugs and/or alcohol.
17. What percentage of matters, where a breach or breaches were indicated, did the DPP bring an application before the court for a review of the licence?

- No: 70%
- Yes: 30%

18. Upon release on licence how many individuals have committed a subsequent offence?

- No: 84%
- Yes: 16%
19. The categories of offences committed by the individuals. 
(Please see details of the breakdown of offences at the end of Appendix B)
20. The categories of formal psychiatric diagnoses
(Please see the breakdown of the diagnosis of Schizophrenia at the end of Appendix B)
1. Offences Creating Risk, Threatening or Causing Physical Harm/ Assault Offences
   - Cause harm
   - Aggravated causing harm with intent to cause harm
   - Aggravated causing serious harm with intent to cause serious harm
   - Aggravated unlawfully causing serious harm with intent to cause serious harm
   - Wounding with intent
   - Creating Risk of Harm
   - Aggravated creating risk of harm
   - Aggravated threatening to cause harm
   - Create risk of serious harm
   - Creating risk of grievous bodily harm
   - Aggravated endangering life
   - Attempt to endanger life
   - Endangering life
   - Aggravated threatening life
   - Threatening life
   - Assault
   - Aggravated assault
   - Aggravated assault causing harm
   - Assault a police officer
   - Assault causing harm
   - Assault occasioning actual bodily harm
   - Indecent assault

2. Property Related Offences
   - Arson
   - Damaging property
   - Property damage
   - Attempt using motor vehicle without consent
   - Possessing firearm without a licence
   - Throwing objects at a vehicle

3. Criminal Trespass
   - Aggravated criminal trespass in a place of residence
   - Aggravated serious criminal trespass
   - Aggravated serious criminal trespass in a place of residence
   - Attempted aggravated serious criminal trespass in a place of residence
   - Serious criminal trespass in a place of residence

4. Offences of Dishonesty
   - Theft
   - Robbery
   - Aggravated robbery
   - Blackmail
   - False imprisonment

5. Police Related Offences
   - Resisting police
• Escape custody
• False report to police
• Aggravated escaping police pursuit by dangerous driving
• Drive dangerously to escape police

6. Diagnosis Groups:
• Schizophrenia
• Schizoaffective disorder
• Paranoid schizophrenia
• Chronic schizophrenia
• Treatment resistant schizophrenia
Part 8A—Mental impairment

Division 1—Preliminary

269A—Interpretation

(1) In this Part—

authorised person means a person authorised by the Minister to exercise the powers of an authorised person under this Part;

defence—a defence exists if, even though the objective elements of an offence are found to exist, the defendant is entitled to the benefit of an exclusion, limitation or reduction of criminal liability at common law or by statute;

defensible—a defendant's conduct is to be regarded as defensible in proceedings under this Part if, on the trial of the offence to which the proceedings relate, a defence might be found to exist;

intoxication means a temporary disorder, abnormality or impairment of the mind that results from the consumption or administration of intoxicants and will pass on metabolism or elimination of intoxicants from the body;

judge includes magistrate;

mental illness means a pathological infirmity of the mind (including a temporary one of short duration);

mental impairment includes—

(a) a mental illness; or
(b) an intellectual disability; or
(c) a disability or impairment of the mind resulting from senility, but does not include intoxication;

Minister means the Minister responsible for the administration of the Mental Health Act 1993;

next of kin of a person means a person's spouse, domestic partner, parents and children;

objective element of an offence means an element of an offence that is not a subjective element;

psychiatrist means a person registered under the Health Practitioner Regulation National Law as a specialist in psychiatry;

subjective element of an offence means voluntariness, intention, knowledge or some other mental state that is an element of the offence;

supervision order — see section 269O;

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victim, in relation to an offence or conduct that would, but for the perpetrator's mental impairment, have constituted an offence, means a person who suffered significant mental or physical injury as a direct consequence of the offence or the conduct.

(2) For the purposes of this Part—

(a) the question whether a person was mentally competent to commit an offence is a question of fact;

(b) the question whether a person is mentally unfit to stand trial on a charge of an offence is a question of fact.

Note—

1 A condition that results from the reaction of a healthy mind to extraordinary external stimuli is not a mental illness, although such a condition may be evidence of mental illness if it involves some abnormality and is prone to recur (see R v Falconer [1990] 171 CLR 30).

269B—Distribution of judicial functions between judge and jury

(1) An investigation under this Part by the Supreme Court or the District Court into—

(a) a defendant's mental competence to commit an offence or a defendant's mental fitness to stand trial; or

(b) whether elements of the offence have been established,

is to be conducted before a jury unless the defendant has elected to have the matter dealt with by a judge sitting alone.

(2) The same jury may deal with issues arising under this Part about a defendant's mental competence to commit an offence, or fitness to stand trial, and the issues on which the defendant is to be tried, unless the trial judge thinks there are special reasons to have separate juries.

(3) Any other powers or functions conferred on a court by this Part are to be exercised by the court constituted of a judge sitting alone.

(4) The defendant's right to elect to have an investigation under this Part conducted by a judge sitting alone is not subject to any statutory qualification.¹

Note—

1 The intention is to ensure that the right to elect for trial by judge alone is unfettered by the statutory qualifications on that right imposed by the Juries Act 1927 (thus preserving the principle enunciated in R v T [1999] SASC 429 on this point).

269BA—Charges on which alternative verdicts are possible

(1) A person charged with an offence is taken, for the purposes of this Part, to be charged in the alternative with any lesser offence for which a conviction is possible on that charge.

(2) It follows that a trial of a charge on which an alternative verdict for a lesser offence is possible is taken to be a trial of a charge of each of the offences for which a conviction is possible.
Division 2—Mental competence to commit offences

269C—Mental competence
A person is mentally incompetent to commit an offence if, at the time of the conduct alleged to give rise to the offence, the person is suffering from a mental impairment and, in consequence of the mental impairment—

(a) does not know the nature and quality of the conduct; or

(b) does not know that the conduct is wrong; or

(c) is unable to control the conduct.

269D—Presumption of mental competence
A person's mental competence to commit an offence is to be presumed unless the person is found, on an investigation under this Division, to have been mentally incompetent to commit the offence.

269E—Reservation of question of mental competence

(1) If, on the trial of a person for an offence—

(a) the defendant raises a defence of mental incompetence; or

(b) the court decides, on application by the prosecution or on its own initiative, that the defendant's mental competence to commit the offence should be investigated in the interests of the proper administration of justice,

the question of the defendant's mental competence to commit the offence must be separated from the remainder of the trial.

(2) The trial judge has a discretion to proceed first with the trial of the objective elements of the offence or with the trial of the mental competence of the defendant.

(3) If, at the preliminary examination of a charge of an indictable offence, the question of the defendant's mental competence to commit the offence arises, the question must be reserved for consideration by the court of trial.

269F—What happens if trial judge decides to proceed first with trial of defendant's mental competence to commit offence

If the trial judge decides that the defendant's mental competence to commit the offence is to be tried first, the court proceeds as follows.

A—Trial of defendant's mental competence

(1) The court—

(a) must hear relevant evidence and representations put to the court by the prosecution and the defence on the question of the defendant's mental competence to commit the offence; and

(b) may require the defendant to undergo an examination by a psychiatrist or other appropriate expert and require the results of the examination to be reported to the court.

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(2) The power to require an examination and report under subsection (1)(b) may be exercised—
   (a) on the application of the prosecution or the defence; or
   (b) if the judge considers the examination and report necessary to prevent a possible miscarriage of justice—on the judge's own initiative.

(3) At the conclusion of the trial of the defendant's mental competence, the court must decide whether it has been established, on the balance of probabilities, that the defendant was at the time of the alleged offence mentally incompetent to commit the offence and—
   (a) if so—must record a finding to that effect;
   (b) if not—must record a finding that the presumption of mental competence has not been displaced and proceed with the trial in the normal way.

(5) The court may, if the prosecution and the defence agree—
   (a) dispense with, or terminate, an investigation into a defendant's mental competence to commit an offence; and
   (b) record a finding that the defendant was mentally incompetent to commit the offence.

B—Trial of objective elements of offence

(1) If the court records a finding that the defendant was mentally incompetent to commit the offence, the court must hear evidence and representations put to the court by the prosecution and the defence relevant to the question whether the court should find that the objective elements of the offence are established.

(2) If the court is satisfied that the objective elements of the offence are established beyond reasonable doubt, the court must record a finding that the objective elements of the offence are established.

(3) If the court finds that the objective elements of the offence are established, the court must find the defendant not guilty of the offence but declare the defendant to be liable to supervision under this Part; but otherwise the court must find the defendant not guilty of the offence and discharge the defendant.

(4) On the trial of the objective elements of an offence, the court is to exclude from consideration any question of whether the defendant's conduct is defensible.

269G—What happens if trial judge decides to proceed first with trial of objective elements of offence

If the trial judge decides to proceed first with the trial of the objective elements of the offence, the court proceeds as follows.
A—Trial of objective elements of offence

(1) The court must first hear evidence and representations put to the court by the prosecution and the defence relevant to the question whether the court should find that the objective elements of the offence are established against the defendant.

(2) If the court is satisfied that the objective elements of the offence are established beyond reasonable doubt, the court must record a finding that the objective elements of the offence are established; but otherwise the court must find the defendant not guilty of the offence and discharge the defendant.

(3) On the trial of the objective elements of an offence, the court is to exclude from consideration any question of whether the defendant's conduct is defensible.

B—Trial of defendant's mental competence

(1) If the court records a finding that the objective elements of the offence are established, the court—

(a) must hear relevant evidence and representations put to the court by the prosecution and the defence on the question of the defendant's mental competence to commit the offence; and

(b) may require the defendant to undergo an examination by a psychiatrist or other appropriate expert and require the results of the examination to be reported to the court.

(2) The power to require an examination and report under subsection (1)(b) may be exercised—

(a) on the application of the prosecution or the defence; or

(b) if the judge considers the examination and report necessary to prevent a possible miscarriage of justice—on the judge's own initiative.

(3) At the conclusion of the trial of the defendant's mental competence, the court must decide whether it has been established, on the balance of probabilities, that the defendant was at the time of the alleged offence mentally incompetent to commit the offence and—

(a) if so—must declare that the defendant was mentally incompetent to commit the offence, find the defendant not guilty of the offence and declare the defendant to be liable to supervision under this Part;

(b) if not—must record a finding that the presumption of mental competence has not been displaced and proceed with the trial in the normal way.

(4) If the trial is to proceed under subsection B(3)(b), the objective elements of the offence are to be accepted as established.
(5) The court may, if the prosecution and the defence agree—
   (a) dispense with, or terminate, an investigation into a defendant’s mental competence to commit an offence; and
   (b) declare that the defendant was mentally incompetent to commit the offence, find the defendant not guilty of the offence, and declare the defendant to be liable to supervision under this Part.

Division 3—Mental unfitness to stand trial

269H—Mental unfitness to stand trial

A person is mentally unfit to stand trial on a charge of an offence if the person's mental processes are so disordered or impaired that the person is—
   (a) unable to understand, or to respond rationally to, the charge or the allegations on which the charge is based; or
   (b) unable to exercise (or to give rational instructions about the exercise of) procedural rights (such as, for example, the right to challenge jurors); or
   (c) unable to understand the nature of the proceedings, or to follow the evidence or the course of the proceedings.

269I—Presumption of mental fitness to stand trial

A person’s mental fitness to stand trial is to be presumed unless it is established, on an investigation under this Division, that the person is mentally unfit to stand trial.

269J—Order for investigation of mental fitness to stand trial

(1) If there are reasonable grounds to suppose that a person is mentally unfit to stand trial, the court before which the person is to be tried may order an investigation under this Division of the defendant's mental fitness to stand trial.

(2) The court's power to order an investigation into the defendant's mental fitness to stand trial may be exercised—
   (a) on the application of the prosecution or the defence; or
   (b) if the judge considers the investigation necessary to prevent a possible miscarriage of justice—on the judge’s own initiative.

(3) If a court orders an investigation into the defendant's mental fitness to stand trial after the trial begins, the court may adjourn or discontinue the trial to allow for the investigation.

(4) If a court before which a preliminary examination of an indictable offence is conducted is of the opinion that the defendant may be mentally unfit to stand trial, the preliminary examination may continue, but the court must raise for consideration by the court of trial the question whether there should be an investigation under this Division of the defendant's mental fitness to stand trial.

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269K—Preliminary prognosis of defendant's condition

(1) Before formally embarking on an investigation under this Division of a defendant's mental fitness to stand trial, a court may require production of psychiatric or other expert reports that may exist on the defendant's mental condition and may, if it thinks fit, itself have a report prepared on the defendant's mental condition.

(2) If it appears from a report that the defendant is mentally unfit to stand trial but there is a reasonable prospect that the defendant will regain the necessary mental capacity over the next 12 months, the court may adjourn the defendant's trial for not more than 12 months.

(3) If after the adjournment the court is of the opinion that the grounds on which the investigation was thought to be necessary no longer exist, the court may revoke the order for the investigation and the trial will then proceed in the normal way.

269L—Trial judge's discretion about course of trial

If the court orders an investigation into a defendant's mental fitness to stand trial, the question of the defendant's mental fitness to stand trial may, at the discretion of the trial judge, be separately tried before any other issue that is to be tried or after a trial of the objective elements of the alleged offence.

269M—What happens if trial judge decides to proceed first with trial of defendant's mental fitness to stand trial

If the trial judge decides that the defendant's mental fitness to stand trial is to be tried first, the court proceeds as follows.

A—Trial of defendant's mental fitness to stand trial

(1) The court—

(a) must hear relevant evidence and representations put to the court by the prosecution and the defence on the question of the defendant's mental fitness to stand trial; and

(b) may require the defendant to undergo an examination by a psychiatrist or other appropriate expert and require the results of the examination to be reported to the court.

(2) The power to require an examination and report under subsection (1)(b) may be exercised—

(a) on the application of the prosecution or the defence; or

(b) if the judge considers the examination and report necessary to prevent a possible miscarriage of justice—on the judge's own initiative.

(3) At the conclusion of the trial of the defendant's mental fitness to stand trial, the court must decide whether it has been established, on the balance of probabilities, that the defendant is mentally unfit to stand trial and—

(a) if so—must record a finding to that effect;

(b) if not—must proceed with the trial in the normal way.

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(5) The court may, if the prosecution and the defence agree—
(a) dispense with, or terminate, an investigation into a defendant's fitness to stand trial; and
(b) record a finding that the defendant is mentally unfit to stand trial.

B—Trial of objective elements of offence
(1) If the court records a finding that the defendant is mentally unfit to stand trial, the court must hear evidence and representations put to the court by the prosecution and the defence relevant to the question whether a finding should be recorded under this section that the objective elements of the offence are established.

(2) If the court is satisfied beyond reasonable doubt that the objective elements of the offence are established, the court must record a finding to that effect and declare the defendant to be liable to supervision under this Part; but otherwise the court must find the defendant not guilty of the offence and discharge the defendant.

(3) On the trial of the objective elements of an offence under this section, the court is to exclude from consideration any question of whether the defendant's conduct is defensible.

269N—What happens if trial judge decides to proceed first with trial of objective elements of offence
If the trial judge decides to proceed first with the trial of the objective elements of the offence, the court proceeds as follows.

A—Trial of objective elements of offence
(1) The court must first hear evidence and representations put to the court by the prosecution and the defence relevant to the question whether the court should find that the objective elements of the offence are established.

(2) If the court is satisfied beyond reasonable doubt that the objective elements of the offence are established, the court must record a finding to that effect; but otherwise the court must find the defendant not guilty of the offence and discharge the defendant.

(3) On the trial of the objective elements of an offence under this section, the court is to exclude from consideration any question of whether the defendant's conduct is defensible.

B—Trial of defendant's mental fitness to stand trial
(1) If the court records a finding that the objective elements of the offence are established, the court—
(a) must hear relevant evidence and representations put to the court by the prosecution and the defence on the question of the defendant's mental fitness to stand trial; and

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(b) may require the defendant to undergo an examination by a psychiatrist or other appropriate expert and require the results of the examination to be reported to the court.

(2) The power to require an examination and report under subsection (1)(b) may be exercised—

(a) on the application of the prosecution or the defence; or

(b) if the judge considers the examination and report necessary to prevent a possible miscarriage of justice—on the judge's own initiative.

(3) If the court is satisfied on the balance of probabilities that the defendant is mentally unfit to stand trial, the court must record a finding to that effect and declare the defendant to be liable to supervision under this Part.

(4) If the court is not satisfied on the balance of probabilities that the defendant is mentally unfit to stand trial, the court must proceed with the trial of the remaining issues (or may, at its discretion, re-start the trial).

(5) The court may, if the prosecution and the defence agree—

(a) dispense with, or terminate, an investigation into a defendant's mental fitness to stand trial; and

(b) declare that the defendant is mentally unfit to stand trial, and declare the defendant to be liable to supervision under this Part.

Division 4—Disposition of persons declared to be liable to supervision under this Part

269O—Supervision

(1) The court by which a defendant is declared to be liable to supervision under this Part may—

(a) release the defendant unconditionally; or

(b) make an order (a supervision order)—

(i) committing the defendant to detention under this Part; or

(ii) releasing the defendant on licence on the following conditions:

(A) the conditions imposed by subsection (1a);

(B) any other conditions decided by the court and specified in the licence.

(1a) Subject to this Act, every licence under subsection (1)(b)(ii) is subject to the following conditions:

(a) a condition prohibiting the defendant from possessing a firearm or ammunition (both within the meaning of the Firearms Act 1977) or any part of a firearm;
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(b) a condition requiring the defendant to submit to such tests (including testing without notice) for gunshot residue as may be reasonably required by a person or body specified by the court.

(1b) A court may only vary or revoke the conditions imposed by subsection (1a) if the defendant satisfies the court, by evidence given on oath, that—

(a) there are cogent reasons to do so; and

(b) the possession of a firearm, ammunition or part of a firearm by the defendant does not represent an undue risk to the safety of the public.

(2) If a court makes a supervision order, the court must fix a term (a limiting term) equivalent to the period of imprisonment or supervision (or the aggregate period of imprisonment and supervision) that would, in the court's opinion, have been appropriate if the defendant had been convicted of the offence of which the objective elements have been established.

(3) At the end of the limiting term, a supervision order in force against the defendant under this Division lapses.

Note—
1 The court should fix a limiting term by reference to the sentence that would have been imposed if the defendant had been found guilty of the relevant offence and without taking account of the defendant's mental impairment.

269OA—Court may direct defendant to surrender firearm etc

(1) The court by which a defendant is declared to be liable to supervision under this Part may, in relation to a supervision order that is subject to the condition imposed by section 269O(1a)(a), direct the defendant to surrender forthwith at a police station specified by the court any firearm, ammunition or part of a firearm owned or possessed by the defendant.

(2) No criminal liability attaches to a person to the extent that he or she is complying with a direction under this section.

(3) The Commissioner of Police must deal with any surrendered firearm, ammunition or part of a firearm in accordance with the scheme set out in the regulations.

(4) No compensation is payable by the Crown or any other person in respect of the exercise of a function or power under this section.

(5) The regulations may provide for the payment, recovery or waiver of fees in respect of this section.

269P—Variation or revocation of supervision order

(1) At any time during the limiting term, the court may, on the application of the Crown, the defendant, Parole Board, the Public Advocate or another person with a proper interest in the matter, vary or revoke a supervision order and, if the order is revoked, make, in substitution for the order, any other order that the court might have made under this Division in the first instance.

(2) If the court refuses an application by or on behalf of a defendant for variation or revocation of a supervision order, a later application for variation or revocation of the order cannot be made by or on behalf of the defendant for six months or such greater or lesser period as the court may direct on refusing the application.

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269Q—Report on mental condition of the defendant

(1) If a defendant is declared to be liable to supervision under this Part, the Minister must, within 30 days after the date of the declaration, prepare and submit to the court by which the declaration was made a report, prepared by a psychiatrist or other appropriate expert, on the mental condition of the defendant containing—

(a) a diagnosis and prognosis of the condition; and

(b) a suggested treatment plan for managing the defendant's condition.

(2) If a supervision order is made against the defendant, the Minister must arrange to have prepared and submitted to the court, at intervals of not more than 12 months during the limiting term, a report containing—

(a) a statement of any treatment that the defendant has undergone since the last report; and

(b) any changes to the prognosis of the defendant's condition and the treatment plan for managing the condition.

269R—Reports and statements to be provided to court

(1) For the purpose of assisting the court to determine proceedings under this Division, the Crown must provide the court with a report setting out, so far as reasonably ascertainable, the views of—

(a) the next of kin of the defendant; and

(b) the victim (if any) of the defendant's conduct; and

(c) if a victim was killed as a result of the defendant's conduct—the next of kin of the victim.

(2) A report is not, however, required under subsection (1) if the purpose of the proceeding is—

(a) to determine whether a defendant who has been released on licence should be detained or subjected to a more rigorous form of supervision; or

(b) to vary, in minor respects, the conditions on which a defendant is released on licence.

(3) If a court is fixing a limiting term in proceedings under this Division relating to an alleged indictable offence or prescribed summary offence, a person who has suffered injury, loss or damage resulting from the defendant's conduct may furnish the court with a statement of a kind referred to in section 7A of the Criminal Law (Sentencing) Act 1988 (a victim impact statement), as if the defendant had been convicted of the offence and the court was determining sentence (and the court must deal with the statement in all respects as if it were a statement furnished under that section).

(4) However, the court need not comply with section 7A(3b) and (3c) of the Criminal Law (Sentencing) Act 1988 if the court is satisfied that—

(a) the defendant is incapable of understanding the victim impact statement; or

(b) having regard to the nature of the defendant's mental impairment, it would be inappropriate for the defendant to be present.

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(5) If a court is fixing a limiting term in proceedings under this Division, the Crown or the Commissioner for Victim's Rights may furnish the court with a statement of a kind referred to in section 7B of the Criminal Law (Sentencing) Act 1988 (a *neighbourhood impact statement* or a *social impact statement*) as if the court were determining sentence for an offence (and the court must deal with the statement in all respects as if it were a statement furnished under that section).

(6) In this section—

*prescribed summary offence* has the same meaning as in section 7A of the Criminal Law (Sentencing) Act 1988.

269S—Principle on which court is to act

In deciding whether to release a defendant under this Division, or the conditions of a licence, the court must apply the principle that restrictions on the defendant's freedom and personal autonomy should be kept to the minimum consistent with the safety of the community.

269T—Matters to which court is to have regard

(1) In deciding proceedings under this Division, the court should have regard to—

(a) the nature of the defendant's mental impairment; and

(b) whether the defendant is, or would if released be, likely to endanger another person, or other persons generally; and

(c) whether there are adequate resources available for the treatment and support of the defendant in the community; and

(d) whether the defendant is likely to comply with the conditions of a licence; and

(e) other matters that the court thinks relevant.

(2) The court cannot release a defendant under this Division, or significantly reduce the degree of supervision to which a defendant is subject unless the court—

(a) has considered at least three reports (*expert reports*) each prepared by a different psychiatrist or other appropriate expert who has personally examined the defendant, on—

(i) the mental condition of the defendant; and

(ii) the possible effects of the proposed action on the behaviour of the defendant; and

(b) has considered the report most recently submitted to the court by the Minister under this Division; and

(c) has considered the report on the attitudes of victims and next of kin prepared under this Division; and

(d) is satisfied that—

(i) the defendant's next of kin; and

(ii) the victim (if any) of the defendant's conduct; and
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(iii) if a victim was killed as a result of the defendant's conduct—the next of kin of the victim, have been given reasonable notice of the proceedings.

(2a) However, the court may act on the basis of one or two expert reports if—

(a) the supervision order arose from proceedings based on a charge of a summary (rather than an indictable) offence; and

(b) satisfied that, in the circumstances of the case, the report or reports adequately cover the matters on which the court needs expert advice.

(3) Notice need not be given under subsection (2)(d) to a person whose whereabouts have not, after reasonable inquiry, been ascertained.

269U—Revision of supervision order

(1) If a person who has been released on licence under this Division contravenes or is likely to contravene a condition of the licence, the court by which the supervision order was made may, on application by the Crown (which may be made, in a case of urgency, by telephone), review the supervision order.

(2) After allowing the Crown and the person subject to the order a reasonable opportunity to be heard on the application for review, the court may—

(a) confirm the present terms of the supervision order; or

(b) amend the order so that it ceases to provide for release on licence and provides instead for detention; or

(c) amend the order by varying the conditions of the licence,

and make any further order or direction that may be appropriate in the circumstances.

(3) When an application for review of a supervision order is made, the court may issue a warrant to have the person subject to the order arrested and brought before the court and may, if appropriate, make orders for detention of that person until the application is determined.

269V—Custody, supervision and care

(1) If a defendant is committed to detention under this Part, the defendant is in the custody of the Minister and the Minister may give directions for the custody, supervision and care of the defendant the Minister considers appropriate.

(2) The Minister may—

(a) place the defendant under the custody, supervision and care of another; and

(b) if there is no practicable alternative—direct that a defendant be kept in custody in a prison.

(3) Supervisory responsibilities arising from conditions on which a person is released on licence are to be divided between the Parole Board and the Minister in the following way:

(a) the supervisory responsibilities are to be exercised by the Minister insofar as they relate to treating or monitoring the mental condition of the person; and

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(b) the supervisory responsibilities are in all other respects to be exercised by the Parole Board.

(4) The Minister or the Parole Board (as the case may be) may delegate a power or function under this section—

(a) to a person for the time being performing particular duties or holding or acting in a particular position; or

(b) to any other person or body that, in the delegator's opinion, is competent to perform or exercise the relevant functions or powers.

(5) A delegation under subsection (4)—

(a) must be by instrument in writing; and

(b) may be absolute or conditional; and

(c) does not derogate from the ability of the delegator to act in any matter; and

(d) is revocable at will by the delegator.

269VA—Effect of supervening imprisonment

(1) If a person who has been released on licence under this Division commits an offence while subject to the licence and is sentenced to imprisonment for the offence, the supervision order is suspended for the period the person is in prison serving the term of imprisonment.

(2) In determining when the term of a supervision order comes to an end, the period of a suspension under subsection (1) is not to be taken into account.

Division 5—Miscellaneous

269W—Counsel to have independent discretion

(1) If the defendant is unable to instruct counsel on questions relevant to an investigation under this Part, the counsel may act, in the exercise of an independent discretion, in what he or she genuinely believes to be the defendant's best interests.

(2) If the counsel for the defendant in criminal proceedings (apart from proceedings under this Part) has reason to believe that the defendant is unable, because of mental impairment, to give rational instructions on questions relevant to the proceedings (including whether to be tried by judge alone), the counsel may act, in the exercise of an independent discretion, in what the counsel genuinely believes to be the defendant's best interests.

269WA—Power to order examination etc in pre-trial proceedings

(1) If in pre-trial proceedings it appears to the court that it might expedite the trial to order the examination of the defendant under this section in anticipation of trial, the court may, by order—

(a) require the defendant to undergo an examination by a psychiatrist or other appropriate expert; and

(b) require that the results of the examination be reported to the court.

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(2) The prosecution and the defence are entitled to access to the report.

269X—Power of court to deal with defendant before proceedings completed

(1) If there is to be an investigation into a defendant's mental competence to commit an offence, or mental fitness to stand trial, or a court conducting a preliminary examination reserves the question whether there should be such an investigation for consideration by the court of trial, the court by which the investigation is to be conducted, or the court reserving the question for consideration, may—

(a) release the defendant on bail to appear later for the purposes of the investigation; or

(b) commit the defendant to an appropriate form of custody (but not a prison unless the court is satisfied that there is, in the circumstances, no practicable alternative) until the conclusion of the investigation.

(2) If a court declares a defendant to be liable to supervision under this Part, but unresolved questions remain about how the court is to deal with the defendant, the court may—

(a) release the defendant on bail to appear subsequently to be dealt with by the court; or

(b) commit the defendant to some appropriate form of custody (but not a prison unless the court is satisfied that there is, in the circumstances of the case, no practicable alternative) until some subsequent date when the defendant is to be brought again before the court.

269Y—Appeals

(1) An appeal lies to the appropriate appellate court against a declaration that a defendant is liable to supervision under this Part in the same way as an appeal against a conviction.

(2) An appeal lies to the appropriate appellate court against a supervision order in the same way as an appeal against sentence.

(3) An appeal lies with the permission of the court of trial or the appropriate appellate court against a key decision by the court of trial.

(4) A key decision is—

(a) a decision that the defendant was, or was not, mentally competent to commit the offence charged against the defendant; or

(b) a decision that the defendant is, or is not, mentally unfit to stand trial; or

(c) a decision that the objective elements of an offence are established against the defendant.

(5) On an appeal, the appellate court may exercise one or more of the following powers:

(a) confirm, set aside, vary or reverse a decision of the court of trial;

(b) direct a retrial of the case or an issue arising in the case;

(c) make any finding or exercise any power that could have been made or exercised by the court of trial;

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4.3.2013—Criminal Law Consolidation Act 1935
Mental impairment—Part 8A

Disposition of persons declared to be liable to supervision under this Part—Division 5

(d) make ancillary orders and directions.

269Z—Counselling of next of kin and victims

(1) If an application is made under Division 4 that might result in a defendant being released from detention, the Minister must ensure that counselling services in respect of the application are made available to—

(a) the defendant's next of kin; and
(b) the victim (if any) of the defendant's conduct; and
(c) if a victim was killed as a result of the defendant's conduct—the next of kin of the victim.

(2) A person does not, in disclosing information about the defendant during the course of providing counselling under this section, breach any code or rule of professional ethics.

269ZA—Exclusion of evidence

A finding made on an investigation into a defendant's fitness to stand trial does not establish an issue estoppel against the defendant in any later (civil or criminal) proceedings, and evidence of such a finding is not admissible against the defendant in criminal proceedings against the defendant.

269ZB—Arrest of person who escapes from detention etc

(1) If a person who is committed to detention under this Part—

(a) escapes from the detention; or
(b) is absent, without proper authority, from the place of detention,

the person may be arrested without warrant, and returned to the place of detention, by a member of the police force or an authorised person.

(2) A Judge or other proper officer of a court by which a person is released on licence under this Part may, if satisfied that there are proper grounds to suspect that the person may have contravened or failed to comply with a condition of the licence, issue a warrant to have the person arrested and brought before the court.
List of Questions Asked in the Discussion Paper

The Defence of Mental Incompetence

1. Should the CLCA be amended to replace reference to ‘knowledge’ with the word ‘understanding’? Should the CLCA be amended to define ‘nature and quality of the conduct’? If so, should the definition include ‘understanding the physical nature of the conduct and its physical consequences’?

2. Should the CLCA provide for a definition of ‘wrongness’ based on whether the defendant was able to ‘reason with a moderate degree of sense and composure’?

3. Alternatively, should the CLCA be amended so as to provide that a consideration of whether there was an ability to reason with a moderate degree of sense and composure be confined to cases of ‘frenzy, uncontrolled emotion or suspended reason’?

4. Should the CLCA be amended to remove the ‘unable to control conduct’ component of the defence?

5. Should the definition of mental illness in s269A of the CLCA be amended to specifically include hypoglycaemia or exclude hyperglycaemia? Should the definition of mental illness in s269A of the CLCA be amended to specifically include or exclude any other problematic medical conditions?

6. Should the definition of mental illness in s269A of the CLCA be amended to expressly declare that the objective test formulated by Mason CJ, Brennan and McHugh JJ in Falconer, must be applied for the purpose of distinguishing between sane and insane automatism in cases involving dissociation?

7. Should the definition of mental impairment under the CLCA be amended to specifically exclude personality disorder including psychopathy?

8. Should the CLCA be amended so that a person charged with an offence would be able to rely on a defence of mental incompetence when, from whatever cause, he or she was unable to understand the nature and quality of their conduct or understand that it was wrong?

9. Should the CLCA be amended so that a person charged with an offence would be barred from reliance on a defence of mental incompetence if their inability to understand the nature and quality of their conduct or inability to understand that it was wrong or incapacity for self control was a consequence of the combined effects of mental illness and a state of self induced intoxication?

10. Should the CLCA be amended so that a person charged with an offence would be barred from reliance on a defence of mental incompetence based on evidence of a mental illness resulting from the use of intoxicants unless the illness is permanent/prolonged/persistent/protracted/enduring?

11. Should the existing provisions on intoxication and mental impairment in the CLCA be retained without change?
The Fixing of Limiting Terms

12. Should there be a reduction in the number of psychiatric reports required under Part 8A?

13. Should Magistrates and Judges have a discretion regarding the type and/or number of reports to be ordered? If so, what factors should guide the exercise of that discretion?

14. Should the court be provided with additional disposal options to apply to persons found not guilty by reason of mental incompetence? If so, what options should be available to the court?

15. The following options are suggested for consideration:
   (a) Should any of the procedures in the interstate models discussed above be adopted in South Australia?
   (b) If the court is to retain the power of fixing a limiting term should it be fixed in a way other than by reference ‘to the term of imprisonment that would have been imposed had the accused been convicted of the offence and sentenced in the usual way’?
   (c) If the court is to retain the power of fixing a limiting term should the court be allowed to take into account a concession by the defence that the objective facts are admitted?

Supervision of Individuals Released on Licence

16. Should Judges and Magistrates have a discretion in requiring a Victim/Next of Kin reports at all stages of the Part 8A proceedings? If so, what factors should guide the exercise of that discretion?

17. Should the court or supervisory agencies nominate a lead agency to be primarily responsible for supervision of an individual licensee?

18. If a lead agency is nominated to be primarily responsible should it instruct the ODPP to determine whether breach proceedings should be instituted?

19. Should the shared supervisory role of the Minister for Health and the Parole Board be extended to include the Minister for Disabilities?

20. In the absence of a purpose built facility for individuals found not guilty of an offence due to mental incompetence (or being found unfit to stand trial) on the basis of an intellectual disability or brain injury, what options are available for housing and supporting these individuals whilst on a licence pursuant to s269.

21. Should breaches of licence particularly, persistent breaches, be dealt with by way of:
   (a) an amendment to the Mental Health Act 2009 to enable a licensee to be assessed and treated as an alternative to revocation of the licence and returning the person to secure detention at James Nash House; and/or
   (b) amending the CLCA (and any other ancillary legislation) to provide for home detention where a licensee is either unable or unwilling to comply with the
conditions of licence, justifying a higher level of restraint on their liberty, but not requiring inpatient medical treatment; and/or

(c) where there is evidence that a breach or persistent breach of licence conditions is not as a result of a mental impairment at the time of the breach, should a breach of licence conditions constitute a criminal offence and attract a criminal sanction?

22. Are additional means of empowering particular agencies (such as the Parole Board) required to deal with non-compliance by licensees?

23. Should the CLCA be amended to allow for administrative detention in the circumstances discussed in *R v Draoui*? Are there any alternatives to administrative detention in these circumstances?

24. (a) Should there be a statutory provision for police officers or authorised officers in South Australia to take care and control of interstate forensic patients who are found in South Australia and to return them to the jurisdiction that made the orders?

(b) Further, should provisions similar to those in Part 7B of the *Victorian Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* be enacted in South Australia?

25. Are the provisions of Part 7A of the Victorian *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* a suitable model for amendments to the South Australian law to enable transfer of persons under supervision to and from South Australia?

26. Are there comments with respect to the Step-Up and Step-Down proposal outlined and being investigated by the Director of James Nash House?

27. Should South Australia consider introducing a Mental Health Review Tribunal, Board or equivalent to assist in the supervision of individuals released on licence? If so, what functions and powers would such a Tribunal, Board or equivalent perform?
List of Submissions

- Aboriginal Legal Rights Movement
- Australian Medical Association (South Australia)
- Australian Psychological Society College of Forensic Psychology (South Australian Branch)
- Judge Elizabeth Bolton, Chief Magistrate
- Commissioner for Victims’ Rights (SA)
- Department for Correctional Services (SA)
- Director of Public Prosecutions (SA)
- Forensic Mental Health Service (SA)
- Gawler Legal
- Law Society of South Australia
- Emeritus Fellow Ian Leader-Elliott, The University of Adelaide
- Legal Services Commission of South Australia
- Office of the Chief Psychiatrist and Mental Health Policy (SA)
- Office of the Commissioner for Equal Opportunity (SA)
- Office of the Public Advocate (SA)
- OmbudsmanSA
- Parole Board (SA)
- Royal Australian and New Zealand College of Psychiatrists (South Australian Branch)
- South Australian Bar Association
- Ms Kellie Toole, Professor Ngaire Naffine, Ms Margaret Castles, Mr David Caruso, Adelaide Law School, The University of Adelaide
- Mr Jamie Walvisch, Faculty of Law, Monash University