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ON THE WESTERN FRONTIER

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THE WA JUSTICE SYSTEM'S RESPONSE

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Youth legal service.

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From the turn of the millennium, it became apparent to practitioners in Western Australia and the Courts alike that the frequency with which accused were presenting before the Courts with significant mental health issues was appreciably greater than that which had been experienced in previous years. This prompted a series of responses from WA's Court system that have met with some success.

I hasten to say however that this paper is by no means intended to be an academic tract; but rather, a view from the trenches.

ORIGINS

The origin of this rise may be traced to the promulgation of the *Criminal Law (Mentally Impaired Accused) Act* ("The MIA Act") in 1996. Prior to the introduction of the MIA Act, the options for a mentally ill person charged with a criminal offence were fairly stark. As with common law jurisdictions, a person found not guilty by reason of unsoundness of mind was liable to be detained at Her Majesty's Pleasure; or as it was colloquially known amongst criminal lawyers, "The Key".

The MIA Act effectively took The Key off the table for the vast majority of mentally ill accused, s.21 only imposing a duty upon Judges in Superior Courts to make a Custody Order in respect of a closed class of offences defined in Schedule 1 of the Act.

As one would expect, Schedule 1 offences are the usual suspects in the cornucopia of criminal offences[2]. Thus, s.22 of the MIA Act enabled the sentencing Judge or Magistrate to impose a range of sentences, enumerated thus:

[1] Senior Criminal Lawyer, Youth Legal Service ("YLS"), Perth, Western Australia
[2] Schedule 1 Appended hereto

22. Orders that may be made by courts

(1) If a court may make an order under this section in respect of an accused, it may-

(a) Release the accused unconditionally it is just to do so having regard to-

(i) The nature of the offence and the circumstances of its commission;

(ii) The accused's character, antecedents, age, health and mental condition; and

(iii) The public interest;

(b) Despite the fact that the accused is not an offender under the Sentencing Act 1995, make a Conditional Release Order (CRO), a Community Based Order (CBO), or an Intensive Supervision Order (ISO) under that Act in respect of the accused; or

(c) Make a Custody Order in respect of the accused.

(2) If an accused is found not guilty of an offence on account of unsoundness of mind, a court must not make a CRO, CBO or ISO in respect of the accused unless, under the Sentencing Act 1995, such an order could have been made in respect of the accused had he or she been found guilty of the offence.

(3) If a court makes a CRO, CBO or ISO in respect of an accused –

(a) Part 7, 9 or 10 of the Sentencing Act 1995, as the case requires, applies in respect of the order; and

(b) Part 18 of the Sentencing Act 1995 applies in respect of the order, but for the purposes of –

(i) Sections 127(2)(b) of that Act;

(ii) Section 130(1)(a)(iii) of that Act; and

(iii) Section 133(1)(a)(iii) and (b) of that Act

If the Court cancels the CRO, CBO or ISO the Court must make a custody order in respect of the accused.

Prior to the MIA Act's introduction, defence lawyers would assiduously avoid the mental health defence wherever possible; largely because of the expected outcome.

NOON LIST

The emerging tide of accused relying upon a mental health defence gave rise to a perception of an unmet need. In 2005, The Magistrates Court; which, as in every other State and Territory, handles the vast majority of our criminal workload, introduced a specific list for cases which had a mental health flavour. This became known as The Noon List, and dealt with all matters under the aegis of the MIA Act. Other, more informal, arrangements arose in some of the suburban Courts, where there was a significant number of accused facing Court with mental health issues.

The Noon List worked well, the Magistrates adopting a far more informal and sensitive approach to accused than that which is normally experienced. Police Prosecutors have in the last decade also exhibited a greater willingness to accept a mental health defence than had been the case in the past.

A significant development at this time was the introduction of Section 66 of the *Criminal Procedure Act,* 2004 (WA) ("CPA"), which provides for a trial on the papers, in circumstances where the accused requests the Court to do so and the prosecution accords its assent to that course. In such a case, both the accused and prosecutor must agree on which of the documents they have lodged with the Court is to be considered in order to determine the charge or decide the issues and the Court must be satisfied that is in the interests of justice to do so.

This course has been preferred by defence and prosecution alike in mental health matters since the introduction of the CPA. Practical experience nevertheless shows that it is important for prosecution and defence to confer prior to the hearing in order to determine whether the availability of s.27 is conceded.

Even if you have satisfied the prosecution, you nevertheless still have to satisfy the judicial officer, so one must read the report very carefully in order to be satisfied that the author has not left more questions than answers.

Of course, the gravamen of the MIA Act still relies upon a version of the definition of circumstances which would ground a verdict of not guilty by reason of unsound mind developed in *R v M'Naghten [1843] 10 C&F 200.*

Daniel M'Naghten sounds like a classic example of paranoid schizophrenia. He believed that the Pope and the British Prime Minister, Robert Peel, were conspiring against him and blamed them for his financial ruin. He shot a man in the back whom he believed to be Peel in Downing Street, who was struck down and ultimately died. The man he did kill was not his intended quarry, but rather, a senior civil servant named Edward Drummond.

M'Naghten was ultimately acquitted both at first instance and by the House of Lords, wherein the dictum now known as the M'Naghten Rules at Common Law were developed.

Shortly put, the principle laid down by Tindal CJ at Common Pleas is that:

"Every man is to be presumed to be sane, and ... that to establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of mind, either of long or short duration, and not to know the nature and quality of the act he was doing; or if he did know it, that he did not know what he was doing was wrong."[3][4][5]

CHALLENGE AND RESPONSE: THE START COURT

However, for many mental health consumers, actions which may have attracted the attention of the criminal justice system did not necessarily denote a mental state that would clear the threshold set by *M'Naghten*; which left many accused between a rock and a hard place.

Thus a person who may fit the clinical definition of being floridly psychotic may not necessarily be insane at law under the elements of *M'Naghten.* Whilst a person's mental state may be powerfully mitigatory with respect to ultimate disposition, that ultimate disposition could be wildly variable; depending on the level of forensic sophistication of the sentencing judicial officer.

Moreover, the experience of traversing through the criminal justice system, which can be a confusing and alienating experience to a person in a euthymic state, could prove to be the trigger of deterioration; or indeed relapse, in the mental state of a mental health consumer.

[3] Note that in Code States, Section 27 of the *Criminal Code*, 1900 (WA) extends the M'Naghten Rules in that it adds the deprivation of the ability to control one's actions to the Common Law dictum. Under s.27, impairment of a person's capacity to control his or her actions is by the words of the statute recognised as an independent basis for establishing unsoundness of mind.

[4] Commentators have raised some doubts about the scope of the third limb. For instance, Colin, Linden and Bunney in Criminal Law in Western Australia and Queensland express doubt that the third limb admits the insanity defence in cases of irresistible impulse where a person has experienced an overwhelming desire to do something and has been unable to restrain him or herself. This view is supported by *R v Moore* (1908) 10 WAR 64 at 66; likewise with *R v Wray* (1930) 33 WALR 67 at 68. The learned authors point out that on this interpretation the additional arm of "incapacity to control one's actions" introduces a true exculpatory defence not available at common law; but that irresistible impulse may well be an indicia of insanity, it does not of itself constitute insanity; vide *A-G for South Australia v Brown* (1960) 1 All ER 734.

The learned authors also point out that an alternative interpretation of incapacity to control one's actions give s.27 a far narrower field of operation, under which incapacity to control one's actions merely refers to those cases where the conduct is involuntary and occurs independently of the exercise of will. The difference between the two interpretations is that on the irresistible impulse interpretation there can be an actual decision (even though irresistible) to engage in the conduct, whereas on the involuntariness interpretation there is no room for any decision to engage in the conduct.

The commentators state that the latter interpretation was adopted in *Falconer's case* (1990) 171 CLR 30 by Mason CJ, Brennan and McHugh JJ. and assumed by Deane, Dawson and Toohey JJ. On this interpretation, the third limb is substantially redundant because the only cases of involuntary conduct due to mental disease which are thereby conceivable would be involuntary states of automatism in which the person was not aware of what was being done

[5] Dealing with the same subject, the learned authors of Carter's Criminal Law of Queensland (14th edition) state explicitly that s.27 contains a third incapacity which does not arise from the M'Naghten Rules; and that the *opus classicus* on the subject is contained in *Falconer's case* in the joint judgment of Mason CJ., Brennan and McHugh JJ.:

"The incapacities to which s.27 refers include the incapacity to control actions whereas the M'Naghten Rules speak only of such a defect of reason "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 he was doing what was wrong."

The significance of these challenges in the context of young people and their interaction with the law is reinforced when one considers the statistics yielded from the 2007 National Survey of Mental Health and Well Being, that 20% of the population experienced one of the common mental disorders in the preceding year. Prevalence (some 26%) was greatest amongst persons aged between16-24 and evidently declined with age; and two-thirds of persons with identified depression and/or anxiety disorders had experienced their first episode before the age of 21[6].

This realisation prompted agitation from both the legal and medical professions, as well as the judiciary for the establishment of a dedicated Mental Health Court, based on the therapeutic justice model. This agitation bore fruit in March 2013 with the establishment of the Specialised Treatment and Referral Team ("START") Court.

The START Court differs markedly from the other Courts in the Criminal Division. Continuity is an important element in the therapeutic value of the START Court, from Kath the Court Orderly, who has been with the Court from the outset and is on a first name basis with most of the accused, to having a dedicated Magistrate assigned to the Court permanently[7], a permanent Police Prosecutor[8], and an integrated Clinical Team consisting of Forensic Psychiatric Nurses, Social Worker, Case Officers from Community Corrections, in addition to a Consultant Forensic Psychiatrist on strength on a part-time basis[9].

The purpose of the Clinical Team is to, inter alia, provide assessments, reports for the Court, liaison with community services and the development of individualised plans to support people with mental illness who are also in the criminal justice system. Families and carers are encouraged and their involvement is welcomed. NGOs, including the Mental Health Law Centre and YLS are involved in providing support to participants and assisting them to access services.

REFERRAL AND ASSESSMENT

People appearing in the Perth Magistrates Courts who may have a mental illness can be referred to START Court. Referrals to START Court can be made by general courts, police or prosecutors, with referral information coming from the person themselves, family member or carer, but most commonly, from defence counsel.

Everyone referred to the court receives an initial assessment, following which the Court will have various options. These options may include the making of a Hospital Order under s.5 of the MIA Act. Some may benefit from simply being reconnected with their GP or mental health service, and some may not need any assistance from the Clinical Team.

[6] Commonwealth Department of Health and Ageing: National Mental Health Report 2013 p.19

[7] Initially Her Honour Magistrate Vicki Stewart (now Her Honour Judge Stewart of the District Court). Presently His Honour Magistrate Kevin Tavener.

[8] Sergeant Kevin Harrison

[9] Dr. Adam Brett

The START Court Clinical Team received 731 referrals between March 2013 and 31 May 2015.[10]After initial appearance, the accused is referred to an information session before being asked whether they wish to proceed in the programme. It must be noted that participation in the START Court programme is by no means a soft option, as it involves a significant investment of time and effort. Some accused opt to proceed straight to sentencing at that stage, without further engaging in the programme. Other accused referred to the START Court programme do not participate beyond the initial hearing because of issues such as ineligibility for bail, or a decision to plead not guilty and proceed directly to trial.

Between March 2013 and 30 June 2015, a total of 448 accused received support from the START Court Clinical Team[11], whilst under the supervision of the START Court. The programme allows for different levels of involvement dependent upon the participant's needs and risk profile. Participants whose needs can be adequately addressed without long-term case management may receive clinical support for 1-2 months before being sentenced by the START Court Magistrate.

Participants who would benefit from longer term case management may be invited to undertake a formal programme of approximately 6 months' duration. As at 30 June 2015, 172 accused had entered this stream of the programme; of whom 84 had successfully graduated and 44 were current participants[12]. The programme is wholly voluntary, and participants can elect to proceed to sentence at any time.

DUAL DIAGNOSIS AND COMORBIDITY

One outstanding feature of the START Court programme is that there is no absolute bar to dual diagnosis accused; it is merely one factor among many.

Dual diagnosis arises from the presence of a mental illness in addition to some other malady, usually drug addiction. In particular, all too often over the last decade we have seen tragic consequences of drug induced psychosis. Combine this with the fact that the last time a National Survey of National Mental Health and Well Being was taken in 2007, the greatest specific increase in mental illness related to drug induced psychosis, highlights the great importance of this issue.[13]

We frequently speak of the stigma associated with mental illness, but in my view the greatest stigma lay in the dual diagnosis patient, as psychiatric facilities seem to have a particular set against these people. Treatment of these individuals presents a dilemma, for treating one malady is often antagonistic to the treatment of the other.

[10] Mental Health Commission, WA Annual Report 2014/5 p.25
[11] Ibid.
[12] Ibid.
[13] Australian Bureau of Statistics 2009-10 1301.0, drawing from statistics in the National Survey of Mental Health and Well Being 2007

This antagonism is best reflected in the frequent absolute refusal of certain psychiatric facilities to provide psychiatric reports which are in any way helpful to the dual diagnosis accused. The general line from these facilities is that the patient should take responsibility for their actions.

INTERVENTION PROGRAMME

Some accused in the START Court are then referred to an intervention programme and will have an individualised intervention plan prepared. This is usually linked to their bail conditions.

Participation in the intervention programme is voluntary and will involve care and coordination by one of the Court team and regular returns to court for a "Check In" Remand.

At the Check in Remand, the accused person will have been interviewed by his or her Case Manager, as well as a member of the Clinical Staff. A report is then prepared for the Court and the matter is called on, the progress of the accused person is discussed by the Magistrate with defence counsel and prosecutor. It is not unusual for the Magistrate to address the accused directly, giving feedback and encouragement on their progress.

The intervention plan is tailored to the specific needs of the accused, in a holistic manner. Intervention Plans typically include treatment by the START Court team, referral to community mental health services and liaison with relevant non-government providers and government departments.

This capacity to stabilise a persons' condition can make the granting of bail more likely, and assist in diverting people away from custody where possible. In this regard, however, the START Court will not accept into the programme accused who are remanded in custody; in no small part because the entire programme is designed around accused who are at liberty.

That said, it is not unusual for an accused remanded in custody to be brought before START Court on a bail application with a view to their release on bail in order to participate in the START Court programme; the changed circumstance required by the *Bail Act* which would ground a grant of bail being the fact that they have progressed from a psychotic to euthymic state whilst incarcerated.

Once an accused has been accepted onto the START Court programme and has made sufficient progress, it is the usual practice to then take a plea to the charge or charges; whereafter the provisions of the *Sentencing Act* 1995 (WA), which provide that the offender must be sentenced within 6 months of conviction.[14]

[14] Sentencing Act, 1995 (WA) s.16(2)

THERAPEUTIC EFFECTS OF PARTICIPATION

During the period between May 2013, when I commenced employment at YLS and 31 August 2015, we have referred 9 clients for assessment to START Court. Of these, two were assessed as suitable but declined to participate because they found the requirements too onerous. One was assessed as suitable, but because his principal charge was indictable and would therefore have to be dealt with by the District Court, he could not be accepted, leaving 6 clients who have participated in the START Court programme; 5 of whom have now been sentenced.

Of those clients, a universal observation has been the beneficial effects of participation in a programme bespoke to their needs, providing structure in their lives, where often chaos otherwise reigns. Moreover, one must observe that the requirement of participation and compliance with their medication regime as part of their bail encourages and enforces compliance for people who otherwise may not be compliant.

The presence of a social worker, as well as the input of community agencies such as Outcare[15] and Foyer Oxford[16] also presents the participant in the START Court programme with a greater number of opportunities to make material changes in their lives for the better.

SENTENCING

The sentencing process in the START Court differs from that which one finds in a run of the mill Court in that it is more akin to a graduation ceremony. Emphasis is placed on the progress made by the client and the sense of achievement in which he or she can take pride.

After the pronouncement of sentence, it is customary for the Magistrate to come down from the bench and present the client with a certificate, words of encouragement are expressed by the Magistrate, the prosecutor, members of the Clinical Team, defence counsel; and, quite often, family members. Without exception, sentencing for the offenders for whom I have acted has been an important moment; but unlike the experience of general criminal courts, sentencing is a pivotal moment in a beneficial sense.

THE PAYOFF

To date, not one of the clients for whom I have acted and who completed the START Court programme has reoffended. Indeed, I recently met one of my former clients by chance at a shopping centre. She was a young woman who had the complicated pathology of having Bipolar Affective Disorder, Oppositional Defiance Disorder, and issues with polysubstance

[15] Outcare is a non-profit providing rehabilitation services, based in East Perth. Services include accommodation, referral to health and addiction support agencies, employment assistance, vocational training, community engagement, emergency relief and assistance and general advocacy.

[16] Foyer Oxford is a foundation housing project, based in Leederville, an inner city suburb of Perth; providing self-contained transitional housing for young people for up to 2 years, combined with personalized social supports and opportunities to access employment, education and training.

abuse. She had been facing serious charges, which otherwise would have almost certainly have ensured a substantial term of imprisonment.

She was profuse in her thanks to me and to the START Programme. She told me that she was no longer using drugs, had been compliant with her medication and was engaged in cognitive therapy with such success that she was now taking a TAFE course and had obtained employment for the first time in her young life.

But this is but one example among many. The START Court has, in my assessment, more than proven its worth since its inception.

THE LINKS PROGRAMME: A HORSE OF ANOTHER COLOUR

In the Childrens Court[17], a rather different approach was taken with respect to young, mentally ill accused. Rather than establish a specialised Court to deal with this issue, the Childrens Court established the LINKS Programme[18]; the rationale being to integrate mental health services into existing case management and multi-agency services working within the Childrens Court. LINKS therefore runs parallel to the justice system and Court processes, and commenced in April 2013.

Since that time, LINKS has received 558 referrals and completed 469 formal assessments. 129 young people have gone on to receive case management through the programme[19]. The case management service is holistic in that it addresses both the clinical needs and broader life issues such as accommodation and education.

The LINKS Programme offer assessments, some clinical intervention, and referrals and assistance in accessing community and NGO services. The services are particularly intended to provide early intervention, and to assist the coordination of the various services to children and young people who are in need of assistance.

LINKS liaise directly with Corrective Services at our juvenile detention centre at Banksia Hill and provide assistance in the identification of 'at risk' offenders. They also have access to Health Department databases, which become germane with respect to devising future treatment plans.

Why then has the Childrens Court not followed the START Court model? In large part, the reason why this type of programme was adopted lay in the fact that having an established mental health court in the Childrens Court system was perceived by Young People as potentially stigmatising them; thereby acting as a disincentive to participation.

[17] In this section, I adopt the language of the *Young Offenders Act* 1994 (WA) which refers to those subject to the Act as a Young Person, per s.3

[18] For this section of my paper, I acknowledge the singular assistance of the LINKS Programme team, who generously made themselves available for interview during my research.

[19] Mental Health Commission, WA, op. cit., p.25

One of the greatest battles faced in dealing with young, mentally ill accused is getting the young person to engage. It is not uncommon for LINKS to see the young person multiple times before they have sufficient insight to engage.

Moreover, the perception from LINKS is that they are somewhat more nimble with respect to therapeutic options. LINKS are not encumbered by having other agencies on their team; and therefore do not have to balance competing interests.

It is therefore to be acknowledged that although LINKS strives to be a holistic outcome option, its greatest strength is mitigatory in character.

Curiously, this flexibility has resulted in a significantly higher number of Aboriginal young people engaging with LINKS than Aboriginal young adults engaging with the START Court. At present, the level of Aboriginal/Non-Aboriginal engagement with LINKS is approximately 50:50; whereas the level of Aboriginal engagement with the START Court hovers at around 2-3%.

YLS' experience with LINKS has been largely positive. One of the LINKS' primary objectives is early intervention. Therefore, for a person already engaged with Child & Adolescent Mental Health Services ("CAMHS"), exclusive engagement with LINKS is somewhat redundant. That said, in a particular matter in which I was involved, LINKS continued to liaise with CAMHS in order that they could monitor my client's progress, compliance and any issues that may require addressing in the context of Court proceedings.

In the case of another client; who although diagnosed with paranoid schizophrenia, was not engaged, LINKS' efforts in getting to engage, getting him onto a treatment plan and helping to gain some insight was outstanding. At that time, he stood accused of serious offences; and his engagement with LINKS and the reports generated thereby were most assuredly the difference between a custodial and a non-custodial disposition.

THE WAY FORWARD

In the cases of both START Court and LINKS, the future is wholly dependent upon that old canard – funding. In an ideal world, not only would the 2 programmes graduate into permanence, but also would receive extended funding to allow outreach to suburban and regional Courts.

The problems associated with mental health services consumers in remote or rural Western Australia are most profound. The sheer size of Western Australia, a state into which the entire land mass of the United Kingdom could fit 10 times, presents unique issues.

In 2005, the Commonwealth Human Rights Commissioner, Dr. Sev Odowski described the psychiatric facilities in the South West of Western Australia as the worst in the nation. One suspects that the good Doctor had yet to examine the facilities in the North West when he

made this pronouncement. The simple fact is that there is no approved hospital, within the meaning of the *Mental Health Act*, north of the 26th parallel.

In practical terms, any person in that region who becomes so unwell as to be unmanageable in the community usually attracts the attention of the Police, in one way or another. This necessitates transporting the accused/patient to Perth for hospitalisation or assessment. The lucky ones get flown down by the Flying Doctor. Many are not so lucky and come down on prison transport, notwithstanding the fact that they have not been convicted of any crime.

One suggestion I would float is the implementation of a number of regional judicial hubs at which the Specialised Courts (and in that class I include the Drug Court and Domestic Violence Courts) could sit on designated days during the month. This would probably involve video links from the Court in Perth to the regional Court, with members of the Clinical Team conducting face to face interviews with the accused/patient.

This would not be a cheap exercise; but what price can you put on human dignity?

It is an axiom almost universally acknowledged that a nation's greatness is measured by how it treats its weakest members[20]. The fact that the Courts are called upon on a daily basis to contend with people with the dual vulnerabilities of youth and mental illness calls for enlightened justice on the Western Frontier. Over the last 15 years, we have seen, in the words of that great humanitarian, Al Swearengen:

"Some advances, none miraculous"

[20] Variously attributed to Mohandas Karamchand ("Mahatma") Gandhi, Winston Churchill or Harry S. Truman. In truth, all 3 were paraphrasing Dostoyevsky: "The degree of civilization in a society can be measured by entering its prisons".

APPENDIX

CRIMINAL LAW (MENTALLY IMPAIRED ACCUSED) ACT 1996 - SCHEDULE 1

Enactment	Description of offence
1. *The Criminal Code*	
s. 279	Murder
s. 280	Manslaughter
s. 281	Unlawful assault causing death
s. 283	Attempt to murder
s. 292	Disabling in order to commit indictable offence etc.
s. 294	Acts intended to cause grievous bodily harm or to resist or prevent arrest
s. 297	Grievous bodily harm
s. 301	Wounding and similar acts
s. 304(2)	Acts or omissions, with intent to harm, causing bodily harm or danger
s. 317	Assaults occasioning bodily harm
s. 317A	Assaults with intent
s. 318	Serious assaults
s. 323	Indecent assault
s. 324	Aggravated indecent assault
s. 325	Sexual penetration without consent
s. 326	Aggravated sexual penetration without consent
s. 327	Sexual coercion
s. 328	Aggravated sexual coercion
s. 330	Incapable person: sexual offences against
s. 331B	Sexual servitude
s. 331C	Conducting business involving sexual servitude
s. 331D	Deceptive recruiting for commercial sexual services
s. 332	Kidnapping
s. 333	Deprivation of liberty
s. 388E(1)(a)	Stalking committed in circumstances of aggravation
s. 378(2)	Stealing a motor vehicle, aggravated by reckless or dangerous driving
s. 392	Robbery
s. 393	Assault with intent to rob
s. 444	Criminal damage
2. *Bush Fires Act 1954*	
s. 32	Wilfully lighting a fire or causing a fire to be lit under such circumstances as to be likely to injure or damage a person or property
3. *Road Traffic Act 1974*	
s. 59	Dangerous driving causing death, injury etc.

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PJMK