Office of the Public Advocate

Submission to the Review of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*

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Summary of recommendations

Recommendation 1. People detained under the CMIA should have a legislative right to access advocacy at regular intervals (for reviews, variations, leave and post discharge placements).

Recommendation 2. A person detained under the CMIA should not have a guardian appointed to approve behaviour-management strategies relating to the offending behaviour. Such strategies should form part of a behaviour/treatment plan that is authorised by the supervising court or other authority established under the Act. The processes set out for Supervised Treatment Orders in the *Disability Act 2006* provide a model for the Commission to consider.

Recommendation 3. Guardianship should only be used where a decision needs to be made in the person's best interests (e.g. health care) but should not be used as a means of obtaining community protection.

Recommendation 4. There should be a legislatively required automatic review of each custodial supervision order under the CMIA at an interval of no longer than every two years, as proposed in recommendation 431 of the VLRC's final guardianship report.

Recommendation 5. An expansion of the role of the Magistrate's Court in relation to unfitness to be tried should be reconsidered.

Recommendation 6. More facilities suitable for people unable to achieve community reintegration should be available for people with an intellectual disability, acquired brain injury or cognitive impairment of a progressive nature (e.g. dementia).

Recommendation 7. Considerations prior to treatment should include:

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

- Consultation with the person with disability and where appropriate their guardian, representatives of disability service providers, and any other person considered to be integral to the treatment
- External monitoring and scrutiny of the treatment.

Recommendation 8. A longitudinal evaluation of treatment provided under DFATS programs should be undertaken to ensure programs are consistent with best practice.

Recommendation 9. Shortages in resources and staffing at Plenty Residential Services should be addressed to ensure patient care plans are able to be implemented.

Recommendation 10. Shortages in resources and staffing at Thomas Embling Hospital should be addressed to ensure patients are provided with a therapeutic environment.

Recommendation 11. There is a need to examine how the CMIA will interact with the new Victorian Mental Health Act and whether the CMIA operates consistently with the framework of this Act and Victoria's human rights obligations pertaining to mental health.

Recommendation 12. The CMIA should have a similar treatment planning, review and appeals framework to that contained in the Disability Act.

Recommendation 13. The carriage of departmental responsibilities for supervision, monitoring, planning and rehabilitation for the person subject to Custodial Supervision Orders and non-Custodial Supervision Orders need greater clarity.

Recommendation 14. The Department of Human Services should provide additional resources to eliminate delays in prison/on remand experienced by prisoners found unfit to be tried due to mental impairment or not guilty due to mental impairment.

1. Introduction

The Office of the Public Advocate (OPA) provides advocacy, guardianship and investigation services to people with cognitive impairment, including people with an intellectual disability, a mental illness, an acquired brain injury and dementia. In the 2012/13 financial year, OPA worked with people with cognitive impairment in 1,590 guardianship matters, 386 investigations and 394 advocacy cases.

OPA coordinates the Community Guardianship Program and the Private Guardian Support Program, as well as the Community Visitors Program and the Independent Third Person Program. OPA also plays a role in community education, the provision of advice and information and undertakes research and policy projects.

In our submission to both the Victorian Law Reform Commission's (VLRC's) 2010 review of the *Guardianship and Administration Act 1986* and the Victorian Parliamentary Law Reform Committee's 2011 'Inquiry into access to and interaction with the Justice System by people with an intellectual disability and their families and carers' (both at www.publicadvocate.vic.gov.au), OPA raised points relating to people subject to proceedings and orders under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (CMIA). We reiterate these points and raise a number of other concerns in this submission.

2. Safeguarding rights

Victorian Charter of Human Rights and Responsibilities

The Victorian *Charter of Human Rights and Responsibilities 2006* promotes and protects human rights. It is unlawful for a public authority to act in a way that is incompatible with a human right or, in making a decision, to fail to give proper consideration to a relevant human right.

The rights most relevant to people subject to orders under the CMIA are:

- Recognition and equality before the law (s.8)
- Protection from torture and cruel, inhuman or degrading treatment (s.10)
- Freedom of movement (s.12)
- Privacy and reputation (s.13)
- Right to liberty and security of person (s.21)
- Humane treatment when deprived of liberty (s.22)
- Fair hearing (s.24)

People on supervision orders under the CMIA, particularly people on custodial supervision orders, do not have easy access to resources or knowledge about how to protect their human rights. OPA supports the view expressed in the VLRC's final report on the review of the *Guardianship and Administration Act 1986* that people detained under the CMIA should have access to advocacy at regular intervals, especially during:

- reviews of supervision orders
- applications to vary an order
- when leave decisions are made by the Forensic Leave Panel
- when decisions about accommodation placements after discharge are made

OPA supports the view expressed in the VLRC's final report that the role of advocacy should be included in the legislation and appropriately resourced (Rec. 430). The case of Mr A below, also raised in the CMIA consultation paper illustrates the importance of advocacy for people found unfit to plead.

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

unacceptable'. Following advocacy by OPA and a request from the Judge to the Secretary of the Department of Human Services, a placement was found for Mr A.

Recommendation 1. People detained under the CMIA should have a legislative right to access advocacy at regular intervals (for reviews, variations, leave and post discharge placements).

3. Guardianship

Role of guardians

Guardianship is necessarily concerned with the best interests of the person and is not constructed around a goal of community protection. Guardians have very limited coercive powers. Guardians should not have substitute decision-making responsibility in relation to custodial accommodation decisions where there is no therapeutic benefit to the offender or where the decision relates solely to the safety of the community (e.g. protecting the community from a known sex offender).

Guardianship is not a mechanism of behaviour control to facilitate a release on bail of people who are likely to come under the CMIA. Where bail is being granted, the Court granting bail should set appropriate parameters of control to prevent the person from committing a further offence or endangering the safety or welfare of the community. If the person requires psychiatric treatment, that should be provided under the *Mental Health Act 1986.*

If behaviour management is required for a person with a disability, that should be provided for according to the *Disability Act 2006*. In situations where neither of these Acts applies, it may be necessary that there be recourse to the Court to establish the appropriate treatment/behaviour management regime after hearing from relevant professionals. This may require changes to the *Bail Act 1977*.

Recommendation 2. A person detained under the CMIA should not have a guardian appointed to approve behaviour management strategies relating to the offending behaviour. Such strategies should form part of a behaviour/treatment plan authorised by

the supervising court or other authority established under the Act. The processes set out for Supervised Treatment Orders in the *Disability Act* provide a model for the Commission to consider.

Decisions relating to consent to the use of chemical restraint (e.g. the use of Androcur for a person found unfit to be tried for a sex offence or not guilty due to mental impairment) raise potential ethical conflicts for guardians. It is questionable to what extent the use of guardianship to manage behaviour is consistent with the best interest principle of guardianship, as the following case illustrates:

CASE STUDY: Mr C was found unfit to plead ten years ago following charges of sexual assault of a child. Mr C served several years in custody. A guardian was appointed to consent to the provision of the anti-libidinal drug, Androcur. The guardian concluded that the use of chemical restraint could be justified if Mr C received a benefit from the use of the drug. The long-term benefit was postulated to be community placement for Mr C built upon the foundation of a reduced libido. Six months into the administration of the drug, there had been some reduction in Mr C's deviant level of arousal. However, Mr C remained attracted to young children and his progress was not sufficient to consider a community placement. The guardian agreed to maintain the use of Androcur but indicated consent would be withdrawn were Mr C not to make progress towards the goal of him living in the community. Otherwise, Mr C suffers the side-effects of taking Androcur for no gain when his behaviour is effectively managed through his detention.

Recommendation 3. Guardianship should only be used where a decision needs to be made in the person's best interests (e.g. health care) but should not be used as a means of obtaining community protection.

Frequency of review of custodial orders

Recommendation 4. There should be a legislatively required automatic review of each custodial supervision order under the CMIA at an interval of no longer than every two years, as proposed in recommendation 431 of the VLRC's final guardianship report.

4. Magistrates' Court

Unfitness to stand trial

OPA has some concerns relating to people with cognitive impairment in the Magistrates' Court for minor offences who are unfit to be tried. In some cases where a person was appearing for an indictable offence, and where there was doubt about their fitness to be tried the person was advised to plead guilty, rather than the matter of their fitness being referred to a higher court. This happens because the procedures are onerous and not commensurate with the offence. OPA sees occasional evidence of this occurring, sufficient to justify a reconsideration of this aspect of the CMIA .

Recommendation 5. An expansion of the role of the Magistrate's Court in relation to unfitness to be tried should be reconsidered.

5. Suitability of the system for people with an intellectual disability or cognitive impairment

Considerations

OPA agrees with the comments in the consultation paper that a gradual or staggered system of release does not necessarily suit persons with an intellectual disability. We further note that the bests interests of people with cognitive impairment of a progressive nature (e.g. dementia) will not be well served by a system focussed on recovery. Similar observations may also apply to those with acquired brain injury.

People with an intellectual disability who have not achieved community reintegration may be transferred to the longer-term Plenty Residential Services facility but there are very few beds available.

Recommendation 6. More facilities suitable for people unable to achieve community reintegration should be available for people with an intellectual disability, acquired brain injury or cognitive impairment of a progressive nature (e.g. dementia).

6. Treatment planning

Considerations

In its foreword, the VLRC's consultation paper states the long-standing legal principle that 'people should only be punished for behaviour for which they are criminally responsible'. The principle is that if people are found unfit to plead or are found not guilty due to mental impairment they should be subject to supervision and treatment, not punishment.

OPA believes that treatment of people under the CMIA should be subject to the same level of independent scrutiny that applies to people being treated involuntarily under the *Mental Health Act 1986* and the *Disability Act 2006*. This raises questions about whether the Act is sufficiently focussed on treatment as there is a lack of specific provisions relating to treatment planning and review in the CMIA unlike the Mental Health Act and the Disability Act.

Recommendation 7. Considerations prior to treatment should include:

- The nature of the treatment that is to be used
- The circumstances in which the proposed form of treatment is to be used
- How the treatment will be of benefit to the person
- The treatment should be the least restrictive of the person as is possible in the circumstances
- Expected duration of the treatment
- Consultation with the person with disability and where appropriate their guardian, representatives of disability service providers, and any other person considered to be integral to the treatment
- External monitoring and scrutiny of the treatment

Treatment outcomes at DFATS

DFATS provides a range of treatment to offenders with an intellectual disability in a residential setting (the 'Intensive Residential Treatment Program' and the 'Long Term Rehabilitation Program'). In 2013, OPA became increasingly concerned that there is insufficient planning for the successful re-integration into the community of persons undertaking treatment at DFATS.

It is understood that the DFATS programs are designed in accordance with best practice as currently envisaged. However, there is a need for research to see that:

- They are implemented consistently with best practice
- People are given the best opportunity for transition into the community
- The outcomes are consistent with what is planned.

Recommendation 8. A longitudinal evaluation of treatment provided under DFATS programs should be undertaken to ensure programs are consistent with best practice.

Community Visitors report from Plenty Residential Services

There are five beds at Plenty Residential Services allocated to the Long Term Rehabilitation Program, which may include persons subject to custodial supervision orders. The Community Visitors annual report 2011-2012, tabled in Parliament in 2012, outlines a number of issues relating to treatment planning for patients at Plenty Residential Services (note, these issues pertain to the Plenty Residential Services client group as a whole).

- Most residents have a patient care plan (PCP). However, Community Visitors (CV) raised concerns about whether planned actions from these lifestyle plans are implemented
- There is a dearth of leisure activities and recreation due to lack of equipment and staffing
- Lack of access to vehicles or insufficient staff are two of the reasons provided for lack of implementation of community access goals
- Some residents are reported to be using their own savings to pay agency staff to take them out to visit family or have a meal (for example)
- Additional staff support and vehicles are required to ensure implementation of PCP goals.

Recommendation 9. Shortages in resources and staffing at Plenty Residential Services should be addressed to ensure patient care plans are able to be implemented.

Community Visitors report from Thomas Embling

People with a mental illness subject to a custodial supervision order are detained at Thomas Embling Forensic hospital, along with prisoners with a mental illness from the broader prison system who require treatment for mental illness.

- The Community Visitors Annual Report 2011/2012, tabled in Parliament in 2012, makes several comments about opportunities for rehabilitation in Thomas Embling Hospital. CV report that a common complaint heard by residents is that there are few or no opportunities for access to education programs and skills development. CVs also report that 'residents complain about boredom and the onerous nature of their lives which can be unstructured and meaningless' (p17).
- CVs report that a new model of care for rehabilitation and education was delayed at Thomas Embling in 2011 due to funding, hiring constraints and industrial action. Some staff have expressed concern that funding constraints limit the availability of recreational programs.
- CVs report that work opportunities are highly valued by patients and are an important part of rehabilitation. However, CVs report that they arise very late in a patient's recovery timeline.
- Paid meaningful work is not available as part of the structured day of patients (as it is in the Corrections system). CVs support research into the practicality and opportunities for providing on-site paid, meaningful work much earlier in the recovery process.

Recommendation 10. Shortages in resources and staffing at Thomas Embling Hospital should be addressed to ensure patients are provided with a therapeutic environment.

7. Consistency with new Mental Health Act and the Disability Act 2006

Victorian Mental Health Act

Thomas Embling is a gazetted facility under the *Mental Health Act 1986.* As such, all forensic patients are subject to the Act. Treatment planning requires regular reviews by the

Mental Health Review Board and the use of seclusion and restraint are monitored by the Chief Psychiatrist.

There is expected to be a stronger focus on supported decision making in the new Mental Health Act than in the 1986 Act. This is consistent with international human rights, in particular Article 12 of the *Convention on the Rights of Persons with Disabilities* which states that:

> 'States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.'

Recommendation 11. There is a need to examine how the CMIA will interact with the new Victorian Mental Health Act and whether the CMIA operates consistently with the framework of this Act and Victoria's human rights obligations pertaining to mental health.

Disability Act 2006

Part 8 of the Disability Act (Compulsory Treatment) specifies that the Authorised Program Officer must prepare a treatment plan for a person admitted to a residential facility, which must be lodged with the Senior Practitioner. A report on the treatment plan must be provided to the Senior Practitioner every six months and reviewed by VCAT every 12 months.

Under Division 3 of the Disability Act, the Secretary is required to prepare a treatment plan for people under a security order (this order does not apply to people detained under the CMIA) which must be submitted to the Senior Practitioner (s.167).

Under Part 7 of the Disability Act (Restrictive Interventions), Behaviour Support Planning is required whenever restrictive interventions will be used. This regime has oversight by the Senior Practitioner and appeals are allowable to VCAT.

Similar statutory arrangements for treatment planning, reporting and review and for the use of restrictive interventions do not exist under the CMIA.

Recommendation 12. The CMIA should have a similar treatment planning, review and appeals framework to that contained in the *Disability Act 2006.*

8. 2011 Inquiry into access to and interaction with the justice system by people with an intellectual disability and their families and carers

OPA submission

The following recommendations are consistent with OPA's submission to the inquiry into access and interactions with the justice system and are also contained within the Victorian Law Reform Committee's final report.

Monitoring of people on custodial and non-custodial orders

Lack of clarity around responsibility for people on custodial and non-custodial orders under the CMIA leads to delays and diffusion of responsibility for outcomes. Of particular concern to OPA is the failure to rehabilitate people and develop a planned transition to the community

Recommendation 13. The carriage of departmental responsibilities for supervision, monitoring, planning and rehabilitation for the person subject to Custodial Supervision Orders and non-Custodial Supervision Orders need greater clarity.

Delays in appropriate accommodation being located for people found unfit to plead due to mental impairment

OPA is concerned about delays experienced by prisoners with cognitive impairment waiting for their case to be heard under the CMIA. Availability of appropriate accommodation is a key reason for the delays experienced by prisoners with an intellectual disability.

CASE STUDY: Mr D, a man with a moderate to severe intellectual disability and paranoid schizophrenia was charged with minor offences. Mr D was found unfit to plead on the basis of mental impairment and was remanded in prison waiting for Disability Services'

supported accommodation. In prison, Mr D's behaviour became very difficult to manage because he was unable to understand why he was there or that he had to comply with prison regulations like providing a urine sample on demand. At regular hearings held during the months he spent in remand, Disability Services told the court they still had no supported accommodation for him. Mr D was being held in seclusion for 23 hours each day, was shackled during his one hour out of seclusion and was sedated to manage his behaviour. The judge threatened to subpoena the Department of Human Services' Secretary if appropriate accommodation was not found within 10 days. Mr D was placed in supported accommodation a few days later. In total, Mr D was imprisoned for one year. As a result of his prison experiences, Mr D became agoraphobic, depressed and now shows signs of post-traumatic stress disorder.

Recommendation 14. The Department of Human Services should provide additional resources to eliminate delays in prison/on remand experienced by prisoners found unfit to be tried due to mental impairment or not guilty due to mental impairment.