



## Submission to Senate Community Affairs References Committee

### Indefinite detention of people with cognitive and psychiatric impairment in Australia

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## Recommendations

**Recommendation 1.** State and territory governments should review practices and procedures for identifying and screening prisoners with a cognitive disability including acquired brain injury to ensure that these functions are carried out by staff with specialist knowledge.

**Recommendation 2.** State and territory governments should improve data collection relating to people with disabilities who are alleged offenders. This includes data about people from Aboriginal and Torres Strait Islander and culturally and linguistically diverse backgrounds, to inform development of culturally appropriate practices.

Data collection and use should be guided by the *Convention on the Rights of Persons with Disabilities* article 31—Statistics and data collection.

**Recommendation 3:** Each jurisdiction in Australia should develop an holistic Disability Justice Strategy, as proposed in the Australian Human Rights Commission report *Equal before the law* (2014), to reduce the number of people with disability incarcerated due to inadequate support for their disability needs, and to enable access to justice more broadly.

**Recommendation 4.** A longitudinal evaluation of treatment provided under Victoria's Disability Forensic Assessment and Treatment Service (DFATS) programs should be undertaken to ensure programs are consistent with best practice.

Any evaluation should be examined with a view of potential application to other Australian jurisdictions.

**Recommendation 5.** State and territory governments should consider whether legislation that enables treatment-based detention should be enacted. The processes set out in the *Disability Act 2006* (Vic) Part 8—Compulsory Treatment—provide a model for state and territory governments to consider. Provisions should be extended to people with acquired brain injury. Treatment based detention orders should only operate for a maximum period of five years.

**Recommendation 6.** Longitudinal evaluations of the outcomes of supervision provided under the existing *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) should be undertaken to compare these with outcomes for people under compulsory treatment under the *Disability Act 2006* (Vic).

Any evaluation should be examined with a view of potential application to other Australian jurisdictions.

**Recommendation 7.** State and territory governments should consider enacting, or amending, legislation governing the detention of people who have been declared mentally-impaired or unfit to plead to enhance safeguards as follows:

- require a court, when making a supervision order in respect of a person, to specify the department that is responsible for the person's supervision (the supervisor)
- require the department responsible to prepare a treatment plan for the person on the supervision order
- require the department responsible to report on the resources available to undertake the treatment set out in the plan
- ensure that there are, minimally, annual processes for reviewing the treatment plan and its implementation and to ensure independent scrutiny and transparency
- ensure that there processes whereby the department responsible and any independent scrutinising bodies report to the supervising court on the treatment, the treatment plan, its implementation and the outcomes of the treatment at the court's biennial review
- require regular, automatic review of each custodial supervision order at an interval of no longer than every two years.



**Recommendation 8.** State and territory governments should invest additional resources to ensure there is alternative accommodation and support for people under indefinite detention. This includes trialling less restrictive and integration options to eliminate delays in prison/on remand experienced by prisoners.

**Recommendation 9.** Longitudinal evaluations of the outcomes of supervision and any treatment provided under the existing *Serious Sex Offenders (Detention & Supervision) Act 2009* (Vic) should be undertaken to compare these with outcomes for people under compulsory treatment under the *Disability Act 2006* (Vic).

Any evaluation should be examined with a view of potential application to other Australian jurisdictions.

**Recommendation 10.** People who at a risk of or are indefinitely detained should have a legislative right to advocacy on commencement of their order, for reviews, variations, leave applications and the determination of post discharge placements.

**Recommendation 11.** State and territory governments should ensure people with disability who have had or who are clearly at risk of having repeat contact with crime have access to an advocacy and referral scheme.

If the Office of the Public Advocate's Independent Third Person Program had an advocacy and referral function, as recommended in *Breaking the Cycle* report, this could be considered a useful model. Such a program must be adequately resourced and ideally be embedded in legislation.

**Recommendation 12.** That custodial bodies (who have identified persons with disabilities (as set out in recommendation 1)) develop protocols with the NDIA to establish whether people with disability held in custody are eligible for NDIS services and support. The protocol should encompass planning processes to be followed for persons found to be eligible.

This obligation on custodial bodies should be set out in legislation.

**Recommendations 13.** That the National Disability Insurance Scheme fund advocacy support and outreach to ensure that long-stay patients in mental health settings are supported to transition to the community where possible.

**Recommendations 14.** That the National Disability Insurance Scheme recognise long-stay patients in Secure Extended Care Units as a priority group when considering alternative accommodation models.

**Recommendation 15.** The Commonwealth, state and territory governments should consider enacting legislation that enables the regulation of restrictive practices. The processes set out in the *Disability Act 2006* (Vic) Part 7—Restrictive Interventions—provide a model for the Commonwealth state and territory governments to consider.



## About the Office of the Public Advocate

The Victorian Office of the Public Advocate (OPA) is a statutory office, independent of government and government services, that works to protect and promote the rights, interests and dignity of people with disabilities in Victoria.<sup>1</sup>

OPA provides a number of services to work towards these goals, including the provision of guardianship, advocacy and investigation services to people with cognitive impairments or mental ill health. In 2014-15, OPA was involved in 1511 guardianship matters, 438 investigations and 381 cases requiring advocacy.

Under the *Guardianship and Administration Act 1986* (Vic), OPA is required to arrange, coordinate and promote informed public awareness and understanding about substitute decision making laws and any other legislation dealing with or affecting persons with disability.<sup>2</sup>

OPA provides an Advice Service which offers information and advice on a diverse range of topics affecting people with disability. The telephone advice line last financial year answered 13,795 calls, a substantial proportion of which relate to guardianship and administration (35%), and enduring powers of attorney and guardianship (25%). OPA coordinates a Community Education Program where staff address both professional and community audiences across Victoria on a range of topics including the role of OPA, guardianship and administration, enduring powers of attorney and medical decision making.

OPA is the coordinating body of four volunteer programs including the Community Visitors Program, the Community Guardian Program, the Independent Third Person Program (ITP Program) and the Corrections Independent Support Officer Program (CISO). OPA provides support to over 900 volunteers.

Community Visitors are empowered by law to visit Victorian accommodation facilities for people with a disability or mental illness at any time, unannounced. They monitor and report on the adequacy of services provided, in the interests of residents and patients. There are 443 volunteers who visit across three streams: disability services, supported residential services and mental health services. Community Visitors conducted 5367 visits during 2014-2015, 1450 of which were to 140 mental health facilities.<sup>3</sup>

Under the *Mental Health Act 2014* (Vic), Community Visitors visit mental health services, including acute and secure extended care units.<sup>4</sup> Community Visitors monitor numbers and reasons for long-stay patients in these settings. Over the years they have identified many patients who are ready for discharge but continue to be detained under the Mental Health Act in locked mental health units due to a lack of alternative accommodation and support. OPA continues to monitor this issue and those patients identified as long stay. This project will be detailed within the scope of this inquiry further below.

Under the *Disability Act 2006* (Vic), among other things, Community Visitors visit residential facilities and make inquiries regarding the facilities' use of restrictive interventions and compulsory treatment. Compulsory treatment, under Part 8 of the Disability Act, is particularly relevant to this inquiry discussed further below.

## OPA and the justice system

OPA provides substantial support to people with a cognitive impairment and mental ill health through the ITP and CISO Programs.

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<sup>1</sup> *Guardianship and Administration Act 1986* (Vic) pt 3.

<sup>2</sup> *Guardianship and Administration Act 1986* (Vic) s 15(e).

<sup>3</sup> Office of the Public Advocate, *Community Visitors Annual Report 2014-2015* (2015) 17 (OPA, *Annual Report 2014-2015*).

<sup>4</sup> OPA has been monitoring the incidence of this and reports current data in the annual report.



An ITP must be present during Victoria Police interviews where the alleged offender, witness or victim may have a cognitive impairment or mental ill health.<sup>5</sup> OPA's ITP Program trains volunteers to perform this support and facilitation role. OPA ITPs attended 2,898 interviews during 2014-2015, 2,500 of which were with people with disability as alleged offenders.<sup>6</sup>

CISOs assist prisoners with an intellectual disability in governor's disciplinary hearings in prisons. Like ITPs, their role is to facilitate communication with the prisoner. CISO volunteers attended 136 hearings in the last financial year.

The Public Advocate has a number of advocacy roles and responsibilities in relation to the *Disability Act 2006* (Vic).<sup>7</sup> The Disability Act Officer advocates for people with disability who receive services under the Act or are subject to restrictive interventions, detention and compulsory treatment imposed under the Act. The Disability Act Officer provides advocacy on matters including the detention and treatment of persons with an intellectual disability who are considered to be a serious risk to the community.<sup>8</sup>

The legislation requires that the Public Advocate be notified of all Supervised Treatment Orders (STO) applications.<sup>9</sup> Furthermore, the Victorian Civil and Administrative Tribunal (VCAT) can join the Public Advocate as a party to an STO hearing.<sup>10</sup> OPA's involvement in STO hearings provides another layer of scrutiny and accountability in the STO regime, outlined further below.

## OPA research

OPA has undertaken significant research in relation to access to justice for people with disability, much of which is relevant to this inquiry and its broad terms of reference. This research, available on OPA's website, draws from OPA's unique experience derived from our various program areas in promoting and protecting the rights of people with disability.

Previous relevant research and publications include:

- *Submission to Inquiry into Access to and Interaction with the Justice System by People with an Intellectual Disability and their Families and Carers* (2013)
- *Submission to the Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (2013)
- *Breaking the Cycle: Using Advocacy-Based Referrals to Assist People with Disabilities in the Criminal Justice System* (2012)
- *Breaking the Cycle of Crime for Young People with Disabilities Submission to the Victorian Government Consultation: Practical Lessons, Fair Consequences – Improving Diversion for Young People in Victoria* (2012)
- *Supervised Treatment Orders in Practice: How are the Human Rights of People Detained under the Disability Act 2006 Protected?* (2010)
- *Long-Stay Patient Project Full Report* (2009)
- Community Visitors annual reports 1988–2015.<sup>11</sup>

<sup>5</sup> Victoria Police, *Victoria Police Manual – Procedures and Guidelines*, Independent third persons, 4 [para 3.2].

<sup>6</sup> OPA, *Annual Report 2014-2015*, 38–42.

<sup>7</sup> The Public Advocate is a Governor in Council appointment and independent of government. If the Public Advocate considers that a STO should be reviewed by VCAT, the Public Advocate may request the Senior Practitioner to make an application to VCAT pursuant to section 196(3) of the *Disability Act 2006* (Vic).

Furthermore, if the Public Advocate believes that a person is being detained outside the parameters of the Disability Act, the Public Advocate can apply to VCAT for an order directing the authorised program officer to make an application for a STO. See *Disability Act 2006* (Vic) ss 194(1)(b).

<sup>8</sup> The Disability Act Officer also has a role in relation to: the protection of tenancy rights for group home residents reports made by independent persons to the Public Advocate in relation to the use of restrictive interventions within a behavioural support plan: Office of the Public Advocate, *Advocacy Services* <<http://www.publicadvocate.vic.gov.au/our-services/advocacy-services>> accessed 18 March 2016.

<sup>9</sup> STO's are discussed later in this submission. See also *Disability Act 2006* (Vic) ss 191(4), 196(2).

<sup>10</sup> *Disability Act 2006* (Vic) s 191(5).

<sup>11</sup> Office of the Public Advocate, *Advocacy and Research* <<http://www.publicadvocate.vic.gov.au/advocacy-research>> accessed 22 March 2016.



## About this submission

OPA welcomes the opportunity to make a submission to the Senate Community Affairs References Committee's (Senate Committee) inquiry into indefinite detention of people with cognitive and psychiatric impairment in Australia.

OPA has research and practice expertise in the Victorian context relevant to the inquiry's terms of reference. OPA sees this as an opportunity to highlight relevant work undertaken by the office and to apply it to the terms of reference.

OPA 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.<sup>12</sup>

This submission will outline Victoria's current legislative framework and point to some strengths and weaknesses in Victoria's models including in relation to reforms being considered by the Victorian Government.

In Victoria, the legislative framework enabling indefinite detention includes the Disability Act, the Mental Health Act, the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) (CMIA), and the *Serious Sex Offenders (Detention and Supervision) Act 2009* (Vic). This submission will detail these laws where relevant, and make recommendations for reform more broadly directed at state and territory governments, drawing from the Victorian experience. OPA uses case studies to illustrate practical application of these laws to people with disability.

OPA's intention is to inform the Senate Committee in the development of its recommendations, pointing to Victoria's various models, with improvements where identified, and to encourage broad application of these models across Australia. Improvement to Victoria's system could lead to benefits for other jurisdictions.

While it is the law's job to regulate, it is governments' responsibility to adequately fund and resource the social system to provide supports and adequate services to complement these laws. That the justice service system is often unable to meet the needs of a person with disability imprisoned or at risk of or indefinitely detained is a failure of the system. While our need to protect is valid, more rigorous and best practice treatment approaches are needed, more skilled people are required and alternative accommodation support options considered.

## 1 Part One: Human rights and the law

This submission applies a human rights approach to address the terms of reference. A human rights approach:

- holds that all people with disabilities have the right to enjoy equality of opportunity and to effectively participate in, and be fully included in, society
- recognises that the challenges experienced by many people with disabilities are a result of disabling systems and environments, rather than being due to an inherent 'lack' in the individual
- does not deny the reality of impairment or its impact on the individual

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<sup>12</sup> See Senate Community Affairs References Committee

<[http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/Indefinite\\_Detention](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Indefinite_Detention)> for full terms of reference.





- does seek to challenge physical and social environments to accommodate impairment as an expected dimension of human diversity.<sup>13</sup>

For people with disability, specific instruments exist to promote and protect their rights. The existing international human rights framework promotes access to justice and disability rights at the international, national and state levels.

### 1.1 International

Australia's human rights framework is guided by the United Nations *Convention on the Rights of Persons with Disabilities* (Convention).<sup>14</sup> The Convention is the most comprehensive international human rights statement on the rights of people with disability. The Convention has very significant implications for the treatment of people with disability who are in contact with the criminal justice system.<sup>15</sup>

OPA wishes to refer to the important articles in the Convention that should guide the Senate Committee in its development of recommendations for law reform:

- Article 12 – Equal recognition before the law;
- Article 13 - Access to justice;
- Article 14 - Liberty and security of person;
- Article 19 - Living independently and being included in the community;
- Article 22 - Respect for privacy;
- Article 26 - Habilitation and rehabilitation.

Other instruments at the international level include the *Standard Rules on the Equalization of Opportunities for Persons with Disabilities 1993*, the *International Covenants of Civil and Political Rights 1966* and the *International Covenant on Economic, Social and Cultural Rights 1966*.

### 1.2 National

The Convention is supplemented by important pieces of legislation and policy documents at the national level including the *Disability Discrimination Act 1992* (Cth), the National Disability Strategy and the *National Disability Insurance Scheme Act 2013* (Cth).

### 1.3 Victorian law

At the Victorian state level, relevant laws and policy include *Equal Opportunity Act 2010* (Vic), the *Guardianship and Administration Act 1986* (Vic) and those laws referred to in the introduction.

Victoria has additional statutory human rights reflected in the *Charter of Human Rights and Responsibilities Act 2006* (Vic). The Charter is an important legislative instrument in Victoria, the constitution of which is not reflected elsewhere in Australia, other than the Australian Capital Territory under the Human Rights Act. OPA understands that Queensland is currently consulting on enacting legislation.

The Charter establishes a legislative framework for the protection and promotion of human rights in Victoria. The Charter establishes a human rights discourse and outlines the basic rights, freedoms and responsibilities of all Victorians. The Preamble to the Charter recognises that 'human rights belong to all people without discrimination', and, although the Charter does not refer specifically to disability, discrimination is defined as having the same meaning on the basis of an attribute set out in the *Equal Opportunity Act 2010* (Vic), which includes disability.

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<sup>13</sup> OPA, *Breaking the Cycle* 24.

<sup>14</sup> *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008).

<sup>15</sup> Chan, J. French, P. Hudson, C. and Webber, L. 'Applying the CRPD to Safeguard the Rights of People with a Disability in Contact with the Criminal Justice System' 19(4) *Psychiatry, Psychology and Law* (2012) 558-565 at p.559-560.





Relevant protected rights under the Charter include:

- Equality before the law (s 8);
- Protection from torture and cruel, inhuman or degrading treatment (s 10);
- Freedom of movement (s 12);
- Right to privacy and reputation (s 13);
- Right to liberty and security of person (s 21); and
- Humane treatment when deprived of liberty (s 22).

The Charter requires that any limitation of human rights be 'demonstrably justified in a free and democratic society based on human dignity, equality and freedom' which is taken to mean that it be proportionate, necessary, justified, and reasonable in all the circumstances.<sup>16</sup>

Importantly, this includes the right to have proceedings decided by a competent, independent and impartial court or tribunal after a fair and public hearing. OPA understands that in relation to civil detention, this process, and its associated safeguards, is lacking in some other jurisdictions in Australia, notably Western Australia and the Northern Territory, and that this disproportionately affects Aboriginal and Torres Strait Islander people.

#### 1.4 Systemic discrimination

Despite the human rights framework that exists, people with disability are being denied access to justice because of systemic discrimination, which fails to recognise their status 'as human rights bearers and citizens with an entitlement to opportunities and outcomes equivalent to others.'<sup>17</sup>

There are many contributing factors. People with disability often have limited opportunities for education and work, are more likely to be poor, are disproportionately subject to all forms of abuse, and so more likely to come into contact with criminal justice system. There is limited access to advocacy and legal representation. This is evident in all states and territories.

The persistence of this systemic discrimination within the justice system in particular gives rise to a real fear; that prisons are becoming a renewed form of institutionalisation of people with disability who lack adequate recognition of their needs and provision of supports.

The over representation of people with disability or mental ill health in the criminal justice system is evidence of this systemic discrimination. The Victorian Ombudsman in her 2015 *Investigation into the rehabilitation and reintegration of prisoners in Victoria* reported that research on the prevalence of cognitive disability in prison populations, in Australia and internationally, indicates that such people are over-represented in the justice system, both as victims and offenders.<sup>18</sup>

Prisons should not be allowed to become the new institution for people with disability in an era of social inclusion and equality before the law.

#### 1.5 Barriers in access to justice and its implications

The reason for the over representation of people with disability and mental illness in our prisons indicates inadequate support of people with disability or mental ill health. This issue has been highlighted in the recently published *Equal before the Law* report of the Australian Human Rights Commission.<sup>19</sup>

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<sup>16</sup> *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 7(2).

<sup>17</sup> Magdalena McGuire, Office of the Public Advocate, *Breaking the Cycle: Using Advocacy-Based Referrals to Assist People with Disabilities in the Criminal Justice System* (2012) 19 ('OPA, *Breaking the Cycle*').

<sup>18</sup> Vic Ombudsman, *Rehabilitation and reintegration of prisoners*, 7, citing S. Brown, and G. Kelly, Reducing Vulnerability to Harm in Adults With Cognitive Disabilities in the Australian Criminal Justice System; McCausland, Baldry, Johnson and Cohen, People with mental health disorders and cognitive impairment in the criminal justice system: Cost-benefit analysis of early support and diversion, August 2013.

<sup>19</sup> Australian Human Rights Commission, *Equal before the Law: Towards Disability Justice Strategies*, 2014. Discussed further below.



OPA's own experience reveals that very many people with disability, particularly those with higher support needs, continue to lead a precarious life. We use the term 'precarious' to refer to the situation of people with disability where many of the following experiences are a large and ongoing part of their lives.<sup>20</sup> There are persistent and historical realities deeply embedded in our society regarding people with disabilities.

These include:

- pervasive discrimination and devaluation
- being treated as a second-class citizen or not a full person
- de-individualisation
- being worn down by an everyday life filled with barriers and stigma
- being socially isolated, even excluded
- having few or no friends
- being dependent on others for everyday assistance causing a power imbalance in relationships
- actual or threatened violence, neglect or exploitation
- being brutalised and bullied
- being constantly questioned or disregarded
- being treated as an object of pity
- being treated as a burden (of charity)
- having been institutionalised in the past
- having experienced special schooling or separation from peers even in a mainstream school
- it being assumed that they have no or little quality of life and that this is a good reason for ending their life
- being treated as a potential menace or dangerous
- being treated as the source of risk that must always be managed and controlled.<sup>21</sup>

These experiences are compounded when a person with disability has interaction with the justice system. Frequently, it is these experiences that lead to that interaction. The Victorian Ombudsman reported on research that has shown that people with a cognitive disability face greater difficulties in dealing with the criminal justice system than other groups, which can lead to a cycle of recidivism.<sup>22</sup> Early identification of disability, and early intervention strategies aimed at minimising people's contact with crime are crucial.

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<sup>20</sup> OPA, Access to Justice submission, 6-7.

<sup>21</sup> OPA, Access to Justice submission, 6-7. After Wolf Wolfensberger, Mark Feigan, "Personal Notes From: 'Syracuse University, Training Institute for Human Service Planning, Leadership and Change Agency' Event [Wolf Wolfensberger, Susan Thomas and Adam (A) Hilderbrand]; 'Social Advocacies on Behalf of Devalued and Disadvantaged People', Adelaide," (unpublished, 1992).

<sup>22</sup> Vic Ombudsman, *Rehabilitation and reintegration of prisoners*, 87.



## 1.6 Prevalence of people with cognitive impairment and mental ill health in the criminal justice system

Previous work published by OPA in this area warrants revisiting and the following excerpts are from previous submissions:

There is strong evidence that, due to the range of systemic disadvantages that they can face, people with cognitive disabilities and mental illnesses are overrepresented in the criminal justice system. While the estimated rates of disability among offenders vary, they are consistently higher than the general community. For example, rates of major mental illnesses, like schizophrenia and depression, have been found to be three to five times higher among alleged offenders compared with the general community. Likewise, people with acquired brain injury are acknowledged to be overrepresented in the prison system.

Other evidence shows that people with intellectual disabilities are more likely to be questioned, arrested and detained for minor public order offences when compared with other offenders. It has also been shown that offenders with cognitive disabilities and mental illnesses tend to be treated less fairly by the criminal justice system, and have higher rates of recidivism compared with other offenders. For example, Baldry, Dowse and Clarence have studied the pathways by which people with cognitive disabilities and mental illnesses arrive in prison. They have found that people with cognitive disabilities:

are more likely to have earlier contact with police,... more likely to have been clients of juvenile justice, have more police episodes through life and more prison episodes than those [without disabilities].

The authors also assert that the offences of these individuals “are almost in all the lowest ten per cent of seriousness”. Therefore, the impact of the criminal justice system on these individuals seems disproportionate to the severity of their offences.<sup>23</sup>

## 1.7 Prevalence of people with cognitive impairment and mental ill health in prisons

The Victorian Ombudsman’s reported that the Victorian prison system has a disproportionate number of people from particular groups compared to the general community:

- 40 per cent of prisoners in Victoria had been identified as having a mental health condition, two to three times higher than the reported rates in the general community, and prisoners are also 10 to 15 times more likely to have a psychotic disorder than someone in the general community.<sup>24</sup>
- prisoners with a registered intellectual disability comprised 3 per cent of the total prisoner population, compared to an estimated 1 per cent in the general Victorian population.<sup>25</sup>
- the rate of prisoners recorded as having an ABI is up to 20 times higher than in the general community.<sup>26</sup> Further,

42 per cent of male and 33 per cent of female prisoners show evidence of an acquired brain injury (ABI). Corrections Victoria however does not systematically record the ABI status of prisoners. There is no consistent process to identify, assess or support this group of vulnerable prisoners, and a significant shortage of specialist beds for them.<sup>27</sup>

<sup>23</sup> See Office of the Public Advocate, *Breaking the Cycle of Crime for Young People with Disabilities Submission to the Victorian Government Consultation: Practical Lessons, Fair Consequences – Improving Diversion for Young People in Victoria* (2012) 7, and for citations.

<sup>24</sup> Vic Ombudsman, *Rehabilitation and reintegration of prisoners*, 34.

<sup>25</sup> Vic Ombudsman, *Rehabilitation and reintegration of prisoners*, 88.

<sup>26</sup> Vic Ombudsman, *Rehabilitation and reintegration of prisoners*, 34.

<sup>27</sup> Vic Ombudsman, *Rehabilitation and reintegration of prisoners*, 7. Corrections Victoria at Department of Justice (and Regulation) carried out a sample study in 2011: Department of Justice, *Acquired Brain Injury in the Victorian Prison System*. Corrections Victoria Research Paper Series, Paper No. 04, April 2011. The Victorian Ombudsman reported that, at this time of her investigation (2015) ‘Corrections Victoria was unable to provide any data on the prevalence of ABI in the prison system, advising that it does not systematically record the confirmed or unconfirmed ABI status of prisoners. It advised that an ABI ‘flag’ was only introduced in late 2013, and noted the difficulty in establishing an accurate number of prisoners with an ABI due to the complexity in diagnosis.’ at 88. The Ombudsman’s concern was that the consequence of not routinely screening for an ABI at reception can result in the responsibility for identifying a prisoner falling to a number of different prison staff members, not just specialists. She made a broader recommendation on this point, which OPA supports (see recommendation 4 in the Ombudsman’s report).



- Aboriginal and Torres Strait Islander people make up 0.7 per cent of Victoria's population yet represent nearly 8 per cent of the state's prisoners.<sup>28</sup>

Recent studies have also shown a high prevalence of cognitive impairment and mental illness amongst Aboriginal prisoners.<sup>29</sup> In Victoria, Monash Centre for Forensic and Behavioural Science, showed a strong correlation between Aboriginal imprisonment and cognitive impairment.<sup>30</sup>

Determining the extent of the problem is necessary to implement better laws and policies, and to develop more appropriate services, supports, accommodation and treatment options for this cohort. Building on the recommendation of the Victorian Ombudsman in her investigation, OPA's own recommendation has been modified to ensure relevance to this inquiry:

**Recommendation 1.** State and territory governments should review practices and procedures for identifying and screening prisoners with a cognitive disability including acquired brain injury to ensure that these functions are carried out by staff with specialist knowledge.

Using the Convention to guide progress in this area, OPA notes the importance of article 31 on gathering and reporting on data to advance the social, economic and legal rights of persons with disability. Article 31 obliges state parties to:

...undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention.

...

The information collected in accordance with this article shall be disaggregated, as appropriate, and used to help assess the implementation of States Parties' obligations under the present Convention and to identify and address the barriers faced by persons with disabilities in exercising their rights.<sup>31</sup>

Implementing this article of the Convention requires significant advancement in data collection and reporting. Where the responsibility for this lies is likely to require a whole of government approach. OPA has recommended in the past that Victoria Police improve data collection relating to people with disabilities as victims of crimes or alleged offenders.<sup>32</sup> It is also important that annual national surveys be inclusive of individuals with a disability to generate up to date and regular analysis of data.<sup>33</sup>

In the context of this national inquiry, OPA makes the following recommendation:

**Recommendation 2.** State and territory governments should improve data collection relating to people with disabilities who are alleged offenders. This includes data about people from Aboriginal and Torres Strait Islander and culturally and linguistically diverse backgrounds, to inform development of culturally appropriate practices.

Data collection and use should be guided by the *Convention on the Rights of Persons with Disabilities* article 31—Statistics and data collection.

<sup>28</sup> Vic Ombudsman, *Rehabilitation and reintegration of prisoners*, 34.

<sup>29</sup> See for example Baldry E, McEntyre E, McCausland R 2015 *Why Aboriginal people with disabilities crowd Australia's prisons*, UNSW. Part of the Conversation series profiling Aboriginal people and the criminal justice system..Found at <http://theconversation.com/why-aboriginal-people-with-disabilities-crowd-australias-prisons-48166>

<sup>30</sup> Ogloff J et al 2013, Koori Prisoner and Cognitive Functioning Study. Monash Centre for Forensic Behavioural Science, Department of Justice.

<sup>31</sup> *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008) art 31(1)–(2).

<sup>32</sup> OPA, Access to Justice submission, 43.

<sup>33</sup> Notably, the most recent ABS personal safety survey did not include individuals with a disability who had significant issues with communication or those who resided in any form of group or service provided accommodation (personal residences only).



## 1.8 Why are people with cognitive and psychiatric impairment imprisoned or detained indefinitely?

The Public Advocate's position statement on STOs recognises that a small number of people with intellectual disabilities can act in ways that put themselves – or others – at risk. Intellectual disability does not cause people to engage in behaviours of risk. Rather, it is the cumulative effect of the social and economic disadvantages faced by many people with intellectual disabilities which can result in some people becoming involved with the criminal justice system.<sup>34</sup>

People with cognitive impairment and mental ill health are imprisoned or detained sometimes for reasons not directly related to their crime. For example, there is often a lack of appropriate accommodation and/or supervision arrangements. This contributes to delays in returning prisoners to less restrictive and rehabilitative environments.<sup>35</sup>

Treatment models may not be best practice or delivered using the necessary tailored approach. Transition and pathways out of prison may not be engaged with early enough, delaying release and jeopardising the effectiveness of the transition. Assistance and advocacy may not be available to those people who have repeat contact with crime or who are, or at risk of, being indefinitely detained.

Safeguards are needed to promote the basic tenants of our democratic society; recognising the rule of law and governing according to international standards of justice and regulation. The high levels of supervision and constant monitoring of people with disability where they are imprisoned or indefinitely detained is often done so in the context of protecting the community and managing risk. It should also be done to secure benefits for the person. OPA suggests that good models do exist and these are detailed in parts 2-5 of this submission.

## 1.9 Towards Disability Justice Strategies

The Australian Human Rights Commission's (AHRC) *Equal Before the Law* report (2014) is a significant document for people with disability, and all Australians. In conducting its research and consultation, the AHRC heard stories of where the criminal justice system had failed people with disabilities, and had compounded disadvantage, in addition to some positive examples of where best practice was occurring.<sup>36</sup> Graeme Innes, the former Disability Discrimination Commissioner, stated that 'the report seeks to point out the barriers, highlight services and programs, and propose possible actions towards the development of Disability Justice Strategies' as a beneficial approach for State, Territory and Commonwealth administrations in their ongoing work in this area.<sup>37</sup>

OPA applauds this work, and to this end makes the following recommendation:

**Recommendation 3:** Each jurisdiction in Australia should develop an holistic Disability Justice Strategy, as proposed in the Australian Human Rights Commission report *Equal before the law* (2014), to reduce the number of people with disability incarcerated due to inadequate support for their disability needs, and to enable access to justice more broadly.

<sup>34</sup> Office of the Public Advocate, *Position Statement Supervised Treatment Orders* (2010) 1.

<sup>35</sup> See case study of Mr A on page 26.

<sup>36</sup> Graeme Innes, Australian Human Rights Commission, *Towards Disability Justice Strategies* <<https://www.humanrights.gov.au/our-work/disability-rights/publications/equal-law>> accessed 4 April 2016.

<sup>37</sup> Graeme Innes, Australian Human Rights Commission, *Towards Disability Justice Strategies* <<https://www.humanrights.gov.au/our-work/disability-rights/publications/equal-law>> accessed 4 April 2016. The report proposed that the strategy should focus on the following outcomes: 1. Safety of people with disabilities and freedom from violence; 2. Effective access to justice for people with disabilities; 3. Non-discrimination; 4. Respect for inherent dignity and individual autonomy including the freedom to make one's own decisions; 5. Full and effective participation and inclusion in the community.



## 2 Part Two: The civil detention regime in Victoria

### 2.1 Compulsory treatment under the *Disability Act 2006* (Vic)

In Victoria, the Disability Act sets out a legal framework for the detention and compulsory treatment of people with intellectual disabilities who are found to pose a significant risk of serious harm to others. 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.<sup>38</sup> The person must be in receipt of state funded 'residential services'.<sup>39</sup>

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.<sup>40</sup> 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.<sup>41</sup>

Since the commencement of the Disability Act, there have been some 65 persons subject to civil detention under STOs. A significant number of the 65 persons have other disabilities concurrent with intellectual disability such as acquired brain injury and mental illness.

Under section 191 of the Disability Act, VCAT can only make a STO if it is satisfied that the person with an intellectual disability meets all of the following criteria:

- they have previously displayed a pattern of violent or dangerous behaviour
- there is a significant risk of serious harm to another person which cannot be substantially reduced by using less restrictive means
- the services to be provided to the person will be of benefit to the person and substantially reduce the significant risk of serious harm to another person
- the person is unable or unwilling to consent to voluntarily complying with the treatment plan
- detention is necessary to ensure compliance with the treatment plan and to substantially reduce the risk of serious harm to another person.<sup>42</sup>

VCAT can make a STO for no longer than 12 months. For a further order to be made a fresh application has to be made and again tested against the legislative criteria. A key element to the test is that the proposed treatment plan is to benefit the person as well as manage any risk to they pose to others.

In making a fresh application, it is possible for an order to be renewed annually. There is no limit in the number of applications that can be made. In this role of periodic review of STOs and in approving any 'material changes' to the person's treatment plan that result in increased levels of supervision or restriction, VCAT plays an important monitoring and safeguard role.

The Disability Act provides a range of provisions in relation to supervised treatment, which are aimed at protecting the rights of people subject to this treatment. The Public Advocate released a position statement on STOs (2010) stating:

Supervised Treatment Orders bring a significant level of transparency and fairness to the detention and compulsory treatment of people with intellectual disabilities in Victoria. Likewise, Supervised Treatment Orders can give some people the treatment they need to live safer lives.<sup>43</sup>

<sup>38</sup> Office of the Public Advocate, *Supervised Treatment Orders in Practice: How are the Human Rights of People Detained under the Disability Act 2006 Protected?* (2010) 1 ('OPA, Supervised Treatment Orders in Practice').

<sup>39</sup> *Disability Act 2006* (Vic) ss 191(1)(a)–(b).

<sup>40</sup> OPA, *Supervised Treatment Orders in Practice*, 6.

<sup>41</sup> *Disability Act 2006* (Vic) s 184. See also OPA, *Supervised Treatment Orders in Practice*, 1.

<sup>42</sup> *Disability Act 2006* (Vic) ss 191(6)(a)–(e).

<sup>43</sup> Office of the Public Advocate, *Position Statement Supervised Treatment Orders* (2010) 1.





In OPA's view, the effectiveness of the STO regime is largely due to the matrix of elements of the regime:

- The process that leads to the development of a treatment plan<sup>44</sup> 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.<sup>45</sup> The Public Advocate also 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.<sup>46</sup>
- Victoria Legal Aid's specialist advocacy for persons proposed for or subject to detention.

### Case study DM: A positive application of the STO regime

DM is a man with an intellectual disability who now resides in a group home under a STO. DM had a history of engaging in unprotected sexual activity without disclosing the status of his sexual health. DM himself was also vulnerable to sexual exploitation. DM was made subject to compulsory treatment by a STO to ensure the management of the risk he posed to others and his treatment. He was unable to institute protective arrangements for himself. The STO regime has provided him with supervision and monitoring and restrictions upon his access to and movement within the community. DM has benefited from the treatment by services and supports defined within his treatment plan. His health has significantly improved and this is carefully monitored. His access to community is via a structured and well managed program of differing levels of step down supervision relative to assessed risk. Consequently he actively engages in many community events and pursues his interests. He regularly sees a counsellor for review of his relapse prevention strategies and is supported to access safe and licensed sex providers.

Source: OPA legal unit case study (2016)

The STO regime is not without its difficulties. OPA's report on this matter – *Supervised Treatment Orders in Practice: How are the Human Rights of People Detained under the Disability Act 2006 Protected* – available on our website, found that the STO regime's emphasis on detention and compulsory treatment may produce unevenly shared benefits. While people who are on STOs are able to gain access to high quality treatment, services and clinical oversight from the Senior Practitioner, people not on STOs are denied access to the same level of state-funded treatment and services.<sup>47</sup> Effectively, this means that a person's access to the benefits associated with supervised treatment is made conditional upon detention.

#### 2.1.1 De facto indefinite detention

A person on a STO could be detained by reason of consecutive fresh applications. This form of detention could become a de facto indefinite detention. It will be up to the safeguarding processes and bodies to ensure that this does not happen. One of these safeguarding bodies is VCAT, which can only make an order if it is satisfied the person meets all the criteria under section 191 of the Disability Act.<sup>48</sup>

<sup>44</sup> *Disability Act 2006* (Vic) pt 8. The Act also sets out in s 191(7) what must be included in the treatment plan.

<sup>45</sup> OPA's *Supervised Treatment Orders in Practice* report stated: 'A further benefit of the regime is its provision of high quality services to people with intellectual disabilities on STOs. According to some of the professional interviewees who took part in this project, people on STOs are likely to receive better, more streamlined and targeted treatment than people who are not on STOs. Several people who were, or had been, on STOs also spoke positively about the treatment they received under an STO. These STO clients felt that the treatment they received under an STO would ultimately help them to lead better, safer lives' at: 86.

<sup>46</sup> *Disability Act 2006* (Vic) s 194.

<sup>47</sup> OPA, *Supervised Treatment Orders in Practice*, 86 'This position does not correspond with the principles and values of international human rights law. Therefore, in order to truly 'strengthen the rights of people with disabilities', all people with cognitive disabilities who need treatment for problematic behaviour should be entitled to access state-funded services' at: 86

<sup>48</sup> See page 14 for the s 191 criteria.





VCAT must also have regard to the Charter which provides that a human right may only be limited where it is reasonable, necessary, justified and proportionate.<sup>49</sup>

There are currently 23 persons receiving compulsory treatment who are detained under a STO. Of that cohort of 23 persons, there are only three persons who were subject to orders made within the first 12 months of the Disability Act coming into operation. These figures do not disclose how others previously subject to the STO regime have fared since their orders ended. There is a need for such longitudinal research. However, the STO regime aspires to enable people to develop the capabilities to reintegrate into the community, to exercise rights responsibly, and to ultimately lead fuller, freer lives.<sup>50</sup>

## 2.2 Provision of appropriate treatment

In Victoria, people with an intellectual disability who come before the criminal justice system may be detained in the Disability Forensic Assessment and Treatment Service (DFATS).<sup>51</sup> DFATS is a 'state-wide disability forensic service that delivers time-limited treatment, support and residential services for people with a disability who display high-risk anti-social behaviour and are involved, or at risk of being involved, in the criminal justice system.'<sup>52</sup> DFATS provides a range of treatment to offenders with an intellectual disability in a residential setting (the 'Intensive Residential Treatment Program').

In this context, 'treatment', although undefined within the Disability Act, is a broad and dynamic notion embracing, services, psychosocial interventions such as modified use of mainstream offender treatment programs and programs that have been developed specifically and individually for persons with intellectual disability. Although restrictive interventions may be utilised in the context of a treatment plan, restrictive interventions are not within the conceptualisation of treatment.

### CASE STUDY BL: the importance of a tailored treatment regime

BL is a man with intellectual disability residing in a community group home. He has a significant history of personal exposure to sexual abuse as a victim and as an offender against children. BL has a history of observed and self reported inappropriate sexual arousal to children. BL has a 20 year history where his risk was significantly managed by the use of anti-libidinal chemical restraint. BL has been subject to a STO for the past 5 years. Consequently, his treatment is now monitored through the Senior Practitioner and VCAT. BL is showing deteriorated health consistent with the adverse side effects associated with the use of anti-libidinal chemical restraint. There is an increasing focus to manage his risk through alternative arrangements and to ameliorate the adverse side effects. Without the matrix of safeguards and VCAT review provided by the compulsory treatment regime this may not have occurred.

Source: OPA legal unit case study

In the past 10 years, there has been development of rehabilitative, habilitative practices and treatment programs for offenders with cognitive impairment. DFATS is at the forefront in implementing these new treatments. It is understood that the DFATS programs are designed in accordance with best practice as currently envisaged.

Nonetheless, OPA holds some concerns for the operation and effectiveness of the DFATS model in that the service has, in more recent times, moved towards a more containment and corrections model. As a consequence, OPA is concerned that there is insufficient scope for, and structures in place to, foster the successful re-integration into the community of persons undertaking treatment at DFATS.

<sup>49</sup> *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 7(2).

<sup>50</sup> *Disability Act 2006* (Vic) ss 1, 5.

<sup>51</sup> DFATS is funded through the Victorian Department of Health and Human Services.

<sup>52</sup> Department of Health and Human Services, *Criminal justice services for people with disabilities* <<http://www.dhs.vic.gov.au/for-individuals/disability/specialist-disability-services/criminal-justice-services-for-people-with-disabilities?>> accessed 30 March, 2016.



OPA also has concern about transition planning and pathways out of DFATS. OPA is of the view that planning a person's transition to the community, and less restrictive approaches should commence as soon as a person enters the service. This promotes the person's rehabilitation by setting goals that they are committed to, will be achievable when they cease detention, and result in a safer community.<sup>53</sup>

OPA is of the view that longitudinal evaluation of the accessibility and efficacy of the DFATS programs is timely. OPA considers, for example, that a longitudinal evaluation of the outcomes for DFATS residents should be undertaken. This could result in improved programs that are consistent with best practice in both design and implementation. We want to ensure people have the best opportunity for transition into the community with outcomes consistent with what was planned.

OPA is not aware of the extent to which similar facilities and treatment regimes exist in other states and territories in Australia. Any evaluation of the DFATS model could be used to inform work done in other Australian jurisdictions.

On this point, OPA makes the following recommendation:

**Recommendation 4.** A longitudinal evaluation of treatment provided under Victoria's Disability Forensic Assessment and Treatment Service (DFATS) programs should be undertaken to ensure programs are consistent with best practice.

Any evaluation should be examined with a view of potential application to other Australian jurisdictions.

### 2.2.1 Extending supervised treatment orders in the Disability Act

OPA has expressed the view in the past that more work needs to be done in considering whether the benefits of the supervised treatment regime should be extended to people with acquired brain injury.

The Victorian Law Reform Commission in its review of the Guardianship and Administration Act, when considering its interaction with the Disability Act, found no reason to exclude people with an acquired brain injury from the Disability Act's STO provisions. OPA agrees with the recommendation made by the VLRC on extending provisions for people with acquired brain injury.

OPA considers that the processes set out in the Victorian Disability Act Part 8—Compulsory Treatment—provide a model for state and territory governments to consider, and that these provisions should be extended to people with acquired brain injury.

**Recommendation 5.** State and territory governments should consider whether legislation that enables treatment-based detention should be enacted. The processes set out in the Disability Act 2006 (Vic) Part 8—Compulsory Treatment—provide a model for state and territory governments to consider. Provisions should be extended to people with acquired brain injury. Treatment based detention orders should only operate for a maximum period of five years.

### 2.3 Compulsory treatment under the *Mental Health Act 2014* (Vic)

The Victorian Mental Health Act enables someone who appears to have a mental illness to be detained where they present a danger to themselves or others, or to be released on Community Treatment Orders subject to certain conditions. The Mental Health Act prescribes a regime for compulsory mental health treatment for people who meet the criteria under the Act. One of the criteria is that "there is no less restrictive means reasonably available to enable the person to receive the immediate treatment" (s 5(d)).

<sup>53</sup> Office of the Public Advocate, *Annual Report 2013-2014* (2014) 30 ('OPA, *Annual Report 2013-2014*').



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. OPA maintains a project to identify this problem, and the number of people who are affected.

### **2.3.1 OPA's Long-Stay Patient Project**

The long-stay patient project involves a bi-annual data collection in mental health units across Victoria, identifying patients who are detained in mental health units for extended periods of time.<sup>54</sup> Long-stay patients are defined as patients spending more than three months in an adult acute unit and more than two years in a Community Care Unit (CCU) or Secure Extended Care Unit (SECU). OPA Community Visitors request this data from staff on their visits to facilities and report this in the program's annual report.

The long-stay patient project has consistently identified a significant number of patients in the mental health system who appeared to be indefinitely involuntarily detained under the Mental Health Act due to the lack of availability of less restrictive accommodation and support options. This system failure leads to a significant deprivation of liberty and is counter to section 21 of the Charter which states that 'every person has the right to liberty and security'.<sup>55</sup>

While much reform has occurred in mental health policy and service delivery over the last three decades in Australia, the closure of psychiatric facilities in Victoria has not gone hand in hand with the adequate expansion of community-based accommodation and support. The capacity of the mental health system to meet its human rights obligations with regards to patient discharge is compromised by shortages in community-based accommodation and support discharge options.

### **What the data says**

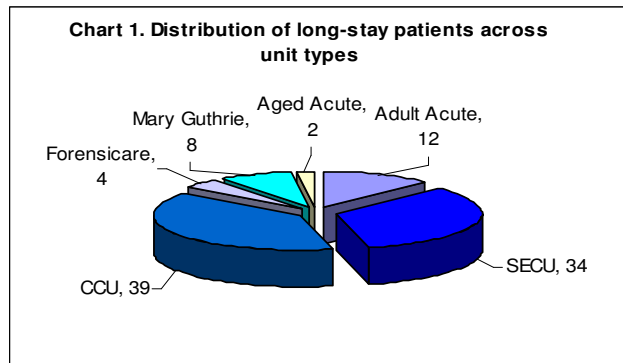
#### *Long-stay patients 2007-2008*

In 2009, OPA delivered a report to the then Victorian Minister for Community Services, Lisa Neville, detailing the situation of stay patients across the state in the 2007-2008 financial year. This report provides the most detailed analysis of contributing factors to long stay patients in mental health units that Community Visitors have done to date. As such, an overview will be provided here.

The report identified 99 long stay patients, mostly in Community Care Units (CCUs) and Secure Extended Care Units (SECUs) (see graph 1). Length of stay included forty patients who had been in mental health units for five years or more. Seventeen patients had been in mental health units for ten years or more.

<sup>54</sup> Dearn, L, Office of the Public Advocate, *Long-Stay Patient Project report* (2009) available at Office of the Public Advocate, *Mental Health* <<http://www.publicadvocate.vic.gov.au/our-services/publications-forms/research-reports/mental-health/mental-health-facilities-research/297-long-stay-patient-project-1>> accessed 4 April.

<sup>55</sup> *Charter Of Human Rights and Responsibilities Act* (2005) s 21.



**Source: Office of the Public Advocate, Long-Stay Patient Project full report 2009**

A detailed analysis showed that there were three main reasons for the lack of discharge of long stay patients: 'not able to be discharged', 'no suitable accommodation available' and 'waiting on a vacancy'. Two thirds of long-stay patients were either on waiting lists for suitable accommodation or there was no suitable accommodation available to enable their discharge.

Half of the long-stay patients identified in the 2009 report were found to have dual disabilities or complex needs. This includes people with dual diagnoses (mental illness and intellectual disability or mental illness and ABI/polysubstance abuse), aggressive and unmanageable behaviour and physical health problems exacerbated by cognitive incapacity and complex conditions (e.g. Huntington's disease).

In many cases patients did not meet the eligibility criteria for available accommodation, were on waiting lists for programs with limited funding, or were unable to gain access to the specialist accommodation because of their behaviour (for example they did not meet the criteria for specialist accommodation).

#### *Long-stay patients 2013-2014*

Since the commencement of the long stay patient project in 2007, many long term, former institutionalised patients have been discharged. Current long-stay patients have been there for relatively shorter periods of time than the original cohort.

Sixty-one long stay patients were identified in 2013-2014, the majority in SECU and CCU settings. Only four of the 19 SECU patients found had been there more than eight years. Six of the 23 CCU patients found had been there more than three years.

Nine patients were found in Mary Guthrie House, a Brain Disorders Unit. These patients had been there for between two and 22 years. Community Visitors did not collect data from Thomas Embling Forensic Hospital on this occasion but previous Community Visitor reports have identified up to four people who have completed their sentences and were waiting for accommodation before being able to be discharged. These figures will be updated in this year's Community Visitors annual report.

In 2013-2014, most patients remaining in SECUs for any length of time have ongoing psychoses and are not able to function independently in the community due to risks to self or others. While for patients with very complex needs and enduring psychoses, SECUs provide the only suitable clinical option in the current system, there is a need to consider alternative non-institutional models for long-stay SECU patients requiring lifetime clinical care in a secure environment.

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.

OPA makes recommendations in relation to long-stay patients and advocacy, and accommodation matters under the NDIS in part 4 of this submission.



### 3 Part Three: The criminal detention regime in Victoria

#### 3.1 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)*

In Victoria, Criminal detention is provided for and regulated under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)* (CMIA). The CMIA sets out the law and procedure regarding:

- the process and criteria for determining if a person is unfit to stand trial
- the process and criteria for the statutory defence of mental impairment (which replaced the common law defence of insanity)
- the consequences of findings of unfitness to stand trial and of not guilty because of mental impairment
- the supervision and management of people found unfit to stand trial or not guilty because of mental impairment.<sup>56</sup>

A court can make an order under the CMIA if it finds an accused is one of the following:

- unfit to stand trial but has committed the offence charged
- unfit to stand trial and not guilty because of mental impairment
- not guilty because of mental impairment.<sup>57</sup>

The order requires the person to be subject to supervision. It can be custodial or non-custodial.

Supervision orders under the CMIA operate for an indefinite period.<sup>58</sup> However, the court must set a 'nominal term' for the supervision order.<sup>59</sup> The court must make a major review of the supervision order at least three months before the end of the nominal term and after that, at least every five years.<sup>60</sup> OPA is of the view that legislation enabling the detention of people who have been declared mentally impaired or unfit to plead to require regular, automatic review of each custodial supervision order at an interval of no longer than every two years. See recommendation 7 on this point.

##### 3.1.1 Improving the suitability of the system for people with an intellectual disability or other cognitive impairment

The system delivering treatment and appropriate accommodation models for people with intellectual disability or other cognitive impairment under a CMIA disposition is not subject to the same level of scrutiny as other civil detention regimes.

<sup>56</sup> The Victorian Law Reform Commission published its *Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 Report* in June 2014. The review made 107 recommendations, many of which are relevant to the Senate's Committee's inquiry.

<sup>57</sup> Victorian Law Reform Commission, *Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 Report* (2014) xix ('VLRC, review of the CMIA').

<sup>58</sup> A supervision order may—(a) commit the person to custody ("custodial supervision order")—(i) subject to sub-section (3), in an appropriate place; or (ii) subject to sub-section (4), in a prison; Or (b) release the person on conditions decided by the court and specified in the order ("noncustodial supervision order"): *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)* s 26(2).

<sup>59</sup> *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)* s 28.

<sup>60</sup> *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)* s 27(1). When it makes a supervision order, the court may direct that the matter be brought back to the court for review at the end of the period specified by the court: at s 27(2).

25 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)* s 28.

26 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)* s 35(1). The court must vary a custodial supervision order to a non-custodial supervision order, unless satisfied that the safety of the person subject to the order or members of the public will be seriously endangered as a result of the release of the person on a non-custodial supervision order: at s 35(3)(a)(i). If it is a non-custodial supervision order, it may confirm the order, vary the conditions of the order or revoke the order: at s 35(3)(b).



OPA made the following comment in our submission to the Victorian Law Reform Commission's (VLRC) recent review of the CMIA:

OPA believes that treatment of people under the CMIA should be subject to the same level of independent scrutiny that applies to people being treated involuntarily under the Mental Health Act and the Disability Act. This raises questions about whether the Act is sufficiently focused on treatment as there is a lack of specific provisions relating to treatment planning and review in the CMIA unlike the Mental Health Act and the Disability Act.<sup>61</sup>

Treatments provided to people with intellectual disability or mental illness on compulsory orders are relatively well established, based on the notion that behaviours (in the case of people with intellectual disability) and illness (in the case of mental illness) may respond to treatment over time. The same does not exist for people with intellectual disability or other cognitive impairment under the CMIA. Case study KH illustrates this.

**CASE STUDY KH: Failure of the CMIA to provide the same protections to people with intellectual disability**

KH is a young man with an intellectual disability who is subject to a CMIA non custodial supervision order (NCSO). KH has a developmental history of inappropriate sexualised behaviours. In 2006 he was placed on the NCSO for charges of an indecent act with or in the presence of a child under 16. Subsequently he committed a number of further offences involving inappropriate and indecent touching, internet pornography and indecent exposure that involved subsequent reviews before the court. During this time KH resided with family.

In 2012 KH's NCSO was again confirmed but with a residential condition that he reside within a DHHS managed accommodation. The accommodation is locked and provides levels of supervision that prevent his freedom of movement. Although he is not held in custody he is effectively detained (and detained within the meaning of the *Disability Act 2006* (Vic)). As he is lawfully contained under the CMIA, he is not required to have a treatment plan under the Disability Act. Accordingly, he does not benefit from the statutory regime the Disability Act provides. For example, the NCSO directs him to comply with treatment which includes an anti-libidinal drug as a form of chemical restraint. However, he is not provided with a coordinated treatment plan involving oversight by the Senior Practitioner and VCAT review in relation to treatment and supervision whilst detained, or to the use of and effect of chemical restraints upon his health.

Source: OPA Legal unit case study

The CMIA is not in the same way mindful of people with intellectual disability or other cognitive impairments as it is of mental ill-health. Nor is it mindful that people with an intellectual disability and other cognitive impairments can also grow and change with treatment.

An instance of the inequity between provisions under the CMIA and the Disability Act can be found in the way persons subject to CMIA dispositions are treated when detained under Part 8 of the Disability Act. In section 153, the authorised program officer for Victoria's Disability Forensic Assessment and Treatment Service must prepare a treatment plan for persons admitted under a residential treatment order, a parole order, an order transferring the person from prison, an extended order under the *Serious Sex Offenders Monitoring Act 2005* or a supervision or interim supervision order within the meaning of the *Serious Sex Offenders (Detention & Supervision) Act 2009* (Vic). But there is no such requirement when a person is admitted under a custodial supervision order made under the CMIA. The Disability Act does not require that persons admitted to the treatment facility on CMIA dispositions to have a treatment plan with clinical oversight provided by the Senior Practitioner, and review of the plan and the use of restrictive interventions by VCAT. The below case study illustrates this inequity.

<sup>61</sup> OPA, Submission to CMIA review, 9.





### **CASE STUDY SR: Inequity of the CMIA system for people with intellectual disability**

SR is a young man with an intellectual disability who has an offence history of substance abuse violent behaviour and armed robbery. SR was made subject to a non-custodial supervision order (NCSO) in 2009 but due to a series of further offences was resentenced in 2013 to a custodial supervision order. The court directed that he be detained within prison as the Department of Health and Human Services (DHHS) was unable to identify suitable or appropriate community accommodation or a custodial setting alternative to prison. In 2014 the Court further reviewed SR's order as the DHHS could then accommodate SR within the residential treatment facility. He was admitted to this facility. SR's progress in treatment is uncertain. He is not entitled to a treatment plan though he may have one in practice. This treatment plan, nor the treatment provided under it, is not subject to external scrutiny, such as the clinical supervision of the Senior Practitioner nor of VCAT.

Source: OPA Legal unit case study

In its final report on the review of the CMIA, the VLRC agreed that changes were needed to ensure the legislative framework for supervision and management created by the CMIA and the Disability Act operate in a manner that is appropriate for people with an intellectual disability.<sup>62</sup> The VLRC noted the overwhelming view in submissions and consultations, including that expressed by OPA, that 'people with an intellectual disability are not afforded the same treatment that is provided to people with a mental illness.'<sup>63</sup> OPA understands that the Victorian Government is currently considering a number of the recommendations made by the VLRC with a view to amending the CMIA.

The VLRC referred to research undertaken by Janet Ruffles, relevant to this inquiry, which described people found not guilty because of mental impairment on the ground of intellectual disability (and cognitive impairment) as:

a forgotten sub-group of forensic patients for whom indefinite detention and supervision remains a likely consequence

[and that]

serious questions as to whether it is appropriate to apply the same legal principles governing management and release to both mentally ill and intellectually disabled acquittees. The absence of research regarding intellectually disabled acquittees, in both Australia and overseas, further compounds this invisibility status.<sup>64</sup>

Like all persons, people with an intellectual disability and other static disabilities change; persons have developmental capabilities. The system needs to promote pro-social change through the programs it provides. For people with intellectual disability, this is as much as about habitation as rehabilitation. People with intellectual disability often have histories of poor developmental opportunities. Treatment and psychosocial interventions need to inform life skills and pro-social behaviors, through specific and individually tailored programs.

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<sup>62</sup> VLRC, review of the CMIA, xxxv. OPA notes that the VLRC's recommendations are important because people with intellectual disability would be brought into the safeguards of the Disability Act, which is necessary given people with intellectual disability fair less well in the current legal framework. The value of the recommendations have wider application. If implemented, there will be more structure, safeguards, transparency and developmental opportunities for people with intellectual disability subject to orders under the CMIA. OPA made a recommendation to the VLRC on this matter.

<sup>63</sup> VLRC, review of the CMIA, 436.

<sup>64</sup> VLRC, review of the CMIA, 433.





OPA made the following recommendation on the considerations that should occur prior to treatment provided to a person with intellectual disability under CMIA dispositions:

Considerations prior to treatment should include:

- the nature of the treatment that is to be used
- the circumstances in which the proposed form of treatment is to be used
- how the treatment will be of benefit to the person
- the treatment should be the least restrictive of the person as is possible in the circumstances
- expected duration of the treatment.

Consultation with the person with disability and, where appropriate their guardian, representatives of disability service providers, and any other person is considered to be integral to the treatment.<sup>65</sup>

OPA considers that there should also be longitudinal research undertaken in relation to rehabilitation outcomes for people with an intellectual disability who are subject to supervision orders under the CMIA.

**Recommendation 6.** Longitudinal evaluations of the outcomes of supervision provided under the existing *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) should be undertaken to compare these with outcomes for people under compulsory treatment under the *Disability Act 2006* (Vic).

Any evaluation should be examined with a view of potential application to other Australian jurisdictions.

OPA understands that the current frameworks in other jurisdictions, or sometimes lack thereof, do not sufficiently protect and promote the rights of people with disability. In considering amendments required to Victoria's legislation, and with a view to encourage legislative change in other jurisdictions, OPA makes the following recommendation.

**Recommendation 7.** State and territory governments should consider enacting, or amending, legislation governing the detention of people who have been declared mentally-impaired or unfit to plead to enhance safeguards as follows:

- require a court, when making a supervision order in respect of a person, to specify the department that is responsible for the person's supervision (the supervisor)
- require the department responsible to prepare a treatment plan for the person on the supervision order
- require the department responsible to report on the resources available to undertake the treatment set out in the plan
- ensure that there are, minimally, annual processes for reviewing the treatment plan and its implementation and to ensure independent scrutiny and transparency
- ensure that there processes whereby the department responsible and any independent scrutinising bodies report to the supervising court on the treatment, the treatment plan, its implementation and the outcomes of the treatment at the court's biennial review
- require regular, automatic review of each custodial supervision order at an interval of no longer than every two years.

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<sup>65</sup> OPA, Submission to CMIA review, 10.



### 3.1.2 Provision of appropriate and alternate accommodation

The availability of appropriate accommodation for people is a problem that affects all states and territories in Australia. Consultation participants to the VLRC in its review of the CMIA, observed that there was a lack of less restrictive facilities for people on supervision orders to 'step down' levels of supervision and restriction in Victoria.

The VLRC's stated that 'the system's lack of flexibility in this area could result in a mismatch between the supervision the person should ideally receive and the supervision order that is actually made.'<sup>66</sup> The VLRC went on to note that slow progression to 'step down' options is even more pronounced for people with intellectual disability under the CMIA, and noted attribution to a lack of specialist accommodation, support and treatment.<sup>67</sup>

OPA has expressed concern about delays experienced by prisoners with cognitive impairment waiting for their case to be heard under the CMIA.<sup>68</sup> It is OPA's experience that the availability of appropriate accommodation is a key reason for the delays experienced by prisoners.

#### CASE STUDY JD: Lack of appropriate accommodation

JD, a man with a moderate to severe intellectual disability and paranoid schizophrenia was charged with minor offences. JD was found unfit to plead on the basis of mental impairment and was remanded in prison waiting for Disability Services' supported accommodation. In prison, JD's behaviour became very difficult to manage because he was unable to understand why he was there or that he had to comply with prison regulations like providing a urine sample on demand.

In total, JD was imprisoned for one year and for part of that time, he was detained in his cell for 23 hours a day and at times shackles were used to restrain him.

At regular hearings held during the months he spent in remand, Disability Services told the court they still had no supported accommodation for him. The judge threatened to subpoena the Department of Human Services' Secretary if appropriate accommodation was not found within 10 days. JD was placed in supported accommodation a few days later. As a result of his prison experiences, JD became agoraphobic, depressed and now shows signs of post-traumatic stress disorder.

Source: OPA Legal unit case study

OPA makes the following recommendation on this point:

**Recommendation 8.** State and territory governments should invest additional resources to ensure there is alternative accommodation and support for people under indefinite detention. This includes trialling less restrictive and integration options to eliminate delays in prison/on remand experienced by prisoners.

### 3.2 *Serious Sex Offenders (Detention and Supervision) Act 2009 (Vic)*

In Victoria, the *Serious Sex Offenders (Detention and Supervision) Act 2009* (Vic) (SSO (D&S) Act) provides for the continued detention of serious and high-risk sex offenders post-sentence. The court can require an offender to reside at a residential facility, or under high levels of supervision with imposed conditions and restrictions if they reside in the community. Persons subject to these dispositions are managed through the Detention and Supervision Order Division of the Adult Parole Board.

<sup>66</sup> VLRC, review of the CMIA, 433.

<sup>67</sup> VLRC, review of the CMIA, 433.

<sup>68</sup> OPA, submission to CMIA review, 10.



The main purpose of the SSO (D&S) Act is to enhance community protection 'by requiring offenders who have served custodial sentences for certain sexual offences and who present an unacceptable risk of harm to the community to be subject to ongoing detention or supervision'.<sup>69</sup> The secondary purpose of the SSO (D&S) Act is to facilitate the treatment and rehabilitation of such offenders.<sup>70</sup> The SSO (D&S) Act provides a role for sentencing courts to set conditions on orders, and control all conditions made, including core and suggested conditions. Conditions must constitute the minimum interference with offenders' liberty, privacy and freedom of movement necessary to ensure the purpose of the condition as well as being reasonably related to the gravity of risk of reoffending.<sup>71</sup>

OPA does not hold data about the prevalence of disability and disability type amongst the cohort of persons under SSO (D&S) Act orders. However, OPA understands that people with disability are over represented in the cohort.

While the SSO (D&S) Act permits, and encourages, the offender to undergo treatment, it does not include a form of compulsory treatment, where this may be appropriate, with attendant safeguards under the Disability Act 2006.

OPA holds concern that the primary focus of this regime does not seek to emphasise and balance benefit to the person in the same way as the Disability Act does; this regime is not open or transparent. It is difficult to see what pathways may be available for persons' treatment and transition pathway to community.

#### **CASE STUDY HM: Not afforded treatment and transition planning**

HM has an intellectual disability and was sentenced with a non parole period of 5 years for significant sexual offences. HM was paroled to the community with a residential condition with which he did not comply. He was later paroled to a residential treatment facility however his parole was revoked due to a violent incident. He was subsequently paroled again to the residential treatment facility where he has been considered to progress well within the treatment program under the *Disability Act 2006* (Vic). As he approached release, HM was advised that an application would be made for him to be placed on a SSO(S&D) 2009 supervision order. This proposal may deny him the opportunities and benefits for continued treatment and effective risk management that the Disability Act regime may otherwise provide him if he were to transition to a STO.

Source: OPA Legal unit case study

OPA considers that there should also be longitudinal research undertaken in relation to rehabilitation outcomes for people with an intellectual disability or other cognitive impairment who are subject to supervision orders under the SSO (D&S) Act.

**Recommendation 9.** Longitudinal evaluations of the outcomes of supervision and any treatment provided under the existing *Serious Sex Offenders (Detention & Supervision) Act 2009* should be undertaken to compare these with outcomes for people under compulsory treatment under the *Disability Act 2006* (Vic).

Any evaluation should be examined with a view of potential application to other Australian jurisdictions.

<sup>69</sup> *Serious Sex Offenders (Detention and Supervision) Act 2009* (Vic) s 1(1).

<sup>70</sup> *Serious Sex Offenders (Detention and Supervision) Act 2009* (Vic) s 1(2).

<sup>71</sup> *Serious Sex Offenders (Detention and Supervision) Act 2009* (Vic) s 15.



### 3.3 Prisons - a view to rehabilitation and reintegration?

The Victorian Ombudsman noted the following concerns in her recent report on *Investigation into the rehabilitation and reintegration of prisoners in Victoria*. OPA suspects these comments would apply equally or to varying degrees to other states and territories in Australia.

The current system is not sustainable. We are witnessing spiraling numbers of prisoners and higher rates of return than ever before. Throughout this investigation, my officers have observed areas of good practice and good intent across the criminal justice system, but the rapid growth in numbers of people in the system and behind bars has overwhelmed the capacity to deliver consistent and effective rehabilitation or reintegration for prisoners.

One of the results of the significant increase in prisoner numbers is that many are not able to access rehabilitation programs or adequate support while they are imprisoned and less than a quarter are provided with post-release support.

Over 99 per cent of prisoners will be released back into the community, so programs and services that improve outcomes make sense both in terms of public safety and the public purse.

While there are many reasons people reoffend and return to prison, it is evident that insufficient access to rehabilitation and reintegration programs has a significant bearing on the likelihood of returning.<sup>72</sup>

While the Victorian Ombudsman's comments above relate to prisoners more broadly, she noted elsewhere in the report that people with cognitive impairment are significantly overrepresented in the prison population.<sup>73</sup> Her comments in relation to insufficient access to rehabilitation and reintegration programs would be more acutely felt by people with disability.

## 4 Part Four: Improving the accessibility of the service and support system

### 4.1 Provision of assistance and advocacy support

Advocacy can play a crucial role for people with cognitive impairment or mental ill health who are at risk of or who are indefinitely detained. Many people who find themselves in these situations are often socially isolated and without a network of support to assist them to navigate the justice and/or service system. Advocacy and assistance is also relevant to enable greater access to early intervention and diversion supports.

Advocacy and assistance can be provided both through legal representation and independently to safeguard the rights of people on custodial and non-custodial supervision orders under the CMIA.<sup>74</sup>

OPA has called in the past for a legislated right for people on supervision orders to access advocacy at regular intervals, especially during reviews of supervision orders, for applications to vary orders and for decisions about leave and the determination of post-discharge placements. In an era where the concept of 'least restrictive' option is enshrined under the Victorian charter and compulsory legislation, it is important that people who at a risk of being/or are indefinitely detained have access to advocacy to support them through this process and to enhance protection of their human rights.

<sup>72</sup> Vic Ombudsman, *Rehabilitation and reintegration of prisoners in Victoria*, 8.

<sup>73</sup> Vic Ombudsman, *Rehabilitation and reintegration of prisoners in Victoria*, 88.

<sup>74</sup> The CMIA allows the person subject to a supervision order to be legally represented at any hearing in which the court is considering: making, varying or revoking a supervision order in respect of the person; granting extended leave to the person; revoking a grant of extended leave: *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic). The VLRC's conclusion in its CMIA review, referring to the submission from Victoria Legal Aid (VLA), is that additional legal representation is not required at CMIA hearings. The VLRC made a recommendation in relation to advocacy – that DHHS should undertake a gap analysis of advocacy services for people who are subject to CMIA to ensure that all people subject to the Act have access to advocacy services: VLRC, review of the CMIA, 282, recommendation 61.



### CASE STUDY AM: The benefit of advocacy

AM has an intellectual disability. At age 41 he spent 371 days in remand prior to being found unfit to plead by a jury. Mr A spent an extended period in custody due to the lack of availability of a suitable disability accommodation treatment facility. His period of incarceration resulted in distress for AM. During his incarceration he was chemically restrained as staff did not know how to manage his behaviour. The OPA advocate involved in the case made the point that there was a link between AM's deterioration and the lack of services that he received. She said that to continue in the current situation was a significant breach of his human rights. The County Court Judge involved in the case said the circumstances of AM were 'intolerable and unacceptable'. Following advocacy by OPA and a request from the Judge to the Secretary of the Department of Human Services a placement was found for AM.

Source: Legal unit case study

#### 4.1.1 Independent Mental Health Advocacy program

Under the Mental Health Act, people who are receiving compulsory psychiatric treatment can access advocacy provided by Victoria Legal Aid's Independent Mental Health Advocacy program. The goal is to provide advocacy assistance to enable the person receiving compulsory treatment to have a say as much as possible about their assessment, treatment and recovery. This new program was established following the commencement of the Mental Health Act in 2014.

This advocacy program is not available to persons receiving psychiatric treatment voluntarily. Like compulsory patients, these persons should be able to access independent advocacy.

The import and effectiveness of such advocacy programs require adequate resourcing and skilled persons to best promote and protect the rights of people who at a risk of or who are indefinitely detained.

On the right to advocacy, OPA makes the following recommendation:

**Recommendation 10.** People who at a risk of or who are indefinitely detained should have a legislative right to advocacy on commencement of their order, for reviews, variations, leave applications and the determination of post discharge placements.

#### 4.1.2 OPA's Independent Third Person Program

OPA's ITP Program provides volunteers to attend police interviews where the alleged offender, witness or victim may have a cognitive impairment or mental illness.

Although the remit of the ITP Program is primarily during the interview phase, ITPs also provide support in Video Audio Recorded Evidence (VARE) interviews, which are used to record evidence-in-chief for cases of sexual offence and assault where the witness or victim is a child or has a cognitive impairment.<sup>75</sup>

Over 260 trained OPA ITPs are available 24 hours, 7 days a week to attend any police station throughout Victoria. The primary role of the ITP is to facilitate communication between the alleged offender and the police. It is also part of their role to ensure that the alleged offender understands and can exercise their rights if they so wish. OPA ITPs attended 2,898 interviews during 2014-2015, 2,500 of which were with people with disability as offenders.<sup>76</sup>

<sup>75</sup> *Criminal Procedures Act 2009* (Vic) ss 367–370.

<sup>76</sup> OPA, *Annual Report 2014-2015*, 38-42.



A research study undertaken by OPA titled *Breaking the Cycle: Using Advocacy-Based Referrals to Assist People with Disabilities in the Criminal Justice System* (2013) found that:

- people with cognitive impairments and mental illnesses can be particularly vulnerable to having repeat contact with crime
- just under one third of ITP clients are 'repeat presenters' before the program. These people account for roughly 60 per cent of the total number of ITP interviews
- many people within the ITP client group are known to services. However, service provision to this group of people is inadequate
- people in the ITP client group are often under-supported, or ineffectively supported, by services. Advocacy interventions are required to ensure that services work more effectively for these people

The research report found that the ITP program has a clear opportunity to provide an early intervention strategy targeted at people with disability who are at risk of having repeat contact with crime. In this way, the program would be able to provide a more comprehensive form of assistance, in assuming an advocacy and referral function, to link the person up with appropriate support services, in addition to support at police interview. For victims, ITPs with an advocacy and referral function could also assist with early intervention and diversion. People who are victims may often become offenders. Case study BL, referred to earlier in this submission, illustrates this. BL has a significant history of personal exposure to sexual abuse as a victim, and later in his life, of sexual offending against children.

In adapting recommendations contained in the *Breaking the Cycle* report, OPA makes the following recommendation to the Senate Committee:

**Recommendation 11.** State and territory governments should ensure people with disability who have had or who are clearly at risk of having repeat contact with crime have access to an advocacy and referral scheme.

If the Office of the Public Advocate's Independent Third Person Program had an advocacy and referral function, as recommended in *Breaking the Cycle* report, this could be considered a useful model. Such a program must be adequately resourced and ideally be embedded in legislation.

#### 4.1.3 OPA's Corrections Independent Support Officer Program

CISO are experienced volunteers recruited from OPA's ITP program. Their role is to provide assistance and support to prisoners with a confirmed intellectual disability during Governors' Disciplinary Hearings (GDH), at all adult prisons in Victoria.

A CISO actively participates in the disciplinary hearings process. They must explain to the prisoner what their rights are at a GDH, be assured they understand them and are able to freely exercise them in order to participate in a disciplinary hearing, before it can commence. The CISO then facilitates communication and supports the prisoner through the hearing process. OPA notes that Governors' hearings are about consequences. A person with cognitive impairment often does not understand consequences – this process, therefore, is not useful or fair to them.

During 2014-2015, CISOs were requested to attend a total of 237 hearings in seven of Victoria's 13 prisons (excluding the Judy Lazarus Transition Centre). This is an increase of 15.6 per cent in requests to attend hearings. The hearings related to 323 individual charges.<sup>77</sup>

People with intellectual disability are at risk of being penalised within the prison system, due to them not understanding the regulations placed on them. This can impact work privileges, access to the canteen, and sometimes television and phone services. OPA is aware of one person with cognitive impairment, who did not understand the regulation which outlined that failure to provide urine on demand results in a failed drug test. Nor could he meet this demand on request. The

<sup>77</sup> OPA, *Annual Report 2014-2015*, 41.





CISO program was able to negotiate with the prison in order to change its practice to deal with this situation.

OPA understands that one hundred people with suspected intellectual disability are waiting to be assessed in prison for access to a CISO. OPA sustains this program on a minimal budget and has advocated in the past for further funding to maintain the program, and respond to growing demand.]

#### 4.2 Impact of the National Disability Insurance Scheme

The transition to the NDIS could bring with it much hope for people in or at risk of indefinite detention. It also brings serious concerns in relation to where the responsibility for the provision of civil and criminal detention for people with cognitive impairment and mental illness will sit.

Announcements from key departments, including DHHS in Victoria and ADHC in NSW, will devolve of disability service provisions and, as yet unanswered questions about who will be responsible for the monitoring and regulation of services, have raised concerns in relation to a number of key areas, including access to justice.

NSW Council for Intellectual Disability (NSW CID) has raised its concerns for existing clients of the Criminal Justice Program (CJP), funded by NSW ADHC, to accommodate and support young people and adults with an intellectual disability in exiting correctional facilities. NSW CID has stated that the specialist skills and functions of these services need to be maintained in the NDIS.<sup>78</sup> NSW CID suggests there are indications that the NDIA will take a narrower view of its role than the CJP creating major risks of reoffending and imprisonment.<sup>79</sup>

In the Victorian context, the Bilateral Agreement between the Commonwealth and Victoria Transition to a National Disability Insurance Scheme outlines the arrangements for the interface between the NDIS and mainstream services in transition (see schedule I). The schedule notes that it 'is critical to ensure that participants in the scheme achieve positive outcomes, and cost-shifting, duplication and/or the creation of service gaps is avoided'. Mainstream services include those related to justice, health, aged care and mental health, among others.

OPA is concerned about people with cognitive impairment or mental ill health within the civil and criminal justice system. In particular:

1. Who will maintain the rigorous safeguards provided under the Victorian Disability Act when the full roll out of the NDIS is complete?
2. Will the civil and criminal detention regime be adequately resourced using best practice models?

On the criminal detention regime, schedule I seeks to clarify the funding responsibility for the provision of services under the NDIS and the justice system. Schedule I states:

The criminal justice system (and relevant elements of the civil justice system) will continue to be responsible for meeting the needs of people with disability in line with the National Disability Strategy and existing legal obligations, including making reasonable adjustments in accordance with the *Disability Discrimination Act 1992* (Cth).

The Bilateral Agreement outlines 'Principles to Determine the Responsibilities of the NDIS and Other Service Systems.' It indicates that a revised 'Mainstream Interface Principles and Tables of Support' (to be contained in attachment A to sch I of the Bilateral Agreement) is awaiting agreement by COAG before release.

The implications of this, particularly for the civil detention regime in Victoria is unclear.

The ability of individuals with cognitive and psychiatric impairment to receive support under the National Disability Insurance Scheme while in detention is an important element of the terms of reference of this inquiry. The extent to which transition to the NDIS national quality and safeguarding framework will change how supports are provided in this area is unknown. OPA's

<sup>78</sup> NSW Council on Intellectual Disability IDC, *When ADHC stops and the NDIS starts* <<http://www.nswcid.org.au/blog/when-adhc-stops-and-the-ndis-starts.html>> accessed 30 March 2016.

<sup>79</sup> NSW Council on Intellectual Disability IDC, *When ADHC stops and the NDIS starts* <<http://www.nswcid.org.au/blog/when-adhc-stops-and-the-ndis-starts.html>> accessed 30 March 2016.





concern is about any loss to funding and service provision responsibility in Victoria, which is currently dictated under relevant legislation.

The *National Disability Insurance Scheme (Supports for Participants) Rules 2013* (Cth) indicate that the NDIS will not be responsible the day-to-day care and support needs of a person in custody, including supervision, personal care and general supports.<sup>80</sup> Person in custody means a person in a custodial setting, whether on remand or as a result of a sentence or other court order (including in a youth detention and training facility), or in a secure mental health facility, and therefore meets the definition of indefinite detention for the purposes of this inquiry.<sup>81</sup>

Encouragingly, the rule states that the NDIS will be responsible for reasonable and necessary supports in relation to a person in custody:

- i. reasonable and necessary supports other than the day-to-day care and support needs of a person in custody (including supervision, personal care and general supports) to the extent appropriate in the circumstances of the person's custody, and
- ii. transition supports.<sup>82</sup>

The Supports for Participants Rules define transition supports for a person in custody as supports to facilitate the person's transition from the custodial setting to the community that are reasonable and necessary, and, are required specifically as a result of the person's functional impairment.<sup>83</sup>

Will it be the responsibility of the custodial body to engage the NDIS about transition support including, in necessary, to determine the eligibility of a person to access the scheme? OPA considers responsibility should fall on the custodial body.

OPA considers that formal protocols need to be formed with those departments and agencies providing custodial services and the NDIA to establish a process for linking prisoners within the target group into the scheme with eligibility and assessment processes.

Clarity in responsibility and consistency in service provision is crucial in the transition and reintegration planning of prisoners. The responsibility for service provision cannot simply end, and start, with the release of a person. Reintegration supports must be provided while a person with disability is still in detention and transition planning must be done early.

To expect a person with cognitive impairment to reintegrate into the community from an environment where they have been subject to a high level of supervision and restrictive interventions is unrealistic. An NDIS plan for a person, at the very least developed while the person is in the custodial environment, is crucial. Ideally their NDIS plan would incorporate a step down approach to their reintegration. Ensuring there is appropriate accommodation for a person is crucial to their ongoing engagement with the NDIS. It is also critical that a person be provided with supports to decrease the likelihood of reoffending, and improve their social inclusion and engagement in the community.

On this point, OPA makes the following recommendations:

**Recommendation 12.** Custodial bodies (who have identified persons with disabilities (as set out in recommendation 1)) develop protocols with the NDIA to establish whether persons with disability held in custody are eligible for NDIS services and support. The protocol should encompass planning processes to be followed for persons found to be eligible.

This obligation on custodial bodies should be set out in legislation.

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<sup>80</sup> *National Disability Insurance Scheme (Supports for Participants) Rules 2013* (Cth) r 7.25.

<sup>81</sup> *National Disability Insurance Scheme (Supports for Participants) Rules 2013* (Cth) r 7.23.

<sup>82</sup> *National Disability Insurance Scheme (Supports for Participants) Rules 2013* (Cth) r 7.24.

<sup>83</sup> *National Disability Insurance Scheme (Supports for Participants) Rules 2013* (Cth) r 7.23.



OPA makes the following recommendations in relation to long-stay patients and advocacy, and accommodation matters under the NDIS to address concerns about people who are at risk of or who are indefinitely detained under a mental health act, OPA makes the following recommendation in relation to funding under the NDIS:

Recommendations 13. That the National Disability Insurance Scheme fund advocacy support and outreach to ensure that long stay patients in mental health settings are supported to transition to the community where possible.

Recommendations 14. That the National Disability Insurance Scheme recognise long stay patients in Secure Extended Care Units as a priority group when considering alternative accommodation models.

## 5 Part Five: The use of restraints and other restrictive interventions

OPA has long-standing concerns about the use of restraints and other restrictive interventions on people with cognitive impairments and mental illness. OPA's concerns extend to practices in many spheres including: 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. As discussed earlier, there are legislative frameworks that provide varying levels of authorisation of restrictive practices in such accommodations.

Human rights are a significant factor in the Australian commitment to the reduction and elimination of seclusion and restraint. Article 17 of the Convention states that 'every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others'. Article 15 further states that 'no one shall be subject to torture or to cruel, inhuman or degrading treatment or punishment'.<sup>84</sup>

The United Nations Special Rapporteur on Torture and Cruel and Inhuman and Degrading Treatment released a report in March 2013 on human rights associated with treatment in detention in health care facilities. In the report he states that the imposition of solitary confinement 'of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment'.<sup>85</sup> He recommends an 'absolute ban' on restraint and solitary confinement of people with psychological or intellectual disabilities should apply in all places of deprivation of liberty, including psychiatric and social care institutions.<sup>86</sup>

### 5.1 Restrictions on the liberty of people with disability – a broader problem

Dr John Chesterman, Director of Strategy, OPA, published a roundtable paper discussing the notion of closed environments, the content of which OPA wishes to refer to in the context of this inquiry.

The paper, *Restrictions on the Liberty of People with Disabilities: The View from the Office of the Public Advocate* (2012), discusses the notion of compliant detention, which, although not explicitly referred to in the terms of reference to this inquiry, nonetheless warrants the consideration of the Senate Committee.

Compliant detention refers to those people with disability who are detained, by their apparent compliance with the restrictive environment in which they live. This has, until now, obviated the need for any due legal process to sanction their effective detention. 'Until now' refers to international developments such as the legal case in the United Kingdom known as the Bournemouth decision of 2004.<sup>87</sup>

<sup>84</sup> *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008) arts 15, 17.

<sup>85</sup> Méndez, Juan E 2013, Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, 22nd session of the Human Rights Council, 4. March. Geneva, p 4.

<sup>86</sup> Note that Australia is a signatory to the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) which entered into force on 22 June 2006.

<sup>87</sup> John Chesterman explains that this case involved the European Court of Human Rights decision that an autistic patient who lacked capacity but who was 'compliant' was unlawfully detained as an 'informal patient' at the Bournemouth hospital in contravention of the European Convention for the Protection of Human Rights and Fundamental Freedoms: at 69. See also *H.L. v United Kingdom* (European Court of Human Rights) [2004] ECHR 471.



The paper raises the argument that 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. In these accommodations, restrictive interventions are applied without external authorisation of a court or tribunal. Similarly, someone whose behaviours of concern lead them to be subject to chemical restraint that greatly inhibits their movement is, at least for that time, effectively in a closed environment.<sup>88</sup>

### 5.1.1 Disability service settings

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.<sup>89</sup> Restrictive practices are most often applied to address or manage 'behaviours of concern' of people with a disability or mental ill health.<sup>90</sup>

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.<sup>91</sup> The broader application on this model in legislation at the Commonwealth, state and territory levels would need to be carefully adapted to the circumstances within the jurisdiction to which it relates and the facilities to which it would apply.

**Recommendation 16.** The Commonwealth, state and territory governments should consider enacting legislation that enables the regulation of restrictive practices. The processes set out in the *Disability Act 2006* (Vic) Part 7—Restrictive Interventions—provide a model for the Commonwealth, state and territory governments to consider.

<sup>88</sup> See broadly Dr John Chesterman, 'Restrictions on the liberty of people with disabilities: The view from the Office of the Public Advocate', in Naylor, B. et al (eds), *Monitoring and Oversight of Human Rights in Closed Environments: Proceedings of a Roundtable* (Monash University Law Faculty 2012), pp. 65-79.

<sup>89</sup> *Disability Act 2006* (Vic) pt 7. OPA's position statement on restrictive intervention states that 'Restrictive interventions are defined as the deliberate or unconscious use of coercive power to restrain or limit an individual's freedom of action or movement, through a range of different mechanisms. These mechanisms used to restrict an individual can be chemical, environmental, mechanical or physical in nature: Office of the Public Advocate, Position Statement, *Restrictive interventions* (2011) <<http://www.publicadvocate.vic.gov.au/file/file/Research/Position%20statements/Rebranded%20position%20statements/Position%20statement%20on%20restrictive%20interventions,%20February%202011.pdf>>.

<sup>90</sup> OPA's view is that restrictive practices fundamentally infringe upon a person's human rights. OPA has long-standing concerns about the widespread use of restraints and other restrictive interventions on people with disability and mental ill health.

<sup>91</sup> In Western Australia, for example, there is a voluntary code of practice; there is no legislative framework for authorisation and regulation.