**SUBMISSION**

**of**

**THE SOUTH AUSTRALIAN PUBLIC ADVOCATE**

**to**

**THE SENATE COMMUNITY AFFAIRS LEGISLATON COMMITTEE**

**regarding**

**THE SOCIAL SERVICES LEGISLATION AMENDMENT BILL 2015**

1. On 26 March 2015, the Senate referred the *Social Services Legislation Amendment Bill 2015* (the Bill) to the Senate Community Affairs Legislation Committee (the Committee) for inquiry and report. The Committee is currently accepting submissions to inform its inquiry and report. This is the submission of the Public Advocate of South Australia appointed pursuant to section 19 of the *Guardianship and Administration Act 1993 (SA).*
2. The Public Advocate is an independent statutory appointment of the Governor of South Australia. The functions of the Public Advocate include speaking for and promoting the rights and interests of people with mental incapacity and acting as an adult guardian of last resort.
3. This submission considers the nature of Forensic Patients, who in this submission are defined as people who have been found not guilty by reason of mental impairment, or unfit to plea in court. Such people are patients, not prisoners, and retain key rights as Australian citizens, such as their right to vote and currently to receive social security benefits. Any loss of personal rights is limited to the requirements of treatment and rehabilitation and the maintenance of community safety. Any additional loss of rights would be a defacto **punishment** for people who have become forensic patients because they are mentally ill, or experience an intellectual disability, brain injury or autism.
4. By making this amendment the Government will **discriminate** against people who have a mental illness or cognitive disability. While s51 (1) (d), *Disability Discrimination Act 1992* (**DDA**) might permit the *Social Security Act* to include discriminatory provisions; this places a greater obligation on the Parliament to articulate *a sound justification* for any such provisions. In this submission it is explained why there is no such justification for discrimination in these circumstances.
5. Furthermore this strategy is contrary to national policy approaches to improve the mental health of Australians. In this regard, **stigma**, is a significant barrier for the full and equal participation in the community of people who experience mental illness. While the *Social Services Legislation Amendment Bill 2015* has arisen in the context of budget savings, it has shone light on an existing legislative provision that in itself is discriminatory and stigmatizing, although a court decision has ensured that the discriminatory provisions are not widely applied. This stigma is not only directed to people directly affected by these provisions, but also more broadly to people who

experience a significant mental illness because such statute contributes to the overall community view as to how people with serious mental illness are seen.

6. The current focus on these provisions creates an opportunity for discrimination and stigma towards forensic patients to be proactively addressed by Parliament. Such an outcome could be achieved by removing entirely from the *Social Security Act* s1158, the category of people defined as "undergoing psychiatric confinement because the person has been charged with an offence." Doing so would ensure equal social security treatment of all people who are before the courts. Such an action would communicate to the community Parliament's understanding of the nature of forensic patients; that forensic patients are not prisoners and it is unnecessary to have statute that equates patients to prisoners. This would be an action without additional cost to the social security budget as forensic patients already receive benefits following the decision to recognize rehabilitation services provided to them in *Franks v Secretary, Department of Family and Community Services* [2002] FCAFC 436. Of course it would mean forgoing the proposed savings that would flow from the current Amendment Bill.

The Nature of Forensic Patients

7. The Bill seeks to cease social security payments to persons who are confined in a psychiatric institution and have either been found not guilty of a serious offence by reason of mental incompetence or been found mentally unfit to stand trial. The Bill thus equates the position of such persons to the position of prisoners yet they are not prisoners: they have not been found guilty of a crime and are cared for by health or disability professionals rather than correctional officers.

8. The insanity defence has had a long history in Common Law. As early as 1505 there is record of a person acquitted of being of unsound mind.[1] The most significant case influencing current legal practice, was that of Daniel McNaughten who in London in 1843 was charged after shooting and killing Edward Drummond, the private secretary of the Prime Minister. He was under the influence of delusions, and on the basis of strong medical evidence he was found "not guilty by reason of insanity."[2]

9. Subsequently the Chief Justice at the time laid out what became known as the McNaughten rules.

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

10. McNaughten's rules are reflected in our current Australian statutes. In South Australia, at least, a person can be found to be mentally incompetent to commit an

[1] Walker, N, Crime and Insanity in England, Edinburgh University Press, 1968, cited by the Sentencing Council of South Australia (2013), A Discussion paper considering the operation of Part 8A of the Criminal Law Consolidation Act 1935 (SA).
[2] West D.J and Walker A, Daniel McNaughton: His Trial and Aftermarth, Gaskell Books, 1977, cited by the Sentencing Council of South Australia (2013), *ibid*.

offence if, at the time of the conduct alleged to give rise to the offence, the person is suffering from a mental impairment and, in consequence of that impairment, (a) does not know the nature and quality of the conduct; or (b) does not know that the conduct is wrong; or (c) is unable to control the conduct.[3] The term 'mental impairment' is defined to include not only a mental illness but also intellectual disability and a disability or impairment of the mind resulting from senility.[4] The cessation of social security payments proposed by the Bill would therefore apply inter alia to persons who, through intellectual disability or dementia, have been found to be mentally incompetent to commit an offence.

11. A person found not guilty in this way, is then not punished.[5] A person instead receives treatment and rehabilitation, in clinical facilities. The treatment and rehabilitation benefits the person, but also because of the relationship between illness and the offending behaviour, these interventions ultimately keep the community safe, when a person is discharged from residential supervision, into the community.

12. The involuntary hospitalisation of such patients is informed by a well established and pre-eminent function of government in relation to "those who are not able to take care of themselves.[6] This is the protective jurisdiction of *parens patriae* recognised for people with intellectual disability in the *Statute Prerogativa Regis* of 1324, functions which by 1696 had been delegated to the Chancellor and passed to the Court of Chancery. The jurisdiction of the Court of Chancery where it is not affected by statute is administered by the Supreme Court.[7]

13. The benevolent and protective nature of the *parens patriae* jurisdiction is the common law basis of statutory guardianship regimes, including the guardianship work undertaken by the Office of the Public Advocate in South Australia. In the forensic mental health and disability setting the power given to a Minister of the Crown to treat, rehabilitate and supervise a person with a cognitive or psychiatric disability is at the very least strongly informed by the protective and benevolent jurisdiction, and is likely to incorporate it.

14. The application of *parens patriae* can lead to a loss of autonomy of the individual, so that the person can be treated, rehabilitated and protected. In both the common law and in statute, it is usual for the loss of rights to be limited to those that are absolutely necessary. For example in South Australian statute restriction of the forensic patient's freedom and personal autonomy, should be kept to the minimum consistent with the safety of the community.[8] The focus is on treatment; for example the Court

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[3] Section 269C of the *Criminal Law Consolidation Act 1935 (SA).*
[4] Section 269A (1) of the *Criminal Law Consolidation Act 1935 (SA).*
[5] In South Australia the court must fix a limiting term "equivalent to the period of imprisonment or supervision … that would, in the court's opinion, have been appropriate if the defendant had been convicted of the offence …" (section 269O(2)). However it is important to recognise that detention under a supervision order for the period of the limiting term is not imprisonment, and does not constitute punishment, or the imposition of a penalty (R v Draoui ; R v Behari ). A defendant committed to detention under a supervision order for a limiting term will have been found not guilty of the offence (by reason of the declaration of mental incompetence). It is inconsistent with such a verdict that the defendant would then be considered in Social Security Law to be equivalent to a convicted prisoner, or be expected to lose rights as lost by prisoners.
[6] *Wellesley v. Duke of Beaufort* (1827) 38 ER 236, at 243 (Lord Eldon LC)
[7] *DoCS v Y* [1999] NSWSC 644, at [85] – [87]; see, s 17 (2) (a) (i), *Supreme Court Act 1935* (SA)
[8] *Criminal Law Consolidation Act (CLCA) 1935* s269s

receives reports on treatment that has been provided, a patient's prognosis and the current treatment plan.[9]

15. It is not intended that other rights are lost, in particular those unrelated to care and protection. This can be seen in current practice. For example patients in forensic facilities vote at Federal and State Elections, and voting can be seen as an important marker of citizenship.[10] Electoral Officers either conduct pre-poll visits to forensic facilities or arrange for postal voting. Similarly social security income is received, and used in the same way as it would be to meet similar expenses occurred by patients confined under civil mental health legislation or patients in physical rehabilitation hospitals. If a person lacks the mental capacity to manage their finances an administrator will be appointed for this purpose under *Guardianship and Administration* legislation.

16. The expectation of State Law that treatment and rehabilitation be provided is relevant to the decision of *Franks* ([202] FCSFC 436). As noted in the explanatory memorandum, this court decision determined that the majority of people in a psychiatric institution would be undertaking a course of rehabilitation, and therefore eligible for social security support.

17. This is how it should be as treatment and rehabilitation is the purpose of forensic mental health detention. This should apply to all forensic patients. For example in South Australia, forensic patients who are subject to an order for detention (under s 269O (1) (b) (i), *Criminal Law Consolidation Act* (CLCA)) are under the custody, supervision and care of the Minister (s 269V (1), CLCA) which, places the Minister under a duty to provide the forensic patient with essential care, proper treatment and *rehabilitation*.

18. The Office of the Public Advocate (SA), advocates for adequate services for forensic patients. Our advocacy is necessary because services are underfunded, and limited in scope, both with respect to the range of services offered and the number of beds available, but these conflicts with State Government relate to the adequacy and extent of services offered to individuals and groups. The duty to provide treatment and rehabilitation is always accepted.

Discrimination

19. It may be important to identify just exactly what this amendment is doing. As things *presently* stand, the relevant provisions are these:

> **Section 1158**
> **Some social security payments not payable during period in gaol or in psychiatric confinement following criminal charge**
> An instalment of a social security pension, a social security benefit, a parenting payment, a carer allowance, a mobility allowance or a pensioner education supplement is not payable to a person in respect of a day on which the person is:

[9] *CLCA* 1935 s269Q.
[10] Law S, McMillan J, Comley Z, Smith A, and Brayley J (2014) Mental health recovery and voting: why being treated as a citizen matters and how we can do it, *Journal of Psychiatric and Mental Health Nursing*, 21:289-295.

(a) in gaol; or
(b) undergoing psychiatric confinement because the person has been charged with an offence
Note 1: For ***in gaol*** see subsection 23(5).
Note 2: For ***psychiatric confinement*** see subsections 23(8) and (9).

**Section 23**
(5) For the purposes of this Act, a person is ***in gaol*** if:
(a) the person is being lawfully detained (in prison or elsewhere) while under sentence for conviction of an offence and not on release on parole or licence; or
(b) the person is undergoing a period of custody pending trial or sentencing for an offence.

(8) Subject to subsection (9), ***psychiatric confinement*** in relation to a person includes confinement in:
(a) a psychiatric section of a hospital; and
(b) any other place where persons with psychiatric disabilities are, from time to time, confined.
(9) The confinement of a person in a psychiatric institution during a period when the person is undertaking a course of rehabilitation is not to be taken to be ***psychiatric confinement*** **.**

20. It can be seen that the 'bar' on social security payments applies to two categories of persons: those "in gaol", and those in "psychiatric confinement" because they have been "charged with an offence" (s 1158). By reason of s 23 (9), however, it is *not* "psychiatric confinement" if the person is there "undertaking a course of rehabilitation", even if the confinement is because the person was charged with an offence. This removes the 'bar' for most forensic patients. The Full Court of Federal Court held in *Franks* ([202] FCSFC 436) that this was indeed the operation of these provisions and the removal of the 'bar' effected by s 23 (9) applied with full force and effect despite the charge.

21. The Minister seems to accept the authority of *Franks* ([202] FCSFC 436) which has the effect that those in a psychiatric institution undertaking a course of rehabilitation could continue to receive social security benefits (i.e. s 1158 does not apply) notwithstanding that they are confined there "because [they] had been charged with an offence".

22. What the Minister seems to be doing by this proposed amendment is enabling the s 1158 bar to apply to those who are in psychiatric confinement *even though they are undertaking a course of rehabilitation while in psychiatric confinement,* where that confinement was because of having been charged with "*a serious offence*". In other words, the bar in s 1158 (b) is now to be read *without* the limiting provision of s 23 (9) whenever the offence charged is a "serious offence".

23. The proposed amendment therefore affects all forensic patients who are confined because they were charged with (even though acquitted of) a "serious offence" (i.e. offences of violence to person or property punishable by imprisonment for at least 7 years: proposed subsecs 23 (9E) & (9F)). The extended bar is proposed to be relaxed only where the confinement is during a period of integration back into the community (proposed subset 23 (9) (B)).

24. While s51 (1) (d), *Disability Discrimination Act 1992* (**DDA**) might permit the *Social Security Ac*t to include discriminatory provisions, that places a greater obligation on the Parliament to articulate *a sound justification* for any such provisions; and further, does not exempt the Parliament from the scrutiny required by the *Human Rights (Parliamentary Scrutiny) Act 2011* (**HRPSA**).

25. The proposed amendment will have a discriminatory effect.

26. The "Statement of Compatibility" (**SOC**) in this case is flawed. For the purpose of identifying discrimination – whether under international conventions or under the DDA - the discriminatory action must have a 'comparator' against which to compare the treatment of the disabled person. The SOC seems to have chosen for its comparator the person who has been "charged with an offence", whether in custody *awaiting trial* or in custody having been *convicted* of the charged offence:

> *One of the effects of the Bill will be that a social security payment will not be payable to a person who is undergoing psychiatric confinement because they have been charged with a serious offence. A person may be undergoing psychiatric confinement on this basis because, for example, they are unfit to stand trial or because they are found not guilty on the grounds of mental impairment.* ***These people will be treated in the same way as a person who is in gaol having been convicted of an offence, or who is remanded in custody while awaiting trial after being charged with an offence***. (emphasis added)[11]

27. That is a false comparator. A forensic patient is not a convicted prisoner, or a charged person awaiting trial (this latter category is, in any event, highly suspect). The correct comparator is an adult person with the same need for social services as the disabled person, but without the disability (which is now defined in the DDA as including "[an impairment] that results in disturbed behaviour" (s 4) - the '*Purvis*' amendment in 2009).

28. The Minister's chosen comparator (a person 'charged with an offence') is false because it seizes on a common fact which lacks commonality in any legally significant sense; in short, a legally irrelevant common feature. Only in the case of a charged person awaiting trial does the chosen feature (being charged) explain why he or she is in detention; in the other cases, the detention is explained, on the one hand, by the fact of conviction and sentence, and on the other hand, by the fact of acquittal by reason of mental impairment, and consequential detention on grounds only of public protection and treatment, not punishment.

29. The detention of a forensic patient is not because he or she has been charged with an offence, but because, having been charged, they have been acquitted but detained, or held not fit to plead but detained. The detention of a convicted prisoner is not because he or she has been charged, but because, having been charged, they have been convicted and sentenced to imprisonment as punishment. By reason of his or her disability, the person with disability is being treated in a way "not materially different from" a convicted prisoner (which the above extract openly and startlingly confirms).

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[11] The above extract is the Minister's assessment (under s 8 of the HRPSA) of the application of Art 26 of the International Covenant on Civil and Political Rights and Article 2 (2) of the International Convention on Economic, Social and Cultural Rights, both of which recognise the rights of equality and non-discrimination.

30. Therefore the bill discriminates, there is not a sound justification for this discrimination and the human rights assessment under s8 of the HRPSA applies the wrong comparator. For these reasons Parliament should not take measures to discriminate against this group of people with mental illness and/or other cognitive disabilities.

31. This proposed amendment to the *Social Security Act*, now raised for budget reasons has highlighted the problematic nature of the category in s1158 of that Act, "psychiatric confinement following criminal charge". This category could be removed entirely from the Act, removing the possibility of future discrimination based on psychiatric confinement, and the stigma created in defining this category. Because the *Franks* decision has in effect already removed the bar to payments for people receiving rehabilitation in the category, there should be little or no financial cost in removing this category entirely from the Act.

Stigma

32. People who experience psychiatric disorders experience stigma; forensic patients more than most. Press stories of serious crime can influence public perception of mental illness.

33. The National Mental Health Commission in its recently published report of Mental Health Programmes and Services said the following.[12]

> Stigma is associated with poorer physical and emotional health, as well as poorer employment outcomes. It can discourage individuals from disclosing their illness and from seeking help, both of which are important steps to gaining assistance in managing symptoms and preventing the development of a more serious experience of mental illness. In this way, stigma presents barriers to service access, creates additional distress and mental ill-health and ultimately drives up system costs.

34. Australia's current mental health policy, states that all Australians, including those with mental health problems have a right to participate meaningfully in individual and community life without discrimination, stigma or exclusion.[13]

35. The Fourth National Mental Health Plan seeks to improve community and service understanding and attitudes through a sustained and comprehensive national stigma reduction strategy, seeking to reduce the rates of stigmatising attitudes in the community.[14]

36. Self-stigma can be particularly problematic with a strong negative association between a person with mental illness having internalised stigma, and experiencing a lack of hope, self-esteem and empowerment.

37. The perceived link with violence contributes to this. Rare, sometimes tragic events reported in the media affect perceptions not only of forensic patients but people who

[12] National Mental Health Commission (2014) Contributing lives, thriving communities Report of the National Review of Mental Health Programmes and Services. NMHC, Sydney.
[13] Australian Health Ministers Conference (2009) National Mental Health Policy 2008, Commonwealth Government.
[14] Commonwealth Government (2009) Fourth National Mental Health plan. An agenda for collaborative government action in mental health 2009-2014. Commonwealth of Australia.

experience severe illness generally. The link between serious mental illness and the risk of violence has been the subject of extensive research with mixed results. It is reasonable to conclude that community perceptions and fears are not borne out by the evidence. For example a major American study published in the Archives of General Psychiatry concluded that the presence of severe mental illness did not independently predict violent behaviour and this should challenge public perceptions. The rate of violence only was significantly higher for the population of people with co-morbid substance use. Other factors that could be associated with reports of violence involving people with mental illness included historical factors (past violence, juvenile arrest, physical abuse, parental arrest record) clinical factors (substance abuse, perceived threats), dispositional factors (a person's age, sex and income) and context (recent divorce, unemployment, experience of victimisation.)[15]

38. Community misperceptions about the nature of forensic mental illness are common. It is not unheard of in our work to meet members of the community who confuse the actions of people who are unwell due to mental impairment, with the actions of criminals who commit heinous crimes. Because the actions of criminals in the latter group are so difficult to comprehend a false assumption is made that the criminal must have a mental illness, whereas a court of law sees the person as responsible, and will convict on the evidence. This falsely puts stigma on forensic patients.

39. In this context unreasonable expectations of denunciation and retribution can be made of a defendant who experiences a mental illness. Denunciation and the stripping away of rights is part of the process of removing the full status of people who are convicted of a crime and sent to prison. The same process of denunciation and rights removal should not be applied to a patient who is hospitalised having been found not guilty by reason of mental impairment, who retains their civic status; the most immediate manifestations of this are the right to vote, and to receive social security payments. It is not uncommon for patients who recover and regain insight into events, to experience remorse and distress at their actions when unwell. It is neither relevant nor appropriate to diminish the status of people caught in these tragic situations further.

40. Depending on the sequence of events prior to an incident it can be arbitrary whether a person who is very unwell with an illness receives treatment before an incident therefore preventing it, or slips through gaps without receiving treatment or involuntary care delivered under civil mental health law, and then becomes involved in a violent incident.

41. Our Annual Report in 2012 described the gaps in the communication of clinical information in one person's care prior to a tragic incident occurring for which the person was found not guilty by reasons of mental impairment.[16] Some of the gaps in communication are now being filled through improved computerised information systems linking services, but community mental health services still need more capacity to respond to their clients' needs. These situations illustrate the arbitrariness of events and outcomes, when a person is unwell, not in control of their own behaviour, but subject to the vagaries of an imperfect care system.

[15] Elbogen E and Johnson S (2009) The intricate link between Violence and Mental Disorder, *Archives of General Psychiatry*, 2009:152-161.
[16] Office of the Public Advocate (2012) Annual Report, OPA Adelaide. Page 27

42. This is consistent with the National Mental Health Commission's current description of the experiences of many mental health consumers.[17]

> In many places we have ended up with what is effectively a new 'institutionalisation in the community', where people experiencing mental illness live in the community but do not live well. They receive fragmented help or no help at all, and become stuck in a vicious cycle of poor health and limited life chances. They are moved between disconnected silos of intervention, including hospital wards, patchy support systems in housing, education and employment, and overstretched community and nongovernment services. Because these silos only support part of the person, whole-of-life needs are neglected and overall quality of life does not improve.

In this context it is not surprising that people with mental illness come before the law. People can be sent to prison if competent when a crime is committed. Prison is rapidly becoming the new mental health institutions of the 21st Century.[18] At the same time other people who are very unwell, and are not guilty by reason of mental impairment, are admitted to hospital. The result is that people who should have received a service, do now get one, but in a sense when it is too late.

43. The evidence of what reduces community stigma with respect to mental illness in general and forensic mental health issues is inconclusive. However Parliament can act in a model way in this regard, consistent with National Mental Health Policy objectives to reduce and eliminate discrimination and stigma.

44. Ensuring that the *Social Security Act* treats patients in forensic mental health wards in the same way it treats patients in general wards receiving care for a range of physical and mental illness, will prevent additional stigma directed towards not only forensic patients, but also to other people in the community who experience a serious mental illness.

45. Self-stigma would also be reduced. It is hypothetical what the impact on individuals directly affected by these provisions would be. It is likely though that patients who lose their benefits, could see themselves to be similar to prisoners in status increasing self stigma.

Costs of care

46. During the second reading speech of the Bill, the Minister for Social Services stated that *'it is the relevant State or Territory government that is responsible for taking care of a person's needs while in psychiatric confinement, including funding their treatment and rehabilitation'*. In my submission, an attempt to justify the provisions of the Bill by reference to costs of treatment and rehabilitation is unconvincing because the terms of the Bill apply only to persons who have been charged with 'serious offences'. If this were in fact the rationale for the change of law, the Bill would suspend social security payments not only to all forensic patients, whatever crime

[17] National Mental Health Commission (2014) Report of the National Review of Mental Health Programmes and Services Volume 2, page 16.
[18] See White P and Whiteford H (2006) Prisons: mental health institutions of the 21st Century, *Medical Journal of Australia*, 185:302-303, also Brayley J (2013) A Rights Based Approach for the planning of mental health services for the prison population, Annual Congress of ANZAPPL, http://www.opa.sa.gov.au/files/200_anzappl_presentation_v3.pdf

they had been charged with, but extend it to all areas of mental health and physical health rehabilitation where the state provides services. It is discriminatory to remove benefits from one group with psychiatric diagnoses, but not other groups. The benefit should be retained for all.

47. As forensic patients are usually long term patients, health departments and disability providers can charge them for accommodation and living expenses, in the same way they charge other long stay patients in the health system. States still pay for clinical services; the accommodation is a contribution for food, energy and other charges. If the Bill were to become law and forensic patients were to be deprived of their social security payments such charges could not be levied. Already stretched State and Territory health and disability agencies would be forced to forego this contribution to the accommodation costs of clients.

Conclusion

48. This submission has explained why there is a greater obligation on the Parliament to articulate a sound justification for discriminatory provisions in the *Social Security Act*, although the *Disability Discrimination Act 1992* might permit the act to include such provisions.

49. In putting forward this Amendment Bill no such justification has been made, and by comparing the treatment of forensic patients to that of prisoners, the wrong comparator is used in the "Statement of Compatibility" with human rights.

50. In considering changes to the *Social Security Act*, it is necessary to consider the nature of forensic patients, and the objectives of Australia's mental health policy to reduce stigma and discrimination.

51. For these reasons, now that this area has been raised through Budget discussions, Parliament could take a lead in tackling stigma, and completely remove the category of "psychiatric confinement" when charged from the *Social Security Act.* This would reduce the potential for future discrimination to occur.

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