



7 April 2016

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
CANBERRA ACT 2600

By email to community.affairs.sen@aph.gov.au

Dear Committee Secretary

Re: Senate Inquiry into the indefinite detention of people with cognitive and psychiatric impairment in Australia

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide a submission to the Senate Community Affairs References Committee Inquiry into indefinite detention of people with cognitive and psychiatric impairment in Australia.

As detailed in the submission attached, this inquiry provides the opportunity to raise the significant concerns of the RANZCP membership. There are a range of population groups with cognitive and psychiatric impairment who come under the inquiry definition of indefinite detention. These include people detained under mental health legislation, people with intellectual and developmental disability, people within the criminal justice system, and people in immigration detention. The RANZCP has serious concerns that the current provisions that allow for indefinite detention are discriminatory, incompatible with human rights, and have the potential to cause long term harm.

The RANZCP believes that significant change is required in this area to address these issues and has identified key recommendations within its submission. These recommendations will help improve outcomes for people who are detained indefinitely and promote compliance with Australia's human rights obligations. Key to any strategy is the adequate provision of mental health services and services that provide care for people with intellectual and developmental disability.

If you would like to discuss any of the issues raised in the submission, please contact Ms Rosie Forster, Senior Manager, Practice, Policy and Partnerships

Yours sincerely

Prof Malcolm Hopwood
President

Ref: 0202o



The Royal
Australian &
New Zealand
College of
Psychiatrists

Senate Community Affairs References Committee inquiry into indefinite detention of people with cognitive and psychiatric impairment in Australia

April 2016

maximising opportunities for recovery

Royal Australian and New Zealand College of Psychiatrists submission

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About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation responsible for training, educating and representing psychiatrists in Australia and New Zealand. Psychiatrists are medical doctors who are specialists in the treatment of mental illness, substance abuse and addiction. Psychiatrists play a crucial role in the provision of evidence-based mental health care using a range of therapies including medication and psychotherapy to support a person in their journey to recovery.

The RANZCP has over 5,500 members including 4,000 fully qualified psychiatrists and 1,400 doctors who are training to qualify as psychiatrists. The RANZCP is guided on policy issues by a range of expert committees whose membership is made up of leading psychiatrists with relevant expertise, as well as consumer, carer and community representatives.

Introduction

The RANZCP welcomes the opportunity to provide feedback to the Senate Community Affairs References Committee inquiry into indefinite detention of people with cognitive and psychiatric impairment in Australia. The RANZCP consulted widely in developing this submission, obtaining feedback from Committee and members representing expertise in the area of forensic psychiatry; psychiatry of intellectual and developmental disability; asylum seeker and refugee mental health; as well as considering state and territory perspectives and the insight of the RANZCP's consumer and carer representatives. The RANZCP membership has serious concerns that the current provisions that allow for indefinite detention are discriminatory, incompatible with human rights, and have the potential to cause long term harm. The RANZCP believes that significant change is required in this area to address these issues.

The RANZCP notes that this inquiry has been called following the report of [the Community Affairs Committee inquiry into violence, abuse and neglect of people with disability](#), which recommended that the Australian Government work with state and territory governments on the implementation of initiatives to improve access to justice for people with disability contained in the reports by the Law Reform Commission (*Equality, Capacity and Disability in Commonwealth Laws*), the Human Rights Commission (*Equal Before the Law*) and Productivity Commission (*Access to Justice Arrangements*). The report of this inquiry included a specific focus on the need to investigate further the indefinite detention of people with cognitive impairment or psychiatric disabilities. The RANZCP welcomes the opportunity to address the issue of indefinite detention within this submission.

Acknowledging the different legislative frameworks between states and territories that allow for varying application of indefinite detention, the RANZCP has noted that for the purposes of this inquiry:

- indefinite detention includes all forms of secure accommodation of a person without a specific date of release
- 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.

Key recommendations

Compliance with human rights for people in indefinite detention under mental health legislation or with an intellectual or development disability

- The RANZCP supports mental health legislation that is compliant with the *UN Principles for the Treatment of Persons with Mental Illness 1991* ('The UN Principles') and the *Convention on the Rights of Persons with Disabilities* ('The Convention') and believes every effort should be made to implement these principles in practice to protect the rights of the individual. This should include adequate provision of mental health services that provide care for people with intellectual and developmental disability with or without a comorbid mental disorder, including those people who have behaviours that are difficult to manage.

People in indefinite detention within the criminal justice system

- The RANZCP supports the insanity defence, the determination of fitness to stand trial, and the principle that those who are found not guilty due to mental illness or not fit to stand trial should not be subject to punishment. The RANZCP considers that the clinical opinion of psychiatrists, and other clinicians involved as appropriate, should be respected in making these determinations.
- Persons found unfit to stand trial or acquitted on an insanity finding must only be treated in appropriately designated health facilities, outside of custodial environments, that are appropriate to individual clinical and risk management needs. They must not be treated as convicted criminals for that offence.
- Diverting people with cognitive and psychiatric impairment away from the criminal justice system requires improved accessibility and efficacy of treatment for people who are at risk of harm to themselves and others. This requires a multifaceted approach that can be achieved through adherence to the legal and treatment principles, as outlined in this submission.
- That further consideration be given to law reform proposals to determine how to better incorporate a modern test of decision-making capacity into the fitness to plead determination.
- That the psychiatrists and other clinicians involved in making determinations of fitness to plead should have adequate formal forensic mental health training, to ensure that decisions are rigorous and respected.
- Curtailment of individual liberties should be matched by providing adequate interventions and resources to assist in rehabilitation/long term care. Improved and better resourced advocacy for people within the criminal justice system and increased forensic mental health workforce is required to improve outcomes.
- Sufficient resources to increase the number of forensic mental health inpatient beds and places for people with cognitive impairment to be managed and treated so they are not in prison.
- A review of the Criminal Law Mentally Impaired Accused Act 1996 (the CLMIA Act) in Western Australia to produce legislation that is in line with national and international standards of care for people with mental illness and cognitive disability, whilst ensuring the best possible balance between protecting the public and protecting the rights of those who come under the CLMIA Act.
- That the provision of specialised rehabilitation programs in prison and outside of prison be improved to support the people who may be subject to preventative detention measures, with particular consideration given to ensuring appropriate services for those with an intellectual disability.

- That the need for preventative detention be based on structured clinical judgments, which requires better training for frontline clinical decision makers and the creation of an independent body to facilitate and regulate best-practice in relation to risk-assessment and risk management.
- That the National Disability Insurance Scheme (NDIS) continues to work with the RANZCP and other relevant organisations to ensure that it adequately accounts for people with mental or intellectual impairment in its approach, funding and scope – including consideration of people within the criminal justice system.

People in immigration detention

Amendments to the *Migration Act 1958* be made to bring Australian law into conformity with the demands of justice and of human rights in regard to processing of asylum seeker applications. Specifically:

- Detention of children is a contravention of responsibility under the United Nations Convention on the Rights of the Child and violates children's rights to care in developmentally appropriate environments. The RANZCP opposes the detention of child asylum seekers and families with children and urges the government to immediately remove all families and children from detention.
- The RANZCP opposes the indefinite detention of adults and children with identified cognitive and psychiatric impairment in immigration detention.
- Asylum seeker applications should be processed as fast as reasonably practical possible to minimise risk to mental health and wellbeing.

General concepts

When a person lacks capacity and presents a significant risk they may need to be detained. People with severe psychiatric and/or cognitive impairment are not detained because of their impairments, but because of the risk and lack of capacity. This is usually secondary to the psychiatric or cognitive impairment but it is an important distinction. In all situations of detention, there is a need for a protection of rights of the individual in line with human rights legislation. Anyone in detention for any reason should have processes for appeal and review and their detention should not be 'indefinite'.

People with cognitive and psychiatric impairment in detention should not be subject to punitive responses but instead supported through high quality treatment and management that provides evidence-based, ethical pathways to recovery and development. This promotes self-care and destigmatises mental illness and disability to create a more accepting and equal society. As a general principle, the notion of indefinite detention does not support this.

Recovery-focused treatment is essential to help reduce and limit the number of people with significant mental disorders in indefinite detention, with an increased number of dedicated facilities to meet the needs of this population. These facilities should be culturally appropriate to meet the needs of Aboriginal and Torres Strait Islander peoples, and people from culturally and linguistically diverse backgrounds.

Compliance with Australia's human rights obligations

The decision to detain an individual has the effect of depriving that individual of his or her liberty, and should be subjected to rigorous scrutiny according to rule of law principles, such as access to justice, the right to a fair trial, the prohibition of torture and inhuman and degrading treatment and the right to liberty and security (Charles, 2014).

In regard to human rights obligations international law has developed rapidly in this field, shaping recent Australian Mental Health Acts in many ways, although the Acts continue to show striking differences from one another with room for improvement. The key international documents have been the *UN Principles for the Treatment of Persons with Mental Illness 1991* ('The UN Principles') and the *Convention on the Rights of Persons with Disabilities* ('The Convention'), which entered into force in 2008.

In regard to indefinite detention, there are specific human rights considerations consistent with Article 14 of the Convention, which commits State Parties to ensuring that persons with disabilities '*are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty*' (United Nations General Assembly, 2006).

A key passage is found in United Nations Principle 9.1: 'Every patient shall have the right to be treated in the *least restrictive environment* and with the *least restrictive or intrusive treatment* appropriate to the patient's health needs and the need to protect the physical safety of others.' This provision not only reinforces the aim of providing care in the community, it also directs mental health professionals to use coercive powers and substituted decision-making only as a last resort.

In setting out the issues for particular groups of people in indefinite detention below, the RANZCP makes recommendations relevant to legislation and human rights obligations.

Types of people in indefinite detention

In developing this submission the RANZCP has identified key groups of people who are indefinitely detained and sets out recommendations to improve outcomes for these groups. These are:

- people requiring involuntary commitment and treatment under mental health acts
- people with intellectual and developmental disability
- people within the criminal justice system including specifically:
 - people unfit to stand trial or acquitted on an insanity finding
 - people subject to preventive detention sentences
- people in immigration detention.

Involuntary commitment and treatment under mental health acts and other legislation

Involuntary treatment can be issued to those undergoing inpatient treatment in hospital as well as those on community treatment orders. Involuntary mental health treatment refers to compulsory mental health treatment provided without a person's consent. In Australian jurisdictions, this is provided for under the provisions of mental health legislation which also articulate the principles and safeguards under which involuntary mental health treatment should be administered.

Those within secure inpatient facilities would meet the terms of definition of this inquiry, usually under the relevant mental health act legislation. All mental health acts within Australia express a tension between the contesting values of *autonomy*, and the perceived need for coercion to prevent *danger* or *harm* (to the patient or others) (Fistein, Holland, Clare, & Gunn, 2009). This latter value is normally complemented by provisions that enable coercion to ensure patients receive vital *care* – the *need for treatment* criterion. The clear trend in recent decades has been toward greater emphasis on autonomy and a corresponding erosion in the coercive powers available to psychiatrists. This is in line with human rights legislation.

There is a significant divergence between mental health acts as to the criteria that must be applied before involuntary treatment is enacted. Divergence is not limited to differing criteria; it finds expression

in the frameworks that operate after initial assessment in a mental health facility. Processes which enable the imposition and review of compulsory treatment vary even more between states and jurisdictions than do the criteria themselves, although convergence is starting to occur on this level as well.

In addition to mental health acts, there are many other different legislative provisions that allow for involuntary treatment. For example, in Victoria, in addition to the Mental Health Act 2014, involuntary treatment can also be mandated under the Disability Act 2006, the Guardianship and Administration Act 1986, the Powers of Attorney Act 2014, the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997, the Sex Offenders Registration Amendment Act 2014 and the Severe Substance Dependence Treatment Act 2010. Similar legislative provisions exist in other states and jurisdictions.

The impact of this is that the review mechanisms and protections for the individual vary widely depending on what legislation is used. For example, under the Mental Health Act involuntary treatment is reviewed by a Tribunal with psychiatrist, lawyer and public member. No such review is undertaken under the Guardian and Administration Act and the decision rests with guardian. This means that people receiving involuntary treatment can have wildly different standards of care and protection.

Specific consideration should be given to people with psychiatric and/or cognitive impairment who are detained within secure residential aged care facilities and some 'secure residential' facilities managed by disability services. People in this situation are often detained without any formal consent or review, and sometimes even oppose it.

The new paradigm of supported decision making reflects a central concern of the Convention, which is to 'guarantee the maximum possible collaboration' between clinicians and their patients, while respecting the latter's choices is supported. Increasingly, this places a duty on psychiatrists to carefully identify deficits in capacity and try to overcome these with supports, rather than trying to substitute a decision.

The RANZCP supports recent moves to amend Australian mental health acts to bring them more in line with human rights obligations, and has contributed extensively to recent reviews of the relevant mental health acts (including those in Victoria, Western Australia, and Queensland). The RANZCP supports ongoing review of relevant legislation to ensure compliance with human rights obligations.

Key points that support best practice in this area in regard to indefinite detention include:

- There is a need to take account of the differing requirements for the protection of the rights of people who have some limitations to their capacity, from those who are detained because that detention is about public protection.
- Provisions for people who have limited capacity are required to allow for guardianship supported decision making, including appropriate consent to treatment. Proactive use of Guardianship Tribunal or equivalents should be encouraged, and these should be adequately resourced (currently inadequate resourcing in this area provides a very clear limitation to use).
- Where some form of contained and supervised environment is in keeping with the individual's needs and best interests, then there needs to be a process that independently reviews the ongoing need.
- There should be no provision for arbitrary imposition of indefinite detention as a solution for people who require involuntary treatment. Appropriate review mechanisms and protections must

be in place for the individual. Recovery-focused treatment should be a priority to limit the number of people with a mental illness detained indefinitely.

- There should be appropriate facilities and treatment available to meet the needs of people who require involuntary treatment. This requires adequate number of inpatient facilities, with specific consideration of the needs of different populations who require them – for example residential aged care services should be inclusive of the needs of people with mental illness, including removal of care exclusions in the *Aged Care Act 1997* that are based on the presence of a mental health condition.

People with intellectual and developmental disability

There is a small but significant population of people who present with persistent aggression, antisocial behaviour or in some cases as a risk to themselves. A percentage of this population will also have a disability. In this population the risk is usually secondary to a neurodevelopmental mental disorders which can be characterised as long term, life-long patterns of functioning and include diagnoses such as personality disorder, autism, treatment resistant psychotic disorders, specific learning problems or unspecified behaviour problems. Due to their difficult behaviours, they are often unable to access the normal range of community services available and may be found in a range of settings including prison, mental health facilities and 'secure residential' facilities managed by disability services.

These mental disorders are long term and are resistant to treatment but their impact can be significantly ameliorated with appropriate therapy, careful management of the environment and social interactions.

Disability services are well able to meet their disability needs which are usually very minor, such as help with budgeting, transport and supported accommodation. The antisocial behaviour however cannot be attributed to a disability and should not be seen as an issue for disability services to manage. This behaviour is usually due to a co-morbid mental disorder and many would be identified as having personality disorder or autism, however it is usually just labelled as 'behavioural'. These disorders require a long term therapeutic approach delivered by a highly skilled workforce. This falls well beyond the remit, current scope and capacity of existing disability mental health or justice service systems. The National Disability Insurance Scheme (NDIS) model is based on people receiving funds to access disability services of their choice and will be unlikely to be able to address the problems in managing this population.

A number of difficulties within the current system are encountered. These are explored in a paper highlighting the difficulties the services system in Victoria has in responding to people with intellectual disability (ID) and mental health problems (Bennett, 2014). This highlights that generic services have difficulty responding to the needs of people with dual disability (co-morbid mental disorders in people with intellectual disability) due to a range of patient, professional and service system factors as well as some of the conceptual issues underpinning policy and legislation and indicates the need for service improvement.

Usually this group of people do not have a specific treatable mental illness or treatment that has been optimised and no further improvement is expected and as such would not be seen as clinically appropriate for ongoing mental health services. When admitted to the mental health service system, the staff do not have the resources to manage this population who do not fit into the existing models of care due to their cognitive and communication impairments. The majority of this population do not meet the criteria for detention under mental health legislation as they do not have specific mental illnesses with defined treatments leading to remission and recovery (as described above they have neurodevelopmental mental disorders that are usually persistent and lifelong).

Disability services are able to provide support for the functional deficits but lack the infrastructure to contain and manage difficult or dangerous behaviour. The philosophy of disability services is to support people to lead a normal life and to access normal community facilities; this paradigm is diametrically opposed to the practice of having to restrict a person's freedom to prevent harm. In addition, disability services do not have the range of professional resources to deliver the disorder specific management that this population requires. Currently there are a substantial number of people with disability who are cared for in houses in the community who require constant supervision (often on a 2:1 ratio over 24 hours). Due to their difficult behaviours they are often unable to access the normal range of activities available to people with a disability and are effectively detained in their own homes and are subject to indefinite detention but are less identifiable and visible.

This population often have extensive involvement with the criminal justice system due to their behaviours. However, prisons lack the infrastructure and skill base for managing people with significant communication and cognitive impairments who have complex mental disorders associated with difficult behaviour.

Although living in the community and accessing normal community facilities would remain the long term goal this is not possible when people with significant mental disorders continue to exhibit behaviours that put themselves and others at risk. For this reason a secure model of care is required that has the ability to deliver a range of services 'in house'. These would include therapeutic, educational, (re)-habilitative and recreational services as well as fully supported accommodation. The capacity to contain and manage dangerous behaviours will involve significant restriction of a person's rights and requires appropriate legislative oversight. Delivery of such a model requires a skilled staff group to provide therapy and management based on a theoretical understanding of the underlying mental disorders and would require sufficient numbers of staff and residents to be viable. This model is no longer readily available which is why people in this situation often remain incarcerated in inappropriate settings such as prison, mental health facilities and in restricted residential settings.

Key points that support best practice to provide care for people with intellectual and developmental disability with co-morbid mental disorders who present as a significant risk include:

- Provision of appropriate models of care that have the ability to deliver a range of services 'in house'. These should include therapeutic, educational, (re)-habilitative and recreational services as well as fully supported accommodation.
- Appropriate legislation that allows for the management of people with significant and persistent mental disorders who lack capacity and/or ability to change but present with persistent aggression and antisocial behaviours that put themselves and others at risk.
- The development of appropriate service models to meet the mental health and disability needs of this population in a secure setting.

A further consideration is the needs of people with intellectual disability, including those with comorbid mental disorders, who are within the criminal justice system. Specifically people who, owing to their disability, are considered unfit to stand trial for their offence. There remains concern about the services available to manage this group, as outlined in section 9.1.3. The impact of the National Disability Insurance Scheme (NDIS) is a further issue to consider, as outlined in section 11.

Recommendation:

The RANZCP supports mental health legislation that is compliant with the *UN Principles for the Treatment of Persons with Mental Illness 1991* ('The UN Principles') and the *Convention on the Rights of Persons with Disabilities* ('The Convention') and believes every effort should be made to implement these principles in practice to protect the rights of the individual. This should include adequate provision of mental health services and services that provide care for people with intellectual and developmental disability with or without a comorbid mental disorder including those people who have behaviours that are difficult to manage.

People within the criminal justice system

Incarceration rates in Australia have increased dramatically over the past decade¹ (Australian Bureau of Statistics, 2015). The prevalence of mental disorder amongst those in custody is much higher than it is for the general community, with studies showing the overall prevalence of any mental disorder for those in custody to be 80% (Butler et al., 2006; World Health Organization, 2014). Therefore a large population of individuals with mental disorder are detained in prisons.

There are challenges in meeting the mental health needs of those in custody more generally, and the RANZCP strongly advocates the need for improved provision of mental health services within the criminal justice system generally, and strongly supports adherence to the [National Statement of Principles for Forensic Mental Health](#), endorsed by the Mental Health Standing Committee of the Australian Health Ministers Advisory Committee (Mental Health Standing Committee of the Australian Health Ministers' Advisory Council, 2006).

Key United Nations principles, frameworks and conventions also acknowledge that all individuals have the right to access health care appropriate to their needs irrespective of their legal status. This includes the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991), the Convention on the Rights of Persons with Disabilities (2008), and the Basic Principles for the Treatment of Prisoners (1990) (United Nations General Assembly, 1990, 1991, 2006). This position was also supported through the World Health Organization international statement on prisons and prison health care, made in Trencín, Slovakia, which states '*there must be clear acceptance that penal institutions are seldom, if ever, able to treat and care for seriously and acutely mentally ill prisoners*' (World Health Organization, 2007).

In order for Australia to be compliant with these principles, it is critical that people in prison suffering from mental illness are able to access the same quality of service or treatment as their non-offender counterparts. This is known as the 'principle of equivalence'. Presently both correctional and health agencies can have responsibilities in relation to this population. The differing priorities of these agencies with respect to security and health care can be difficult to reconcile. However, a fundamental principle is that prisons are not hospitals and should never be viewed as such. The risk of not providing an equivalent service to prisoners requiring treatment is well documented through a number of recent Ombudsmen reports and inquests which identified key issues of concern including mentally ill people not being transferred to hospital beds, lack of privacy, inappropriate management in custody, treatment of

¹ In Australia the prison population has increased from 25,400 in 2005 to 36,104 in 2015 in Australia. This demonstrates an increase in incarceration rates of 25% from 155 per 100,000 in 2005 to 196 per 100,000 in 2015. In New Zealand the prison population increased from 6,048 in 2002 to 8,618 in 2012 in New Zealand. This equates to an incarceration rate of 203 per 100,000. In Australia over 25% are Aboriginal and Torres Strait Islander peoples whilst just 3% of the Australian population is Indigenous.

those without capacity, and long waiting lists (Victorian Ombudsman, 2014, 2015; Western Australian Ombudsman, 2000).

As a general concept, there is a need for more and better mental health facilities to support the needs of people within the criminal justice system. This need is paramount in regard to people with cognitive and psychiatric impairment who are subject to indefinite detention. People with cognitive or psychiatric impairment are among the most likely to be detained indefinitely within the criminal justice system. These people are frequently subject to discriminatory treatment, which is incompatible with human rights and has the potential to cause long-term harm.

For the purposes of this inquiry, the RANZCP has focused its attention on two groups of people, subject to indefinite detention, within the criminal justice system:

- people unfit to stand trial or acquitted on an insanity finding
- people subject to preventive detention sentences.

People unfit to stand trial and persons acquitted on an insanity finding

This section concerns people who are insanity acquittees² or who are unfit to stand trial due to mental illness and/or cognitive disability.³ The RANZCP supports the need for improved management and support of people who:

- are insanity acquittees (those found not guilty of an offence by reason of mental illness or cognitive disability), or
- are unfit to stand trial (either permanently or temporarily).

Whilst acknowledging that legislation and terminology differs between Australian jurisdictions and New Zealand, the term 'forensic patient' when referred to in this submission refers specifically to these people.

Legislation allows for the detention of people in secure facilities, and release of persons held in custody because they were unfit for trial or who have been found not guilty by reason of mental illness. There are vast differences in legislation across Australia, which outlines the complexity of the various regimes in place in the Australian jurisdictions, and the potential for highly varying experiences between the Australian states and jurisdictions.

Recommendations:

- The RANZCP supports the insanity defence, the determination of fitness to stand trial, and the principle that those who are found not guilty due to mental illness or not fit to stand trial should not be subject to punishment. The RANZCP supports that the clinical opinion of psychiatrists, and other clinicians involved as appropriate, should be respected in making these determinations.
- Diverting people with cognitive and psychiatric impairment away from the criminal justice system requires improved accessibility and efficacy of treatment for people who are at risk of harm to others. This requires a multifaceted approach which can be achieved through adherence to legal and treatment principles, as outlined in this submission.
- Persons found unfit to stand trial or acquitted on an insanity finding must only be treated in appropriately designated health facilities, outside of prison environments, that are appropriate to

² Persons found not guilty due to mental illness or mental impairment, or found of unsound mind in relation to an offence

³ Cognitive disability includes intellectual disability, acquired brain injury, and other organic brain syndromes.

individual clinical and risk management needs. They must not be treated as convicted criminals for that offence. A key principle is that prisons are not hospitals and should never be viewed as such. This is consistent with Article 14 of the Convention and commensurate with section 82(1) of the United Nations standard minimum rules for the treatment of prisoners which states that 'persons who are found to be insane shall not be detained in prisons and arrangements shall be made to remove them to mental institutions as soon as possible' (First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, 1955).

- Across Australia, a variety of legislative tests exist to establish whether defendants are unfit to stand trial. A number of law reform proposals have been considered – most notably, approaches that would align fitness tests with the current approach to assessing decision-making capacity. The RANZCP considers it appropriate that reform proposals be considered to determine how to better incorporate a modern test of decision-making capacity into the fitness to plead determination.

Treatment and support

Rules that govern the imprisonment and release of convicted criminals should not be applied to forensic patients (as previously defined to be those who are insanity acquittees or unfit to stand trial).

Those whose mental impairment is so significant that they are not considered responsible for their actions are seriously unwell and should be admitted to an appropriate facility. Those unfit for trial due to mental illness should be placed in a psychiatric hospital for treatment, and this would include people with cognitive impairment and mental illness. Those unfit due to a cognitive or other developmental disability, should be placed in a designated facility to receive appropriate support, supervision and management although these do not currently exist.

The RANZCP supports the implementation of these principles across all Australian states and jurisdictions.

Forensic patients must receive equity of access to health care and legal representation

- Forensic patients must be able to access an equivalent quality of service or treatment as their non-offender or convicted offender counterparts irrespective of their placement. The range of treatment and interventions available and the qualifications and experience of the mental health staff must be at least congruent with that available in the general community. This is known as the 'principle of equivalence'.
- The capacity or right to consent is not forfeited simply due to a history of offending or forensic patient status.
- All forensic patients must have their civil rights protected equivalent to that other persons. They must have access to competent legal representation as required.
- Health care should be provided based on the individual forensic patient taking into account biological, psychosocial and cultural factors. Individualised care includes facilitated access, assessment and unimpeded treatment including the involvement of significant others in treatment, support and care.

Forensic patients must be managed by mental health services not correctional services

- Once a legal decision is made placing a person in the forensic patients category (as defined in this submission), the person must be immediately released from prison/custody and transferred to an appropriate health/care facility.

- Forensic patients must be managed by dedicated mental health services and not by correctional or custodial services.
- People with developmental disability and co-morbid mental disorder with forensic issues would best be managed by a specialist mental health service.
- Mental health services for forensic patients must be staffed by mental health personnel employed by a health service. Specialist inpatient forensic mental health services (secure facilities) should be owned, funded and staffed by the jurisdictional health directorate, preferably co-located with other health services. Security staff, where required, should be employed by health services. The mental health service must be beyond the geographic boundary of a prison and be run independently from any correctional service. Correctional agencies must not be involved in forensic patient management.

Decision regarding detention, release of transfer must be made by courts or independent statutory bodies

- Decisions to detain, release or transfer mentally ill forensic patients must be made by courts, tribunals or independent statutory bodies of competent jurisdiction, not by political processes or the Governor/Administrator in Council.
- Decisions to detain, release or transfer mentally ill forensic patients must be appealable (to a higher court) with appeals being easily accessible to all parties including the forensic patient.
- Judicial and Mental Health Review Tribunal hearings which determine detention, transfer, release and discharge must be transparent, accountable and accessible to families, carers, victims and appropriate support services. These decisions should only be made in accordance with applicable legislation and legal principles, on the advice of suitably qualified mental health practitioners.
- In relation to any court or tribunal hearing, forensic patients must be afforded the same level of confidentiality of clinical information as other mental health patients.
- There should be consistent cross-border agreements between states and territories with respect to management of forensic patients to allow for planned movements of patients.

Treatment must be in the least restrictive environment appropriate, consistent with individual circumstances and the safety of the community

- The public and, in particular, victims are entitled to demand accountability from the system charged with the task of rehabilitating forensic patients, but they do not have the right to stipulate punishments or excessively restrictive treatment in hospital or the community.
- Treatment should be in the least restrictive environment appropriate, consistent with individual circumstances and the safety of the community. Inpatient care is not mandatory. The Victorian Law Commission stated that “*the ‘principle of least restriction’ is an important feature of mental health and disability law both in Australia and overseas*” and “*the principle of least restriction is fundamental to considering the protection of the community, as the rehabilitation of people through successful community reintegration is the best way to ensure protection of the community, as well as restoring the person to a state in which they can be a functioning member of the community*” (Victorian Law Reform Commission, 2014). Discharge from hospital is an important rehabilitative step and must be enabled when residual risk can be safely managed in the community.
- Where inpatient treatment is deemed necessary, forensic patients should be released in accordance with clinical recovery and reduction of risk rather than after a period of detention proportional to the severity of any offending. Arbitrary timeframes for the inpatient phase of rehabilitation of forensic patients are not justified by the relative low rates of criminal recidivism following release (Skipworth,

Brinded, Chaplow, & Frampton, 2006). Timeframes of inpatient treatment must not be longer than necessary to assess, treat, and manage clinical issues and ensure that risk can be properly managed.

- Forensic patients must not be subject to longer periods of confinement than their non-offender counterparts based purely on their forensic status. Forensic patients must not be subject to greater restrictions than their equivalent convicted offenders beyond the least restrictive measures necessary to manage risk, including supervisory measures in the community. Any period of confinement must be based on clinical need rather than lack of resources, for example lack of placement in transitional or community housing.
- Treatment decisions must remain the responsibility of the treating psychiatrist. Courts or tribunals must not 'order' specific intervention programs but should be able to recommend any specific treatments suggested by the treating or assessing psychiatrists. It is important to acknowledge that the patient's diagnosis and treatment needs may change over time in a therapeutic context and that treatment recommendations made at the time of the hearing may no longer be required after a period of time. Mental health treatment recommendations made by courts and tribunals must be available at no cost to the patient.

The level of security required for any individual should be based on a valid professional risk assessment

- Forensic mental health services are dually tasked with facilitating patient recovery and protecting the public. The level of security required for any individual should be related to the person's treatment needs as well as consideration for safety of the community, based on valid professional risk assessment.
- Restraint and/or seclusion is an intervention, not a treatment, and should only be used as a safety measure of last resort where all other interventions have been tried, considered and/or excluded. Seclusion and restraint must never be used as a method of punishment.
- Enforcement of electronic global positioning system (GPS) monitoring (also known as 'tagging'), upon a forensic patient is unethical, is not a substitute for proper treatment, and is a contravention of human rights, in particular Article 14 of the Convention. The use of such devices is unnecessary and ineffective in reducing the risk of reoffending. Such devices are highly stigmatising and counterproductive in building therapeutic relationships, which foster disclosure by patients and establish trust which are critically important for promoting recovery, rehabilitation and risk management (Simpson, 2012). Of further concern is that that tags will be imposed on patients who would not previously have been required to wear them, or be viewed as a substitute for proper clinical supervision and monitoring.
- Where legislation allows for specific monitoring, any order for this must be made and reviewed by a Mental Health Court or Mental Health Review Tribunal. Monitoring may be considered where two independent psychiatrists recommend such monitoring. This would be part of a comprehensive individualised risk assessment and management plan, not as an alternative to proper treatment. Patients subject to an application to apply GPS monitoring must be afforded legal representation at no cost to the patient.
- Forensic patients must never be automatically placed on a Child Protection Register or Sex Offender Register. Where this is a consideration having regard to the nature of the offence/offences resulting in the person becoming a forensic patient, a formal application should be made to a court to determine the need for that person to be placed on such a register.

Rehabilitation and effective treatment is required to decrease recidivism

- Effective treatment of mental illness is the best method to decrease recidivism in mentally ill offenders.
- Forensic mental health services must promote positive mental health and minimise negative impacts on patient's mental health. Services are responsible for supporting mental health within the constraints of needing to maintain a secure and safe environment. Patients need to be involved, to the full extent of their capabilities and without discrimination, in educational, occupational and rehabilitation activities available.
- There must be access to acute interventions including treatment directed to alcohol and substance dependence, and to psychosocial rehabilitation and pre-release planning, in order to minimise the acute effects of illness and longer-term disability. Provision of support to links with community services at the point of release reduces the risk of relapse of illness and will likely reduce recidivism risk.
- There must be access to appropriate facilities to provide for people with cognitive impairment and other developmental disabilities who may require different models of care.
- Ongoing research to review the effectiveness of treatment programs in rehabilitating forensic patients, including an increased understanding of reoffending rates, is needed to inform policy in respect of public accountability and to influence public attitudes.

Legislative variation

Legislation and regulatory frameworks that enable the detention of individuals who have been declared mentally-impaired or unfit to plead is complex and varies significantly between each Australian jurisdiction. In many instances, there are a number of Acts that can be referred to that allow for the detention of forensic patients in secure facilities (for example, in Tasmania there are up to nine Acts which can apply).

There is an extraordinary lack of uniformity of approach to the management of forensic patients – across the nine Australian jurisdictions, there are very different approaches to the same issue. The release criteria frequently differ, and vary in their consideration and application of limiting terms, whether sufficient custody has been considered, the principle of least restriction, and the extent to which the victim is involved.

For example, in Queensland, the Mental Health Court (the MHC) – which is a branch of the Supreme Court - deals with people charged with serious offences and found to be suffering from mental disorders. The MHC has inquisitorial powers. If a person referred is found to be of unsound mind at the time of the alleged offence(s) or permanently unfit for trial then the MHC makes a determination about the person, and can make forensic, custody, detention, non-contact and other orders.

Persons who are found to have unsoundness of mind in relation to an alleged offence or who are found permanently unfit for trial may be placed on a Forensic Order which mandates close psychiatric follow-up and regular reviews by a Mental Health Review Tribunal. The orders made by the MHC vary widely, according to the nature of the alleged offence, the mental state of the person and their response to treatment, and their assessed risk of reoffending. Thus, the MHC has considerable flexibility.

In South Australia if people are found not guilty by reason of mental impairment (which includes intellectual disability) or not fit to plead/stand trial, they become subject to a period of supervision that lasts the equivalent length of time they would have received if they were convicted. The court then has the option to commit the person to detention to secure hospital or release on licence. If people are

committed to detention, they need to apply to the court for release on licence. This can be done at any time unless the person has been previously turned down in which case they have to wait six months before reapplying. There is no automatic review of a person's detention although an annual report has to be submitted to the court by the treating team.

Many patients in South Australia therefore do not come under the inquiry definition of indefinite detention as they will have an end date to their period of supervision even if this extends for many years. However, they could, in theory, end up detained indefinitely for the entire period without any hearing to review their detention. On the other hand, patients who commit a serious offence such as homicide will end up under supervision for life, and are likely to be committed to detention, and therefore do meet the definition for indefinite detention.

Whilst the legislative criteria and provisions are always likely to differ as long as each jurisdiction maintains its own laws, it is the view of the RANZCP that by applying the principles as listed in section 9.1.1 above that many of these variances will be reduced and support the move towards meeting human rights obligations. The RANZCP recommends that, in future reviews of legislation, these factors be taken into account.

Available facilities and advocacy

As a general issue there is concern that the principle of reciprocity is often overlooked, i.e. curtailment of individual liberties should be matched by providing adequate interventions and resources to assist in rehabilitation/long term care. There are marked differences in the availability of community facilities across the jurisdictions; generally they are inadequate, but they are certainly better in some jurisdictions than in others, for example the Forensicare model in Victoria. It is important to ensure that there are sufficient community facilities to manage persons who are in all other respects qualified for release from forensic custody, particularly given that the availability of suitable facilities is frequently a consideration in the decision to release.

It is important that, in considering what facilities are required, to take account of the needs of the individual people concerned. For example, in relation to older persons, it may be common to order that they remain with their family (e.g. if that level of supervision will contain the risk to others), that they be admitted to an acute psychiatric facility for further treatment (e.g. if they remain psychotic), that they be admitted to a nursing home (e.g. if they have dementia), or that they be admitted to a forensic hospital (e.g. if they are considered dangerous to others). As always, treatment should be in line with the principle of least restriction.

The situation for patients with an intellectual disability is often complicated by the wording of the legislation and the approach of disability services. As an example from South Australia and Victoria, disability services often can only offer support to clients on a voluntary basis and cannot have any coercive/supervisory role. It is difficult to see how the National Disability Insurance Scheme (NDIS) would fund such a role. Any individual who is unfit and subject to supervision is therefore outside the model of care and, further, setting up appropriate levels of care and services in the community is difficult. This greatly extends the length of time patients with an intellectual disability need to spend in detention. This problem is exacerbated by the wording of the legislation. 'Health', 'Mental Health' and 'Disabilities' (including intellectual disability) and 'Justice' are all separate government departments.

If a person is found incompetent or unfit the legislation places them under the supervision of the Minister of Mental Health even if the cause of their being unfit or incompetent is an intellectual disability. This means that these people often end up as inpatients at forensic mental health facilities. Often it is inappropriate to place these people in the community because they continue to present with antisocial behaviour. If antisocial behaviours are not present then it is possible that they can be placed community

facilities which are available, however these are in short supply. Whilst disability services are able to manage the disability, antisocial behaviours require further engagement with services designed to support them (see section 8 for further information).

Lack of appropriate services means that there is inadequate care for those who are forensic and committed to detention. So if a patient had a life supervision order (i.e. indefinite detention) they could expect to be stuck in a secure hospital for years with few alternative options to accommodate them. For example, members in South Australia have stated that, in practice, it is very hard to find services for patients with an intellectual disability while they are inpatients at James Nash House (the forensic mental health facility in South Australia). As they approach the end of their supervision, there is often an issue as that is when disability services are required to take responsibility again and there is a need to consider what services are available and appropriate. Frequently, as no such services exist, patients are detained indefinitely.

Advocacy is limited. Officially appointed guardians seem to lack the powers, resources and time needed to effectively intervene on the behalf of patients with an intellectual disability. More general advocacy services such as the Community Visitor Scheme do not appear to have the capacity to provide services to people with an intellectual disability in this situation. This is because they usually have to focus their scarcely available time on issues concerning day-to-day hospital management rather than advocating about broader issues such as excessive detention, which may be considered secondary to a lack of adequate community resources. Of further concern is that the NDIS will be reliant on users applying for funding which will exacerbate the difficulties described above, and reduce access further to those who are with the system of forensic mental health services.

It is also noted that there is a lack of appropriate experts who can fully assess and manage forensic patients, including intellectually disabled forensic patients with or without comorbid mental illness given the complexity of the area.

Recommendation:

- Curtailment of individual liberties should be matched by providing adequate interventions and resources to assist in rehabilitation/long term care. Improved and better resourced advocacy for people within the criminal justice system and increased forensic mental health workforce is required to improve outcomes.

Legislative concerns specific to Western Australia

Whilst the RANZCP has ongoing concerns about the treatment of people in indefinite detention throughout Australia, the RANZCP is gravely concerned about the system in Western Australia for the indefinite detention of people with mental illness and/or cognitive impairment found not guilty by reason of unsoundness of mind and those found unfit to stand trial. This is the only state remaining that uses the executive release model, which results in particular concerns in respect of human rights.

The two most pressing issues are the legislation itself and the lack of resources to develop services that meet the needs of this group. The WA legislation - the *Criminal Law Mentally Impaired Accused Act 1996* (the CLMIA Act) - effectively criminalises the mentally ill and those with cognitive impairment by detaining them indefinitely, usually in prison, and discriminates against them by giving them fewer rights than other people with mental disorders and other defendants. In the RANZCP's view, it does not protect society either as it is underused because it is so flawed. This means many people with serious mental and cognitive impairment go through the prison system untreated. There is also a serious lack of forensic psychiatric hospital beds and appropriate placements for people with cognitive impairment to be treated.

The CLMIA Act outlines the procedures to be followed against people who are found not guilty by reason of unsoundness of mind or unfit to stand trial. They may be suffering from mental illness or cognitive impairment.

If people are found unfit to stand trial and are likely to remain so for more than six months the court has only two options: to release them unconditionally or to impose a custody order which leads to indefinite detention in a prison, a juvenile detention centre, an authorised hospital, or a disability justice centre. If they are found unfit to stand trial and made subject to indefinite detention by way of a custody order, there is no trial and no testing of the facts as to whether they committed the act that they are accused of or not. This can lead to them spending many years in prison for a crime they did not commit.

In the case of people found not guilty by reason of unsoundness of mind, the court must be satisfied beyond reasonable doubt that the person committed the acts of the offence. The court has three options in cases of not guilty by reason of unsoundness of mind: a custody order (i.e. indefinite detention in a prison, a juvenile detention centre, an authorised hospital or a disability justice centre); unconditional release; or a community based sentence under the *Sentencing Act 1995*. However there are a number of offences for which a custody order is mandatory regardless of the persons' clinical state or risk at the time of the court hearing.

People detained on custody orders can be placed in an authorised hospital if they have a treatable mental illness. However this is dependent on availability of beds. There are 30 secure and 8 open forensic inpatient hospital beds in WA, the same numbers as in 1995 when the prison population was 2197. These beds now serve double the prison population which is about 5000. The lack of beds was highlighted in the Stokes Inquiry into mental health services in WA, by the Mentally Impaired Accused Review Board in their annual reports and by the Office of the Inspector of Custodial Services (Mentally Impaired Accused Review Board, 2013; Office of the Inspector of Custodial Services, 2014; Stokes, 2012). The Western Australian Mental health, Alcohol and Other Drug Services Plan 2015-2025 estimated that the number of forensic beds was less than half those needed to meet demand in 2014 (Government of Western Australia, 2014). There are currently no dedicated secure inpatient beds for adolescents or for women. There is also a paucity of community accommodation and services for managing people in the community which leads to people being detained far longer than they need.

Until recently there was no alternative to prison for those detained on custody orders with a cognitive impairment. However a disability justice centre has now been opened to provide an alternative to prison.

Nonetheless a significant proportion of those on custody orders with mental illness and those with cognitive impairment are detained indefinitely in prison. The Mentally Impaired Accused Review Board reported that on 30 June 2015, 15 people detained on custody orders were detained in prison compared with 6 in an authorised hospital and none in a declared place (disability justice centres) and 19 in the community (Mentally Impaired Accused Review Board, 2015)

Not only is indefinite detention of people found not guilty by reason of unsoundness of mind in direct contravention of the United Nations Standard Minimum Rules of the Treatment of Prisoners and international standards for the treatment of people with mental illness and disability; but it prevents them from accessing the necessary multidisciplinary specialist rehabilitation they need to reduce risk, improve their mental health and help them return to productive community life. The Office of Inspector of Custodial Services in WA highlighted the fact that the Department of Corrective Services in WA did not have a specific policy for managing people in prison detained under the CLMIA Act to plan their care and treatment, manage challenging behaviour, initiate leave of absence, develop release plans and provide appropriate programs (Mentally Impaired Accused Review Board, 2013). They found that people

detained in prison were less likely to progress towards conditional or unconditional release than those in hospital.

People detained on custody orders are reviewed regularly by the Mentally Impaired Accused Review Board (the Board) but they have limited decision making authority. Decisions about leaves of absence and conditional and unconditional release all require approval from the Governor based on recommendations of the Attorney General. Both the Office of the Inspector of Custodial Services (OICS) and a review of the WA legislation expressed concerns about this arrangement.

The OICS report (OICS, 2014) drew attention to the review of Chapter 5 of the Mental health Act 1990 (NSW) as it related to forensic patients and related matters arising from the Mental Health (Criminal Procedures) Act 1990 in New South Wales (James, 2007) which described the executive discretion process in the following way:

The present system of exercise of Executive discretion for decisions on the care, detention, treatment, leave of absence and release of forensic patients:

- *Results in the detention of unconvicted patients in jail so long that in many cases that detention extends longer than public safety would require and also longer than any sentence which would have been imposed had the patient been convicted and sentenced.*
- *Such detention often extends longer than required by any clinical necessity for treatment which can often be safely and effectively given by existing Health Department agencies in the community.*
- *The system is cumbersome, lengthy, overly bureaucratic, resource intensive, operates without transparency or accountability, without conformity to the general principles of mental health legislation, and is liable to administrative challenge.*
- *It has been the subject of widespread criticism. It is out of accord with other systems for care and treatment of forensic patients in Australia and elsewhere.*
- *It is counterproductive to appropriate detection and treatment of those with mental illness coming into the justice system.*
- *The system presents difficulties for patients, families, carers and victims who need a formal transparent process in which to express their views and concerns. The present process can be anti-therapeutic for patients and distressing for other affected persons (James, 2007).*

This sums up the position in WA currently. There are too many competing political interests to allow the executive to be able to make impartial and timely decisions based on the principles of the CLMIA Act. The decision should lie with either the Board, a specialised mental health court or a Mental Health Review Board. The NSW review contributed to changes that led to the Mental Health Review Tribunal replacing the governor as the determining authority for release of mentally impaired accused in NSW.

Similar systems work effectively, including Mental Health Review Boards, and the role of the courts in considering release decisions for Dangerous Sex Offenders. All other states have removed or greatly reduced the executive discretion components of the decision making power and given it to a judicial body. This has not led to an increase in adverse events and has improved the systems and their operation and reduced delays in decision making.

There are no principles set out in the CLMIA Act to explain why WA has a special law for people with mental disorder who offend. The reason that such laws exist are in recognition of the fact that people with mental disorder may be vulnerable within the criminal justice system and need protection to ensure a fair trial. There is also recognition that they may be less culpable as a result of their mental disorder;

and that rehabilitative approaches to sentencing may be more effective, compared with retributive. All this needs to be balanced with the need to protect the community.

The current CLMIA Act and its operation are not consistent with these principles. In particular it is not consistent with principles adopted in other states such as Victoria, nor those suggested in WA by the Holman review of the CLMIA Act: such as not being punished if they are not held criminally responsible; having access to gradual reintegration; procedural fairness, open and transparent decision making and rights of appeal; principal of equivalence of care and least restrictive alternative.

People detained under the CLMIA Act have no rights to appear before the Board and no rights of appeal against their recommendations or the decisions of the Governor. They are often held in much higher security than is necessary for the risk they pose and for far longer than people who have been found guilty of a similar offence. Notions of punishment such as time served seep into decisions about release

As a result of the fundamental problems with the CLMIA Act and the lack of resources to increase the number of beds, very few people are found unfit to stand trial or not guilty by reason of unsoundness of mind. Board figures show that since 2010 only 11 custody orders have been made (an average of two custody orders per year). Of those only four were detained in hospital; five detained in dual place (either prison or hospital, which means predominantly prison in practice) and four in prison (Mentally Impaired Accused Review Board, 2015). In the last five years, one person has been released from a custody order. This is in stark contrast to other states where significantly more people are found not guilty by reason of mental impairment or unfit to stand trial.

Recent research in WA found very high rates of mental illness in people coming into prison with 20% of women and 13% of men having a severe mental disorder in the form of schizophrenia or other psychotic illness (Davison et al., 2015). Nearly a third of women and 18% of men had previously been inpatients on a psychiatric unit. This suggests that there are many people within the prison system with severe mental illness and with cognitive impairment. Some may not be fit to stand trial and some may have fulfilled the criteria for not guilty by reason of unsoundness of mind. Being managed in prison does not meet their rehabilitation needs and may increase risk as they do not have access to graded rehabilitation into the community.

Recommendations:

- A review of the CLMIA Act to produce legislation that that is in line with national and international standards of care for people with mental illness and cognitive disability, whilst ensuring the best possible balance between protecting the public and protecting the rights of those who come under the CLMIA Act.
- Sufficient resources to increase the number of forensic mental health inpatient beds and places for people with cognitive impairment to be managed and treated so they are not in prison.
- The urgent service developments needed to improve the effective and safe care and management of people who come under the CLMIA Act are: increasing the number of secure inpatient psychiatric beds, developing a secure forensic unit for adolescents, developing safe and therapeutic declared places for people with cognitive disability and developing improved community accommodation, treatment, supervision and support options. This will help prevent the indefinite detention of people found not fit to stand trial or not guilty by reason of unsoundness of mind in prison and reduce unnecessarily lengthy detention in hospitals or declared places.

Further information about the concerns in Western Australia can be read in the RANZCP Western Australia Branch submissions in regard to the [Review of the Criminal Law Mentally Impaired Accused Act 1996 \(May 2013\)](#) and the [Criminal Law \(Mentally Impaired Accused\) Act 1996 \(the 'CLMIA Act'\) Discussion Paper \(December 2014\)](#).

Assessing people with cognitive and psychiatric impairment: fitness to stand trial and mental capacity

Notwithstanding some differences in legislation and terminology, the insanity defence in all Australian jurisdictions requires evidence of mental impairment, causing the person to have difficulty understanding the nature and quality of their actions, or knowing that their actions were wrong (Allnutt, Samuels, & O'Driscoll, 2007).

It is a fundamental legal principle that if a person was of unsound mind at the time of an alleged offence, the person is not criminally responsible for the offence and should not be punished for the offence. This is known as an insanity defence based on the M'Naghten Rules (Allnutt et al., 2007). Further, a person who is found unfit to be tried for an alleged offence (either temporarily or permanently), is by definition, unable to participate in their defence and was not convicted, and thus should not be punished for the alleged offence.

Pivotal to the insanity defence in all jurisdictions is the presence of a mental condition. It is this criterion that leads the courts to consult with psychiatrists and sometimes other mental health professionals, with the caveat that what constitutes a mental condition in the insanity defence is not necessarily a medical or psychiatric diagnosis but a legal conception (Spencer & Tie, 2013).

Psychiatrists, particularly forensic psychiatrists, have a central role to play in addressing issues relevant to the M'Naghten Rules and fitness to stand trial and making these accessible and comprehensible to courts and jurors (Allnutt et al., 2007), including being specific about how patient's symptoms linked to deprivation of capacity. It is not unusual for an expert to be of the opinion that the defendant was mentally incompetent at the time of the offence and also mentally unfit to stand trial at the time of trial.

Across Australia, a variety of legislative tests exist to establish whether defendants are unfit to stand trial. These tests are grounded in longstanding common law authority which has been criticised as establishing an 'unduly narrow test of a defendant's intellectual abilities' (Brookbanks & Mackay, 2010). A number of law reform proposals have been considered – most notably, approaches that would align fitness tests with the current approach to assessing decision-making capacity.

Broadly speaking, Australia continues to follow the approach set out in *Pritchard*⁴ and developed in *Presser*.⁵ The *Pritchard* test establishes basic requirements (ability to *plead* and *comprehend the proceedings so as to make a proper defence*) and the seven '*Presser* criteria' are as follows; if the accused is unable to do perform one or more of the following tasks, he or she is unfit to stand trial:

1. Understand the charge
2. Plead to the charge and exercise the right to challenge jurors
3. Understand generally, the nature of proceedings (that it is an inquiry) as to whether the accused person did what they are charged with
4. Follow the course of proceedings
5. Understand the substantial effect of any evidence that might be used against them
6. Make their defence or answer the charge; or

⁴ *R v Pritchard* (1836) 173 ER 135.

⁵ *R v Presser* [1958] VR 45.

7. Give any necessary instructions to their legal counsel.

The essential elements of this test are found in Acts across all but three of the jurisdictions (although Victoria, the Northern Territory, the ACT and Tasmania also note that memory loss is not enough to establish unfitness).⁶ NSW and the Commonwealth have not legislated the test, and so rely on the common law (NSW Law Reform Commission, 2013) while Queensland has enacted a minimal test that still allows for the operation of the common law. Further there is common law (case law) provision that takes into account whether the accused's mental state will deteriorate by the time of the trial, or during the length of the trial. In *Kesavarajah v R* (1994) 181 CLR 230, the Australian High Court endorsed *Presser* and added a refinement that the court should have regard to the length of the trial, given that an accused's fitness may vary through the trial.

As the Australian Law Reform Commission observed:

'The common law test of unfitness to stand trial has been criticised in a number of recent inquiries in Australia and overseas. In particular, the common law may place an undue emphasis on a person's intellectual ability to understand specific aspects of the legal proceedings and trial process, and too little emphasis on a person's decision-making ability' (Australian Law Reform Commission, 2014).

This statement echoes calls from law reform bodies in Victoria (Victorian Law Commission, 2014) and The Law Commission (England and Wales) that 'Incapacity...may arise from an inability to use of negotiate information that has been understood' (The Law Commission, 2010).

This affirms the widespread belief among forensic psychiatrists that many mentally ill defendants in the current system may not be receiving a fair trial. The test is best suited to measuring intellectual deficiency, but psychotic conditions like schizophrenia are not usually associated with such deficiency, even though they present obvious challenges to the conduct of a defence (Brookbanks & Mackay, 2010).

The current tests also fail to take into account the ability to give evidence, or the fact that 'fitness' in this context may fluctuate by the time of the trial, or the widespread inconsistency in assessments by psychiatrists applying the criteria. This point is addressed by Dr Russ Scott, in a detailed paper on the need for a new test in Queensland where he observed that 'Lack of a clearer standard for determining fitness may...result in imprecise and idiosyncratic practices developing' (Scott, 2007).

The role of support in this context is likely to affect fitness assessments, and its provision would meet the duty set out in Article 12 of the Convention to ensure equal legal capacity by providing necessary assistance. Dr Stewart et.al surveyed Australian law regarding persons who may assist vulnerable witnesses and defendants in the courtroom (Stewart, Woodward, & Hepner, 2015). Such law is sparse and insufficient (for instance, it may allow support persons to be present in the courtroom but not to speak) or underutilised (such as courts using their powers to modify their own procedures). England and Wales, by contrast, has adopted a system of *Registered Intermediaries* to actively facilitate communication with young witnesses who are vulnerable on account of 'mental disorder or impairment of intelligence and social functioning or physical disability/disorder' (Stewart et al., 2015), quoting from the *Youth Justice and Criminal Evidence Act 1999* (UK).

⁶ *Crimes Act 1900* (ACT) s 311; *Criminal Code* (NT) s 43J; *Criminal Law Consolidation Act 1935* (SA) s 269H; *Criminal Justice (Mental Impairment) Act 1999* (Tas) s 8; *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 6(1); *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 9

Stewart sets out that UK courts have considered such support for defendants:

‘Plainly consideration should be given to the use of these powers or other ways in which the characteristics of a defendant evident from a psychological or psychiatric report can be accommodated with the trial process so that his limitations can be understood by the jury, before a court takes the very significant step of embarking on a trial of fitness to plead.’

Various reform proposals have been suggested in order to incorporate a modern test of decision-making capacity into the fitness determination. Brookbanks et al. note there is a ‘yawning gap’ between the old fitness tests and current medical knowledge, which may amount to discrimination, however there are also challenges that this model would present’ (Peay, 2010). A further observation is that the test is not always rigorously applied by psychiatrists and psychologists who write reports but who may not have adequate forensic training. There are a considerable numbers of individuals are found not fit to plead when this is may not always be appropriate.

Recommendations:

- That further consideration be given to law reform proposals to determine how to better incorporate a modern test of decision-making capacity into the fitness to plead determination.
- That the psychiatrists and other clinicians involved in making determinations of fitness to plead should have adequate formal forensic mental health training, to ensure that decisions are rigorous and respected.

Continued and preventive detention

For over a century, courts have possessed the power to impose indefinite detention at the time of sentencing, although the use of this power has gone in and out of favour depending on prevailing attitudes to law and order (Keyzer & McSherry, 2015). The power has recently been supplemented by preventive detention schemes which allow courts to impose restraints at the end of an offender’s prison sentence (Tulich, 2015).

The restraints may amount to a substantial extra term spent in prison or subject to heavily supervised and conditioned release into the community. Preventive detention schemes rely on forensic psychiatrists to craft accurate risk assessments and effective rehabilitation, but the penal context also makes these tasks more challenging in several ways. Instead of detailing and contrasting the varied legislative provisions that apply, an attempt is made to highlight complications that clinicians face in this context when addressing *risk* and *rehabilitation*.

When an offender in Queensland convicted of a serious sexual offence has entered the last six months of their prison term, the Attorney-General may apply to the Supreme Court for an order or orders available under the *Dangerous Prisoners (Sexual Offenders) Act 2003* (Qld) (DPSOA).⁷ If the court is satisfied that the prisoner is a serious danger to the community, it can make a *continuing detention order* (which allows an indefinite term of custody) or a *supervision order* (which allows for release subject to conditions).⁸ The court may require two psychiatrists to independently examine the offender and assess the risk that they will commit another serious sexual offence.⁹ These reports must be considered, along

⁷ *Dangerous Prisoners (Sexual Offenders) Act 2003* (Qld) s5.

⁸ *Ibid*: s13 (5).

⁹ *Ibid*: ss8, 9 and 11.

with the degree to which the prisoner cooperated with the assessment, the prisoner's efforts to address the causes of their behaviour through rehabilitation and the like, and a range of other factors.¹⁰ The paramount concern of the court must be protection of the community,¹¹ but the DPSOA also aims to provide the control, care or treatment needed to facilitate rehabilitation.¹²

After the DPSOA survived a High Court challenge to its constitutionality,¹³ similar legislation was introduced in Western Australia, New South Wales, Victoria and the Northern Territory (Keyzer & McSherry, 2015). These Acts are closely modelled on High Court authority that indefinite detention for a criminal offence is only lawful where 'adequate and complete' psychological reports are provided (Smith, 2008). New South Wales has since extended the reach of the Act to encompass 'high-risk violent offenders' as well (Keyzer & McSherry, 2015).

Sentencing Councils in Victoria and NSW have considered these laws and identified problems with the risk assessment provisions (but also some possible solutions, discussed below). The NSW body has noted that the reoffending risks of violent offenders are particularly hard to assess, given the great diversity of violent offences and the people who commit them (when compared to sex crimes and sex offenders) (Tulich, 2015).

As noted in a discussion paper by the Victorian body, which opposed the introduction of preventive detention orders, 'a defensible continuing detention scheme depends on the accurate and reliable assessment of an individual's risk of reoffending. But risk assessment is notoriously difficult and fraught' (Victorian Sentencing Advisory Council, 2007). The paper notes dilemmas at various stages of the process here; a risk assessment in the absence of a therapeutic relationship may fail to grasp the offender's situation, while an assessment by a treating doctor risks discouraging the honest engagement by offenders that effective therapy requires.

According to Geoffrey Smith, writing in 2008, these concerns have not been borne out by the Queensland experience. Few orders have been breached and no released prisoner is known to have committed a serious sexual offence. Multi-instrumentation and targeted instrumentation strategies by psychiatrists coupled with sound use of opinion evidence by judges have combined to minimise unjust outcomes (Smith, 2008). The paper goes on to discuss the progressive development of favoured tools from clinical prediction to actuarial risk assessments to structured clinical judgments – the last being 83% accurate according to one study. It is important to note however that structured clinical judgments tools are not designed for prediction but to inform management. It is still not possible to predict accurately, and research looking at their predictive powers are purely to validate the risk factors that are taken into account.

The NSW Sentencing Council favourably cited Drs Ogloff and Davis in regard to the efficacy of this last technique, noting that it aids not only risk assessment but risk *management*. The Council went on to accept the view of Professor McSherry that frontline clinical decision makers need better training to apply these tools, and urged the creation of an independent body to 'facilitate and regulate best-practice in relation to risk-assessment and risk management. This body would draw on the experience of the Scottish Risk Management Authority, crafting guidelines, researching and validating new tools to assess and manage risk, as well as training and validating practitioners (NSW Sentencing Council, 2012).

¹⁰ Ibid: s13 (4).

¹¹ Ibid: s6 (a).

¹² Ibid: s3 (b).

¹³ *Fardon v Attorney-General (Qld)* (2004) HCA 46.

This approach has received support from Keyzer and McSherry, among others, although it would be resource intensive. With this point in mind, the Victorian Sentencing Advisory Council has instead recommended that a single experienced clinician act as a Risk Management Monitor with similar powers, as well as an additional power to inspect documents, premises and treatment interventions.

The combined approach to assessment and management of risks may enable more effective rehabilitation strategies to be pursued, thus serving therapeutic goals and the secondary aims of preventive detention legislation. The NSW Sentencing Council observed that one of the difficulties of attempting to predict recidivism is that new, more effective treatments may emerge to address the offending behaviour (NSW Sentencing Council, 2012).

Recent work by Keyzer and McSherry has drawn on extensive interviews with police, corrections officers, lawyers, mental health professionals and others to explore the operation of preventive detention schemes in several Australian jurisdictions. The lack of specialised rehabilitation programs in prison was a serious concern that emerged, as was the dearth of such programs altogether outside of prison. This has obvious therapeutic implications, but legal ones too, as the effect of such programs is a factor that courts must weigh when deciding the level of danger posed by the offenders.¹⁴ There is further need to consider people with an intellectual disability as they will not fit into normal treatment models but are high prevalence in the sexual offender population. There is a need for specific and appropriate models of care for this group.

Another major issue is the emphasis placed by Corrective Services on compliance over rehabilitation, which leads to draconian monitoring regimes, heavy-handed enforcement and supervision orders which are excessively detailed and difficult to understand; this context, coupled with the lack of forensically qualified psychiatrists and other mental health professionals in the supervision apparatus, increases the possibility of breaches and subsequent return to custody. In summary, it was observed that 'care must be taken to ensure that in practice such schemes actually do protect the community through evidence-based treatment and rehabilitation of offenders (Keyzer & McSherry, 2015).

Recommendations:

- That the provision of specialised rehabilitation programs in prison and outside of prison be improved to support the people who may be subject to preventative detention measures, with particular consideration given to ensuring appropriate services for those with an intellectual disability.
- That the need for preventative detention be based on structured clinical judgments, which requires better training for frontline clinical decision makers and the creation of an independent body to facilitate and regulate best-practice in relation to risk-assessment and risk management.

People in immigration detention

Australia is the only country to detain asylum seekers indefinitely in jail-like conditions, for months, sometimes years, at a time while necessary background and security checks are completed and asylum claims are processed. This includes adults and children with severe psychiatric impairment as well as those with identified developmental and cognitive disabilities. This represents a clear breach of Australia's Human Rights obligations and of the rights of these individuals (Newman, Proctor, & Dudley, 2013).

¹⁴ For example: *Dangerous Prisoners (Sexual Offenders) Act 2003* (Qld) s13 (4) (f).

Australia's *Migration Act 1958* states that any 'unlawful non-citizen' who is in Australia's migration zone must be detained until they can be given permission to remain in Australia; if permission is refused, they must be deported as soon as is practical. The difficulty is that asylum seekers held on off-shore islands are not deemed to be *in Australia*, the Act does not give people power to apply for a protection visa, but it does give the Immigration Minister the power to lift this restriction on a case-by-case basis. A 2014 case gave some support to the case that asylum seekers cannot be detained indefinitely, confirming that the process of determining whether or not to grant a visa to a non-citizen must be undertaken and completed as soon as reasonably practicable.¹⁵ However, for those seeking justice for asylum seekers, litigation is not a sufficient strategy: the ultimate goal must be amendments to the Act that will bring Australian law into conformity with the demands of justice and of human rights (Emerton, 2014).

A more recent legal case¹⁶ was held to determine the legality or otherwise of detention on Nauru. The recent High Court ruling on the legality of detention in Nauru was that retrospective legislation legalised it, but that at the time the case was brought to the High Court that detention had been illegal. There was however a noteworthy dissenting judgement. Her Honour Justice Gordon wrote that the detention remains illegal. She did not accept that detention has been passed to the Government of Nauru and showed that the administrative arrangements confirm that the Australian Government governs the prison. She pointed out that the High Court ruled previously that prolonged detention without judicial process is unconstitutional in Australia, and she states that it therefore cannot be constitutional for Australia to administer long-term detention without trial abroad.

The RANZCP is particularly concerned about the high incidence of asylum seekers with psychiatric, developmental and/or cognitive impairment who are being held in detention. Prolonged immigration detention has been shown to worsen mental illness in those already suffering when detained and to result in new illnesses in those without mental illness on arrival (Steel et al., 2006). The detention environment has also been shown to result in developmental regression and delays in children and to be developmentally inadequate (Australian Human Rights Commission, 2014; Mares, 2016). It is the environment itself rather than the adequacy or otherwise of health and rehabilitative facilities that is responsible for this negative impact. Children and those adults with developmental disability are profoundly vulnerable and their wellbeing and safety is compromised in the institutionalised detention environment. There have been particular concerns raised about the safety of children and adults with identified developmental or cognitive disability(s) who are held in remote offshore processing facilities (Nauru and Manus Island). These people have very significant limitations to health, education and welfare services and minimal access to legal, advocacy and other support services (Moss, 2015; Proctor, Sundram, Singleton, Paxton, & Block, 2014).

RANZCP concurs with refugee advocacy organisations in holding real concerns for the emotional wellbeing of all people held in detention centres. Many asylum seekers have suffered persecution, war, famine and sometimes torture in their countries of origin (United Nations Human Rights Commissioner, 2010). They have suffered the stress of separation from family and familiar surroundings. The Australian Human Rights Commission (AHRC) has criticised the Commonwealth Government, saying uncertainty over their future and delays in processing refugee claims is detrimental to the mental health of detainees (Australian Human Rights Commission, 2011). The mental health of asylum seekers was a key concern arising from the United Nations (UN) Universal Periodic Review of Australia's human rights record in January 2011. The lack of independent scrutiny and review of both the immigration detention system

¹⁵ Plaintiff S4-2014 v Minister for Immigration and Border Protection [2014] HCA 34 (11 September 2014)

¹⁶ Plaintiff M68/2015 v Minister for Immigration and Border Protection & ORS [2016] HCA 1 (3 February 2016)

itself, of health service provision, of the circumstances for individual detainees, significant barriers to individuals obtaining independent health assessment and advice, the lack of independent health advisory oversight and legislation that criminalises expressions of concern by health staff involved in provision of services the detained adults and children all raise very severe concerns about the safety and wellbeing of detained children and adults, including those with cognitive and psychiatric disabilities, held onshore and particularly in offshore remote facilities (Dudley, 2016; Sanggaran, Ferguson, & Haire, 2014).

Indefinite detention of asylum seekers has negative impact on their mental health. Children and those with developmental or other disabilities are particularly vulnerable to a decline in their health and wellbeing, to abuse and or neglect within the immigration detention system, and to limited or inadequate access to the assessment, support and intervention they and their families require. The RANZCP has developed position statements that advocate for the mental health needs of asylum seekers and refugees and a practice guideline to provide guidance for psychiatrists working with asylum seekers and refugees.

[Position Statement 46 'The provision of mental health services to asylum seekers and refugees'](#) (2012)

[Position Statement 52 'Children in immigration detention'](#) (2015)

[Guidance for psychiatrists working in Australian immigration detention centres](#) (2016)

Recommendations

- Amendments to the Migration Act 1958 be made to bring Australian law into conformity with the demands of justice and of human rights in regard to processing of asylum seeker applications. Specifically:
 - Detention of children is a contravention of responsibility under the United Nations Convention on the Rights of the Child and violates children's rights to care in developmentally appropriate environments. The RANZCP opposes the detention of child asylum seekers and families with children and urges the government to immediately remove all families and children from detention.
 - The RANZCP opposes the indefinite detention of adults and children with identified cognitive and psychiatric impairment in immigration detention.
 - Asylum seeker applications should be processed as fast as reasonably practical possible to minimise risk to mental health and wellbeing.

The introduction and application of the National Disability Insurance Scheme

The RANZCP has significant and ongoing concerns that the National Disability Insurance Scheme (NDIS) does not adequately account for people with mental or intellectual impairment in its approach, funding or scope. The RANZCP hopes to continue to work with Government and the National Disability Insurance Agency (NDIA), to address these concerns. These concerns are outlined in the [RANZCP submission to the Independent Review of the operation of the NDIS Act](#).

In regard to people who are in indefinite detention, there are specific considerations identified that need to be taken into account, as these may have an impact on the ability of people to access appropriate services. As a general principle the RANZCP supports the NDIS as a method of delivering appropriate services to those with mental and cognitive impairment who are detained indefinitely to assist these people on their road to recovery. Specific points for consideration by the inquiry include:

- There is a lack of clarity with regards to consumers on community treatment orders (CTOs), particularly as CTOs are not accepted by the NDIS retrospectively meaning there will be a significant number of severely unwell consumers who are known not to have full insight into their illness who are at high risk of falling through the gaps.
- The NDIS Mental Health Sector Reference Group's December Communique features feedback from Dr Martin Cohen (Mental Health Service Director) on the NDIS trial site in Hunter New England. Dr Cohen identified that the timeframe of inpatient stays often exceeds the timeframe for applying for the NDIS, risking consumers being discharged without their application being completed and without adequate community supports established.
- The report Further Unravelling Psychosocial Disability found that, in the NSW Trial Site, consumers were being referred to the NDIS who had been residing in hospital for many months as a result of lack of appropriately supported community care. In this scenario, the NDIS could be a positive way of supporting consumers to return to the community, with adequate supports established. However, the social worker at the NSW Trial Site reported that the first three referrals to the NDIS she undertook for such consumers dominated her full time workload for three months. All three consumers were eventually successful in obtaining full support under the NDIS, however this was not considered an efficient use of scarce resources.
- The document Principles to Determine the Responsibilities of the NDIS and Other Services Systems sets out how the NDIS is expected to interact with the mental health sector, among others. The mental health sector will be responsible for 'services and therapies in which the primary function is to provide treatment'. This would seem to indicate that during inpatient stays the NDIS supports may take a step back, while the focus is on treatment, and as the consumer stabilises and is discharged the community-based NDIS reports will be reinstated.
- The Principles document also sets out the way the NDIS will interact with the justice system. Overall, the document states: '*the criminal 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*'. The NDIS will fund supports while the person is on bail or a community based order. It will also fund specialised supports to assist people with disability to live independently in the community, including supports delivered in custodial settings (including remand) aimed at improving transitions from custodial settings to the community. The document acknowledges the complexity of coordination between the NDIS and the justice sector, and states that the details will be clarified based on the experience of trial sites. Page 24 of the Principles document sets out specifically what the NDIS can provide while the person is in a custodial setting, and page 25 looks at participants residing at youth training centres/youth justice centres/youth detention centres.
- As a more general issue, RANZCP is concerned that people who detained indefinitely, including those within the criminal justice system, are not well placed to be able to self-advocate or have anyone to assist with their application to NDIS.

Recommendations:

- That the National Disability Insurance Scheme (NDIS) continues to work with the RANZCP and other relevant organisations to ensure that it adequately accounts for people with mental or intellectual impairment in its approach, funding and scope – including consideration of people within the criminal justice system.

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