Mental Health Act 2016
Chief Psychiatrist Guidelines

Guidelines for preparing psychiatrist reports (Chapter 4 reports)

Contents

1 Purpose

The purpose of these guidelines is to provide authorised psychiatrists with information to assist in the preparation of psychiatrist reports. These reports are required to be prepared about a person in relation to a charge of a serious offence, under a direction of the Chief Psychiatrist as per sections 91 and 93 (Chapter 4) of the *Mental Health Act 2016* (the Act).

These guidelines also apply to a direction by the Chief Psychiatrist, under section 100 of the Act, to prepare a second psychiatrist report about the person.

These guidelines support the *Chief Psychiatrist Policy Psychiatrist reports for persons charged with a serious offence*.

2 Background

2.1 Queensland Criminal Code

The *Criminal Code Act 1899* (Criminal Code) allows for consideration of the criminal responsibility of a defendant with a mental condition through the legal construct of 'insanity'.[1] In relation to the charge of murder, the Criminal Code also provides for the charge to be downgraded to manslaughter through the concept of diminished responsibility[2] (see Appendix 1 – Relevant legislation).

2.2 Mental Health Act 2016

The provisions in Chapter 4 of the *Mental Health Act 2016* allow the Chief Psychiatrist to direct a psychiatrist report about a person charged with a serious offence[3] either:

- on request of the person or other specified persons, or
- on the Chief Psychiatrist's own initiative.

The provisions apply to a person charged with a serious offence who, at the time of the alleged offence or any time after the alleged offence, is subject to a Treatment Authority, Forensic Order or Treatment Support Order. The psychiatrist report should address the serious offence or offences and any associated offences, which will be listed in the *Chief Psychiatrist Direction for Psychiatrist Report*.

Offences against a law of the Commonwealth are excluded from these provisions.

[1] Sections 27 and 28 Queensland Criminal Code.

[2] Section 304A Queensland Criminal Code

[3] As defined in the schedule to the *Mental Health Act 2016*, serious offences are indictable offences other than those that, under the Criminal Code, must generally be heard and decided summarily.

2.2.1 Second psychiatrist reports

Section 100 of the Act also provides that if the Chief Psychiatrist believes that the matters in a psychiatrist report require further examination, the Chief Psychiatrist may:

- direct the Administrator of the person's treating health service to arrange for an authorised psychiatrist to prepare a second psychiatrist report (second report) on the matters, or
- direct an authorised psychiatrist to prepare the second report, including someone from outside the treating health service if considered more appropriate.

2.2.2 Timeframes for preparation of a psychiatrist report

Psychiatrist reports **must** be prepared within **sixty (60) days** of the Chief Psychiatrist's direction. The Chief Psychiatrist may extend this by granting an extension of up to **thirty (30) days**. This extension may be granted upon receipt of a request and explanation from the reporting psychiatrist. The request **must** be received as close to and no less than **seven (7) days** prior to the report due date. Only **one** extension may be given.

3 Purpose of a psychiatrist report

A psychiatrist report provides a medico-legal assessment of a person's mental state at the time of alleged offending, and in relation to fitness for trial. These reports are used to inform a Court's decision regarding the person's criminal responsibility in relation to the crime that they have allegedly committed, or current fitness for trial. The report may have significant implications for how a person's criminal charges are dealt with and the future care and treatment of the person.

Key points

These reports may be used to:

- assist the person or their legal representative to decide how to proceed with their matter and to assist any further proceedings,
- assist the Chief Psychiatrist to determine whether or not the matter of the person's mental state relating to an offence should be referred to the Mental Health Court (MHC) in the public interest, and
- assist the MHC in making a determination about whether or not the person was of unsound mind at the time of the offence (i.e. not criminally responsible) and whether the person is unfit for trial, and if so, whether the unfitness for trial is of a permanent nature.

4 Examination for the purpose of the report

Section 95 of the Act provides that the psychiatrist **must** prepare a report based on **their own** examination of the person and must consider the person's health records, the brief of evidence and any other relevant information.

Examinations may occur at any location the doctor considers is clinically appropriate, including in an authorised mental health service, a public sector health service facility, a person's home or by audio-visual link.

The psychiatrist report must contain details of the results of the examination of the person and the psychiatrist's associated medico-legal conclusions.

4.1 Ethical considerations

Potential or perceived conflicts of interest may arise in the preparation of a report. Such potential conflicts can include the situation in which a psychiatrist may be preparing a report for an individual whose alleged offences occurred in the Hospital and Health Service setting, or affected staff who work in the service in which the psychiatrist works.

To address any such potential conflicts of interest, it is recommended that the psychiatrist raise the issue with the Administrator of the Authorised Mental Health Service (AMHS) if the psychiatrist forms the opinion that the report would be more appropriately allocated to a different psychiatrist. This must occur in a timely manner noting the prescribed timeframe in which reports must be completed.

If the psychiatrist does not form the opinion that a different psychiatrist should be allocated the report, the perceived conflict should be raised with the patient during the informed consent process at the outset of the assessment. The views and wishes of the patient in relation to the assessment should be respected and any concerns raised with the AMHS Administrator in a timely manner.

The informed consent process, including discussion of the perceived conflict, should be documented within the report.

If appointed, the person's substitute decision maker should also be consulted regarding the assessment and any perceived conflicts of interest.

5 Content of psychiatrist reports

Key points

The key terms to be addressed in the psychiatrist's analysis are:

- **Substantial dispute** about whether the person committed the offence
- **Unsoundness of mind** (deprivation of one or more of the relevant capacities)
- **Diminished responsibility** (only in cases where the person is accused of murder)
- **Fitness for trial**

The standard of proof that the psychiatrist should base their conclusions on is **'the balance of probabilities'**. This means that something is **more likely, or more probable, than not**.

- The psychiatrist is not required to be satisfied 'beyond a reasonable doubt'.
- The psychiatrist should clearly explain the rationale and facts upon which their opinion is based.

The report **must only** be in relation to the charges listed in the Chief Psychiatrist's direction. This includes the serious offences and any associated offences[4] that the Chief Psychiatrist requests to be addressed.

Section 95(5) of the Act outlines what **must** be included in the report:

(1) The person's mental state and, to the extent practicable, the person's mental state when the serious offence was allegedly committed

(2) Whether the psychiatrist considers the person was of unsound mind when each of the offences listed in the direction was allegedly committed

(3) Whether the psychiatrist considers the person is fit for trial

(4) If the psychiatrist considers the person is unfit for trial – whether the psychiatrist considers the unfitness is permanent.

[4] An associated offence is an offence that the person is alleged to have committed at or about the same time as the serious offence.

5.1 Substantial dispute

The Mental Health Court **must not** make a decision in relation to unsoundness of mind or diminished responsibility if it is satisfied that there is a substantial dispute about whether the person committed the offence as particularised in the brief of evidence, unless the dispute exists only because of the person's mental condition.

Legal test and application

When addressing whether there is a substantial dispute a two-part test **must** be applied:

1. Is there a substantial dispute about whether the person committed the offence?
2. Does this dispute exist only as a result of the person's mental condition?

The person being unable to recall the offence does not constitute a dispute.

The psychiatrist should report the person's account of events. If the person's account is substantially different to the brief of evidence, the psychiatrist **must** address whether the dispute exists **only** because of the person's mental condition.

If the dispute does exist only because of the person's mental condition, then the Court may proceed to make a finding in relation to unsoundness of mind or diminished responsibility.

5.2 Unsoundness of mind

Unsoundness of mind is defined at section 109 of the Act by reference to section 27 and 28 of the Criminal Code (see Appendix 1 – Relevant Legislation).

Legal test and application

The legal test that **must** be applied for a finding of unsoundness of mind is:

- Whether **at the time of the alleged offence** the person was in such a **state of mental disease or natural mental infirmity** as to deprive them of:
  - The capacity to understand what they were doing, or
  - The capacity to control their actions, or
  - The capacity to know that they ought not do the act or make the omission.[5]

Unsoundness of mind **does not** include a state of mind resulting, **to any extent**, from intentional intoxication or stupefaction alone or in combination with some other agent at or about the time of the alleged offence (see 5.2.3).[6]

Key points

- The psychiatrist **must** express an opinion as to whether the person was of unsound mind according to the legal test stated above.
- The test must be applied as at the time of the offence.
- 'Mental disease' has the same meaning as mental illness.[7] 'Natural mental infirmity' includes an intellectual impairment.[8] (See 5.2.1.)
- 'Deprivation' of capacity refers to a complete or total loss of capacity. 'Impairment' refers to merely a partial loss. There cannot be a partial deprivation.
- The functional link between the person's mental illness or natural infirmity (or a combination of both) and the identified deprivation of capacity must be detailed in the report.
- The issue of intoxication will need to be addressed (see 5.2.3).
- Each capacity should be addressed separately within the report.
- Each of the alleged offences must be considered, and different conclusions may be reached in relation to different offences.

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[5] Section 27 Criminal Code.

[6] Section 109(2) Mental Health Act 2016.

7 *R v Radford* (1985) SASR 266; *R v Falconer* [1990] HCA 49; (1990) 171 CLR 30.

[8] See R v Falconer (1990) 171 CLR 30 and the Queensland Supreme and District Court Bench book No. 82.1 - Insanity, March 2017.

5.2.1 Mental disease or natural mental infirmity

These are legal concepts, not medical concepts, and are not strictly defined.

Generally speaking, a mental disease refers to a mental illness, be it permanent or temporary, that is:

- caused from an internal defect or vulnerability,
- not merely an exaggeration of human emotion,
- not the reaction of a healthy mind to extraordinary external stimulus, and
- prone to recurrence.[9]

A natural mental infirmity refers to a defect in intelligence or of the higher intellectual processes such as abstract thinking or problem solving. It may be caused by an external insult to the brain or an internal defect or vulnerability. It is usually stable and permanent. An intellectual impairment is a natural mental infirmity.[10]

5.2.2 The three capacities

The fact that a person has a mental disease or natural mental infirmity alone does not necessarily result in a finding of unsoundness of mind. The Mental Health Court will only make a finding of unsound mind if it concludes that a person's mental disease or natural mental infirmity **deprived** them of one or more of the relevant capacities at the time of the alleged offence[11].

The opinions given by psychiatrists on a person's capacities at the time of an alleged offence are critical to the Court's decision-making process.

[9] Ibid

[10] Ibid.

[11] See *Re W* (1997) QMHT 170 per Dowsett J for further explanation of the capacities.

Key points

The three capacities are:

1) the person's **capacity to understand what they were doing** in relation to the offence, i.e. –

    a) the **capacity to appreciate the nature and quality of the act** they were doing **at the time** of committing the offence or to understand the physical nature of the act (**not** its moral or legal consequences)

2) the person's **capacity to control their actions** in relation to the offence:

    a) it may be relevant to consider whether or not a person has the capacity to exercise willpower to control their actions.[12]

3) the person's **capacity to know that they ought not do the act or make the omission** constituting the offence, i.e. –

    a) The **capacity to know the difference between right and wrong** in relation to the action according to the **ordinary standard of reasonable people**.

    b) Awareness that the act is wrong according to law is relevant, but it is **not** decisive.

    c) Consideration must be given to whether the person was able to appreciate the rightness or wrongness of the particular act they were doing at the particular time, and were able to think rationally of the reasons which to ordinary people make that act right or wrong and reason about the matter with a moderate degree of sense and composure.

5.2.3 The role of intoxication

The question of the effect of an intoxicant on the patient's mental state is clinically and legally complex.

The definition of unsound mind in the Act does not include 'a state of mind resulting, to any extent, from intentional intoxication or stupefaction alone or in combination with some other agent at or about the time of the alleged offence'.[13]

[12] See *R v Byrne* [1960] 2 QB 396 at 403.

[13] Section 109(2) Mental Health Act 2016

Legal test and application

The Courts have held that the following test must be applied when addressing the issue of intoxication:

- A person who was deprived of one of the relevant capacities at the time of an alleged offence will not be found to be of unsound mind if intoxication **contributed to any extent** to that deprivation of capacity.

Application of the test:

The psychiatrist should use the following steps to address the test:

- whether the person was **deprived of one of the relevant capacities at the time** of the offending,
- if so, is there **evidence** that the person **used alcohol or any other intoxicating substance around the time of the alleged offence**,
- If there is evidence of use, whether in the psychiatrist's opinion, on the available evidence, the person was **intoxicated at the time of the alleged offence**?
  - When applying s109(2) of the Act, it is essential to distinguish the specific question of whether the person was **intoxicated at the time of the alleged offence, from the question of their more general substance use**.
- if the psychiatrist considers the person was intoxicated, whether the intoxication **contributed to the deprivation of capacity to any extent**.[14]

When assessing intoxication, the psychiatrist should consider what evidence there is of intoxication having regard to the brief of evidence and the patient's account.

- Reference to self-account, witness statements and laboratory investigations all assist with an objective comment in this area.

The psychiatrist should provide reasoned argument to support their opinion. Where intoxication is a relevant consideration in determining whether a person was of unsound mind, it is **not** relevant whether the person's mental illness was capable of depriving them of a capacity despite the intoxication or in the absence of intoxication. If the intoxication contributed to **any extent** to the deprivation of a capacity the person **cannot** be found of unsound mind.

However, it is open to the psychiatrist to conclude that a person who was deprived of a capacity was intoxicated but their intoxication **did not** contribute to the deprivation. In those circumstances, the person may still be found unsound of mind.

[14] Re Clough [2007] QMHC 002; Re Smith [2015] QMHC 8; SCN v Director of Public Prosecutions (Qld) & Anor [2016] QCA 237

5.3 Diminished responsibility

Diminished responsibility only relates to a charge of murder and is defined at section 108 of the Act in reference to section 304A of the Criminal Code (see Appendix 1 – Relevant Legislation).[15]

Legal test and application

What is required to be considered is whether, at the **relevant time**:

- the person was suffering from an **abnormality of mind**, and
- that such abnormality of mind:
  - arose from something **endogenous or inherent** in the person (whether illness, injury or another inherent cause such as a condition of arrested or retarded development of mind), and
  - was such as to have **substantially impaired** the person's capacity to understand what they were doing, or their capacity to control their actions, or their capacity to know that they ought not do the act or make the omission at the time of the alleged offence of murder.

Key points

The requirements for an **'abnormality of mind'** under section 304A of the Criminal Code are different to what is required for **'mental disease or natural mental infirmity'** under section 27.

- **Abnormality of mind** refers to **state of mind so different from that of ordinary human beings that the reasonable person would term it abnormal**.
- **Substantially impaired** does not mean a complete or total loss of the capacities, but **it must be more than a trivial or minimal impairment.** The abnormality of mind must be a real cause of the person's conduct because it substantially impaired a relevant capacity. It does not have to be the sole cause of the conduct, but it must be more than a merely trivial one which made no real or appreciable difference to the relevant capacity.[16].
- The causal relationship between the underlying pathology said to amount to a **mental abnormality** and the **substantial impairment of capacity** must be clearly identified.

[15] Section 304A Queensland Criminal Code.

[16] See R v Lloyd [1967] 1 QB 175, Regina v Biess [1967] Qd R 470, R v Smith (aka Stella) [2021] QCA 139

In all cases where the person is charged with murder, the psychiatrist **must** address both the issue of unsoundness of mind and the issue of diminished responsibility, even if the psychiatrist's opinion is that the person was of unsound mind.

5.3.1 Intoxication in relation to diminished responsibility

The courts have determined that when addressing the matter of diminished responsibility in circumstances where the person was intoxicated at the time of the killing, the effect of drugs or alcohol (intoxicants), should be disregarded and the question that should be addressed is:

- Whether, even though the person was intoxicated, the abnormality of mind (mental illness or intellectual impairment) did in fact substantially impair their capacity or capacities.[18]

5.4 Fitness for trial

The definition and test of 'fit for trial' is not defined within the Act and accordingly, common law principles apply.[17] In Australia, this was established in the case *R v Presser* [1958] VR 45.

Legal test and application

The principles established in *R v Presser*, known as the **Presser Criteria**, were later articulated as follows:

- The minimum standards that a person must meet to satisfy the requirements of fitness for trial, require the person's ability to:
  - **understand the nature of the charge**
  - **plead to the charge** and to **exercise the right of challenge**
  - **understand the nature of the proceedings**, namely, that it is an inquiry as to whether the accused committed the offence charged
  - **follow the course of the proceedings**
  - **understand the substantial effect of any evidence that may be given in support of the prosecution**, and
  - **make a defence or answer the charge.**

[18] R v Dietschmann [2003] 1 AC 1209; Re Greenfield [2017] QMHC 4

[17] R v Pritchard (1836) 173 ER 135.

Key points

- The psychiatrist's report should address factors that would affect the question of whether the patient, for any reason whatsoever, is unable to comprehend the course of proceedings of the trial so as to make a proper defence.
- Each of the Presser Criteria must be considered as part of the test of fitness for trial and must be individually addressed.
- The psychiatrist must determine and indicate in their report whether or not in their opinion the person is fit for trial and, if unfit for trial, whether or not it is temporary or permanent in nature.

The application of the **Presser Criteria** involves a consideration of the person's ability:

- to understand the nature of the charges and to enter, and understand the nature of, a plea,
- to understand the general nature of court proceedings (that it is an inquiry as to whether they did what they are charged with),
- to follow the course of proceedings in a general sense, but they need not understand all the formalities,
- to understand their right to challenge a prospective juror and capacity to do so,
- to understand and make sense of the substantial effect of any evidence given against them and appreciate whether there are any facts which contradict or explain the evidence against them
- ability to decide what defence to offer, and
- ability to explain their version of the facts to counsel and legal representatives and, if necessary, to the court.

Special considerations – The psychiatrist should also address whether any special considerations could be provided by the court, which would assist a person to meet the Presser Criteria and be fit for trial.

This may include, for example:

- The person being granted frequent breaks,
- The presence or assistance of support persons

5.4.1 Temporarily unfit for trial

Key points

- The Chief Psychiatrist may defer the referral of a matter to the MHC for a period of up to **four (4) months**, if the Chief Psychiatrist considers the patient is unfit for trial, but is likely to be fit for trial within the extended **four (4) month** period.
- This may occur, for example, when a period of time to optimise medication would likely result in a person becoming fit for trial.

The Chief Psychiatrist's decision as to whether or not a person is temporarily unfit for trial is informed by the psychiatrist report.

Where a psychiatrist finds a person is temporarily unfit for trial, it is important to clearly state the likely duration of the person's unfitness.

5.4.2 Permanently unfit for trial

When determining whether to refer a matter to the MHC, the Chief Psychiatrist must consider whether a person is permanently unfit for trial. This is informed by the psychiatrist report.

If the psychiatrist making the report considers the patient is unfit for trial, the psychiatrist should then provide an opinion as to whether the unfitness is of a permanent nature. The basis for the permanence of the unfitness for trial should be clearly explained in the report.

5.5 Future management

5.5.1 Future management plan

The psychiatrist should provide an overview of the proposed shorter and longer-term plans for the patient's future management, addressing both psychosocial needs and biological management of the person's illness.

In considering the psychosocial needs of the patient, the psychiatrist should address the supports available to the patient to meet these needs. Psychosocial supports include, though are not limited to, current National Disability Insurance Scheme (NDIS) funding and supports, and current accommodation and family, carer and support service supports.

When considering future management and required supports it is recommended to consider the factors that inform your recommendation as to whether the court should make an order. Refer to key points in section 5.6.2.

5.6 Recommendations

5.6.1 Should the matter be referred to the Mental Health Court?

On receipt of the report, the Chief Psychiatrist **may** make a reference to the MHC if:

- satisfied that the person may have been of unsound mind or may be unfit for trial; and
- having regard to the report and the protection of the community, there is **compelling reason in the public interest** to refer the matter to the MHC.

The psychiatrist is required to provide advice in the report to enable the Chief Psychiatrist to decide whether to make a public interest referral. This **must** include consideration of both **individual** and **community interests** when evaluating and reporting on this.

A psychiatrist's opinion alone that a person was of unsound mind is not a compelling reason in the public interest to refer the matter to the Mental Health Court.

5.6.2 The question of public interest

Chief Psychiatrist decisions take account of the policy intent for individuals to, as far as possible, make their own decisions about how legal matters are dealt with. This includes acknowledging the rights of individuals to decide not to request for their matter to be referred to the Mental Health Court. However, the matter may still be referred by the Chief Psychiatrist if it is in the public interest.

The Chief Psychiatrist will not make a reference to the Mental Health Court solely on the basis that a person may have been of unsound mind at the time of an alleged offence. A reference will only be made if the Chief Psychiatrist is satisfied that the person may have been of unsound mind at the time the offence(s) were committed or may be unfit for trial; and, having regard to the report and the protection of the community, there is a **compelling reason in the public interest** for the person's mental state in relation to the serious offence(s) to be referred to the Mental Health Court.

Key points

When considering and addressing questions of public interest, the psychiatrist should consider and address both **individual** and **community interests**, including for example, the following:

- **Individual interests:**
  - The person's mental condition and whether this condition significantly impacts their capacity to represent their own interests in relation to the charge(s).
  - Additional supports that may be available, such as guardians, attorneys and legal representatives, who may protect the person's interests.
  - The person's treatment and care requirements.
- **Community Interests:**
  - Reducing the risk of reoffending (where offending behaviour is consequent to the person's mental illness).
  - The seriousness of the offending.
  - All members of the community are entitled to a fair legal process.

Having regard to all relevant factors, the psychiatrist should advise whether they believe it is in the public interest for the matter to proceed through the Mental Health Court.

Psychiatrists should also be aware that there are alternate mechanisms for the charges to be dealt with, including referral to the Mental Health Court by the person's legal representative or dismissal of the charges via the Magistrates Court in certain circumstances.

Further information regarding public interest can be found in the *Chief Psychiatrist Policy Psychiatrist reports for persons charged with a serious offence*.

5.6.3 Should the Mental Health Court make a Forensic Order or Treatment Support Order or no order?

The psychiatrist should give consideration to, and provide an opinion on, whether the MHC should make a forensic order or a treatment support order or no order, if the MHC finds that the person was of unsound mind at the time of the alleged offence or is unfit for trial.

This will ultimately involve a consideration of whether a Forensic Order, or alternatively a Treatment Support Order, is necessary, because of the person's mental condition and to protect the safety of the community, including from the risk of serious harm to other persons or property.[18]

Note, however, that the MHC must make either a Forensic Order or a Treatment Support Order if it finds that a person is temporarily unfit for trial.[19]

Key points

When providing comment on the making of a forensic order or treatment support order, the psychiatrist should consider the key differences in these types of orders (See Appendix 2 – Treatment Support Order vs Forensic Order).

In particular the intention that a forensic order operates in a way that is **more restrictive** of a persons' rights and liberties than a treatment support order.

- Key points to consider and comment on include:
  - The person's **level of insight and engagement** in treatment
  - the **nature of offences**
  - **Adherence** to any current treatment (for example, if currently under a treatment authority, is there a history of absence without approval)
  - **Risk assessment** - Can the risk management needs be met under a treatment support order rather than a forensic order?

[18] Section 134 and 143 Mental Health Act 2016.

[19] Section 132 Mental Health Act 2016.

5.6.4 Provision of the report to the person subject to the report

The Chief Psychiatrist must provide a copy of the report to the person subject to the report, unless satisfied that this may adversely affect the persons health and wellbeing.

The psychiatrist should address this matter, including how and why, providing the person a copy of the report will adversely affect their health and wellbeing. Clear reasons should be provided to assist the Chief Psychiatrist in determining whether the report should or should not be provided to the person.

If the Chief Psychiatrist determines that the report should not be provided to the person, a copy of the report may be provided to another person who has sufficient interest in the person's health and wellbeing.

Further information

Copies of cases cited in this document can be obtained from:

Mental Health Act Liaison Service
Office of the Chief Psychiatrist
Phone: 07 3328 9899
Email: MHA2016@health.qld.gov.au

Referenced policies and resources

Chief Psychiatrist policies and associated resources

- Chief Psychiatrist Policy – Psychiatrist reports for persons charged with a serious offence
- Chief Psychiatrist Policy – Forensic Orders and Treatment Support Orders: Category, Conditions and Limited Community Treatment
- Flowchart 1: Overview
- Flowcharts 2(a)–(b): Report on request and direction for report
- Flowchart 3: Direction for report (Chief Psychiatrist initiative)
- Flowchart 4: Determining referral to Mental Health Court

Legislation

- *Criminal Code Act 1899*
- *Mental Health Act 2016*

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Appendix 1 – Relevant legislation

Section 27 of the Criminal Code provides:

1) A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission the person is in such a state of mental disease or natural mental infirmity as to deprive the person of capacity to understand what the person is doing, or of capacity to control the person's actions, or of capacity to know that the person ought not do the act or make the omission.

2) A person whose mind, at the time of the person's doing or omitting to do an act, is affected by delusions on some specific matter or matters, but who is not otherwise entitled to the benefit of the foregoing provisions of this section, is criminally responsible for the act or omission to the same extent as if the real state of things had been such as the person was induced by the delusions to believe to exist.

Section 28 of the Criminal Code provides:

1) The provisions of section 27 apply to the case of a person whose mind is disordered by intoxication or stupefaction caused without intention on his or her part by drugs or intoxicating liquor or by any other means.

2) They do not apply to the case of a person who has, to any extent intentionally caused himself or herself to become intoxicated or stupefied, whether in order to afford excuse for the commission of an offence or not and whether his or her mind is disordered by the intoxication alone or in combination with some other agent.

3) When an intention to cause a specific result is an element of an offence, intoxication, whether complete or partial, and whether intentional or unintentional, may be regarded for the purpose of ascertaining whether such an intention in fact existed.

Section 304A of the Criminal Code provides:

1) When a person who unlawfully kills another under circumstances which, but for the provisions of this section, would constitute murder, is at the time of doing the act or making the omission which causes death in such a state of abnormality of mind (whether arising from a condition of arrested or retarded development of mind or inherent causes or induced by disease or injury) as substantially to impair the person's capacity to understand what he is doing, or the person's capacity to control the person's actions, or the person's capacity to know that the person ought not do the act or make the omission, the person is guilty of manslaughter only.

2) On a charge of murder, it shall be for the defence to prove that the person charged is by virtue of this section liable to be convicted of manslaughter only.

3) When two or more persons unlawfully kill another, the fact that one of such persons is by virtue of this section guilty of manslaughter only shall not affect the question whether the unlawful killing amounted to murder in the case of any other such person or persons.

Appendix 2 – Treatment Support Order vs Forensic Order

Greater oversight and review is required for people on a Forensic Order than a Treatment Support Order.

Further information can be found in the *Chief Psychiatrist Policy Forensic Orders and Treatment Support Orders: Category, Conditions and Limited Community Treatment*.

Treatment Support Order	Forensic Order

• A Treatment Support Order (TSO) must be made if the MHC/MHRT considers a TSO, but not a FO, is necessary to protect the safety of the community, including a risk of serious harm to others or property.
• Must be 'Community Category' unless the person's treatment and care needs, safety and welfare or the safety of others cannot be met in the community.
• Only available for those with a mental condition other than an intellectual disability or dual disability.
• Cannot be made for a person with an intellectual disability alone.
	• A Forensic Order (FO) must be made if the MHC considers a FO is necessary to protect the safety of the community, including the risk of serious harm to others or property.
	• Can only be 'Community Category' if there is not an unacceptable risk to the safety of the community, including serious risk of harm to other persons or property.
	• FO (mental health) is for treatment of people with:
	  ○ a mental condition other than intellectual disability, or
	  ○ a mental condition and intellectual disability.
	• FO (Disability) is for care of persons with intellectual disability only.
	• MHC can recommend intervention programs (e.g. drug and alcohol program or sexual offender program).
	• MHC can impose non-revocation period of up to 10 years for prescribed offences.

Treatment Support Order	Forensic Order
Monitoring and Review	

• No minimum timeframe for a psychiatrist's initial assessment after the TSO is made.
• No mandatory ARMC review within a specified timeframe after the order is made.
• ARMC review is only required:
  ○ within 90 days when the person's order is changed from FO to TSO,
  ○ if there is an increase in risk (Tier 2 or 3 of VRAM framework),
  ○ at the Clinical Director or Chief Psychiatrist's discretion.
• All monitoring and review timeframes are determined by the treating psychiatrist.
	• A Psychiatrist must assess a person within 7 days of the person becoming subject to the FO.
	• ARMC review is required within 30 days of the person becoming subject to the FO.
	• Minimum of 2 ARMC reviews per year (at least every 6 months)
	• CFOS referral for prescribed offences must be made and a review undertaken within 60 days of the FO being made.
	• ARMC determines timeframes for reviews.