

The Senate

Community Affairs
References Committee

Indefinite detention of people with cognitive
and psychiatric impairment in Australia

November 2016

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ABBREVIATIONS

ABI	Acquired Brain Injury
ACAT	ACT Civil and Administration Tribunal
ACT	Australian Capital Territory
ADHC	NSW Department of Ageing, Disability and Home Care
ADJC	Aboriginal Disability Justice Campaign
AGD	Attorney General's Department
AHRC	Australian Human Rights Commission
AIHW	Australian Institute of Health and Welfare
ALRC	Australian Law Reform Commission
ALSWA	Aboriginal Legal Service of Western Australia
AMA	Australian Medical Association
ARC	Assessment and Referral Court (Victoria)
ASCC	Alice Springs Correctional Centre
ATSILS	Aboriginal and Torres Strait Islander Legal Service
Bennett Brook DJC	Bennett Brook Disability Justice Centre
CAIDS-Q	Adolescent Intellectual Disability Screening Questionnaire (NSW)
CBU	Complex Behaviour Unit (within the DCP)
Civil Society Report	<i>Civil Society Report to the United Nations Committee on the Rights of Persons with Disabilities (2012)</i>
CJP	Community Justice Program (NSW)
CLANT	Criminal Lawyers Association of the Northern Territory
CLMIA Act	<i>Criminal Law (Mentally Impaired Accused) Act 1996 (WA)</i>
CMHC	Community mental health care
CMIA Act	<i>Crimes (Mental Impairment and Unfitness to be Tried) Act 1997</i>

	(Vic)
COAG	Council of Australian Governments
CRPD	UN Convention on the Rights of Persons with Disabilities
CSO	Custodial Supervision order in WA, NT and Victoria, also known as a forensic order in other jurisdictions
CVP	Community Visitor Program (NT)
DCP	Darwin Correctional Precinct
Disability Act	<i>Disability Act 2006</i> (Vic)
Disability Alliance	Australian Cross Disability Alliance
DMHF	Declared mental health facility (NSW)
DSC	Disability Services Commission (WA)
EEO	Emergency Examination Order (QLD)
FACS	Department of Family and Community Services (NSW)
FASD	Fetal Alcohol Spectrum Disorders
IDPP	Intellectual Disability Diversion Program (WA)
Inspector	Office of the Inspector of Custodial Services (WA)
ISP	Individual Support Plan (also known as a behavioural support plan)
ITO	Inpatient Treatment Order (Victoria)
JSS	Jesuit Social Services
Law Council	Law Council of Australia
LCCSC	Law, Crime and Community Safety Council (COAG)
MHC	Mental Health Court (QLD)
MHRB	Mental Health Review Board (WA)
MHRT	Mental Health Review Tribunal (NSW)
MIARB	Mentally Impaired Accused Review Board (WA)
NAAJA	North Australian Aboriginal Justice Agency
National Principles	National Statement of Principles Relating to Persons Unfit to Plead or Found Not Guilty by Reason of Cognitive or Mental Health

	Impairment
NCSO	Non-Custodial Supervision Orders
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDMP	National Decision Making Principles
NHMC	National Mental Health Commission
NSW	New South Wales
NSW Mental Health Act	<i>Mental Health Act 2007</i> (NSW)
NT	Northern Territory
OPG-QLD	Office of the Public Guardian (QLD)
PTO	Psychiatric treatment order (ACT)
Public Advocate QLD	Office of the Public Advocate (QLD)
Public Advocate Victoria	Office of the Public Advocate (Victoria)
QLD	Queensland
QMHT	QLD Mental Health Tribunal
RANZCP	Royal Australian New Zealand College of Psychiatrists
RMHC	Residential mental health care
SA	South Australia
SACAT	South Australian Civil and Administrative Tribunal
SCF	Secure Care Facility
Sentencing Council	Sentencing Advisory Council of South Australia
SNFP	Special notification forensic patient (QLD)
Start court	Specialist Treatment and Referral Team court (WA)
STO	Supervised treatment order
TAS	Tasmania

TMHT	Tasmanian Mental Health Tribunal
TBI	Traumatic Brain Injury
ToR	Terms of reference
UK	United Kingdom
UN	United Nations
UN Disability Committee	UN Committee on the Rights of Persons with Disabilities
UN Disability Convention	<i>UN Convention on the Rights of Persons with Disabilities</i>
VCAT	Victorian Civil and Administrative Tribunal
VLRC	Victorian Law Reform Commission
VMHT	Victorian Mental Health Tribunal
WA	Western Australia
WAAMH	Western Australian Association for Mental Health
YOT	Youth on Track (NSW)

LIST OF RECOMMENDATIONS

Recommendation 1

9.11 The committee recommends the Australian Government work with state and territory governments on the implementation of initiatives to improve access to justice for people with disability contained in the reports by the Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, the Human Rights Commission, *Equal Before the Law* and Productivity Commission, *Access to Justice Arrangements*, with particular focus on:

- better intervention and support services;
- expanded Community Visitor's schemes;
- improved witness support services to people with disabilities;
- creation of an assessment protocol that assists police, courts, and correctional institutions in identifying people with disabilities. Where identified, a trained officer will provide support;
- transparent, effective and culturally appropriate complaints handling procedures;
- training for police, lawyers and others in justice in needs of people with disability; and
- where a person who has been found unfit to plead is to be held in detention, demonstrate that all reasonable steps have been taken to avoid this outcome, and that person must be held in a place of therapeutic service delivery.

Recommendation 2

9.12 The committee also recommends that each state and territory implement a Disability Justice Plan.

Recommendation 3

9.13 The committee believes that there is a need for further investigation of access to justice issues, with a focus on:

- the implementation requirements for supported decision-making;
- investigating the potential for the UK system of registered intermediaries; and
- the indefinite detention of people with cognitive impairment or psychiatric disabilities.

Recommendation 4

9.15 The committee recommends the Australian Government work with state and territory governments on a nationally consistent approach to existing state and territory disability oversight mechanisms, to include;

- increased funding for community visitor schemes, with consideration these schemes be professionalised in all jurisdictions and with a mandatory reporting requirement for suspected violence, abuse or neglect; and
- greater crossover in oversight and complaints mechanisms between aged care and disability.

9.16 A nationally consistent approach to disability oversight mechanisms is best overseen by the national disability watchdog.

Recommendation 5

9.18 The committee recommends that the Australian Government drive a nationally consistent move away from substitute decision-making towards supported decision-making models.

Recommendation 6

9.19 The committee recommends that the Australian Government work with state and territory governments to implement the recommendations of the Australian Law Reform Commission report *Equality, Capacity and Disability in Commonwealth Laws*, in relation to legal capacity and supported decision-making.

Recommendation 7

9.20 The committee recommends the Australian Government work with state and territory governments to create national consistency in the administration of guardianship laws to ensure:

- public advocate and guardianship functions are separate to ensure independent oversight;
- mandatory training on supported decision-making for guardians;
- that service delivery organisations or accommodation providers are never given guardianship;
- automatic increased oversight where service delivery organisations or accommodation providers recommend families lose guardianship; and
- that Aboriginal and Torres Strait Islander peoples' particular circumstances are taken into account in developing guardianship systems.

Recommendation 8

9.24 The committee recommends that the forthcoming national statement of principles adopt the position that indefinite detention is unacceptable and that state and territory legislation be amended in line with this principle.

- The committee recommends that the LCCSC endorse and adopt the National Principles at its earliest opportunity.

Recommendation 9

9.25 The committee recommends that the LCCSC complete its data collection project at its earliest opportunity.

Recommendation 10

9.27 The committee recommends that the COAG develop and implement a disability screening strategy (including hearing assessments) for all Australian jurisdictions. This screening strategy would apply to all people (adults and minors) who engage with the criminal justice system. The strategy would be applied at multiple points throughout the criminal justice system such as first contact with police, courts, prisons and related facilities.

Recommendation 11

9.29 The committee recommends that the COAG work together to ensure that recently developed tools such as the FASD diagnosis tool are provided as a supported resource to police, courts, legal aid and other related groups.

Recommendation 12

9.31 The committee recommends that the Australian Government, through the COAG, actively encourage support worker programs which assist people with cognitive and psychiatric impairment to engage with and participate in the court process. The Australian Government should work closely with the states and territories to identify suitable programs to be funded for expansion where they are currently being trialled, and establish new programs where they currently do not exist.

Recommendation 13

9.33 The committee recommends that COAG develop a range of culturally appropriate resources for Aboriginal and Torres Strait Islander peoples that can be deployed to service providers, police and the judiciary. These resources will assist the service providers, police and the judiciary to communicate more effectively with Aboriginal and Torres Strait Islander peoples engaged in the criminal justice system.

9.34 The committee recommends that the Australian Government, through COAG, fund a number of Aboriginal and Torres Strait Islander identified support worker positions across a number of population centres, particularly in the NT and WA. This would include positions or funding for signing and translation services.

9.35 The committee recommends that Aboriginal controlled organisations should be resourced to provide specialised and culturally appropriate support to Aboriginal and Torres Strait Islander peoples with cognitive and psychiatric impairments in detention and community care.

Recommendation 14

9.37 The committee recommends that the COAG work together to modify guidelines for police interrogation of Aboriginal and Torres Strait Islander peoples in each state and territory to include a requirement that a hearing assessment be conducted for any Aboriginal and Torres Strait Islander person who is having communication difficulties, irrespective of whether police officers consider that the communication difficulties arise from language and cross-cultural issues.

Recommendation 15

9.40 The committee recommends that the COAG consider an appropriate mechanism for jurisdictions with specialist courts to share their expertise and experience with other jurisdictions.

9.41 The committee recommends that the COAG develop and implement appropriately resourced mobile courts for remote parts of WA and the NT.

Recommendation 16

9.43 The committee recommends that the COAG ensures a consistent legislative approach across all Australian jurisdictions to provide a range of options for the placement of forensic patients beyond unconditional release and prison.

Recommendation 17

9.45 The committee recommends that the COAG ensures a consistent legislative approach with respect to limiting terms for forensic patients in all Australian jurisdictions.

Recommendation 18

9.46 The committee recommends that the COAG works together to cease the use of mandatory sentencing.

Recommendation 19

9.49 The committee recommends that the LCCSC extend its data collection project to identify and quantify the supply shortfall for forensic accommodation placements in secure care facilities and supported accommodation in the community.

Recommendation 20

9.51 The committee recommends that the Australian Government work closely with the NT Government to plan, fund and construct non-prison forensic secure care facilities and the acquisition of supported accommodation options in communities across the NT.

9.52 The committee recommends that the Australian Government work closely with the NT Government to ensure that all forensic facilities are appropriately staffed.

Recommendation 21

9.54 The committee recommends that the COAG ensure that ISPs in all Australian jurisdictions have consistent objectives and are clear on who is responsible for delivery of services, regardless of where a forensic patient is housed.

Recommendation 22

9.56 The committee recommends that the Australian Government work closely with the NT Government to ensure that its ISP (or equivalent) for forensic patients have clear objectives of transitioning a forensic patient from prison to secure care, and where appropriate, from secure care to the community.

Recommendation 23

9.58 The committee recommends that COAG establish a working group:

- to review existing early intervention programs for people with cognitive and/or psychiatric impairment; and
- develop and implement programs which engage with people with cognitive impairment at the youngest appropriate age.

Recommendation 24

9.60 The committee recommends that the COAG develop and implement a series of justice reinvestment projects across the country to showcase the long-term social and economic benefits of justice reinvestment.

Recommendation 25

9.62 The committee recommends that the Joint Standing Committee on the National Disability Insurance Scheme conduct an inquiry into the issue of eligibility and access to the NDIS for people held in prisons and the criminal justice system more broadly.

Recommendation 26

9.64 The committee recommends that the WA and NT Governments transition forensic patients currently held in prison to the relevant secure care forensic facility in each state as a matter of urgency.

Recommendation 27

9.67 The committee recommends that state and territory governments facilitate improved first responses to incidents involving people with cognitive or psychiatric impairment by ensuring:

- Police and ambulance officers are provided with appropriate frontline training to recognise and respond to situations involving cognitive or psychiatric impairment issues.
- Police and ambulance officers are provided with specialist resources, such as state-wide 24/7 access to mental health teams to provide immediate advice during first response incidents.
- Increased funding for health transport to ensure that police resources are not used to transport people for mental health assessments.

Recommendation 28

9.69 The committee recommends that state and territory governments investigate the appropriateness of early intervention mental health treatment, with a specific goal to reduce 'risk-induced' treatment-related detention.

Recommendation 29

9.71 The committee recommends the Australian Government work with state and territory governments to create national consistency in the approach to compulsory treatment orders, to ensure:

- appropriate 'risk of harm' levels are set for assessments that can result in detention for the purposes of therapeutic intervention;
- mandated requirements for 'least restrictive' treatment;
- regular reviews, including assessment of treatment against therapeutic benchmarks; and

- independent oversight.

Recommendation 30

9.73 The committee recommends that state and territory governments consider and implement legislative change to strengthen the effect of supported decision-making tools such as Advance Directives.

Recommendation 31

9.75 The committee recommends the state and territory governments consider adopting elements of the Victorian disability frameworks.

Recommendation 32

9.77 The committee recommends that state and territory governments proactively fund the construction or acquisition of a range of appropriate supported accommodation options across metropolitan and regional locations for people with cognitive and/or psychiatric impairments.

Chapter 1

Introduction

1.1 Recognition of the need for this inquiry grew out of this committee's 2015 inquiry into violence, abuse and neglect against people with disability (abuse inquiry), during which a range of evidence was presented on the indefinite detention of people with cognitive or psychiatric impairment.¹ The committee heard that people who have been charged with a criminal offence and found unfit to plead, or not guilty by reason of mental incapacity, can find themselves detained for the purpose of involuntary therapeutic treatment. This form of detention is indefinite, as it has no specified end date. Detention often occurs in prison, even though the person has not been found guilty of any offence, and too often the therapeutic intervention, the purported reason for the detention, is either not adequately provided or not provided at all.

1.2 In its report for that inquiry, the committee wrote:

The indefinite detention of people with disability is an issue of serious concern to the committee. This is made more serious by the sometimes arbitrary nature of such detention without appropriate periodic review, and where that detention occurs in a criminal justice facility.²

1.3 Concurrent to the 2015 inquiry, two cases received greater media and advocacy attention: that of Mr Marlon Noble³ in Western Australia, and Ms Rosie Ann Fulton⁴ in the Northern Territory—both Aboriginal people deemed unfit to plead due to intellectual impairment, both imprisoned indefinitely without trial.

1.4 The terms of reference (ToR) for this current inquiry take account both the evidence presented during the abuse inquiry as well as the mounting public evidence on the issue of indefinite detention. The ToR (which are provided in full at the end of this chapter) direct the committee to investigate aspects of the indefinite detention of people with a cognitive and/or psychiatric impairment, including: the prevalence, the experiences of individuals, the legal frameworks, the quality of therapeutic treatments, diversion programs to reduce the number of people entering detention and programs and pathways to assist people to transition from indefinite detention.

1.5 This inquiry deals with two discrete groups of people who are subject to indefinite detention. There are two common pathways by which a person with a cognitive or psychiatric condition may find themselves in indefinite detention:

1 Senate Community Affairs References Committee, *Inquiry into Violence, abuse and neglect against people with disability (Abuse inquiry)*, November 2015, pp 179–181.

2 Community Affairs Committee, *Abuse inquiry*, November 2015, p. 180.

3 See: Malarndirri McCarthy, 'Indigenous Australian disabled man wrongfully jailed, UN hears', *SBS TV*, 18 November 2015.

4 See: ['Urgent need for law change as mentally-impaired accused detained indefinitely, WA Chief Justice Wayne Martin says'](#), *ABC News*, 10 July 2015, (accessed 23 November 2015)

- a forensic (or criminal) order;⁵ or
- a civil route via a scheduled order under mental health, disability or guardianship frameworks (the more common pathway)⁶.

1.6 This chapter outlines the structure of the report, provides a number of definitions and a summary of how the inquiry was conducted.

Structure of the report

1.7 As the two pathways to indefinite detention are subject to different legislation and processes, the Senate Community Affairs Reference Committee (committee) has chosen to write this report in two parts to discuss the pathways separately. Accordingly, the report is structured as two parts with nine chapters.

1.8 Chapter 1 is an introductory chapter which outlines the context and administrative details of the inquiry.

Part A (Chapters 2–5): Forensic orders

- Chapter 2 provides background and context to forensic orders with a summary of the pathways, a description of the statistics and the people being detained, relevant legislation and recent reviews.
- Chapter 3 examines issues relating to sentencing and access to justice for people with cognitive impairment including law reform options and additional legal support for people with cognitive and psychiatric impairment to negotiate the legal system.
- Chapter 4 looks at the experiences of people who are indefinitely detained in prison, the treatment options available, and how to improve the transition of people out of prison.
- Chapter 5 focuses on alternatives to prison for secure treatment delivery, pathways back into the community and the role of the National Disability Insurance Scheme (NDIS).

Part B (Chapters 6–8): Involuntary mental health orders, involuntary treatments and other involuntary detentions

- Chapter 6 provides background and context to mental health treatment orders with a summary of statistics, relevant legislation and recent reviews.
- Chapter 7 considers involuntary mental health orders with a focus on the use of emergency services as transports for mentally ill patients, review

5 A forensic or criminal mental health detention order can be placed on an individual alleged to have committed a crime who is deemed 'unfit to plead' or 'unfit to stand trial'.

6 A person may be scheduled or involuntarily detained under a state or territory mental health act for their safety, the safety of others or for recovery purposes. Similar orders can also be given under state and territory disability and guardianship frameworks, and these are more generally for issues around cognitive impairment.

mechanisms for involuntary mental health orders and transition back to the community from involuntary detention.

- Chapter 8 focuses on guardianship and the use and regulation of involuntary treatments and restrictive practices in the aged care and disability sectors.

Report conclusion (Chapter 9)

- Chapter 9 draws together the committee's conclusions and recommendations from both parts of the report.

Definitions

1.9 The terms 'mental illness', 'mental disorder', 'psychiatric impairment' and 'psychiatric disability' and 'cognitive impairment' are viewed similarly by state and territory mental health legislation and all may lead to an individual being placed into indefinite detention. The Australian Institute of Health and Welfare (AIHW) has outlined some of the difficulties in fleshing these concepts out into discrete definitions⁷ and this is discussed in greater detail below.

Cognitive impairment

1.10 Cognitive impairments are permanent conditions which can be acquired such as resulting from traumatic brain injury or through substance abuse, or genetic conditions that people are born with such as downs syndrome. People with cognitive impairments such as intellectual disabilities 'are highly likely to have severe limitations in all three core activities of daily living—self-care, mobility and communication'. The AIHW noted that even for people with cognitive impairment who can:

function relatively well in the familiar routines of self-care and domestic life, and be independently mobile, people with intellectual disability often have considerable difficulty in managing emotions and relating to other people. It is therefore important to also consider the level of support that is needed in non-core activity areas, especially making friendships, maintaining relationships and interacting with others.⁸

1.11 Cognitive impairments can co-exist with psychiatric impairments. The next section will explore the conflation of cognitive and psychiatric impairments within legislation.

Conflation of psychiatric and cognitive impairment

1.12 Psychiatric and cognitive impairment are interchangeable within all state and territory mental health and forensic mental health legislation. In a paper entitled *Disability at the margins: limits of the law*, Professor Eileen Baldry notes that:

7 Australian Institute of Health and Welfare, *Disability prevalence and trends*, December 2003, pp 31–33, <http://www.aihw.gov.au/publication-detail/?id=6442467543> (accessed 14 December 2015).

8 AIHW, *Disability in Australia: intellectual disability*, Bulletin 67, November 2008, p. 2.

Generally, cognitive impairment is elided in the law with mental health impairment: that is, people with cognitive impairment usually have been dealt with under mental health legislation. This regularly results in cognitive being thought of as an illness, similar to mental illness, and therefore to be treated in the same way.⁹

1.13 The *No End in Sight* report by the Aboriginal Disability Justice Campaign points to significant problems created by the conflation of psychiatric and cognitive impairment within the forensic mental health framework. The report found that most mental health legislation is founded on the idea of treatable illness, whereby initial detention, treatment and pathways to release are based on the premise that a person has a treatable condition which rendered them unfit to plead or not guilty of the offence. This premise is incompatible with the issue of cognitive impairment, which is generally a permanent condition that is not treatable in the same way as a mental illness. As such, a person with a cognitive impairment cannot meet the basic requirements of release from an indefinite forensic mental health order, which is an improvement in their condition.¹⁰

1.14 With this in mind, the NSW Law Reform Commission offers two separate definitions for these concepts that reflect the respective temporary and on-going nature of each condition. "Mental illness" (or psychiatric impairment) as a:

temporary or continuing disturbance of thought mood, volition perception or memory that impairs emotional wellbeing, judgment or behaviour so as to affect functioning in daily life to a material extent...

It may arise from anxiety, affective, and substance induced disorders or psychoses (although not limited to these), but excludes personality disorders.¹¹

1.15 And "cognitive impairment" as an:

ongoing impairment in comprehension, reason, adaptive functioning, judgment, learning or memory that is the result of any damage to, dysfunction, developmental delay or deterioration of the brain or mind. It may arise from but is not limited to intellectual disability, borderline

9 Eileen Baldry, 'Disability at the margins: limits of the law', *Griffith Law Review*, volume 23, no. 3, pp 372–373, <http://www.tandfonline.com/doi/pdf/10.1080/10383441.2014.1000218> (accessed 14 December 2015).

10 Aboriginal Disability Justice Campaign, *No End in Sight: The imprisonment, and indefinite detention of Indigenous Australians with a Cognitive Impairment*, September 2012, pp 46–47, www.pwd.org.au/documents/pubs/adjc/NoEndinSight.pdf (accessed 11 February 2016).

11 Eileen Baldry, 'Disability at the margins: limits of the law', *Griffith Law Review*, volume 23, no. 3, p. 372. Other useful definitions for 'mental illness' can be found at: NSW Mental Health Review Tribunal, *Civil Hearing Kit: Involuntary Patient Reviews*, August 2015, p. 2, http://www.mhrt.nsw.gov.au/assets/files/mhrt/pdf/HearingKit_Section1_%20InvoluntaryDetention_Aug15.pdf (accessed 7 December 2015); ABS 4326.0, *National Survey of Mental Health and Wellbeing: Summary of Results*, October 2008, [http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/6AE6DA447F985FC2CA2574EA00122BD6/\\$File/43260_2007.pdf](http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/6AE6DA447F985FC2CA2574EA00122BD6/$File/43260_2007.pdf) (accessed 7 December 2015).

intellectual functioning, dementias, acquired brain injury, drug or alcohol related brain damage and autism spectrum disorders.¹²

1.16 The terms "mental illness", "mental disorder" and "cognitive and psychiatric impairments" are umbrella terms used to describe a range of symptoms and illnesses that impact on a person's mental processes of perception, memory, judgement and reasoning, or describe a clinical diagnosis of a disease or disorder. Although legislation relevant to this inquiry will be examined in later chapters, it is useful to highlight here that this legislation does not specify the types of 'cognitive and psychiatric impairments' that may lead to indefinite detention.

1.17 For the purposes of this inquiry:

- cognitive impairments or conditions may include (but are not limited to) acquired conditions such as acquired brain injuries (ABI) and traumatic brain injuries (TBI) and progressive and degenerative neurological diseases such as dementia and Parkinson's disease; intellectual disabilities such as Downs syndrome, specific learning or attention deficit disorder, developmental delay and severe autism; mental and behavioural disorders caused by substance abuse (including foetal alcohol spectrum disorder); and
- psychiatric impairments may include (but are not limited to) bipolar affective disorder, schizophrenia, and major depressive episodes leading to psychosis.¹³ It is also possible that some psychiatric conditions lead to, or may co-exist with cognitive impairments.

1.18 The committee also notes that for the purposes of this inquiry:

- (a) indefinite detention includes all forms of secure accommodation of a person without a specific date of release; and
- (b) this includes, but is not limited to, detention orders by a court, tribunal or under a disability or mental health act and detention orders that may be time limited but capable of extension by a court, tribunal or under a disability or mental health act prior to the end of the order.¹⁴

The inquiry

Background

1.19 In the committee's recent abuse inquiry (November 2015), the committee noted evidence about the extent to which people with cognitive and psychiatric

12 Eileen Baldry, 'Disability at the margins: limits of the law', *Griffith Law Review*, volume 23, no. 3, pp 372–373.

13 Australian Institute of Health and Welfare, *Disability prevalence and trends*, December 2003, p. 6.

14 See: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Indefinite_Detention

impairment were being indefinitely detained. Box 1.1 details the evidence and view on this issue.

Box 1.1: Extract from the Senate Community Affairs References Committee's Final Report of the *Inquiry into Violence, Abuse and Neglect against people with disability*

Indefinite detention

The issue of the indefinite detention of people with disability was raised as an issue with the committee, particularly when people with a mental health or cognitive disability intersect with the criminal justice system. The Disability Alliance outlined the process by which people with a mental health condition or cognitive impairment who have been charged with an offence and found not fit to stand trial or not guilty by reason of their disability, are then detained indefinitely, sometimes within the prison environment itself:

All Australian jurisdictions have in place legislation that addresses a defendant within the criminal justice system and their fitness to stand trial. These justice diversion provisions are applied when people with cognitive or psychosocial disability are deemed 'unfit' to stand trial. An unfitness test may arise as an issue before or during the trial process. These justice diversion provisions have resulted in people with disability being detained indefinitely in prisons or psychiatric facilities without being convicted of a crime, and for periods that may significantly exceed the maximum period of custodial sentence for the offence.

The Human Rights Commission expressed concern with the negative consequences this has for vulnerable people:

The Commission is also concerned that the practice of indefinite incarceration in prison, if not considered to be a form of violence, exposes people with disability to violence in an institutional setting. This practice is particularly experienced by Aboriginal and Torres Strait Islander people with cognitive impairment and was reported on by the Social Justice Commissioner in his 2012 Social Justice Report.

NAAJA provided evidence to the committee about the over-representation of Aboriginal and Torres Strait Islander peoples in the Northern Territory criminal justice system, pointing out that many of those people had a long history of escalation of behaviour while their underlying cognitive impairment or mental health issues went untreated. The Disability Alliance has also provided evidence that Aboriginal and Torres Strait Islander peoples are disproportionately affected by this form of arbitrary detention.

The UN Disability Committee has made comment on the practice of indefinite detention after a finding of 'unfitness' and found in relation to the Disability Convention that:

The Committee has established that declarations of unfitness to stand trial or incapacity to be found criminally responsible in criminal justice systems and the detention of persons based on those declarations, are contrary to article 14 of the Convention since it deprives the person of his or her right to due process and safeguards that are applicable to every defendant.

Committee view

The indefinite detention of people with disability is an issue of serious concern to the committee. This is made more serious by the sometimes arbitrary nature of such detention without appropriate periodic review, and where that detention occurs in a criminal justice facility.

The committee is of the view that if a person is detained in indefinite detention, then there is an obligation on the part of the state to provide therapeutic treatment in a facility not attached to the criminal justice system. To do any less would result in the state imposing criminal justice punishment on people as a direct result of them having a disability.

Source: Senate Community Affairs References Committee, [*Inquiry into Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability*](#), November 2015, pp 179–181.

1.20 In light of this evidence, the committee made the following recommendation:

Recommendation 8

The committee believes that there is a need for further investigation of access to justice issues, with a focus on...

- The indefinite detention of people with cognitive impairment or psychiatric disabilities.¹⁵

Referral

1.21 This inquiry was referred by the Senate for inquiry on 2 December 2015. The inquiry lapsed on 9 May 2016 with the dissolution of the Senate; however, was re-referred to the committee at the commencement of the 45th Parliament. Details of the inquiry are available on the committee's [website](#).¹⁶

1.22 The terms of reference for this inquiry are:

- (1) The indefinite detention of people with cognitive and psychiatric impairment in Australia, with particular reference to:
 - (a) the prevalence of imprisonment and indefinite detention of individuals with cognitive and psychiatric impairment within Australia;
 - (b) the experiences of individuals with cognitive and psychiatric impairment who are imprisoned or detained indefinitely;
 - (c) the differing needs of individuals with various types of cognitive and psychiatric impairments such as foetal alcohol syndrome, intellectual disability or acquired brain injury and mental health disorders;
 - (d) the impact of relevant Commonwealth, state and territory legislative and regulatory frameworks, including legislation enabling the detention of individuals who have been declared mentally-impaired or unfit to plead;
 - (e) compliance with Australia's human rights obligations;
 - (f) the capacity of various Commonwealth, state and territory systems, including assessment and early intervention, appropriate accommodation, treatment evaluation, training and personnel and specialist support and programs;

15 Senate Community Affairs References Committee, *Inquiry into Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability*, November 2015, p. xvii, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Violence_abuse_neglect/Report (accessed 4 December 2015).

16 See: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/IndefiniteDetention

- (g) the interface between disability services, support systems, the courts and corrections systems, in relation to the management of cognitive and psychiatric impairment;
- (h) access to justice for people with cognitive and psychiatric impairment, including the availability of assistance and advocacy support for defendants;
- (i) the role and nature, accessibility and efficacy of programs that divert people with cognitive and psychiatric impairment from the criminal justice system;
- (j) the availability of pathways out of the criminal justice system for individuals with cognitive and psychiatric impairment;
- (k) accessibility and efficacy of treatment for people who are a risk of harm to others;
- (l) the use and regulation of restrictive practices and their impact on individuals with cognitive and psychiatric impairment;
- (m) the impact of the introduction and application of the National Disability Insurance Scheme, including the ability of individuals with cognitive and psychiatric impairment to receive support under the National Disability Insurance Scheme while in detention; and
- (n) the prevalence and impact of indefinite detention of individuals with cognitive and psychiatric impairment from Aboriginal and Torres Strait Islander and culturally and linguistically diverse backgrounds, including the use of culturally appropriate responses.¹⁷

Conduct of the inquiry

1.23 The committee received 78 submissions from a diverse range of individuals and organisations. The committee acknowledges those who contributed to the inquiry through submissions or as witnesses. A list of the individuals and organisations who provided submissions to the inquiry is available at Appendix 1.

1.24 Public hearings were held throughout Australia: Brisbane on 23 March 2016; Melbourne on 29 April 2016; Perth on 19 September 2016; Darwin on 25 October 2016; Alice Springs on 26 October 2016; and Canberra on 8 November 2016. Transcripts of these hearings are available on the committee's website, and a list of witnesses who gave evidence at the public hearings is provided at Appendix 2.

1.25 The committee acknowledges the Northern Territory (NT) Government's submission and appearance at the committee's Darwin hearing; the appearance of the Western Australian (WA) Disability Services Commission at its Perth hearing; and the submission from the NSW Government. The committee also thanks the NT Department of Corrective Services and the NT Department of Health (Office of

17 See: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Indefinite_Detention

Disability) for facilitating site visits for the committee to the Complex Behaviour Unit (Darwin Correctional Precinct) and the Cottages in Darwin; and the Alice Springs Correctional Centre and the Secure Care Facility in Alice Springs. The committee also thanks the WA Disability Services Commission for facilitating a site visit to the Bennett Brook Disability Justice Centre in Perth. The committee extends its sincere gratitude to all of the residents who warmly invited the committee into their homes during these visits.

PART A—Forensic orders

Chapter 2

Forensic or criminal orders—statistics, legislation and reviews

Introduction

2.1 As noted in Chapter 1, there are two common pathways by which a person with a cognitive or psychiatric condition may find themselves in indefinite detention:

- a forensic or criminal mental health order;¹ or
- a civil route via a scheduled order under mental health, disability or guardianship frameworks (the more common pathway).²

2.2 Part A (Chapter 2–6) of this report deals with people subject to forensic orders. This chapter provides background on the forensic pathway and how people end up indefinitely detained in prison; who and how many are being indefinitely detained in prison; and a summary of the relevant legislation and reviews recently conducted on this issue.

How do people end up in indefinite detention

2.3 When a person with a cognitive or psychiatric condition is alleged to have committed a crime, there is provision in all states and territories for that person to declare themselves or be declared 'unfit to stand trial'. People who are deemed unfit to stand trial may become subject to a forensic or criminal order. The court, or mental health review tribunal, will assess that person's risk to themselves or others and the need for ongoing treatment, and will impose forensic orders to detain the person in a prison, hospital, mental health care facility or prison hospital for mental health treatment. In some cases they may be allowed to live in the community in a designated location.³

2.4 During the 1990s, most jurisdictions amended laws that allowed for the indefinite detention of people with mental impairment found unfit to plead. Three jurisdictions, South Australia (SA) the Australian Capital Territory (ACT) and the Commonwealth, require the court to set a limiting term for supervision orders, beyond

1 A forensic or criminal mental health detention order can be placed on an individual alleged to have committed a crime who is deemed 'unfit to plead' or 'unfit to stand trial'.

2 A person may be scheduled or involuntarily detained under a state or territory mental health act for their safety, the safety of others or for recovery purposes. Similar orders can also be given under state and territory disability and guardianship frameworks, and these are more generally for issues around cognitive impairment.

3 Forensic or criminal orders can be issued for those those alleged to have committed a crime and who are found unable to plead or not guilty by reason of mental incapacity ('unfit to plead'). A mental health review board or tribunal oversees forensic or criminal mental health orders in all states and territories except for South Australia.

which the defendant's detention or supervision may not extend. Other jurisdictions have mechanisms for reviewing and potentially revoking supervision orders:

- Victoria (VIC) and the Northern Territory (NT)—court sets 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;
- Queensland (QLD), Tasmania (TAS) and Western Australia (WA)—provide for periodic reviews by a mental health review board or tribunal, which may result in orders being varied or revoked;
- New South Wales (NSW)—provides that the defendant may only be released when it is considered safe to do so.⁴

2.5 Three jurisdictions (WA, Victoria and NT) still allow, at least nominally, for indefinite detention. Legislation governing the detention of people with cognitive impairment or intellectual disability found unfit to plead has been the subject of recent reviews in WA, Victoria, NSW and SA. These reviews are outlined later in this chapter.

2.6 Part A of this report will focus primarily on the jurisdictions of WA and the NT, where indefinite detention is still provided for under current legislation. Although Victoria still has provision for indefinite detention, it is unlikely to become an issue in this state for two reasons. Firstly, Victoria has forensic disability services where people subject to forensic orders can be placed to receive treatment in a secure environment. The second reason is that Victorian courts have a range of other orders that can be applied when someone is deemed 'unfit to plead'. This chapter will examine a number of each jurisdictions to provide points of comparison.

2.7 Most states provide for a Mental Health Tribunal or equivalent to review forensic orders on a regular basis. The details for each state and territory are outlined later in this chapter.

Statistics

2.8 The committee has received evidence which 'estimates that there are at least 100 people detained across Australia without conviction in prisons and psychiatric units under mental impairment legislation; and that at least 50 people from this group would be Aboriginal and Torres Strait Islanders'.⁵ The most up-to-date official statistics for involuntary detention for those held under involuntary forensic orders in prisons and the community are summarised below in Table 2.1.

4 Sentencing Advisory Council of South Australia, *Mental impairment and the law: A Report on the operation of Part 8A of the Criminal Law Consolidation Act 1935 (SA)*, November 2014, p. 133, <http://www.agd.sa.gov.au/about-agd/what-we-do/services-government/sentencing-advisory-council-south-australia> (accessed 11 January 2015).

5 Louis Andrews et al, 'New project to tackle the detention of Aboriginal and Torres Strait Islander people with disabilities', *Croakey Online*, 6 January 2016, <http://croakey.org/new-project-to-tackle-the-detention-of-aboriginal-and-torres-strait-islander-people-with-disabilities/> (accessed 8 January 2016).

Table 2.1: Numbers of forensic detention orders issued by jurisdiction and the facility type

		Involuntary forensic or criminal orders			
State	Year	Inpatient	Correctional facility	Outpatient	TOTAL
NSW	2014–15 ⁶	269 ⁷	51	128	448
ACT	2014–15	UKn	1	UKn	UKn
VIC	2014–15	105	UKn	0	105
TAS	2014–15	10	UKn	22	33
SA	2014–15	42	8	383	UKn
WA	2014–15	6	15	19	40
NT	2016	7	13	16	36
QLD	2014–15	781	UKn	0	UKn

Source: NSW Mental Health Review Tribunal, [2014/15 Annual Report](#); Tasmanian Mental Health Tribunal, [Annual Report 2014–15](#); Victorian Mental Health Tribunal, [2014/15 Annual Report](#); Queensland Director of Mental Health, [Annual Report 2014–2015](#); South Australian Chief Psychiatrist, [Annual Report 2014–15](#); Western Australian Mentally Impaired Accused Review Board (MIARB), [2014/15 Annual Report](#); Northern Territory Department of Correctional Services, [Annual Statistics 2013–14](#), p. 16; Law Council of Australia, *Submission 72*, pp 6–7; Christopher Knaus, ["Mentally ill man sent to prison because there's "nowhere else for him to go"](#), *The Canberra Times*, 8 January 2016; Barriers 2 Justice, *Submission 67*; NT Government, *Submission 75*, Appendix A.

2.9 A more in-depth breakdown of these statistics for each state and territory follows.

Northern Territory

2.10 There are 16 people on forensic (custodial supervision) orders in the NT, with 13 of those people held within the Darwin and Alice Springs Corrections Centre. Five of these people reside in the Secure Care Facility in Alice Springs (adjacent to the prison) and one person lives in the cottages (adjacent to the Darwin Correctional Precinct. Both the Cottages and the SCF are operated by the NT Department of Health (Office of Disability).⁸

6 More up-to-date statics are provided by the NSW Government which indicate that there are 412 forensic prisoners in total. However, this data does not provide a breakdown of outpatients.

7 This includes 51 involuntary orders for people receiving treatment in a hospital on the campus of a correctional facility.

8 NT Government, *Submission 75*, Appendix A.

2.11 The NT Government has recently opened (September 2015) the new Darwin Correctional Precinct (DCP) which includes a 36-bed secure Complex Behaviour Unit (CBU).⁹ Although this facility is housed in a corrections environment (different to the WA Bennett Brook Centre), and is operated by the NT Correctional Services.

2.12 All of these facilities will be discussed in more detail later in the report.

Western Australia

2.13 In WA, the Mentally Impaired Accused Review Board (MIARB) is charged with reviewing and making orders for people found 'unfit to plead'.¹⁰ As of 30 June 2015, there were 40 people who are held on 'custody orders' under the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA). The numbers of mentally impaired accused has increased since 2010–2011 (32–40 people), with numbers of those being held in prison fluctuating up and down during this period (15–18 people). The numbers of those on conditional release in the community has also increased during this period (8–22 people).¹¹ Table 2.5 provides a breakdown of the places of custody where these people are held.

Table 2.2: Place of custody as at 30 June 2015 for mentally impaired accused in Western Australia

Authorised Hospital	Prison	Juvenile Detention Centre	Declared Place	Not in Custody
6	15	0	0	19
15%	37.5%	0	0	47.5%

Source: MIARB, 2014/15 Annual Report, p. 23.

2.14 The Bennett Brook Disability Justice Centre (DJC)—WA's first 'declared place'—was opened in 2015 with beds for 10 people 'accused but not convicted of a

9 See: <http://www.nt.gov.au/infrastructure/projects/dcp/index.shtml>. This facility accommodates male and female offenders with mental health issues; people who have been found unfit to plead or are not guilty of an indictable offence due to mental impairment; offenders placed on a custodial supervision order or prisoners with severe disabilities. A range of security, treatment, life skills, rehabilitation and recreational options which are tailored to individual needs and promoting realistic expectations of successful reintegration into the community are available. The facility provides a range of low, medium and high dependency male and female accommodation, as well as 'step down' cottage accommodation.

10 WA Mentally Impaired Accused Review Board (MIARB), *Mentally Impaired Accused Review Board: About us*, http://www.miarb.wa.gov.au/A/about_us.aspx?uid=3762-9988-8324-2583 (accessed 3 November 2016).

11 MIARB, 2014/15 Annual Report, pp 27–28, http://www.miarb.wa.gov.au/files/MIARB_Annual_Report_2014_15.pdf (accessed 11 December 2015).

crime and have been deemed by a court as unfit to plead because of their disability'.¹² The DJC will be discussed in more detail later in the report.

New South Wales

2.15 The NSW Mental Health Review Tribunal (MHRT) reviews all forensic patients 'usually every six months'.¹³

2.16 As of March 2016, there were 412 forensic patients in NSW. Of these, 235 are held in a medium security facility or in the community; 106 are held in a forensic hospital; and 71 are held in a correctional facility. Eighteen of this group are on limited terms for up to 5 years. Only the Supreme Court of NSW can extend a limited term if it is 'satisfied that a person poses an unacceptable risk of serious harm to others, and that risk cannot be adequately managed by less restrictive means'.¹⁴

2.17 In NSW, there were 448 forensic or correctional patients on 30 June 2015. These numbers have steadily increased since 1996. Of these, 218 are living in a hospital or mental health care facility; 128 people in the community; 51 in a correctional facility; and 51 in a prison hospital on the campus of a correctional facility in a secure environment with other prisoners. In comparison, this is an increase from 30 June 2014 when 32 people were held as forensic or correctional patients in correctional facilities. Of the 51 people held in a correctional facility, 36 were housed at the Metropolitan Remand and Reception Centre which houses prisoners on a temporary basis (that is, up to a few months) until an alternate location is found.¹⁵

Tasmania

2.18 The Tasmanian Mental Health Tribunal (TMHT) may make, vary, renew or review an 'involuntary' treatment order under the *Mental Health Act 2013* (Tas). In the 2014–15 period, the TMHT reviewed 11 forensic restriction orders and found that in all cases that the person should not be detained in a secure mental health facility. The TMHT also reviewed 21 supervision orders and found that in 10 of these cases, supervision in the community was required. There were no reviews conducted on transfers from a prison to a secure mental health facility. It is not clear whether each of these cases were different people or individuals being reviewed multiple times.

2.19 It is also not clear whether there are any Tasmanians held on forensic orders in prisons. It should also be noted that as the TMHT must review all restriction and

12 WA Disability Services Commission, [*Bennett Brook Disability Justice Centre: Questions and Answers*](#).

13 NSW Mental Health Review Tribunal, <http://www.mhrt.nsw.gov.au/forensic-patients/forensic-procedures.html> and <http://www.mhrt.nsw.gov.au/the-tribunal/>

14 NSW Government, *Submission 66*, pp 2–3.

15 NSW Mental Health Review Tribunal, *2014/15 Annual Report*, p. 43, <http://www.mhrt.nsw.gov.au/assets/files/mhrt/pdf/MHRT%20Annual%20Report%202015.pdf> (accessed 11 December 2015).

supervision orders every 12 months, this would also indicate that there are no Tasmanians held in secure mental health facilities under forensic orders.¹⁶

Victoria

2.20 The Victorian Mental Health Tribunal (VMHT) reviews all 'involuntary' mental health patients.

2.21 In Victoria, a 'security patient is a patient who is subject to either a Court Secure Treatment Order or a Secure Treatment Order'. The VMHT is required to review these patients within 28 days of a patient entering a designated secure mental health service and thereafter every six months. A security patient cannot be held under an order longer than the term of their imprisonment would have been had the order not been made. If the VMHT determines that a patient should not be a security patient, 'they are returned to prison custody for the duration of their term'.¹⁷

2.22 In 2014–15, the VMHT 'made 105 determinations in relation to security patients'. In 101 of these cases, the VMHT determined that person should remain a security patient.¹⁸

Queensland

2.23 The QLD Mental Health Tribunal (QMHT) reviews Forensic Orders within 6 months of the orders being made by the Mental Health Court.¹⁹ In 2014–15, the QMHT confirmed most Forensic Orders with the majority being confirmed with limited community treatment (1396) and confirmed (40). A small minority of cases were revoked (77). A flowchart describing 'entry into the Forensic Mental health system' for QLD can be found below in Figure 2.1.²⁰

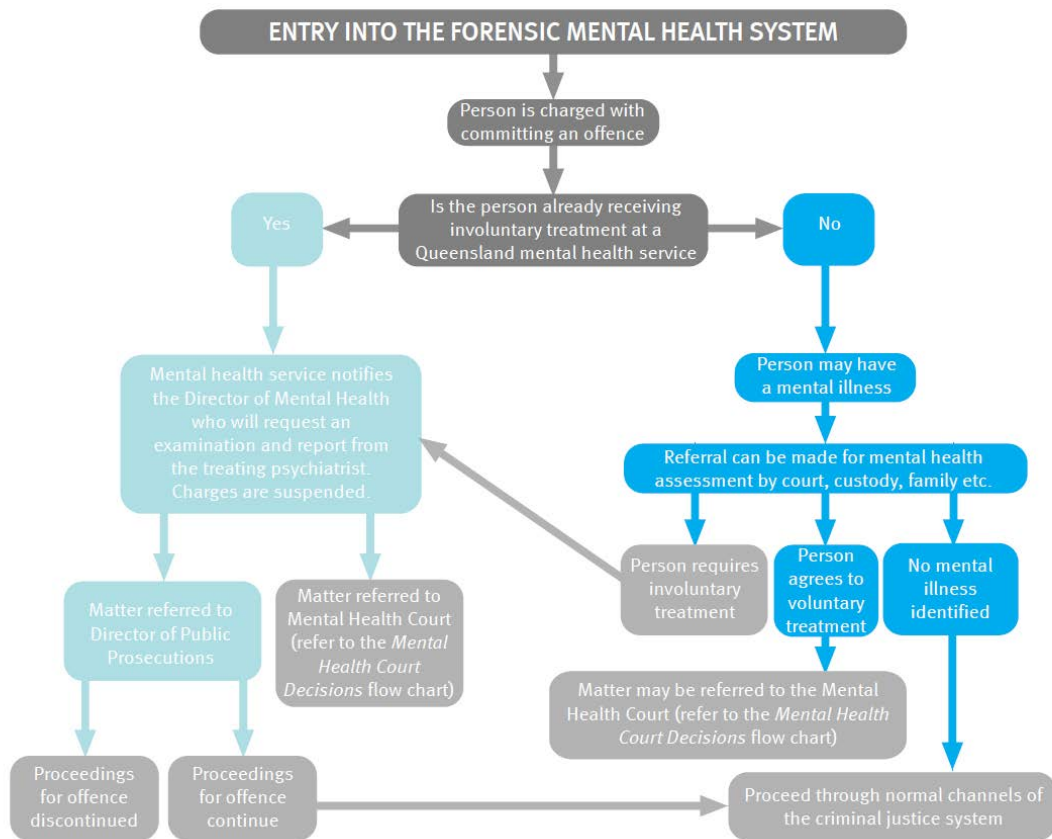
16 Tasmanian Mental Health Tribunal, *Annual Report 2014–15*, pp 10–11 and 16–17.

17 Victorian Mental Health Tribunal, *2014/15 Annual Report*, p. 9.

18 Victorian Mental Health Tribunal, *2014/15 Annual Report*, p. 23.

19 The Mental Health Court's 'role is to decide whether or not the person facing court was of unsound mind at the time of the alleged offence, and also whether or not the person is fit to plead'. This is a unique institution with a unique role that is only seen in Queensland.

20 Queensland Mental Health Tribunal, *Annual Report 2014–15*, pp 10, 19–20. Queensland is the only state to have a dedicated Mental Health Court. See also: <https://www.health.qld.gov.au/forensicmentalhealth/media/default.asp>

Figure 2.1: Entry into the Queensland Forensic Mental Health System

Source: Queensland Department of Health, '[Entry into the Forensic Mental Health System](#)'.

2.24 There were 781 patients with Forensic Orders (increased from 741) in QLD in 2014–15 with 132 new Forensic Orders being made. A special sub-category of Forensic Orders called the special notification forensic patient (SNFP) was created in 2008 to capture patients charged with serious crimes such as 'unlawful homicide, attempted murder, dangerous operation of a motor vehicle involving the death of another person, rape or assault with the intent to commit rape'. There were 139 SNFP in 2014–15.²¹ In addition to forensic patients, there were an additional 43 classified patients who were transferred involuntarily from court, remand centre or correctional facility for treatment in a secure mental health facility. It is not clear whether any of the Forensic Order patients in QLD are currently being detained in prison.

2.25 The committee received evidence in Brisbane from Mr Joseph Briggs QC which highlighted the practice of defendants of unsound mind being encouraged to plead guilty as a means to avoid indefinite detention. In one example, a defendant was sentenced to over 15 years, despite being a likely forensic patient.²² This practice will be discussed further in Chapter 3.

21 Queensland Director of Mental Health, *Annual Report 2014–2015*, pp 27–28.

22 Mr Joseph Briggs, Barrister, Designated Counsel to the Queensland Mental Health Court, Legal Aid Queensland, *Committee Hansard*, Brisbane, 23 March 2016, p. 3.

South Australia

2.26 The South Australian Civil and Administrative Tribunal (SACAT) has the power to review and make certain orders relating to the involuntary treatment and detention of people with mental illness.²³

2.27 According to SACAT, of those on forensic or criminal mental health orders, 383 were receiving care in the community whilst 42 were detained and receiving treatment as an inpatient.²⁴ Eight people on forensic orders were being held in prison as of July 2015.²⁵

Australian Capital Territory

2.28 Although there are no formal statistics, there is anecdotal evidence of at least one person being held in an ACT prison on a court order.²⁶

A comment on official statistics

2.29 The committee notes that official statistics on the issue of indefinite detention are largely piecemeal and inconsistent between the states. It is often difficult to drill down into data sets due to insufficient detail. In some cases, no statistics are publicly available at all. As there is no one-stop shop for statistics in this area this chapter has used statistics from two sources—the Australian Institute of Health and Welfare (AIHW) and each of the states' and territories' mental health review board or tribunal. The numbers are not exactly the same—close but not exact—as they sometimes cover different periods of time and sometimes include or exclude certain types of data. State and territory corrections departments do not maintain a public register of the numbers of people being held on a forensic or criminal mental health order.

2.30 The Law Council of Australia (Law Council) reiterated the NT Ombudsman's comments from 2008 where it was noted that 'at present there is no quantitative or qualitative data which would reliably indicate the level of mental health and disability needs among NT prisoners'.²⁷

2.31 At a recent meeting, the Council of Australian Governments (COAG) Law, Crime and Community Safety Council (LCCSC) acknowledged the lack of consistent statistics in this area and agreed to:

establish a working group to collate existing data across jurisdictions and develop resources for national use on the treatment of people with cognitive

23 SACAT, *Mental health*, <http://www.sacat.sa.gov.au/types-of-cases/mental-health> (accessed 16 January 2016).

24 South Australian Chief Psychiatrist, *Annual Report 2014-15*, pp 16, 19.

25 Barriers 2 Justice, *Submission 67*, p. 2.

26 Christopher Knaus, 'Mentally ill man sent to prison because there's "nowhere else for him to go"', *The Canberra Times*, 8 January 2016, <http://www.canberratimes.com.au/act-news/mentally-ill-man-sent-to-prison-because-theres-nowhere-else-for-him-to-go-20160108-gm1rvs.html> (accessed 11 January 2016).

27 Law Council of Australia (Law Council), *Submission 72*, p. 6.

disability or mental impairment unfit to plead or found not guilty by reason of mental impairment.²⁸

2.32 In correspondence to the committee, the Attorney-General's Department (AGD) noted that 'existing gaps, or unavailability of data have made it challenging to assess the current situation in Australia regarding the experience of people with cognitive disability or mental health impairment in the criminal justice system to date'. The AGD also noted that the working group has drafted a 'National Statement of Principles Relating to Persons Unfit to Plead or Found Not Guilty by Reason of Cognitive or Mental Health Impairment' (National Principles). A draft of the National Principles has been provided to the LCCSC in October 2016. The LCCSC will further consider the data collection project and whether to endorse the National Principles at its first meeting in 2017.²⁹

2.33 The committee notes this preliminary move by COAG as the first steps to better understanding and reducing the prevalence of indefinite detention of people with a cognitive or psychiatric impairment in Australia.

Who are the people indefinitely detained?

2.34 The majority of people who are indefinitely detained on forensic orders predominantly share the following characteristics:

- they are predominantly Aboriginal and Torres Strait Islander persons;
- they have been prescribed the forensic order in WA and NT; and
- they have a cognitive impairment or cultural communication barrier or hearing loss.

2.35 Aboriginal and Torres Strait Islander peoples are currently held indefinitely in prison on forensic orders (and in prison more generally) at a disproportionately higher rate than their non-indigenous counterparts. In WA, Aboriginal and Torres Strait Islander peoples comprise 34 per cent of people subject to forensic orders, despite making up less than 4 per cent of the total population.³⁰

2.36 Further evidence suggests that as many as 50 per cent of the people currently detained indefinitely without charge in prison are Aboriginal and Torres Strait Islander peoples.³¹ As noted earlier in this chapter, currently there is a lack of data on

28 COAG Law, Crime and Community Safety Council, '[Draft Communique](#)', 5 November 2015, p. [3].

29 Additional Information, Civil Law Unit, Attorney-General's Department, received 8 November 2016.

30 Western Australian Mentally Impaired Accused Review Board (MIARB), [2014/15 Annual Report](#), p. 20. See: ABS 3238.0.55.001, [Estimates of Aboriginal and Torres Strait Islander Australians](#).

31 Louis Andrews et al, 'New project to tackle the detention of Aboriginal and Torres Strait Islander people with disabilities', *Croakey Online*, 6 January 2016, <http://croakey.org/new-project-to-tackle-the-detention-of-aboriginal-and-torres-strait-islander-people-with-disabilities/> (accessed 8 January 2016).

the prevalence of indefinite detention in Australia. In its submission to the committee, the Law Council highlighted that Aboriginal and Torres Strait Islander peoples with mental and cognitive disabilities are forced into the criminal justice system early in life in the absence of alternative pathways'.³²

2.37 Later chapters will examine in more detail the challenges that Aboriginal and Torres Strait Islander peoples face.

Cognitive impairments

2.38 As noted in Chapter 1, cognitive impairment is a broad descriptor for a wide range of conditions that can result in profound limitations in undertaking core daily living activities such as self-care, mobility and communication. Cognitive impairments are permanent conditions which can be acquired as a result of traumatic brain injury or through substance abuse (Foetal Alcohol Spectrum Disorders (FASD)), or can be genetic conditions that people are born with such as downs syndrome. As also noted in Chapter 1, cognitive impairments do not improve as such; however, behaviour can be improved through the use of behavioural management plans and supports.

2.39 The Law Council identifies FASD as a cognitive disorder that is more prevalent in Aboriginal and Torres Strait Islander communities, especially in the Northern Territory and Western Australia. Aboriginal and Torres Strait Islander peoples disproportionately experience two types of cognitive impairment: FASD; and hearing loss and communication barriers.³³

Foetal Alcohol Spectrum Disorders

2.40 FASD is 'an umbrella term used to describe a range of physical and cognitive, behavioural and neurodevelopmental abnormalities that result from exposure to alcohol in utero'.³⁴ In its submission, the Australian Medical Association (AMA) notes that:

The symptoms and behaviours relating to FASD increase the likelihood that impacted individuals will come into contact with the criminal justice system (particularly those that are undiagnosed). This includes, but is not limited to: low impulse control, inappropriate reactions to loud and or frightening noises, inappropriate sexual behaviour and being easily convinced to engage in criminal activities.³⁵

2.41 People with FASD 'are more vulnerable to suggestion than other young people, will struggle to learn from the consequences of their actions, and are more

32 Law Council, *Submission 72*, p. 14.

33 Law Council, *Submission 72*, p. 14.

34 Australian Medical Association, *Submission 12*, p. 5.

35 AMA, *Submission 12*, p. 5.

inclined to confess to things they haven't done without awareness of the consequences'.³⁶

2.42 FASD is not easily identifiable and, in many cases, remains undiagnosed. The Telethon Kids Institute notes in its submission that an Australian FASD diagnostic instrument—which they developed, under contract to the Department of Health—did not exist until mid-2016. As a consequence, FASD has been misunderstood and under-diagnosed in Australia.³⁷

2.43 People with FASD are often unaware that they have broken the law or not complied with a court order such as paying fines resulting in ongoing interactions with the criminal justice system.³⁸ Non-compliance with administrative requirements of the court such as the non-payment of a fine as a result of poor cognitive functioning can lead to imprisonment.

2.44 High rates of FASD and poor cognitive functioning flow into the high prevalence of people with FASD in court, with the Chief Justice of WA acknowledging that FASD:

is an increasing problem in our courts. It is one of those conditions that are almost certainly chronically underdiagnosed ... It is a condition that is inherently likely to put them in conflict with the justice system.³⁹

2.45 There are a range of concerning statistics relating to those with FASD including that:

- juveniles with FASD are 19 times more likely to be incarcerated;
- prisoners with FASD are far more likely to be recidivist;
- 60 per cent of the people with FASD over the age of 12 have criminal histories; and
- prisoners with FASD are prone to exploitation, higher rates of victimisation, are highly vulnerable to sexual abuse by other prisoners and tend to repeat those behaviours in the community following their release from prison.⁴⁰

2.46 People with FASD engaging with the criminal justice system are likely to travel down one of two pathways:

- They remain undiagnosed and are assumed by the court to have normal cognitive functioning. They participate in court proceedings on that basis with no additional support. If convicted, they are incarcerated.

36 Amnesty International Australia, *Submission 38*, p. 3.

37 Telethon Kids Institute, *Submission 45*, p. 3.

38 AMA, *Submission 12*, p. 5.

39 Amnesty International Australia, *Submission 38*, p. 2. In the mainly Aboriginal and Torres Strait Islander community of Fitzroy Crossing in northern WA, 12 per cent of children have been diagnosed with FASD.

40 Disability Rights Advocacy Service, *Submission 37*, p. 2.

- They are diagnosed with FASD, are found to be unfit to be tried and are indefinitely detained.⁴¹

2.47 In both cases, an individual with a serious cognitive impairment is imprisoned, usually not appropriately supported and likely to interact significantly with the criminal justice system for the rest of their life.

2.48 Mr Peter Collins, of the Aboriginal Legal Service of WA agreed noting that nearly all Aboriginal and Torres Strait Islander peoples alleged offenders have undiagnosed cognitive and/or psychiatric impairments.

In my estimation, 95 per cent of Aboriginal people charged with criminal offences appearing before the courts have either an intellectual disability, a cognitive impairment or a mental illness. The overwhelming majority of those are undiagnosed and, therefore, untreated. If they go to jail it is almost impossible to conceive of them being diagnosed in jail; therefore, they are untreated. If you receive a community-type sanction, if you are from a regional or remote area, you will go to a place where you do not receive any meaningful interventions to deal with your problem.⁴²

Hearing loss and communication barriers

2.49 Nearly 12 per cent of Aboriginal and Torres Strait Islander people have a disease of the ear with at least 7 per cent reporting some form of hearing loss. This equates to nearly double the rate of the non-indigenous population.⁴³

2.50 People with hearing loss face many challenges when communicating with the dominant verbal form of English, especially if a person is not competent in signing. As Ms Jodi Barney, a certified Aboriginal Disability Cultural Safety Trainer, noted in her evidence, access to signing training and cultural differences may play a large factor in a person's capacity to communicate.

It takes a long time to sit with a client to find out how they communicate. For example, they may be on Larrakia country but they might come from Kalkarindji or Maningrida. So I need to find exactly what signing systems they are using, where they are in their development and then work with the hearing members of that community to ensure that they follow a process. Often when we see Aboriginal men and women who are incarcerated with a high prevalence of hearing loss or deafness they are deemed unfit to plea because they have no communication strategy or no communication at all.⁴⁴

41 Professor Harry Blagg et al., *Submission 8*, p. [13]. In Western Australia, diagnosis with FASD triggers indefinite detention in a prison or a declared place under the CLMIA Act 1996. Such a person cannot be taken to a secure mental health unit unless they have a treatable mental illness.

42 Mr Peter Collins, Director, Legal Services, Aboriginal Legal Service of WA, *Committee Hansard*, Perth, 19 September 2016, p. 16.

43 ABS [4727.0.55.001—Australian Aboriginal and Torres Strait Islander Health Survey: 2012–13](#), November 2013.

44 Ms Jodi Barney, Deaf Indigenous Community Consultancy, *Committee Hansard*, Melbourne, 29 April 2016, p. 49.

2.51 Hearing loss, in itself, can present many challenges for a person when communicating with others. These challenges are significantly larger when hearing loss is combined with an intellectual disability and/or cultural differences.⁴⁵

2.52 The North Australian Aboriginal Justice Agency (NAAJA) has noted its concern 'about the lack of culturally appropriate responses by service providers working with Aboriginal people with cognitive and psychiatric impairment', highlighting the lack of 'NT Indigenous-specific cognitive tests; or culturally relevant materials for psycho-education'.⁴⁶ Culturally appropriate responses will be discussed further in Chapter 5.

General prison population—observations on cognitive and psychiatric impairment and the use of mandatory sentencing

2.53 This report will focus primarily on people with cognitive and psychiatric impairment who are held indefinitely in prison, however, the committee will highlight two observations about the general prison population—the rates of cognitive and psychiatric impairment in the general prison population and the use of mandatory sentencing.

Cognitive and psychiatric impairment in the general prison population

2.54 The overwhelming majority of prisoners with cognitive and psychiatric impairments are detained as the result of being found guilty of an offence with a custodial sentence imposed. This section will identify trends that will provide a broader context to this inquiry.

2.55 There are high rates of cognitive and psychiatric impairment in the general prison population. In its submission to the committee, the NSW Mental Health Commission noted that 'three quarters of NSW prisoners have been told they have a mental illness at some point in their lives'.⁴⁷ The Australian Lawyers Alliance made the following observation:

Estimates of the proportion of individuals in prisons with cognitive impairment or intellectual disabilities ranging from 8 to 20 per cent in New South Wales, to a national figure of 12 per cent of prisoners having an intellectual disability (IQ less than 70) and a further 30 per cent having a borderline intellectual disability (IQ 70–80).⁴⁸

2.56 In addition to the previous statistics, the Australian Institute of Health and Welfare indicated that 38–50 per cent of prisoners may have an acquired brain injury compared to 9–17 per cent in the general population.⁴⁹

45 See: Chatter Matters Tasmania, *Submission 54*, p. [4].

46 The North Australian Aboriginal Justice Agency (NAAJA), *Submission 60*, p. 10.

47 NSW Mental Health Commission, *Submission 21*, p. 4.

48 Australian Lawyers Alliance, *Submission 33*, p. [5].

49 Australian Lawyers Alliance, *Submission 33*, pp [5–6].

2.57 Mr Peter Collins of the Aboriginal Legal Service of Western Australia estimated that '95 per cent of Aboriginal people charged with criminal offences appearing before the courts have either an intellectual disability, a cognitive impairment or a mental illness'.⁵⁰ There is a disproportionate representation of Aboriginal and Torres Strait Islander peoples in the general prison population. Aboriginal and Torres Strait Islander peoples make up 27 per cent of prisoners yet comprise only 2 per cent of the total Australian population. In addition, there has been a '95% increase in the rate of Aboriginal and Torres Strait Islander peoples imprisonment rates between 2004–2015, while the non-indigenous rate rose by 27% over the same period'.⁵¹ Compounding these numbers is that Aboriginal and Torres Strait Islander peoples are 1.7 times more likely to live with a disability than the general Australian population. FASD is discussed earlier in this chapter and has a special significance to Aboriginal and Torres Strait Islander peoples.⁵²

2.58 One of the concerns raised in evidence to the committee is the lack of access to mental health and other therapeutic services and supports for people with a cognitive or psychiatric impairment in prison.⁵³ Queensland Advocacy Incorporated noted the determinants that drive these trends:

People with intellectual and psychiatric impairments are in watch houses, courts, remand centres, jails and forensic facilities because they are disadvantaged in myriad ways...vulnerability, disempowerment and marginalisation—which translate into unemployment, homelessness, poverty and social isolation—are strongly linked to crime for people with an intellectual, cognitive and psychiatric impairment.⁵⁴

Mandatory sentencing

2.59 One of the impediments to the diversion of mentally and cognitively impaired people from the justice system is the requirement for courts to impose mandatory sentencing for certain offences under certain circumstances. In most Australian jurisdictions, mandatory sentencing requirements exist for people convicted of certain serious and/or violent crimes. For example, in WA, a person must receive a mandatory sentence for 'repeat adult and juvenile offences convicted of residential burglary, grievous bodily harm or serious harm to a police officer'. In the NT, a similar requirement exists for 'murder, rape and offences involving violence'.⁵⁵

50 Mr Peter Collins, Director, Legal Services, Aboriginal Legal Service of Western Australia, *Committee Hansard*, Perth, 19 September 2016, p.16.

51 National Aboriginal and Torres Strait Islander Legal Services, *Submission 34*, p. 8. See also: NSW Mental Health Commission, *Submission 21*, pp 4–5; Australian Lawyers Alliance, *Submission 33*, p. [6].

52 National Aboriginal and Torres Strait Islander Legal Services, *Submission 34*, pp 6–7.

53 NSW Mental Health Commission, *Submission 21*, p. 4.

54 Queensland Advocacy Incorporated, *Submission 7*, p.6.

55 Law Council, *The mandatory sentencing debate*, <http://www.lawcouncil.asn.au/lawcouncil/index.php/law-council-media/news/352-mandatory-sentencing-debate> (accessed 2 June 2016).

2.60 This inquiry is not going to examine the broader deficiencies inherent in mandatory sentencing provisions for violent and serious crime; however, the committee is concerned about the mandatory sentencing framework in Western Australia which imposes custodial sentences for adult and juvenile offenders convicted of non-violent offences including residential burglary. There have been a number of prominent instances in recent years where the sentence imposed has not been proportionate to the crime committed, which included:

- a 16 year old with one prior conviction received a 28 day prison sentence for stealing 1 bottle of spring water;
- a 17 year old first time offender received a 14 day prison sentence for stealing orange juice and "Minties";
- a 15 year old Aboriginal boy received a 20 day mandatory sentence for stealing pencils and stationery worth less than \$100. He died while in custody; and
- an Aboriginal woman and first time offender who received a 14 day prison sentence for stealing a can of beer.⁵⁶

2.61 Mr Shane Duffy, Chief Executive Officer of the Aboriginal and Torres Strait Islander Legal Service (ATSILS) told the committee that mandatory sentencing deprives the courts of discretion and the 'ability to take into account a person's disability when determining an appropriate sentence'.⁵⁷ The Western Australian Association for Mental Health noted that mandatory imprisonment of people with mental health issues deprives them of access to the more appropriate option of 'contemporary mental health treatment and support'.⁵⁸ Further:

As a period of imprisonment imposed under minimum mandatory sentencing laws will usually be relatively short, prisoners are unlikely to receive the supports or the accommodations they need in prison and will be separated from the supports and accommodations that they might receive in the community.⁵⁹

2.62 The other significant impact that mandatory sentencing has on a person is that it provides a gateway to a life spent in and out of prison. Once a person has entered prison, it is highly likely that they will continue to spend periods of time in prison for the rest of their life.⁶⁰ Research collated by the Australian Institute of Criminology found that 'a strong relationship existed between "sterner punishments and higher levels of re-offending"' and that 'even a relatively short term in custody on remand was found to significantly increase subsequent offending (64.3 per cent) compared to

56 Law Council, *The mandatory sentencing debate*.

57 Mr Shane Duffy, CEO, ATSILS, *Committee Hansard*, Brisbane, 23 March 2016, p. 42.

58 Western Australian Association for Mental Health, *Submission 27*, p. 13.

59 Mr Shane Duffy, CEO, ATSILS, *Committee Hansard*, Brisbane, 23 March 2016, p. 42.

60 Australian Bureau of Statistics, ABS 4517.0, *Prisoners in Australia 2014*. Nearly 60 per cent of prisoners are repeat offenders.

being placed on remand at home at home (36.6 per cent)'. Life in prison plays a significant role in criminal socialisation and normalisation that leads to higher rates of re-offending and incarceration.⁶¹

2.63 A review of the Western Australian *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) was recently conducted. In its response to this review, the WA Government acknowledged the concern raised by most submitters that mandatory sentencing (custody) orders may be viewed as potentially unfair to an accused. However, the government was reluctant to make any changes to these requirements due to the 'paramount consideration of community safety'.⁶²

2.64 Members of the roundtable held during the Melbourne public hearing for this inquiry agreed that the repeal of mandatory sentencing should be a priority for the Western Australian government.⁶³ In its 2015–16 Annual Report, the Mental Health Advocacy Service has highlighted mandatory sentencing as an ongoing systemic problem, recommending that:

An amendment to the mandatory sentencing laws to exclude people who were mentally unwell at the time of their alleged offence is needed. This law remains unchanged.⁶⁴

Relevant legislation and reviews

2.65 The next section will outline the regulatory and legal framework relevant to this inquiry, including the Commonwealth's international obligations under the United Nations *Convention on the Rights of Persons with Disabilities* (Disability Convention). As a signatory to the Disability Convention, the Commonwealth is responsible to ensure that the treatment of people with disability in Australia is compatible with the provisions of the Convention. This section will also highlight a number of recent reviews and rulings that have been conducted or made at a national and state/territory level; and the legislative changes that have resulted or have been recommended to result from these reviews.

61 Mark Lynch, Julieanne Buckman, Leigh Krenske, *Youth Justice: Criminal Trajectories*, Australian Institute of Criminology, September 2003, No. 265, p. 2, http://www.aic.gov.au/media_library/publications/tandi_pdf/tandi265.pdf (accessed 2 June 2016).

62 Western Australian Department of the Attorney General, *Review of the Criminal Law (Mentally Impaired Accused) Act 1996: Final Report*, April 2016, pp 11–12.

63 Dr Glenn Jessop (Policy Manager, Jesuit Social Services) & Dr John Chesterman (Director of Strategy, Victorian Office of the Public Advocate), *Committee Hansard*, Melbourne, 29 April 2016, pp 3 & 6. Also, see: Ms Carly Warner, EO, NATSILS, *Committee Hansard*, Melbourne, 29 April 2016, p. 12.

64 WA Mental Health Advisory Service, *2015–16 Annual Report*, p. 75.

International obligations

United Nations—International Covenant on Civil and Political Rights and Convention on the Rights of Persons with Disabilities

2.66 The right to liberty and security is a fundamental human right. Under Article 9 of the United Nations (UN) *International Covenant on Civil and Political Rights*:

Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.⁶⁵

2.67 Furthermore, under Article 15, 'no one shall be held guilty of any criminal offence on account of any act or omission which did not constitute a criminal offence'.⁶⁶

2.68 Under Article 14 of the UN Disability Convention, Australia is obliged to ensure that people with disabilities, on an equal basis with others:

- (a) Enjoy the right to liberty and security of person;
- (b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.⁶⁷

Commonwealth responsibility for disability standards

2.69 As a signatory to the Disability Convention, the Commonwealth has a responsibility to ensure that it uphold the rights of people with disability according to the Disability Convention. The Aboriginal Disability Justice Campaign (ADJC) noted that it has been working with a number of people with disability subject to indefinite detention to lodge complaints with the UN Disability Committee.

[W]e have been lodging complaints with the Australian Human Rights Commission and with the United Nations regarding breaches of various conventions that are occurring. The Commonwealth is the respondent to those actions because it is the signatory to the conventions. We hope that might provide some incentive to the Commonwealth to start thinking more in national terms and frameworks, and perhaps in supportive legislation and so forth.⁶⁸

2.70 The committee is aware of a number of pending cases before the UN Disability Committee that relate to people with disability subject to indefinite

65 *International Covenant on Civil and Political Rights*, Article 9, <http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx> (accessed 15 December 2015).

66 *International Covenant on Civil and Political Rights*, Article 15.

67 *United Nations Convention on the Rights of Persons with Disabilities*, Article 16, <http://www.un.org/disabilities/convention/conventionfull.shtml> (accessed 21 August 2015).

68 Mr Ian McKinlay, Spokesperson, Aboriginal Disability Justice Campaign, *Committee Hansard*, Melbourne, 29 April 2016, p. 14.

detention.⁶⁹ A recent ruling by the Disability Committee on Mr Marlon Noble is described later in this chapter.

2.71 In its submission, the ADJC noted that the NT's 'legislative or executive power can be affected by inconsistent Commonwealth regulation'. ADJC goes further noting:

It is very readily apparent that the [NT] needs support and assistance to address the human rights issues identified in this [submission]. If the [NT] cannot adequately address the human rights issues identified in this [submission] and the communications incorporated in it, then the Commonwealth should intervene directly to ensure that the human rights issues are addressed consistent with domestic and international law.⁷⁰

Report on Australia—United Nations Committee on the Rights of Persons with Disability

2.72 In its concluding observations on Australia's first report on the Disability Convention (October 2013), the UN Committee on the Rights of Persons with Disabilities (UN Disability Committee) expressed particular concern that:

...persons with disabilities, who are deemed unfit to stand trial due to an intellectual or psychosocial disability can be detained indefinitely in prisons or psychiatric facilities without being convicted of a crime, and for periods that can significantly exceed the maximum period of custodial sentence for the offence. It is equally concerned that persons with disabilities are over-represented in both the prison and juvenile justice systems, in particular women, children and Aboriginal and Torres Strait Islander peoples with disability.⁷¹

2.73 The UN Disability Committee recommended that Australia, 'as a matter of urgency':

- (c) Ends the unwarranted use of prisons for the management of un-convicted persons with disabilities, with a focus on Aboriginal and Torres Strait Islander persons with disabilities, by establishing legislative, administrative and support frameworks that comply with the Convention;
- (d) Establishes mandatory guidelines and practice to ensure that persons with disabilities in the criminal justice system are provided with appropriate supports and accommodation;
- (e) Reviews its laws that allow for the deprivation of liberty on the basis of disability, including psychosocial or intellectual disabilities, and repeal

69 See: <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/Tablependingcases.aspx>

70 Aboriginal Disability Justice Campaign, *Submission 76*, pp 4–5.

71 United Nations Committee on the Rights of Persons with Disabilities (UN Disability Committee), *Concluding observations on the initial report of Australia, adopted by the Committee at its tenth session (2–13 September 2013)*, 4 October 2013, p. 5. See: Attorney-General's Department, Convention on the rights of persons with disabilities, <http://www.ag.gov.au/RightsAndProtections/HumanRights/Pages/UnitedNationsConventionontherightsofpersonswithdisabilities.aspx> (accessed 24 September 2016).

provisions that authorize involuntary internment linked to an apparent or diagnosed disability.⁷²

2.74 The UN Disability Committee expressed further concern that 'a person can be subjected to medical interventions against his or her will, if the person is deemed to be incapable of making or communicating a decision about treatment' and recommended that Australia:

...repeal all legislation that authorises medical interventions without free and informed consent of the persons with disabilities concerned, and legal provisions that authorize commitment of individuals to detention in mental health services, or the imposition of compulsory treatment either in institutions or in the community via Community Treatment Orders (CTOs).⁷³

2.75 The 2012 *Civil Society Report to the United Nations Committee on the Rights of Persons with Disabilities* (Civil Society Report), prepared by Australian disability support organisations, argued that the detention in prison of people with disability found not guilty or unfit to plead, especially those with cognitive impairment, is due to 'the lack of alternative and appropriate accommodation and support options' and is most prevalent in QLD, WA and the NT among Aboriginal and Torres Strait Islander communities.⁷⁴ The Civil Society Report recommended:

That Australia ensures that legislative, administrative and policy frameworks that deprive people with disability of their liberty and impact on their security are fully consistent with the CRPD.

That Australia, as a matter of urgency, ends the unwarranted use of prisons for the management of unconvicted people with disability, with a focus on Aboriginal and Torres Strait Islander people with disability, by establishing legislative, administrative and support frameworks that comply with the CRPD.

That Australia establishes mandatory guidelines and practice to ensure that people with disability who are deprived of their liberty in the criminal justice system are provided with appropriate supports and accommodation.

That Australia amends legislation in relation to crime to include the specific (statutory) offence of deprivation of liberty.⁷⁵

72 UN Disability Committee, *Concluding observations*, p. 5.

73 UN Disability Committee, *Concluding observations*, p. 5.

74 Disability Representative, Advocacy, Legal and Human Rights Organisations (DRALHRO), *Disability Rights Now: Civil Society Report to the United Nations Committee on the Rights of Persons with Disabilities*, August 2012, pp 85–86, <http://www.pwd.org.au/issues/crpd-civil-society-shadow-report-group.html> (accessed 24 September 2015).

75 DRALHRO, *Disability Rights Now*, p. 89.

Ruling on Mr Marlon Noble's case—United Nations Committee on the Rights of Persons with Disabilities

2.76 In January 2012, Mr Marlon Noble, an Aboriginal man from Western Australia was released from prison with strict bail conditions—including regular drug testing and overnight home detention—after nearly a decade behind bars. During and since that time, Mr Noble has not had the opportunity to legally challenge the allegations against him. Mr Noble submitted his case to the UN Disability Committee for its consideration. In September 2016, the committee made a ruling on this case, and noted that:

throughout Mr. Noble's detention, "the whole judicial procedure focused on his mental capacity to stand trial without giving him any possibility to plead not guilty and test the evidence submitted against him."

"He therefore never had the opportunity to have the criminal charges against him determined and his status as an alleged sexual offender cleared," the Committee members found, highlighting that the charges were never proven. In addition, the authorities did not provide adequate support to enable him to stand trial and plead not guilty.⁷⁶

2.77 The UN Disability Committee has called on all Australian governments to work together to 'provide Mr Noble with an effective remedy and immediately revoke the 10 conditions of his release'. The committee also noted that 'Australia is obliged to take measures to prevent similar violations' through amending state and territory legislation, in particular, the Western Australian *Criminal Law (Mentally Impaired Accused) Act 1996* (WA).

2.78 Correspondence to the committee from the Attorney-General's Department notes that the department is working closely with the WA Government in preparing a response; however, the department did not indicate how it would respond.⁷⁷

Reviews of forensic and criminal mental health legislation

2.79 During the 1990s, most jurisdictions amended laws that allowed for the indefinite detention of people with mental impairment found unfit to plead. Three jurisdictions (SA, ACT and Cth) require the court to set a limiting term for supervision orders, beyond which the defendant's detention or supervision may not extend. Other jurisdictions have mechanisms for reviewing and potentially revoking supervision orders:

- Victoria and NT—court sets 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;

76 United Nations Office of the High Commissioner, *Australia urged to amend laws that lead to people with mental disabilities being detained indefinitely*, 23 September 2016, <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20566&LangID=E> (accessed 13 October 2016).

77 Correspondence from Mr Andrew Walter, Assistant Secretary, Civil Law Unit, Attorney-General's Department, 8 November 2016.

- QLD, Tasmania and WA—provides for periodic reviews by a mental health review board or tribunal, which may result in orders being varied or revoked;
- NSW—provides that the defendant may only be released when it is considered safe to do so.⁷⁸

2.80 Three jurisdictions (WA, Victoria and NT) still allow, at least nominally, for indefinite detention. Legislation governing the detention of people with cognitive impairment or intellectual disability found unfit to plead has been the subject of recent reviews in WA, Victoria, NSW and SA. These reviews are outlined below.

2.81 A mental health review board or tribunal oversees forensic or criminal mental health orders in all states and territories except for SA. The review of these orders is conducted by the relevant law court.

National

2.82 In 2014, three major reviews were undertaken at a national level to examine the issue of involuntary forensic detention of people with psychiatric and cognitive impairments. These are:

- *Equality, Capacity and Disability in Commonwealth Laws* (Australian Law Reform Commission).
- *Equal Before the Law: Towards Disability Justice Strategies* (Australian Human Rights Commission).
- *Report into arbitrary detention, inhumane conditions of detention and the right of people with disabilities to live in the community with choices equal to others* (Australian Human Rights Commission).

2.83 This section will also briefly discuss the *National Seclusion and Restraint Project*.

Review—Equality, Capacity and Disability in Commonwealth Laws (Australian Law Reform Commission)

2.84 The Australian Law Reform Commission's (ALRC) 2014 report on equal recognition and legal capacity for people with disability under Commonwealth legal frameworks, *Equality, Capacity and Disability in Commonwealth Laws*, noted a wide range of concerns about the processes and outcomes of unfitness determinations. The ALRC recommended that state and territory laws governing determinations that a person is ineligible to stand trial should provide for 'limits on the period of detention

78 Sentencing Advisory Council of South Australia, *Mental impairment and the law: A Report on the operation of Part 8A of the Criminal Law Consolidation Act 1935* (SA), November 2014, p. 133, <http://www.agd.sa.gov.au/about-agd/what-we-do/services-government/sentencing-advisory-council-south-australia> (accessed 11 January 2016).

that can be imposed' and 'regular periodic review of detention orders'.⁷⁹ The ALRC agreed that:

...limits on the period of detention should be set by reference to the period of imprisonment likely to have been imposed, if the person had been convicted of the offence charged. If they are a threat or danger to themselves or the public at that time, they should be the responsibility of mental health authorities, not the criminal justice system. The framework for detention and supervision orders should be flexible enough to ensure that people transition out of the criminal justice system, in a way consistent with principles of community protection and least restriction of rights.⁸⁰

2.85 The ALRC noted that the *Commonwealth Crimes Act 1914* contains a series of safeguards to limit how long a person may be detained, including:

- judicial discretion in determining unfitness to plead and alternatives to custody;
- limiting terms of detention to a period not exceeding the maximum period of imprisonment that could have been imposed if the person had been convicted of the offence charged; and
- regular periodic reviews of detention.⁸¹

2.86 However, the ALRC highlighted that these safeguards are not consistently applied across jurisdictions. In particular, WA, the NT and Victoria do not set time limits for detention under custody orders.⁸² The ALRC described WA's review mechanism as 'inadequate' as there is no provision in the legislation for review; instead the person is detained 'at the Governor's pleasure'.⁸³

2.87 At the time of writing, there has not been a government response to this report.⁸⁴

Review—Equal Before the Law: Towards Disability Justice Strategies (Australian Human Rights Commission)

2.88 In February 2014, the Australian Human Rights Commission (AHRC) published a report, *Equal Before the Law: Towards Disability Justice Strategies*, found that 'indefinite detention of people with disabilities is a persistent issue and of

79 Australian Law Reform Commission (ALRC), *Equality, Capacity and Disability in Commonwealth Laws*, Law Reform Commission Report 124, August 2014, p. 206, <https://www.alrc.gov.au/publications/equality-capacity-disability-report-124> (accessed 15 December 2015).

80 ALRC, *Equality, Capacity and Disability in Commonwealth Laws*, p. 210.

81 ALRC, *Equality, Capacity and Disability in Commonwealth Laws*, pp 207–208.

82 ALRC, *Equality, Capacity and Disability in Commonwealth Laws*, pp 208–209.

83 ALRC, *Equality, Capacity and Disability in Commonwealth Laws*, p. 209.

84 ALRC, ['Modelling Supported decision making in Commonwealth Laws—The ALRC's 2014 report and making it work'](#), 20 October 2016.

grave concern'.⁸⁵ The AHRC recommended that each jurisdiction should develop 'holistic, over-arching' disability justice strategies, that included provision that:

Where a person who has been found unfit to plead is to be held in detention, demonstrate that all reasonable steps have been taken to avoid this outcome.⁸⁶

2.89 In March 2014, in response to revelations of Rosie Ann Fulton's case in WA and the NT, the Disability Discrimination Commissioner, Graeme Innes and Aboriginal and Torres Strait Islander Social Justice Commissioner, Mick Gooda, called for the NT and WA Governments to conduct an audit of all people being held in prison who had not been found guilty of a crime.⁸⁷

2.90 At the time of writing, there has not been a government response to the AHRC report.

Inquiry— Report into arbitrary detention, inhumane conditions of detention and the right of people with disabilities to live in the community with choices equal to others (Australian Human Rights Commission)

2.91 In 2014, the AHRC conducted an inquiry into complaints made by four Aboriginal men with intellectual disability held in the maximum security Alice Springs Correctional Centre in the NT. Three of the men were found unfit to stand trial due to their disability, and the fourth was found 'not guilty by reason of insanity' and all were placed on custodial supervision orders. The men were detained in the maximum security prison as, until March 2013, there were no other places in the NT where people subject to a custodial supervision order could be committed to custody.⁸⁸

2.92 Each of the men had spent a significant amount of time in detention that far exceeded the amount of time they would have been detained had they been found guilty of the offence:

- Mr KA—detained for over four years and still in detention;
- Mr KB—detained for almost six years (12 month term of imprisonment if found guilty);

85 Australian Human Rights Commission (AHRC), *Equal Before the Law: Towards Disability Justice Strategies*, February 2014, p. 30, <https://www.humanrights.gov.au/our-work/disability-rights/publications/equal-law> (accessed 15 December 2015).

86 AHRC, *Equal Before the Law*, p. 37.

87 AHRC, 'Jailed without conviction: Commissioners call for audit', 13 March 2014, <https://www.humanrights.gov.au/news/stories/jailed-without-conviction-commissioners-call-audit> (accessed 15 December 2015).

88 AHRC, *KA, KB, KC and KD v Commonwealth of Australia (Department of Prime Minister and Cabinet, Department of Social Services, Attorney-General's Department): Report into arbitrary detention, inhumane conditions of detention and the right of people with disabilities to live in the community with choices equal to others*, [2014] AusHRC 80, p. 3, <https://www.humanrights.gov.au/our-work/legal/publications/ka-kb-kc-and-kd-v-commonwealth-australia> (accessed 21 March 2016).

- Mr KC—detained for four and half years (12 month term of imprisonment if found guilty);
- Mr KD—detained for over 18 years and still in detention.⁸⁹

2.93 The AHRC found that the detention of the four men was contrary to Australia's obligations under the *International Covenant on Civil and Political Rights* and *Convention on the Rights of Persons with Disabilities*. The Commission found that the Commonwealth Government had failed in its obligations under international law to:

...take measures to work with the Northern Territory to provide accommodation and other support services, other than accommodation in a maximum security prison, for people with intellectual disabilities who are unfit to plead to criminal charges.⁹⁰

2.94 The AHRC made seven recommendations for the Commonwealth to cooperate with the NT government to provide improved accommodation options and other support services for people with intellectual disabilities. This included a recommendation that eligibility for the National Disability Insurance Scheme (NDIS) be extended to the complainants and other persons found unfit to plead and held in detention.⁹¹

2.95 In response to the inquiry, the Commonwealth Government argued that the issue of detention is a matter for state and territory governments and disagreed with the AHRC's interpretation of Australia's human rights obligations that the Commonwealth has a responsibility to act. The Commonwealth argued that the report fell outside of the Commission's jurisdiction and therefore it did not engage with the inquiry's recommendations.⁹²

Review—Access to Justice Arrangements (Productivity Commission)

2.96 In 2014, the Productivity Commission released its report into Access to Justice Arrangements. Part of this report focused on the difficulties that some people have in understanding and navigating the legal system, particularly for disadvantaged groups with complex legal needs, such as people with disability. This report made a number of recommendations to improve accessibility for people with disability.⁹³

89 AHRC, *KA, KB, KC and KD v Commonwealth of Australia*, p. 3.

90 AHRC, *KA, KB, KC and KD v Commonwealth of Australia*, p. 4.

91 AHRC, *KA, KB, KC and KD v Commonwealth of Australia*, pp 49–52.

92 AHRC, *KA, KB, KC and KD v Commonwealth of Australia*, pp 52–53.

93 Productivity Commission, *Access to Justice Arrangements*, Inquiry Report Overview, No. 72, 5 September 2014, pp 41–42, <http://www.pc.gov.au/inquiries/completed/access-justice/report/access-justice-overview.pdf> (accessed 28 November 2016). See also: Appendix 4 of this report for the full recommendations relevant to this inquiry.

National Seclusion and Restraint Project

2.97 In 2015, with the agreement of all Australian Governments, the National Mental Health Commission (NHMC) commenced 'a project to look at best practice in reducing and eliminating the seclusion and restraint of people with mental health issues and to help identify good practice approaches'.

2.98 In May 2015, the NHMC released a report and a position paper that highlighted the following principles for adoption by COAG to reduce the use of seclusion and restraint:

- jurisdictional agreement on definitions for seclusion, physical restraint, mechanical restraint and chemical restraint that is then reflected in jurisdictional legislation
- targets and reporting frameworks that ensure that we have consistent, national data that give an accurate and meaningful account of what's really going on
- a national approach to the regulation of seclusion and restraint that includes:
 - standards and guidelines to support national consistency in approach to reducing the use of seclusion and restraint
 - inclusion of a standard specifically addressing restrictive interventions in the next revision of the National Safety and Quality Health Service Standards
 - national monitoring and reporting on seclusion and restraint across jurisdictions and services.

In addition, the Commission considers that research into the prevention and safe management of behavioural emergencies involving people experiencing mental health difficulties, in all settings, is essential.⁹⁴

Western Australia

2.99 In April 2014, the Office of the Inspector of Custodial Services (Inspector) in WA released a report on indefinite detention under the *Criminal Law (Mentally Impaired Accused) Act 1996*. The Inspector found that the Western Australian system for managing mentally impaired accused is 'unjust, under-resourced and ineffective'⁹⁵ and made a series of recommendations, including giving greater flexibility to the

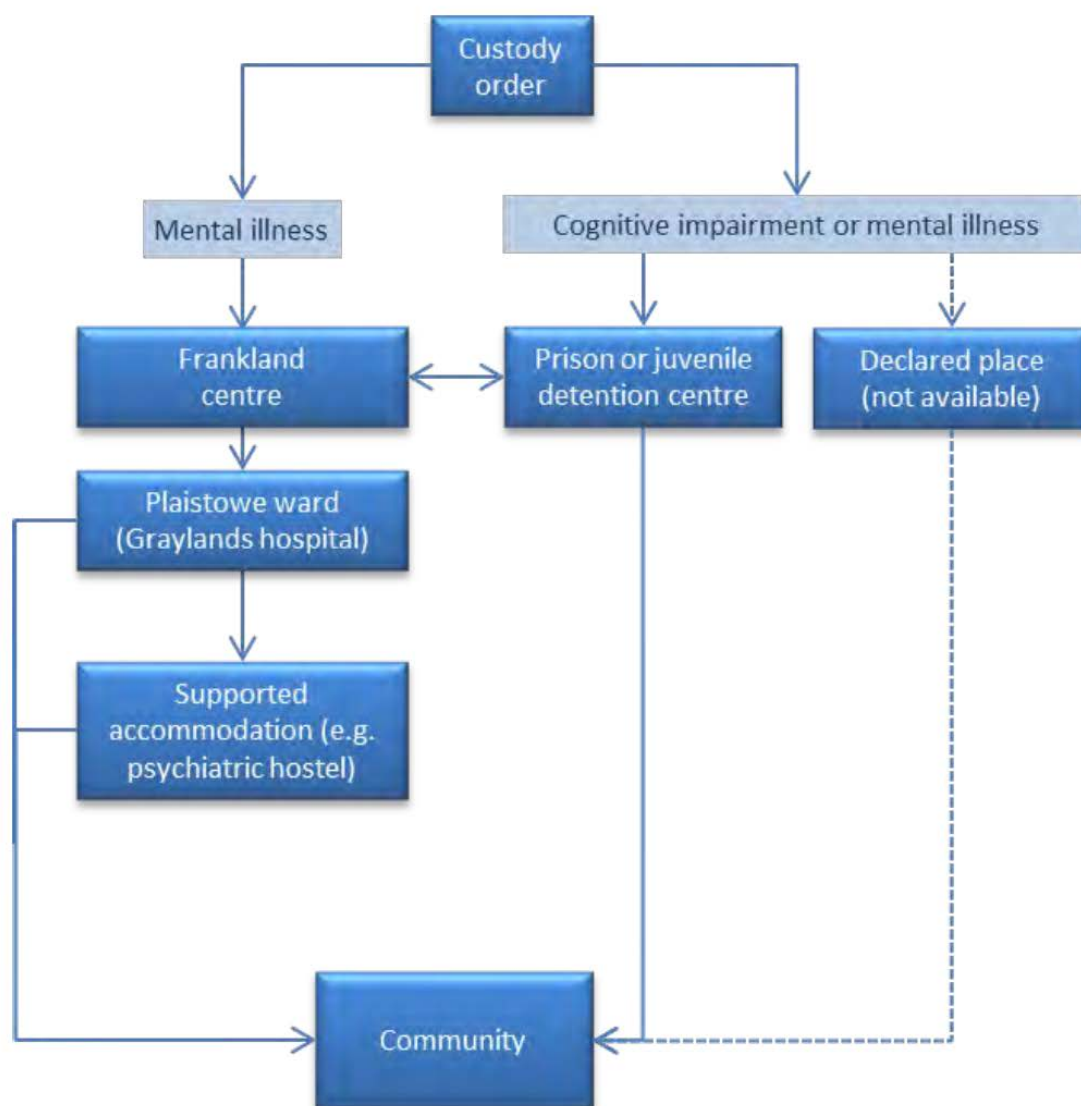
94 National Mental Health Commission, *Position Statement on seclusion and restraint in mental health*, May 2015, [http://www.mentalhealthcommission.gov.au/media/123607/Position%20Statement%20seclusion%20and%20restraint%20FINAL%20ENDORSED%2020%20MAY%202015%20\(D15-676981\).PDF](http://www.mentalhealthcommission.gov.au/media/123607/Position%20Statement%20seclusion%20and%20restraint%20FINAL%20ENDORSED%2020%20MAY%202015%20(D15-676981).PDF) (accessed 11 January 2016).

95 Office of the Inspector of Custodial Services in Western Australia, *Mentally impaired accused on 'custody orders': Not guilty, but incarcerated indefinitely*, April 2014, p. iii, <http://www.oics.wa.gov.au/reports/mentally-impaired-accused-custody-orders-guilty-incarcerated-indefinitely/> (accessed 17 December 2015).

courts to make community based alternatives to custody orders for people found unfit to stand trial.⁹⁶

2.100 The Inspector highlighted that unlike other jurisdictions, the courts in WA have only two options if a person is found unfit to plead: either unconditional release or a custody order.⁹⁷ These pathways are outlined in Figure 2.2.

Figure 2.2: Custody options for people held under the WA *Criminal Law (Mentally Impaired Accused)* Act 1996



Source: Office of the Inspector of Custodial Services in Western Australia, *Mentally impaired accused on 'custody orders': Not guilty, but incarcerated indefinitely*, April 2014, p. 5. It should be noted that the 'declared place'—the Bennett Brook Disability Justice Centre—is now complete and operational.

⁹⁶ *Mentally impaired accused on 'custody orders'*, p. 10.

⁹⁷ *Mentally impaired accused on 'custody orders'*, p. 8.

2.101 The Inspector was also critical of the 'executive discretion' model of review and release procedures for people on custody orders. Unlike other jurisdictions, in WA, decisions about leaves of absence, conditional release or unconditional release require approval from the Governor, based on recommendations from the Attorney-General. The Inspector recommended that the parliament consider vesting this decision making power in either the courts of an independent body such as the Mentally Impaired Accused Review Board or the Mental Health Review Board.⁹⁸

2.102 The Inspector further highlighted the lack of support services for people with mental impairment, including the shortage of forensic mental health beds and lack of a 'declared place' to detain and treat people with mental impairment.⁹⁹ The first 'declared place' in WA was opened by the Chief Justice of WA, the Hon Wayne Martin AC, on 4 August 2015.¹⁰⁰ The Bennett Brook Disability Justice Centre provides residential care for up to 10 people deemed to be 'mentally impaired accused'.¹⁰¹

2.103 In September 2014, the WA Attorney-General, the Hon Michael Mischin MLC, released a discussion paper on the operation of the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) (CLMIA Act).¹⁰² The WA Attorney-General's Department noted in its *Annual Report 2014-15* that two interim reports were completed on the review following extensive consultation with key stakeholders.¹⁰³

2.104 In April 2016, the WA Attorney-General released a final report looking at the CLMIA Act. The Act was assessed against its key objectives, identified as:

- the paramount safety of the community, and
- the fair and equitable treatment of mentally impaired accused, consistent with the principle of least restriction.¹⁰⁴

98 *Mentally impaired accused on 'custody orders'*, pp 10–12.

99 *Mentally impaired accused on 'custody orders'*, p. 29.

100 WA Supreme Court, 'Speeches: Opening of the Bennett Brook Disability Justice Centre by the Hon Wayne Martin AC, Chief Justice of Western Australia', 4 August 2015, http://www.supremecourt.wa.gov.au/S/speeches_2015.aspx (accessed 15 December 2015).

101 WA Disability Services Commission, Bennett Brook Disability Justice Centre, <http://www.disability.wa.gov.au/reform1/reform/disability-justice-centre/> (accessed 15 December 2015).

102 Attorney-General, Western Australia, 'Mentally impaired accused paper released', Media Statement, 25 September 2014, <https://www.mediastatements.wa.gov.au/Pages/Barnett/2014/09/Mentally-impaired-accused-paper-released.aspx> (accessed 15 December 2015).

103 Department of the Attorney General, Western Australia, *Annual Report 2014-15*, 'Services to Government', <http://www.ar.dotag.wa.gov.au/R/reviews.aspx?uid=1305-2232-3428-1256> (accessed 15 December 2015).

104 Department of the Attorney General, Western Australia, [Review of the Criminal Law \(Mentally Impaired Accused\) Act 1996: Final Report](#), p. 6.

2.105 The report made 35 recommendations. These focused on refining definitions of mental illness and impairment, improving tests of mental fitness to stand trial, securing a tangible increase in the level and quality of support provided for the accused, and enhancing procedural fairness.

2.106 Whilst the report noted that prison is 'often not an ideal place for mentally impaired accused', the WA Attorney-General held that—citing community safety as the primary consideration and in the absence of suitable alternatives—prison should continue to be used as a place of custody under the CLMIA Act.

2.107 The report made no recommendations in respect to the indefinite nature of custody orders, but did, however, acknowledge concerns and recommend that a working group be established and tasked with reviewing the operation of indefinite custody orders.¹⁰⁵

Northern Territory

2.108 As noted earlier in this chapter, like WA, the NT is a jurisdiction where indefinite detention can still nominally occur. Mental impairment and unfitness to be tried are provided for by Part IIA of the *Criminal Code Act* (NT). There have been no significant reviews of these provisions in recent times.

2.109 Mental impairment is defined as being when the 'accused did not know the nature and quality of their conduct, did not know the conduct was wrong or was not able to control their actions...as a consequence of mental impairment'. Unfitness is defined 'by reference to the ability of a person to understand the charges and proceedings, and to instruct their counsel'. Under both of these defences, the court must declare a person liable to supervision (custodial or non-custodial) order or that they are released unconditionally.¹⁰⁶

2.110 Ostensibly, the over-riding principle that a court should consider when imposing a supervision order is that 'restrictions on a supervised person's freedom and personal autonomy are to be kept to the minimum that is consistent with maintaining and protecting the safety of the community'.¹⁰⁷ However, the experience of people subject to a custodial supervisory order, has often been that 'custody means jail' or 'custody by default', partly resulting from a lack of suitable alternatives to prison. In its submission, NAAJA noted that:

a lack of suitable alternatives to prison—for example, supported accommodation for people with high needs—leaves courts with little option but to remand a person in custody, or to commit them to prison under a supervisory order.¹⁰⁸

105 Department of the Attorney General, Western Australia, [*Review of the Criminal Law \(Mentally Impaired Accused\) Act 1996: Final Report*](#), pp 6–17.

106 North Australian Aboriginal Justice Agency, *Submission 60*, pp [2–4].

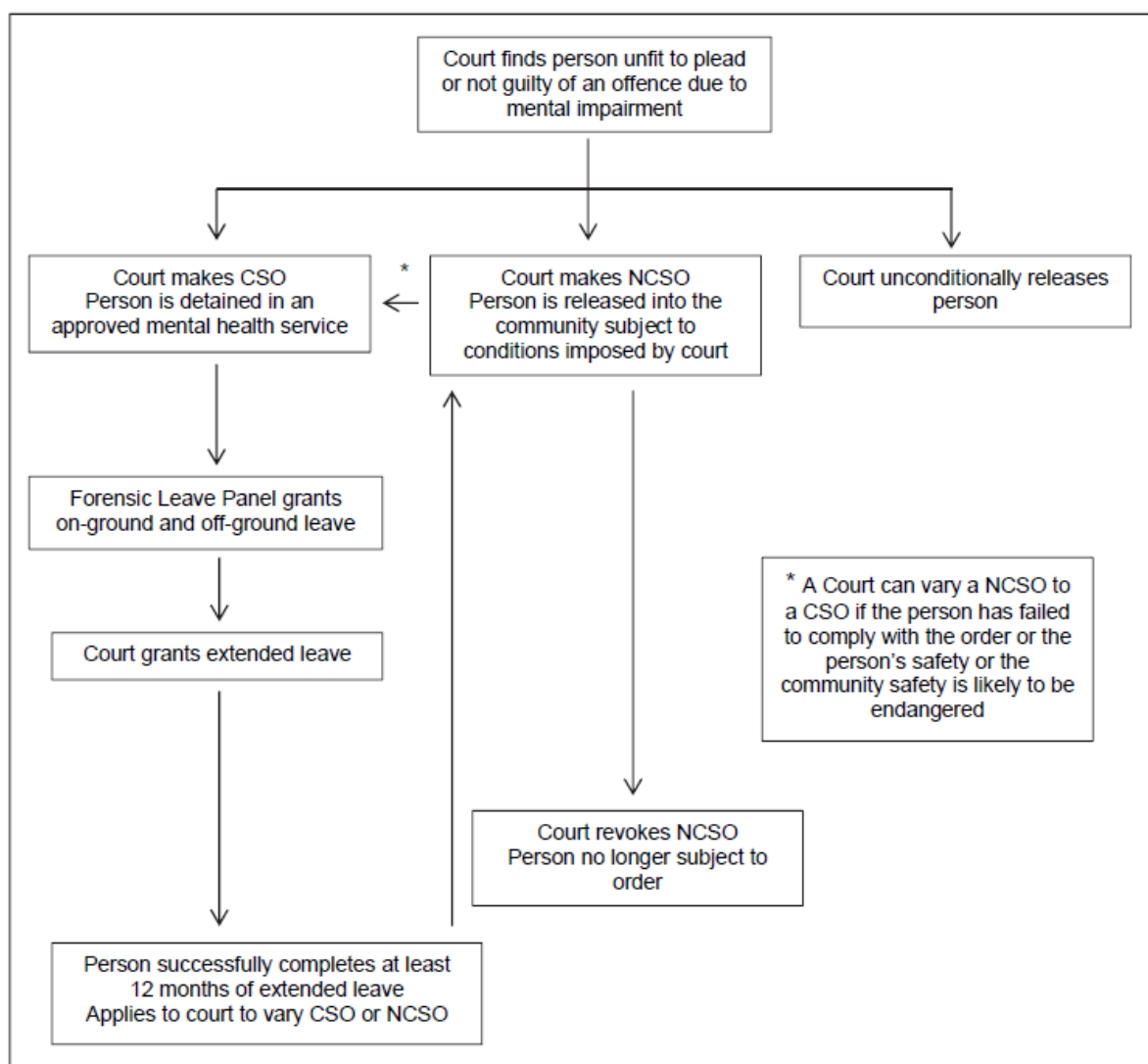
107 NAAJA, *Submission 60*, p. [4].

108 NAAJA, *Submission 60*, p. [45].

Victoria

2.111 Unlike WA, Victorian legislation provides the court with powers to make a number of different orders following the determination of unfitness to plead on the basis of mental impairment. These powers were introduced following a legislative review in 1997 that recognised that previous provisions enabling defendants to be detained indefinitely were unjust. These powers are outlined in Figure 2.3 and include Custodial Supervision Orders (CSOs) and Non-Custodial Supervision Orders (NCSOs).

Figure 2.3: Options for treatment of persons found unfit to stand trial in Victoria under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*



Source: Victorian Parliament Law Reform Committee, *Inquiry into access to and interaction with the justice system by people with an intellectual disability and their families and carers*, March 2013, p. 244.

2.112 In March 2013, the Victorian Parliament Law Reform Committee (Law Reform Committee) reported on its *Inquiry into access to and interaction with the justice system by people with an intellectual disability and their families and carers*.¹⁰⁹

The Law Reform Committee suggested that people with an intellectual disability or cognitive impairment experience a number of significant disadvantages that may increase the likelihood that they will come into contact with and be overrepresented in the criminal justice system.¹¹⁰ The Law Reform Committee made a series of recommendations aimed at:

- improving data collection on people with an intellectual disability or cognitive impairment and their interactions with the justice system;
- clarifying definitions of mental impairment;
- improving awareness by and guidance for the community and justice system personnel (including police, lawyers and courts) in working with people with intellectual disability or cognitive impairment; and
- ensuring adequate, accessible and effective services and supports are available for people with intellectual disability or cognitive impairment in the community and during their transitions through the justice system.¹¹¹

2.113 Under the Victorian *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic), a custodial supervision order commits the person into either an 'appropriate place' (i.e. an approved mental health service or residential service) or prison. A person cannot be committed into custody in an appropriate place unless they are assessed as having an intellectual disability or a mental illness. Custodial supervision orders are for an indefinite period; however, the Act contains safeguards setting nominal periods after which the court must review the order.¹¹²

2.114 In June 2014, the Victorian Law Reform Commission (VLRC) completed its review of the operation and application of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic).¹¹³ The review supported the retention of indefinite supervision orders, noting:

They are consistent with the therapeutic—not punitive—focus of the CMIA [Crimes Mental Impairment Act]. The duration of an order should be based

109 Parliament of Victoria Law Reform Committee, *Inquiry into access to and interaction with the justice system by people with an intellectual disability and their families and carers*, March 2013, <http://www.parliament.vic.gov.au/57th-parliament/lawreform/article/1461> (accessed 7 January 2015).

110 Law Reform Committee, *Inquiry into access to and interaction with the justice system*, p. xxi.

111 Law Reform Committee, *Inquiry into access to and interaction with the justice system*, p. xxi.

112 Law Reform Committee, *Inquiry into access to and interaction with the justice system*, pp 245–246.

113 Victorian Law Reform Commission, *Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Review of the CMIA)*, 21 August 2014, <http://www.lawreform.vic.gov.au/all-projects/crimes-mental-impairment> (accessed 7 January 2016).

on the time required to ensure protection of the community and the recovery and progression of a person along a process of gradual reintegration. An indefinite order allows the risk assessment to occur throughout the period of supervision, rather than at the time the order is made.¹¹⁴

2.115 As an additional safeguard, the VLRC recommended replacing the nominal terms for reviews of indefinite orders with five year 'progress reviews', noting that this would 'clarify and promote transparency in this area of the law'.¹¹⁵

2.116 Acknowledging that people with an intellectual disability who are subject to supervision orders 'may also be subject to detention and restrictions on their liberty', the VLRC recommended that the department responsible for every person subject to a supervision order prepare a treatment plan. It supported similar recommendations by the Victorian Law Reform Committee relating to departmental oversight, noting that people may be treated differently according to which department they are supervised by, particularly those in prison supervised by the Department of Justice:

There will be difficulties in requiring that a treatment plan is provided for people who are supervised by the Department of Justice because compulsory treatment cannot be provided to people in a prison environment. This is a significant problem, which has also been recognised in other jurisdictions such as the Northern Territory and Western Australia.¹¹⁶

New South Wales

2.117 In 2012, the NSW Law Reform Commission released two reports on people with cognitive and mental health impairments in the criminal justice system.¹¹⁷ The first report focussed on opportunities to enhance diversion at all stages of the criminal justice system, consistent with the NSW Government's priorities under the *NSW 2021 plan*.¹¹⁸ Like the VLRC it identified the need for improved data collection and clarification of definitions of mental impairment. The *Diversion* report recommended improving the services available for people with mental impairment and justice

114 Victorian Law Reform Commission, *Review of the CMIA*, p. xxxiii.

115 Victorian Law Reform Commission, *Review of the CMIA*, p. xxxiv.

116 Victorian Law Reform Commission, *Review of the CMIA*, p. 438.

117 NSW Law Reform Commission, *People with cognitive and mental health impairments in the criminal justice system*, http://www.lawreform.justice.nsw.gov.au/Pages/lrc/lrc_completed_projects/lrc_peoplewithcognitiveandmentalhealthimpairmentsinthecriminaljusticesystem/lrc_peoplewithcognitiveandmentalhealthimpairmentsinthecriminaljusticesystem.aspx (accessed 8 January 2016).

118 NSW Law Reform Commission, *People with cognitive and mental health impairments in the criminal justice system: Diversion*, Report 135, June 2012, http://www.lawreform.justice.nsw.gov.au/Pages/lrc/lrc_completed_projects/lrc_peoplewithcognitiveandmentalhealthimpairmentsinthecriminaljusticesystem/lrc_peoplewithcognitiveandmentalhealthimpairmentsinthecriminaljusticesystem.aspx (accessed 8 January 2016).

system personnel to divert people from the court system where possible, particularly for young people.¹¹⁹

2.118 The second report focussed on issues of criminal responsibility, fitness to plead and management of forensic patients.¹²⁰ The *Criminal responsibility and consequences* report recommended some minor changes regarding the decision making functions, powers and procedures of the Mental Health Review Tribunal (MHRT).¹²¹

2.119 Under the NSW *Mental Health (Forensic Provisions) Act 1990* (NSW), courts cannot set a limiting term for supervision orders for defendants found not guilty by reason of mental illness. The person is subject to the supervision of the MHRT and may only be released if and when either:

- (i) the MHRT makes order for the person's unconditional release; or (ii) the person is released subject to time-limited conditions, and the time specified for compliance with those conditions expires.¹²²

2.120 The processes available to the NSW courts following a finding of not guilty by reason of mental illness are outlined in Figure 2.4.

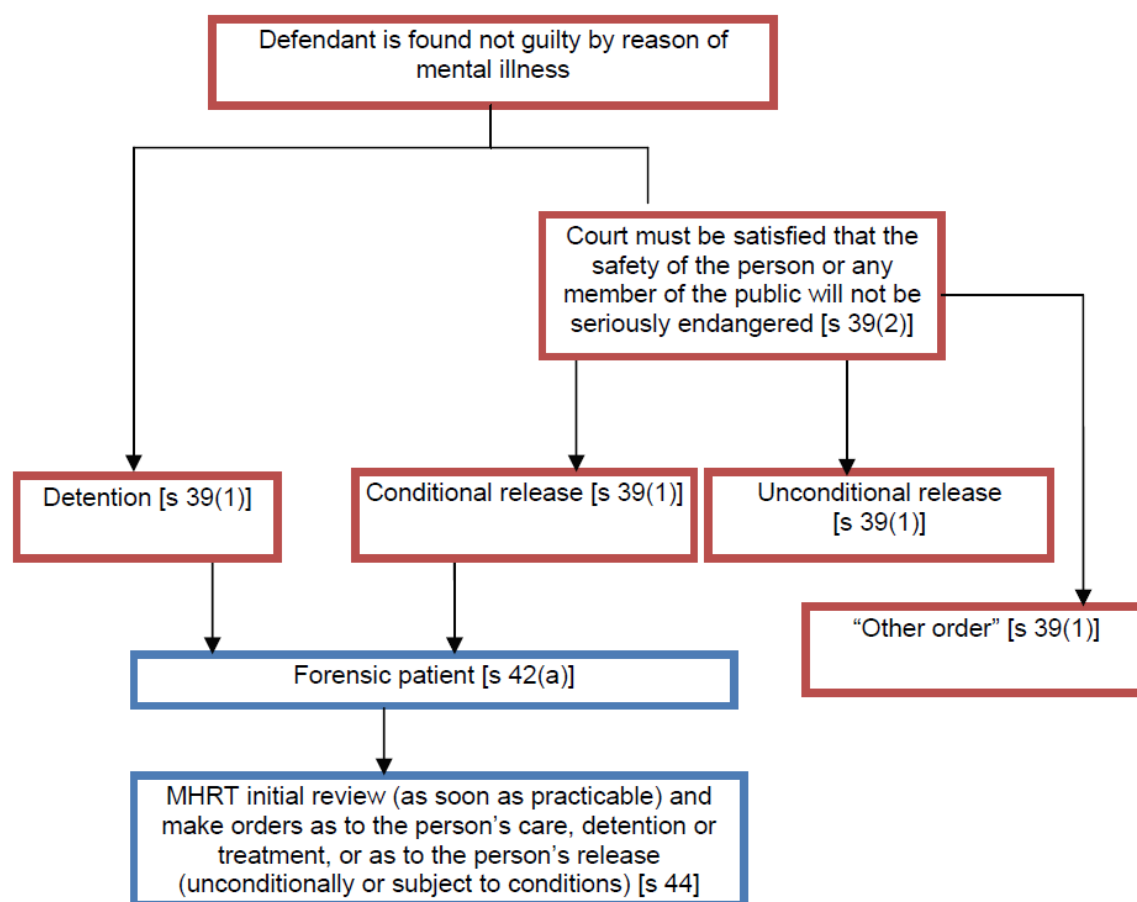
119 NSW Law Reform Commission, *Diversion*, pp xxvii–xxxiv.

120 NSW Law Reform Commission, *People with cognitive and mental health impairments in the criminal justice system: Criminal responsibility and consequences* (Criminal responsibility), Report 138, May 2013, http://www.lawreform.justice.nsw.gov.au/Pages/lrc/lrc_completed_projects/lrc_peoplewithcognitiveandmentalhealthimpairmentsinthecriminaljusticesystem/lrc_peoplewithcognitiveandmentalhealthimpairmentsinthecriminaljusticesystem.aspx (accessed 8 January 2016).

121 NSW Law Reform Commission, *Criminal responsibility*, p. xxii–xxiii.

122 *Mental Health (Forensic Provisions) Act 1990* (NSW) s 51(1).

Figure 2.4: NSW court processes following a finding of not guilty by reason of mental illness



Source: NSW Law Reform Commission, *Criminal responsibility*, p. 160.

2.121 The NSW Law Reform Commission recommended that limiting terms be introduced for defendants found to be not guilty by reason of mental illness who the court would have sentenced to imprisonment, whereby the court must set a limiting term which should be the length of the sentence of imprisonment that would have been imposed had that person been found guilty at a normal trial. A person should then cease to be a forensic patient at the expiry of the limiting term, if not released earlier by the MHRT.¹²³

2.122 The NSW Law Reform Commission noted that a 'significant consequence' of this recommendation would be that people found to be not guilty by reason of mental illness would no longer be at risk of being detained indefinitely. Justification for time limits included that it would:

- provide an important protection for forensic patients;

¹²³ See: Recommendation 7.2, NSW Law Reform Commission, *Criminal responsibility*, pp 180–181.

- be fair, and would not provide for forensic patients to be detained or managed within the forensic system for longer than they would have been detained following conviction; and
- support raising pleas of not guilty by reason of mental illness in appropriate cases so that people enter the forensic system rather than the correctional system.¹²⁴

2.123 The NSW government adopted recommendation 11.1 from this report which provides for the Supreme Court to be able 'to revoke an extension order if circumstances change significantly so that the order is no longer necessary'.¹²⁵

South Australia

2.124 In 2014, the Sentencing Advisory Council of South Australia (Sentencing Council) released its report on the operation of Part 8A of the *Criminal Law Consolidation Act 1935* (SA) relating to the defence of mental incompetence and associated legal processes.¹²⁶

2.125 In South Australia, if a defendant is found unfit to plead, they are found not guilty by 'reason of mental impairment' and subject to special powers of the court. These powers enable the court to either release the defendant unconditionally or make a supervision order that may commit the defendant to detention or release under conditions. The court must specify a limiting term for which the defendant may be subject to supervision and/or detention, which should be equal to the length of the sentences that would have been imposed if the defendant had been convicted of the offence.¹²⁷

2.126 The Sentencing Council supported retaining the current limiting term system with reference to the term of imprisonment that would have been imposed if the defendant had been convicted. The Sentencing Council recommended that, consistent with the *Crimes Act 1914* (Cth), the court should be given additional powers to impose conditional bonds on defendants for less serious offences.¹²⁸ The Sentencing Council also recommended that a working group be established to consider the viability of establishing a mental health review tribunal or board, similar to other

124 NSW Law Reform Commission, *Criminal responsibility*, p. xx.

125 See: Recommendation 11.1, NSW Law Reform Commission, *Criminal responsibility*, p. xxv; *Mental Health (Forensic Provisions) Act 1990*, Division 2, s. 7(1)(2).

126 Sentencing Advisory Council of South Australia, *Mental impairment and the law: A Report on the operation of Part 8A of the Criminal Law Consolidation Act 1935* (SA), November 2014, <http://www.agd.sa.gov.au/about-agd/what-we-do/services-government/sentencing-advisory-council-south-australia> (accessed 11 January 2016).

127 Sentencing Advisory Council of South Australia, *Mental impairment and the law: A Report on the operation of Part 8A of the Criminal Law Consolidation Act 1935* (SA), p. 6.

128 Sentencing Advisory Council of South Australia, *Mental impairment and the law: A Report on the operation of Part 8A of the Criminal Law Consolidation Act 1935* (SA), p. 9.

jurisdictions, to assist in the supervision of people with mental impairment under supervision orders, including operating 'step-up and 'step-down' services.¹²⁹

Concluding comments

2.127 This chapter has provided a legislative and statistical background to forensic orders in most Australian jurisdictions. This chapter has shown that there is not a consistent approach across the jurisdictions with regard to forensic legislation and practices. The next chapter will focus on some of the legislative differences which have resulted in the high rates of indefinite detention in WA and the NT. The committee is concerned that accurate statistics on the numbers of forensic patients held in prison do not appear to be available. The committee notes the work being undertaken by COAG in this regard and looks forward to the establishment and ongoing maintenance of a centralised register.

2.128 This chapter has also examined the types of cognitive impairment—including the high prevalence of FASD and cultural communication issues—and highlighted the high proportion of Aboriginal and Torres Strait Islanders peoples amongst those detained. These are trends which are mirrored in the general prison population. The next chapter will further examine this particularly in relation to the need for screening and diagnostic services in courts, and the need for specialist courts to help identify and divert some of these people from the criminal justice system.

2.129 Although many of forensic patients are being indefinitely detained under state and territory legislation, this chapter has outlined the Commonwealth's responsibility for disability standards as a signatory to the Disability Convention. The Commonwealth has an obligation to uphold its responsibilities under the convention.

2.130 This chapter has also summarised a number of reviews which relate to forensic patients. These reviews have raised the need for limiting terms and increasing the options for the judiciary when imposing forensic orders which will be discussed further in the next chapter.

129 Sentencing Advisory Council of South Australia, *Mental impairment and the law: A Report on the operation of Part 8A of the Criminal Law Consolidation Act 1935* (SA), p. 13.

Chapter 3

Sentencing and access to justice

I would argue that, just as wheelchair users need ramps to enter banks, people with cognitive disabilities require adjustment to access justice on an equal basis with others. It is not about providing special treatment but more about creating an even playing field.¹

3.1 The purpose of the next three chapters is to sequentially outline the issues relating to the three stages that a person who is indefinitely detained under a forensic order will undertake.

- Chapter 3 examines a person with cognitive and/or psychiatric impairment's intersection with the criminal justice system where they are brought before a court and subjected to a forensic order.
- Chapter 4 looks at the challenges faced in prison by a person subject to a forensic order.
- Chapter 5 focuses on the challenges transitioning from prison back to the community for people on forensic orders.

Introduction

3.2 As noted above, this chapter outlines the interactions between a person with cognitive and/or psychiatric impairment and the court system. The committee has received considerable evidence raising deficiencies with how the pre-trial and sentencing process currently works for people with cognitive and/or psychiatric impairment. This chapter outlines:

- the current Northern Territory (NT) and Western Australia (WA) legislation for people subject to forensic orders, and highlights the respective elements which lead to indefinite detention;
- the role of limiting terms for forensic orders;
- questions of legal capacity and support to engage with the courts;
- use of screening and diagnostic tools in courts pre-trial; and
- review of forensic orders using specialist courts.

Current sentencing practice that leads to indefinite detention

3.3 There are two prominent cases that have brought the issue of indefinite detention of people with cognitive and/or psychiatric impairment into the public eye—Mr Marlon Noble and Ms Rose Ann Fulton.

1 Dr Piers Gooding, Post-Doctoral Researcher, University of Melbourne, *Committee Hansard*, Darwin, 25 October 2016, p. 3.

3.4 As noted in Chapter 2, Mr Marlon Noble, an Aboriginal man from Western Australia, spent nearly a decade behind bars after being found unfit to plead, despite being neither tried nor convicted of the crimes he was alleged to have committed at any stage prior to, or during his incarceration.² In January 2012 he was released from prison with strict bail conditions—including regular drug testing and overnight home detention. Despite Mr Noble's release from the confinement of a prison, Mr Noble has still not had the opportunity to legally challenge the allegations against him:

I'm from Geraldton. I went to prison for the rest of my life. Been there for ten years of my life. No...I am not free. I am out of prison, but I am not free yet.³

3.5 This experience is not unique. In March 2014, it was reported that Ms Rosie Ann Fulton, a 23 year old woman, had 'spent the past 18 months in a Kalgoorlie jail without a trial or conviction after she was charged with driving offences'. The magistrate in this case found that Ms Fulton:

was unfit to plead because she is intellectually impaired—a victim of foetal alcohol syndrome—and has the mental capacity of a young child.

Her legal guardian, former police officer Ian McKinlay, says Ms Fulton ended up on a prison-based supervision order because there were no alternatives in the area at the time.

"At the moment this outcome is almost entirely reserved for Aboriginal, Indigenous Australians," he said.

The Aboriginal Disability Justice Campaign says there are at least 30 Indigenous people in a similar situation around the country.

Western Australia's Inspector of Custodial Services, Neil Morgan, says the state has no option but to incarcerate Ms Fulton as existing options are limited.

"One is a 'declared place', which was always intended to be for people like this. Unfortunately we still don't have any declared places 15 years after the Act came into force," he said.

"The second option is an authorised hospital, and that's only for a person with a treatable mental illness.

"And the third option, which is almost the option of default, is that the person ends up in prison or in a juvenile detention centre."⁴

2 Hayley Roman, 'Marlon Noble continues campaign for freedom', *ABC News Online*, <http://www.abc.net.au/news/2013-05-08/marlon-noble-attends-film-of-incarceration/4676620> (accessed 10 December 2015).

3 Unfinished Business, *Stories from Australian Aboriginal and Torres Strait Islander People with Disabilities: Marlon Noble*, <http://www.unfinishedbusiness.net.au/portfolio/marlon-noble-2/> (accessed 10 December 2015). See also: <http://croakey.org/new-project-to-tackle-the-detention-of-aboriginal-and-torres-strait-islander-people-with-disabilities/>

3.6 Ms Fulton's adult guardian, Mr Ian McKinlay updated the committee on Ms Fulton's progress since this media report.

Now I come to the Rosie Anne Fulton case, which I provided details on earlier. As I mention in the document provided, she was born with fetal alcohol brain damage, and this was compounded by a life of abuse. She was dumped by NT health after she ended up in indefinite prison-based supervision in Kalgoorlie. She was forced back into the NT health domain by a media and public outcry. This clearly caused resentment. It was reflected in the denial of a transitional support plan earlier discussed. Instead, she was placed under a clearly designed-to-fail support plan, which has seen her under conviction for 70 per cent of the time since her return to the Northern Territory. She has now lapsed into full-blown chemical addiction, and to all intents and purposes she is back on the streets and at serious risk. Yesterday I found her drunk with facial injuries; she was again bashed overnight and she appeared in court today. This support hides behind a pretence of freedom of choice values that contradicts repeated guardianship court findings that she lacks decision-making capacity. The external pressure needed to compel NT Health to accept responsibility for Rosie Anne has also been needed to maintain even tokenistic levels of commitment, the latest re-engagement prompted by monitoring by the Office of the Prime Minister and Cabinet plus the current Don Dale media coverage.⁵

3.7 The Aboriginal Disability Justice Campaign (ADJC) noted that indefinite detention of people with cognitive and/or psychiatric impairment predominantly occurs in WA and the NT. The next section will explore the legal process that leads to indefinite detention in these jurisdictions.

Northern Territory

3.8 Part IIA of the *Criminal Code Act* (NT) (Criminal Code) provides for alleged offenders to be deemed not guilty by way of mental impairment or unfit to stand trial. There are two key elements within the Criminal Code which lead to the indefinite detention of people with cognitive and psychiatric impairment in prison. Firstly section 43ZC of the Criminal Code provides that any supervision order (custodial or non-custodial) is 'for an indefinite term'.⁶ Secondly, section 43ZA(2) of the Criminal Code provides that a 'Court must not make a Custodial Supervision Order committing

4 John Stewart, 'Aboriginal woman's jailing highlights plight of intellectually impaired Aboriginal offenders', *ABC News Online*, 13 March 2014, <http://www.abc.net.au/news/2014-03-12/intellectually-disabled%C2%A0aboriginal-people-stuck-in-legal-limbo/5316892> (accessed 4 December 2015). See also: "'Urgent need" for law change as mentally impaired accused detained indefinitely', *ABC News Online*, 10 July 2015, <http://www.abc.net.au/news/2015-07-10/push-for-mentally-impaired-accused-law-change-in-wa/6611010> (accessed 4 December 2015).

5 Mr Ian McKinlay, *Committee Hansard*, Alice Springs, 26 October 2016, p. 19.

6 NT Government, *Submission 75*, p. 1.

an accused person to custody in a Correctional facility unless the Court is satisfied that there is no practicable alternative'.⁷

3.9 As noted in Chapter 2, the NT is one of the few Australian jurisdictions that still issues forensic orders with indefinite terms of duration. Ostensibly, the NT Supreme Court conducts annual reviews in which it must consider, amongst many things, the risk to any individual or the community if the accused is released. However, this process essentially reverses the onus of decision making from requiring a justification to detain, to requiring a justification to release. This is shown in the release statistics: of the sixty separate people to have had their cases reviewed by the court since 2002, 20 people have been released unconditionally at some point (five of whom were released unconditionally prior to any custodial order). Currently, there are 36 people subject to a custodial or non-custodial supervision order.⁸ Despite this review process, more than half of these 36 people remain subject to custodial orders, with the majority living in correctional facilities.

3.10 The committee notes that the Criminal Code provides for the imposition of fixed terms:

When first making a supervision order, the Court is required is required to fix a term under section 43ZG which is equivalent to the sentence of imprisonment the person would have received if the person had been found guilty of the offence. The court may backdate the term fixed under section 43ZG to when the person was first taken into custody.⁹

3.11 However, the committee also notes that these fixed terms are nominal as the fixed term is only a trigger for a major review. Supervision orders remain an indefinite proposition.¹⁰

3.12 As noted earlier, the Criminal Code states that a 'practicable alternative' to prison must be sought in the first instance. Again, this reverses the onus from a presumption of release triggered by a timeframe, to a presumption of continued detention unless criteria are met. This is exacerbated by the limited options for a practicable alternative in the NT. There is no dedicated forensic mental health facility in a non-prison environment for people held on custodial supervision orders. Currently, people subject to custodial supervision orders can be held in the Complex Behaviour Unit (within the walls of the Darwin Correctional Precinct), the Secure Care Facility (in Alice Springs), or in prison. Witnesses at the Darwin hearing highlighted the lack of appropriate supported accommodation in the community as the greatest barrier to people on custodial supervision orders being transitioned out of

7 NT Government, *Submission 75*, p. 3.

8 Mr Greg McDonald, NT Government Solicitor, *Committee Hansard*, Darwin, 25 October 2016, pp 26–27. See also: *Answer to Question on Notice No. 1*, NT Government.

9 NT Government, *Submission 75*, p. 4.

10 NT Government, *Submission 75*, p. 4.

indefinite detention in prison.¹¹ Without practicable alternatives, people with cognitive and/or psychiatric impairments will continue to be indefinitely detained in prisons. Supported accommodation will be discussed in more detail in Chapter 5.

Western Australia

3.13 Similar to the NT legislation, the WA *Criminal Law (Mentally Impaired Accused Act 1996* (CLMIA Act) provides for two pathways for a person found unfit to plead—unconditional release or a custody order. If a custody order is imposed on a person with a cognitive impairment they can either be placed in prison or in a declared place.¹²

3.14 The first, and only declared place in WA—Bennett Brook Disability Justice Centre (DJC)—was completed late last year.¹³ Until its completion, the only alternative was prison. Since its opening, two residents have successfully transitioned back into the community; two residents currently live in the DJC; and two prospective residents are being considered for placement in the DJC.¹⁴ This compares with the fifteen people being held in WA prisons on custody orders. Clearly, despite the opening of the DJC, which has a capacity for ten people, there are still significant numbers of people being held indefinitely in prison.

3.15 During its Perth hearing, the committee received evidence highlighting that under the CLMIA Act there is no provision for the judiciary to recommend that an alleged offender deemed unfit to plead is placed directly into a declared place. Placement in a declared place can only occur through a Mentally Impaired review Board (MIARB) review which is held after a custody order has been imposed by the court.¹⁵ This means that the CLMIA Act itself restricts the judiciary from placing people into an appropriate therapeutic environment in the first instance.

3.16 Chief Justice Martin explained the challenges he, and other judicial officers, face when dealing with cases under the CLMIA Act with no third option between unconditional release and prison:

There was an allegation of inappropriate behaviour of a lower order with children. He was a management risk. It was very low order seriousness offending. He was a management risk. He could be managed in his community, if there were conditions imposed about where he would live and not going near the school and those sorts of things. But I could not

11 Ms Vanessa Harris, EO, NT Mental Health Coalition, *Committee Hansard*, Darwin, 25 October 2016, pp 16–17. See also: NAAJA, *Submission 60*.

12 Office of the Inspector of Custodial Services in Western Australia, [*Mentally impaired accused on 'custody orders': Not guilty, but incarcerated indefinitely*](#), April 2014, p. 5.

13 Disability Services Commission (WA), *Bennett Brook Disability Justice Centre*, <http://www.disability.wa.gov.au/individuals-families-and-carers/for-individuals-families-and-carers/disability-justice-centre/> (accessed 8 November 2016).

14 Dr Ron Chalmers, Director-General, WA Disability Services Commission, *Committee Hansard*, Perth, 19 September 2016, p. 43.

15 Chief Justice Wayne Martin, *Committee Hansard*, Perth, 19 September 2016, p. 6.

impose those conditions, so I had to either take a punt to lock him up indefinitely, which I was not prepared to do because his behaviour just was not that serious, or take a punt and hope that the community itself would impose those conditions on him. The evidence I got was that the community were aware of his needs. There were a couple of relatives who were going to step up and look after him, and so I took the punt. But we should not have to take a punt in cases like that. We should have had the option of saying, 'I'm not going to put you into custody, but here are the conditions you have to live by, and if you breach those conditions then some action could be taken.'¹⁶

3.17 More often than not though, courts err in the other direction and impose a custodial sentence:

The problem is where you do not have any middle ground—it is either unconditional release or custody—you get to custody much quicker than you would if there were some opportunities in the middle.¹⁷

Legal capacity and support to engage with the court system

3.18 This section discusses how a person with cognitive and/or psychiatric impairment might be empowered to engage with the legal system. The committee examines the concept of legal capacity and the fundamental principle that a person should not have their legal capacity removed simply on the basis of disability.

3.19 As noted earlier in this chapter, the current sentencing practices in the NT and WA remove legal capacity when an 'unfit to plead' ruling is made and this displacement often leads to indefinite detention. In many circumstances, people who would normally be classified as unfit to plead—and their defendants—choose to plead guilty to crimes in order to be sentenced to a defined period as opposed to an indefinite sentence as a forensic patient.

3.20 Evidence was provided to the inquiry about alternative approaches such as specialist support workers to assist someone during the legal process and also the use of specialist courts as a means to better support people with cognitive and psychiatric impairment through the legal process.

Legal capacity

3.21 Legal capacity is defined as 'a person's power or possibility to act within the framework of the legal system'.¹⁸ An element of legal capacity relevant to forensic law is legal standing 'in the sense of being viewed as a person before the law'.¹⁹ The

16 Chief Justice Wayne Martin, *Committee Hansard*, Perth, 19 September 2016, p. 4.

17 Chief Justice Wayne Martin, *Committee Hansard*, Perth, 19 September 2016, p. 5.

18 Council of Europe's Commissioner for Human Rights, [Who gets to decide? Right to Legal Capacity for Persons with Intellectual and Psychosocial Disabilities](#), Issue Paper No. 2, 20 February 2012. Referenced in: Professor Bernadette McSherry, 'Mental Health Laws: Where to from here?', *Monash University Law Review*, Vol. 40, No. 1, 2014, p. 186.

19 Professor Bernadette McSherry, 'Mental Health Laws: Where to from here?', *Monash University Law Review*, Vol. 40, No. 1, 2014, p. 186.

practical application of this is described in more detail in chapter 2; however, in essence, legal standing applies to those deemed (by a legal process) as 'unfit to plead' and detained under forensic and criminal orders.

3.22 In a 2014 paper, Professor Bernadette McSherry highlighted the two main mechanisms that displace legal capacity:

(1) The *status approach* focuses on a certain characteristic of the person in order to find that the person lacks capacity. Hence, having a particular disability—in particular having a severe mental or intellectual impairment—has led to an automatic loss of legal capacity in both terms of legal standing and legal agency.

(2) The *cognitive approach* focuses on assessing the decision-making abilities of the individual concerned. The cognitive approach encompasses the notion of 'mental capacity' or 'mental competence', the latter term being used most often in North America.²⁰

3.23 As noted above and in Chapter 2, the legal capacity and legal agency of many people has been, and continues to be, removed on the basis of their cognitive and/or psychiatric impairments, in some cases resulting, in the involuntary detention of these people. However, Article 12 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) states that 'State Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life'.²¹ Furthermore, Article 14 of the CRPD states that persons with disabilities, on an equal basis with others:

(a) Enjoy the right to liberty and security of person;

(b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.²²

3.24 As noted previously in this report, state and territory legislation currently allows for people to be involuntarily detained for forensic or mental health reasons on the basis of cognitive and/or psychiatric impairments.

Committee view

3.25 The committee agrees with the evidence that a person's legal standing should not be removed on the basis of a disability. Where possible, participation in the legal process should be encouraged for all people. Support programs which assist and improve such participation are discussed later in this chapter.

20 Professor Bernadette McSherry, 'Mental Health Laws: Where to from here?', *Monash University Law Review*, Vol. 40, No. 1, 2014, p. 186.

21 United Nations Convention on the Rights of Persons with Disabilities, Article 12, s. 12, <http://www.un.org/disabilities/convention/conventionfull.shtml> (accessed 1 March 2016).

22 United Nations Convention on the Rights of Persons with Disabilities, Article 16, <http://www.un.org/disabilities/convention/conventionfull.shtml> (accessed 21 August 2016).

Outcomes of displacing legal capacity

3.26 Witnesses and submitters, including the NT Government Solicitor, acknowledged the perverse incentive that exists where a person pleads guilty (even to a crime that they have not committed) in order to receive a defined shorter period of time in prison rather than an indefinite period on a custodial supervision order.

At the early times that part IIA was in place, there was certainly a very severe reluctance on the part of defence counsel to go anywhere near part IIA because of the fear of indefinite incarceration. It is certainly also the case that there have been some persons who have served longer in a correctional facility—I say 'served', although they are not serving a sentence but they have been detained there in custody—than they would otherwise have been there, had they been able to plead guilty.²³

3.27 The Chief Justice of WA concurred:

There are very significant implications for criminal practice in this state, in particular individuals who plead guilty despite their impairment or their disability because they do not want to take the risk of being detained in custody indefinitely, possibly for a period longer than they would serve if convicted of an offence on a plea of guilty. As a consequence of that, the legal profession of this state is understandably reluctant to bring clients within the scope of the act. I am sure that there are cases in which proper legal advice is to a client to plead guilty rather than raise the question of the act and take the risk of indefinite detention.

3.28 The Aboriginal Legal Service of WA (ALSWA) agreed, noting that despite 'ethical and professional obligations to clients...we run from fitness to plead at a million miles per hour'.²⁴ In its submission, Office of the Public Advocate (QLD) provided many examples where the period of time that someone can expect to spend in a forensic facility or indefinitely in prison if they are deemed unfit to plead is sometimes double that of a custodial sentence.²⁵

3.29 Submitters have argued that there are many cases where people, with an appropriate level of support, could be expected to engage with the legal system and avoid being deemed unfit to plead. At the committee's Brisbane hearing, Mr Simon Wardale, the Director of Forensic Disability at the Queensland Department of Communities, Child Safety and Disability Services, noted:

23 Mr Greg McDonald, NT Government Solicitor, *Committee Hansard*, Darwin, 25 October 2016, pp 26–27. See also: Chief Justice Wayne Martin, *Committee Hansard*, Perth, 19 September 2016, p. 2.

24 Mr Peter Collins, Director, Legal Services, Aboriginal Legal Service of WA, *Committee Hansard*, Perth, 19 September 2016, p. 18.

25 Office of the Public Advocate (Qld), *Submission 36*, pp 13–14.

I certainly would not doubt the determination of the court, but what I saw was people with very, very mild intellectual disabilities being found unfit to plead.' And also where people are pleading guilty out of expediency.²⁶

3.30 The committee received evidence supporting this move away from people being found unfit to plead through the provision of supports:

Most of the critiques of fitness-to-stand-trial laws across the country—I am thinking particularly of some of the work done out of the University of Melbourne—would basically argue that we should be doing everything we can to minimise the notion of people not being found fit, so we should be adapting our court processes to ensure that we are doing everything possible to get rid of the need for people to be found unfit. I do not think we could say in any way that we are doing everything we can to create environments where we assume capacity and we are supporting people as effectively as possible to plead. Then, once you have a regime that does everything it can to avoid people being found unfit, you have to get rid of these inherent injustices which are always going to create a legal barrier, I suppose, to people navigating the process as they would with someone who did not have a disability.²⁷

Committee view

3.31 The committee is concerned that there is potentially a large group of people who, in the normal course of events would be found unfit to plead, but in an effort to avoid indefinite detention in prison are choosing to plead guilty, even to crimes they have not committed. The committee is concerned that these people's cognitive and/or psychiatric impairments are being criminalised and that they are not being provided with access to appropriate supports.

3.32 The next section will examine a range of initiatives that seek to improve participation in the legal system for alleged offenders with cognitive impairment.

Access to justice—Participation in, and support for alleged offenders during legal proceedings

3.33 One of the issues that arises when a court deems a person to be unfit to plead or stand trial, is that consideration is often not given to whether that person is indeed guilty or likely to be found guilty. This next section looks at some of the reasons why providing support and improving participation in legal proceedings for alleged offenders can result in improved outcomes with an examination of examples of such programs. Importantly, improved participation through support may lead to fewer forensic orders, diversion to genuine supported accommodation and therapy, and ultimately, less people being indefinitely detained.

26 Mr Simon Wardale, *Committee Hansard*, Brisbane, 23 March 2016, p. 27. See also: Ms Tania Collins, Senior Criminal Legal Officer, Central Australian Aboriginal Legal Aid Service, pp 19–20.

27 Ms Taryn Harvey, CEO, Developmental Disability WA, *Committee Hansard*, Perth, 19 September 2016, p. 26.

3.34 The committee has received evidence suggesting that the current legal process does not support people with cognitive and/or psychiatric impairment to understand what actions they are accused of committing. ALSWA noted that:

the reflex reaction of so many offenders is to blame someone else: 'It's the victim's fault,' or, 'It's my co-offender's fault.' Things get off on a bad footing from the word go, because that then dovetails into a refusal to accept responsibility, a lack of insight into their offending behaviour, a lack of victim empathy and therefore a lack of remorse. So things are heading south from a sentencing point of view from the word go.²⁸

3.35 ALSWA further noted that the presence of an Aboriginal and Torres Strait Islander support worker may lead to improved outcomes as this early point of interaction with the criminal justice system.

But if you had an Aboriginal person there, either as a support or as the person who is actually doing the report, hopefully there would be some sort of rapport established and the person would not be so reflexively defensive from the word go.²⁹

3.36 In its submission, Jesuit Social Services provided a case study from its *Enabling Justice Acquired Brain Injury Project* that illustrates the practical benefits of supporting a person with cognitive and/or psychiatric impairment through the legal process:

Only after my last offence have I ever got an ITP [Independent Third Party]. So everything prior, I went to court about once a year, every year, since I've been 16 years old... It [having the ITP] changed the ways the police asked the questions. I think they were a lot more softer, softly spoken. Rather than in an interview room by yourself with a police officer and he's very daunting. Knowing that you had an independent third person there, you realise yourself that you're not capable of answering the questions correctly. So you're very slow on answering, double checking, saying to the person, 'Is this what they said? Is this what they want to know?' as you get very daunted.³⁰

3.37 A 2009 paper by the Law and Justice Foundation of NSW noted that 'once in the criminal justice and correctional systems, people with cognitive impairment appear vulnerable to extended and repeat incarceration'.³¹ There are many barriers to legal assistance and legal processes for people with cognitive and/or psychiatric

28 Mr Peter Collins, Director, Legal Services, ALSWA, *Committee Hansard*, Perth, 19 September 2016, p. 21.

29 Mr Peter Collins, Director, Legal Services, ALSWA, *Committee Hansard*, Perth, 19 September 2016, p. 21.

30 Jesuit Social Services, *Submission 53*, p. 20.

31 A. Gray, S. Forell & S. Clarke, 'Cognitive impairment, legal need and access to justice', *Justice Issues*, Paper 10, March 2009, p. 5, [http://www.lawfoundation.net.au/ljf/site/articleIDs/2EDD47C8AEB2BB36CA25756F0018AFE0/\\$file/JI10_Cognitive_impairment.pdf](http://www.lawfoundation.net.au/ljf/site/articleIDs/2EDD47C8AEB2BB36CA25756F0018AFE0/$file/JI10_Cognitive_impairment.pdf) (accessed 1 March 2016).

impairments including the 'intimidating and alienating atmosphere of the courtroom'. Other barriers include:

- cross-examination techniques undermining the confidence and credibility of an offender;
- length and formality of proceedings; and
- participation in proceedings that they do not understand.³²

3.38 In January 2016, the Law Commission of England and Wales completed its inquiry into "unfitness to plead" laws in the United Kingdom (UK). In its report, it recommended a reform to the test of unfitness whereby:

the test for capacity to participate effectively in a trial should require the defendant to be able to participate effectively "in the proceedings on the offence or offences charged", and that assessment of the defendant's abilities in that regard should reflect consideration of the actual proceedings.³³

3.39 Furthermore, it also recommended that intermediary assistance and other assistance mechanisms should be deployed by courts to enable effective participation in court proceedings, where appropriate.³⁴

3.40 At the committee's Brisbane hearing, Mr Patrick McGee, Co-ordinator of the ADJC, indicated his support for the UK Law Commission's recommendations:

[P]eople with cognitive impairments should be provided with the level of support needed to fully participate in the legal process. Where they are unable to participate in the legal process due to their impairment, the process should not be a legal response but rather a social response. Basically, what they said was this: there should be a 'full trial wherever fair and practicable'; 'accurate and efficient identification of defendants who cannot participate effectively in the trial' should occur; there should be 'diversion out of the criminal justice process where appropriate'; there should be 'fair procedures for scrutinising the allegation'; and there should be 'effective and robust community disposals'. Basically, they are saying: 'You know what? If you can't actually participate in the legal process'—which is the design of the mental impairment process—'then you shouldn't be before a court and you certainly shouldn't be detained in jail as a result of that process.'³⁵

32 A. Gray, S. Forell & S. Clarke, 'Cognitive impairment, legal need and access to justice', *Justice Issues*, Paper 10, March 2009, pp 5–8.

33 Law Commission of England and Wales, [Unfitness to Plead—Volume 1: Report](#), 12 January 2016, p. 321. See also: Australian Law Reform Commission, [Equality, Capacity and Disability in Commonwealth Laws](#), May 2014, paragraph 7.17–7.18.

34 Law Commission of England and Wales, [Unfitness to Plead—Volume 1: Report](#), 12 January 2016, p. 319.

35 Mr Patrick McGee, Coordinator, Aboriginal Disability Justice Campaign, L Trobe University, *Proof Committee*, Brisbane, 23 March 2016, p. 36

3.41 In its 2013 consultation paper, the Victorian Law Reform Commission described some of the key characteristics of this new test, with the new test requiring an accused person to:

- *Understand the information relevant to the decisions that they will have to make in the course of the trial*—for example, an accused person with an acquired brain injury who has very low cognitive ability and is unable to understand new or unfamiliar information would be unfit to stand trial.
- *Retain that information*—for example, someone with Attention-Deficit Hyperactivity Disorder (ADHD) who cannot focus and finds it almost impossible to remember any new information given to them would be unfit to stand trial.
- *Use or weigh that information as part of a decision-making process*—for example, an accused person who suffers from paranoid schizophrenia who has a factual understanding of the charge, but indicates to the court that he wants to plead guilty because he sees no point in pleading not guilty as everyone in court is part of a conspiracy, would be unfit to stand trial.
- *Communicate their decisions*—for example, an accused person with autism who is able to understand information and process it but does not acknowledge others, may be unfit to stand trial.³⁶

Innovative programs supporting people with cognitive and/or psychiatric impairment in the justice system

3.42 In a previous report, the committee acknowledged the positive work undertaken in South Australia, including by the police, in developing a Disability Justice Plan.³⁷ This plan is intended to support people with disability in the corrections and court systems, and focus on the needs of people with disability who participate in legal proceedings as a witness or as an alleged offender.

3.43 Notwithstanding this, the committee received evidence from Ms Anna Tree of Dignity for Disability on the need for more resources to properly implement the Disability Justice Plan, including education for all levels of the justice system. Ms Tree also highlighted problems with the use of volunteer workers who assist police and court officials to better recognise and support the needs of people with cognitive and psychiatric impairment in the justice system. Ms Tree argued that programs of this kind require specialist trained professional staff.³⁸

36 Victorian Law Reform Commission, [*Review of the Crimes \(Mental Impairment and Unfitness to be Tried\) Act 1997: Consultation Paper*](#), June 2013, p. 60.

37 Senate Community Affairs References Committee, *Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability*, November 2015, p. 164.

38 Ms Anna Tree, Chief of Staff, Dignity for Disability, *Committee Hansard*, Alice Springs, 26 October 2016, pp 16–17.

3.44 During this inquiry the committee has received evidence on a range of innovative programs which provide supported legal decision making to people with cognitive and psychiatric impairment. These programs and projects are being trialled in some cases or more broadly implemented in others. The most successful characteristics of each of these programs is that they firstly facilitate a better understanding of the legal process and the specific charges that a person is alleged to have committed. A support person can also provide an opportunity to divert people with cognitive and psychiatric impairment away from the criminal justice system to receive therapeutic and other services. Ideally, a support person can provide case management or at least identify the need for a range of supports to be provided co-operatively by the different government departments. This section will focus on several examples of initiatives which provide such support to people with cognitive and/or psychiatric impairment that engage with the court system.

3.45 The University of Melbourne and University of New South Wales have received funding for a two year project (2015–2017) to develop practical and legal solutions to the problem of people with cognitive impairments, including Aboriginal and Torres Strait Islander people with cognitive impairments, being found "unfit to plead" and subject to indefinite detention in Australia. A secondary aim is to better ensure that people with cognitive disabilities can meaningfully participate, on an equal basis with others, in criminal proceedings brought against them.³⁹ A more detailed explanation of this project and its benefits can be found in Box 3.1.

39 See <http://www.socialequity.unimelb.edu.au/projects/unfitness-to-plead-and-indefinite-detention-of-persons-with-cognitive-impairments-addressing-the-legal-barriers-and-creating-appropriate-alternative-supports-in-the-community/> (accessed 1 March 2016).

Box 3.1: Unfitness to plead project

The researchers from the University of New South Wales and University of Melbourne have partnered with the North Australian Aboriginal Justice Agency (NT), the Intellectual Disability Rights Service (NSW), and a Victorian legal aid service to identify Aboriginal and Torres Strait Islander peoples and non-Indigenous people with cognitive impairments charged with a crime and provide support to them. The project is planning to support approximately 20 people (per service) in each jurisdiction.

The objective of this project is to:

- analyse the social, legal and policy issues leading to unfitness to plead findings and indefinite detention in Australia, with a focus on the experiences of Aboriginal and Torres Strait Islander peoples;
- provide and evaluate supported decision-making for up to 60 individuals with cognitive impairments who have been charged with a crime and who may be subject to unfitness to plead processes; and
- recommend options for the reform of unfitness to plead law and policy.

The expected outcomes will be:

- analysis of the differences and similarities in unfitness to plead laws and policy across the Australian states and territories;
- creation of good practice model(s) in supported decision-making in the criminal justice context that can be used in Australia and abroad; and
- creation of recommendations for law and policy reform in compliance with human rights standards.

The support is through a flexible supported decision-making model adapted from a model developed by the South Australian Office of the Public Advocate. The model includes the creation of a role for a 'supporter' for decision-making, with supervision and support being provided by the post-doctoral researcher and the relevant, local legal agency. People with cognitive impairments, including Aboriginal and Torres Strait Islander peoples, are contributing to the development of the supported decision-making model through the advisory panel, which meets for tele-meetings approximately three times per year for the duration of the project. The advisory panel is comprised of Disabled Peoples Organisations representatives, community experts, and academics.

As an example, the support worker will 'coordinate meetings between relevant people and services', pursue 'reports from various government and non-government agencies' and 'assisting a person to attend a psych assessment to see whether or not they are unfit to stand trial or even referring clients to relevant services'.

Sources: Dr Piers Gooding, Postdoctoral Research Fellow, Disability Research Initiative, Melbourne Social Equity Institute, Melbourne Law School, University of Melbourne, *Committee Hansard*, Darwin, 25 October 2016, p. 2; *Submission 5*. The project is funded as part of the Australian Government Department of Social Services, National Disability Research and Development Research Scheme.

3.46 Dr Piers Gooding, a post-doctoral researcher on this project outlined some of the practical supports offered by this project:

The type of support that they provided to clients with disabilities was varied and included providing communication aids, including plain language materials; sometimes sitting with the person in court and helping them to follow along; or even just providing emotional support for people who were appearing before courts. Sometimes the supporters would call persons to remind them about legal appointments, which was particularly important for some people with cognitive disabilities who could miss appointments, which would cause unnecessary delay. Sometimes

supporters would remind lawyers and others to speak in plain language, and they would also model what it means to do so.⁴⁰

3.47 Preliminary cost-benefit findings from this pilot program indicate there are significant net financial savings throughout the court process alone in providing a supporter. A normal guilty plea to avoid an unfitness finding in a NT court is estimated to cost \$5 619. This compares to an unfitness to plead finding which can cost in excess of \$16 000. An actual outcome using a support worker to assist an individual to navigate the court process is estimated to cost \$5 068.⁴¹

Committee view

3.48 It is the committee's view that people with cognitive and/or psychiatric impairments can and should be supported to engage with the court process. There are many successful, but disparate, examples of this type of support. It is the committee's view that appropriate resources should be allocated to expand these programs to reach all people likely to be subject to forensic orders.

Specialist courts and diversion programs

3.49 The committee has heard evidence that some jurisdictions are trialling or have implemented a new approach to diverting people with cognitive and psychiatric impairment through the use of specialist courts, which provide a more 'therapeutic jurisprudence' rather than the traditional punitive approach.⁴² Specialist courts are able to better recognise and support the needs of people with cognitive and psychiatric impairment in the justice system. This section examines a number of specialist court examples which are used around the country.

Examples of specialist court programs

3.50 The committee has received significant evidence outlining many different models of specialist courts which are operated around the country, either as pilot programs or on-going elements of the court system in some states.

3.51 In Queensland, the Queensland Mental Health Court (MHC) is part of the Supreme Court of Queensland. Typically, criminal cases can be referred to the MHC 'if it is believed that the alleged offender is mentally ill, was mentally ill, has an intellectual disability, or at the relevant time was deprived of a relevant capacity'. The MHC has two main purposes. One is 'to decide whether an alleged offender was of unsound mind when they committed an offence. The second function is to hear

40 Dr Piers Gooding, Postdoctoral Research Fellow, Disability Research Initiative, Melbourne Social Equity Institute, Melbourne Law School, University of Melbourne, *Committee Hansard*, Darwin, 25 October 2016, p. 2.

41 Additional Information, *Unfitness to plead project: Cost-Benefit Analysis of Supporter*, University of Melbourne, October 2016, pp 4–5.

42 Mr Daniel Clements (General Manager, Justice Programs, Jesuit Social Services) & Ms Eleanore Fritze (Senior Lawyer, Mental Health and Disability, Victoria Legal Aid), *Committee Hansard*, Melbourne, 29 April 2016, pp 6–7.

appeals from the Mental Health Tribunal and make inquiries into whether someone is being lawfully detained in authorised mental health facilities.⁴³

3.52 Currently in Western Australia, there are two diversionary programs operated as part of the Magistrates Court—the Intellectual Disability Diversion Program (IDDP), and the Specialist Treatment and Referral Team (Start) court.

3.53 The objective of the IDPP is 'to reduce recidivism among the intellectually disabled offender group, to reduce the rate of imprisonment by diversion and appropriate dispositions and to generally improve the ways in which the justice system deals with intellectually disabled offenders'.⁴⁴

3.54 The Start Court is part of the magistrates court in Western Australia. Established in early 2013, this initiative sought 'to provide more options for people in court with mental illness and more capacity for the court to respond in ways that support people whilst addressing their offending behaviour'. This program also operates a similar children's program in the Perth Children's court.⁴⁵ Referrals are made from the magistrates court. The Start Court aims to achieve the following:

- To increase an individual's connection with treatment support services and re-engage individuals with the most appropriate services to help manage their mental illness.
- To find a therapeutic solution to address offending behaviour in a manner which helps an individual manage their mental health issues and make positive changes to their life to help reduce the likelihood of future contact with the criminal justice system.
- To increase public safety and ensure those with mental health issues who need help receive it.⁴⁶

3.55 At face value, these two Western Australian programs appear to offer a more tailored approach for people with cognitive and/or psychiatric impairments. However, these programs do not seem to reach out to remote, Aboriginal and Torres Strait Islander communities. In his submission to the committee, Professor Harry Blagg of the University of Western Australia has proposed the concept of mobile needs focused courts that could be developed for, and deployed in remote Kimberley area of WA. These courts would be based in part on the Victorian Koori court model and the Neighbourhood Justice Centre, used in Collingwood. Importantly, this needs based approach 'shifts the focus from processing offenders to identifying solutions and

43 Queensland Courts, *Mental Health Court*, <http://www.courts.qld.gov.au/courts/mental-health-court> (accessed 16 May 2016).

44 Law Reform Commission of Western Australia, *Court Intervention Programs: Consultation Paper*, p. 105, <http://www.lrc.justice.wa.gov.au/files/Ch03-CIP.pdf> (accessed 16 May 2016).

45 Western Australia Department of the Attorney General, *Mental Health Court (Start and Links Courts)*, http://www.ar.dotag.wa.gov.au/M/mental_health_court_start.aspx?uid=5761-1625-4607-8265 (accessed 16 May 2016).

46 Magistrates Court of Western Australia, *Start Court*, http://www.magistratescourt.wa.gov.au/S/start_court.aspx (accessed 16 May 2016).

places emphasis on: the co-location of services; a trauma informed practice; a no wrong door approach to treatment; and respect for Aboriginal and Torres Strait Islander knowledge'. The essential components of this type of court are:

- Single magistrate (ideally with a deep understanding of local communities);
- A 'lite' screening tool that can be administered by local social workers and psychologists);
- Rapid entry into a treatment program and provision of necessary supports; and
- The use of 'on-country' alternative punishment options.⁴⁷

3.56 Mr Peter Collins of the ALSWA argued for the introduction of Aboriginal Courts as used in places like Victoria. Mr Collins noted that the:

whole process of sentencing Aboriginal people without the engagement of Aboriginal people in the process is largely meaningless. People just cycle through the system endlessly and, at the end of the day, as I said earlier, the protection of the community completely falls away. We could really do with Aboriginal sentencing courts in the Supreme Court, in the District Court, in all of the regional circuit courts, in the Magistrates Court—on it goes. And, as part of that, they could have a role with people who are enmeshed in the mentally impaired domain. If we are not going to do that, things will not change, and they will probably get worse.⁴⁸

3.57 The Darwin Magistrates Court (NT) has recently introduced a trial 'mental health list' which ensures that 'all cases which issues of mental impairment or fitness for trial are raised are being referred to the list so that they can be given special consideration and oversight'.⁴⁹

3.58 In its submission to the committee, the Victorian Ombudsman noted the use of the Assessment and Referral Court (ARC) List used in the Melbourne Magistrates Court. The ARC list is used 'to assist defendants on bail experiencing mental illness or cognitive impairment (including ABI), by addressing the underlying causes of their behaviour through facilitating access to treatment and support services'. The Victorian Department of Justice and Regulation noted that its internal independent evaluation of this program found that the ARC List had a 'return on investment of between \$2 and \$5 for every dollar [spent], when compared to the costs of imprisonment'.⁵⁰ The Victorian Ombudsman made the following observation:

I noted that despite evidence of the results such programs are achieving and their return on investment, the funding historically made available to them

47 Professor Harry Blagg, Dr Tamara Tulich & Ms Zoe Bush, *Submission 8a*, p. [4]. See also: Professor Harry Blagg, Professor of Criminology, University of Western Australia, *Committee Hansard*, Perth, 19 September 2016, p. 28.

48 Mr Peter Collins, Director, Legal Services, ALSWA, *Committee Hansard*, Perth, 19 September 2016, p. 17.

49 NAAJA, *Submission 60*, p. [6].

50 Victorian Ombudsman, *Submission 20*, p. 7.

has been very limited compared to the spending in the corrections system more broadly.⁵¹

3.59 The role of specialist courts is not to ignore offending and illegal behaviour; rather, it is to ensure that such behaviour is acknowledged in concert with appropriate therapeutic supports and services, as described by Mr Daniel Clements of Jesuit Social Services (JSS):

We would probably argue that there is an opportunity to think about restorative practice and restorative processes that support the individual to better understand the impact of the offending on families and on community, and that can work parallel to targeted, purposeful, tailored case management support.⁵²

Diversionary options

3.60 In addition to supports for people engaging with the court system, Professor Harry Blagg noted that 'diversionary practices favour the least intrusive option at any point of interaction between an accused person and the justice system'.⁵³

3.61 In its submission, JSS also raised diversion programs that utilise restorative justice principles. These approaches 'seek to hold the offenders to account for their actions and to provide them with the opportunity to restore their broken relationship with the victim, the community and in many cases, their own family'.⁵⁴ JSS went further and noted:

The creation of diversion programs targeting people with cognitive impairment at a pre-plea or presentence stage could prevent people entering prison and experiencing isolation from community connections and primary care givers, as well as preventing the harm that many people experience in prison. Diversion programs have the capacity to more effectively prevent further reoffending, by addressing the risk factors that contribute to a person's involvement in the justice system.⁵⁵

3.62 JSS highlighted a comparative analysis of its Youth Justice Group Conferencing diversion program in which 80 per cent of participants had not re-offended after two years as opposed to over half of those sentenced to youth detention who had re-offended.⁵⁶

3.63 During the committee's Brisbane hearing, Mr Simon Wardale highlighted Victoria as having a best practice model for the provision of support and diversionary

51 Victorian Ombudsman, *Submission 20*, p. 7.

52 Mr Daniel Clements, General Manager, Justice Programs, Jesuit Social Services, *Committee Hansard*, Melbourne, 29 April 2016, p. 6.

53 Professor Harry Blagg et al, *Submission 8*, p. [13].

54 JSS, *Submission 53*, p. 20.

55 JSS, *Submission 53*, p. 20.

56 JSS, *Submission 53*, p. 20.

services for people with cognitive impairment.⁵⁷ Mr Wardale firstly explained the legislative amendment that the Victorian Government undertook, and the policy response that was implemented to complement this change:

The Sentencing Act in Victoria was amended some time ago to allow community based orders to waive the obligation for community work and require the person with a disability to participate in support and therapeutic programs.

That was a change in the legislation. What happened from a policy perspective then was that the state based disability service department developed the requisite capacity and expertise to make those recommendations and put them before the court. So the court immediately had an option and it was not linked to the significance of the disability, which is where we get our 'unfitness' and 'unsoundness' sorts of determinations, which often result in indefinite detention. I am happy to talk about this in more detail. But in this example it was just a sentencing option available to a magistrate. The legislation was changed and the policy response emerged to be able to facilitate the effective implementation of that legislation.⁵⁸

3.64 Mr Wardale went further, describing the establishment of the Victorian Disability Forensic Assessment and Treatment Service which has provided for the integration of disability, correctional services, and diversionary services for people with cognitive impairment:

The other thing that happened that I think is a good example of the Victorian system is that the state based disability service department developed a response to offenders with an intellectual disability through the Disability Forensic Assessment and Treatment Service. That is a secure service that is based in Fairfield, and people can find themselves in that service either through sentencing or as a function of the Disability Act. But what that service did as well was outreach clinical support in Marlborough prison and Loddon-Mallee prison, provided case management support as part of both of those outreach options and also established a clinical position that was there to support the various departmental regions across the state that were supporting offenders with an intellectual disability.

So what we had was a hub of expertise created that then interfaced with the correctional system and with regional disability service systems so that we did not have clogged service, if that makes sense, where people went to live but there was nowhere for them to move out to and no effective response to their needs in the community. To my mind, that also underlies some of the challenges with the interface principles as they are currently written in terms of correctional response to people with intellectual disability, because

57 Mr Wardale is currently the Director of Forensic Disability at the Queensland Department of Communities, Child Safety and Disability Services. Previously he has served as the Director of Practice Leadership at the Queensland-based Centre of Excellence for Behaviour Support and as a Regional Senior Practice Advisor with the Victorian Department of Human Services.

58 Mr Simon Wardale, *Committee Hansard*, Brisbane, 23 March 2016, p. 26.

in Victoria the correctional response is entirely caused by the disability service response.⁵⁹

3.65 Diversionary programs are discussed further in Chapter 5.

Committee view

3.66 The committee has heard evidence of examples of specialist courts and diversion programs throughout this inquiry. Elements of these models could be adapted and utilised in WA and the NT to provide more appropriate supports for people with cognitive and/or psychiatric impairment and as a mechanism to divert these people from the criminal justice system.

3.67 Specialist courts provide one mechanism to divert people with cognitive and/or psychiatric impairments from the criminal justice system to more appropriate therapeutic supported environments. The committee is heartened by the 'mental health list' trials in the Darwin Magistrates Court; however acknowledges that this is not a legislated requirement and hence relies on individual people in the magistrates court to ensure its continuation or expansion. The committee considers that the 'mental health list' is an important initiative with the potential to help ensure that people with cognitive and/or psychiatric impairment are diverted from the criminal justice system, diagnosed and provided with appropriate supports. Consideration should be given to whether this initiative and ones like it could be continued and expanded across the NT, particularly in more remote locations, and implemented in other jurisdictions.

3.68 The committee is concerned by the lack of culturally and locally appropriate court services for regional and remote populations, particularly for Aboriginal and Torres Strait Islander peoples. The IDPP and Start Court initiatives in Perth are an important method for identifying and diagnosing alleged offenders with mental or psychiatric impairment; however, do not reach out to the vast majority of that state. The committee is of the view that remote, mobile courts—as described by Professor Harry Blagg—may be an appropriate way for the criminal justice system to reach out to remote Aboriginal and Torres Strait Islander communities. Such mobile courts could deal with alleged criminal activity in a culturally appropriate way that acknowledges the inappropriateness of any proven negative behaviours and then provides a suitable therapeutic on-country pathway forward.

3.69 Culturally appropriate responses and pathways to country are discussed in more detail in Chapter 5. The role that screening and diagnostic tools can play within the court system as a means to diagnose a person's disability and provide more information to a court officer is discussed in the next section.

Limiting terms

3.70 As noted in Chapter 2, the NT, WA and Victoria (VIC) are the only Australian jurisdictions that do not place limits on detention for those people subject

59 Mr Simon Wardale, *Committee Hansard*, Brisbane, 23 March 2015, p. 26.

to forensic orders. Many submitters and witnesses to this inquiry have highlighted the 'need for limits on the period of detention that can be imposed'.⁶⁰

3.71 Limiting terms was a key recommendation of the Australian Law Reform Commission's report *Equality, Capacity and Disability in Commonwealth Laws*.⁶¹ The North Australian Aboriginal Justice Agency (NAAJA) agreed noting that 'the priority for any legislative change should be the introduction of 'limiting terms', in place of supervision orders. Further, NAAJA argued that 'the length of any term should be dictated by the need to protect the community, balanced against the principle that a person's liberty should be subject to the minimum restriction necessary'.⁶²

3.72 The ADJC agreed with the sentiments of this recommendation, noting that limiting terms are a practical alternative to indefinite detention. NSW was cited as an example where limiting terms 'prevents a person found unfit to be tried being imprisoned for longer than if he or she had been convicted of the offence'.⁶³ The University of Western Australia is also supportive of statutorily prescribed limited terms similar to New Zealand or for 'courts, like on the east coast, who have the ability to say what the best estimate is of the sentence that we would have given someone and then go with that best estimate'.⁶⁴

3.73 As noted earlier in this chapter, all supervision orders in the NT must be handed down with a nominal fixed term. This fixed term forms the timeframe for the first major review of that order; it does not mean removal from prison.⁶⁵ As Mr Russell Goldflam, President of the Criminal Lawyers Association of NT noted:

As an example, I currently act for a client who engaged in conduct contrary to the Northern Territory Criminal Code back in March 2011. He was acutely psychotic at the time. Indeed, he engaged in the conduct while an involuntary patient in the psychiatric ward of the Alice Springs Hospital. He was eventually found not guilty by way of mental impairment and placed on a Part IIA custodial supervision order. The judge fixed a term of three months, being the sentence he would have imposed had my client been convicted of the offence. By that time, he had already served seven months, but he was not released from prison for a further seven months, essentially, because no suitable community-based placement had been arranged or funded. Since then, he has been on a non-custodial supervision order for the last two years and three months, which significantly curtails his freedom. He is not permitted to leave the home he lives in without an

60 Law Council of Australia, *Submission 72*, p. 16. See also: Mr Russell Goldflam, President, Criminal Lawyers Association of the Northern Territory, *Committee Hansard*, Alice Springs, 26 October 2016, p. 2.

61 Australian Law Reform Commission, *Submission 4*, p. [1].

62 NAAJA, *Submission 60*, pp [10–11].

63 Aboriginal Disability Justice Agency, *Submission 76*, p. [3].

64 Dr Tamara Tulich, Lecturer, University of Western Australia, *Committee Hansard*, Perth, 19 September 2016, p. 29

65 *Answer to Question on Notice No. 2*, NT Government.

escort. Physically and mentally, he is going nowhere. If we can stitch together a robust care plan for him, the judge managing his case has indicated that he will consider discharging my client soon. In the meantime, he has endured 3½ years of restricted liberty for engaging in misconduct which the court found justified a sentence of three months' imprisonment. This is obviously unfortunate and unsatisfactory, and, arguably, unfair. But my client is difficult to manage in the community. He was released on bail some years ago and promptly absconded. While at large, he resumed the sort of conduct that had brought him to the attention of police in the first place. However, in my view, even under the current law, my client could, and should, have had his liberty restored much more quickly. What prevented this was the lack of access to better, more coordinated, more proactive service providers who work together to positively plan for the restoration of his liberty and not wait for a judge to give them a nudge to do so. That is just one example, but, in my submission, it is illustrative and instructive.⁶⁶

3.74 This circular and frustrating type of evidence has become familiar to the committee throughout this inquiry. Nominally, pathways exist for people in both the NT and WA; however, in practice is leading to poor, unintended outcomes. As it stands now, a person is found unfit to plead and placed on a forensic order; a lack of suitable supported accommodation options results in a person being placed in prison; little or no support services are provided in prison resulting in static or regressive behaviours; regular reviews are conducted, but as that person shows little sign of improvement, they remain in prison—indeinitely detained.

3.75 NAAJA noted that the use of limited terms will 'more clearly place an onus on government to justify continuing any restriction on a person's liberty'.⁶⁷ If a government is placed in a position where detention in a prison is no longer an option, that government's efforts will be focused on ensuring that appropriate accommodation is provided in the community prior to the release of that person.

Committee view

3.76 The current legislative approach in WA and the NT is inadequate. In the absence of appropriate supported accommodation options for people on forensic (custodial) orders, a 'custody by default' model is adopted instead.⁶⁸ The introduction of limiting terms would drive a shift in these jurisdictions by shifting the onus from the 'custody by default' model to one where government must actively plan where a person will be placed at the end of their limiting term. As such, it is the committee's view that limiting terms could be an effective mechanism to prevent the indefinite incarceration of people with cognitive and/or psychiatric impairment when applied in concert with access to appropriate therapeutic programs whilst in prison.

66 Mr Russell Goldflam, President, Criminal Lawyers Association of the NT, *Committee Hansard*, Alice Springs, 26 October 2016, p. 2.

67 NAAJA, *Submission 60*, p. [11].

68 NAAJA, *Submission 60*, p. [7].

3.77 The committee also notes that law reform is required in the NT and WA. Such reform would provide greater flexibility—described as a 'middle ground' by the Chief Justice of WA—to the judiciary when considering and handing down forensic orders and prevent unnecessary incarceration in prison.

Screening and diagnostic tools

3.78 Specialist courts and other diversion programs are only useful when a person's disability is appropriately identified. However, many people with cognitive and/or psychiatric impairment are not aware of their disability at the time they are brought into contact with the criminal justice system. Without refined screening and diagnostic tools, specialist courts and support workers are unable to identify people with a cognitive and/or psychiatric impairment and are unable to identify the specifics of the individual's disability, which can help inform the court and support workers about the needs and the most appropriate pathway for each alleged offender with cognitive and psychiatric impairment. This section looks at the role of screening and diagnostic tools with a specific focus on Foetal Alcohol Spectrum Disorders (FASD).

3.79 The committee has received evidence about the importance of screening and diagnostic tools for use when people first interact with the criminal justice system. This can be at the court or on entry to prison. The aim of these tools is to provide support and diversion for people with cognitive and/or psychiatric impairments. Dr Glenn Jessop from Jesuit Social Services highlighted the importance of:

...appropriately resourced, accessible and specialised assessment and screening tools at all key points of the justice system...We believe diagnosis and therapeutic support at the earliest opportunity would reduce the likelihood of further contact with the criminal justice system as well as ensuring compliance with Australian human rights obligations.⁶⁹

3.80 Currently, in Victoria, prisoners do not undergo formal screening and assessment for cognitive impairment such as Acquired Brain Injury (ABI)—despite the presence of a diagnostic tool developed by Corrections Victoria. The Victorian Ombudsman submitted:

In Victoria at present, prisoners are not routinely screened for an ABI at reception. As a result, the responsibility for identifying a prisoner can fall to a number of different staff members, not just specialists. Staff are required to refer prisoners for a screening where they 'suspect' a cognitive impairment based on a prisoner's behaviour or interactions, or where a prisoner discloses that they have an ABI.⁷⁰

3.81 This compares with NSW where 'all adults in custody undergo screening for disability (including cognitive, sensory, physical) and mental illness'. The results of

69 Dr Glenn Jessop, Policy Manager, Jesuit Social Services, *Committee Hansard*, Melbourne, 29 April 2016, p. 4.

70 Victorian Ombudsman, *Submission 20*, p. 3.

these assessments are centrally available to all corrections officers and helps inform daily management and even referrals to the NDIS and state disability services.⁷¹

3.82 As noted in the previous section on specialist courts, the 'mental health list' at Darwin Magistrate Court provides an initial screening and assessment for offenders by a court-based mental health clinician. This process helps provide an:

an early indication of possible mental health or cognitive impairment issues and allowing for cases to be more efficiently progressed (for example, by providing a preliminary view that a person may or may not have a defence of mental impairment available).⁷²

3.83 More broadly, the Australian Medical Association recommended that screening of all prisoners should also be conducted upon admission to prison 'from a medical practitioner for physical, addiction-related and psychiatric disorders, and potential suicide risk. These screenings should also include 'evaluation of substance use, hearing loss, acquired brain injury, intellectual disability and other cognitive disabilities' as a guide to determine appropriate treatments'.⁷³ The next section will focus on screening and diagnostics for people with FASD.

Foetal Alcohol Spectrum Disorders

3.84 As described in Chapter 2, FASD is 'an umbrella term used to describe a range of physical and cognitive, behavioural and neurodevelopmental abnormalities that result from exposure to alcohol in utero'.⁷⁴ The cognitive impairment caused by FASD can lead to a wide range of behaviours including ones which result in a person being brought into contact with the criminal justice system.

3.85 In its submission, the Law Council of Australia recommended 'that all governments invest in methods to ensure the detection and treatment of Foetal Alcohol Spectrum Disorders (FASD) and other disabilities' which lead to detention, especially for Aboriginal and Torres Strait Islander peoples.⁷⁵ Professor Blagg from the University of Western Australia expressed his support for:

...better diversionary programs that redirect young people with FASD out of the justice system at an early stage. However, on the basis of our research we feel that, to be effective, diversion for Indigenous young people with FASD must involve diversion into Indigenous owned, non-stigmatising, therapeutic alternatives, particularly in the emerging sphere of Indigenous on-country initiatives. So ours is what we call a country centric model... We think some kind of hybrid of the Neighbourhood Justice Centre model in Melbourne and the Aboriginal court would serve to

71 NSW Government, *Submission 66*, pp 11–12.

72 NAAJA, *Submission 60*, p. [6].

73 AMA, *Submission 12a*, p. 6.

74 Australian Medical Association, *Submission 12*, p. 5.

75 Law Council of Australia, *Submission 72*, p. 15.

increase the rate of diversion at the front end and also provide much needed services.⁷⁶

3.86 At its Perth hearing, the committee was told an all too common story of undiagnosed FASD by Mr Peter Collins, Director at the ALSWA:

This was a young boy who was raised by a concerned, devoted grandmother, who lived next door to his natural parents, who were caught in the vortex of acute alcohol and drug abuse, domestic violence and dysfunction. The court reports spoke heartbreakingly of the fact that his parents lived next door to him and months, and sometimes years, would go by when they did not say anything to their young son. Eventually the penny dropped. It took way too long, but he was assessed with a provisional diagnosis of FASD. By then it was too late: he was 17 years old, he had committed some extremely serious offences of violence and was sentenced to a lengthy term of imprisonment. Worse still, he was angry, he was embittered and he was disaffected. The waste of human life was palpable. One of his teachers at the Clontarf college in Kununurra said he was the best junior AFL footballer he had ever seen. He is never going to realise that potential, because he will be behind bars.⁷⁷

3.87 The importance of early diagnosis was underscored by Professor Raelyn Mutch of Telethon Kids Institute at the committee's Perth hearing:

There is recognition of the need to understand why the child is having problems...Consistently, across the young people that we are meeting, they are running into problems very early on and in primary school. They are being perceived to be naughty rather than understood as having a learning difficulty. If, at that early stage, they were assessed appropriately then that may enable them to be taught through their strengths. And if they were taught through their strengths they would be less likely to fail, because that recognition is not happening at that stage, then they are acting up very early on and failing at high school and disengaging, and then that is when they become engaged with juvenile justice.⁷⁸

3.88 Telethon Kids Institute noted in its evidence to the committee that it has recently completed the development of the first Australian FASD diagnosis tool. Diagnosis of this complex cognitive impairment is the first step in preventing a person with FASD 'having the life trajectory that brings them into early engagement with justice systems and mental health facilities'.⁷⁹ Ideally such diagnosis would occur

76 Professor Harry Blagg, University of Western Australia, *Committee Hansard*, Perth, 19 September 2016, p. 28.

77 Mr Peter Collins, Director, Legal Services, Aboriginal Legal Service of WA, *Committee Hansard*, Perth, 19 September 2016, p. 16.

78 Clinical Associate Professor Dr Raewyn Cheryll Mutch, Post-Doctoral Senior Research Fellow and Paediatrician, Telethon Kids Institute, *Committee Hansard*, Perth, 19 September 2016, p. 34.

79 Clinical Associate Professor Dr Raewyn Cheryll Mutch, Post-Doctoral Senior Research Fellow and Paediatrician, Telethon Kids Institute, *Committee Hansard*, Perth, 19 September 2016, p. 32.

prior to a person interacting with the justice system; however, at the very least, comprehensive health, language, cognition and social wellbeing assessments' including FASD screening should be made available 'for all children and youth at their very first point of contact with the juvenile justice system'.⁸⁰

Committee view

3.89 Screening of people with cognitive and/or psychiatric impairments needs to be made a priority, particularly for those with severe impairments such as FASD, to ensure that the judiciary can make early informed choices about diversion and therapeutic treatment for this group of vulnerable Australians. The completion of the FASD diagnosis tool provides an ideal opportunity to provide this as a supported resource to courts, legal aid and other related groups.

3.90 The committee considers that all jurisdictions should adopt the NSW Corrections' approach of regular disability screening tools for disability of all prisoners, both adults and minors. Such a practice would help to ensure that all prisoners with disability are provided with access to therapeutic and other supports appropriate to their needs.

Review of forensic orders

3.91 Currently forensic (custodial) orders are reviewed on a regular basis either by the relevant mental health tribunal in most states, the MIARB in WA, or the Supreme Court in the NT.

3.92 The Chief Justice of WA has argued that—in addition to the legislated introduction of limiting terms—there is a requirement for a 'full, transparent judicial review of risk' similar to the 'dangerous sexual offender legislation in [WA] whereby the court reviews every year the risk that they pose to the community'.⁸¹

3.93 The WA Inspector of Custodial Services agreed and went further noting that 'dangerous sex offenders' in WA currently have greater protections than people subject to forensic orders. Dangerous sex offenders held on indefinite detention orders are subject to reviews by the WA Supreme Court annually. In order for the order to be extended:

The court must be satisfied—picking up the Chief Justice's theme—that the risk that that person poses cannot be managed in the community and can only be managed in a custodial setting. If you have a look at the case law there is a very significant body of case law that basically says there is a presumption that the person will be released under community supervision unless there are exceptional reasons based on risk as to why they need to be detained. Every year—I think it is every year, or every two years—it is referred back to the court for another public hearing, legal representation in

80 Clinical Associate Professor Dr Raewyn Cheryll Mutch, Post-Doctoral Senior Research Fellow and Paediatrician, Telethon Kids Institute, *Committee Hansard*, Perth, 19 September 2016, p. 33.

81 Chief Justice Wayne Martin, *Committee Hansard*, Perth, 19 September 2016, p. 5.

full and all-of-court paraphernalia. It strikes me that that makes an interesting parallel with the mentally impaired accused act.⁸²

3.94 The WA Disability Services Commission contended that the review process in place through MIARB occurs 'at least once a year'.⁸³ Currently, the MIARB reviews (and makes) forensic (custody orders) in Western Australia. One of the criteria to be considered during this process is the 'degree of risk' that a person poses to the community. MIARB must report on each person under its jurisdiction at least once per year.⁸⁴ Developmental Disability WA has agreed that this review process does exist; however, submitted that 'it still comes down to who is making that decision every year' and that 'as long as you have the person making that decision not being a court, you are constantly' going to have continued instances of indefinite detention.⁸⁵

3.95 Some submitters have highlighted that the review process is heavily dependent on the reports issued by medical and psychiatric experts. Mr Russell Goldflam of the Criminal Lawyers Association of the NT described a "'tick and flick" approach to annual reports in some cases, and particularly those in which the supervised person has been institutionalised (whether in custody or in the community) for a lengthy period'.⁸⁶ Mr Goldflam noted an example where an independent opinion was sought which led to a more favourable outcome:

If I could go back to the example I mentioned before: the gentleman who was given a three-month term several years ago and is still under an order. This year I have been provided with three reports by health department psychiatrists—I think it was within the last 12 months—and they all say, 'This person should stay on the order.' That probably would have kept going until he died if I had not commissioned a report, which cost the Northern Territory Legal Aid Commission some thousands of dollars, from an independent expert from somewhere else who said, 'No, this person is not a serious risk.' That is why the judge has given an indication that he is considering releasing him. Unless we had taken that proactive step, we were just going to be stuck with this bloke sitting comfortably, but unhappily, in his supported accommodation and never being allowed to go out in the street without a chaperone.⁸⁷

82 Professor Neil Morgan, Inspector of Custodial Services, Office of the Inspector of Custodial Services, *Committee Hansard*, Perth, 19 September 2016, p. 9.

83 Dr Ron Chalmers, Director-General, Disability Services Commission, *Committee Hansard*, Perth, 19 September 2016, p. 45.

84 Mentally Impaired Accused Review Board, [Annual Report 2015/16](#), pp 13 & 22.

85 Ms Taryn Harvey, CEO, Developmental Disability WA, *Committee Hansard*, Perth, 19 September 2016, p. 26.

86 *Answer to Question on Notice No. 1*, Mr Russell Goldflam.

87 Mr Russell Goldflam, President, Criminal Lawyers Association of the NT, *Committee Hansard*, Alice Springs, 26 October 2016, p. 5.

Committee view

3.96 The committee concedes that a regular review process currently exists in WA and the NT; however, agrees with witnesses that additional protections should be instituted so as to provide people subject to forensic orders at least the same protections as those provided to dangerous sex offenders. It is the committee's view that where a person is subject to a review process that an independent third party appraisal of any professional medical and psychiatric assessments is sought to inform the review process.

Concluding committee view

3.97 The committee acknowledges that forensic patients are not detained with the intention of it being indefinite and prolonged. Nevertheless, as this chapter has shown, there are a range of factors—from legislation to court practice—that converge and ultimately result in forensic patients being indefinitely detained. This chapter has covered substantial and complex terrain focusing on the front-end of the justice system where alleged offenders come into contact with the courts. Notwithstanding the complexity of the issues, the committee considers there are several concrete themes which can be taken from this chapter to provide a pathway forward that will reduce the indefinite detention of forensic patients in prison—these are legislative reform including limiting terms, and supported decision-making and diversionary mechanisms.

Law reform—limiting terms and increasing sentencing options for judiciary

3.98 The committee considers that prison is not a suitable place for forensic patients, and will elaborate on this view in the next chapter. However, as it stands, forensic patients are being indefinitely detained and the committee is interested in mechanisms that prevent this from occurring, regardless of the nature of the detention facility.

3.99 The committee is concerned by reports of people with cognitive and/or psychiatric impairment pleading guilty to avoid the risk of indefinite detention as a forensic patient. There is a need for reforms to address this.

3.100 Limiting terms is one option to prevent indefinite detention. Currently, limiting terms for forensic patients are provided for in all Australian jurisdictions except the NT, WA and Victoria. It is the committee view that limiting terms need to be adopted for forensic patients in these states. Limiting terms become a mechanism that forces government to accept greater responsibility for forensic patients in their care. The committee's support for limiting terms is based on the proviso that appropriate therapeutic support services are provided to forensic patients in prison whilst noting that prison is not the most appropriate place to deliver those services. The committee is also strongly of the view that a limiting term should not become the default period, but rather the maximum period that forensic patients spend in prison.

3.101 The committee considers that specific legislative reform in the NT and WA which expands the options available to a sentencing judge beyond unconditional release and prison will result in less forensic patients being placed in prison. Secure options and transitional placements that both reduce risk to the community and also

provide a therapeutic, non-punitive environment for forensic patients are discussed further in Chapter 5.

Supported decision-making and diversion

3.102 The committee also heard about a number of successful support-worker programs including the unfitness to plead project which assist people to engage with and understand the court process. Importantly, improved participation in legal processes through support may lead to less forensic orders, diversion to genuine supported accommodation and therapy, and ultimately, less people being indefinitely detained. The committee is supportive of such programs being maintained and expanded.

Screening and diagnosis

3.103 The committee agrees with evidence that many alleged offenders are people with undiagnosed cognitive and psychiatric impairments that continue to remain undiagnosed. Appropriate, timely screening and diagnosis mechanisms, such as the new FASD Diagnostic Tool developed by the Telethon Kids Institute, can help inform the courts and other disability and health service providers to divert a person, where appropriate, to identify therapeutic treatments.

Specialist courts

3.104 Specialist courts are another means to intercept and screen people with cognitive and psychiatric impairments, leading to diagnosis and diversion from the criminal justice system. There are excellent examples of such specialist courts which should be adopted and expanded where necessary. The committee also has a strong view that there is a need for such courts to be adapted for remote Aboriginal and Torres Strait Islander communities. The committee highlights the remote, mobile courts—as described by Professor Harry Blagg—as an appropriate way for the criminal justice system to reach out to remote Aboriginal and Torres Strait Islander communities. Such mobile courts could deal with alleged criminal activity in a culturally appropriate way that acknowledges the inappropriateness of any proven negative behaviours and then provide a suitable therapeutic on-country pathway forward. Chapter 5 will further explore culturally appropriate care and pathways to country for Aboriginal and Torres Strait Islanders.

Chapter 4

The inappropriate use of prison for forensic patients

If he's not guilty what is he doing here?¹

...They are not prisoners, they are not convicts and they should not be treated as such.²

4.1 This chapter focuses on the experiences of people subject to forensic (custodial) orders who are indefinitely detained in prisons, and the lack of therapeutic options available to forensic patients in this environment.

4.2 The committee received evidence from Mr David Egege, Executive Director of the Disability Advocacy and Complaints Service of South Australia which highlighted an example of a forensic patient's experience in prison:

Mr X was found guilty of an offence by reason of mental incompetence and he was sentenced to a limiting term of 13 years. After spending a couple of months of his sentence at the forensic facility James Nash House, he was transferred to Yatala Labour Prison, where he was incarcerated for seven years. A number of those years were spent in G-Division and a number of those years were also spent in solitary confinement. The public advocate has been very involved in this case. Patient X was, at times, kept on handcuff regime in a cell, where he slept on a concrete slab. I believe, as a forensic patient, he clearly should have had access to a clinical program available to any person who is in that situation, in custody, and who is a forensic patient.³

4.3 In its submission to the committee, Barriers 2 Justice described the circumstances of a person with an intellectual disability held in prison:

The individual had been in prison for approximately one month. During this time he had been sexually propositioned by other prisoners. Although it is understood no abuse occurred, those with an intellectual disability in prison are likely to be at a higher risk of assault due to their increased vulnerability. It is also believed the individual may have been showing more extreme behaviours due to his reaction to the prison environment and his treatment by other prisoners.⁴

4.4 Ms Alison Youssef noted that some forensic patients are confused as to why they are being held in prison, with mental health issues emerging as a consequence:

1 Barriers 2 Justice, *Submission 67*, p. 8.

2 Mr Russell Goldflam, President, Criminal Lawyers Association of the Northern Territory, *Committee Hansard*, Alice Springs, 26 October 2016, p. 3.

3 Mr David Egege, *Committee Hansard*, Alice Springs, 26 October 2016, p. 15.

4 Barriers 2 Justice, *Submission 67*, p. 12.

Christopher and Kerry have suffered mentally during their time in prison. They both feel sad that they are unable to see family members and be part of their community... A neuro-psychological assessment conducted for the review recommended that it was not appropriate for Christopher to be in prison, and that his mental health was going to deteriorate markedly if he remained there.⁵

4.5 A number of submitters, in particular the Royal Australian New Zealand College of Psychiatrists (RANZCP), disagreed with the use of prisons to accommodate people with a cognitive or psychiatric impairment who had not been found guilty of any offence:

Persons found unfit to stand trial or acquitted on an insanity finding must only be treated in appropriately designated health facilities, outside of prison environments, that are appropriate to individual clinical and risk management needs. They must not be treated as convicted criminals for that offence. A key principle is that prisons are not hospitals and should never be viewed as such.⁶

Experience of prison for people with cognitive and psychiatric impairment

4.6 The Aboriginal Disability Justice Campaign (ADJC) has raised concerns about the 'use of maximum security prisons as default accommodation and support options' and 'the lack of clinical treatment which focus[es] on reducing the person's risk of harm to others'.⁷ As noted in the previous chapter, people with cognitive and/or psychiatric impairment are held in prisons because there is a lack of other supported options in the community. In its submission to the committee, the Criminal Lawyers Association of the Northern Territory (CLANT) noted:

People with complex cognitive and psychiatric needs and offending behaviours, or who are assessed as a risk to the community, are incarcerated and held indefinitely in maximum-security prisons in the [Northern Territory] NT largely because there is no or no sufficient alternative provision and no services to effect crime prevention through health and welfare.⁸

4.7 The ADJC agreed, adding that:

prisons are not safe spaces for people with cognitive and psychiatric disabilities. Human rights breaches occur and people who remain unconvicted often languish in this centre with no exit pathway. It is a convenient place for governments to hide people away who have inconvenient circumstances who require intensive and expensive treatment, but does nothing to meet the legislative criteria that pertains to this group of people: that people are detained for the purposes of treatment in order to

5 Ms Alison Youssef, *Submission 73*, p. 6.

6 Royal Australian New Zealand College of Psychiatrists (RANZCP), *Submission 17*, pp 11–12.

7 ADJC, *Submission 76*, p. [3].

8 Criminal Lawyers Association of the Northern Territory, *Submission 18*, p. 3.

reduce their risk of harm to others and to keep the community safe and that this occurs in the least restrictive manner possible.⁹

4.8 Ms Amanda Muller of the Geraldton Resource Centre likened Mr Marlon Noble's indefinite detention as a forensic patient in a prison thousands of kilometres from his home of Geraldton to her own experience of leaving home to go to university. Both left the support networks of home, but for vastly different reasons:

I felt very isolated, very lonely, and that had quite an impact on me in terms of wanting to keep going and being able to make a go of that. Then I think about Marlon, who at a very similar age, as a teenager as well, got sent away from his home and his family. All those feelings that I experienced he would have experienced. But I was away for a positive reason; he was away because he had a disability. And I knew that I had to serve only five years; that was the length of time I had to do before I could return to my home and family. He had no idea how long he was going to be away. I was able to communicate on a regular basis with my family when I wanted to. There were four times a year when I was able to return home to them. He was not able to return home even when his mother went missing, and then when eventually she was found murdered his opportunity to return home for her funeral was with the embarrassment of being a prisoner and accompanied by a prison officer.¹⁰

4.9 In its submission, Barriers 2 Justice noted that 'forensic patients have complex psychiatric, medical and social needs that cannot be adequately addressed in a prison environment' adding that correctional officers often are not trained to provide support for forensic patients. This submission went further and noted:

Holding forensic patients in the unsuitable prison environment causes their condition to deteriorate. Those placed in the general prison population are also at risk of both physical and sexual assault. According to Dr John Brayley: 'People in prison on the James Nash [South Australia forensic hospital] waiting list can exhibit a combination of distress and bewilderment. Their situation is reminiscent of historical descriptions of 19th century mental hospitals before modern treatments developed.'¹¹

4.10 The committee has received evidence suggesting that not only do people on forensic orders lack access to therapeutic services, but that being in prison exposes them to substances and behaviours that result in further restriction and confinement. Ms Taryn Harvey of Developmental Disability WA highlighted the case of Jason who had been:

...denied his right to a leave of absence, as given to him by the Mentally Impaired Accused Review Board under the act, by virtue of the fact that he was in Acacia Prison. Acacia Prison does not do day releases, so for many,

9 ADJC, *Submission 76*, p. [4].

10 Ms Alison Muller, Principal Solicitor, Geraldton Resource Centre Inc., *Committee Hansard*, Perth, 19 September 2016, p. 22.

11 Barriers 2 Justice, *Submission 67*, pp 9–10.

many months he was denied that right—one of the very few rights that he has—because of the security rating that he was given. That rating had nothing to do with any [violent] pattern of behaviour or aggravated behaviour within prison. It was a long-standing issue around substance abuse, regarding substances that he was having ready access to in prison and substances that he was not getting any support with in prison to address. Also, be aware that in Western Australia we have no adapted drug and alcohol treatment programs for people who are living with impairments.¹²

4.11 Chapter 5 will discuss the inappropriateness of Corrective Services being responsible for the therapeutic and support needs of forensic patients. Two case studies of people with cognitive and/or psychiatric impairments held in prison under forensic orders are presented below in Box. 4.1

12 Ms Taryn Harvey, CEO, Developmental Disability WA, *Committee Hansard*, Perth, 19 September 2016, p. 23. See also: Barriers 2 Justice, *Submission 67*, p. 8.

Box 4.1—Inappropriateness of prison for people with cognitive and/or psychiatric impairments

CASE STUDY 1: Mr X

Mr X was arrested and taken to the Silverwater remand centre (NSW) in March 2001 after assaulting a friend during a psychotic episode. Despite his psychosis and long history of violent crime, he was placed in a cell with [an offender] who had requested protective custody. Mr X kicked [the other man] to death within 15 minutes and was later charged with murder.

Over the next three years, Mr X who had previously attempted suicide in prison, was kept in segregation cells at various jails. During this time he suffered severe psychotic symptoms (auditory hallucinations, suicidal urges and a belief his mind was under control of the Australian Security Intelligence Organisation (ASIO)), for which he received no hospital treatment. In letters from jail, Mr X said he felt he was being slowly tortured to death. Mr X's clinical notes show that psychiatrists and nursing staff at Goulburn jail repeatedly requested his transfer to Long Bay jail hospital. One nurse wrote personally to a senior bureaucrat in the Health Department to express his concern. Instead, Mr X was isolated to a cell in the jail's high-risk-management unit in early 2003. A departmental letter to his family claimed that the transfer would help manage his condition.

At a court hearing three months later, one psychiatrist testified that the impact of Mr X's schizophrenia had a detrimental impact on his wellbeing. Two other psychiatrists disagreed with each other over Mr X's mental state; one said Mr X's psychotic symptoms had dissolved completely because of medication, the other said he was only in minor remission and required long term care.

In March 2004, Mr X was found not guilty of murder by reason of mental illness. It was recommended he be placed under supervision of the Mental Health Review Tribunal. Nine weeks later, Mr X was found hanging in his segregation cell in the main jail at Long Bay. At the time of his death, Mr X was still on the waiting list for the hospital. The correction officers who discovered Mr X hanging from the bars of his cell did not immediately attend to him, or attempt resuscitation, as they feared that Mr X had faked his own hanging and helping him would put their safety at risk.

Mr X had sent his last letter to his mother three weeks before he died. He ended the letter with a scrawled: 'HELP ME'.

CASE STUDY 2: Patient X

Patient X was found not guilty of an offence by reason of mental incompetence and sentenced to a limiting term of 13 years. After spending seven months of his sentence at the main forensic facility, James Nash House, Patient X was transferred to Yatala Labour Prison where he was incarcerated for seven years.

In Yatala, almost all of Patient X's time was spent in solitary confinement. Solitary confinement, officially known as 'segregated custody', is when a prisoner is detained in isolation from all other prisoner in a segregated cell for all or nearly all of the day, with minimal environmental stimulation.

For the first two and a half years of his sentence, Patient X did not have access to psychiatric support. At one stage, he was placed in a very small dark cell, known by prisoners as the 'fridge'. Patient X was kept on handcuff regime in the cell, where he slept on a concrete slab. Patient X in this period also requested time out of G Division, to have time with others in B division. He also wanted to have time in the gym to work out, a privilege that is usually available to forensic patients (and can be available to prisoners.) Patient X was a forensic patient and should have had access to a clinical program available to any person who is in the custody, supervision and care of the Minister for Mental Health, whether he was in G Division at Yatala or any other location.

It is worthy of note that in the 2011 United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan Méndez stated that there should be a world-wide ban on the practice of prolonged solitary confinement except in very exceptional circumstances and for as short a time as possible, with an absolute prohibition in the case of juveniles and people with mental health issues.

Source: Barriers 2 Justice, *Submission 67*, pp 6 & 8.

Cognitive and/or psychiatric impairment in the general prison population

4.12 Although this inquiry is primarily focused on people subject to forensic orders, the committee is concerned more broadly with people with cognitive and/or psychiatric impairments who are in prison on regular custodial sentences. The Aboriginal Legal Service of WA provided an example of why prison is also inappropriate for many people with cognitive and/or psychiatric impairment:

...last year I acted for a young Aboriginal man from the south west of Western Australia. At 17 he was diagnosed, fortuitously, with a brain tumour. It was untreatable. He was operated on, but the tumour would grow back. Some of the sequelae of the condition were epileptic fits and visual and auditory hallucinations. During a drug fuelled psychotic episode he burnt down the family home because he was aggrieved by his sisters giving his mother alcohol. He then went on and committed some very serious further offences. He was sentenced to a term of immediate imprisonment.

He would talk to himself in jail. He would get on the roof of the jail when he was hallucinating. He would have epileptic fits. The prisoners he was with in his unit could not cope and nor could the guards. The response was to place him in solitary confinement. He is destined to spend many years in jail in solitary confinement by dint of his impairment—no wonder he was also suicidal.¹³

Committee view

4.13 The committee is extremely concerned about the inappropriate detention of forensic (custodial) patients in prison. The needs of this vulnerable group of people have not been met prior to their forensic or custodial order; equally, the committee is not convinced that the needs of this group have or will be met in a prison environment.

4.14 The committee is also concerned that legislative requirements to maintain and protect the safety of the community appear to far outweigh consideration given to the requirement to provide the least restrictive environment for a forensic patient. It is the committee's view that a more appropriate balance can be struck between these requirements that will deliver better outcomes for forensic patients.

4.15 The next section will discuss some of the issues with providing therapeutic services to people on forensic (custodial) orders held in prison.

Therapeutic and behavioural treatment options in prison

4.16 A number of submitters and witnesses discussed the general principle that where a person is detained because they have a cognitive or psychiatric impairment, then there is a corresponding obligation to provide that person with therapeutic treatment that condition requires. RANZCP submitted that:

13 Mr Peter Collins, Director, Aboriginal Legal Service of WA, *Committee Hansard*, Darwin, 25 October 2016, p. 16.

Curtailment of individual liberties should be matched by providing adequate interventions and resources to assist in rehabilitation/long term care.¹⁴

4.17 Associate Professor Dan Howard, a lecturer in forensic mental health at the University of New South Wales, submitted:

For a person found 'not guilty on the grounds of mental illness' to be detained in a prison is not acceptable by modern standards of clinical practice and human rights.¹⁵

4.18 Beyond a general principle of whether it is appropriate to accommodate people not found guilty of any offence in a prison, submitters stated that prisons were not an appropriate therapeutic environment for people with cognitive and/or psychiatric impairment. The Aboriginal Legal Service of Western Australia said that 'the services available for mentally impaired accused in prison (and for convicted prisoners with mental health issues) are seriously deficient.'¹⁶

4.19 In their submission, the Western Australian Association for Mental Health outlined a report which found that accommodating people in prisons has been found to have a detrimental impact on therapeutic outcomes:

The OICS [Office of the Inspector of Custodial Services] review of mentally impaired accused persons in 2014 found that people detained in prison were less likely to progress towards conditional or unconditional release than those in hospital.¹⁷

4.20 In its submission to the committee, the Northern Territory Government summarised the legislative approach to provision of therapeutic supports for forensic prisoners:

Part IIA of the Criminal Code contemplates rehabilitation of supervised persons and envisages a process of transition from Custodial to Non-Custodial Supervision Orders, and ultimately, unconditional release. The principle of least restriction in sections such as 43ZM permeates reporting and decision making under Part IIA, and significant efforts are made to ensure a Supervision Order is tailored and reviewed periodically so as to impose the least restriction practicable in the circumstances having regard to the resources available, and the risk profile and needs of the supervised person.¹⁸

4.21 The committee acknowledges that provision of therapeutic supports and a transitional pathway out of prison is the intent of the legislation and indeed of the government. However, this is not the experience of forensic prisoners detained in

14 Royal Australian New Zealand College of Psychiatrists (RANZCP) *Submission 17*, p. 4.

15 Associate Professor Dan Howard, *Submission 44*, p. 2.

16 Aboriginal Legal Service of Western Australia, *Submission 23a*, p. 3.

17 WAAMH, *Submission 27*, p. 12.

18 NT Government, *Submission 75*, p. 3.

prison. Mr Ian McKinlay, Spokesperson of the ADJC noted the resources being focused on a 'massive criminal justice infrastructure expansion' in the NT which is 'testimony to a continuing prison focused culture and unwillingness to build a community where all are accepted'.¹⁹

4.22 A significant impediment to the provision of therapeutic supports to forensic patients in prisons is that they are often not recognised as having different needs to the general prison population. In its submission to the committee, Barriers 2 Justice highlighted a common reaction of prison officers to forensic patients:

In speaking with a veteran officer, with many years of service at South Australia's Yatala Labour Prison, whom I have come to know fairly well, I expressed my dismay that a forensic patient would be held in solitary confinement in prison for so many years. His reaction was, "What is 'forensic'?" I explained that it was someone who had been found not guilty by reason of mental impairment and he asked, "If he's not guilty what is he doing here?" Unfortunately, his reaction was far from unusual. Many of the officers do not have any knowledge of what forensic means. And if some do know, I found out that the daily notes given to officers about the various prisoners never even stated that he (Patient X) was forensic. This explained why he was treated exactly as though he had been found guilty with no tolerance or understanding shown for his mental condition, (Antisocial and Narcissistic Personality Disorder with Psychopathy) including his Obsessive Compulsive Disorder, which caused him to ask for cleaning products and bin liners (often denied) because he had to have his cell spotless.²⁰

4.23 Another impediment to the therapeutic environment is where there is a blending of therapeutic objectives with the punitive nature of the corrections system. The two different objectives, one being to heal and the other being to punish and correct, have been described to the committee as often being in conflict. Mr David Woodroffe of the North Australian Aboriginal Justice Agency (NAAJA) described the original intent of the new Complex Behaviour Unit (CBU), which was constructed as part of the new Darwin Correctional Precinct.

One of the key things that is particularly concerning is the need to have this sort of facility. The original purpose of this facility was to be a health primary focus, but something that was adjacent to the prison rather than being in the prison, and primarily being run by health professionals rather than by corrections as part of the prison system. That is the primary concern.²¹

4.24 NAAJA has highlighted this 'as a significant lost opportunity', noting that the CBU is 'now within the razor wire and part of the prison'. There are no facilities for

19 Mr Ian McKinlay, Adult Guardian and Spokesperson, ADJC, *Committee Hansard*, Alice Springs, 26 October 2016, p. 19.

20 Barriers 2 Justice, *Submission 67*, pp 8–9.

21 Mr David Woodroffe, Principal Legal Officer, NAAJA, *Committee Hansard*, Alice Springs, 26 October 2016, p. 11.

forensic patients outside of a corrections environment in the NT.²² Although the NT Department of Health (Office of Disability) is involved in providing services to patients in the CBU, the CBU remains a facility operated by corrections officers. Delivery of therapeutic and support services for forensic patients is explored further in Chapter 5.

4.25 Despite these criticisms, submitters have noted that in the NT the 'bones of a functioning forensic system exist'.²³ The ADJC added:

This last point is one I wish to emphasise above all else: the barebones facilities that exist in the Northern Territory—with a proper expansion, with the proper clinical oversight and with the use of this behavioural support methodology—is totally capable of seeing all of those under current prison based supervision, after receiving initial behavioural support, transition to less restricted disability support, ideally within home communities and with family.²⁴

4.26 The next chapter explores in more detail how forensic pathways might be improved and lead to enhanced outcomes for people with cognitive and/or psychiatric impairment.

Site visits to correctional facilities

4.27 As part of this inquiry, the committee visited three facilities where forensic patients are held. Two such units, both in the Northern Territory, are located within corrections facilities. The Western Australian facility is a purpose built Disability Justice Centre, and is described in Chapter 5.

4.28 Following the committee's Darwin public hearing on 25 October 2015, the committee travelled to the Darwin Correctional Precinct (DCP) south of Darwin to conduct a site visit of the Complex Behaviour Unit (CBU) and the Step-Down Cottages. These facilities were opened in September 2015 and are described in box 4.2 below.

22 NAAJA, *Submission 60*, p. [7].

23 ADJC, *Submission 76*, p. [5].

24 Mr Ian McKinlay, Adult Guardian and Spokesperson, ADJC, *Committee Hansard*, Alice Springs, 26 October 2016, p. 19.

Box 4.2—Committee site visit to the Darwin Correctional Precinct and Complex Behaviour Unit**Complex Behaviour Unit**

At the time of the visit, there were thirteen people on custodial supervision orders (forensic orders) housed in the CBU, with four people having been transitioned to the step-down cottages.

The CBU currently accommodates male and female forensic patients placed on a custodial supervision order or prisoners with severe disabilities. A range of therapeutic treatment options, life skills, rehabilitation and recreational options tailored to individual needs, are provided in the CBU with the aim of providing a transition pathway to supported living in the community. The facility provides a range of low, medium and high dependency male and female accommodation, although the low security part of this centre is not able to be staffed at this time due to a lack of dedicated funding. Staff at the CBU provide reports to the Supreme Court for a person's annual review. Staff will also develop and implement transition and treatment plans for people subject to custodial supervision orders in the CBU.

The CBU is housed in a corrections environment (different to the WA Bennett Brook Disability Justice Centre which is operated by the WA Disability Services Commission) and is operated by the NT Department of Corrections with support from the NT Department of Health. The CBU is led by a Clinical Manager as opposed to a corrections officer to ensure that the CBU is primarily focused on therapeutic outcomes rather than feeling like a jail. A Senior Corrections Officer and a number of Corrections Officers support the Clinical Manager and a range of professional medical and disability staff to operate the CBU. These Corrections Officers have volunteered to work in the CBU, and seek to fulfil a wide range of disability support services in addition to their standard corrective officer duties. DCP described a "partnership between Corrective Officers and professional staff". DCP also acknowledged that the CBU is still only new and developing new operating procedures and continually working to improve and optimise performance of the CBU.

4.29 Similarly, forensic patients are also kept in the Alice Springs Correctional Centre (ASCC) and in a separate step-down facility run by the Department of Health, the Secure Care Facility (SCF). The committee's visit to the ASCC and SCF on 26 October 2016 is documented in Box 4.3.

Box 4.3—Committee site visit to the Alice Springs Correctional Centre – G Block (John Bens Unit)

The Alice Springs Correctional Centre (ASCC) is located 20 minutes' drive south-west of Alice Springs. At the time of the visit, there were two people on custodial supervision orders (forensic orders) housed in the ASCC in G Block (John Bens Unit). One of the people living in G-Block visits the SCF three to five times a week on day trips as part of his transition plan.

The John Bens Unit (Unit) is a repurposed part of the maximum security wing (G-block) of the ASCC, designed to cater for people on custodial supervision orders. The Unit is sectioned off from the rest of the maximum security prisoners as a means to protect vulnerable people on custodial supervision orders from bullying and being taken advantage of.

People placed in the Unit are provided with a transition and treatment plan developed and coordinated by ASCC in conjunction with the Office of Disability, the Adult Guardian and medical professionals. This report may be commented on by the Supreme Court at the annual review; however, the development and on-going review of these plans can commence prior to the annual review and continue to occur over the rest of the year without input or oversight by the Supreme Court. Typically, these plans will have five stages whereby a person is progressively given greater freedoms, introduced to the SCF (a few hours then expanding to day trips) and a gradual removal of correctional officer in the presence of positive behaviours. ASCC and SCF utilise opposing behavioural approaches and philosophies reflective of the underlying purpose of each department—ASCC is more disciplinary—"you do this; you lose that"; whereas the SCF focuses on rewards—"you can have whatever you want if you display good behaviour". ASCC noted the vast improvement in specific individual's behaviour when exposed to the SCF approach, with a noticeable decrease in violent behaviour, and improved impulse control and understanding of consequences that flow from actions. An example of positive behavioural change is that if good behaviour is displayed when travelling to and from day visits at the SCF, then this will result in future visits to the SCF. Positive behaviour results in progression through the stages and can ultimately result in complete transfer to the SCF from the ASCC; likewise regressive behaviour results in demotion through the stages within the plan.

During the committee's visit to G-Block, the committee was shown to the cell of one custodial supervision (forensic) patient (Prisoner B). Prisoner B's cell is cordoned off from a central courtyard used by other prisoners. Prisoner B is not allowed to access the courtyard when other inmates are present; and is generally not allowed to mingle with other inmates. When Prisoner B does use the courtyard to play basketball, the other inmates are told not to speak to Prisoner B in case they aggravate or unsettle him. Prisoner B spends much of his day isolated and alone in his cell.

The committee commends the hard work and dedication of the corrections officers and other support staff who work with Prisoner B. The committee acknowledges Prisoner B's extremely challenging and sometimes violent behaviour and commend the corrections officers and disability support staff of the SCF who facilitate Prisoner B's day-trips to the SCF. Notwithstanding this, the committee is firmly of the view that a maximum prison is not an acceptable place for a severely intellectually impaired man to be indefinitely detained.

Committee view

4.30 The committee notes there are limited options for therapeutic services and supports to be delivered to forensic patients within a prison environment. The committee acknowledges that there are practical considerations to support people with profoundly complex needs in prison, which include that correctional officers and their departments are generally not trained to support people with disability and there is limited funding within the corrections department to provide specialist disability supports and therapy.

4.31 In addition to the lack of therapeutic support, the committee is concerned that placement of people on forensic orders in prison unnecessarily exposes them to physical and sexual predation, and to extreme isolation—both within the prison and from the community. It is the committee's view that these two factors—lack of therapeutic support and exposure to a negative environment—lead to a regression in the behaviour of a person on forensic orders. So much so, that at the time of a regular review such regression ultimately leads to that forensic patient remaining in prison. It is the committee's strong view that in order to recalibrate this paradigm, forensic patients should not be held in prison.

Chapter 5

Pathways to supported living within the community

The main drivers of indefinite detention in the Northern Territory are the lack of a forensic mental health facility; the shortage of supported accommodation options and appropriate outreach support; and a lack of support for families and people with disability, particularly in remote Aboriginal communities.¹

Introduction

5.1 The preceding two chapters have examined the front-end of the justice system where people with cognitive and psychiatric impairment first interact with courts and the experiences of these people within the prison system.

5.2 This chapter examines pathways to supported living for forensic patients from when an order is handed down by a court; and also transition options for those currently being detained in prison.

5.3 As noted in Chapter 3, courts and review processes tend to err on the side of mitigating risk to the community at the expense of providing the least restrictive method of detaining a forensic patient. Evidence to this inquiry has shown that, too often, particularly in Western Australia (WA) and the Northern Territory (NT), the risk to the community becomes the paramount consideration resulting in people being indefinitely detained in prison. The Chief Justice of Western Australia shared his thoughts on risk management and the restrictions inherent in the *Criminal Law (Mentally Impaired Accused) Act 1996*.

If, as I suggest, the focus ought to be on risk management, then the problem is that, because of this diversion away from that system, risk is not being managed. There is just a short-term prison sentence or a fine that will never get paid and, no, the problem is not addressed. Whereas a properly designed system would identify people who need management and manage them in a way that would address risk and, hopefully, manage them in a way that is least invasive in the sense that it involves the least interference with their right to live a normal life within the community so that again, as we say throughout the system, custody ought to be an absolute last result. The problem is where you do not have any *middle ground*—it is either unconditional release or custody—you get to custody much quicker than you would if there were some opportunities in the middle.²

5.4 The committee is cognisant of the need for an appropriate balance to be struck between community safety and provision of the least restrictive environment for this vulnerable group. Notwithstanding this, the committee has earlier stated its view, in

1 NAAJA, *Submission 60*, p. [1].

2 Chief Justice Wayne Martin, *Committee Hansard*, Perth, 19 September 2016, p. 5. Italics and emphasis added.

Chapter 3, that prison is not an appropriate place for a forensic patient. So, if law reform which provides a middle ground for the judiciary is made available—consistent with the Chief Justice of WA's comments above—what are the alternative forensic pathways to prison and what are the pathways from prison to the community for forensic patients.

5.5 Previously, in this report, the committee has noted evidence from the Aboriginal Disability Justice Campaign that the 'bones of a functioning forensic system exist' in the NT. Arguably, the same could be said for WA. The committee has received evidence about and visited the Complex Behaviour Unit within the Darwin Correctional Precinct (DCP) (described in Chapter 4) and The Cottages adjacent to the prison (described later in this chapter); the Secure Care Facility (SCF) adjacent to the Alice Springs Correctional Centre (described later in this chapter); and the Bennett Brook Disability Justice Centre (DJC) in Perth (also described later in this chapter). This evidence and subsequent site visits have informed the committee's understanding of the transition pathways as they currently stand. These facilities—how they are structured, who operates them and where they are—and the subsequent lack of 'access to safe and affordable housing' in the community for forensic patients to transfer to is at the heart of why forensic patients are being indefinitely detained.³

5.6 The committee agrees that the 'bones' of a forensic system are present in the NT and WA, but that significant work remains to be undertaken to fashion these pathways and facilities into real supported living outcomes for people on forensic orders. This chapter looks broadly at some of the problems highlighted by submitters and puts forward the committee's views on the path forward, including:

- the failure to plan, including individual support plans, supported accommodation and the role of the National Disability Insurance Scheme (NDIS);
- the departments that are responsible for providing therapy and support for forensic patients;
- culturally appropriate care; and
- an early intervention approach.

Failure to plan

5.7 Submitters to this inquiry have described forensic patients held indefinitely in prison as resulting from a 'delay in developing, or a failure to develop' a plan for these patients. The failure to plan leads to 'custody by default'⁴ in the first instance, and then a lack of further planning can exacerbate the likelihood of extended indefinite custody. Mr David Woodroffe from the North Australian Aboriginal Justice Agency (NAAJA) explained:

3 Mr Daniel Clements, General Manager, Justice Programs, Jesuit Social Services, *Committee Hansard*, Melbourne, 29 April 2016, p. 6.

4 NAAJA, *Submission 60*, p. [7].

I can say that I think the failure to plan stems throughout, as they say, the journey of a mentally ill person in the Northern Territory—the failure to plan so that they do not go into the justice system and the failure to plan for having appropriate testing and identification, whether it is at the first one contact, such as interactions with the police and first interactions with the courts. It is the failure to plan for getting people out on bail, and the services and supports people need. Obviously, the ultimate and key issue now is the failure to plan for the regular reviews, as we are pushing for. You have strict limits that people have to plan for, but there should be a default position that a person will be released.⁵

5.8 Mr Woodroffe elaborated on this failure to plan in an answer to a question on notice to the committee:

It has been our experience that for 3 clients under custodial supervision orders that there still exists either a lack or inadequate committed long term planning in equipping suitable persons, family members or remote communities with the skills, supports and access to resources for clients to transition to their original home...

I can only recall one example of where there has been an escort visit of 1–2 days for a person to their home community.⁶

5.9 Ms Sally Sievers, the NT Community Visitor told the committee that transition planning for people held in the NT was not adequate to facilitate people to transition from the Secure Care Facility to the community:

What was really clear to us, as soon as we went in there, was this issue of transition planning. Secure care is not supposed to be the final place where all these people who go through it end up...

But it was really clear, even when we first went in, that the documentation that was being prepared and the positive behaviour support plans for these people had not identified that actually this is the start of their journey and our aim is to upskill them and they are to end up out in the community in the least restrictive environment that they possibly can. That concern has continued for the past three years during which we have reported on the secure care facility—that the documentation that is prepared and the therapeutic program that is provided to people is not skilling them up with enough clarity and purpose for them then to be released into supported accommodation in the community. That is an ongoing concern—that in fact this was never meant to be the final destination for people. And of the number of people who have gone through, only one has gone out into the community; one person has gone back into custody at the CBU [Complex Behaviour Unit] in Darwin.⁷

5 Mr David Woodroffe, Principal Legal Officer, North Australian Aboriginal Justice Agency, *Committee Hansard*, Alice Springs, 26 October 2016, p. 12.

6 Answer to Question on Notice No. 2, NAAJA.

7 Ms Sally Sievers, Principal Community Visitor, Northern Territory Anti-Discrimination Commission, *Committee Hansard*, Darwin, 25 October 2016, p. 9.

5.10 This section discusses deficiencies around planning and implementation in relation to individual support plans, the lack of supported accommodation, and the role of the NDIS for forensic patients.

Individual support plans

5.11 As noted earlier, the purpose of a behaviour support plan or individual support plan (ISP)⁸ is to provide treatment and support options to facilitate the transition of a forensic patient from prison (or a secure care facility) to supported living in the community. A key concern around this approach is that it is based to address psychiatric impairments which can improve with therapeutic intervention. Cognitive impairments do not respond to therapeutic intervention in the same manner, and such people will therefore never reach the recovery level required to transition to lower security accommodation options.⁹

5.12 In its submission to the committee, the NT Government noted that:

Treatment plans providing for clinical services and support are in place for all supervised persons who are subject to Supervision Orders. It is the overriding objective of treatment plans to rehabilitate all supervised persons safely to a less restrictive situation and ultimately to the community. It is acknowledged that some supervised persons are likely to remain on some form of supervision order for their lifetime, due to the complexities of their case.¹⁰

5.13 In WA, Dr Ron Chalmers of the Disability Services Commission noted that the Bennett Brook DJC utilises a 'flow-through model, so from the day that someone is placed in the centre, we start working to get them out of the centre'.¹¹

5.14 Despite this intent, the committee has received evidence suggesting that ISP's are not working for forensic patients who are indefinitely detained in prison. Mr Russell Goldflam, President of the Criminal Lawyers Association of the NT noted that:

Individual care plans are in use in the Northern Territory with persons on supervised orders—both custodial and non-custodial—but often they appear to be more in the nature of a tick-a-box form filling exercise than an effective tool to manage the rehabilitation and care and supervision of the client.¹²

8 An ISP can be referred interchangeably as an individual support plan, behaviour support plan, or individual care plan.

9 RANZCP, *Submission 17*, p. 8.

10 NT Government, *Submission 75*, p. 4.

11 Dr Ron Chalmers, Director-General, WA Disability Services Commission, *Committee Hansard*, Perth, 19 September 2016, p. 46.

12 Mr Russell Goldflam, President, Criminal Lawyers Association of the NT, *Committee Hansard*, Alice Springs, 26 October 2016, p. 2.

5.15 The committee received evidence that individual (behaviour) support plans do not work where a forensic patient is detained in prison, because of the overlap between different departments—primarily disability and corrections—with vastly different philosophies and approaches to people within their care. Patrick McGee, Convenor of the Aboriginal Disability Justice Campaign submitted an example of the breakdown in the implementation of an ISP:

It was a really good behaviour support plan that did everything that it should have done, but there are a couple of things about that. Firstly, the disability system constructed the plan, but it was completely and utterly overridden at any time by the wishes and the policy requirements and the resource issues of the department of corrections. One of those issues was the management of his behaviour and the use of restraint. It is hit and miss in that you can have a system that does not work very well but then allows for these spontaneous and individualised moments where something great happens, or you can have a system that is supposed to work but is not properly resourced, so you do not get the sustained outcomes that these people need.¹³

5.16 Mr Patrick McGee, also noted that there is confusion about who is resourced and responsible for delivering aspects of an ISP for forensic patients held in prison:

It is hard at the moment because the assumption from the department of corrections is that Disability will provide this support and the assumption from Disability is, of course, that Corrections will provide the support. At the end of the day it has always been Disability that has been called upon by the courts, by Corrections, by the prisons, to provide whatever support is needed whilst the person is in prison. I think probably Victoria has gone beyond that somewhat, but most of the states and territories do not. So it is individualised, not systemic; the outcomes do not seem to be learned from and drawn upon in terms of understanding what else to do, and there are no connections between the various different parts of the system that might play a part in getting those programs and activities and supports into the prison in a regular way that leads to sustained outcomes.¹⁴

5.17 The NT Community Visitor Program (CVP) highlighted that leadership or responsibility paralysis can even occur within departments:

The CVP has observed that clients receiving services from different areas of the Department of Health can find themselves in a position where there are no clear lines of responsibility or leadership for resolving their community accommodation needs. In one instance, a young person with a cognitive and psychiatric impairment has been detained for a number of years in a mental health facility while these issues remain unresolved. The mental health and disability needs of this client are such that release from involuntary detention poses unacceptable risks, however the discharge destination with

13 Mr Patrick McGee, Convenor, ADJC, *Committee Hansard*, Brisbane, 23 March 2016, pp 36–37.

14 Mr Patrick McGee, Convenor, ADJC, *Committee Hansard*, Brisbane, 23 March 2016, pp 36–37.

appropriate support cannot be agreed by all relevant agencies involved in this care.¹⁵

5.18 In WA, the committee received evidence from Ms Chelsea McKinney, Manager from WA Association for Mental Health, that some of these barriers are being broken down, with the WA Disability Services Commission providing a more active role in delivering services in prisons:

There have historically been many problems with people being provided with treatment from or support from any agency other than the Department of Corrective Services. In recent years, that has improved with the Disability Services Commission coming to the party. Their hand was kind of forced.¹⁶

5.19 Unfortunately though, where individual support plans do exist, many are not working—that is, not facilitating transition to the community—due to an absence of clear objectives with a specific target of providing the support people need to transition to less secure accommodation, as opposed to a generalised risk assessment approach. Ms Felicity Gerry noted:

That is exactly what I was trying to say about general health care. The through plan is part of that. If the long-term goal is to get somebody out and living independently in the community then you have to work towards a plan for enabling that to happen. Currently that does not happen. The question is, 'Do we still keep this person here?' rather than, 'How do we make sure that this person can live independently in the community?'¹⁷

Committee view

5.20 Individual support plans form a critical element of transitioning forensic patients from prison (or secure care) to living in supported accommodation in the community. The committee acknowledges that such plans are being developed for most forensic patients; however, questions some of the fundamental components that underpin these individual support plans.

5.21 The committee notes that all ISP's should be predicated on the clear objective of transitioning a forensic patient to supported living in the community, or from prison to secure care. Clear lines of responsibility for the different departments must be underscored within the ISP, so it is clear how services and supports will be delivered, particularly where the lines of responsibility can be blurred such as between corrective services and disability services. The committee's view on which department is best placed to care for forensic patients is outlined later in this chapter.

15 NTCVP, *Submission 24*, p. 4.

16 Ms Chelsea McKinney, Manager, Systemic Advocacy, WA Association for Mental Health, *Committee Hansard*, Perth, 19 September 2016, p. 38.

17 Ms Felicity Gerry QC, Vice-President, Criminal Lawyers Association of the Northern Territory (CLANT), *Committee Hansard*, Alice Springs, 26 October 2016, p. 5.

Lack of supported accommodation

5.22 Many submitters and witnesses have highlighted the shortage of supported accommodation as a critical impediment to ending the indefinite detention of forensic patients within the prison system.¹⁸ The Principal Community Visitor for the NT submitted to the committee that:

We have a real dearth in the Northern Territory of supported accommodation options. This has been an issue of concern for the Community Visitor Program for the decade before secure care came online. They monitored mental health facilities. It has always been a problem that there has been no step-down facility for people in mental health facilities, so people stay in secure settings for much longer than what is necessary. What has become even more obvious with secure care is that they are in secure care and the planning for them to move into the community becomes stuck by the fact that there are actually no supported accommodation options.¹⁹

5.23 In an answer to a question on notice, NAAJA pointed out that in the NT:

a court cannot commit a person to an 'appropriate place' (or provide for a person to receive treatment or services in 'an appropriate place') unless the court has received certificate from the CEO (Department of Health) stating that facilities or services are available in that place for the custody, care or treatment for that person.²⁰

5.24 The committee understands that Golden Glow Nursing is the only non-government provider of supported accommodation for forensic patients in the NT. Ms Maureen Schaffer, Director of Golden Glow Nursing noted that there is a significant waiting list to enter their programs due to a lack of infrastructure. In many cases, forensic patients with more complex needs are the ones who are being denied placements.

We have a bit of a waiting list for clients. They are always phoning us—especially from Cowdy Ward—to see if we have got any beds. There are some clients that we have not been able to accept, because they cannot fit in with the clients that we have got. If we had a different infrastructure available, they could go there, but, at the moment, it just will not work. They have been out on trial and for some reason they are the wrong skin group, they do not like each other to start with, they already know they do not like each other or something has happened in the past and they remember that. Other times, if they sit down and share a smoke, we know it is going to be okay. They will talk and give permission for that person to

18 See: Mr David Woodroffe, Principal Legal Officer, NAAJA, *Committee Hansard*, Alice Springs, 26 October 2016, p. 9; Mr Russell Goldflam, President, CLANT, *Committee Hansard*, Alice Springs, 26 October 2016, p. 5; NT Community Visitor Program, *Submission 24*, p. 3.

19 Ms Sally Sievers, NT Principal Community Visitor, *Committee Hansard*, Darwin, 25 October 2016, pp 9–10.

20 *Answer to Question on Notice No. 1*, NAAJA.

come and live with them for a while—until things go pear-shaped a little bit.²¹

5.25 The lack of supported accommodation options is driven in part by state governments that are not planning for the needs of forensic patients. The Principal Visitor (NT) recommended that an audit be undertaken to assist with infrastructure needs and planning:

I would be asking for an audit of needs in the Northern Territory for supported accommodation, both for people who are in the mental health facilities and for people who are in secure care facilities.²²

5.26 Golden Glow Nursing highlighted the need for a range of supported accommodation options in the community, noting that in some cases, the conversion of residential homes for this purpose may be more appropriate and cost-effective than purpose building large institutional infrastructures:

I think what Maureen is bringing out as well is that [Golden Glow Nursing] actually purchase homes in the community, so people are coming to a home. I have visited them and they are actually a home environment. If you could purchase more homes rather than build a facility like a Cowdy Ward—it makes more sense to have more homes based in the suburbs; most of the neighbours would not even know, because the home is maintained like any other normal home—that would be the way to go.²³

5.27 The committee also received evidence at its Brisbane hearing which highlighted the need for specialist secure supported accommodation options for people with complex needs such as those with Foetal Alcohol Spectrum Disorders (FASD). Mrs Elizabeth Russell noted the need for:

supported accommodation staffed by people who have accredited training in FASD. Clearly there is a high need for secure supported accommodation suitable for high-risk individuals who are unable to live independently.²⁴

5.28 Professor Patrick Keyzer of La Trobe University said that state governments have an obligation to ensure that forensic patients have 'reasonable access to a secure care facility or other supported accommodation and care and treatment'.²⁵ The ADJC agreed and recommended the need for 'accommodation and support programs both as an alternative to prison and post-release'. The ADJC cited the specialist forensic

21 Ms Maureen Schaffer, Director, Golden Glow Nursing, *Committee Hansard*, Darwin, 25 October 2016, p. 20.

22 Ms Sally Sievers, Principal Community Visitor—NT, *Committee Hansard*, Darwin, 25 October 2016, pp 9–10.

23 Ms Vanessa Harris, Executive Officer, Northern Territory Mental Health Coalition, *Committee Hansard*, Darwin, 25 October 2016, p. 21.

24 Mrs Elizabeth Russell, Chief Executive Officer, Russell Family Fetal Alcohol Disorders Association, *Committee Hansard*, Brisbane, 23 March 2016, p. 22.

25 Professor Patrick Keyzer, Head of School and Chair of Law and Public Policy, La Trobe Law School, La Trobe University, *Committee Hansard*, Melbourne, 29 April 2016, p. 29.

accommodation services utilised in Victoria and NSW as being a practical alternative to prison.²⁶

Lack of dedicated facilities for women

5.29 The committee received conflicting evidence about the availability of non-prison secure forensic care options for female forensic patients in the NT. Ms Schaffer of Golden Glow Nursing explained some of the complexities of mixed sex housing in forensic units:

we have had experiences with a female requiring support in the community, and there is absolutely no way it would be appropriate for her to mix with males at all. There are a lot issues behind that, and if you want to go further we can certainly go into it. But it is just not an appropriate thing for someone with mental illness, cognitive impairment and all the social implications that go along to be in a mixed-sex facility.²⁷

5.30 The NT Community Visitor noted that the lack of appropriate facilities for women forensic patients actually resulted in prison placement.²⁸ Ms Schaffer also noted that 'there is nothing available for women in the community', citing an example of a recent failed trial:

We did have one lady that came out on a trial into a separate unit by herself. She kept absconding, and it did not really work.²⁹

5.31 Mr Richard Champion, Acting General Manager at the NT Department of Health (Office of Disability) acknowledged that positions in forensic facilities largely favoured males due to their configuration, but contended that the department made other provisions for females:

It is the case that the provision is predominantly for males and most of the referrals that we do get are males, but we acknowledge that there are females out there who require the support, and we have had that issue in the past. When that has arisen, in the absence of a female-dedicated facility, we have spot purchased. We have purchased a facility, a house, somewhere where we can provide that service and we have commissioned staff in that facility to support the females. So, we have not left women without the service where it has been required.³⁰

26 ADJC, *Submission 76*, p. [3].

27 Ms Maureen Schaffer, Director, Golden Glow Nursing, *Committee Hansard*, Darwin, 25 October 2016, p. 17.

28 Ms Sally Sievers, Principal Community Visitor, Northern Territory Ant-Discrimination Commission, *Committee Hansard*, Darwin, 25 October 2016, p. 14.

29 Ms Maureen Schaffer, Director, Golden Glow Nursing, *Committee Hansard*, Darwin, 25 October 2016, p. 21.

30 Mr Richard Champion, Acting General Manager, Top End Mental Health Services and Alcohol and Other Drugs Services, Department of Health, Northern Territory, *Committee Hansard*, Darwin, 25 October 2016, p. 28. See also: *Answer to Question on Notice No. 5*, NT Government.

5.32 When questioned, Mr David Woodroofe of NAAJA did not know about any properties that the department has bought in the community.³¹

5.33 The committee is concerned at the lack of secure care and community options in general, and particularly for female forensic patients.

Underutilisation of secure care facilities

5.34 A common theme heard in WA and the NT was about the underutilisation of new secure care facilities. The Principal Community Visitor for the NT, Ms Sally Sievers noted that the Alice Springs Secure Care Facility is currently underutilised.³² Professor Neil Morgan, the Inspector of Custodial Services agreed, making the point that the WA Government has focused on using the Bennett Brook DJC as a pre-release centre rather than as a diversion option for new forensic patients.

You have talked about the Bennett Brook facility. I agree with everything that was said this morning. It has not been used for many people, to date. It was really designed as a prerelease facility, so we are always going to have this issue with people who are being detained in prison prior to being able to access that place.³³

Committee view

5.35 It is clear that where no supported accommodation placements exist, a person cannot be transitioned from prison or secure care to a less restrictive environment in the community. The committee is concerned that there is a lack of facilities that provide supported accommodation in the community.

5.36 The committee recognises that the Complex Behaviour Unit and the Bennett Brook DJC have only recently been opened late last year and acknowledges that there are a range of practical considerations in the commissioning of new facilities that result in initial underutilisation. The committee also understands, as noted in Box 5.1, that the Alice Springs Correctional Centre has been established as a transition centre, and as such, numbers will fluctuate as people progress into and out of the centre. Notwithstanding this, since the opening of the Complex Behaviour Unit and the Bennett Brook DJC, there still remain a large number of forensic patients in prison in WA and NT. It is the committee's view that where vacancies exist in secure care facilities that forensic patients are either transitioned from prison as a priority or new forensic patients are simply diverted directly to these facilities.

5.37 There is a need for additional resources to be made available to build or acquire supported accommodation options for forensic patients in the community,

31 Mr David Woodroofe, Principal Legal Officer, NAAJA, *Committee Hansard*, Alice Springs, 26 October 2016, p. 12.

32 Ms Sally Sievers, Principal Community Visitor, Northern Territory Anti-Discrimination Commission, *Committee Hansard*, Darwin, 25 October 2016, p. 14.

33 Professor Neil Morgan, Inspector of Custodial Services, *Committee Hansard*, Perth, 19 September 2016, p. 10.

particularly in regional and remote locations. Later in this chapter, the issue of culturally appropriate care and placements will be dealt with in more detail.

Box 5.1—Committee site visit to the Alice Springs Secure Care Facility

Introduction

At the conclusion of its visit to the Alice Springs Correctional Centre (ASCC) (as described in Chapter 4), the committee visited to the Secure Care Facility (SCF), a facility operated by the Department of Health (Office of Disability). The SCF supports people who have transitioned from the ASCC on custodial supervision orders. The committee was welcomed by the staff and residents of the SCF, and provided with a short briefing and tour of the facility.

At the time of the visit, there were two people on custodial supervision orders (forensic orders) housed in the ASCC in G Block (John Bens Unit). G Block is a section of the ASCC repurposed to house people on custodial supervision orders. Seven people are currently being supported by the SCF. Six of those people live permanently in the SCF after being transitioned from the ASCC. One of the people living in G-Block visits the SCF three to five times a week on day trips as part of his transition plan. Four of the people living in the SCF are being prepared to transition into supported accommodation in the community.



Figure 1.1: A view of an outside courtyard within the SCF

Transition to the Secure Care Facility

The Secure Care Facility (SCF) is located adjacent to the ASCC and is operated by the Office of Disability. The SCF provides secure, supported accommodation for people subject to custodial supervision orders. As noted previously, transition to the SCF commences once a person has a transition and treatment plan in place. Subject to certain criteria being met, primarily management of violent behaviours, a person may commence being introduced to the SCF. Depending on the level of cognitive functioning, the starting point for transition may range from a person being shown photos of the facility and told a story about it to spending a few hours in the SCF, then extending to day trips. Transition is conducted at a pace commensurate with the person's capacity to process changes in their physical and social environment. Subject to the transition process being successful, a person could be expected to move into and live in the SCF. It is expected that people can over time then be expected to move into and live in supported accommodation in the community.

Despite being a secure facility, the SCF is a home-like environment, with televisions, computer access, communal areas (outdoor and indoor), kitchen and private individual rooms. Access to vehicles and the capacity to undertake chaperoned community visits is provided on a daily basis. Freedom of movement is generally not constrained. Disability Support Workers (DSW) provide day-to-day support in the SCF at a ratio of two workers to one patient. DSW work closely with patients to meet the objectives of their plans; whilst access to medical professionals is also provided.

Role of the NDIS

5.38 The committee has received some evidence suggesting that prisoners or people in prisons are not eligible for support under the NDIS. At the Canberra hearing,

the Department of Social Services noted that people deemed eligible for the NDIS before entering prison remain eligible for some supports and services such as aids and equipment after entering prison. However, in presenting evidence to the committee, the department did not provide clarity on whether 'allied health and other therapy directly related to their disability...including for challenging behaviours' is provided for under the NDIS or becomes the responsibility for the relevant corrective services department. Furthermore, it was not made clear to the committee by the department whether someone not evaluated for the NDIS prior to entering prison may seek an eligibility assessment (and be approved) for the NDIS after entering the prison system.³⁴ This is particularly concerning in light of evidence received and examined in Chapter 4 regarding the lack of diagnosis and therapeutic support options available within prisons.

5.39 The NSW Council for Intellectual Disability has noted that:

The NDIS provides an opportunity to provide reasonable and necessary disability support to people with criminal justice involvement. This will only occur if there are strong outreach, engagement and linking systems to support individuals into the NDIS.³⁵

5.40 In its submission, NSW Council of Intellectual Disability described the Community Justice Program (CJP) trial being operated in the Hunter Valley in NSW. This trial seeks to provide 'a small number of offenders with intellectual disability' with 'disability support for the first time through funded packages'. Although this trial was commended for utilising 'best practice' to 'support some of its clients to see the potential benefit of accessing the NDIS, go through the NDIS processes and achieve positive participant plans', only three people had been placed by April 2016. The Barwon trial site in Victoria was highlighted as having worked better due to working with 'a long-standing "justice plan" arrangement between Victorian justice and disability agencies'.³⁶

5.41 In November 2016, in an answer to a question on notice, the Department of Social Services provided a brief summary of the CJP's progress and indicated slightly higher participation rate, but still only half the expected number:

In February 2015, FACS [NSW Family and Community Services], CJP and the National Disability Insurance Agency (NDIA) agreed to utilise the CJP as a pilot to oversee the transition of CJP clients into the NDIS during the Hunter Trial. Two providers were identified to provide support for 20 people who were due to transition to the NDIS. Ten of those people achieved an approved plan during the pilot.³⁷

34 Mr James Christian (Group Manager) & Mr John Riley (Branch Manager), Department of Social Services, *Committee Hansard*, Canberra, 8 November 2016, pp 19–20. See also: *Answer to Question on Notice No. 9*, Department of Social Services.

35 NSW Council for Intellectual Disability, *Submission 40*, p. 2.

36 NSW Council of Intellectual Disability, *Submission 40*, pp 6–7.

37 *Answer to Question on Notice No. 6*, Department of Social Services.

5.42 There are other concerns more generally with the NDIS. The committee heard evidence from Developmental Disability WA that there are groups of people with mild intellectual disabilities who may not be eligible for the NDIS, but who still require supports:

The National Disability Insurance Scheme offers lots of opportunities if we can get ways of modelling that interface right and if we can get over the usual argy-bargy of who pays for what where. I also have concerns though, based on the huge amount of work we are doing at the moment to support people who are caring for people with fetal alcohol spectrum disorder, that the reality is that there are a whole lot of people who we are talking about who would not be eligible for the NDIS. This idea that the NDIS is going to give full access to support pathways for people with spectrum conditions like FASD is simply not realistic, so we need to make sure that those people who are at the margins of eligibility for schemes like the NDIS are being supported.³⁸

5.43 The committee has also heard concern in this inquiry regarding the withdrawal of state governments' disability services as the NDIS is being rolled out. There are concerns about forensic patients, and other people with disability more generally, falling through the cracks during this process. The NSW Government was cited as an example by the NSW Council on Intellectual Disability:

In parallel with the implementation of the NDIS in New South Wales, the New South Wales government is exiting from service...³⁹

5.44 In response, the Department of Social Services noted that:

Prior to the full nationwide implementation of the National Disability Insurance Scheme (NDIS) under the National Disability Agreement, state and territory governments remain responsible for non-NDIS trial site disability services in their respective jurisdictions, including but not limited to the provision of supported accommodation, respite, community access and community support services.⁴⁰

Committee view

5.45 The committee agrees with evidence that the NDIS could provide significant disability support for people with cognitive and psychiatric impairment in the prison system. The committee is concerned with the conflicting evidence it has received regarding eligibility and access to supports through the NDIS for people held in prisons. Noting not only the cognitive and/or psychiatric impairments of forensic patients, but the prevalence of these disabilities in the general prison population, there is a need to better understand how the NDIS will interface with people held in prison.

38 Ms Taryn Harvey, CEO, Developmental Disability WA, *Committee Hansard*, Perth, 19 September 2016, p. 23.

39 Mr Jim Simpson, Senior Advocate, NSW Council on Intellectual Disability, *Committee Hansard*, Canberra, 8 November 2016, p. 2.

40 *Answer to Question on Notice No. 2*, Department of Social Services.

The responsible department

5.46 There are different operating arrangements for the secure treatment facilities in the NT and WA. For instance, in WA, the declared place, the Bennett Brook DJC is operated by the WA Disability Services Commission. Likewise, in the NT, the SCF and The Cottages, despite being located adjacent to the DCP are also operated by the NT Department of Health (Office of Disability). The primary facility in the NT for forensic patients, the Complex Behaviour Unit is managed by the NT Correctional Services, with the support of officers and medical professionals from the Department of Health (Office of Disability).

5.47 The previous chapter has noted some of the negative aspects of placing forensic patients in a prison environment. The committee also notes that the Complex Behaviour Unit, when originally conceived was to be outside the perimeter of the prison and operated by the NT Department of Health (Office of Disability). Later design plans incorporated the Complex Behaviour Unit 'within the razor wire' and made it 'part of the prison'.⁴¹ The committee has visited the Complex Behaviour Unit, and recognises and commends the hard work and dedication of corrections officers assigned to the Complex Behaviour Unit.

5.48 The committee acknowledges that the Complex Behaviour Unit is also used to provide support for regular custodial prisoners who have mental health or cognitive issues. Notwithstanding this, there is a requirement for 'a forensic mental health facility which can provide specialist therapeutic care' outside a prison environment in the NT.⁴²

5.49 After its Darwin public hearing, the committee visited the DCP. Part of this visit was to The Cottages. Transition to The Cottages from the Complex Behaviour Unit is an option for those who demonstrate improved behaviour in accordance with their treatment and transition plan and who are also deemed a low risk to the community. The Cottages provide an intermediate form of accommodated support between a secure location such as a prison, and living in the community with no restrictions and limited supports. The Cottages are operated by the Department of Health (Office of Disability). The objective of The Cottages is to provide a supported accommodation model that allows a person to learn or re-establish a range of life skills before potentially being transitioned into the community into a supported living arrangement. The committee's visit to the Bennett Brook DJC is documented in Box 5.2. The Bennett Brook DJC has similar objectives and is operated by the Disability Services Commission rather than Corrective Services.

5.50 In NSW, the Justice Health and Forensic Mental Health Network 'provides health services to those in contact with the forensic mental health system and the NSW criminal justice system'.⁴³ This Network is directly responsible to the Secretary

41 NAAJA, *Submission 60*, p. [7].

42 NAAJA, *Submission 60*, p. [7].

43 See: NSW Health, [About Justice Health & Forensic Mental Health Network](#).

of NSW Health. Similar arrangements apply in other states such as Victoria and South Australia.⁴⁴

Committee view

5.51 Consistent with the committee's view in Chapter 3 and 4 that prison is not a suitable place for forensic patients to be held, the committee also considers that secure care facilities—such as the Complex Behaviour Unit—should be operated by the relevant disability department rather than corrective services. It is the committee's view that a therapeutic approach, rather than punitive, is more likely to lead to behavioural improvements which are consistent with a reduction of risk that will ultimately lead to less restrictive accommodation options for forensic patients.

44 See: Victorian Government, *Forensicare*, <http://www.forensicare.vic.gov.au/> (accessed 25 November 2016); SA Health, *Forensic mental health*, www.sahealth.sa.gov.au, (accessed 25 November 2016).

Box 5.2—Committee site visit to the Bennett Brook Disability Justice Centre

Introduction

Following the public hearing in Perth on 19 September 2016, the committee visited the Bennett Brook Disability Justice Centre (DJC) in the Swan region of Perth. The committee was welcomed to the DJC and provided with a tour by Ms Myra Parry, Manager of Disability Justice Services and staff of the DJC.

Until late last year, one of the reasons that people subject to forensic orders were being indefinitely detained in WA prisons was the lack of a 'declared place' or a DJC—a secure alternative to prison where therapeutic and other support services can be provided. This has now been partially rectified with the construction of the state's first declared place, a ten bed facility. The DJC is operated by the WA Disability Services Commission (DSC).

Description of the facility

This purpose-built secure facility consists of a ring of buildings built around a central courtyard with paths, basketball court, vegetables gardens and shared social spaces including a firepit. The buildings surrounding this area consist of apartments where the residents live, a common amenities area with kitchen, laundry, lounge room, games facilities and computers; a workshop with woodworking tools; and an administrative area with observation rooms, meeting rooms, medical rooms and staff offices.



Figure 1.1: An aerial view of the DJC at Caversham showing the buildings situated around a central courtyard; and view across the central courtyard area to the administrative and activities buildings

Placements in the facility

Placements in the DJC are limited to people with cognitive impairments subject to custody or forensic orders. Placement can only be recommended by the Mentally Impaired Accused Review Board (MIARB). Residents are selected on the basis that they will be suitable to transition to live in the community. Similarly, any leave of absence or separation from the DJC can only be approved by the MIARB.

Support provided in the DJC and pathways to the community

DJC staff and external private service providers support residents to live independent, positive and purposeful lives in the centre and in the community on leave of absence. Leaves of absence are an opportunity for residents to spend extended periods of time living in the community. Residents are transitioned to independently live and manage their own home (e.g. cooking meals, washing, cleaning) and engage in social activities with positive friends and acquaintances. A staged and supported transition back to the community ensures that this transition to the community is sustainable for that individual in the longer term.

Progress so far

Since the DJC's opening late last year, two residents have successfully transitioned back into the community; two residents currently live in the DJC; and three prospective residents are being considered for placement. In evidence to the committee, the DSC suggested that the centre will be close to full capacity by the end of this year. During the tour, committee members were able to meet with two current residents. DJC staff noted that there had been a vast improvement in the social interactions and functioning of the residents since moving to live in the DJC.

Culturally appropriate care

5.52 The committee has received evidence that there needs to be greater involvement of Aboriginal and Torres Strait Islander support workers in the journey of Aboriginal and Torres Strait Islander peoples subject to forensic orders. The Aboriginal Disability Justice Campaign (ADJC) noted its concern about the 'lack of culturally responsive service systems' for Aboriginal and Torres Strait Islander peoples.⁴⁵ The Aboriginal Legal Service of Western Australia outlined why culturally appropriate care is important.

...if things are going to improve there needs to be a greater involvement of Aboriginal people in helping these people. If you get blackfellas involved—ideally where people are on country, but where they are surrounded by people from their own community who they trust and who they have a rapport with—that is a hope for the future. So often what I find in my job at the ALS is if you have non-Aboriginal people dealing with these people things go off the rails in a heartbeat. We are continually confronted with pre-sentence reports done on these people and other clients—psychological reports—which are indescribably damning about the client and very seriously adversely affect their prospects in terms of the disposition that a court may impose.⁴⁶

5.53 A lack of rapport and cultural understanding between Aboriginal and Torres Strait Islander peoples and non-indigenous support workers often results in extended detention and a person's underlying disability remaining undiagnosed. Mr Peter Collins, Director at the Aboriginal Legal Aid Service of Western Australia (ALSWA):

On the boy that I acted for between the ages of 10 and 18 from the East Kimberley, the reports would routinely come back in terms of him being defiant, uncooperative, unwilling to listen—all of those things. Well, he had [Foetal Alcohol Spectrum Disorders] FASD. But, in terms of the compilation of those sorts of reports, the issue is there is no rapport established, there are often language difficulties, and Aboriginal interpreters are never used to assist in the compilation of these reports, so these people are at cross-purposes absolutely with the clients, and then it dovetails further down the track. So I am very strongly of the view and very passionate about the need for the involvement of Aboriginal people in assisting, assessing and so on with these people—in a culturally appropriate way, obviously.⁴⁷

5.54 Mr David Woodroffe from the North Australian Aboriginal Justice Agency noted the issue of cultural and language communication issues were brought up in Alice Springs. The demand for culturally appropriate signing supports is simply not being met.

45 Aboriginal Disability Justice Campaign, *Submission 76*, p. [3].

46 Mr Peter Collins, Director, ALSWA, *Committee Hansard*, Perth, 19 September 2016, p. 17.

47 Mr Peter Collins, Director, ALSWA, *Committee Hansard*, Perth, 19 September 2016, p. 17.

That has been a key learning thing for our organisation. NAAJA itself literally today in Oenpelli is working with an Auslan interpreter on assessing a person and establishing communication and obtaining obstructions. NAAJA has also worked with cognitive impairment and also deafness where one of the key gaps in the Northern Territory with Auslan is the fact of Aboriginal signing and community signing. There are 55 signing languages in Australia and in the Northern Territory there eight key groups. You can have community signing and individual or family signing so one of the key gaps in the service in the Northern Territory has been relay signing or and Aboriginal cultural broker signing. I can recall a most fascinating and powerful case where we had a person with hearing loss and also with cognitive issues. A family member from their community was signing and assisting, we had Ms Jodie Barney, who was the Aboriginal relay interpreter, and then we had an Auslan interpreter so we had in fact three people involved. That can be the level of complexity that an individual person has so obviously they are very resource intensive proceedings but sometimes it is imperative that you go to that level. It is clear that we do not have the level of support to the lengths we wish we could have in servicing remote regions in particular.⁴⁸

5.55 NAAJA also noted that the:

Northern Territory could and should be taking a lead—for example, by developing NT Indigenous-specific cognitive tests; or culturally relevant materials for psycho-education. It is also important for such materials to be developed given the very high staff turnover experienced by many professions in the NT, including health.⁴⁹

5.56 Mr Joseph Knuth of Danila Dilba Health Service was quite direct in his advice to the committee:

The only way you are going to fix the cultural understanding is actually employ Indigenous people to be in those positions. Give them the skill sets to be able to do it.⁵⁰

Pathways to country

5.57 The committee has heard evidence about the locations of secure care facilities such as the Bennett Brook DJC. Although there were mixed opinions on facilities such as the Bennett Brook DJC, many witnesses agreed that the establishment of the state's first declared place is a step in the right direction in WA.⁵¹ As a first step, the establishment of the Bennett Brook DJC in the Perth metropolitan area makes sense;

48 Mr David Woodroffe, Principal Legal Officer, NAAJA, *Committee Hansard*, Alice Springs, 26 October 2016, pp 12–13.

49 NAAJA, *Submission 60*, p. [10].

50 Mr Joseph Knuth, Acting Head of Programs, Danila Dilba Health Service, *Committee Hansard*, Darwin, 25 October 2016, p. 21.

51 Chief Justice Wayne Martin, *Committee Hansard*, Perth, 19 September 2016, p. 2. See also: Professor Neil Morgan, Inspector of Custodial Services, Office of the Inspector of Custodial Services, *Committee Hansard*, Perth, 19 September 2016, p. 12.

however, greater consideration needs to be given to where the next declared place will be. The WA Inspector of Custodial Services observed the following about geographical demand for placements:

I also have a fundamental problem, and it is this: the declared place that we have set up is in Perth; it is a metropolitan place. When you look at the backgrounds of the people who are caught by the act, lots of them are not from Perth. So what is the point of a prerelease facility in the metropolitan area for people are going to go back and live in the Kimberley or the lands. So it does not meet the needs of all of the cohort. It is also going to be very difficult, if not impossible, in my view, to set up adequate declared places, given the gender, male-female; the age differences; the cultural differences; and, with some of the people who are caught by the act, the issues around sexual behaviour. It would be very difficult to manage the large cohort of different need. So I welcome the centre, but as I say I have a fundamental difficulty as to whether a Perth based declared place, or two, is really going to meet the cohort that we have.⁵²

5.58 Mr Peter Collins of ALSWA concurred, noting that transitional forensic facilities need to be made available closer to the home communities that people will transition to:

Consider the need for more regional and remote declared places. If these centres could be located in regional areas all the better, in my view. For example, I have acted for a client from a community called Tjuntjunjara. Tjuntjunjara is probably one of the most isolated Aboriginal communities in Australia if not one of the most isolated communities in the world. It is on the Northern Territory- South Australian border, several hundred kilometres south of Warburton, which in itself is a very isolated community. Warburton is 800 kilometres from Kalgoorlie and about 1,600 kilometres from Alice Springs.

This client was what I have described as a 'first contact person'. He and his family had been living in the bush before they first came into contact with non-Aboriginal people. This was in the mid- to late eighties, from memory. He was sentenced in relation to the manslaughter of his best friend. He was in a Perth jail and he had no visits for the entirety of his jail sentence. He had no telephone contact. There were no video link-ups. So these people are being locked up in Perth jails incredibly socially isolated, and the only prospect of any interaction with someone they know is if there is another prisoner, a countryman, who is in the same unit as them.⁵³

5.59 Mr Collins recommended:

If you can decentralise these centres so that they are in places like Kalgoorlie, Broome, Hedland, all the better because, at least, it offers the hope that these people will get visits from family and they will have that

52 Professor Neil Morgan, Inspector of Custodial Services, *Committee Hansard*, Perth, 19 September 2016, p. 10.

53 Mr Peter Collins, Director, ALSWA, *Committee Hansard*, Perth, 19 September 2016, p. 19.

critical interaction with Aboriginal people, which can only help their mental health.⁵⁴

5.60 The other consideration raised about declared places, but that equally applies to transitional forensic health facilities, is that they need not necessarily be an institution or a prison. Ms Taryn Harvey of Developmental Disability WA noted:

Depending on the nature of the support that they need and the particular risks that they present, a declared place can be a supported accommodation facility, for example. There is nothing in the legislation that actually says a declared place must be an institution with 10 beds. To declare a place is to effectively gazette it. It has to meet certain conditions in terms of being secure and other things, but there is nothing that mandates that it has to represent an institutional model.⁵⁵

Committee view

5.61 The committee considers that Aboriginal and Torres Strait Islander forensic patients should have access to culturally appropriate therapeutic and support services. It is imperative that Aboriginal and Torres Strait Islander peoples with cognitive and/or psychiatric impairment are able to communicate effectively with service providers, police and the judiciary. Chapter 3 discussed programs which might assist to improve participation for people with cognitive and psychiatric impairment in the justice system. For Aboriginal and Torres Strait Islander peoples, this may also require additional supports from culturally specific aids and trained Aboriginal and Torres Strait Islander support workers.

5.62 The committee reiterates the evidence of the intellectually impaired Tjuntjuntjara man who was held over 1100 kilometres from his home in the eastern goldfields desert country of WA. The committee considers that there is a need for more geographically and culturally appropriate secure care facilities or declared places that allow forensic patients to maintain connections to family, community and country.

An early intervention approach

5.63 This inquiry has focused primarily on people with cognitive and/or psychiatric impairment once they have come into contact with the criminal justice system and are held in prison indefinitely as a forensic patient.

5.64 Many submitters to the inquiry have highlighted the importance of early intervention approaches, with a move away 'from sentences to services'.⁵⁶ The Western Australian Association for Mental Health (WAAMH) acknowledged that 'there are far too few forensic mental health beds in WA'; however, noted that the

54 Mr Peter Collins, Director, ALSWA, *Committee Hansard*, Perth, 19 September 2016, p. 19.

55 Ms Taryn Harvey, Chief Executive, Developmental Disability WA, *Committee Hansard*, Perth, 19 September 2016, p. 25.

56 Change the Record Coalition, *Submission 64*, p. [2]. See also: Australian Cross Disability Alliance, *Submission 61*, p. 26.

'investment and focus on prevention and early intervention in forensic mental health is woefully inadequate'.⁵⁷

5.65 The National Disability Insurance Agency (NDIA) has a critical role in providing outreach to people with cognitive and/or psychiatric impairment and ensuring that diagnosis and early intervention occurs as early as possible in a person's development to ensure the necessary supports are provided. The NSW Council for Intellectual Disability submitted that:

Through outreach and engagement and working closely with early childhood services, schools, child protection and juvenile justice, the NDIA should provide early intervention to children and young people with intellectual disability who are [at] risk of lives of offending.⁵⁸

5.66 In its submission, the Department of Social Services highlighted two early intervention programs—the Personal Helpers and Mentors program and Family Mental Health Support Services—that 'provide early intervention services to assist families, children and young people up to the age of 18 who are affected by, or at risk of mental illness'.⁵⁹ At face value, these appear to be good programs, however, there do not appear to be any federally funded programs which focus on people with intellectual or cognitive impairments. In fact, those with cognitive impairments are actively excluded from these two programs.

5.67 The NSW Government, through Juvenile Justice Australia operate:

a specific diversion program Youth on Track (YOT) to provide early intervention support. Uniting-Care Burnside are contracted to coordinate a range of services for 10–17 year old young people before they become entrenched in the criminal justice system in Newcastle, Mid North Coast and Blacktown. YOT engage young people and their families in case work and interventions targeted at addressing the young person's individual needs.

All young people in the YOT Program are assessed using the Adolescent Intellectual Disability Screening Questionnaire (CAIDS-Q) that identifies whether the young person may have an intellectual disability. This is followed up with a referral for further assessments and to disability services.⁶⁰

5.68 Again, ostensibly this appears to be a good program; however, the committee questions why early intervention programs are not being made available to younger cohorts of people. Engagement with younger people at earlier stages of development is crucial. In its submission, the Australian Medical Association (AMA) noted that:

Early intervention for children with intellectual disabilities, including Foetal Alcohol Spectrum Disorder, is necessary to improve developmental

57 WAAMH, *Submission 27*, p. 14.

58 NSW Council for Intellectual Disability, *Submission 40*, p. 9.

59 Department of Social Services, *Submission 50*, pp 9–10.

60 NSW Government, *Submission 66*, p. 16.

outcomes, minimise the development of secondary disabilities, and reduce the likelihood of future involvement with the criminal justice system.⁶¹

5.69 The NSW Council of Intellectual Disability highlighted the economic sense of early intervention, which will be explored further in the next section:

There is a net saving to governments from early action to meet the disability support needs of potential and actual offenders with intellectual disability rather than allowing justice systems to bear large cost from responding to their offending.⁶²

Investing in people and their futures

5.70 There is a substantial economic cost in detaining people deemed unfit to plead. The 2016 Report on Government Services noted that the annual cost of detaining a person in a WA correctional facility is over \$131 000. The cost in the NT is slightly lower at nearly \$118 000.⁶³ This compares to the significantly lower cost of community corrections which equates to \$17 144 and \$15 877 respectively.⁶⁴

5.71 There remain questions as to whether this money is not better deployed to therapy, housing and other supports for people with cognitive and psychiatric impairment who should not be held in the criminal justice system having been deemed unfit to plead.

5.72 There is a strong economic case to be made for investment in lifetime support for people deemed unfit to plead. In an August 2013 research paper, Professor Eileen Baldry and her colleagues highlighted a series of lifetime cost-benefit analyses for people with cognitive and/or psychiatric impairment who come into contact with the criminal justice system. This research highlighted that the provision of early support and diversion services not only yielded improvements to wellbeing and other outcomes for this group, but that for every dollar spent, the government realised savings of between \$1.40 and \$2.40 over the lifetime of this person.⁶⁵ A case study that examines the cost-benefit analysis for "Casey" is outlined below in Box 5.3.

61 Australian Medical Association, *Submission 12a*, p. 12.

62 NSW Council for Intellectual Disability, *Submission 40*, p. 9. See also: Change the Record Coalition, *Submission 64*, pp [3–4].

63 Productivity Commission, *Report on Government Services 2016: Volume C: Corrective Services*, p. 1 of Table 8A.7, <http://www.pc.gov.au/research/ongoing/report-on-government-services/2016/justice/rogs-2016-volume-c-justice.pdf> (accessed 10 May 2016). See also: Just Reinvest NSW, *Submission 57*, pp 5–6.

64 Productivity Commission, *Report on Government Services 2016: Volume C: Corrective Services*, p. 1 of Table 8A.7, <http://www.pc.gov.au/research/ongoing/report-on-government-services/2016/justice/rogs-2016-volume-c-justice.pdf> (accessed 10 May 2016).

65 E. Baldry, R. McCausland, S. Johnson, A. Cohen, *People with mental health disorders and cognitive impairment in the criminal justice system: Cost benefit analysis of early support and diversion*, August 2013, pp 9–12, <https://www.humanrights.gov.au/sites/default/files/document/publication/Cost%20benefit%20analysis.pdf> (accessed 19 May 2016). See also: Just Reinvest NSW, *Submission 57*, pp 5–6.

Box 5.3: Cost-benefit analysis for "Casey" quantifying the benefits of early support and diversion over a lifetime.

Casey is an Aboriginal woman in her early 20s who has an intellectual disability and has been diagnosed with a range of mental and other cognitive conditions, including Attention Deficit Hyperactivity Disorder, conduct disorders, adjustment disorders, personality disorder and bipolar affective disorder. She has a long history of self-harm, physical abuse and trauma.

Casey's intellectual disability and personality disorders are key factors precipitating her very high levels of institutional contact from a young age, particularly with police. The extreme costs of Casey's contact with the criminal justice system are significantly reduced after she becomes a client of the NSW Ageing, Disability and Home Care (ADHC) Community Justice Program at the age of 18.

Casey's lifecourse institutional costs by age 20 are

\$5,515,293

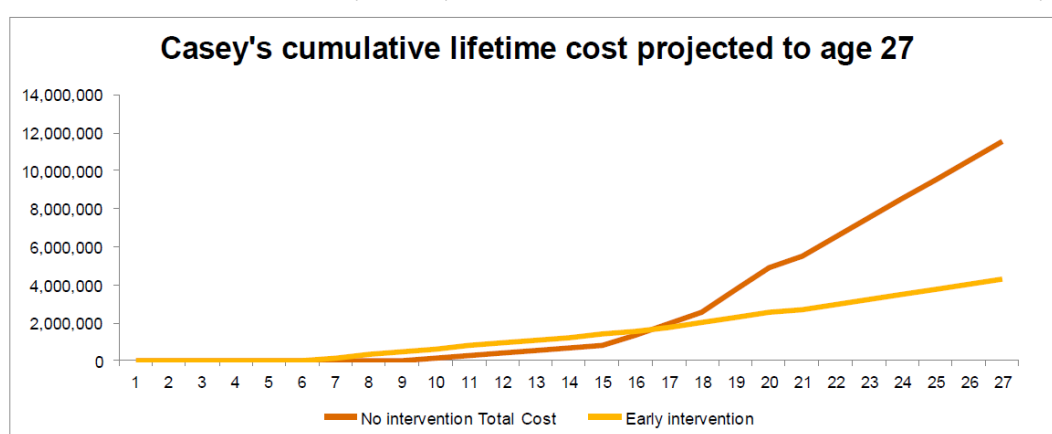
This includes 356 police incidents, 604 days in custody and 270 days in hospital.

By age 20, Casey ends up on an intensive support package from ADHC and on Centrelink supports, amounting to \$1 million per annum. If Casey is given an early intervention from the age of seven, that would mean she didn't offend, come into the criminal justice system, or end up on such an intensive package, substantial savings of up to \$2.9 million could be achieved by age 20. In another five years, further savings of up to \$3.7 million could be achieved.

The following assumptions are made in the calculation of the benefits for Casey:

- from age 7, Casey is provided with an intensive early intervention package of \$150,000 pa
- from age 18, Casey moves to an increased level of support, including accommodation, of \$250,000 pa
- these supports prevent Casey from contact with the criminal justice system and such high contact with the health system, and mean that she does not require crisis supports from ADHC.

The figure below compares the trajectory of Casey's lifetime cost without investment to the lifetime cost with early intervention. The extra investment early in Casey's life is not much more than was invested between 7 and 15 years of age.



****Please note that the No Intervention Total Cost for Casey is the actual institutional cost up to age 20, plus a projected institutional cost from age 21 to age 27.**

The cumulative savings from early intervention become apparent at age 16.

By age 20 the benefit cost ratio is estimated to be

2.1

By age 27, the benefit cost ratio is estimated to be

2.4

Source: E. Baldry, R. McCausland, S. Johnson, A. Cohen, *People with mental health disorders and cognitive impairment in the criminal justice system: Cost benefit analysis of early support and diversion*, August 2013, pp 7, 10.

Justice reinvestment

5.73 In NSW, one non-government organisation is endeavouring to take an investment approach with its justice reinvestment program, Just Reinvest NSW.⁶⁶ In its submission to the committee, Just Reinvest NSW described justice reinvestment:

The aim of Justice Reinvestment (JR) is to redirect funding from the corrections system to the community to fund programs and services to support people in the community to reduce offending behaviours and build community capacity (Tucker & Cadora 2003). The Justice Reinvestment for Aboriginal Young People Campaign advocates that the methodology and objectives of justice reinvestment must be:

- Data driven
- Place based
- Fiscally sound
- Supported by a centralised strategic body⁶⁷

5.74 An example of such an approach is the justice reinvestment project being run with Maranguka in the north-west NSW town of Bourke. This town, which has a population of less than 2 500 people has over \$4 million spent annually incarcerating the children and youth.⁶⁸ The community of Bourke experiences significant economic and social disadvantage characterised by a high Aboriginal and Torres Strait Islander peoples population, high unemployment rates, low levels of education, and predominantly non-violent crime.⁶⁹ Mr Alistair Ferguson, Executive Officer for Maranguka highlighted the problem:

Kids were being taken away. Too many of my community were being locked up. Families were being shattered, again and again, and this was happening despite the huge amount of money government was channeling through the large number of service organisations in this town.⁷⁰

66 Just Reinvest NSW, *Justice Reinvestment in Bourke*, <http://www.justreinvest.org.au/jr-calculator/> (accessed 1 June 2016). Importantly, the NSW Government has sought to not only quantify the cost of the criminal justice system to individual communities, but to also make this information publicly available.

67 Just Reinvest NSW, *Submission 57*, p. 8.

68 ABS Census QuickStats, http://www.censusdata.abs.gov.au/census_services/getproduct/census/2011/quickstat/SSC10306?opendocument&navpos=220 (accessed 1 June 2016). See also: KPMG, *Unlocking the future: Maranguka Justice Reinvestment Project in Bourke—Preliminary Assessment*, September 2016, p. ix.

69 Alison Vivian and Eloise Schnierer, *Factors affecting crime rates in Indigenous communities in NSW: a pilot study in Bourke and Lightning Ridge*, Community Report, November 2010, p. 6, <https://www.uts.edu.au/sites/default/files/FinalCommunityReportBLNov10.pdf> (accessed 1 June 2016). Non-violent crime includes vehicle and property crime, and breach of bail not occasioning bodily harm. In 2008, 56 per cent of crimes in the Bourke community were non-violent crimes.

70 Just Reinvest NSW, *Justice Reinvestment in Bourke*.

5.75 The purpose of the Maranguka initiative is to:

create better coordinated support to vulnerable families and children in Bourke through community-led teams working in partnership with existing service providers, so that together we could look at what's happening in our town and why Aboriginal disadvantage was not improving, and together we could build a new accountability framework which wouldn't let our kids slip through.⁷¹

5.76 In September 2016, KPMG released a report which noted that the cost of the Maranguka community-led initiative has an 'annual staffing cost of \$554 800' compared to the over \$4 million spent on incarcerating the youth of Bourke.⁷² This initiative is still in its early implementation stage, so it is too early to meaningfully measure outcomes, however, KPMG noted that:

When contrasted with several other crime prevention approaches, the Justice Reinvestment approach was found to be promising on a number of criterion. The approach has the potential to address the underlying causes of crime, the approach is data-driven and the approach is community-led...

The development of the approach is being progressed and has the potential to have a significant impact in Bourke.⁷³

5.77 Although the Maranguka initiative in Bourke focuses more broadly on the incarceration of young Aboriginal people, this community investment initiative is a useful template to consider for communities in other parts of Australia with high levels of youth incarceration. The AMA 'would like to see a greater commitment to justice investment principles being used to fund early intervention and diversion efforts, particularly for people with mental health problems, substance use disorders, and cognitive disabilities, in Aboriginal and Torres Strait Islander communities'.⁷⁴

5.78 In its submission to the committee, Just Reinvest NSW reiterated the work of Professor Eileen Baldry summarising the successful approach of Justice Reinvestment.:

The evidence is stark that...early lack of adequate services is associated with costly criminal justice, health and homelessness interactions and interventions later...Millions of dollars in crisis and criminal justice interventions continue to be spent on these vulnerable individuals whose needs would have been better addressed in early support or currently in a health, rehabilitation or community space. It is obvious that access to integrated and responsive support services including drug and alcohol

71 Just Reinvest NSW, *Justice Reinvestment in Bourke*.

72 KPMG, *Unlocking the future: Maranguka Justice Reinvestment Project in Bourke—Preliminary Assessment*, September 2016, p. ix.

73 KPMG, *Unlocking the future: Maranguka Justice Reinvestment Project in Bourke—Preliminary Assessment*, September 2016, p. xiii.

74 Australian Medical Association, *Submission 12b*, p. 21.

support, mental health and disability services or other psycho-social forms of support is needed.⁷⁵

Committee view

5.79 The committee considers the preceding section one of the more important components of this inquiry. Much of this report has dealt with what happens and what should happen to people with cognitive and/or psychiatric impairment once they come into contact with the criminal justice system. Ideally, an early intervention approach, where people with cognitive and/or psychiatric impairment are identified and given appropriate supports, is a more preferable pathway and outcome than attempting to divert a person once they have been charged, are subject to forensic orders or are in prison.

5.80 The committee notes some of the programs being conducted at a state and federal level, and commends the work of such programs. However, the committee is concerned that such programs are not targeted at those with cognitive impairment, and they are targeted at older cohorts of children. To paraphrase one submitter, intervention must commence at earlier stages of development 'to improve developmental outcomes, minimise the development of secondary disabilities, and reduce the likelihood of future involvement with the criminal justice system'.⁷⁶

5.81 The committee also notes the economic sense of up-front funding and implementation of early intervention programs to facilitate people with cognitive and psychiatric impairment to lead full and productive lives.

Concluding committee view (Chapter 5)

5.82 This chapter has explored the challenges that face forensic patients as they attempt to transition from prison or secure care facilities into supported accommodation in the community.

Failure to plan

5.83 The committee is concerned that there is a failure to plan on a number of levels. ISP's are not structured with the key objective of moving forensic patients out of prison or secure care into the community. ISP's are also not clear on who is responsible for the provision of services and supports. The committee considers that ISP's must have the clear objective of providing therapeutic (or behavioural support) which leads to a person living as independently as possible in the community. The committee also considers that disability services must be the lead agency to implement and provide supports under an ISP.

5.84 There is a need to plan more effectively for the numbers of forensic patients who need supported accommodation in the community. It is the committee's view that supported accommodation options need to be made available to enable forensic patients to live supported in the community. There is also a need to better understand

75 Just Reinvest NSW, *Submission 57*, pp 5–6.

76 Australian Medical Association, *Submission 12a*, p. 12.

the role that the NDIS will play in providing supports to forensic patients in prison, secure care facilities and in the community.

The responsible department

5.85 Consistent with the committee's view in Chapter 3 and 4 that prison is not a suitable place for forensic patients to be held, the committee also considers that secure care facilities—such as the Complex Behaviour Unit—should be operated by the relevant disability department rather than corrective services. It is the committee's view that a therapeutic approach, rather than punitive, is more likely to lead to behavioural improvements which are consistent with a reduction of risk that will ultimately lead to less restrictive accommodation options for forensic patients.

Culturally appropriate care

5.86 The committee considers that Aboriginal and Torres Strait Islander forensic patients should have access to culturally appropriate therapeutic and support services. These services need to be provided by trained Aboriginal and Torres Strait Islander support workers at all stages of a forensic patient's journey. Culturally appropriate care must be made available in locations closer to the family, community and country of Aboriginal and Torres Strait Islander forensic patients.

Early intervention

5.87 The committee considers the need for early intervention services to be equally important as the support provided once a person with cognitive and/or psychiatric impairment reaches the courts and becomes a forensic patient. Preventing a person from reaching this point through early identification, diagnosis and provision of support services is a much better outcome than someone remaining undiagnosed and/or unsupported and engaging with the criminal justice system. There are a handful of programs that seek to provide early intervention services; however, the committee is concerned at the lack of programs to engage children with cognitive impairments at a younger age.

Conclusions—forensic orders (Chapters 2–5)

5.88 'Prisoner B' is one of thirteen forensic patients currently indefinitely detained in a Northern Territory (NT) prison; there are fifteen forensic patients held in similar circumstances in Western Australian prisons. Anecdotally, there are nearly 100 people on forensic orders held indefinitely in Australian prisons. Most are Aboriginal and Torres Strait Islander peoples; all have severe cognitive and/or psychiatric impairments. These are some of the most vulnerable Australians, and they are detained in the harshest of facilities and are denied the natural justice of knowing when they will be freed:

I am the guardian for [Prisoner B], who is detained in Alice Springs Correctional Centre. His life was actually pretty full of tragedy and

injustice, and his life whilst he has been detained is full of tragedy and injustice.⁷⁷

5.89 They are ostensibly held for therapeutic purposes, but without the necessary supports required to make a transition back into the community. Many have lifetime cognitive impairments, yet are required to 'recover' in order to be considered for release.

Pre-detention

5.90 The committee received a range of evidence which shows that good quality therapeutic treatment and intervention for people with a cognitive or psychiatric impairment is often delivered as a last-minute, crisis-induced response, and often comes after police involvement once a person has deteriorated to the point of being a risk of harm to themselves or others.

5.91 The committee acknowledges the weight of evidence that shows early intervention, diversion programs, court advocacy and the use of advance directives for people with cyclical impairment issues, would significantly reduce the need for this belated therapeutic response. It would bring mental health treatment in line with other branches of health service delivery, where prevention and early intervention are universally acknowledged as better health approaches.

5.92 The failure to appropriately divert people with a cognitive or psychiatric impairment away from the criminal justice system is highlighted by the evidence presented to the committee, that people are pleading guilty to offences rather than mounting an appropriate mental impairment defence. The committee heard people are likely to be released much faster and be dealt with in a more regulated fashion in the criminal justice regime.

Detention

5.93 The committee has received a significant body of evidence which has highlighted that prisons are not appropriate places for forensic patients. The committee is concerned that the therapeutic and support needs of this vulnerable group of people have not been met prior to an escalation of their condition which resulted in detention. Equally, the committee is not convinced that the needs of this group have or will be met in a prison environment. In addition to the lack of therapeutic support, the committee is concerned that placement of people on forensic orders in prison unnecessarily exposes them to physical risk and to isolation—both within the prison and from the community.

5.94 The committee strongly concurs with the advice put forward by the Australian Medical Association and the Australian New Zealand College of Psychiatrists, that prisons are not appropriate places to hold people with a cognitive or psychiatric impairment, and that prisons are not hospitals and should never be viewed as such.

77 Mr Patrick McGee, Convenor, Aboriginal Disability Justice Agency, *Committee Hansard*, Brisbane, 23 March 2016, p. 36.

5.95 The committee notes evidence that forensic detention is largely founded on the premise that a person is detained for the purpose of involuntary treatment, and once the impairment has improved and the person is no longer a risk, they will be released. However, cognitive impairments are generally constant impairments, from which a person does not 'recover'. The committee is deeply concerned with this conflation of permanent cognitive impairments within a regime designed for people with a recoverable psychiatric impairment.

Exiting detention

5.96 The committee also has received disturbing evidence that many people remain indefinitely detained in secure facilities, not because they are a safety risk, but because there is no other place to house them.

5.97 Evidence has been presented that across Australia, people languish in detention, often in harsh facilities which are counter-productive to their recovery, simply because there is no appropriate community-based accommodation to allow for their release. There are few issues of greater injustice, than the continued detention of people because of a lack of appropriate spending on disability accommodation.

Conclusion

5.98 Because indefinite detention takes so many forms and has so many causes, there is no simple one-stop fix. It will take a concerted effort from all jurisdictions, and will require coordination and leadership at a Commonwealth level.

5.99 The committee acknowledges that this issue does not impact a large number of Australians. However, the committee contends that despite being a small population, the deeply negative impact to these Australian's lives and human rights is one that a just society cannot accept.

**PART B—Involuntary mental health orders,
involuntary treatments and other involuntary
detentions**

Chapter 6

Involuntary treatment orders—statistics, legislation and reviews

6.1 The first half of this report focuses on indefinite detention within the criminal or forensic mental health system. Part B of this report (Chapters 7–10) will focus on the civil systems which lead to indefinite detention of people with a cognitive or psychiatric impairment. These include involuntary treatment orders under mental health frameworks, as well as orders under guardianship or disability-related legislation.

6.2 A range of evidence has been presented to the committee, and is discussed in the following chapters, which indicates that civil frameworks—mental health, guardianship and disability frameworks—are generally more informal mechanisms than the forensic system. On one side, this often provides greater flexibility in providing tailored solutions for individuals, but can also involve less structured review rights or oversight, leading to unnecessarily prolonged detention.

6.3 Part B of the report will also review the operation of the civil systems used for detaining people to provide involuntary treatment. If recommendations for early intervention and diversion from the forensic system are acted upon, the civil system will be called upon to a greater extent to provide treatment pathways. It is therefore of critical importance to assess the capacity of those civil systems to deliver improved outcomes for patients leaving the forensic system.

Introduction

6.4 There are three key mechanisms for detaining people cognitive or psychiatric impairment within the civil systems: mental health acts, disability acts and guardianship acts.

6.5 Chapter 7 will focus on mental health acts, and will provide an overview of mental health facilities and treatment order review provisions across the jurisdictions.

The mental health pathway to indefinite detention

6.6 A common entry point for a person to be detained indefinitely under a scheduled mental health order, is where a referral to a designated mental health facility or hospital for assessment is made by another party such as a medical practitioner, or a friend or family member.

6.7 However, many referrals are made during an incident attended by a first responder (generally a police or ambulance officer). Often first responders make these referrals under duress and use the act of referral as a form of crisis management to mitigate against a perceived risk of serious harm.¹

1 For a longer discussion on first responder mental health referrals, see: Dr Joanne Bradbury, *Submission 63*.

6.8 During an incident attended by a first responder, often an arbitrary decision is made by the first responder as to whether or not a person is immediately diverted to a mental health pathway or charged with a crime and later enters the forensic mental health system. An individual first responder's training and capacity to recognise a mental health situation and assess the likelihood of risk of harm can be the deciding factors as to the pathway that person will be diverted to for treatment.²

6.9 For example, in New South Wales (NSW), first responders including police officers and paramedics are empowered to:

apprehend and transport a person to a declared mental health facility (DMHF) for psychiatric assessment if the officer believes the person: is committing or has recently committed an offence; has recently attempted or is probably going to attempt to kill himself or herself or someone else; or will probably attempt to cause serious physical harm to himself or herself or someone else (s. 22(1)(a)); *and* that it would be "beneficial to the person's welfare" to be dealt with under mental health, rather than criminal, legislation (s. 22(1)(b)).³

6.10 If a person is assessed by a medical officer within the DMHF and found to be 'mentally disordered' or a 'mentally ill person' then they may be detained in the DMHF for an indefinite period on an involuntary order, outlined in greater detail below. If not detained on an involuntary order, they must be returned to police custody (for possible charges) or released into the community.⁴

Declared mental health facilities

6.11 There are three broad types of specialist mental health care in Australia—*community mental health care* where the person resides in the community, *residential mental health care*, which is mental health care provided on an overnight basis in a domestic-like environment, or *admitted patient care* provided in a specialist psychiatric hospital or psychiatric unit within a hospital.

Community mental health care

6.12 Community mental health care (CMHC) is defined as 'government-funded and -operated specialised mental health care provided by community mental health

2 NSW Police Force, *NSWPF Mental Health Intervention Team*, http://www.police.nsw.gov.au/community_issues/mental_health (accessed 10 November 2016).

3 Dr Joanne Bradbury, Matt Ireland, Helen Stasa, 'Mental Health emergency transport: the pot-holed road to care', *The Medical Journal of Australia*, 2014, volume 200, number 6, p. 348, https://www.mja.com.au/system/files/issues/200_06_070414/bra10093_fm.pdf (accessed 7 December 2015). Similar provisions exist in other states, although mostly only for police officers.

4 NSW Legal Aid, *The Practice and Procedure Manual for Mental Health Advocacy (Civil and Forensic Work)*—2.12 Procedures after admission of involuntary patients, October 2008, <http://www.legalaid.nsw.gov.au/for-lawyers/policyonline/practice,-procedures-and-directions/2.-the-practice-and-procedure-manual-for-mental-health-advocacy-civil-and-forensic-work/2.12.-procedures-after-admission-of-involuntary-patients> (accessed 7 December 2015).

care services and hospital-based ambulatory care services, such as outpatient and day clinics'.⁵

6.13 Nearly 14 per cent of the 8.7 million CMHC episodes recorded in 2013–14, were for involuntary patients. However, these people are not held indefinitely and are allowed to return to their place of residence after attending treatment. This inquiry did not investigate involuntary community treatment orders.

Residential mental health care

6.14 Residential mental health care (RMHC) is mental health care that is provided on an overnight basis in a dedicated facility with a domestic-like environment. A residential mental health service is a specialised mental health service that:

- employs mental health trained staff on-site
- provides rehabilitation, treatment or extended care to residents for whom the care is intended to be on an overnight basis and in a domestic-like environment
- encourages the residents to take responsibility for their daily living activities.

These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing. However, all these services employ on-site mental health trained staff for some part of the day.⁶

6.15 In 2013–14, the Australian Institute of Health and Welfare (AIHW) found a national trend of an increase in RMHC episodes of nearly 75 per cent over 5 years, but a decrease in the overall percentage of involuntary admissions from 29 per cent (2009–10) to 18 per cent (2013–14). Greater detail on the changing rates of RMHC episodes are provided at the end of this chapter in a section on statistics.

Admitted patient care

6.16 Admitted patient care takes place within a clinical setting such as a psychiatric hospital or a psychiatric unit within a hospital.⁷ The AIHW found that:

In 2014–15, there were 157,104 mental health-related separations with specialised psychiatric care; equivalent to a national rate of 6.8 per 1,000 population.

In 2014–15, there were 48,857 mental health-related separations with specialised psychiatric care where the mental health legal status was 'involuntary'—representing about a third (31.1%) of these separations.⁸

5 Australian Institute of Health and Welfare (AIHW), *State and territory community mental health care services: Key concepts*, https://mhsa.aihw.gov.au/services/community-care/data-source/#4_cmhc (accessed 1 November 2016).

6 AIHW, *Mental Health Services in Australia: Key concepts*, https://mhsa.aihw.gov.au/key-concepts/#4_cmhc (accessed 8 December 2015).

7 AIHW, *Admitted patient mental health-related care*, <https://mhsa.aihw.gov.au/services/admitted-patient/>, (accessed 2 November 2016).

Involuntary mental health orders

6.17 Each state and territory in Australia has enacted legislation which allows for the detention of people deemed at risk of harm to themselves or others, to enable the provision of mental health treatment via an involuntary treatment order (involuntary order).

6.18 Table 6.1 below, shows that there were 12 085 people being treated as inpatients and 14 797 as outpatients subject to involuntary orders from the relevant state or territory mental health review board or tribunal.⁹

Table 6.1: Numbers of involuntary mental health detention orders issued in each jurisdictions and the locations of the detention

State	Year	Involuntary mental health orders		
		Inpatient	Outpatient	TOTAL
NSW	2014–15	1339	4219 ¹⁰	5558
ACT	2014–15	UKn ¹¹	UKn	921
VIC	2014–15	2324	2588	4912
TAS	2014–15	UKn	UKn	1446 ¹²
SA	2014–15	1543	7327	8870
WA	2011–12	2626	329	2955
NT	2012–13	235	252	487
QLD	2014–15	4018	82	4100

Source: NSW Mental Health Review Tribunal, *2014/15 Annual Report*; Tasmanian Mental Health Tribunal, *Annual Report 2014–15*; Victorian Mental Health Tribunal, *2014/15 Annual Report*; Queensland Director of Mental Health, *Annual Report 2014–2015*; South Australian Chief Psychiatrist, *Annual Report 2014–15*; Western Australian Mentally Impaired Accused Review Board (MIARB), *2014/15 Annual Report*; Northern Territory Department of Correctional Services, *Annual Statistics 2013–14*, p. 16; Law Council of

8 AIHW, *Specialised care characteristics*, <https://mhsa.aihw.gov.au/services/admitted-patient/specialised-patient-characteristics/> (accessed 2 November 2016).

9 A useful discussion of involuntary mental health care can be found at: <http://www.aihw.gov.au/publication-detail/?id=60129549463> pp 20–22.

10 This includes those discharged into community mental health supports or moved to voluntary status.

11 UKn is unknown.

12 A treatment order can include detention. These statistics are not broken down into inpatient or outpatient, but it should be noted that Tasmania is more likely to use community based or outpatient care. These statistics also include 552 interim treatment orders which last for up to 10 days.

Australia, *Submission 72*, pp 6–7; Barriers 2 Justice, *Submission 67*; NT Government, *Submission 75*, Appendix A.

6.19 Each Australian state and territory has a mental health review board or tribunal to provide an oversight and review process for all involuntary mental health orders. These boards and tribunals are also empowered to make, renew and vary mental health orders. The Royal Australian New Zealand College of Psychiatrists submitted that there is great divergence between the various state and territory mental health acts as to the criteria that must be applied for involuntary treatment is enacted, and also in the processes that subsequently review compulsory treatment orders.¹³

6.20 Details on these boards and tribunals are provided below.

New South Wales

6.21 The NSW Mental Health Review Tribunal (MHRT) reviews 'involuntary patients in mental health facilities, usually every three or six months, and in appropriate cases, every twelve months, with forensic patients 'usually every six months'.¹⁴

6.22 In its annual report, the MHRT noted that:

In 2014/15 of the 22 252 persons taken involuntarily to a mental health facility or reclassified from voluntary to involuntary: 2 701 were not admitted; 2 491 people were admitted as a voluntary patient and 17 060 were detained as either a mentally ill or mentally disordered person - a total of 19 551 admissions (including 1 720 of the 1 940 people who were reclassified from voluntary to involuntary).

There were 6 633 mental health inquiries commenced with 5 558 involuntary patient orders made. Of these only 1 339 patients remained in a mental health facility until the end of the involuntary patient order (which could be made for a maximum of three months) and were reviewed by the Tribunal. This means 4 219 people were discharged from a mental health facility or reclassified to voluntary status prior to the end of their initial involuntary patient order.¹⁵

[Of the 17 060 involuntary admissions, 12 018 were mentally ill and 5 042 were mentally disordered].¹⁶

13 Royal Australian New Zealand College of Psychiatrists, *Submission 17*, pp 6–7.

14 NSW Mental Health Review Tribunal, <http://www.mhrt.nsw.gov.au/forensic-patients/forensic-procedures.html> and <http://www.mhrt.nsw.gov.au/the-tribunal/>

15 NSW Mental Health Review Tribunal, *2014/15 Annual Report*, p. 46, <http://www.mhrt.nsw.gov.au/assets/files/mhrt/pdf/MHRT%20Annual%20Report%202015.pdf> (accessed 11 December 2015).

16 Although this is not expressly stated, of the 17 060 involuntary admissions, only 1339 were held as involuntary inpatients for longer than three months (hence subject to a review by the MHRT).

Queensland

6.23 As at 30 June 2015, there were 4100 involuntary order patients in Queensland (QLD) mental health facilities of which 98 per cent were inpatients.¹⁷ In 2014–15, the QLD Mental Health Tribunal (QMHT) reviewed 8165 involuntary orders, of which the vast majority were confirmed (7981). On top of this, nearly 5500 involuntary orders were revoked prior to hearing highlighting 'that clinical assessment and review prior to the scheduled hearing promotes voluntary acceptance of treatment negating the need for further use of involuntary treatment for a significant number of patients. An involuntary order must be reviewed 'within six weeks of the order being made and afterwards of intervals of not more than six months'.¹⁸

6.24 The Director of Mental Health highlights that 21 per cent of the nearly 24 200 people who have an open patient record at a public mental health facility are involuntary patients.¹⁹ Similar to NSW, involuntary assessment can be initiated by a front line responder (police or ambulance officer) or medical professional (psychiatrist) under an Emergency Examination Order (EEO). Of the 12 487 EEO's made in 2014–15, 44 per cent were made by ambulance officers and 56 per cent by police officers.²⁰

Tasmania

6.25 The Tasmanian Mental Health Tribunal (TMHT) may make, vary, renew or review an involuntary order under the *Mental Health Act 2013* (Tas). In the 2014–15 period, the TMHT made 552 interim orders, made 410 new orders, varied 361 and renewed 123. The TMHT also reviewed 777 cases. These treatment orders can only be issued for a period of up to 6 months and must be reviewed within 30 days initially and then every 90 days thereafter. It is not clear whether these are separate cases or contain multiple cases for individuals.²¹

Victoria

6.26 The Victorian Mental Health Tribunal (VMHT) reviews all 'involuntary' mental health patients and made the following involuntary orders in 2014–15:

- 2 324 inpatient treatment orders;
 - 1–6 week (10 per cent)
 - 7–13 week (24 per cent)

17 Queensland Director of Mental Health, *Annual Report 2014–2015*, pp 19 & 23, <http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2015/5515T1884.pdf> (accessed 4 January 2016).

18 Queensland Mental Health Tribunal, *Annual Report 2014–15*, pp 11, 19–20.

19 Queensland Director of Mental Health, *Annual Report 2014–2015*, p. 7.

20 Queensland Director of Mental Health, *Annual Report 2014–2015*, pp 14–15.

21 Tasmanian Mental Health Tribunal, *Annual Report 2014–15*, pp 7–9 and 15, http://www.mentalhealthtribunal.tas.gov.au/_data/assets/pdf_file/0008/329462/Annual_Report_Mental_Health_Tribunal_2014-15.pdf (accessed 18 December 2015).

- 14–20 week (7 per cent)
- 21–26 week (59 per cent)²²
- 417 temporary treatment and permanent treatment orders revoked.

6.27 The maximum duration of an involuntary order in Victoria is six months.²³

South Australia

6.28 There are two types of involuntary orders used in South Australia, inpatient orders and community orders. An inpatient order allows a 'person to receive compulsory, inpatient treatment for a mental illness'; whereas a community order 'allows a person with a mental illness to receive compulsory, community-based treatment for a mental illness'. At 30 June 2015, there were 8870 mental health treatment orders, of which 1543 were inpatient orders and 7327 were community orders. Overall this was an increase of about 10 per cent from the previous year. These numbers include individuals who receive multiple orders.²⁴

6.29 The South Australian Civil and Administrative Tribunal has powers to review and make certain orders relating to the involuntary treatment and detention of people with mental illness. This tribunal's work is quite complex and reflects the fact that there are a number of different inpatient and community orders for different treatment lengths (that is, short, medium and long).²⁵

Western Australia

6.30 In Western Australia, the Mental Health Review Board (MHRB) conducts periodic reviews of the status of involuntary patients at least every six months. The MHRB can review more often if they deem it necessary or if a request is made. In 2011–12, there were 2955 involuntary orders commenced with 2626 detained in hospital and 329 on a community order. These numbers are roughly similar over the preceding period. Other relevant orders were 936 orders that were continued with

22 There were 2588 community orders.

23 Victorian Mental Health Tribunal, *2014/15 Annual Report*, p. 17, <http://www.mht.vic.gov.au/wp-content/uploads/2015/10/MHT-2014-2015-Annual-Report.pdf> (accessed 18 December 2015). A maximum duration of a community order is 12 months.

24 South Australian Chief Psychiatrist, *Annual Report 2014-15*, p. 21, http://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0ahUKEwiCn8iXqI_KAhVjIKYKHZZNC58QFggnMAI&url=http%3A%2F%2Fwww.parliament.sa.gov.au%2FHouseofAssembly%2FBusinessoftheAssembly%2FRecordsandPapers%2FTabledPapersandPetitions%2FPages%2FTabledPapersandPetitions.aspx%3FTPLoadDoc%3Dtrue%26TPDocType%3D0%26TPP%3D53%26TPS%3D2%26TPItemID%3D464%26TPDocName%3DChief%252BPsychiatrist%252BAnnual%252BReport%252B2014-15.pdf&usq=AFQjCNEwQUAL1gKM1LrjtYmEZKd88oScUQ (accessed 4 January 2016). An involuntary order allows a 'person to receive compulsory, inpatient treatment for a mental illness'; whereas a community order 'allows a person with a mental illness to receive compulsory, community-based treatment for a mental illness'.

25 SACAT, *Mental health*, <http://www.sacat.sa.gov.au/types-of-cases/mental-health> (accessed 16 January 2016).

extension of a community order (298), issuance of a community order on discharge from hospital (516), and revocation of community order and readmission to hospital (122).²⁶

Australian Capital Territory

6.31 In 2014–15, there were 1020 people apprehended by a first responder—police (723) and ambulance (158)—or medical practitioner (139). Of those apprehended, there were 698 detained. Of those detained, 387 were kept for 72 hours or less and 311 had applications lodged for an extension of involuntary detention.

6.32 The Australian Capital Territory (ACT) Chief Psychiatrist is also responsible for the 'treatment and care of a person to whom a psychiatric treatment order (PTO) applies. A PTO can be issued for six months by the ACT Civil and Administration Tribunal (ACAT) whereupon it requires review and re-issue. There were 921 PTOs granted and 156 revoked by ACAT in 2014–15. Although PTOs subject an individual to involuntary treatment, an additional 'restriction order' is required in order for someone to be involuntarily detained or be 'required to reside at a specified place'. There were 14 restriction orders issued by ACAT in 2014–15 and all were in relation to a 'community care order'.²⁷ It is not clear how many of these are being held as an inpatient in a hospital mental health unit. The ACT currently does not have a secure mental health unit, but is constructing a new low to medium security facility, expected to open in late 2016.²⁸

Northern Territory

6.33 There were 235 involuntary detention (inpatient) orders issued in the Northern Territory (NT) in 2012–13. A further 252 community management orders were also issued. These statistics represent a 14 per cent decrease and a 95 per cent increase respectively since 2011. Over 63 per cent of matters scheduled before the NT Mental Health Review Tribunal were with Aboriginal and Torres Strait Islander peoples.²⁹

Reviews of involuntary mental health order legislation

6.34 This section will examine and summarise key findings of recent reviews into the administration of involuntary mental health orders, conducted at the national level and for New South Wales, Queensland, South Australia and the Australian Capital Territory.

26 Western Australia Mental Health Review Board, *Annual Report 2012*, p. 9, http://www.mhrbwa.org.au/publications/pdfs/Annual_Report_2012.pdf (accessed 4 January 2016).

27 ACT Chief Psychiatrist, *Annual Report 2014–15*, <http://www.health.act.gov.au/research-publications/reports/annual-reports/2014-2015-annual-report/attachment-1/chief-psychiatrist> (accessed 4 January 2016).

28 See: <http://www.health.act.gov.au/dhulwa-mental-health-unit> (accessed 2 November 2016).

29 Northern Territory Mental Health Review Tribunal, *Annual Report 2012–13*, pp 10–14, http://www.nt.gov.au/justice/general/documents/Annual_report_2012-13/mhrt_and_lpmt/Annual%20Report2012_13.pdf (accessed 4 January 2016).

National —Australian Law Reform Commission

6.35 In 2014, the Australian Law Reform Commission (ALRC) conducted an inquiry into Commonwealth laws and legal frameworks that impact on the recognition of people with disability before the law. As discussed in Chapter 2, the report investigated the system of 'unfit to plead' and forensic mental health orders. Importantly, it also included decisions on medical treatment in the terms of reference.

6.36 In the final report, *Equality, Capacity and Disability in Commonwealth Laws*, the ALRC proposed National Decision Making Principles (NDMP) (and guidelines) that would apply to the provision of disability and health services including mental health services. The NDMP are:

- All adults have an equal right to make decisions that affect their lives and to have those decisions respected.
- Persons who require support in decision-making must be provided with access to the support necessary for them to make, communicate and participate in decisions that affect their lives.
- The will, preferences and rights of persons who may require decision-making support must direct decisions that affect their lives.
- Laws and legal frameworks must contain appropriate and effective safeguards in relation to interventions for persons who may require decision-making support, including to prevent abuse and undue influence.³⁰

6.37 The ALRC report recommended state and territory governments review laws and legal frameworks that impact the decision making rights of people with disability and that:

Any review should include, but not be limited to, laws with respect to guardianship and administration; consent to medical treatment; mental health; and disability services.³¹

6.38 The ALRC report also highlighted new mental health legislation in Tasmania and Victoria which 'has changed the focus of criteria for the involuntary detention and treatment from the risk of harm to a person's capacity to consent to treatment' and 'protects the rights of mental health patients through statements of rights'. These rights include the:

right to communicate, make advance statements and have a nominated person to support them and help represent their interests. The role of a nominated person is to receive information about the patient; be one of the persons who must be consulted in accordance with the Act about the patient's treatment; and assist the patient to exercise any right under the Act. A person can only nominate another person in

30 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws (Report 124)*, 24 November 2014, p. 63, https://www.alrc.gov.au/sites/default/files/pdfs/publications/alrc_124_whole_pdf_file.pdf (accessed 8 January 2016).

31 *Equality, Capacity and Disability in Commonwealth Laws (Report 124)*, p. 21.

writing and the nomination must be witnessed. A nomination can be revoked in the same manner by the person who made the nomination or if a nominated person declines to act in the role.³²

Outcomes

6.39 As outlined in Chapter 2, in 2015, with the agreement of all Australian Governments, the National Mental Health Commission (NHMC) commenced 'a project to look at best practice in reducing and eliminating the seclusion and restraint of people with mental health issues and to help identify good practice approaches'. The outcomes of that project are discussed in greater detail in a section on 'restrictive practice' in Chapter 9.

New South Wales

6.40 In May 2013, the NSW Ministry of Health concluded a review into the *Mental Health Act 2007* which assessed current legislation and practice to improve mental health services.

Outcomes

6.41 The *Mental Health Amendment Act (Statutory Review) Act 2014* was passed in late 2014. The amendments sought to align the NSW approach to 'national and international trends towards a consumer-led approach to treatment.' The key changes were:

- requirements that clinicians make every effort to take into account the consumers' views and wishes about their treatment to ensure the principles of recovery are supported;
- increased safeguards that protect the rights of people with mental illness such as enhanced rights of young people undergoing treatment;
- strengthened emergency mental health care by empowering more clinicians to undertake assessments – a measure which will save mental health consumers in country areas from arduous travel in seeking assessment of their mental health condition and treatment; and
- recognising the need for a consumer's primary care provider to receive certain information.³³

32 *Equality, Capacity and Disability in Commonwealth Laws (Report 124)*, pp 286–288.

Western Australian legislation also provides for a 'nominated person', someone chosen by the person with mental illness to assist them in ensuring their rights under the Act are observed and their interests and wishes are taken into account by medical practitioners and mental health workers. A nominated person is entitled to 'uncensored' communication with the person with mental illness, and to receive information related to that person's treatment and care.

6.42 A subtle amendment to the objects and principles of the Act saw the replacement of 'control' with 'to promote the recovery of', with the effect being that the first object of the Act now reads:

(a) to provide for the care and treatment of, and **to promote the recovery of**, persons who are mentally ill or mentally disordered...³⁴

Queensland

6.43 The review of the Queensland *Mental Health Act 2000* commenced in July 2013 with a discussion paper released in May 2014.³⁵ This paper made a number of recommendations with regard to involuntary detention and treatment of people with mental illness. Key recommendations were:

- An authorised doctor may not make both a recommendation for assessment and an involuntary treatment order for the same person in the same examination and assessment process, unless the doctor is located in a regional, rural or remote area designated by the Director of Mental Health.
- Simplification of documentation leading up to and including detention.
- Timely transfer of acutely unwell prisoners from prison to an authorised mental health service.
- Clarification of treatment plans, and that statutory requirements for treatment and care of involuntary patients should be aligned with 'good clinical practice'. Improved recognition of and consultation by medical professionals with the involuntary patient's family and carers.
- Increased clarity on the role and powers of the Mental Health Tribunal.
- Improved provisions that provide 'consistency, clarity and effectiveness of restraint and seclusion'. These improved provisions should lead to a reduction in the use of restrictive practices and improve safeguards when they are used.³⁶

33 The Hon Jai Rowell MP, Minister for Mental Health & Assistant Minister for Health, 'NSW Government delivers key improvements to mental health care', Media Release, 19 November 2014, http://www.health.nsw.gov.au/news/Documents/20141119_00.pdf (accessed 11 January 2016). See also: NSW Ministry of Health, *Review of the NSW Mental Health Act 2007—Report for NSW Parliament*, May 2013, pp i–iv, <http://www.health.nsw.gov.au/mhdao/Documents/Review-of-the-Mental-Health-Act-2007.pdf> (accessed 11 January 2016).

34 *Mental Health Act 2007* (NSW), s. 3(a).

35 The Mental Health Bill 2015, a product of the review, is still being considered by the Queensland parliament.

36 Queensland Health, 'Review of the *Mental Health Act 2000*: Discussion Paper, May 2014, pp 10, 11, 23, 28 & 34, <http://www.qmhc.qld.gov.au/wp-content/uploads/2014/02/Mental-Health-Act-Discussion-Paper.pdf> (accessed 15 January 2016).

Outcomes

6.44 The Queensland parliament has recently passed the *Mental Health Act 2016*. The main objects of the Bill are:

- to improve and maintain the health and wellbeing of persons with a mental illness who do not have the capacity to consent to treatment
- to enable persons to be diverted from the criminal justice system if found to have been of unsound mind at the time of an alleged offence or to be unfit for trial, and
- to protect the community if persons diverted from the criminal justice system may be at risk of harming others.³⁷

Victoria

6.45 The Victorian Government recently passed the *Medical Treatment Planning and Decisions Bill 2016* (Bill), which provides for the Victorian Civil and Administrative Tribunal to make an order in relation to the decision making capacity of a person in relation to medical decisions, and establishes who can be appointed as a medical decision maker of behalf of a person deemed not to have such capacity. The Bill also contains provisions around advanced care planning.³⁸

6.46 The Victorian Government stated the reasons for the change was to give statutory recognition to advance care directives, and to 'simplify Victoria's medical treatment laws to clarify people's rights and obligations by removing the current array of relevant laws to create a single framework for medical treatment decision making for people without capacity.' The changes include separating medical decisions from other powers of attorney to ensure such decisions are considered separately from issues such as financial decisions.³⁹

South Australia

6.47 The South Australian *Mental Health Act 2009* was reviewed by the Office of the Chief Psychiatrist with a report issued in May 2014. It should be noted that SA is the only jurisdiction that has three levels of inpatient and community treatment orders that reflect the differing durations of illnesses and treatment (i.e. short, medium and long).

6.48 This review found that

37 Explanatory Note (EN), *Queensland Mental Health Bill 2015*, p. 1, <http://www.legislation.qld.gov.au/Bills/55PDF/2015/MentalHealthB15E.pdf> (accessed 7 March 2016).

38 Explanatory Memorandum, *Medical Treatment Planning and Decisions Bill 2016* (Bill), pp. 1–3.

39 Department of Health and Human Services (Victoria), *Medical Treatment Planning and Decisions Bill 2016 - frequently asked questions*, <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/medical-treatment-planning-and-decisions-bill/frequently-asked-questions> (accessed 3 November 2016).

- Level 1 community orders were underutilised and recommended that these types of involuntary orders be made more accessible by removing the requirement for these to be reviewed by the Guardianship Board.⁴⁰ Broader use of and easier access to Level 1 community orders may lead to a reduction in Level 1 inpatient treatment orders (inpatient orders).
- There is a need for early revocation of level 3 orders if a psychiatrist deems that a patient has sufficiently recovered to continue their treatment in the community without a review tribunal hearing.
- Simplification of the administrative requirements for psychiatrists.
- A 'threshold criteria for involuntary treatment should include a capacity criterion' as is the case in NT, Queensland, Tasmania and WA'.⁴¹

6.49 The impact of the review recommendation on practise in South Australia is not known to the committee.

Australian Capital Territory

6.50 A review of the *Mental Health (Treatment and Care) Act 1994* commenced in 2006.

Outcomes

6.51 The *Mental Health Act 2015* was passed in late 2015. This new Act incorporates some of the suggested changes made during the review of the former Act including:

- A focus on recovery.
- Availability and access to early preventative treatment for people with mental illness.
- Extension of permissible period for involuntary detention from 10 up to 14 days.⁴²
- That the ACT Civil and Administrative Tribunal must take into account the following when making a forensic mental health order:
 - whether the person consents, refuses to consent or has the decision-making capacity to consent, to the proposed treatment, care or support.

40 A Level 1 community order requires an individual to receive involuntary treatment for a mental health issue whilst living in the community. It has effect for 28 days.

41 South Australian Health, Office of the Chief Psychiatrist, 'The Review of the *Mental Health Act 2009*', May 2014, pp 44–46, 48–51, <http://www.sahealth.sa.gov.au/wps/wcm/connect/f2df5880450e379a8164d1005ba75f87/Mental+Health+Act+Review+Report+MHSA+20140805.pdf?MOD=AJPERES&CACHEID=f2df5880450e379a8164d1005ba75f87> (accessed 15 January 2016).

42 This can result in a longer initial involuntary holding but mitigates the risk of the 'ACAT having to make a longer term order than it might have, had the treating team had more time in which to observe the person's responses to treatment and had the person had more time in which to recover'.

- whether there are reasonable grounds that the person has seriously endangered or is likely to seriously endanger public safety.
- A new scheme for the transfer of prisoners with a mental illness from a correctional facility to an approved mental health facility.⁴³

Committee view

6.52 The committee notes work undertaken at a Commonwealth level to provide advice to states and territories on ways to make mental health laws more consistent across the jurisdictions, particularly with a view to sharing best practice initiatives:

- Australian Law Reform Commission's *Equality, Capacity and Disability in Commonwealth Laws* report, and
- Council of Australian Governments *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector*.

6.53 However, the implementation of best practice initiatives across Australia has been left to states and territories to address individually and remains patchy at best. It is clear that a significant task remains for some states and territories to bring mental health acts into line with nationally accepted standards.

43 Revised Explanatory Statement, Mental Health (Treatment and Care) Amendment Bill 2014 (ACT), pp 5–33, http://www.legislation.act.gov.au/es/db_49560/20141030-59397/pdf/db_49560.pdf (accessed 15 January 2016).

Chapter 7

Involuntary mental health orders

Because intervention comes so late, consumers and families report that once the police are involved and no matter how the police are, there is still a sense of not being treated with dignity . . . "I know when I get sick that I quickly lose insight and will resist treatment but I am sick and there I am being handcuffed by police. No other groups of people with an illness are treated like this. Why are we? Surely there can be a better way. I think it starts with me being able to say, I'm becoming unwell and clinicians taking me seriously".¹

7.1 This inquiry is predominantly concerned with the indefinite detention of people within the forensic mental health system. However, a significant number of people with a cognitive and/or psychiatric impairment are also detained under various state and territory mental health legislation. Provisions for detention within mental health frameworks often involve less oversight and structured review than is found in the forensic system.

7.2 In addition, the goal of diverting people with cognitive and/or psychiatric impairment away from the criminal/forensic mental health system into a civil/health system, is likely to result in an increased use of controlled orders under existing state and territory mental health Acts. As such, it is important to review how those civil frameworks are currently operating.

7.3 This chapter will look at:

- the impact of the current 'risk' approach to mental health orders;
- the involvement of police during mental health crises and the use of police vehicles for transport;
- legal capacity and Advance Directives;
- mechanisms to review controlled treatment orders; and
- the framework for transitioning back to the community.

7.4 The committee notes that multiple submitters argued that mental health legislation is in itself discriminatory, in that this legislation allows for the indefinite detention of people based on their disability.

7.5 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) said:

When a person lacks capacity and presents a significant risk they may need to be detained. People with severe psychiatric and/or cognitive impairment are not detained because of their impairments, but because of the risk and

1 Dr Joanne Bradbury, Matt Ireland, Helen Stasa, 'Mental Health emergency transport: the pot-holed road to care', *The Medical Journal of Australia*, Volume 200, no. 6, p. 348.

lack of capacity. This is usually secondary to the psychiatric or cognitive impairment but it is an important distinction.²

7.6 RANZCP also submitted that the mental health regime has, in general, moved towards greater compliance with human rights principals:

The clear trend in recent decades has been toward greater emphasis on autonomy and a corresponding erosion in the coercive powers available to psychiatrists. This is in line with human rights legislation.³

7.7 However, as the committee noted in the final report of its 2015 inquiry into violence, abuse and neglect against people with disability (abuse inquiry). '[u]nder the guise of 'therapeutic treatment', people with disability can be subjected to forcible actions that could be considered assault in any other context.'⁴ The issue of 'disability specific lawful violence' and how it impacts people with a cognitive or psychiatric impairment is discussed in greater detail in Chapter 9.

Risk approach to controlled orders

7.8 Evidence presented to this inquiry outlined the ethical tensions in detaining a person for involuntary mental health treatment:

All mental health acts within Australia express a tension between the contesting values of *autonomy*, and the perceived need for coercion to prevent *danger* or *harm* (to the patient or others) (Fistein, Holland, Clare, & Gunn, 2009). This latter value is normally complemented by provisions that enable coercion to ensure patients receive vital *care* – the *need for treatment* criterion.⁵

7.9 In her submission, Dr Joanne Bradbury outlined that laws giving the state the right to detain a person with mental illness have evolved from centuries old English 'lunacy' laws, where the King has an obligation to protect the vulnerable in society and ensure they are provided for. These laws evolved, and later included the provision of treatment for persons with a 'mental incapacity'. However, as these laws are currently applied and practised in Australia, the right to personal liberty prevails and such involuntary treatment is now only imposed when a person is deemed a risk of harm to themselves or another person.⁶

Within the Mental Health Act there is no provision for earlier interventions based on reduced mental capacity—at least no legal provisions. Carers, caseworkers and doctors are powerless to invoke the act earlier in the process at the point where they observe a decline in mental capacity but the

2 Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Submission 17*, p. 5.

3 RANZCP, *Submission 17*, p. 6.

4 Community Affairs Committee, *Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability*, November 2015, p. xxvi.

5 Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Submission 17*, p. 6.

6 Dr Joanne Bradbury, *Submission 63*, pp 4–6.

person is still a low risk of harm. They must watch and wait until the person becomes a serious risk before they can legally intervene.⁷

7.10 A submitter who described a parent's lived experience argued against early interventions to provide involuntary treatment, recommending that 'in the interests of keeping people involved in their own decision making that involuntary detention is only used as last resort when the safety of people is at risk.'⁸

7.11 However, Dr Bradbury argued that using forcible intervention only as a last resort necessitates police involvement which can be detrimental to the delivery of appropriate health care:

Under current legislation in NSW, no one can legally intervene unless the person is considered to be a high risk of physical harm. Police and ambulance services are frustrated by this interpretation of the MHA, which seems to place them in the front line. As first responders, they are frequently called upon to attend an emergency situation where a person is behaving erratically, but not necessarily criminally, and it could be caused by mental health disorders or drug or alcohol intoxication. The scene of an incident is not the place to make diagnostic decisions about mental capacity.⁹

7.12 Dr Bradbury recommended changes to the legislation to allow for earlier intervention which may not require police involvement.¹⁰ This is in line with the recommendations for more early intervention programs made in submissions by many medical, advocacy and service delivery organisations.¹¹

7.13 The Australian Cross Disability Alliance (Disability Alliance) submitted that there is no consistency across state and territory mental health laws in assessing, or determining the level of risk of harm to self or others, or in assessing a person's ability to provide consent to treatment. The Disability Alliance wrote:

As a result, many people with psychosocial disability and cognitive impairment experience serious breaches of their human rights and widespread abuse, neglect and exploitation within the current legislative, policy and practice framework that purports to 'protect' them.¹²

7 Dr Bradbury, *Committee Hansard*, 23 March 2016, p. 31.

8 Name withheld, *Submission 41*, p. 6.

9 Dr Bradbury, *Submission 63*, p. 11.

10 Dr Bradbury, *Committee Hansard*, 23 March 2016, p. 31.

11 Among other submissions, see: Queensland Advocacy Inc. *Submission 7*; Australian Medical Association, *Submission 12b*; Australian College of Mental Health Nurses, *Submission 14*; NSW Council on Intellectual Disability, *Submission 40*; Office of the Public Guardian, Queensland, *Submission 56*; Office of the Public Advocate Victoria, *Submission 58*; Australian Cross Disability Alliance, *Submission 61*; Forensicare, *Submission 65*; Law Council of Australian, *Submission 72*; Aboriginal Disability Justice Campaign, *Submission 76*.

12 Australian Cross Disability Alliance, *Submission 61*, pp 12–13.

7.14 RANZCP also submitted evidence about the inconsistency in legislation and practice:

There is a significant divergence between mental health acts as to the criteria that must be applied before involuntary treatment is enacted. Divergence is not limited to differing criteria; it finds expression in the frameworks that operate after initial assessment in a mental health facility. Processes which enable the imposition and review of compulsory treatment vary even more between states and jurisdictions than do the criteria themselves, although convergence is starting to occur on this level as well.¹³

7.15 The QLD Office of the Public Guardian (OPG-QLD) submitted evidence that even within the one jurisdiction, legislation is inconsistent in how it responds to differing impairments:

For example, under the new mental health legislation, while provision is made for a new and less restrictive order (treatment support order) as an alternative to a forensic order, this alternative only applies to persons with a mental illness. A person who is found to be of unsound mind or unfit for trial due to an intellectual or cognitive disability can only be placed on the restrictive forensic order. No less restrictive option is available for this cohort. Under the less restrictive order, the default is that persons should be placed upon community category orders, unless it is necessary for the person to be an inpatient. The default position under a forensic order is detention unless the Mental Health Court is satisfied that there is not an unacceptable risk to the safety of the community, because of the person's mental condition, including the risk of serious harm to other persons or property. The result is that the default for people with intellectual or cognitive disability is detention.¹⁴

7.16 The QLD Office of the Public Advocate (Public Advocate QLD) submission also discussed the new provisions in the recently passed *Mental Health Act 2016* (QLD). The Public Advocate QLD contended that while some parts are consistent with best-practice frameworks, the framework does not go far enough in 'supporting a recovery orientation to mental health treatment when compared with other contemporary legislative approaches.'¹⁵

7.17 The Disability Alliance submitted that one consistency across jurisdictions, is that all laws regulating mental health treatment 'have failed to prevent, and in some cases, actively condone unacceptable practices, including the widespread use of non-consensual psychiatric medications, electroconvulsive therapy (ECT), restrictive practices, such as seclusion and restraints and arbitrary detention.'¹⁶

13 RANZCP, *Submission 17*, pp 6–7.

14 Office of the Public Guardian (QLD), *Submission 56*, p. 5.

15 Office of the Public Advocate (QLD), *Submission 36*, p. 11.

16 Australian Cross Disability Alliance, *Submission 61*, p. 18.

7.18 RANZCP outlined that legislative provisions outside the various state and territory mental health legislation also allow for involuntary treatment, such as disability and guardianship Acts.¹⁷ These are also discussed in greater detail in Chapter 9.

Committee view

7.19 There is an inherent conflict in the imposition of involuntary mental health treatment: while it is intended for a person's best interest, it is both imposed against their will and often requires a deprivation of liberty. Understandably, the current system is weighted towards individual liberty, where detention is only imposed where there is deemed a significant risk to life or safety. However, this flies in the face of medical advice for most other illnesses, where early intervention is generally advised.

7.20 The committee is concerned that the mental health care system has not followed the general move in healthcare towards preventative care. The committee believes that more early intervention programs would result in fewer people being detained as a result of police being used as first responders.

7.21 The committee is also concerned with the widely differing standards of care, protection and oversight that legislation affords across the jurisdictions, and believes that more can be done to replicate best practice examples across Australia.

Transport

7.22 As discussed above, a last-resort approach to intervention in a mental health context often necessitates police involvement in situations of risk of imminent harm. This often leads to police being used to provide a de facto mental health transport service.

7.23 Evidence presented to the inquiry highlighted the frequent use of police to transport people to involuntary mental health treatment:

The Mental Health Act had been changed in 2007 in an attempt to reduce police involvement, and police were expecting that Ambulance and Health would assume responsibility for mental health transports under the act. In fact, in the New South Wales parliamentary speech introducing the bill in 2007, the Minister Assisting the Minister for Mental Health, Paul Lynch, clearly stated the intention to transfer the burden of responsibility to Health. He said:

The new provisions aim to emphasise that NSW Health will take primary new provision will the responsibility for patient transports, with requests for police involvement to be limited to where there are serious concerns about patient and/or staff safety.

However, in practice, police were continuing to provide the bulk of mental health transports under the act after it had been changed.¹⁸

17 RANZCP, *Submission 17*, p. 7.

18 Dr Bradbury, *Committee Hansard*, 23 March 2016, p. 31.

7.24 It was submitted that this form of transport is highly inappropriate, as it not only traumatised people to be 'picked up by police' but the paddy wagon itself was described as:

a cold, dark, plastic/metal box-like cage with no seat cushioning, nothing to hold on to, no proper windows and no proper ventilation. There is no way of monitoring someone who is in the back during the transport.¹⁹

Dr Bradbury further contended that the use of police vehicles, particularly paddy wagons, is not consistent with least restrictive practice.

7.25 Dr Bradbury outlined the process by which police then 'hand over' a person for assessment or treatment:

Upon arrival at the emergency department, police (or ambulance if they were the transporters) must wait with the person until they can be triaged in turn by the nurse, who will then call the psychiatrist to come in to undertake the psychiatric assessment. The wait times in emergency are extraordinarily long and cause a lot of time stress for police and ambulance officers, who might hear other calls coming out on their radios but are unable to attend. This process is a bottle neck for emergency services.

A recent Victorian study found that the time a person, who was bought [sic] in by police under mental health legislation, spends in the ED could range from 79 – 416 minutes, with a median of 156 mins (2.6 hours). These wait times may also exacerbate the condition of the person who may be waiting in the back of the paddy wagon in the driveway.²⁰

7.26 A NSW Police Force initiative aims to address issues such as those raised above, by redrafting the Memorandum of Understanding between NSW Police, Health and Ambulance, with the goal to:

...ensure that persons detained by the NSWPF under Sect 22 of the Mental Health Act are always transported to a health facility for assessment by a NSW Ambulance vehicle. The use of Police vehicles for this purpose only serves to add to the stigma surrounding mental health, whereas Ambulance facilitated transport ensures a least restrictive, dignified and clinically supervised transition into care.²¹

7.27 In rural and regional areas, it was submitted that it is common practice to use a paddy wagon, largely due to limitations in health resources such as ambulances.

In rural and regional Australia, and particularly after-hours, travel in the back of a paddy wagon may involve long distances between regional towns, due to the fact that only the larger regional towns have a psychiatrist available to make the assessment. Apart from the extreme discomfort and distress caused to the person in the back, this can also take police and/or

19 Dr Bradbury, *Submission 63*, p. 10.

20 Dr Bradbury, *Submission 63*, p. 12.

21 NSW Police Force, *NSWPF Mental Health Intervention Team*, http://www.police.nsw.gov.au/community_issues/mental_health (accessed 16 November 2016).

ambulance resources away from small regional centers for long periods of time.²²

7.28 Dr Bradbury presented evidence that the use of video conferencing for psychiatric assessment reduced long distance transport by 20 per cent over a 20 month period, and argued this type of program should be further explored to reduce the use of transport by paddy wagon of people experiencing mental health episodes.²³

Committee view

7.29 It is clear that the current mental health system relies on waiting for a crisis to occur before involuntary treatment orders are invoked, and this in turn significantly increases the chances of police involvement due to risk of harm to the individual or others. The result is that people when at their most vulnerable during a mental health episode, are transported to a health facility in an inappropriate way that does not accommodate their needs.

7.30 The committee believes that a key way to address this issue, in addition to increased funding for health transport services particularly in regional and rural regions, is to increase early interventions in mental health, rather than wait for a crisis to occur before taking action. The committee strongly supports a move to early intervention in mental health care as a better model of health service delivery.

Legal capacity and Advance Directives

7.31 The committee heard evidence from a range of submitters that a loss of legal capacity for decision making for a person with a mental health condition is often temporary or episodic, and linked to a periodic mental health crisis. However, during times of mental health stability, the person may be quite capable of demonstrating legal capacity. Broader issues of legal capacity and guardianship are discussed in greater detail in Chapter 9.

7.32 In an article for the Medical Journal of Australia, Dr Bradbury has noted the important role that a legal mechanism could play for people with periodic mental incompetence in pre-determining agreed trigger points for non-consensual assessment and treatment during times of a mental health crisis:

A legal mechanism for non-consensual assessment based on decisional capacity could be explored. People living with mental illness could be supported, during periods of capacity, to identify indicators of diminished capacity as key intervention points, and doctors making clinical assessments in chronic and potential first-episode psychosis could give serious consideration to capacity. Thinking about capacity at an earlier intervention point may reduce the number of people requiring an emergency response.

Ideally, people living with mental illness should be able to access quality mental health services voluntarily, long before non-consensual intervention

22 Dr Bradbury, *Submission 63*, p. 12.

23 Dr Joanne Bradbury, *Submission 63*, p. 13.

is required. Once voluntary options have been exhausted, the point at which a person loses decisional capacity may represent an earlier, more benevolent juncture for non-consensual intervention. Reaching the point of emergency services intervention in a mental health incident should be the *last* option along the pot-holed road to care.²⁴

7.33 One such mechanism presented to this inquiry is an Advance Directive or Advanced Care Directive.²⁵ These are legally binding documents prepared by an individual to indicate their health care assessment and treatment preferences, and preferred advocate in the circumstance that they are temporarily or permanently unable to make their own decisions. Typically, these are used by someone with a terminal illness to provide clear direction on their healthcare; however, these directives are now being used by those with mental or psychiatric illnesses that temporarily incapacitate a person's decision making functions.²⁶

7.34 A 2008 paper aptly summarises the role that an Advance Directive plays:

In a sense, the Advance Directive becomes the voice of the person at a time when they may not be able to convey their preferences. An Advance Directive can articulate the person's preferences or nominate another person to make particular decisions. The document may state the negative effects of particular treatments and the reasons that other medications are preferred. Advance Directives for people with a mental illness aim to extend beyond medical treatment to all aspects of the person's life.²⁷

7.35 The Public Advocate QLD described how Advance Directives function in QLD:

The *Powers of Attorney Act 1998* (Qld) allows people to make decisions and/or arrangements for decision-making that can be implemented in the future. These arrangements are primarily made through an advance health directive or an enduring power of attorney, and enable people to have a voice in their future health care should they later develop a condition that prevents them from consenting to treatment.²⁸

24 Dr Bradbury et al, 'Mental Health emergency transport: the pot-holed road to care', pp 350–351. See also: V. Topp, M. Thomas, 'Advance Directives for Mental Health', *The Australian Journal on Psychosocial Rehabilitation*, Autumn 2008, pp 51–55, [http://www.communitylaw.org.au/mhlc/cb_pages/files/advance%20directivesnew%20paradigm-1\(2\).pdf](http://www.communitylaw.org.au/mhlc/cb_pages/files/advance%20directivesnew%20paradigm-1(2).pdf) (accessed 7 March 2016).

25 For further discussion of advance care directives, see: *Submission 36*, *Submission 58* and *Submission 63*.

26 South Australian Government, *Advance Care Directives*, <http://www.advancecaredirectives.sa.gov.au/about> (accessed 29 February 2016). These can also be known as Ulysses pacts/contracts/agreements, in that they are designed and intended to bind oneself in the future.

27 Vivienne Topp, Martin Thomas, 'Advance Directives for Mental Health', *The Australian Journal on Psychosocial Rehabilitation*, Autumn 2008, p. 51.

28 Office of the Public Advocate (QLD), *Submission 36*, p. 16.

7.36 The Office of the Public Advocate Victoria (Public Advocate Victoria) outlined how Advance Directives are included in Victorian legislation:

The Mental Health Act in Victoria provides a model for consideration in the way clinical oversight and review mechanisms are provided, with access to a second opinion, legal aid assistance, the opportunity to appoint a nominated person and provisions for a patient advance statement to be considered by the authorised psychiatrist.²⁹

7.37 However, the Mental Health Legal Centre highlights some of the practical complications that exist in the current health service delivery environment:

In Victoria common law regarding Advance Directives suggests that when a person is deemed to be 'competent', their Advance Directive will be respected. However, once a person is defined as 'incompetent' the Advance Directive holds a much weaker position. This causes considerable problems because what consumers think they're doing when making an Advance Directive is putting in place something that will be there for them if they do become very distressed and ill later on.³⁰

Committee view

7.38 Increasing the use of supported decision-making was recommended by this committee in the final report of the 2015 abuse inquiry.³¹ This current inquiry has received more evidence to affirm the committee's view formed during the abuse inquiry, and the committee continues to recommend increased use of supported decision making models across the jurisdictions.

7.39 For people with a mental health condition that involves periodic loss of legal capacity, the committee notes that Advance Directives appear to offer a way to increase their autonomy and involvement in decisions about their health care. The committee notes the need to enact legislative change to address the issue of Advance Directives being ignored.

Review mechanisms

7.40 Chapter 7 outlined the various state and territory involuntary mental health order review mechanisms. This section will look broadly at some of the problems highlighted by submitters, which include the need for time limited detention, differing standards for review across jurisdictions and the difficulty detained people have in meeting the safety standards required for release.

29 Office of the Public Advocate (VIC), *Submission 58*, p. 18.

30 Mental Health Legal Centre, *Advance Directives—Maximising consumers autonomy dignity and control*, http://www.communitylaw.org.au/mentalhealth/cb_pages/living_wills.php (accessed 7 March 2016).

31 See Community Affairs Committee, *Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability*, recommendations 10–12, November 2015, p. xviii.

Time limited detention

7.41 A key issue discussed by multiple submitters in regards both the forensic and civil mental health systems, is the lack of statutory time limits on the period of detention. The Disability Alliance recommended that 'State and territory laws should provide for limits on the period of detention of a person who has been found unfit to stand trial, and for regular periodic review of other detention orders.'³²

7.42 The Australian Law Reform Commission recommended that, in their view, the most fundamental change that should happen to the regime around the detention of people with cognitive and/or psychiatric impairment, is the imposition of limits on the period of detention as well as regular periodic review.³³

7.43 The Public Advocate QLD made a similar recommendation:

In instances where indefinite detention is effected, it must be employed as a transitional strategy and be subject to strict time-limitations.³⁴

7.44 However, Victoria Legal Aid submitted that even where time limited detention exists, the system of review can render this, in effect, indefinite detention:

Whilst an ITO can only be made for 6 months, this order can be renewed indefinitely where a person continues to meet the ITO criteria under the Mental Health Act as further applications may be made prior to the expiry of each order. There are people who have been continually detained in the same hospital for many years under an ITO. Our advocacy work focusses on representation at hearings where the primary issue for the decision maker is whether a person continues to meet the criteria under the Mental Health Act. Unlike the best practice framework for STO's, the Mental Health Act does not require consideration of planning for future reduction of interventions, or for leveraging of supports to transition to a less restrictive environment.³⁵

7.45 The Disability Alliance submitted similar evidence, stating 'people under involuntary treatment orders can reside in secure accommodation with no release date, or with the possibility that their treatment order will be continually extended prior to expiry.'³⁶

7.46 Ms Karly Warner, Executive Officer of the National Aboriginal and Torres Strait Islander Legal Services, recommended that to address this failing in the review process, an additional level of review is created:

32 Australian Cross Disability Alliance, *Submission 61*, p. 24.

33 Prof. Rosalind Croucher, President, Australian Law Reform Commission, *Committee Hansard*, Melbourne, 29 April 2016, p. 35.

34 Office of the Public Advocate (QLD), *Submission 36*, p. 19.

35 Victoria Legal Aid, *Submission 71*, p. 9.

36 Australian Cross Disability Alliance, *Submission 61*, p. 12.

[W]e recommend that determinations about release of mentally impaired accused from custody or community release orders should be made by the relevant board, with an annual right of review before the Supreme Court.³⁷

Different standards for review

7.47 The RANZCP raised the issue of differing mechanisms for review across the various regimes used for the imposition of compulsory treatment orders, which results in different levels of protection for individuals:

[T]he review mechanisms and protections for the individual vary widely depending on what legislation is used. For example, under the Mental Health Act involuntary treatment is reviewed by a Tribunal with psychiatrist, lawyer and public member. No such review is undertaken under the Guardian and Administration Act and the decision rests with guardian. This means that people receiving involuntary treatment can have wildly different standards of care and protection.³⁸

7.48 Mr Povey from Victoria Legal Aid went further, and submitted to the committee that this absence of a really consistent and clear framework for the detention of people with cognitive or psychiatric impairment was not simply difficult to navigate, but could itself 'create an environment for abuse.'³⁹

Safety triggers for release

7.49 The NSW Government outlined the review provisions of the *Mental Health Act 2007* (NSW) (NSW Mental Health Act) in its submission, stating that where the Mental Health Review Tribunal orders detention, it must 'review that decision every three months during the first year of a person's detention and every six months thereafter' and also states that the NSW Mental Health Act directs that a detained person must be released as soon as an authorised medical officer no longer considers them to be mentally ill' or that there is alternative appropriate community-based accommodation.⁴⁰

7.50 However, as discussed in Chapter 3, this essentially reverses the onus of decision-making from one which requires a justification for detention, to one which requires a justification for release. In order to meet the trigger for release, a person is entirely reliant on the actions of external parties: for example, they require the provision of therapeutic interventions to improve their mental health and/or the provision of appropriate community based accommodation.

7.51 The Public Advocate Victoria raised this issue, stating that despite existing safeguards in the Victorian regime, people continue to be detained beyond the period required for treatment:

37 Ms Karly Warner, Executive Officer, National Aboriginal and Torres Strait Islander Legal Services, *Committee Hansard*, 29 April 2016, p. 23.

38 RANZCP, *Submission 17*, p. 7.

39 Mr Chris Povey, Victoria Legal Aid, *Committee Hansard*, Melbourne, 29 April 2016, p.4.

40 NSW Government, *Submission 66*, p. 2.

The Mental Health Act in Victoria provides a model for consideration in the way clinical oversight and review mechanisms are provided, with access to a second opinion, legal aid assistance, the opportunity to appoint a nominated person and provisions for a patient advance statement to be considered by the authorised psychiatrist. In this way, accountability and safeguards are contained in the Mental Health Act.

Despite these safeguards, some people subject to detention and treatment under the Mental Health Act at least, continue to be detained beyond the time when they need treatment in a clinical mental health unit.⁴¹

7.52 The OPG-QLD contends in its submission that '[i]n Queensland, once a person enters the system as an involuntary mental health patient, there can be significant challenges and obstacles for those with serious mental illness to exit the system, regardless of whether there are regular reviews by the Mental Health Review Tribunal (MHRT).'⁴²

7.53 Queensland Advocacy Inc. concurred with this view of how the system operates in QLD:

The Mental Health Review Tribunal tends to take a conservative approach to its assessment of risk and will renew orders by default. This is particularly problematic because the more time that passes without satisfying the risk test, the more difficult it then becomes to demonstrate the ability to successfully reintegrate into the community, which increases the institutionalisation and further erodes a person's ability to live independently. It is quite a vicious circle.⁴³

7.54 Mental Health and Wellbeing Consumer Advisory Group, Being, submitted that a lack of adequate communication led to patients feeling as though they were being indefinitely detained:

Too often, mental health consumers are not informed about when they will be discharged from the hospital. Consumers tell us that they are also not informed about when they can see a doctor to discuss these issues. Some consumers told us that even when they are told when they will see the doctor, this may not necessarily happen, and they may have to wait much longer than promised. These factors make people feel like they are being held in the hospital indefinitely.⁴⁴

7.55 Being further submitted that people in mental health in-patient units perceive doctors and staff as having power over what happens to them, including making them stay longer as punishment.⁴⁵

41 Office of the Public Advocate (VIC), *Submission 58*, p. 18.

42 Office of the Public Guardian (QLD), *Submission 56*, p. 4.

43 Dr Emma Phillips, Systems Advocate, Queensland Advocacy Inc., *Committee Hansard*, Brisbane, 23 March 2016, p. 9.

44 Being, *Submission 49*, p. 9.

45 Being, *Submission 49*, p. 10.

7.56 Challenges impeding a person's transition to the community are discussed in greater detail in the next section.

Transition back to community

7.57 RANZCP highlighted that where a person has been detained because their mental impairment puts them or others at risk, there is a moral obligation to provide therapeutic treatment to address the impairment. RANZCP submitted that '[c]urtailment of individual liberties should be matched by providing adequate interventions and resources to assist in rehabilitation/long term care.'⁴⁶

7.58 Evidence presented to the inquiry suggests that indefinitely detained people are not being provided with the treatment that is a necessary part of their future release: people must improve in their mental state so they are no longer a danger to themselves or others, which is largely impossible without adequate therapeutic assistance.

Therapeutic treatment

7.59 In its submission, the OPG-QLD stated that programs and interventions designed to assist people to live in the community often fail to deliver and there are 'little if any repercussions upon the system that fails to deliver services.' The OPG-QLD highlighted that 'a set of nationally-endorsed public standards and monitoring of these systems with power to enforce the standards, may assist to bring pressure to bear on these systems and provide incentives for them to transition people from detention to community living.'⁴⁷

7.60 Victoria Legal Aid echoed this view, and stated that the current strong emphasis on preventing people from entering the indefinite detention system, must be matched with an equally strong emphasis on getting people out once they are in.⁴⁸

7.61 The Public Advocate Victoria outlined positive aspects of the *Mental Health Act 2014* (Vic) which incorporates some of the standards recommended by the OPG-QLD:

The Mental Health Act in Victoria provides a model for consideration in the way clinical oversight and review mechanisms are provided, with access to a second opinion, legal aid assistance, the opportunity to appoint a nominated person and provisions for a patient advance statement to be considered by the authorised psychiatrist. In this way, accountability and safeguards are contained in the Mental Health Act.⁴⁹

7.62 However the Public Advocate Victoria did acknowledge that even with these safeguards, some people are detained within the mental health system for longer than

46 RANZCP, *Submission 17*, p. 4.

47 Office of the Public Guardian (QLD), *Submission 56*, p. 4.

48 Mr Povey, Victoria Legal Aid, *Committee Hansard*, Melbourne, 29 April 2016, p. 4.

49 Office of the Public Advocate (Victoria), *Submission 58*, p. 18.

they need to be.⁵⁰ During a hearing for the inquiry, the Public Advocate Victoria discussed a recent research study which found that of 99 long-stay mental health patients in secure facilities, 75 were detained because there was no alternative accommodation for them.⁵¹

7.63 Victoria Legal Aid submitted similar evidence on the regime in Victoria, and stated that a lack of statutory requirements to provide treatment has the effect of prolonging detention for individuals:

In our advocacy work for people under the CMIA [Crimes (Mental Impairment and Unfitness to be Tried) Act 1997] or those subject to inpatient treatment order ("ITO") under the Mental Health Act we see many instances of prolonged, indefinite detention where there is insufficient impetus or structural supports to enable the person to progress and receive treatment in an environment that would be less restrictive of their freedom.⁵²

7.64 The Public Advocate QLD submitted that to address this issue, formal requirements for treatment plans should be incorporated into legislation:

The instigation of appropriate planning and review processes is an essential safeguard for people who are detained in authorised facilities for the purpose of treatment and/or behaviour support. Formal plans hold facilities to account by requiring staff to work according to specific objectives and standards, establishing outcomes against which agency practice can be measured, and documenting progress against these benchmarks. Provisions for treatment plans based on a recovery framework, positive behaviour support plans, and/or transition plans should, therefore, be incorporated into relevant legislation.⁵³

7.65 The Public Advocate Victoria has submitted that an increase in in-patient therapeutic services has resulted in a reduction in long-stay patients:

The reduction in long stay patients in Victoria has been assisted by a range of policy and funding factors. These include the provision of intensive in-reach for long-stay patients (funded originally through the Intensive Rehabilitation Recovery Care Project; then through the SECU diversion project and the Intensive Home Based Outreach Service). Together these projects have helped to divert people from SECU units and provide intensive support for their recovery and transition into the community.⁵⁴

50 Office of the Public Advocate (Victoria), *Submission 58*, p. 18.

51 Dr John Chesterman, Director of Strategy, Office of the Public Advocate (Victoria), *Committee Hansard*, 29 April 2016, p. 15.

52 Victoria Legal Aid, *Submission 71*, p. 9.

53 Office of the Public Advocate (QLD), *Submission 36*, p. 21.

54 Office of the Public Advocate (Victoria), *Submission 58*, p. 19.

Appropriate facilities and accommodation

7.66 Evidence presented to the inquiry has shown there is a dearth of appropriate facilities, both within the mental health detention system, as well as supported accommodation in the community to allow for gradual release.

7.67 The lack of facilities for people who require involuntary treatment often results in people being held under higher security than is actually required, such as in prisons (see Chapter 4), or being held in facilities which do not lend themselves to assist in therapeutic care.

7.68 The Public Advocate Victoria submitted that across all states and territories, there is a lack of less restrictive facilities to allow people on supervision orders to 'step down' levels of restriction, and noted a report from the Victorian Law Reform Commission found this could result in a mismatch between the supervision required and the supervision order that is actually made.⁵⁵

7.69 Many submitters discussed a serious lack of community-based accommodation and support services which would allow people to be released from detention. The Public Advocate Victoria submitted that while there has been a closure of psychiatric facilities over the last three decades, there has not been a corresponding increase in community-based accommodation and support. The Public Advocate Victoria argued this compromised the ability of the mental health system to meet its human rights obligations.⁵⁶

7.70 The Disability Alliance submitted a case study to support a similar assertion on the lack of community-based options:

Ms A. was homeless when she was placed under an involuntary treatment order in 2010. Despite reviews of her involuntary treatment order, it was deemed to be in her 'best interests' to continually detain Ms A. in a psychiatric unit as she was considered to be a risk to herself, and there was a view that there were no community mental health supports that could be tailored to her specific needs. This detention lasted for six years, until advocacy support successfully negotiated her release to appropriate community accommodation and support.⁵⁷

7.71 Submitters also raised evidence that many existing community-based service providers were reluctant to take on clients where managing complex behaviours or risk was involved:

The OPG has also observed that as the complexity of disability needs increases; the availability in choice of services, supports and accommodation decreases. There are therefore limited accommodation choices for people with high and complex needs.⁵⁸

55 Office of the Public Advocate (Victoria), *Submission 58*, p. 24.

56 Office of the Public Advocate (Victoria), *Submission 58*, p. 18.

57 Australian Cross Disability Alliance, *Submission 61*, pp 12–13.

58 Office of the Public Guardian (QLD), *Submission 56*, p. 8.

7.72 RANZCP also raised the issue of people with long-term behaviours which continue to put themselves and others at risk, and called for a secure model of care which can deliver a range of services in-house, without which 'people in this situation often remain incarcerated in inappropriate settings such as prison, mental health facilities and in restricted residential settings.'⁵⁹ RANZCP further submitted that a general principle across all forms of treatment should be applied, where treatment 'should be in the least restrictive environment appropriate, consistent with individual circumstances and consideration for the safety of the community.'⁶⁰

7.73 The OPG-QLD argued that without increasing the availability of community-based accommodation, the problem of indefinite detention is likely to continue.⁶¹

Committee view

7.74 The committee strongly agrees with the principle set out by RANZCP and other submitters, that where the state deprives a person of their liberty due to the risk factors associated with a cognitive or psychiatric impairment, the state has an obligation to provide therapeutic treatment for that impairment. It is clear to the committee from the evidence presented, that for a range of reasons such treatment is not always delivered. The situation is critical enough to require legislated mandatory requirements for service delivery and oversight of time-limited care plans with a clear goal of release from detention.

7.75 The evidence has also clearly shown there is a shortage of accommodation. This includes secure accommodation that is an appropriate environment to deliver therapeutic treatment while addressing risk factors. More importantly, there is a dire shortage of appropriate community-based accommodation to allow people to step down from secure treatment environments back into the community. This accommodation shortage is resulting in increased rates of indefinite detention.

59 RANZCP, *Submission 17*, p. 9.

60 RANZCP, *Submission 17*, p. 13.

61 Office of the Public Guardian (QLD), *Submission 56*, p. 8.

Chapter 8

Disability, guardianship and aged-care detention

Introduction

8.1 As outlined in earlier chapters, indefinite detention for the purpose of involuntary treatment for people with a cognitive or psychiatric impairment can occur not just under forensic and civil mental health frameworks, but also under various state and territory disability and guardianship frameworks, particularly for those with a cognitive impairment. It can also occur in aged-care settings.

8.2 Detention that occurs from provisions within mental health legislation, as covered by Chapter 8, generally occurs within large therapeutic medical facilities. This brings an inherent level of protection from the oversight mechanisms that exist within such facilities. However, detention that occurs from provisions within disability or guardianship legislation can occur in a range of locations from large hospitals or disability-specific therapeutic facilities, through to smaller disability accommodation units, aged care facilities or even in private homes.¹

8.3 The Office of the Public Advocate Victoria (Public Advocate Victoria) identified a form of informal detention in disability and aged care settings as 'compliant detention', which refers to 'those people with disability who are detained, by their apparent compliance with the restrictive environment in which they live.' The Public Advocate Victoria said the 'the definition of indefinite detention could apply to people in an aged-care facility or a secure section of a group home, that are locked or from which they are not free to leave.'²

8.4 Although not a key focus of this inquiry, the use of involuntary treatments and restrictive practices, which can be viewed as indefinite detention in the disability and aged care context, is also discussed in this chapter.

The disability or guardianship pathway to indefinite detention

8.5 In addition to mental health-specific legislation which allows for the detention of people for the purpose of providing mental health treatment, various disability and guardianship acts also provide for indefinite detention of people with a cognitive or psychiatric impairment, who pose a risk to themselves or others. Similar to the complexity of mental health frameworks outlined in Chapter 8, evidence presented to the committee was that both within and across the jurisdictions, the detention of people within the disability and guardianship context is a web of complex legislation and practise.

1 For a lengthy discussion of the wide range of detention types and locations in the disability, guardianship and aged-care context, see Victoria Legal Aid, *Submission 71*. See also Office of the Public Guardian (Queensland), *Submission 56*, p. 4.

2 Office of the Public Advocate (Victoria), *Submission 58*, p. 31.

8.6 The Royal Australian New Zealand College of Psychiatrists (RANZCP) outlined just how many pieces of legislation contain provisions for involuntary detention:

For example, in Victoria, in addition to the Mental Health Act 2014, involuntary treatment can also be mandated under the Disability Act 2006, the Guardianship and Administration Act 1986, the Powers of Attorney Act 2014, the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997, the Sex Offenders Registration Amendment Act 2014 and the Severe Substance Dependence Treatment Act 2010. Similar legislative provisions exist in other states and jurisdictions.³

8.7 The Office of the Public Advocate QLD (Public Advocate QLD) cited a similar environment in QLD, stating 'In Queensland, the regime for the indefinite detention of, involuntary treatment of, and use of restrictive practices with people with impaired decision-making capacity is essentially fragmented across multiple pieces of legislation, systems and service responses.'⁴

8.8 The complexity of the various legislative systems was cited as in and of itself being a key contributor to conditions of detention. Victoria Legal Aid put forward the view that 'the absence of a really consistent and clear framework quite often in relation to people who are indefinitely detained can create an environment for abuse.'⁵

8.9 As there are many different pieces of legislation or practises which result in detention, this report has focused on presenting an overview of concerns, as well as reforms being undertaken in certain jurisdictions which could be replicated across Australia.

Disability detention

8.10 Across all jurisdictions in Australia, disability frameworks allow for the detention of people with a cognitive impairment, through various formal and informal means. The committee received detailed evidence on the frameworks in Victoria, as many submitters and witnesses across Australia focused on providing a critical evaluation of the Victorian framework, with a view to identifying positive changes that could be replicated in other jurisdictions. The next section will focus on key elements of the Victorian model, which were highlighted by submitters as 'best-practice' examples, acknowledging that even this framework still requires improvement.

Victoria: a best practice framework

8.11 Victoria Legal Aid put forward in their submission that any framework that authorises detention for people with cognitive or psychiatric impairment must include the following elements:

3 Royal Australian New Zealand College of Psychiatrists, *Submission 17*, p. 7.

4 Office of the Public Advocate (Queensland), *Submission 36*, p. 9.

5 Mr Chris Povey, Program Manager, Mental Health and Disability Law Sub-program, Victoria Legal Aid, *Committee Hansard*, 29 April 2016, p. 4.

- There must be clear statutory authority for any detention;
- The person detained has a right of legal representation, and access to state-funded legal services;
- Any decisions authorising detention beyond a short, emergency period must be made by an independent court or specialist tribunal;
- Orders authorising detention must be subject to a right to review or appeal against the initial order;
- Any decision to detain must be demonstrably justified on the basis of cogent evidence;
- Detention may only be authorised if there is no less restrictive means of achieving the objective of the detention;
- Orders authorising detention must be time-limited and subject to periodic review by the independent court or specialist tribunal; and
- The person detained must have a statutory right to apply for revocation of the detention order at regular intervals.⁶

8.12 Victoria Legal Aid further submitted that, in their view, the *Disability Act 2006* (Vic) (Disability Act) contains the best practice example of putting these principles into legislation and practice.⁷

8.13 The Disability Act sets out the framework for detention and involuntary treatment for people with an intellectual disability who pose a risk of harm to others. A supervised treatment order (STO) can be made by the Victorian Civil and Administrative Tribunal (VCAT) only if satisfied the person has previously displayed violent or dangerous behaviour, there is a significant risk of harm that cannot be mitigated in a less restrictive environment, and that detention is necessary to ensure compliance with the treatment plan. Some important safeguards have been built into the framework:

The legislation requires that the person with an intellectual disability derives a 'benefit' from being placed on a supervised treatment order (STO), and that the levels of restrictions on the person's life are reduced over time. The person must be in receipt of state funded 'residential services'.

The STO regime was introduced in order to regulate what was happening in residential facilities. The STO regime brought a greater fairness and scrutiny to decisions affecting the personal liberty of people with intellectual disabilities. The legislation makes it clear that disability service providers must not detain a person with an intellectual disability unless the person is under a STO.⁸

6 Victoria Legal Aid, *Submission 71*, pp 2–3.

7 Victoria Legal Aid, *Submission 71*, p. 3.

8 Office of the Public Advocate (Victoria), *Submission 58*, p. 14.

8.14 Mr Pappos, of disability service provider Australian Community Services Organisation, outlined the difficulties in the regime which require the service provider, in some cases, to be the applicant for an STO:

It is important to articulate that we do not practice detention. We have participants who might be subject to high levels of supervision in the community because of their assessed risk to others. What is important there is that we balance our obligations to their human rights with the risks that they are assessed as posing to either themselves or others in the community. The tension for us, I suppose, is we are the applicant of these orders in Victoria—because that is what it requires, that the authorised program office under the Disability Act is required to apply for an order—but we are also the service provider. For us, that is a constant tension.⁹

8.15 The Public Advocate Victoria submitted that VCAT plays an 'important monitoring and safeguard role' in that duration of an STO can be no longer than 12 months, and at each renewal must be again tested against the legislative requirements for detention. According to Public Advocate Victoria, since the commencement of the Disability Act, there have been 65 persons detained on an STO.¹⁰

8.16 The Public Advocate Victoria further submitted that the effectiveness of the STO regime was not just in the legislative framework, but also due to:

- The process that leads to the development of a treatment plan⁴⁴ which includes the engagement of skilled professionals, the scrutiny of the Senior Practitioner who must approve the plan, and VCAT who must make the STO having regard to the plan.
- The external bodies involved in regulating and scrutinising the use of STOs (VCAT, the Senior Practitioner, and OPA) are obliged to ensure that the rights, dignity and best interests of the person with the intellectual disability are protected. The Public Advocate also has the power to apply to VCAT for an order directing the authorised program officer to make an application for a STO. This would occur where the Public Advocate believes that a person is being detained to prevent a significant risk of serious harm to others and an application for a STO has not been made.
- Victoria Legal Aid's specialist advocacy for persons proposed for or subject to detention.¹¹

8.17 However, the Public Advocate Victoria pointed out in its submission that the Disability Act may produce uneven benefits, as people who are not on STOs are denied access to the same state-funded high quality treatments, services and clinical oversight from the Senior Practitioner that people on STOs have. The Public Advocate Victoria said that this effectively means 'a person's access to the benefits associated

9 Mr Stan Pappos, Senior Manager, Forensic Housing Services, Australian Community Services Organisation, *Committee Hansard*, 29 April 2016, p. 43.

10 Office of the Public Advocate (Victoria), *Submission 58*, p. 14.

11 Office of the Public Advocate (Victoria), *Submission 58*, p. 15.

with supervised treatment is made conditional upon detention.' Public Advocate Victoria also submitted that as STOs can be renewed, this could lead to a form of de facto indefinite detention.¹²

8.18 Victoria Legal Aid summed up their views on the reforms undertaken in Victoria to the committee:

If you think about what has happened in Victoria, I think it is important to acknowledge, as it has been acknowledged, it is not perfect...The updated Mental Health Act is an interesting example because it does talk quite strongly about human rights, about recovery and about supported decision-making. All of these sorts of things are not the answer absolutely but this idea about changing culture, about moving away from punitive responses, lead the way.¹³

Committee view

8.19 The committee heard from a range of submitters and witnesses on the positive aspects of the detention provisions of the Disability Act. In some cases, this was from other jurisdictions, citing the reforms as the way forward within their own states and territories. While there are still some concerns with the framework in Victoria, the requirement that the detained person must experience a therapeutic benefit from that detention is clearly a necessary embedding of rights within the legislation. The committee is of the view that this would be an important first step for other jurisdictions.

8.20 The committee received evidence that state-funded treatments are triggered by an STO. The committee is concerned that this may create an incentive for service delivery organisations to seek STOs for clients, in order to receive funding for those services. The committee is further concerned that this creates a link between treatment and indefinite detention.

Guardianship

8.21 Across all jurisdictions, people with a cognitive or psychiatric impairment can be subject to guardianship orders to protect their health and welfare. These orders are administered by tribunals and courts within each jurisdiction, and the guardian can be an individual such as a family member, and organisation such as a disability accommodation services, or can be a public official such as a state or territory Public Advocate or Public Guardian. Guardianship provisions generally allow for orders to

12 Office of the Public Advocate (Victoria), *Submission 58*, p. 15. This issue was also raised by Ms Karly Warner, Executive Officer, National Aboriginal and Torres Strait Islander Legal Services, *Committee Hansard*, Melbourne, 29 April 2016, pp 22–23 and Professor. Rosalind Croucher, President, Australian Law Reform Commission, *Committee Hansard*, Melbourne, 29 April 2016, pp 35–36.

13 Mr Povey, Victoria Legal Aid, *Committee Hansard*, 29 April 2016, p. 17.

include involuntary health treatments as well as specifying where a person must reside.¹⁴

Some guardianship orders include functions permitting the guardian to authorise a service provider to contain or seclude an adult. Others have functions permitting retrieval of a person (usually by police) in order to return them to their place of accommodation.¹⁵

8.22 Evidence presented to this inquiry showed that across Australia, indefinite detention operates under guardianship frameworks in a much more informal way than under forensic or civil mental health regimes. The Office of the Public Advocate Queensland (Public Advocate QLD) submitted that while the *Guardianship and Administration Act 2000* (Qld) does not specifically provide for indefinite detention, the health care and restrictive practices provisions of that legislation, allows for substitute decision-making with regards treatment and behaviour support matters.¹⁶

8.23 The Office of the Public Guardian Queensland (Public Guardian QLD) submitted similar evidence on the use of the QLD guardianship framework to underpin indefinite detention:

Another means of ‘indefinite detention’ under the civil system, is through the use of restrictive practices which are unmonitored in the community in private homes. In certain cases, if an adult displays challenging behaviours that could cause harm to themselves, or others, a guardian may be appointed by the Queensland Civil and Administrative Tribunal (QCAT), with special responsibilities to help manage these behaviours. The appointed guardian is required to consider the use of a Positive Behaviour Support Plan which could include a range of ‘restrictive practices’ including: containment and seclusion; chemical, physical or mechanical restraint; or restrictive access.¹⁷

8.24 Victoria Legal Aid submitted that while the *Guardianship and Administration Act 1986* (VIC) does not specifically authorise detention, it allows a guardian to issue an accommodation order that a person reside in a locked facility and provides no process for oversight of a person’s detention. Furthermore:

People subject to guardianship orders have no legal avenue to challenge a guardian’s decision on its merits and there is no regular review of such a decision. Further, once an accommodation decision is made, a guardianship order will often be revoked, meaning that the person will remain detained in the accommodation.¹⁸

14 See: Intellectual Disability Rights Service, Guardianship and administration laws across Australia, http://www.idrs.org.au/pdf/Guardianship_and_administration_laws_across_Australia_by_Ben_Fogarty.pdf (accessed 22 November 2016)

15 Intellectual Disability Rights Service, Guardianship and administration laws across Australia, p. 17.

16 Office of the Public Advocate (Queensland), *Submission 36*, p. 10.

17 Office of the Public Guardian (Queensland), *Submission 56*, p. 4.

18 Victoria Legal Aid, *Submission 71*, p. 5.

8.25 The New South Wales (NSW) Government presented evidence that in that jurisdiction, the Guardianship Tribunal can issue a guardianship order with a 'restrictive practices' function, which can include the power to restrict a person's movements or freedom.¹⁹

8.26 The issue of guardianship being used to authorise detention or involuntary health treatment of people with a cognitive or psychiatric impairment is not new to this committee. This issue was investigated in great detail in the committee's 2015 inquiry report into violence, abuse and neglect against people with disability (abuse inquiry). Beyond benign uses of guardianship orders to undertake a protective function, the abuse inquiry heard from submitters that disability service providers would sometimes apply for guardianship orders in order to streamline or create efficiencies in service delivery, sometimes resulting in involuntary and indefinite detention.²⁰

8.27 The abuse inquiry report concluded:

It is clear that the guardianship arrangements in all jurisdictions require some reform, including improved guidelines on appropriate decision-making through to oversight of the guardians themselves.²¹

Legal capacity

8.28 Underpinning the various regimes of guardianship, is the notion that a person with a cognitive or psychiatric impairment may have a legal incapacity for decision-making. This issue was investigated in detail in the 2015 abuse inquiry, which found:

In some circumstances, a person is deemed to have a legal incapacity to make their own decisions. Disability-related legal incapacity refers to:

[T]he level of cognitive ability that is required before a person can lawfully do various things. Because lack of capacity can prevent people from participating in many of the activities that form part of daily life, alternative decision-making arrangements are necessary.

Although legislation varies slightly in each state and territory, the principles that underpin a determination of legal incapacity are similar. Generally, there is a distinctly binary approach to the determination of legal incapacity—that is, a person is deemed to be either capable or not.²²

8.29 This view was also put forward by Dr Joanne Bradbury in her submission to this inquiry:

19 NSW Government, *Submission 66*, p. 19.

20 Community Affairs Committee, *Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability*, (Abuse inquiry) November 2015, pp 79–84.

21 Community Affairs Committee, *Abuse inquiry*, November 2015, p. 87.

22 Community Affairs Committee, *Abuse inquiry*, November 2015, p. 72.

It is important to note that decisional capacity is not an all-or-none phenomena. People are competent to a greater or lesser degree across a range of skills and tasks. In a legal and health care context, competence is regarded as a *threshold* concept. If, at a certain point along the degree of competence continuum, the capacity to make binding decisions about one's own health is reduced beyond a certain threshold point, the power to make legally binding decisions can be legally be transferred from the person to a surrogate. While the transfer of legal powers is all-or-nothing, the decisional capacity itself is not categorical.²³

8.30 Dr Bradbury recommended supported decision-making be used to 'help fill the apparent gap in service provision for people with mental health challenges between loss of capacity and risk of harm.'²⁴

8.31 The Australian Cross Disability Alliance (Disability Alliance) submitted that designating a person as lacking legal capacity can have far-reaching consequences:

The deprivation of legal capacity for people with disability is not only a breach of that particular right. It leads to further actual and potential breaches of rights such as the right to live in the community, the right to access justice, the right to be free from violence and abuse, torture, inhuman and degrading treatment, the right to physical and mental integrity, and the right to liberty.²⁵

8.32 The Alliance recommended reforms to legal frameworks to change the onus from limiting people with disability to exercise legal capacity, to supporting people with disability to have control over decisions that affect their lives.²⁶

Supported decision-making

8.33 Supported decision-making is a mechanism to assist people with a cognitive or psychiatric impairment to effectively participate in decisions that impact their lives:

[T]he human rights-based model of disability implies a shift from the substitute decision-making paradigm to one that is based on supported decision-making.²⁷

8.34 The Australian Medical Association submitted evidence on the changeable nature of legal capacity, and the role that supported decision-making can have to address this in a health care context:

For many, a loss of decision-making capacity may not be permanent – it may be temporary or may be progressive rather than immediate, and the

23 Dr Joanne Bradbury, *Submission 63*, p. 6.

24 Dr Bradbury, *Submission 63*, p. 6.

25 Australian Cross Disability Alliance, *Submission 61*, p. 21.

26 Australian Cross Disability Alliance, *Submission 61*, p. 21

27 United Nations Convention on the Rights of Persons with Disabilities, Declarations and Reservations: Australia, https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV15&chapter=4&lang=en#EndDec (accessed 22 November 2016).

condition may fluctuate over time. In health care, patients with limited or impaired capacity are encouraged to participate in decision-making consistent with their level of capacity at the time a decision needs to be made.²⁸

8.35 The 2015 abuse inquiry considered the practise of supported decision-making, and reviewed the findings of the Australian Law Reform Commission (Law Reform Commission) 2014 discussion paper *Equality, Capacity and Disability in Commonwealth Laws*. In this paper, the Law Reform Commission recommended reform of Commonwealth, state and territory laws, to be consistent with the following national decision-making principles to 'recognise people with disabilities as persons before the law and their right to make choices for themselves':

- The equal right to make decisions—all adults have an equal right to make decisions that affect their lives and to have those decisions respected;
- Support—persons who require support in decision-making must be provided with access to the support necessary for them to make, communicate and participate in decisions that affect their lives;
- Will, preferences and rights—the will, preferences and rights of persons who may require decision-making support must direct decisions that affect their lives; and
- Safeguards—laws and legal frameworks must contain appropriate and effective safeguards in relation to interventions for persons who may require decision-making support, including to prevent abuse and undue influence.²⁹

8.36 The Australian Cross Disability Alliance made a series of strong recommendations on employing supported decision-making to the 2015 abuse inquiry,³⁰ and repeated its key recommendation to this inquiry:

Australia should establish a nationally consistent supported decision-making framework that strongly and positively promotes and supports people to effectively assert and exercise their legal capacity and enshrines the primacy of supported decision-making mechanisms.³¹

8.37 In the context of this inquiry into indefinite detention, Queensland Advocacy Inc. noted that supported decision-making practices 'decreases the incidence of communicative behaviours that may lead to the application of a Restrictive Practice.'³²

28 Australian Medical Association, *Submission 12*, p. 3.

29 Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, p. 24, <https://www.alrc.gov.au/publications/equality-capacity-disability-report-124> (accessed 22 November 2016)

30 Australian Cross Disability Alliance, *Submission 147 to the 'Abuse inquiry'*, pp 13–15, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Violence_abuse_neglect/Submissions, (accessed 22 November 2016).

31 Australian Cross Disability Alliance, *Submission 61*, p. 8.

32 Queensland Advocacy Inc., *Submission 7*, p. 39.

Committee view

8.38 In considering the issue of supported decision-making, the committee concurs with the view expressed during the 2015 abuse inquiry:

The committee agrees with the Law Reform Commission report and its recommendations about supported decision-making. It is the committee's view that while legislative reform is clearly a necessary step to effect these reforms, more work needs to be done to investigate supported decision-making models in Australia and oversee jurisdictions to ensure that the most sustainable form of supported decision-making is implemented in Australia.³³

8.39 Indeed, more evidence has now been presented to the committee on the need for such reforms, as a mechanism to address some of the causes of the indefinite detention of people with cognitive and psychiatric impairment.

Restrictive practice

8.40 Restrictive practice refers to seclusion and restraint interventions in mental health and other settings, to control or manage a person's behaviour. Restraint can refer to physical, chemical (pharmacological), mechanical or psychological forms of restraint.³⁴

8.41 The Disability Alliance described restrictive practice in its submission:

People with disability in Australia are routinely subjected to unregulated and under-regulated behaviour management or treatment programs, known as restrictive practices that include chemical, mechanical, social and physical restraint, detention, seclusion and exclusionary time out. These practices can cause physical pain and discomfort, deprivation of liberty, prevent freedom of movement, and alter thought and thought processes.³⁵

8.42 As outlined in Chapter 2, in 2015 the National Seclusion and Restraint Project (restraint project) looked at the operation of restrictive practice and made a number of recommendations to be implemented at a Council of Australian Governments level. However, the restraint project is limited to reviewing restrictive practice in the mental health sector. This inquiry has received a range of evidence that clearly shows restrictive practices are used across a variety of settings.

8.43 The Law Reform Commission submitted:

The term 'restrictive practices' refers to the use of interventions that have the effect of restricting the rights or freedom of movement of a person in order to protect them. Serious concerns have been expressed about

33 Community Affairs Committee, *Abuse inquiry*, November 2015, p. 77. A summary of all relevant legislation and policies relating to the use of restrictive practice can be found at p. 94 of that report.

34 National Mental Health Commission, *A case for change: Position Paper on seclusion, restraint and restrictive practices in mental health services*, May 2015.

35 Australian Cross Disability Alliance, *Submission 61*, pp 15–16.

inappropriate and under-regulated use of restrictive practices in a range of settings in Australia.³⁶

8.44 The Public Advocate Victoria submitted restrictive practices occur in:

aged-care accommodation; day programs and activities; employment and training services; hospital emergency departments and wards; institutions; schools; shared and supported accommodation services; and supported services—and not just those being applied in prisons or to those who are at risk of or who are indefinitely detained in various accommodations.³⁷

8.45 The Public Guardian QLD also discussed the prevalence of restrictive practice occurring outside formal disability accommodation service settings:

While most of the persons subject to the use of restrictive practices live ‘in the community’, there is anecdotal evidence to suggest that many experience containment and seclusion on an ongoing basis for long periods of time, effectively detained in their own homes. While effectively ‘detained’ in their own homes, these persons may also be subject to the use of unmonitored physical and/or mechanical restraint. While QCAT may make an appointment regarding the use of restrictive practices, under the current regime, these people may face effective detention for a period of up to 12 months without a review.³⁸

8.46 The committee's 2015 abuse inquiry considered the issue of restrictive practice. In her submission to the abuse inquiry, Dr Linda Steele used the term disability specific lawful violence' to describe interventions such as restrictive practice.³⁹

8.47 The abuse inquiry heard from the Disability Alliance that restrictive practice, while considered by the health, legal and disability service sectors to be lawful therapeutic practice, if used in any other context would likely be a form of assault:

Many of the practices would be considered crimes if committed against people without disability, or outside of institutional and residential settings. However, when "perpetrated against persons with disabilities", restrictive practices "remain invisible or are being justified" as legitimate treatment, behaviour modification or management instead of recognised as "torture or other cruel, inhuman or degrading treatment or punishment".⁴⁰

8.48 Queensland Advocacy Inc. put forward a similar view on restrictive practice to this inquiry:

In plain language, they are tantamount to assault, drugging and false imprisonment. They would not be tolerated and would be considered in

36 ALRC, *Submission 4*, p. 3.

37 Office of the Public Advocate (Victoria), *Submission 58*, p. 31.

38 Office of the Public Guardian (Queensland), *Submission 56*, p. 4.

39 Community Affairs Committee, *Abuse inquiry*, November 2015, p. 77.

40 Australian Cross Disability Alliance in Community Affairs Committee, *Abuse inquiry*, November 2015, p. 77.

contravention of the criminal law if they were done on people who did not have a disability. They are also never a solution. Even aside from all the human rights violations, they never solve the problem. When a person is exhibiting behaviours of concern, we know that the application of restrictive practices usually escalates, rather than calms, their behaviour.⁴¹

Chemical restraint

8.49 The committee heard evidence on the use of chemical (pharmacological) restraint during the Melbourne inquiry hearing:

A lot of people with intellectual disability are treated with psychotropic medication, and they are not consenting to it. If they were treated under the Mental Health Act, that would be reviewed by a panel of a layperson, a psychiatrist and a lawyer. Under the Guardianship Act, they are not. It is either a family member or someone appointed by VCAT.⁴²

8.50 The Australian Community Services Organisation told the committee that in Victoria, the Disability Act requires that any use of psychotropic medication without a specific diagnosis, administered to a person with an intellectual disability within a residential service, must be reported to the Office of Professional Practice as to why that chemical restraint is being used.⁴³

8.51 However, Dr Chad Bennett of RANZCP responded that the Senior Practitioner does not have jurisdiction over the prescriber, so any comments are not enforceable. Dr Bennett went further to say:

I think the other interesting thing about the idea of chemical restraint is that, for example, in mental health acts the idea of chemical restraint does not exist. It is purely something that exists within a disability kind of framework, although it is not usually a disability you are treating.⁴⁴

8.52 The issue of chemical restraint in aged care settings is discussed later in this chapter.

Safeguards

8.53 As discussed above, the NMHC restraint project made a number of recommendations on safeguards for restrictive practice to be discussed at a Council of Australian Governments level.

41 Dr Emma Phillips, Systems Advocate, Queensland Advocacy Inc. *Committee Hansard*, Brisbane, 23 March 2016, p. 11.

42 Dr Chad Bennett, Chair, Section for the Psychiatry of Intellectual and Developmental Disabilities, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, Melbourne, 29 April 2016, p. 43.

43 Mr Stan Pappos, Senior Manager, Forensic Housing Services, Australian Community Services Organisation, *Committee Hansard*, 29 April 2016, p. 43.

44 Dr Chad Bennett, Chair, Section for the Psychiatry of Intellectual and Developmental Disabilities, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, Melbourne, 29 April 2016, p. 43.

8.54 The Law Reform Commission noted that the establishment of a nationally consistent approach to safeguards on restrictive practice was endorsed by the Commonwealth:

Current regulation of restrictive practices occurs mainly at a state and territory level. However, the Commonwealth, state and territory disability ministers endorsed the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (National Framework) in March 2014 to forge a consistent national approach.⁴⁵

8.55 Four jurisdictions, Victoria, Queensland, Tasmania and the Northern Territory, have enacted legislation to regulate the use of restrictive practice. However, as noted by the Public Advocate QLD, that regulation is limited to state-funded disability services and 'restrictive interventions used in privately funded services or in hospitals, aged care and other health facilities remain unregulated.'⁴⁶

8.56 The Public Advocate Victoria, while expressing some concerns about the use of restrictive practice in general, noted the safeguards incorporated into the regime in Victoria:

In Victoria, Part 7 of the Disability Act allows the use of restrictive practices by disability service providers only in specific circumstances, namely when there are no less restrictive options available and only to prevent harm to the person and/or harm to others. Restrictive practices are most often applied to address or manage 'behaviours of concern' of people with a disability or mental ill health.

The Disability Act provides a model for consideration by other jurisdictions, where there is not otherwise a legislative framework for the regulation and monitoring of the use of restrictive interventions.⁴⁷

8.57 Victoria Legal Aid similarly recommended the Disability Act as a model which could be replicated in other jurisdictions to improve the regulation of restrictive practice:

Essential to the operation of the Disability Act are two elements otherwise absent in Victorian legislation: the need for intervention to benefit a person, and the requirement for planning with a view to reducing restrictions over time. In combination they assist to ensure the potency of interventions, increase the speed of a person's trajectory through those interventions and ensure regular scrutiny of the efficacy of supports.⁴⁸

8.58 However, Victoria Legal Aid expressed similar concerns to the Public Advocate Victoria, that the regulation of restrictive practice did not extend to all sectors where such restrictions are being used:

45 Australian Law Reform Commission, *Submission 4*, p. 3.

46 Office of the Public Advocate (Queensland), *Submission 36*, p. 16.

47 Office of the Public Advocate (Victoria), *Submission 58*, p. 32.

48 Victoria Legal Aid, *Submission 71*, p. 3.

Aged care facilities, disability residential services and mental health services regularly restrict the freedom of movement of residents without any clear legal authority to do so. For example, services may prevent residents from leaving their rooms or the premises (whether or not the doors are locked). People who are informally detained are not subject to any legal oversight or, generally, any independent clinical oversight as to the necessity and appropriateness of the restrictions on their freedom. Further, the informal nature of the restrictions and lack of legal oversight, also mean there is no mechanism to prompt the involvement of a lawyer to provide independent advice and no real means to end detention.⁴⁹

Committee view

8.59 The committee has heard additional evidence in a similar vein to the extensive evidence presented to the 2015 abuse inquiry and concurs with the views expressed by the committee in its report of that inquiry:

The committee considers that the right to liberty is a fundamental human right. The committee is concerned with the extent to which restrictive practice is used, and is deeply concerned with the system which allows service providers to arbitrarily deprive people of their liberty.

The Committee acknowledges the development of the National Framework for Reducing and Eliminating the use of Restrictive Practices in the Disability Service Sector. However, the committee is concerned that this implementation of this framework has stalled, and has not been consistently implemented across Australian jurisdictions, with many states and territories still relying on a voluntary code of conduct from disability service providers.

The committee notes that the implementation of the framework has stalled, and in some jurisdictions has never really begun. The committee sees a place for commonwealth legislation, should the framework not be vigorously taken up across all jurisdictions as a priority.⁵⁰

Aged care

8.60 The committee has received evidence that the indefinite detention of people with a cognitive or psychiatric impairment is also an issue in the aged care context.

8.61 More than 50 per cent of residents in Australian Government-subsidised aged care facilities have dementia⁵¹ and almost half (44 per cent) of permanent residents with dementia also had a diagnosis of a mental illness.⁵² These conditions are often managed with the use of detention:

49 Victoria Legal Aid, *Submission 71*, p. 4.

50 Community Affairs Committee, *Abuse inquiry report*, p. 99.

51 Alzheimer's Australia defines dementia as 'a complex chronic condition caused by one or more of a large number of illnesses affecting the brain. It is a terminal and devastating condition that affects people's abilities and memories.' See Alzheimer's Australia, *Submission 42*, p. 4.

52 Professor Richard Fleming, Kate Swaffer, Dr. Lyn Phillipson and Dr. Linda Steele, University of Wollongong, *Submission 19*, p. 2

The confusion which accompanies dementia determines the need for a variety of safety features to be built into the environment. Among other things, they often include the provision of a secure perimeter [3] and/or the establishment of locked dementia specific units which effectively confine the residents to one area.⁵³

8.62 Alzheimer's Australia estimates the 'presence of physical restraint in aged care facilities varies, and the evidence suggests prevalence rates from 12 per cent to 49 per cent' and submitted:

There is extensive evidence that both physical and chemical restraint is often used to respond to the behavioural and psychological symptoms of dementia, despite clinical evidence suggesting that psychosocial responses should be the first line approach. Often behavioural and psychological symptoms are an indication of unmet needs, such as untreated pain, hunger or thirst, or boredom.⁵⁴

8.63 Evidence has been presented which indicates that detention in aged care settings often occurs 'informally' in that it is not specifically authorised under any legislation and is therefore unlawful. In their submission, Global Action for Personhood cites policy prepared by the Office of the Public Advocate South Australia:

In the 'Guardian Consent for Restrictive Practices in Residential Aged Care Settings' (2015) policy document from the Office of the Public Advocate (OPA, South Australia), detention in the aged care setting is defined as:

.... a situation where a person is unable to physically leave the place where he or she receives aged care services. The means of detention may include locked doors, windows or gates, and the constant supervision and escorting of a person to prevent the person from exercising freedom of movement.

Of particular relevance is their comments on detention and keypad operated doors, a common feature of 'dementia specific' or 'memory' units in residential aged care. The policy notes that:

If a person lives in a locked area, and is able to operate the keypad that person is not detained. If a person lives in a locked area, and cannot operate the keypad, or alternatively cannot ask to have the doors opened on request, and have this request granted, then the person is detained (OPA, 2015: 4).

There is no doubt then, that people with dementia, who reside in units where access is restricted in this way, are detained unlawfully.⁵⁵

8.64 The Public Advocate Victoria submitted similar evidence, that in aged care and disability settings 'restrictive interventions are applied without external authorisation of a court or tribunal.'⁵⁶

53 Professor Fleming et al, *Submission 19*, p. 2

54 Alzheimer's Australia, *Submission 42*, pp 3 & 7.

55 Global Action on Personhood, *Submission 26*, pp 1–2.

56 Office of the Public Advocate (Victoria), *Submission 58*, p. 31.

8.65 The President of the Guardianship and Administration Board of Tasmania has observed:

Residential Aged Care Facilities continue to systematically detain people with dementia without clear authority to do so and in circumstances where the establishment of a requirement to do so under their duty of care might be questionable, or in other words, in circumstances where the defence of necessity to a charge or claim of unlawful detention might not exist or, at best, be limited. It seems that most facilities are prepared to 'risk it' that no-one will bring criminal or civil proceedings in relation to unlawful detention.⁵⁷

8.66 Alzheimer's Australia highlighted that of chemical (pharmacological) restraint is also prevalent in aged care:

It is estimated that about half of people in aged care and about 80% of those with dementia are receiving psychotropic medications, although this varies between facilities. There is evidence to suggest that in some cases these medications have been prescribed inappropriately. The evidence supporting the use of antipsychotic medications is modest at best, with international data suggesting that only 20% of people with dementia derive any benefit from antipsychotic medications.⁵⁸

8.67 Prof Flemming et al recommended:

The capacity of the aged care system to provide appropriate care to people with dementia could be increased by the delivery of education to managers and staff on human rights and the care of people with dementia and by increasing the emphasis placed by the Department of Health on the provision of suitably designed environments to accommodate those people with dementia who have a real need for secure accommodation. Both of these activities could be undertaken by the Department of Health funded Dementia Training Study Centres.⁵⁹

8.68 Alzheimer's Australia made a range of recommendations for addressing indefinite detention in the aged care sector which included, staff training, improved information for consumers and carers, quality standards and assessment process to include benchmarks on reducing physical and chemical restraint and improved complaints mechanisms. Alzheimer's Australia stressed the importance of addressing this issue:

Dementia is one of the major chronic diseases of this century. With the continued ageing of the population and the growing numbers of people with dementia, human rights issues in relation to people with dementia who are

57 Anita Smith, *Detention of People with Dementia in Secure Facilities in State Care in Tasmania*, http://www.guardianship.tas.gov.au/_data/assets/pdf_file/0009/203967/Detention_of_people_with_dementia_in_secure_facilities.doc_31.7.12.pdf, (accessed 31 March 2016).

58 Alzheimer's Australia, *Submission 42*, p. 8.

59 Professor Fleming et al, *Submission 19*, p. 4

imprisoned, and those who are restrained within the aged care system, need to be considered and addressed.⁶⁰

Committee view

8.69 It is clear from the evidence provided that indefinite detention of people with cognitive or psychiatric impairment is a significant problem within the aged care context, occurring both within external facilities and private homes. It is also clear this detention is often informal, unregulated and unlawful.

8.70 The evidence presented to this inquiry further supports the views formed by the committee during its 2015 abuse inquiry that action needs to be taken in the aged care setting to protect vulnerable people from abuse.

Concluding committee view

8.71 It is clear there is a prevalence of indefinite detention of Australians with cognitive or psychiatric impairment within the mental health, disability, guardianship and aged-care contexts. This detention takes place in a number of location types and comes in many forms. It can stem from formal orders under mental health, disability or guardianship legislation. It can stem from restrictive practice or seclusion that creates a de facto form of indefinite detention. It can also be informal and unregulated, as a result of practices within the disability or aged-care, and in some cases in private homes.

8.72 It is also clear to the committee that evidence for this problem has been well-known to states and territories, and the Commonwealth, for some time. Although there have been some moves to address this form of indefinite detention, they have been patchy at best, and significantly underfunded.

8.73 As with the forensic mental health regimes, changes to these sectors will require effort from the states and territories, as well as coordination and leadership from the Commonwealth.

60 Alzheimer's Australia, *Submission 42*, pp 11–12.

Chapter 9

Recommendations

9.1 This is the first major inquiry that has focused solely on the specific question of the indefinite detention of people with a cognitive or psychiatric impairment. However, this issue has arisen in the course of other inquiries and reports into disability or justice issues.

9.2 These inquiries and reports include the committee's 2015 inquiry report 'Violence, abuse and neglect against people with disability in institutional and residential settings'¹ (abuse inquiry), the Australian Law Reform Commission 2014 report 'Equality, Capacity and Disability in Commonwealth Laws'² (Law Reform Commission report) and the Australian Human Rights Commission 2014 report 'Equal Before the Law: Towards Disability Justice Strategies'³ (Human Rights Commission report).⁴ There have also been state or territory level health or justice reviews, as well as complaints using United Nations mechanisms.

9.3 Each of those inquiries or reports made a series of recommendations to address broader mental health, justice or disability issues. It is clear to the committee that although the recommendations were drafted to address wider problems in the disability or justice space, had they been fully implemented they would have largely addressed many of the causes of indefinite detention of people with cognitive and psychiatric impairment.

The Australian Government's role

9.4 A key consideration in formulating recommendations to address an issue such as this is determining the appropriate responsibility for each level of government.

9.5 As noted in Chapter 2, the Australian Government is a signatory to the United Nations *Convention on the Rights of Persons with Disabilities* (Disability Convention).⁵ As a signatory to the Disability Convention, the Australian Government is responsible for ensuring the treatment of people with disability in Australia is compatible with the provisions of the Convention. The committee is aware of the recent ruling by the Committee on the Rights of Persons with Disabilities (UN

1 Community Affairs Committee, *Violence, abuse and neglect against people with disability in institutional and residential settings, (Abuse inquiry)* November 2015, pp 267–283.

2 Australian Law Reform Commission, 'Equality, Capacity and Disability in Commonwealth Laws', August 2014, pp 11–21.

3 Australian Human Rights Commission, 'Equal Before the Law: Towards Disability Justice Strategies', February 2014.

4 The full list of relevant recommendations from those inquiries and reports can be found in Appendix 3.

5 United Nations, *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008), <http://www.un.org/disabilities/convention/conventionfull.shtml> (accessed 25 November 2016).

Disability Committee), on the indefinite detention of Mr Marlon Noble, which noted that he has 'never had the opportunity to have the criminal charges against him determined' yet has spent over a decade in prison.⁶ He remains on conditional release from prison. The committee is also aware of a number of pending cases before the UN Disability Committee relating to the indefinite detention of people with cognitive and/or psychiatric impairment. The ruling on Mr Noble was directed to the Australian Government as the signatory to the UN Disability Convention. When rulings are made in respect to the other cases, these rulings will also be directed to the Australian Government.

9.6 The committee acknowledges that it is the states and territories that have primary carriage of forensic legislation, and the delivery of corrective services and disability services. This does not absolve the Australian Government of any responsibility in this area. The Australian Government must do more than simply facilitate a response from the relevant state government to the UN.

9.7 In addition, in 2009 the Australian Government voluntarily assumed certain responsibilities for disability services under the National Disability Agreement, such as 'investing in initiatives to support nationally agreed policy priorities, in consultation with States and Territories.' The committee notes the reform priorities of that agreement specifically include reference to 'people at risk of interaction with the criminal justice system (including those on forensic orders), and those who require support due to challenging behaviours, including those who are subject to restrictive practices.'⁷

9.8 The committee makes the following recommendations taking into account the rights and responsibilities of the states and territories, and the Australian Government.

Committee recommendations arising from the abuse inquiry

9.9 The committee notes that one year on from the tabling of the previous committee's 2015 abuse inquiry report, many of the key issues in relation to the indefinite detention of people with cognitive and psychiatric impairment identified in that report remain the same. The committee therefore wishes to highlight the following recommendations, made in that 2015 report.

Access to justice

9.10 Access to justice for people with a disability, as eloquently put in evidence to the committee, is more than simply providing a wheelchair ramp into a courtroom⁸. It

6 United Nations Office of the High Commissioner, *Australia urged to amend laws that lead to people with mental disabilities being detained indefinitely*, 23 September 2016, <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20566&LangID=E> (accessed 13 October 2016).

7 Council of Australian Governments, *National Disability Agreement*, 1 January 2009, http://www.federalfinancialrelations.gov.au/content/npa/national_agreements/national-disability-agreement.pdf (accessed 25 November 2016.)

8 Dr Piers Gooding, Disability Research Initiative, Melbourne Law School, University of Melbourne, *Committee Hansard*, 25 October 2016, p. 2.

is about fully supporting a person with a disability to appropriately intersect with all aspects of criminal justice systems, including identifying disability, provision of supported decision making and providing appropriate exit mechanisms.

Recommendation 1

9.11 The committee recommends the Australian Government work with state and territory governments on the implementation of initiatives to improve access to justice for people with disability contained in the reports by the Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, the Human Rights Commission, *Equal Before the Law* and Productivity Commission, *Access to Justice Arrangements*, with particular focus on:

- **better intervention and support services;**
- **expanded Community Visitor's schemes;**
- **improved witness support services to people with disabilities;**
- **creation of an assessment protocol that assists police, courts, and correctional institutions in identifying people with disabilities. Where identified, a trained officer will provide support;**
- **transparent, effective and culturally appropriate complaints handling procedures;**
- **training for police, lawyers and others in justice in needs of people with disability; and**
- **where a person who has been found unfit to plead is to be held in detention, demonstrate that all reasonable steps have been taken to avoid this outcome, and that person must be held in a place of therapeutic service delivery.⁹**

Recommendation 2

9.12 The committee also recommends that each state and territory implement a Disability Justice Plan.¹⁰

Recommendation 3

9.13 The committee believes that there is a need for further investigation of access to justice issues, with a focus on:

- **the implementation requirements for supported decision-making;**
- **investigating the potential for the UK system of registered intermediaries; and**
- **the indefinite detention of people with cognitive impairment or psychiatric disabilities.¹¹**

9 Abuse inquiry, Recommendation 6.

10 Abuse inquiry, Recommendation 7.

Oversight

9.14 It is clear to the committee that improved oversight of facilities would provide another avenue through which situations of indefinite detention could be identified; particularly as such detention often starts from an initial period of time-limited detention which is then continually reaffirmed. Regular oversight would address this form of indefinite detention.

Recommendation 4

9.15 The committee recommends the Australian Government work with state and territory governments on a nationally consistent approach to existing state and territory disability oversight mechanisms, to include;

- **increased funding for community visitor schemes, with consideration these schemes be professionalised in all jurisdictions and with a mandatory reporting requirement for suspected violence, abuse or neglect; and**
- **greater crossover in oversight and complaints mechanisms between aged care and disability.**

9.16 A nationally consistent approach to disability oversight mechanisms is best overseen by the national disability watchdog.¹²

Supported decision-making

9.17 Evidence was presented to the inquiry that supporting a person with a cognitive or psychiatric impairment to be involved in decision-making about their own treatment, is not only a matter of justice and human rights, but it can often lead to increased voluntary participation in therapeutic intervention, resulting in fewer instances of involuntary detention.

Recommendation 5

9.18 The committee recommends that the Australian Government drive a nationally consistent move away from substitute decision-making towards supported decision-making models.¹³

Recommendation 6

9.19 The committee recommends that the Australian Government work with state and territory governments to implement the recommendations of the Australian Law Reform Commission report *Equality, Capacity and Disability in*

11 Abuse inquiry, Recommendation 8.

12 Abuse inquiry, Recommendation 9.

13 Abuse inquiry, Recommendation 10.

*Commonwealth Laws, in relation to legal capacity and supported decision-making.*¹⁴

Recommendation 7

9.20 The committee recommends the Australian Government work with state and territory governments to create national consistency in the administration of guardianship laws to ensure:

- public advocate and guardianship functions are separate to ensure independent oversight;
- mandatory training on supported decision-making for guardians;
- that service delivery organisations or accommodation providers are never given guardianship;
- automatic increased oversight where service delivery organisations or accommodation providers recommend families lose guardianship; and
- that Aboriginal and Torres Strait Islander peoples' particular circumstances are taken into account in developing guardianship systems.

New recommendations—Forensic orders

9.21 The following recommendations relate to people held under forensic orders.

Quantifying and establishing national principles

9.22 Earlier in Chapter 2 of the report, the committee noted that official statistics on the issue of indefinite detention are largely piecemeal and inconsistent between the states. In 2014, the Disability Justice Commissioner and the Aboriginal and Torres Strait Islander Social Justice Commissioner called for an audit of all people being held in prison who had not been found guilty of a crime. This call was directed specifically at the NT and WA Governments; however, the call is applicable to all Australian jurisdictions.

9.23 The committee acknowledges the work being undertaken by the Council of Australian Governments (COAG) Law, Crime and Community Safety Council (LCCSC). The LCCSC has recognised that there is a lack of consistent statistics in this area and is working on collating a consistent national data-set. The committee agrees that this is an important initiative to quantify the extent of indefinite detention in Australia. The LCCSC is also considering a draft of the 'National Statement of Principles Relating to Persons Unfit to Plead or Found Not Guilty by Reason of Cognitive or Mental Health Impairment' (National Principles). The committee considers the LCCSC as an appropriate forum within COAG to discuss and advance many of the committee's concerns relating to the indefinite detention of forensic patients.

¹⁴ Abuse inquiry, Recommendation 11.

Recommendation 8

9.24 The committee recommends that the forthcoming national statement of principles adopt the position that indefinite detention is unacceptable and that state and territory legislation be amended in line with this principle.

- The committee recommends that the LCCSC endorse and adopt the National Principles at its earliest opportunity.

Recommendation 9

9.25 The committee recommends that the LCCSC complete its data collection project at its earliest opportunity.

Screening and diagnosis

9.26 The committee notes that many alleged offenders are people with undiagnosed cognitive and/or psychiatric impairments that continue to remain undiagnosed. The committee is of the view that all people in the justice system should be screened for cognitive and psychiatric impairment at multiple points throughout the criminal justice system to ensure that people with disability are provided with therapeutic and other supports, and diverted from the criminal justice system where appropriate. The committee notes the disability screening approach used by the NSW Government.

Recommendation 10

9.27 The committee recommends that the COAG develop and implement a disability screening strategy (including hearing assessments) for all Australian jurisdictions. This screening strategy would apply to all people (adults and minors) who engage with the criminal justice system. The strategy would be applied at multiple points throughout the criminal justice system such as first contact with police, courts, prisons and related facilities.

9.28 The committee makes the following recommendation on the issue of specialist diagnosis tools.

Recommendation 11

9.29 The committee recommends that the COAG work together to ensure that recently developed tools such as the FASD diagnosis tool are provided as a supported resource to police, courts, legal aid and other related groups.

Supported decision-making

9.30 The committee makes the following recommendations on the issue of supported decision-making, making particular note of the Unfitness to Plead project as a useful model for the delivery of such services.

Recommendation 12

9.31 The committee recommends that the Australian Government, through the COAG, actively encourage support worker programs which assist people with cognitive and psychiatric impairment to engage with and participate in the court process. The Australian Government should work closely with the states and territories to identify suitable programs to be funded for expansion where they are currently being trialled, and establish new programs where they currently do not exist.

Aboriginal and Torres Strait Islander peoples

9.32 The committee considers that Aboriginal and Torres Strait Islander forensic patients should have access to culturally appropriate therapeutic and support services. It is imperative that Aboriginal and Torres Strait Islander peoples with cognitive and/or psychiatric impairment are able to communicate effectively with service providers, police and the judiciary.

Recommendation 13

9.33 The committee recommends that COAG develop a range of culturally appropriate resources for Aboriginal and Torres Strait Islander peoples that can be deployed to service providers, police and the judiciary. These resources will assist the service providers, police and the judiciary to communicate more effectively with Aboriginal and Torres Strait Islander peoples engaged in the criminal justice system.

9.34 The committee recommends that the Australian Government, through COAG, fund a number of Aboriginal and Torres Strait Islander identified support worker positions across a number of population centres, particularly in the NT and WA. This would include positions or funding for signing and translation services.

9.35 The committee recommends that Aboriginal controlled organisations should be resourced to provide specialised and culturally appropriate support to Aboriginal and Torres Strait Islander peoples with cognitive and psychiatric impairments in detention and community care.

9.36 The committee is concerned that nearly 12 per cent of Aboriginal and Torres Strait islander peoples have a disease of the ear with at least seven per cent reporting some form of hearing loss. This is nearly double the rate of the non-indigenous population. The committee notes evidence received which indicates that Aboriginal and Torres Strait islander peoples with hearing loss can face many challenges when communicating with the dominant form of English, especially when a person is not competent in signing. These challenges are compounded when hearing impairment is combined with an intellectual disability and/or cultural differences. The committee notes the committee's 2009 Inquiry into Hearing Health in Australia, which focused on the importance of the diagnosing hearing impairment. Current interview guidelines for police in the NT leave the decision of providing an interviewee with an interpreter

up to the discretion of individual police officers. The committee considers that these guidelines must go further.

Recommendation 14

9.37 The committee recommends that the COAG work together to modify guidelines for police interrogation of Aboriginal and Torres Strait Islander peoples in each state and territory to include a requirement that a hearing assessment be conducted for any Aboriginal and Torres Strait Islander person who is having communication difficulties, irrespective of whether police officers consider that the communication difficulties arise from language and cross-cultural issues.

Specialist courts

9.38 The committee received a range of evidence which highlighted the use of specialist courts in many Australian jurisdictions which led to diagnosis and diversion from the criminal justice system. In some cases, the use of specialist courts has improved the participation in legal proceedings by alleged offenders with cognitive and psychiatric impairments.

9.39 The committee also heard evidence which noted the need for specialist courts for Aboriginal and Torres Strait Islander peoples, particularly in remote parts of WA. Importantly, the committee considers that such courts have the capacity to deal with alleged criminal activity in a culturally appropriate way that both acknowledges the inappropriateness of any proven negative behaviours and then provides a suitable therapeutic on-country pathway forward.

Recommendation 15

9.40 The committee recommends that the COAG consider an appropriate mechanism for jurisdictions with specialist courts to share their expertise and experience with other jurisdictions.

9.41 The committee recommends that the COAG develop and implement appropriately resourced mobile courts for remote parts of WA and the NT.

State and territory law reform

9.42 The committee has received evidence noting that the judiciary in WA and the NT have limited options when choosing to issue a forensic order. The most compelling element of this evidence came from the Chief Justice of WA, the Hon Wayne Martin AC. The committee agrees with the Chief Justice's position that the judiciary needs to have legislated options beyond unconditional release and prison for forensic patients. These options should include secure care and transitional placements which provide a therapeutic, non-punitive environment consistent with the purpose of the forensic order. The committee makes the following recommendation on the issue of state and territory law reform which relates to the issuing of forensic orders.

Recommendation 16

9.43 The committee recommends that the COAG ensures a consistent legislative approach across all Australian jurisdictions to provide a range of options for the placement of forensic patients beyond unconditional release and prison.

9.44 As noted in Chapter 3 and 4, the committee does not consider prison to be a suitable place for forensic patients. Notwithstanding this, the committee has received significant evidence noting the importance of limiting terms as a means to place an upper limit on the time a person may spend in prison, and as a result put an end to indefinite detention. In so far as the limiting terms may assist in this process, the committee recommends the adoption of limiting terms in the NT, WA and Victoria.

Recommendation 17

9.45 The committee recommends that the COAG ensures a consistent legislative approach with respect to limiting terms for forensic patients in all Australian jurisdictions.

Recommendation 18

9.46 The committee recommends that the COAG works together to cease the use of mandatory sentencing.

Accommodation

9.47 The committee is concerned about the placement of forensic patients in prison and the lack of therapeutic support in this environment. Placement of forensic patients unnecessarily exposes them to physical risk and to isolation—both within the prison and from the community. The following recommendations focus on what needs to change so that forensic patients can transition from prison, or ideally bypass prison, and live in a secure forensic facility or live supported in the community.

9.48 The committee has noted earlier that where no supported accommodation placements exist, a person cannot be transitioned from prison or secure care to a less restrictive environment in the community. The committee is concerned that there is a lack of facilities that provide supported accommodation in the community. A logical extension of the data collection project being undertaken by the LCCSC is to for it to identify where gaps exist in the supply of forensic placements in secure care facilities or supported accommodation in the community.

Recommendation 19

9.49 The committee recommends that the LCCSC extend its data collection project to identify and quantify the supply shortfall for forensic accommodation placements in secure care facilities and supported accommodation in the community.

9.50 The committee notes the higher levels of social disadvantage and the geographic challenges that exist in the NT and to a lesser extent in WA. It is the committee's view that the NT requires additional financial assistance from the

Australian Government in order to fund the establishment of non-prison forensic secure care facilities and the acquisition of supported accommodation options in communities across the NT, including remote areas. Further support may be necessary with respect to disability support workers for these types of accommodation.

Recommendation 20

9.51 The committee recommends that the Australian Government work closely with the NT Government to plan, fund and construct non-prison forensic secure care facilities and the acquisition of supported accommodation options in communities across the NT.

9.52 The committee recommends that the Australian Government work closely with the NT Government to ensure that all forensic facilities are appropriately staffed.

Individual support plans

9.53 Individual support plans (ISP) form a critical element of transitioning forensic patients from prison to secure care, and where appropriate, to living in supported accommodation in the community. The committee acknowledges that such plans are being developed for most forensic patients; however, questions some of the fundamental components that underpin these ISPs. As noted earlier, there are issues around lines of responsibility for the delivery of services under an ISP between corrective services and disability services, particularly in the NT.

Recommendation 21

9.54 The committee recommends that the COAG ensure that ISPs in all Australian jurisdictions have consistent objectives and are clear on who is responsible for delivery of services, regardless of where a forensic patient is housed.

9.55 Noting again the high levels of social disadvantage and geographic challenges in the NT, the committee considers that the Australian Government has a special role in assisting the NT to meet its obligations under the UN Disability Convention.

Recommendation 22

9.56 The committee recommends that the Australian Government work closely with the NT Government to ensure that its ISP (or equivalent) for forensic patients have clear objectives of transitioning a forensic patient from prison to secure care, and where appropriate, from secure care to the community.

Early intervention

9.57 The committee considers that many people with cognitive and/or psychiatric impairment who are classified as forensic patients should never come into contact with the criminal justice system. Through early intervention services, a person with cognitive and/or psychiatric impairment should be diagnosed at the earliest possible

age and provided with a range of wrap-around services that support them to live full, meaningful and productive lives. The committee heard evidence of some programs which seek to provide such interventions; however, noted that currently such programs are limited and do not appear to cater for people with cognitive impairment. These programs also do not seek to engage with children under the age of 10.

Recommendation 23

9.58 The committee recommends that COAG establish a working group:

- **to review existing early intervention programs for people with cognitive and/or psychiatric impairment; and**
- **develop and implement programs which engage with people with cognitive impairment at the youngest appropriate age.**

9.59 The committee has heard evidence about holistic community-driven early intervention strategies such as the Justice Re-Invest program in NSW. Early signs from part of this program being operated in Bourke (NSW) are promising, with the local community taking ownership and developing a holistic range of projects that will reduce the incarceration of the youth of this town. The committee also notes the justice reinvestment approach makes sense economically.

Recommendation 24

9.60 The committee recommends that the COAG develop and implement a series of justice reinvestment projects across the country to showcase the long-term social and economic benefits of justice reinvestment.

National Disability Insurance Scheme

9.61 The committee has received evidence which noted the opportunity that the National Disability Insurance Scheme (NDIS) could offer in providing specialist disability supports to forensic patients and the broader prison population. The committee was concerned with the conflicting evidence it has received regarding eligibility and access to supports through the NDIS for people held in prisons.

Recommendation 25

9.62 The committee recommends that the Joint Standing Committee on the National Disability Insurance Scheme conduct an inquiry into the issue of eligibility and access to the NDIS for people held in prisons and the criminal justice system more broadly.

Transitioning forensic patients out of prison

9.63 The committee notes that there are two new secure care forensic facilities opened late last year in WA and the NT—the Bennett Brook Disability Justice Centre (WA), and the Complex Behaviour Unit (NT). The committee notes that these facilities are not operating at full capacity; and that part of this reflects a range of practical considerations in the commissioning of new facilities that result in initial

underutilisation. Notwithstanding this, there still remain a large number of forensic patients in prisons in the NT and WA.

Recommendation 26

9.64 The committee recommends that the WA and NT Governments transition forensic patients currently held in prison to the relevant secure care forensic facility in each state as a matter of urgency.

New recommendations—civil systems

9.65 The following recommendations relate to the civil systems of mental health, disability, guardianship and aged care sectors.

First responders

9.66 Submitters and witnesses raised the issue that for many people, the pathway to indefinite detention begins with a police officer acting as a first responder to an incident which, rightly or wrongly, has been rated as involving risk of harm to self or others. Often, frontline police or ambulance officers lack the training necessary to de-escalate a situation involving cognitive or psychiatric impairment or do not recognise that cognitive or psychiatric impairment issues are involved in the situation at all.

Recommendation 27

9.67 The committee recommends that state and territory governments facilitate improved first responses to incidents involving people with cognitive or psychiatric impairment by ensuring:

- **Police and ambulance officers are provided with appropriate frontline training to recognise and respond to situations involving cognitive or psychiatric impairment issues.¹⁵**
- **Police and ambulance officers are provided with specialist resources, such as state-wide 24/7 access to mental health teams to provide immediate advice during first response incidents.**
- **Increased funding for health transport to ensure that police resources are not used to transport people for mental health assessments.**

Early intervention

9.68 Evidence was presented to the committee that detention is generally rationalised as being necessary where a person with a cognitive or psychiatric impairment is deemed a risk to themselves or others. Submitters argued that early intervention, taken before a person becomes a risk to themselves or others, would often address cognitive or psychiatric impairment issues before a crisis occurs. Some

15 See Abuse inquiry recommendation 6.

people have suggested this might include some form of compulsion for treatment, it should not require detention for safety issues.

Recommendation 28

9.69 The committee recommends that state and territory governments investigate the appropriateness of early intervention mental health treatment, with a specific goal to reduce 'risk-induced' treatment-related detention.

Risk assessments

9.70 The committee is concerned by the expert legal and medical evidence on the lack of consistency in assessing the level of risk of harm that can trigger an order for detention, both across jurisdictions and across specialist fields or pieces of legislation within a single jurisdiction. This leads to differing approaches for who is detained, based on where they live, or what kind of impairment they have, rather than on the actual risk of harm to themselves or others. The committee also received evidence on the differing approaches to the review of compulsory treatment orders, which highlighted that many reviews fall far short of engaging with the particular needs of the individual.

Recommendation 29

9.71 The committee recommends the Australian Government work with state and territory governments to create national consistency in the approach to compulsory treatment orders, to ensure:

- appropriate 'risk of harm' levels are set for assessments that can result in detention for the purposes of therapeutic intervention;
- mandated requirements for 'least restrictive' treatment;
- regular reviews, including assessment of treatment against therapeutic benchmarks; and
- independent oversight.

Supported decision-making

9.72 The committee considers the use of supported decision making tools such as Advance Directives as a means for people to exercise a level of control during non-consensual assessment and treatment during times of a mental health crisis. There is a need for legislative change to strengthen the effect of such tools.

Recommendation 30

9.73 The committee recommends that state and territory governments consider and implement legislative change to strengthen the effect of supported decision-making tools such as Advance Directives.

Mandated therapeutic benchmarks

9.74 The committee is greatly concerned by evidence that often there is a rush to detain a person on the grounds they require therapeutic intervention in order to address a risk of harm to self or others. However, once the individual has been detained, the impetus for the service delivery agency to provide appropriate therapeutic intervention is not as great. Alternatively, the location at which the individual is detained may limit the range of therapeutic intervention available. Submitters and witnesses pointed to the Victorian disability frameworks, which include a requirement that detention is beneficial to the individual, and contains therapeutic benchmarks that must be met.

Recommendation 31

9.75 The committee recommends the state and territory governments consider adopting elements of the Victorian disability frameworks.

Community accommodation

9.76 One of the key impediments to people being transitioned from indefinite detention in secure care to community-based accommodation is the shortage of accommodation in the community.

Recommendation 32

9.77 The committee recommends that state and territory governments proactively fund the construction or acquisition of a range of appropriate supported accommodation options across metropolitan and regional locations for people with cognitive and/or psychiatric impairments.

Senator Rachel Siewert

Chair

APPENDIX 1

Submissions and additional information received by the Committee

Submissions

- 1** Mr Geoffrey Bird
- 2** Russell Family Fetal Alcohol Disorders Association
- 3** Confidential
- 4** Australian Law Reform Commission
- 5** Melbourne Social Equity Institute and Hallmark Disability Research Initiative
- 6** Australian Human Rights Commission
- 7** Queensland Advocacy Incorporated
- 8** Professor Harry Blagg, Dr Tamara Tulich and Ms Zoe Bush (plus an attachment)
- 9** Sisters Inside
- 10** Legal Aid Western Australia
- 11** Dr Janet Hammill (plus eleven attachments)
- 12** Australian Medical Association (plus two attachments)
- 13** Mental Health Review Tribunal
- 14** Australian College of Mental Health Nurses; Congress of Aboriginal and Torres Strait Islander Nurses and Midwives; and Australian College of Nursing (plus an attachment)
- 15** National Mental Health Commission
- 16** Carers NSW
- 17** Royal Australian and New Zealand College of Psychiatrists (plus a supplementary submission)

- 18** Criminal Lawyers Association of the Northern Territory
- 19** Professor Richard Fleming
- 20** Victorian Ombudsman (plus an attachment)
- 21** Mental Health Commission of New South Wales
- 22** Mr Mark Skinner
- 23** Aboriginal Legal Service of Western Australia (plus an attachment and a supplementary submission)
- 24** NT Community Visitor Program
- 25** Refugee Council of Australia
- 26** Global Action on Personhood
- 27** Western Australian Association for Mental Health
- 28** Advocacy Tasmania Inc
- 29** South Australia Community Visitor Scheme (plus an attachment)
- 30** Ms Jan Barham MLC
- 31** Ms Miranda Bain (plus an attachment)
- 32** National Disability Services
- 33** Australian Lawyers Alliance
- 34** National Aboriginal and Torres Strait Islander Legal Services
- 35** Geraldton Resource Centre Inc. (plus two attachments)
- 36** Office of the Public Advocate Queensland
- 37** Disability Rights Advocacy Service
- 38** Amnesty International Australia
- 39** First Peoples Disability Justice Consortium

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- 40** NSW Council for Intellectual Disability
 - 41** Name Withheld
 - 42** Alzheimer's Australia
 - 43** Mental Health Matters 2
 - 44** Professor Dan Howard SC
 - 45** Telethon Kids Institute
 - 46** Justice Action
 - 47** Chief Justice of Western Australia (plus two attachments)
 - 48** Department of Developmental Disability Neuropsychiatry, UNSW Australia
 - 49** Being
 - 50** Department of Social Services
 - 51** Office of the Inspector of Custodial Services (plus an attachment)
 - 52** Australian Association of Social Workers (plus an attachment)
 - 53** Jesuit Social Services
 - 54** Chatter Matters Tasmania
 - 55** National Organisation for Fetal Alcohol Spectrum Disorders
 - 56** Office of the Public Guardian Queensland
 - 57** Just Reinvest NSW
 - 58** Office of the Public Advocate Victoria
 - 59** Dr Linda Steele
 - 60** North Australian Aboriginal Justice Agency
 - 61** Australian Cross Disability Alliance
 - 62** Legal Aid NSW

- 63** Dr Joanne Bradbury
- 64** Change the Record Coalition (plus an attachment)
- 65** Forensicare
- 66** NSW Government
- 67** Barriers to Justice
- 68** Liberty Victoria
- 69** Director of Forensic Disability Queensland
- 70** Senior Public Psychiatrists, ACT
- 71** Victoria Legal Aid
- 72** Law Council of Australia
- 73** Ms Alison Youssef
- 74** Ms Ida Curtois (plus an attachment)
- 75** Northern Territory Government
- 76** Aboriginal Disability Justice Campaign
- 77** Mental Health Advocacy Service (plus two attachments)
- 78** Confidential
- 79** Name Withheld
- 80** Name Withheld

Additional Information

- 1 Update on Rosie Anne Fulton, from the Aboriginal Disability Justice Campaign and Mr Ian McKinlay (Ms Fulton's Adult Guardian), received 27 April 2016
- 2 A predictable and preventable path: Aboriginal people with mental and cognitive disabilities in the criminal justice system report, from UNSW Indigenous Australians with Mental Health Disorders and Cognitive Disability in the Criminal Justice System project, received 7 April 2016
- 3 Supreme Court of Western Australia's submission to the Review of the Criminal Law (Mentally Impaired Accused) Act 1996, from Chief Justice of Western Australia, received 15 September 2016
- 4 The West Australian newspaper, 8 October 2014, p. 1, from Mental Health Matters 2, received 19 September 2016
- 5 Comorbidity of fetal alcohol spectrum disorder: a systematic review and meta-analysis, Lancet journal article, 5 March 2016, from Telethon Kids Institute, received 28 September 2016
- 6 The Geraldton Guardian newspaper, 30 September 2016, p.10, from Geraldton Resource Centre, received 7 October 2016
- 7 Unfitness to Plead Project: Cost-Benefit Analysis of Supporter, from Melbourne Social Equity Institute and Hallmark Disability Research Initiative, received 24 October 2016
- 8 NT Community Visitor Program Annual Report 2015/2016, from NT Community Visitor Program, received 31 October 2016
- 9 The ITHACA Toolkit, from Criminal Lawyers Association of the NT, received 1 November 2016

Answers to Questions on Notice

- 1 Answers to Questions taken on Notice during 29 April public hearing, received from Melbourne Social Equity Institute and Disability Research Initiative 'Unfitness to Plead Project' Team, 13 May 2016
- 2 Answers to Questions taken on Notice during 19 September public hearing, received from Office of the Inspector of Custodial Services, 4 October 2016
- 3 Answers to Questions taken on Notice during 19 September public hearing, received from WA Disability Services Commission, 5 October 2016
- 4 Answers to Questions taken on Notice during 19 September public hearing, received from University of Western Australia Law School, 14 October 2016
- 5 Answers to Questions taken on Notice during 25 October public hearing, received from Northern Territory Department of Health, 22 November 2016

- 6 Answers to Questions taken on Notice during 26 October public hearing, received from Northern Territory Legal Aid Commission, 17 November 2016
- 7 Answers to Questions taken on Notice during 26 October public hearing, received from North Australian Aboriginal Justice Agency, 23 November 2016
- 8 Answers to Questions taken on Notice during 8 November public hearing, received from Law Council of Australia, 10 November 2016
- 9 Answers to Questions taken on Notice during 8 November public hearing, received from Just Reinvest NSW, 18 November 2016
- 10 Answers to Questions taken on Notice during 8 November public hearing, received from Department of Social Services, 21 November 2016

Correspondence

- 1 Correspondence and additional information from the Civil Law Unit of the Attorney-General's Department, received 8 November 2016
- 2 Correspondence clarifying evidence given at the 26 October 2016 public hearing, received from the Northern Territory Legal Aid Commission, 17 November 2016

Tabled Documents

- 1 Position statement on the Forensic Disability Service, tabled by Queensland Advocacy Inc, at Brisbane public hearing 23 March 2016
- 2 Queensland Forensic Disability Service, Shining light on a closed system through an examination of forensic disability orders for persons with an intellectual or cognitive disability, October 2015, tabled by Queensland Advocacy Inc, at Brisbane public hearing 23 March 2016
- 3 Position statement regarding the use of restrictive practices on people with disability, tabled by Queensland Advocacy Inc, at Brisbane public hearing 23 March 2016
- 4 Conclusions on the use of restrictive practices for people with an intellectual or cognitive disability, How to return respect and control to marginalised people, October 2014, tabled by Queensland Advocacy Inc, at Brisbane public hearing 23 March 2016

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- 5 Disabled Justice, The barriers to justice for persons with disability in Queensland, May 2007, tabled by Queensland Advocacy Inc, at Brisbane public hearing 23 March 2016
 - 6 Dis-Abled Justice, Reforms to justice for persons with disability in Queensland, May 2015, tabled by Queensland Advocacy Inc, at Brisbane public hearing 23 March 2016
 - 7 Human Rights Indicators for People with Disability, A resource for disability activists and policy makers, October 2007, tabled by Queensland Advocacy Inc, at Brisbane public hearing 23 March 2016
 - 8 Information on Fetal Alcohol Spectrum Disorders, tabled by Dr Janet Hammill, at Brisbane public hearing 23 March 2016
 - 9 Opening statement, tabled by Aboriginal Disability Justice Campaign, at Melbourne public hearing 29 April 2016
 - 10 Opening statement, tabled by Victorian Office of the Public Advocate, at Melbourne public hearing 29 April 2016
 - 11 Opening statement, tabled by Victoria Legal Aid, at Melbourne public hearing 29 April 2016
 - 12 Opening statement, tabled by Jesuit Social Services, at Melbourne public hearing 29 April 2016

APPENDIX 2

Public hearings

Wednesday, 23 March 2016

Queensland Parliament House, Brisbane

Witnesses

Legal Aid Queensland

BRIGGS, Mr Joseph Douglas, Barrister, Designated Counsel to the Queensland Mental Health Court

Queensland Advocacy Inc.

PHILLIPS, Dr Emma, Systems Advocate

HAMMILL, Dr Janet Mary, Coordinator, Collaboration for Alcohol Related Developmental Disorders, Perinatal Research Group, University of Queensland Centre for Clinical Research

Russell Family Fetal Alcohol Disorders Association

RUSSELL, Mrs Elizabeth (Anne), Chief Executive Officer

WARDALE, Mr Simon, Private capacity

BRADBURY, Dr Joanne, Lecturer, Southern Cross University

Aboriginal Disability Justice Campaign, La Trobe University

McGEE, Mr Patrick, Coordinator

Aboriginal and Torres Strait Islander Legal Service (Queensland) Ltd

DUFFY, Mr Shane, Chief Executive Officer

Friday, 29 April 2016

Monash Conference Centre, Melbourne

Witnesses

Aboriginal Disability Justice Campaign

McKINLAY, Mr Ian, Spokesperson

Victorian Office of the Public Advocate

CHESTERMAN, Dr John, Director of Strategy

McCARTHY, Ms Tess, Policy and Research Officer

WALKINSHAW, Mr Bryan, Advocate Disability Act Officer

Victoria Legal Aid

POVEY, Mr Chris, Program Manager, Mental Health and Disability Law Sub-program

FRITZE, Ms Eleanore, Senior Lawyer, Mental Health and Disability

Jesuit Social Services

CLEMENTS, Mr Daniel, General Manager, Justice Programs

JESSOP, Dr Glenn William, Policy Manager

First Peoples Disability Network, Australia

EVERY, Mr Scott, Director, Policy and Research

National Aboriginal and Torres Strait Islander Legal Services

MUIR, Mr Wayne, Chairperson

WARNER, Ms Karly, Executive Officer

**Melbourne Social Equity Institute and the Disability Research Initiative,
University of Melbourne**

ARSTEIN-KERSLAKE, Dr Anna, Chief Investigator, Unfitness to Plead Project

KEYZER, Professor Patrick, Head of School and Chair of Law and Public Policy,
La Trobe Law School, La Trobe University

Australian Law Reform Commission

CROUCHER, Prof. Rosalind Frances, President

National Disability Services

BAKER, Dr Ken, Chief Executive

ANGLEY, Ms Philippa, Executive Officer

Australian Community Services Organisation

PAPPOS, Mr Stan, Senior Manager, Forensic Housing Services

Royal Australian and New Zealand College of Psychiatrists

BENNETT, Dr Chad, Chair, Section for the Psychiatry of Intellectual and Developmental Disabilities

Deaf Indigenous Community Consultancy

BARNEY, Ms Jody, Certified Aboriginal Disability Cultural Safety Trainer and Assessor

Monday, 19 September 2016

International on the Water Hotel, Perth

Witnesses**Chief Justice of Western Australia**

MARTIN, The Hon. Wayne

Office of the Inspector of Custodial Services

MORGAN, Professor Neil, Inspector of Custodial Services

DAVIS, Ms Rowena, Director of Reviews

HERITAGE, Mr Kyle, Senior Audit and Research Officer

Aboriginal Legal Service of Western Australia

COLLINS, Mr Peter, Director, Legal Services

Geraldton Resource Centre Inc

MULLER, Ms Alison, Principal Solicitor

Developmental Disability WA

HARVEY, Ms Taryn, Chief Executive Officer

University of Western Australia

BLAGG, Professor Harry, Professor of Criminology

TULICH, Dr Tamara, Lecturer

BUSH, Ms Zoe, Former Research Assistant and Student

Telethon Kids Institute

MUTCH, Clinical Associate Professor Dr Raewyn Cheryll, Post-Doctoral Senior Research Fellow and Paediatrician

WALKER, Ms Noni, Senior Research Fellow

Western Australian Association for Mental Health

McKINNEY, Ms Chelsea, Manager, Systemic Advocacy

Mental Health Matters 2

DOHERTY, Ms Margaret, Convenor

Western Australia Disability Services Commission

CHALMERS, Dr Ron, Director-General

PARRY, Ms Myra, Manager, Disability Justice Service

BASTIN, Ms Simone, Senior Project Officer 2011-2014, Disability Justice Service

Tuesday, 25 October 2016

Parliament House, Darwin

Witnesses**Participants and support workers in the 'Unfit to plead' project**

GOODING, Dr Piers, Postdoctoral Research Fellow, Disability Research Initiative, Melbourne Social Equity Institute, Melbourne Law School, University of Melbourne
CARROLL, Mr Philip, Client Support Worker, North Australian Aboriginal Justice Agency

Northern Territory Community Visitor Program

SIEVERS, Ms Sally, Principal Community Visitor, and Anti-Discrimination Commissioner, Northern Territory Anti-Discrimination Commission

South Australia Community Visitor Scheme

ALDERDICE, Mr John, Office Manager

MIGLIORE, Ms Connie, Mental Health Coordinator

Golden Glow Nursing

SCHAFFER, Ms Maureen, Director

PAINE, Mrs Jody, Operations Manager

Northern Territory Mental Health Coalition

HARRIS, Ms Vanessa, Executive Officer

Danila Dilba Health Service

KNUTH, Mr Joseph, Acting Head of Programs

Northern Territory Government

ANDERSON, Ms Janet, Acting Chief Executive Officer, Department of Health

RILY, Ms Annie, Acting Senior Director, Office of Disability, Department of Health

CAMPION, Mr Richard, Acting General Manager, Top End Mental Health Services and Alcohol and Other Drugs Services, Department of Health

PAYNE, Mr Mark, Commissioner, Northern Territory Correctional Services, Department of the Attorney-General and Justice

CARROLL, Mr Bill, General Manager, Darwin Correctional Centre

MacDONALD, Mr Greg, Lawyer, Solicitor for the Northern Territory

Wednesday, 26 October 2016

Convention Centre, Alice Springs

Witnesses**Criminal Lawyers Association of the Northern Territory**

GOLDFLAM, Mr Russell, President; and Principal Legal Officer, Alice Springs Office, Northern Territory Legal Aid Commission

GERRY, Ms Felicity Ruth, QC, Vice President

North Australian Aboriginal Justice Agency

WOODROFFE, Mr David, Principal Legal Officer

Barriers to Justice

LAUGHTON, Ms Victoria, Research and Advocacy Officer, Victim Support Service
EGEGE, Mr David, Executive Director, Disability Advocacy and Complaints Service of South Australia

YU, Mr Fucheng, Project Manager/Advocate, Disability Advocacy and Complaints Service of South Australia

TREE, Ms Anna, Chief of Staff/Media Advisor, Dignity for Disability

COLLINS, Ms Tania, Senior Criminal Legal Officer, Central Australian Aboriginal Legal Aid Service

McKINLAY, Mr Ian, Adult guardian and Spokesperson, Aboriginal Disability Justice Campaign

Tuesday, 8 November 2016

Parliament House, Canberra

Witnesses

New South Wales Council for Intellectual Disability

SIMPSON, Mr James, Senior Advocate

Mental Health Australia

XAMON, Ms Alison, Immediate outgoing Director

Just Reinvest New South Wales

HOPKINS, Ms Sarah, Chair

Australian Human Rights Commission

TRIGGS, Prof. Gillian, President

EDGERTON, Mr Graeme, Senior Lawyer

Australian Law Reform Commission

CROUCHER, Prof. Rosalind, AM, President

Law Council of Australia

McINTYRE, Mr Greg, Access to Justice and Human Rights Committee Member

Department of Social Services

CHRISTIAN, Mr James, Group Manager, Disability, Employment and Carers

RILEY, Mr John, Branch Manager, Program Transition

APPENDIX 3

Summary of key recommendations from previous reports

Community Affairs Committee

Inquiry into violence, abuse and neglect of people with disability

Recommendations¹

Recommendation 6

10.32 The committee recommends the Australian Government work with state and territory governments on the implementation of initiatives to improve access to justice for people with disability contained in the reports by the Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, the Human Rights Commission, *Equal Before the Law* and Productivity Commission, *Access to Justice Arrangements*, with particular focus on:

- better intervention and support services;
- expanded Community Visitor's schemes;
- improved witness support services to people with disabilities;
- creation of an assessment protocol that assists police, courts, and correctional institutions in identifying people with disabilities. Where identified, a trained officer will provide support;
- transparent, effective and culturally appropriate complaints handling procedures;
- training for police, lawyers and others in justice in needs of people with disability; and
- where a person who has been found unfit to plead is to be held in detention, demonstrate that all reasonable steps have been taken to avoid this outcome, and that person must be held in a place of therapeutic service delivery.

Recommendation 7

10.33 The committee also recommends that each state and territory implement a Disability Justice Plan.

1 Community Affairs Committee, *Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability*, (Abuse inquiry) November 2015, pp 267-283.

Recommendation 8

10.34 The committee believes that there is a need for further investigation of access to justice issues, with a focus on:

- national implementation of the South Australian model to ensure people with disability are able to provide evidence;
- the implementation requirements for supported decision-making;
- investigating the potential for the UK system of registered intermediaries;
- the access to justice needs of specific groups such as women, children, culturally and linguistically diverse communities and Aboriginal and, Torres Strait Islander peoples; and
- the indefinite detention of people with cognitive impairment or psychiatric disabilities.

Recommendation 9

10.38 The committee recommends the Australian Government work with state and territory governments on a nationally consistent approach to existing state and territory disability oversight mechanisms, to include;

- a clear distinction between dispute resolution and complaints investigation processes;
- a requirement that service delivery organisations should not report to funding agencies due to the conflict of interest;
- the principle that immediate action be taken on allegations of abuse to ensure the individual's safety;
- increased funding for community visitor schemes, with consideration these schemes be professionalised in all jurisdictions and with a mandatory reporting requirement for suspected violence, abuse or neglect; and
- greater crossover in oversight and complaints mechanisms between aged care and disability and recognising that over 7000 young people with disability live in aged care facilities, ensure that disability service standards are applicable.

Recommendation 10

10.41 The committee recommends that the Australian Government consider driving a nationally consistent move away from substitute decision-making towards supported decision-making models.

Recommendation 11

10.44 The committee recommends that the Australian Government work with state and territory governments to consider implementing the recommendations of the Australian Law Reform Commission report *Equality, Capacity and Disability in Commonwealth Laws*, in relation to legal capacity and supported decision-making.

Recommendation 12

10.45 The committee recommends the Australian Government work with state and territory governments to create national consistency in the administration of guardianship laws to ensure:

- public advocate and guardianship functions are separate to ensure independent oversight;
- mandatory training on supported decision-making for guardians;
- a requirement for guardianship to achieve positive outcomes, not just avoiding risk of negative outcomes;
- the ability to have nuanced guardianship/decision-making frameworks – to ensure the legal ability of parents to advocate on behalf of adult children without having to establish legal incapacity;
- that service delivery organisations or accommodation providers are never given guardianship;
- automatic increased oversight where service delivery organisations or accommodation providers recommend families lose guardianship; and
- that Aboriginal and Torres Strait Islander peoples' particular circumstances are taken into account in developing guardianship systems.

Recommendation 17

10.55 The committee recommends of the Government consider the following when rolling out the National Disability Insurance Scheme (NDIS):

- an urgent roll out of capacity-building and advocacy support for individuals undertaking negotiations for self-directed disability support;
- increased training for NDIS planners around intellectual impairment and guidelines on when to require decision-making support;
- further investigation of whether the current NDIS unit pricing will have an impact on incidents of violence, abuse or neglect.
- NDIS quality and safeguarding framework must ensure a zero-tolerance approach to restrictive practice, and be tied to the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector*; and
- amendment of the *Quality and Safeguarding Framework* to include advocacy as a key component to reduce and address incidents of violence, abuse and neglect.

Recommendation 18

10.58 The committee recommends the Australian Government work with state and territory governments to implement a national zero-tolerance approach to eliminate restrictive practice in all service delivery contexts. This would entail:

- ensuring the national framework is properly implemented across all jurisdictions, as a mandatory, reviewable and enforceable scheme, with oversight by a qualified senior practitioner and with a mandatory element of positive behaviour support;
- a scheme that is not limited to the disability sector, but applies to all places where restrictive practice is used against people with disability; and
- imposing requirements for the use of positive behaviour management tools. These policies and guidelines would be guided by the following principles:
 - Policies and advice need to be available to the general public and linked in with behaviour and discipline policy.
 - The preferred substitution of positive behavioural management tools such as Applied Behavioural Analysis for 'restrictive practices'.

Australian Law Reform Commission

Equality, Capacity and Disability in Commonwealth Laws, 2014

Recommendations²

3. National Decision-Making Principles

Recommendation 3–1 Reform of Commonwealth, state and territory laws and legal frameworks concerning individual decision-making should be guided by the National Decision-Making Principles and Guidelines (see Recommendations 3–2 to 3–4) to ensure that:

- supported decision-making is encouraged;
- representative decision-makers are appointed only as a last resort; and
- the will, preferences and rights of persons direct decisions that affect their lives.

Principle 1: The equal right to make decisions

All adults have an equal right to make decisions that affect their lives and to have those decisions respected.

Principle 2: Support

Persons who require support in decision-making must be provided with access to the support necessary for them to make, communicate and participate in decisions that affect their lives.

Principle 3: Will, preferences and rights

2 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Final Report, ALRC Report 124, August 2014, pp 11–21, <https://www.alrc.gov.au/publications/equality-capacity-disability-report-124> (accessed 20 November 2015).

The will, preferences and rights of persons who may require decision-making support must direct decisions that affect their lives.

Principle 4: Safeguards

Laws and legal frameworks must contain appropriate and effective safeguards in relation to interventions for persons who may require decision-making support, including to prevent abuse and undue influence.

Recommendation 3–2 Support Guidelines

(1) General

- (a) Persons who require decision-making support should be supported to participate in and contribute to all aspects of life.
- (b) Persons who require decision-making support should be supported in making decisions.
- (c) The role of persons who provide decision-making support should be acknowledged and respected—including family members, carers or other significant people chosen to provide support.
- (d) Persons who require decision-making support may choose not to be supported.

(2) Assessing support needs

In assessing what support is required in decision-making, the following must be considered:

- (a) All adults must be presumed to have ability to make decisions that affect their lives.
- (b) A person must not be assumed to lack decision-making ability on the basis of having a disability.
- (c) A person's decision-making ability must be considered in the context of available supports.
- (d) A person's decision-making ability is to be assessed, not the outcome of the decision they want to make.
- (e) A person's decision-making ability will depend on the kind of decisions to be made.
- (f) A person's decision-making ability may evolve or fluctuate over time.

Recommendation 3–3 Will, Preferences and Rights Guidelines

(1) Supported decision-making

- (a) In assisting a person who requires decision-making support to make decisions, a person chosen by them as supporter must:
 - (i) support the person to express their will and preferences; and
 - (ii) assist the person to develop their own decision-making ability.
- (b) In communicating will and preferences, a person is entitled to:

- (i) communicate by any means that enable them to be understood; and
- (ii) have their cultural and linguistic circumstances recognised and respected.

(2) Representative decision-making

Where a representative is appointed to make decisions for a person who requires decision-making support:

The person's will and preferences must be given effect.

Where the person's current will and preferences cannot be determined, the representative must give effect to what the person would likely want, based on all the information available, including by consulting with family members, carers and other significant people in their life.

If it is not possible to determine what the person would likely want, the representative must act to promote and uphold the person's human rights and act in the way least restrictive of those rights.

A representative may override the person's will and preferences only where necessary to prevent harm.

Recommendation 3–4 *Safeguards Guidelines*

(1) General

Safeguards should ensure that interventions for persons who require decision-making support are:

- (a) the least restrictive of the person's human rights;
- (b) subject to appeal; and
- (c) subject to regular, independent and impartial monitoring and review.

(2) Support in decision-making

- (a) Support in decision-making must be free of conflict of interest and undue influence.
- (b) Any appointment of a representative decision-maker should be:
 - (i) a last resort and not an alternative to appropriate support;
 - (ii) limited in scope, proportionate, and apply for the shortest time possible; and
 - (iii) subject to review.

4. Supported Decision-Making in Commonwealth Laws

Recommendation 4–1 A Commonwealth decision-making model that encourages supported decision-making should be introduced into relevant Commonwealth laws and legal frameworks in a form consistent with the National Decision-Making Principles and Recommendations 4–2 to 4–9.

Recommendation 4–3 Relevant Commonwealth laws and legal frameworks should include the concept of a supporter and reflect the National Decision-Making Principles in providing that:

- (a) a person who requires decision-making support should be able to choose to be assisted by a supporter, and to cease being supported at any time;
- (b) where a supporter is chosen, ultimate decision-making authority remains with the person who requires decision-making support; and
- (c) supported decisions should be recognised as the decisions of the person who required decision-making support.

Recommendation 4–6 Relevant Commonwealth legislation should include the concept of a representative and provide for representative arrangements to be established that reflect the National Decision-Making Principles.

Recommendation 4–10 The Australian and state and territory governments should develop mechanisms for sharing information about appointments of supporters and representatives, including to avoid duplication of appointments and to facilitate review and monitoring.

5. The National Disability Insurance Scheme

Recommendation 5–1 The objects and principles in the *National Disability Insurance Scheme Act 2013* (Cth) should be amended to ensure consistency with the National Decision-Making Principles.

Recommendation 5–2 The *National Disability Insurance Scheme Act 2013* (Cth) and NDIS Rules should be amended to include provisions dealing with supporters consistent with the Commonwealth decision-making model.

Recommendation 5–3 The *National Disability Insurance Scheme Act 2013* (Cth) and NDIS Rules should be amended to include provisions dealing with representatives consistent with the Commonwealth decision-making model.

7. Access to Justice

Recommendation 7–1 and 7–3 The *Crimes Act 1914* (Cth) should be amended to provide that a person cannot stand trial if the person cannot be supported to:

- (a) understand the information relevant to the decisions that they will have to make in the course of the proceedings;
- (b) retain that information to the extent necessary to make decisions in the course of the proceedings;
- (c) use or weigh that information as part of the process of making decisions; or
- (d) communicate the decisions in some way.

Recommendation 7–2 State and territory laws governing the consequences of a determination that a person is ineligible to stand trial should provide for:

- (a) limits on the period of detention that can be imposed; and
- (b) regular periodic review of detention orders.

Recommendation 7–7 The *Evidence Act 1995* (Cth) should be amended to provide that a person is not 'competent to give evidence about a fact' if the person cannot be supported to:

- (a) understand a question about the fact; or
- (b) give an answer that can be understood to a question about the fact.

Recommendation 7–11 Federal courts should develop bench books to provide judicial officers with guidance about how courts may support persons with disability in giving evidence.

8. Restrictive Practices

Recommendation 8–1 The Australian Government and the Council of Australian Governments should take the National Decision-Making Principles into account in developing the national quality and safeguards system, which will regulate restrictive practices in the context of the National Disability Insurance Scheme.

Recommendation 8–2 The Australian Government and the Council of Australian Governments should develop a national approach to the regulation of restrictive practices in sectors other than disability services, such as aged care and health care.

10. Review of State and Territory Legislation

Recommendation 10–1 State and territory governments should review laws and legal frameworks concerning individual decision-making to ensure they are consistent with the National Decision-Making Principles and the Commonwealth decision-making model. In conducting such a review, regard should also be given to:

- (a) interaction with any supporter and representative schemes under Commonwealth legislation;
- (b) consistency between jurisdictions, including in terminology;
- (c) maximising cross-jurisdictional recognition of arrangements; and
- (d) mechanisms for consistent and national data collection.

Any review should include, but not be limited to, laws with respect to guardianship and administration; consent to medical treatment; mental health; and disability services.

Australian Human Rights Commission

Equal Before the Law: Towards Disability Justice Strategies, 2014

Actions³

Disability Justice Strategies

The Australian Human Rights Commission (Commission) considers that each jurisdiction in Australia requires an holistic, coordinated response to the issues raised in this report through a Disability Justice Strategy.

The Commission considers that any Disability Justice Strategy should address a core set of principles and include certain fundamental actions. These are set out in the following six action areas.

4.1 Appropriate communications

Action 4.1.1 Include formal recognition of the requirement to ascertain the need for an interpreter service, communication support worker or hearing assistance when dealing with Aboriginal and Torres Strait Islander people.

Action 4.1.2 Provide access to an appropriate independent communication support worker and interpreter regardless of place of residence or geographical location.

Action 4.1.3 Align terms and conditions of bail, bonds and restraining orders to a person's abilities and capacity to comply.

Action 4.1.4 Communicate bail decisions in a format and mode appropriate to the person with disability.

Action 4.1.5 Provide support to remind a person of bail conditions and support compliance.

4.2 Early intervention and diversion

Action 4.2.1 Make available via an e-referral program information that assists police and courts with appropriate diversion and early intervention.

Action 4.2.2 Make the e-referral program state- or territory-wide and link it to registered local, state and national support service agencies.

Action 4.2.3 Use e-referral programs to provide timely interventions that stream Aboriginal and Torres Strait Islander children with disability to the support services that they need.

4.3 Increased service capacity and support

Action 4.3.1 Design intervention and support services that are:

- age-, gender- and disability-sensitive;

3 Australian Human Rights Commission, *Equal Before the Law: Towards Disability Justice Strategies*, February 2014, pp 31–38, <https://www.humanrights.gov.au/our-work/disability-rights/publications/equal-law> (accessed 20 November 2015).

- appropriate for people with disabilities who have communication impairment or complex support needs; and
- culturally appropriate to the needs of women, children, Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds with disabilities.

Action 4.3.2 Expand Community Visitor's schemes to include a broader range of settings and apply to all people with disabilities.

Action 4.3.3 Provide access to advocacy and legal services with disability expertise regardless of place of residence or geographical location.

Action 4.3.4 Provide during interviews a sexual assault counsellor, disability support advocate or specialist disability lawyer to support adults and children with disabilities who have been sexually assaulted or experienced violence.

Action 4.3.5 Provide to people with disabilities who are lawfully deprived of their liberty the support, adjustments and aids they need to meet basic human needs and participate in custodial life.

Action 4.3.6 Establish as a matter of urgency a national Aboriginal and Torres Strait Island disability individual advocacy program.

Action 4.3.7 Create an assessment protocol that assists police, courts, and correctional institutions in identifying people with disabilities in order to determine:

- the necessity for Independent Communication Support Workers, and Disability Advocate / Support Person;
- the appropriate supports and services to exercise their legal capacity and enhance health, social and welfare outcomes; and
- the requirement for procedural and age-appropriate accommodations to ensure effective access to justice.

Action 4.3.8 Provide pre-court conferencing for children and young people with disabilities.

Action 4.3.9 Provide witness support services to people with disabilities,

Action 4.3.10 Aboriginal and Torres Strait Islander people with disabilities are provided with culturally secure assessment, supports and services that promote full and effective participation in society and a life with dignity.

Action 4.3.11 Adopt individual case management for prisoners/detainees with disability, including through prison in-reach services provided by community organisations, to provide education and support (pre- and post-release) to assist re-integration into the community and reduce offending behaviour.

Action 4.3.12 Make available quiet rooms for people with disabilities to wait, meet or for break times in court.

Action 4.3.13 Sentencing for unpaid fines should involve the exercise of discretion, taking into account the high incidence of poverty among people with disabilities.

4.4 Effective training

Action 4.4.1 Develop and deliver staff training that:

- improves responses and attitudes of staff
- addresses the impact of intersectional experiences of disability, gender and violence.
- emphasises the rights of people with disabilities to make their own decisions, with support if necessary, and that those decisions deserve respect.

Action 4.4.2 Provide to people with a disability, their families and carers appropriate education and information, in a culturally competent manner, so they are confident in using the service system and can acquire the 'inside knowledge' that makes a system work.

4.5 Enhanced accountability and monitoring

Action 4.5.1 Ensure people with disabilities are represented on relevant governance and advisory boards.

Action 4.5.2 Include transparent, effective and culturally appropriate complaints handling procedures.

Action 4.5.3 Implement a transparent independent mechanism to monitor the use of restraint and seclusion of people with disabilities in all settings, with a view to recording and minimising the use of these practices. When the circumstances justify the use of restraint and seclusion safeguards must in place and reported.

4.6 Better policy and frameworks

Action 4.6.1 At every stage of the criminal justice system, recognise the importance of providing procedural and age-appropriate accommodations to people with disabilities.

Action 4.6.2 Recognise that failure to provide necessary accommodations to a person with disabilities can create a legitimate mitigating circumstance that a court should consider.

Action 4.6.3 Where a person who has been found unfit to plead is to be held in detention, demonstrate that all reasonable steps have been taken to avoid this outcome.

Action 4.6.4 Require chief executives of relevant agencies to report every 2 years to the Premier and the Premier's Disability Advisory Council in relation to access to justice for people with disabilities in the criminal justice system.

Action 4.6.5 All criminal justice agencies monitor and evaluate:

- participation rates by people with disabilities as victims of crime, witnesses, accused, defendants, offenders and jurors in all parts of the justice system
- provision of adjustments and supports on critical indicators including age, sex, gender, disability, race, type of violence.

Productivity Commission

Access to Justice Arrangements, 2014

Recommendations – Chapter 5: Understanding and navigating the system⁴

Recommendation 5.1

Legal Assistance Forums should establish Community Legal Education Collaboration Funds (CLECFs) in their jurisdictions to ensure that high quality legal education resources for jurisdictional and Commonwealth matters are developed and maintained. Funding for community legal education should be allocated to projects where the forum has identified significant need. A database of community legal education projects should be used to share community legal education, identify community legal education that may be out of date and minimise duplication. Mechanisms to ensure coordination between CLECFs on matters of Commonwealth law should be put in place.

Recommendation 5.3

To support the identification and assistance of disadvantaged people with complex legal needs:

- legal health checks that are developed for priority disadvantaged groups should be funded through the proposed Community Legal Education Collaboration Funds. The resulting material should be shared amongst providers. Legal Assistance Forums should coordinate this activity to avoid duplication between jurisdictions and maintain the currency of the health checks.
- legal assistance and relevant non-legal service providers should be encouraged to coordinate their services in order to provide more outreach and holistic services where appropriate and need is greatest.
- the proposed Community Legal Education Collaboration Funds should assess the most effective way to support the legal education of non-legal community workers. Training materials should be shared among legal assistance providers and between jurisdictions.

Legal Assistance Forums should regularly reassess the mix of these services in order to promote efficient service delivery by adapting to changing needs.

⁴ Productivity Commission, 'Chapter 5: Understanding and navigating the system,' *Access to Justice Arrangements*, Productivity Commission Inquiry Report no. 72, volume 1, 5 September 2014, pp 149–185, <http://www.pc.gov.au/inquiries/completed/access-justice/report> (accessed 21 October 2015).

APPENDIX 4

Summary of committee site visits related to the inquiry

This appendix contains summaries of the committee's visits to the Bennett Brook Disability Justice Centre (WA), the Darwin Correctional Precinct (NT) and the Alice Springs Correctional Centre (NT).

Site visit to the Bennett Brook Disability Justice Centre

Introduction

Following the committee's public hearing in Perth on 19 September 2016, the committee travelled to the Bennett Brook Disability Justice Centre (DJC) in the Swan region of Perth to conduct a site visit. The committee was welcomed to the DJC and provided with a tour by Ms Myra Parry, Manager of Disability Justice Services and staff of the DJC. Senators Siewert, Duniam, Pratt and Dodson participated in the site visit.

Until late last year, one of the reasons that people subject to forensic orders were being indefinitely detained in WA prisons was the lack of a 'declared place' or a DJC—a secure alternative to prison where therapeutic and other support services can be provided. This has now been partially rectified with the construction of the state's first declared place, a ten bed facility. The DJC is operated by the WA Disability Services Commission (DSC).

Description of the facility

This purpose-built secure facility consists of a ring of buildings built around a central courtyard with paths, basketball court, vegetables gardens and shared social spaces including a firepit. The buildings surrounding this area consist of:

- apartments where the residents live,
- a common amenities area with kitchen, laundry, lounge room, games facilities and computers;
- a workshop with woodworking tools; and
- an administrative area with observation rooms, meeting rooms, medical rooms and staff offices.



Figure 1.1: An aerial view of the DJC at Caversham showing the buildings situated around a central courtyard

Placements in the facility

Placements in the DJC are limited to people with cognitive impairments subject to custody or forensic orders. Placement can only be recommended by the Mentally Impaired Accused Review Board (MIARB). Residents are selected on the basis that they will be suitable to transition to live in the community. Similarly, any leave of absence or separation from the DJC can only be approved by the MIARB.

Support provided in the DJC and pathways to the community

DJC staff and external private service providers support residents to live independent, positive and purposeful lives in the centre and in the community on leave of absence. Leaves of absence are an opportunity for residents to spend extended periods of time living in the community. Residents are transitioned to independently live and manage their own home (e.g. cooking meals, washing, cleaning) and engage in social activities with positive friends and acquaintances. A staged and supported transition back to the community ensures that this transition to the community is sustainable for that individual in the longer term.



Figure 1.2: View across the central courtyard area to the administrative and activities buildings within the DJC

Progress so far

Since the DJC's opening late last year, two residents have successfully transitioned back into the community; two residents currently live in the DJC; and three prospective residents are being considered for placement. In evidence to the committee, the DSC suggested that the centre will be close to full capacity by the end of this year. During the tour, committee members were able to meet with two current residents. DJC staff noted that there had been a vast improvement in the social interactions and functioning of the residents since moving to live in the DJC.

Acknowledgements

On behalf of the committee, Senator Siewert thanked the residents and staff of the DJC and the WA Disability Services Commission for warmly hosting the committee's visit.

Site visit to the Darwin Correctional Precinct

Introduction

Following the committee's public hearing in Darwin on 25 October 2016, the committee travelled to the Darwin Correctional Precinct (DCP) south of Darwin to conduct a site visit of the Complex Behaviour Unit (CBU) and the Step-Down Cottages. These facilities were recently opened in September 2015.

The committee were welcomed to the DCP and provided with a briefing and tour by Mr Bill Carroll (Superintendent-DCP) and staff of the DCP. The committee were also welcomed to the step-down cottages by Mr Michael Pearce and residents of the cottages. The committee were provided with a short briefing and tour of the facility.

Senators Siewert, Duniam, Polley and McCarthy participated in the site visit.

At the time of the visit, there were thirteen people on custodial supervision orders (forensic orders) housed in the CBU, with four people having been transitioned to the step-down cottages.

Complex Behaviour Unit

The CBU currently accommodates male and female offenders placed on a custodial supervision order or prisoners with severe disabilities. A range of therapeutic treatment options, life skills, rehabilitation and recreational options which are tailored to individual needs are provided in the CBU with the aim of providing a transition pathway to supported living in the community. The facility provides a range of low, medium and high dependency male and female accommodation, although the low security part of this centre is not able to be staffed at this time due to a lack of dedicated funding.¹ Staff at the CBU provide reports to the Supreme Court for a person's annual review. Staff will also develop and implement transition and treatment plans for people subject to custodial supervision orders in the CBU.

The CBU is housed in a corrections environment (different to the WA Bennett Brook Disability Justice Centre which is operated by the WA Disability Services Commission) and is operated by the NT Department of Corrections with support from the NT Department of Health. The CBU is led by a Clinical Manager as opposed to a corrections officer to ensure that the CBU is primarily focused on therapeutic outcomes rather than feeling like a jail. A Senior Corrections Officer and a number of Corrections Officers support the Clinical Manager and a range of professional medical and disability staff to operate the CBU. These Corrections Officers have volunteered to work in the CBU, and seek to fulfil a wide range of disability support services in addition to their standard corrective officer duties. DCP described a 'partnership between Corrective Officers and professional staff'. DCP also acknowledged that the CBU is still only new and developing new operating procedures and continually working to improve and optimise performance of the CBU.

¹ The step-down cottages provide an intermediate form of accommodated support between a secure location such as a prison, and living in the community with no restrictions and limited supports.

Transition to the Step-Down Cottages

Transition to the 'step-down' cottages from the CBU is an option for those who demonstrate improved behaviour in accordance with their treatment and transition plan and whom are also deemed a low risk to the community. The Step-Down Cottages are operated by the Department of Health (Office of Disability).

The step-down cottages are located on the grounds of the DCP; however sit outside the DCP wall. The cottages are centred around a courtyard with an administrative building which includes communal areas, kitchen and laundry; a three bedroom residence for new residents and those requiring extra support to reside with staff; and three individual units. There is capacity for six residents with four currently living there. The objective of the step-down cottages is to provide a supported accommodation model that allows a person to learn or re-establish a range of life skills before potentially being transitioned into the community into a supported living arrangement.

Acknowledgements

On behalf of the committee, Senator Siewert thanked the residents and staff of the CBU and the step-down cottages for warmly hosting the committee's visit.

Site visit to the Alice Springs Correctional Centre

Introduction

The morning after its Alice Springs public hearing on 27 October 2016, the committee travelled to the Alice Springs Correctional Centre (ASCC), 20 minutes' drive south-west of Alice Springs. The committee were welcomed to the ASCC and provided with a briefing and tour by Mr Stephen Rosier (Superintendent-ASCC) and staff of the ASCC. The committee was provided with a short briefing and tour of the facility.

At the conclusion of this visit, the committee drove to the Secure Care Facility (SCF), a facility operated by the Department of Health (Office of Disability). The SCF operates as a supported and secure step-down facility which supports people who have transitioned from the ASCC on custodial supervision orders. The committee were welcomed by Mr David Bosanko (Senior Clinician—Forensic Mental Health Service (Office of Disability)), and staff and residents of the SCF. The committee were provided with a short briefing and tour of the facility.

At the time of the visit, there were two people on custodial supervision orders (forensic orders) housed in the ASCC in G Block (John Bens Unit). G Block is a section of the ASCC repurposed to house people on custodial supervision orders.

Seven people are currently being supported by the SCF. Six of those people live permanently in the SCF after being transitioned from the ASCC. One of the people living in G-Block visits the SCF three to five times a week on day trips as part of his transition plan. Four of the people living in the SCF are being prepared to transition into supported accommodation in the community.

Senators Siewert, Duniam, Polley and McCarthy participated in the site visit.

Alice Springs Correctional Centre – G Block (John Bens Unit)

The John Bens Unit (Unit) is a repurposed part of the maximum security wing (G-block) of the ASCC, designed to cater for people on custodial supervision orders. The Unit is sectioned off from the rest of the maximum security prisoners as a means to protect vulnerable people on custodial supervision orders from bullying and being taken advantage of. ASCC works with the Office of Disability to provide reports for annual reviews of any custodial supervision order to the Supreme Court.

People placed in the Unit are provided with a transition and treatment plan developed and coordinated by ASCC in conjunction with the Office of Disability, the Adult Guardian and medical professionals. This report may be commented on by the Supreme Court at the annual review; however, the development and on-going review of these plans can commence prior to the review and continue to occur over the rest of the year without input or oversight by the Supreme Court. Typically, these plans will have five stages whereby a person is progressively given greater freedoms, introduced to the SCF (a few hours then expanding to day trips) and a gradual removal of correctional officer in the presence of positive behaviours. ASCC and SCF utilise opposing behavioural approaches and philosophies reflective of the underlying purpose of each department—ASCC is more disciplinary—"you do this; you lose that"; whereas the SCF focuses on rewards—"you can have whatever you want if you

display good behaviour". ASCC noted the vast improvement in specific individual's behaviour with this approach, with a noticeable decrease in violent behaviour, and improved impulse control and understanding of consequences that flow from actions. An example of positive behavioural change is that if good behaviour is displayed when travelling to and from day visits at the SCF, then this will result in future visits to the SCF. Positive behaviour results in progression through the stages and can ultimately result in complete transfer to the SCF from the ASCC; likewise regressive behaviour results in demotion through the stages within the plan.



Figure 1.1: A view of an outside courtyard within the SCF

Transition to the Secure Care Facility

The Secure Care Facility (SCF) is located adjacent to the ASCC and is operated by the Office of Disability. The SCF provides secure, supported accommodation for people subject to custodial supervision orders. As noted previously, transition to the SCF commences once a person has a transition and treatment plan in place. Subject to certain criteria being met, primarily management of violent behaviours, a person may commence being introduced to the SCF. Depending on the level of cognitive functioning, the starting point for transition may range from a person being shown photos of the facility and told a story about it to spending a few hours in the SCF, then extending to day trips. Transition is conducted at a pace commensurate with the person's capacity to process changes in their physical and social environment. Subject to the transition process being successful, a person could be expected to move into and live in the SCF. It is expected that people can, over time, then be expected to move into and live in supported accommodation in the community.

Despite being a secure facility, the SCF is a home-like environment, with televisions, computer access, communal areas (outdoor and indoor), kitchen and private individual rooms. Access to vehicles and the capacity to undertake chaperoned community visits is provided on a daily basis. Freedom of movement is generally not constrained. Disability Support Workers (DSW) provide day-to-day support in the SCF at a ratio of two workers to one patient. DSW work closely with patients to meet the objectives of their plans; whilst access to medical professionals is also provided. Mr Bosanko noted that when patients have transitioned back to the community, oftentimes, DSWs have volunteered to transfer to support the person in the community.



Figure 1.2: A typical room and ensuite bathroom within the SCF



Figure 1.3: The communal kitchen within the SCF

Acknowledgements

On behalf of the committee, Senator Siewert thanked the residents and staff of both the ASCC and the SCF for warmly hosting the committee's visit.