VICTORIAN LAW REFORM COMMISSION –

REVIEW OF THE *CRIMES (MENTAL IMPAIRMENT AND UNFITNESS TO BE TRIED) ACT 1997* (VIC)

SUBMISSION BY THE VICTORIAN INSTITUTE OF FORENSIC MENTAL HEALTH

August 2013

Forensicare
VICTORIAN INSTITUTE OF FORENSIC MENTAL HEALTH

Victorian Institute of Forensic Mental Health
Yarra Bend Road
Fairfield 3078

telephone 03 9495 9143
www.forensicare.vic.gov.au

SUMMARY

This submission to the Victorian Law Reform Commission's review of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) ("CMIA") is made by the Victorian Institute of Forensic Mental Health, known as Forensicare. Forensicare is a statutory agency that is responsible for the provision of adult forensic mental health services in Victoria.

The views expressed in the submission reflect the formal position of Forensicare. It has been developed through consultation with senior clinicians and management of Forensicare. It is acknowledged that individual staff of Forensicare may hold different views.

INTRODUCTION

Forensicare is a statutory authority which was established by an amendment to the *Mental Health Act 1986* (Vic) in December 1997 and became operational in April 1998 (at the same time as the CMIA). Forensicare is governed by a ten member Council that is accountable to the Minister for Mental Health. Forensicare provides forensic mental health services to adults in Victoria – services that are required to meet the needs of mentally disordered offenders, the mental health and justice sectors and the community. Forensicare aims to meet these needs by providing clinical services, including the effective assessment, treatment and management of patients and clients in a secure hospital and the community, as well as undertaking research, training and professional education.

Forensicare's Roles and Responsibilities under the CMIA

Treatment and Supervision

Forensicare is responsible for the management of all persons in Victoria who have committed a criminal offence but have been found not guilty by reason of mental impairment on the basis of a mental illness (as opposed to an intellectual disability) and have, subsequently, been placed on a supervision order, either custodial or non-custodial, under the CMIA.

Forensic patients who are on custodial supervision orders are detained in Thomas Embling Hospital, a 116-bed secure hospital with seven accommodation units covering acute, sub-acute, continuing care and rehabilitation, and including a separate women's unit. The Acute Care Program is directed primarily towards involuntary patients from the prison system who are in need of psychiatric assessment and/or acute care and treatment, patients from the public mental health system who require specialised management and to forensic patients entering the system. The Sub-Acute and Continuing Care Programs are targeted to patients (predominantly forensic patients) who are assessed as requiring long-term care due to chronic symptomatology and/or behaviours that represent a risk to the community, as well as patients whose mental state has stabilised and who are assessed as ready to commence working towards community reintegration. Forensic patients have consistently comprised the single largest group of patients managed at Thomas Embling Hospital (67%) and are detained as inpatients for an average of 6-8 years, before being granted extended leave. During this time they will undertake graduated program of leaves to the community in preparation for discharge.

Forensic patients on custodial supervision orders who have been granted extended leave from Thomas Embling Hospital to reside in the community are managed on an out-patient basis by Forensicare's Community Forensic Mental Health Service. This service also provides assessment and multidisciplinary treatment services to high risk clients referred from the criminal justice system, Forensicare's inpatient facilities, mainstream mental health services, the courts and other agencies which have contact with mentally disordered offenders.

Forensic patients on non-custodial supervision orders are supervised by the Non-Custodial Supervision Order Consultation and Liaison Program. This program supervises the monitoring and direct treatment of clients placed on non-custodial supervision orders under the CMIA. Clinicians working in the program provide supervision, liaison, education and clinical consultation to area mental health services to assist with the management of clients on these orders. While the monitoring and direct treatment of non-custodial supervision order clients is largely undertaken by area mental health services, Forensicare has a formal statewide supervisory role in their management. The Non-Custodial Supervision Order Consultation and Liaison Program is staffed by Consultant Psychiatrists, a psychiatric registrar, a clinical co-ordinator and clinicians.

Provision of Expert Opinion

In addition to this, Forensicare is responsible for the provision of expert reports regarding the issue of unfitness to stand trial under section 6 and the availability of the mental impairment defence under section 20 of the CMIA. These reports are provided to the Office of Public Prosecutions through long standing arrangements between the agencies and to the court (in response to requests under section 10(1)(d) of the CMIA relating to unfitness).

Table 1 sets out information in regard to the reports provided by Forensicare to the Courts and the OPP in the last two financial years.

Table 1

Requesting Body	Subject Matter		County			Supreme		
			No of requests	No of reports provided	Average Turnaround	No of requests	No of reports provided	Average Turnaround
OPP	Fitness and/or mental impairment	2011/ 2012	26	28	133	8	8	120
OPP	Fitness and/or mental impairment	2012/ 2013	48	28	69	8	10	80
Court	Fitness	2011/ 2012	8	6	60	0	0	-
Court	Fitness	2012/ 2013	18	20	66	0	0	-

TERMS OF REFERENCE – RESPONSE

The Consultation Paper raises a broad range of issues regarding the operation of the CMIA. This response will be limited to addressing those issues directly impacting on the clinical work of Forensicare and the interests of persons found unfit to be tried or not guilty by reason of mental impairment.

Unfitness to stand trial

Generally, Forensicare considers that the current criteria for determining unfitness to stand trial are appropriate and provide a suitable threshold for determining unfitness.

Forensicare submits that the test for determining unfitness to stand trial should not include a threshold definition of the mental condition the accused person would have to satisfy to be found unfit to stand trial. The identification of a particular mental condition is not relevant to the task of determining whether or not a person can understand the trial or participate in it. We also believe that there is no need for the test for unfitness to stand trial to include consideration of the accused person's decision-making capacity more broadly, as such considerations are already taken into account when determining whether or not a person has the ability to instruct counsel. Additionally, the introduction of an explicit requirement to consider an accused person's decision-making capacity may be difficult to apply in practice, given that a person's ability to make decisions at various stages of the trial process may differ depending on the nature and complexity of the decision to be made. Furthermore, Forensicare considers that the current threshold for unfitness to stand trial is appropriate and, therefore, does not support the lowering of the threshold that might result from including a consideration of a person's decision-making capacity.

Additionally, Forensicare does not consider it necessary to include an element of proportionality in the test for unfitness as the complexity of the particular proceedings to be faced by an accused person is taken into account when considering the existing criteria; in particular, whether the person is able to follow the course of the trial and understand the substantial effect of any evidence that may be given in support of the prosecution. Finally, while it may be neater to separate the two elements of the second criterion – ability to enter a plea and the ability to challenge jurors – this would have negligible impact on the practical application of the test as the failure to meet any element of the test (whether the elements are stated separately or together) deems a person unfit to be tried.

However, there are certain areas in which the legal and procedural operation of the test for unfitness to stand trial may benefit from change.

First, Forensicare supports the suggestion that the criteria for unfitness to stand trial exclude the situation where an accused person is unable to understand the full trial process but is able to understand the nature of the charge, enter a plea and meaningfully give instructions to their legal adviser and the accused person wishes to plead guilty to the charge. Forensicare clinicians have grappled with this situation on several occasions in the past but have, ultimately, been required to find such an accused unfit to stand trial on the basis that they would have been unable to follow the course of a trial despite being able to understand the nature of the charge, enter a plea and meaningfully instruct their legal adviser. Excluding this situation from the unfitness to stand trial test could provide a fairer outcome for accused persons in these circumstances.

In relation to procedural issues, Forensicare considers that the introduction of support measures to potentially increase the level of fitness of an accused person is desirable. Currently, there are very limited options for supporting an accused person with a mental illness through the court process. Forensicare's view is that the provision of support and education about court processes to an accused person who falls 'just short' of meeting the test for fitness is a humane option that may ultimately enable them to participate fully in their trial. Suggestions as to the type of support and assistance that may assist an accused person to participate in their trial could be made in expert reports of fitness to stand trial.

In regards to the role of the jury in the unfitness to stand trial process, Forensicare supports the provision of a procedure where unfitness to stand trial is determined by a judge in cases where the prosecution and defence agree on the unfitness of an accused person. In these situations, the question of whether an accused person is unfit to stand trial is not in issue, rendering the role of the jury largely redundant, and there may be benefits to the accused by expediting the often stressful court process.

However, there is a risk that the defence and prosecution, or the judge, would seek to have the experts develop a consensus opinion beforehand to obviate in some cases the need for a fitness hearing. Forensicare supports measures to ensure that the ultimate issue is determined by an independent trier of fact rather than a consensus of expert witnesses.

Where there is disagreement between the parties on whether an accused person is unfit to stand trial, Forensicare considers that the determination as to fitness should be made by a jury. Forensicare notes that the task faced by experts in assessing unfitness is a challenging one that necessarily involves subjective judgments about a defendant's functional abilities and the anticipated demands of a trial. Where there is disagreement about these abilities, the jury is the appropriate means by which to resolve the issue of fitness.

Forensicare does not consider it appropriate for a 'consent mental impairment' hearing to be available following a finding of unfitness to stand trial. Forensicare considers that the inability of an accused person who is unfit to stand trial to instruct their lawyer means that the right of the accused person to recognition and equality before the law, and to a fair hearing, requires that a special hearing be held.

Defence of mental impairment

It is Forensicare's submission that there is no identified need to make significant changes to the current defence of mental impairment.

In relation to the meaning of "mental impairment", Forensicare submits that a statutory definition of mental impairment is undesirable. The current formulation reflects the previous common law definition of the defence, and the boundaries of what constitutes a "disease of the mind" are currently subject to development through the common law. It is suggested that this provides the appropriate method of reflecting societal views and expectations.

The presence of a definition would arguably not serve to clarify those cases which are always going to be uncertain. The core issue in the defence is not whether a person's condition fits into a particular definition or diagnosis, but whether the accused is criminally responsible at the time of the act. Such a consideration is complex, multifaceted and must be examined on a case by case basis.

Forensicare does not support a legal definition of "mental impairment" which includes diagnostic criteria. The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition ("DSM-5") and the International Classification of Diseases, 10th Edition ("ISD-10") are diagnostic instruments and are not designed for medicolegal purposes. While the issue of mental impairment is linked to diagnosis, it goes beyond this and considers other complex issues pertaining to related impairments. It should not be simplified by listing diagnoses which are perceived to be significant enough for the absolving of criminal responsibility. Moreover, the criteria and definitions of mental disorder diagnoses evolve over time. Indeed, the recent release of the DSM-5 has made significant revisions to diagnostic criteria.

Generally, Forensicare is particularly concerned about the resource implications should there be any widening of the defence of mental impairment. The capability of the service system to safely manage large numbers of offenders within current resource levels is an important consideration. On this basis, Forensicare does not support the inclusion of personality disorders in any legal definition of mental impairment. Given the lack of appropriate forensic services in Victoria that cater to the treatment of severe personality disorder, the practical consequence of an expansion of the definition of mental impairment to include personality disorders would be that many patients acquitted under the CMIA by reason of personality disorder would either be

detained in prison or occupy beds in Thomas Embling Hospital, a facility that is ill-equipped to manage severe personality disorders in the absence of mental illness.

Similarly, Forensicare does not support the inclusion of acquired brain injury in any legal definition of mental impairment. While severe cases of neurocognitive disorders may appropriately qualify for the defence as it is currently formulated, there is research that indicates that individuals with some level of acquired brain injury are substantially overrepresented in the Victorian prison population.[1] Accordingly, the explicit inclusion of this condition in the definition of mental impairment could potentially result in an inappropriate widening of the defence of mental impairment. Finally, while recognising the complexity of the issues and of comorbidity, inclusion of substance-induced psychosis disorders (ie, voluntary acute intoxication or withdrawal; and its consequences) would unnecessarily broaden eligibility for a mental impairment defence, without the commensurate capacity to provide effective treatment. Furthermore, significant resource allocation issues would flow from such a decision.

In relation to the test for establishing the defence of mental impairment, Forensicare considers that the operational elements of the M'Naghten test for the defence of mental impairment should be retained, even if a definition of mental impairment were to be included in the CMIA. It should not be enough to find that the defence is available to a person on the basis that they meet the definition of mental impairment; a causal relationship between the mental condition and the accused should also be required. Additionally, Forensicare considers that introducing a volitional element into the test is unnecessary and may bring with it its own set of interpretive issues. This is because an accused who commits an offence whilst mentally impaired is often able to control their conduct but, for example, may feel morally compelled to commit the act. Such circumstances appropriately meet the second limb of the test.

Application of the CMIA in the Magistrates' Court

The issues arising in relation to extending the application of the CMIA in the Magistrates' Court are well summarised in the Consultation Paper. Forensicare's main concerns when considering whether or not such an extension of the CMIA's jurisdiction is appropriate are twofold: (a) that people charged with minor offences are not drawn into a rigorous supervision regime; and (b) that any expansion is appropriately resourced.

Unfitness to stand trial in the Magistrates' Court

In relation to the issue of whether the Magistrates' Court should have the power to determine unfitness to stand trial, it is Forensicare's submission that, in accordance with the principles that underlie the CMIA, the power to determine unfitness to stand trial should extend to all offences that can be heard and determined in the Magistrates' Court. However, the current procedure under section 8 of the CMIA should be retained, requiring the question of a defendant's fitness to be reserved for consideration by the trial judge where the question arises during a committal hearing. The trigger for an investigation into unfitness should reflect the current trigger which applies in the higher courts, namely that there be a 'real and substantial question' as to the unfitness, and the test to determine unfitness to plead should be largely based on the Presser criteria with the removal of the irrelevant requirement that the accused be able to challenge a juror. Magistrates' Court proceedings may be easier to follow and demand a lower level of participation and assistance by the accused than proceedings in higher courts. However, Forensicare considers that the ability of the Presser criteria to take into account the complexity of a particular proceeding means that the criteria can be appropriately applied to the Magistrates' Court. Finally, Forensicare submits that, following a finding of unfitness to stand

[1] Jackson, M., Hardy, G., Persson, P., & Holland, S. *Acquired Brain Injury in the Victoria Prison System.* Corrections Research Paper Series, Paper No 04, April 2011.

trial, the 'special hearing' procedure established by the CMIA should apply to determine whether the accused person committed the offence charged.

The lack of data available on how many people could potentially be drawn into the CMIA cohort if unfitness to stand trial was extended to the Magistrates' Court makes it difficult to comment on resource implications of such an extension. Research in regard to the prevalence of psychiatric disorder in those detained in police cells may provide some indication of this.[2] One of the clear consequences would be the need for expert reports regarding unfitness to be provided. As stated earlier, Forensicare currently provides expert reports regarding the issue of unfitness to stand trial to the court and to the OPP. In 2012-13, Forensicare prepared 49 reports regarding unfitness. Any extension of the jurisdiction to determine unfitness to stand trial to the Magistrates' Court would need to be accompanied by funding for the provision of expert reports in order to implement the change, including dedicated funding for out of custody reports.

Similarly, while Forensicare considers that fairness of the criminal trial process requires that the Magistrates' Court retain a discretion to adjourn an investigation into unfitness to enable the accused person to become fit, such a discretion would require resourcing of services to assist the accused to potentially achieve fitness within the adjournment period, which might include compulsory inpatient treatment, or legal education for cognitively impaired people, extending for some months. Currently, Forensicare does not have the resources to provide intervention geared towards restoration of fitness, such as the use of inpatient beds for this.

Defence of mental impairment in the Magistrates' Court

The Consultation Paper raises the issue of whether the CMIA should be extended to enable the Magistrates' Court to make orders in relation to people found not guilty by reason of mental impairment, Forensicare submits that it would be inappropriate for offences in the Magistrates' Court to be drawn into the rigorous supervision regime that exists under the CMIA. This view is based on the same reasoning that underpinned the decision of the Community Development Committee not to give Magistrates the power to make orders in relation to people found not guilty because of mental impairment; namely, that offences heard in the Magistrates' Court are less serious and do not warrant the kind of treatment and supervision that would be required by someone who commits a more serious offence.

However, Forensicare submits that it would be appropriate and desirable for a 'safety net', as envisaged by the Committee, to be put in place to ensure that people found not guilty because of mental impairment in the Magistrates' Court receive psychiatric or intellectual disability services or are diverted into treatment at a pre-trial stage. Forensicare considers that, for this group of offenders who commit less serious offences, the purpose of any orders that might be made available to the Magistrates' Court should be the provision of treatment rather than on the management of risk which underpins the system established by the CMIA. Accordingly, when a person is found not guilty by reason of mental impairment in the Magistrates' Court, their lower level of offending makes it appropriate for them to be diverted away from the criminal justice system to be managed within the mainstream metal health system rather than being drawn into the forensic mental health system. Where a person's offence raises sufficient concerns about

[2] Baksheev, G., Ogloff, J. R. P., Thomas, S. D. (2012). Identification of mental illness in police cells: A comparison of police processes, the Brief Jail Mental Health Screen and the Jail Screening Assessment Tool. *Psychology, Crime and the Law*, *18*, 529 – 542; Baksheev, G., Thomas, S.D.M & Ogloff, J.R.P. (2010). Psychiatric disorders and unmet needs in Australian police cells. *Australian and New Zealand Journal of Psychiatry, 44,* 1043 – 1051; Ogloff, J.R.P., Warren, L.J., Tye, C., Blaher, F. & Thomas, S.D.M. (2010) Psychiatric symptoms and histories among people detained in police cells. *Social Psychiatry and Psychiatric Epidemiology, 46,* 9, 871-880.

their future risk, the matter should be elevated to a higher court where the existing orders under the CMIA are available.

The consultation paper sets out a range of examples from other jurisdictions of the way in which the power to make orders following a finding of not guilty by reason of mental impairment might apply in the Magistrates' Court. While a number of these options are attractive, the consultation paper does not include details of how these powers are resourced and the wider judicial and legislative context in which they operate.

The lack of data available on the number of people who may qualify for a defence of mental impairment in the Magistrates' Court and, therefore, the impact of any expansion of the orders available, makes it difficult to comment on the resource implications of the various options. However, there is evidence that there is a high prevalence of mental illness in those police custody.[3]

Whilst Forensicare is supportive of the provision of powers in the Magistrates' Court to make diversionary orders in relation to people found not guilty by reason of mental impairment, such powers will be effective only if accompanied by sufficient resources, both within the courts and the mental health service system, including funding for the legally aided court reports and resources for area mental health services to meet assessment and treatment needs. If such resourcing is not possible, then Forensicare submits that the current requirement to discharge should be retained rather than widening the net of the current orders available under the CMIA or introducing a new set of orders that, in practice, cannot be implemented due to resource constraints.

Here, Forensicare notes that the implementation of the orders under Part 5 of the *Sentencing Act 1991* (Vic) is instructive. While these orders, including restricted involuntary treatment orders (s 93) and hospital security orders (s 93A), are well-framed and intended to address an offender's need for psychiatric treatment, they are rarely imposed due to a lack of available services to implement the order. Forensicare considers that any similar powers to admit a person into a public inpatient psychiatric service or to impose a community treatment order coercively may, in the absence of specific resourcing, impose an unfair burden on the public mental health system leading the orders to, ultimately, become redundant as has occurred with the orders under Part 5 of the *Sentencing Act 1991* (Vic).

The uncertainties around the issue of resourcing makes it difficult for Forensicare to make specific recommendations on the most appropriate model for the expansion of orders available in the Magistrates' Court. Forensicare notes, however, that the support and diversion initiatives currently operating in the Magistrates' Court – the Courts Integrated Services Program and the Assessment and Referral Court List –appear to be working well, although there is often reluctance from area mental health services to take on these patients. Given that the focus of these initiatives is on meeting the needs of accused people who have a mental illness and/or cognitive impairment, it seems appropriate that these initiatives be expanded to include people who are unfit to stand trial and those who qualify for a defence of mental impairment and adapted to their needs. Once again, any such expansion should be appropriately resourced.

Finally, as with the expansion of the power to determine unfitness to stand trial into the Magistrates' Court, the introduction of a power to make orders in relation to people found not guilty by reason of mental impairment will require the provision of expert reports, both regarding the availability of the defence and, potentially, the appropriateness of any order to be imposed. Accordingly, any expansion of the orders available in the Magistrates' Court in relation to people found not guilty by reason of mental impairment would need to be accompanied by

[3] See note 1, above.

funding for the provision of expert reports and time in court to give evidence in order to implement the change.

The current funding system for Court Reports to assist sentencing does not adequately resource the production of these reports. While the Department of Justice specifically funds Forensicare for the provision of reports for defendants in custody, there is no specific allocation of funding for the provision of such reports for people on bail. The current system where the Department of Health notionally funds such reports from its general "block" allocation of funds to Forensicare's community programs is inappropriate as it does not respond to potential growth in demand. If the courts request more reports for people on bail, Forensicare is required to divert resources from other clinical work to meet this demand. Specific funding for the provision of *all* psychiatric and psychological reports prepared for the courts is required.

Consequences of findings under the CMIA

Adequacy of services

Funding

To address the issue of whether there are appropriate services, an understanding of current and future health funding models is required. Forensicare currently receives its funding from the Department of Health as "block" funding for two distinct areas of activity; that which is undertaken in the hospital (bed based services) and that which is undertaken in the community (community services). In 2013 – 2014 Forensicare is funded approximately $37.3 million for bed based services and $3.3 million for community services. This funding covers all services which Forensicare provides, not just those to forensic patients. Forensicare is required to internally allocate how it utilises this money. This requires balancing priorities and need, and (as with any publically funded service) requires the organisation to continually ensure it is utilising funding in the most efficient and effective manner.

Under the current National Health Reform Agreement, from 2014-2015 it is intended to move from a mental health funding model of "block" funding to an activity based funding model. Under a new model, services would be funded based more on the actual activities they carry out. Funding would be based on National Weighted Activity Units ("NWAU") which take into account the complexity of type of services delivered. By way of explanation an 'average' hospital service is worth one NWAU; more complex activities are "weighted" as worth multiple NWAUs, the simplest are worth fractions of an NWAU. The move to this type of funding system in mental health is highly complex and the Department of Health is in ongoing negotiation with the Commonwealth and other states in relation to the scheme. In the future, to ensure that forensic patients on custodial supervision orders are not disadvantaged, determining the weighting of this type of activity (compared to other mental health admissions) will need to reflect the additional services which are required for such long stay patients and the complex legal environment which staff are required to work within. It is currently anticipated that the move to new funding arrangements for "admitted" mental health services will be staged prior to any change in community based funding. While there are long timelines and staged implementation, these funding arrangements will be critical in ensuring that people on orders under the CMIA receive adequate and appropriate services.

When considering how funding affects whether there are appropriate or sufficient services for people under the CMIA, Forensicare acknowledges that it has responsibility to deliver those services within the budget provided by government. In many circumstances our organisation could allocate resources (for instance staff) differently to achieve improved services for people subject to the CMIA. This is particularly so in the Thomas Embling Hospital setting. We have a responsibility to consider how our organisation responds to the needs of forensic patients to ensure that we support their recovery, taking into account individual and community safety.

This may require changing systems to ensure that patients' drug and alcohol or offending behaviour needs are addressed, or considering our systems for allowing patients leave to ensure that there are sufficient staff to enable escorted leave to be utilised more frequently. These are questions which we are always considering as part of our responsibility to utilise public funding efficiently and effectively.

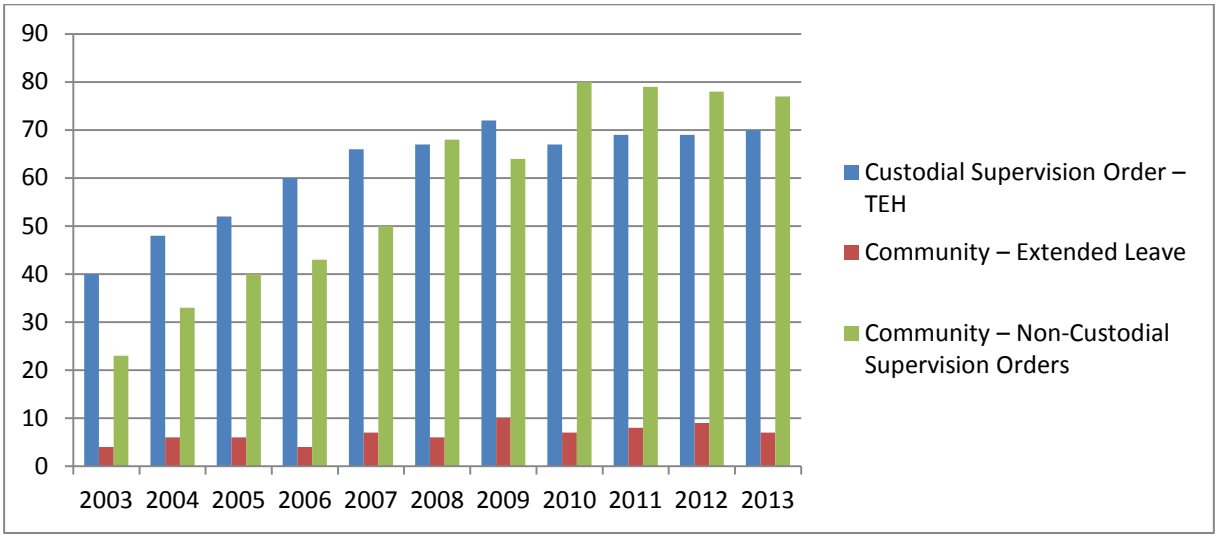
In this submission, where we indicate that we believe more resources are necessary, it because achieving a particular goal or function cannot be done without additional funding.

In-patient facilities

As noted in the Consultation Paper, Thomas Embling Hospital is currently the only facility which provides services under the CMIA for people with a mental illness detained on a custodial supervision order. When TEH opened in 2000, there were 24 patients detained on a CSO who were accommodated at the hospital. As the legal profession and judiciary became more familiar with the regime under the CMIA, more defendants utilised its provisions. At 30 June 2013 there were 76 forensic patients detained at the hospital. The steady growth of patients is indicated in Table 2. Simply put, more people are admitted on a CSO each year than are discharged on extended leave. The more people who are made subject to a NCSO means that is more likely that each year there will be some individuals whose risk cannot be managed in the community or a local area mental health service in-patient unit, who are also then required to be admitted to TEH. Both these factors contribute to the steady growth in numbers of forensic patients at the Hospital.

Table 2

SUPERVISION ORDERS AS AT 30 JUNE 2013



	2003	***2004***	***2005***	***2006***	***2007***	***2008***	***2009***	***2010***	***2011***	***2012***	***2013***
CSO – Thomas Embling	*40*	*48*	*52*	*60*	*66*	*67*	*72*	*67*	*69*	*69*	*70*
Community – Extended Leave	*4*	*6*	*6*	*4*	*7*	*6*	*10*	*7*	*8*	*9*	*7*
Community – NCSO's	*23*	*33*	*40*	*43*	*50*	*68*	*64*	*80*	*79*	*78*	*77*

Analysis of TEH's patient profile shows that forensic patients now constitute the majority of TEH's population accounting for 67% of inpatients receiving treatment at TEH and roughly the same percentage of occupied bed days throughout the whole year. Many stable, lower risk forensic patients are being treated in a high security environment when they could be

accommodated in a medium secure environment. However, such a medium secure environment does not currently exist.

The Jardine unit provides 16 low security beds for stable forensic patients. When it was commissioned in 2007 it was envisaged as a temporary measure to seek to alleviate bed shortages and access pressures for the hospital's acute and sub-acute units.

It should be noted that for some specific groups within the forensic patient cohort, there is current and future needs that are not adequately met within current resources. The Thomas Embling Hospital does not currently provide any gender specific female only sub-acute or rehabilitation beds. The number of female forensic patients is small, and at any given time, women in the "sub-acute" group are often treated in the Barossa acute unit. When they are able to transition to a lower support rehabilitation unit, they are then accommodated in the Daintree or Jardine rehabilitation units, which are mixed gender. This is not ideal.

The size of the forensic patient group who are greater than 60 years old also suggests that some planning needs to be undertaken to consider the appropriate accommodation needs of this cohort, particularly the group who are likely to remain on CSOs.

The Department of Health has recognised all these issues, and is currently commencing a service planning exercise with the Department of Justice which will consider the TEH patient cohorts in terms of their legal status, addressing sub-groups with particular needs including women; patients who are ageing; patients with an intellectual disability; and those who identify as Aboriginal and Torres Strait Islander. The Service Plan is intended to address future service capacity (beds and recurrent resources), physical configuration and define a cost effective and clinically effective model of care that is gender-appropriate for high, medium and low security forensic mental health services. Forensicare strongly supports this approach and will be involved in the development of the Plan with the Departments of Health and Justice.

Services provided to forensic patients in custody at Thomas Embling Hospital must reflect the fact that many of these patients are detained in a custodial environment for long periods of time. They must enable forensic patients to have access to opportunities to maintain and improve their physical health and opportunities to develop skills which assist them in their recovery. This requires access to education and skill development, primary healthcare, spiritual health and recreation facilities. It is Forensicare's submission that there are currently sufficient services for patients at the Hospital in all these areas.

Primary health

A specialist general practitioner service is available to meet the physical health needs of patients, which is augmented by general nursing care and medical oversight by psychiatric registrars. The services of a physiotherapist, dentist and dietician are all provided through contracts. All these general health services are funded through our block funding by the Department of Health.

Health and Leisure

Opportunities to maintain and improve physical health and wellbeing are provided through occupational therapists within the hospital and the provision of recreation services under a contract with an external provider (currently the YMCA). These activities are similarly funded through our block funding.

Education and Skill development

Forensicare currently provides a range of education and skill development opportunities through an external contract with a TAFE provider (Kangan Institute). Classes in construction, hospitality, language, literacy and numeracy, information technology, business, horticulture and visual arts enable patients to develop skills which can assist them in their recovery and provide meaningful occupation while in the hospital. These are currently funded through specific funding from Skills Victoria via the Department of Health. We note that the amount of funds is not indexed and in future years this lack of indexation may have the effect of limiting the services which can be provided. Further resources will be required to meet the needs of forensic patients. This is actively being pursued through the Department of Health.

Spiritual wellbeing

The opportunity for all patients at the hospital to develop spiritually is provided through the provision of chaplaincy services by the Mental Health Chaplaincy service. This service enables spiritual leaders from different faiths to provide support to individuals and groups of patients within the hospital through regular visits.

Community Services

The continued growth in the number of forensic patients residing in the community means that there is considerable pressure on the caseload of Forensicare clinicians providing supervision to this group. Many of these consumers are appropriately treated on a day to day basis by their local mental health services. This reflects the fact that their treatment needs can be met by their local public mental health service and is appropriate from a recovery oriented approach (and the approach of "least restrictive form of treatment"). From time to time some of these forensic patients or the services which treat them require additional input or support from Forensicare to manage difficult situations where levels of risk may change. As we have indicated elsewhere, there are 77 people with a mental illness on such orders residing in the community. It is Forensicare's submission that the steady growth in this area of work means that more resources are required to employ clinicians to work in this area. It is of note that the Service Plan for forensic mental health services being developed by the Department of Health will also address resources and appropriate configuration of community services.

Reports of the mental condition of people declared liable to supervision

Generally, Forensicare considers that the process for providing mental condition reports pursuant to section 41 of the CMIA and section 47 certificates works well in practice. However, there are some improvements that could be made. First, the provisions that apply following a finding that a person is not guilty by reason of mental impairment and before a final decision could be clarified. For example, having found a person not guilty by reason of mental impairment, it is not clear whether the Court is required to immediately determine whether to declare them liable to supervision or order their unconditional release under section 23 or if the court can adjourn the matter off to obtain evidence on this question. Whilst the wording of section 23 suggests that this step must follow immediately, section 40(2) makes it clear that the court cannot order a person to be released unconditionally without obtaining and considering the report of a medical practitioner or psychologist. This is an important issue, because once a person is made liable to supervision, the option of unconditional release is no longer available, regardless of the contents of the report.

There is separate provision requiring a report to be obtained to assist in considering whether to make a custodial or non-custodial supervision order, once a person has been declared liable to supervision (section 41). Providing a clear power for the case to be adjourned to obtain reports in regard to the person's diagnosis, prognosis and appropriate treatment prior to making them

liable to supervision would ensure that the option of unconditional discharge is considered together with supervision in light of relevant information.

Secondly, there is an apparent anomaly in section 12 which deals with what happens after an investigation into fitness. Whilst section 12(2) allows the Court to remand a person who is unfit but likely to become fit within 12 months to an 'appropriate place' upon receipt of a certificate of available services, no such power is set out in regard to a person who is found permanently unfit, pending the holding of a special hearing. The reason for this difference is unclear.

Thirdly, Forensicare submits that the timeframe for the provision of section 47 certificates, which under section 47(4) is seven days (or such longer period as the court allows), should be the same as that for mental condition reports. This is because the question of whether or not services and facilities are available for the custody, care or treatment of a person is dependent on the suggested treatment plan contained within the mental condition report. Accordingly, Forensicare routinely requests that the court provide for a longer period for the provision of the section 47 certificate to allow it to be provided at the same time as the mental condition report.

Nominal term

Forensicare supports the intended purpose of the nominal term; namely, to provide a safeguard against arbitrary and indefinite detention of people when they no longer pose a risk to the community. However, Forensicare submits that the use of the phrase "nominal term" causes significant confusion amongst persons subject to supervision under the CMIA. In many cases, their legal representatives are also confused and do not always have a good understanding of the consequences of an order under the CMIA when providing advice on the decision to proceed down the CMIA pathway. In particular, concerns have been raised that, particularly in the early stages of the journey through the CMIA, the phrase provides people with false hope due to the mistaken understanding that the use of the word 'term' denotes the length of the order or the release date for the person subject to the order. Accordingly, Forensicare submits that the phrase "nominal term" should be replaced with the phrase "minimum review period".

Additionally, Forensicare has some concern regarding the method for setting the nominal term period. In particular, Forensicare agrees with the concerns raised by the Community Development Committee regarding the current approach that is referable to the highest possible penalty for the offence; in particular, that is unfair and misleading to use a maximum penalty where it would be highly unusual to have the maximum sentence imposed if convicted. Additionally, Forensicare notes that, for many persons declared liable to supervision under the CMIA, the nominal term is of such a long period (for example, 25 years for the offence of murder) that its intended purpose (to safeguard against arbitrary and indefinite detention) is lost.

Accordingly, Forensicare considers that it may be more appropriate for the CMIA to set a standard "minimum review period" of five years for all persons declared liable to supervision under the Act, at which point a Major Review of their supervision order would be held. Following the initial Major Review, subsequent Major Reviews could be held at five year periods or at such other time as directed by the court. Such an approach would remove the confusion that surrounds the notion of the nominal term by making it clear to persons subject to supervision under the CMIA (and their legal representatives) that their order is indefinite, but will be subject to judicial review at the five year mark. Additionally, such an approach appropriately divorces the timing of Major Reviews from the comparable criminal sentence and refocuses attention on the clinical progress of the person. Finally, a "minimum review period" of five years better reflects the purpose of the Major Review in ensuring that people subject to supervision orders under the CMIA are not "lost in the system".

Ancillary orders

Generally, Forensicare considers that, even though a finding under the CMIA does not result in a conviction for an offence and that a person found not guilty because of mental impairment is not deemed criminally responsible, it may still be appropriate for there to be administrative consequences of their offence. However, any ancillary order or administrative consequence should not be imposed for a punitive or compensatory purpose. Accordingly, restitution, compensation and recovery orders, and punitive forfeiture orders, would be inappropriate. However, other orders and consequences, such as licence cancellation and disqualification, and sex offender registration, may be appropriate depending on the nature of the person's offence and the nature of their ongoing risk. While such orders may be appropriate for public safety reasons, automatically excluding persons who have received a finding under the CMIA from such orders and administrative consequences also does not accord with rehabilitative principles that encourage people to take responsibility for themselves and their actions.

Forensicare notes the discussion in the Consultation Paper of the series of decisions following from the case of *XFJ v Director of Public Transport (Occupational Business Regulation)* [2008] VCAT 2303 (31 October 2008). The case highlights the different positions that can be taken by various government departments to the safe rehabilitation and recovery of people who offend as a result of mental illness. This is a central purpose of the CMIA and one in which there is significant public interest. Different and at times opposing governmental positions are also often adopted by the government bodies involved in CMIA proceedings, despite all purporting to represent the community's interest. The Consultation Paper recognises the need for consideration of this issue and Forensicare welcomes this and the possibility for a more clear and considered approach.

Supervision: review, leave and management of people subject to supervision

Review, variation and revocation of orders

While Forensicare considers that, generally, the provisions for reviewing, varying and revoking supervision orders operate well, the provision regarding Major Reviews could benefit from some changes. First, Forensicare notes that, on a Major Review of a non-custodial supervision order, there is no presumption in favour of revoking the order. This is in contrast to the presumption in favour of downgrading the order that applies in a Major Review of a custodial supervision order. Forensicare submits that, in accordance with the purpose of a Major Review – to provide a safeguard against arbitrary and indefinite detention of people when they no longer pose a risk to the community – a presumption is favour of revocation should apply to Major Reviews of non-custodial supervision orders.

Second, Forensicare notes that, on face value, 35(3)(a)(i) allows for the court to vary a custodial supervision order to a non-custodial supervision order on a Major Review directly and without an intervening period of extended leave. This is in conflict with section 32(3)(a) which provides that a court must not vary a custodial supervision order to a non-custodial supervision order unless that forensic patient has completed a period of at least 12 months extended leave. Forensicare submits that it would be useful to clarify whether, on a Major Review, a custodial supervision order can be varied to a non-custodial supervision order without an intervening period of extended leave.

In relation to the frequency of reviews under the CMIA, Forensicare notes that it is common for Judges, particularly in the County Court, to order 12 monthly reviews. Indeed, court-ordered reviews, as opposed to those specified in the CMIA, make up the majority of hearings in the County Court; in 2012, for example, 75% of the hearings were at the originating motion of the Judge presiding over the matter.

Forensicare notes that more frequent reviews are not always preferable, both from a resource perspective and the often stressful impact hearings can have on the person subject to the supervision order. Forensicare also notes that, under section 41 of the CMIA, Forensicare is required to provide to the court an annual report detailing a person's treatment, prognosis, and future treatment plan during their previous 12 months of the person's order in order to inform the court of the person's progress. Finally, Forensicare notes that applications to vary a person's status under the CMIA can be made (with limited exceptions) at any time.

Frequency of cases

In 2011 – 2012 Forensicare staff prepared reports for 41 Court hearings under the CMIA in the County Court and Forensicare staff attended to give evidence in 28 of these court hearings. That year there were 20 Court hearings in the Supreme Court and Forensicare staff attended court to give evidence in 18 of these hearings

In 2012 – 2013 Forensicare staff prepared reports for 44 Court hearings under the CMIA in the County Court and Forensicare staff attended to give evidence in 34 of these court hearings. That year there were 25 Court hearings in the Supreme Court and Forensicare staff attended court to give evidence in 25 of these hearings

Leave of absence under supervision orders

Access to leave is an important aspect of recovery and rehabilitation for individuals. There is also a broader community interest in the safe rehabilitation and return to the community of those who offend as a result of a mental illness.

Under the CMIA, leave from Thomas Embling Hospital occurs through an application to the Forensic Leave Panel. In practice, the treating team and Forensicare's internal Leave Review Committee also play an important role in assessing the person's readiness for leave and providing information and recommendations to the Panel.

Each inpatient unit at Thomas Embling Hospital is staffed by a multi-disciplinary team which includes a consultant psychiatrist, a psychiatric registrar, a social worker, an occupational therapist, a psychologist, a nursing unit manager and nursing staff. Each patient has a designated primary nurse who, together with the team, will be involved in supporting the person to apply for leave and in deciding whether or not to support the leave sought at the Forensic Leave Panel hearing. The team will also be important in facilitating the leave granted by the Forensic Leave Panel, by assessing the person's ability to access leave on each occasion, escorting the person when required and supporting the person as required to take unescorted leave.

As noted in the Consultation Paper, the CMIA specifies the types of leave that can be granted and the circumstances in which they can be granted.

Section 50 Special leave for medical treatment.
The CMIA provides for forensic patients to be granted special leave by the authorised psychiatrist. Where special leave is granted for the purpose of medical treatment, it cannot exceed seven days. The Act could be improved by making it clear that where medical treatment is needed for more than seven days, one or more further grants of special leave can be granted to allow for this.

Leave decision-making bodies

Forensicare's Internal Leave Review Committee

As noted in the Consultation Paper, Forensicare's Internal Leave Review Committee was established in response to a recommendation made by the Vincent Review in 2001. The Committee plays an important role in supporting consistency in leave decision and providing input into decision-making by the Forensic Leave Panel. The Committee does not have a legislative basis and given the existence of the statutory independent leave body, the Forensic Leave Panel, Forensicare would not support the Leave Review Committee's existence and operations being legislatively mandated. However, Forensicare recognises a need to review the Committee in light of a recovery approach and would welcome the opportunity to consider and respond to any feedback received about the Committee by the Commission.

Forensic Leave Panel

Currently, an application to the Forensic Leave Panel must be accompanied by an applicant profile under section 54A and a leave plan under section 54B of the CMIA. Section 54A of the CMIA requires that an applicant profile be provided to the Forensic Leave Panel in applications for on-ground leave, limited off-ground leave or variation of leave. The Act requires that, for forensic patients, the profile be provided by the Clinical Director of Forensicare. However, in practice, this profile is prepared and provided by the Authorised Psychiatrist or their delegate. This is appropriate as it is the treating psychiatrist who is best placed to provide this information, rather than the Clinical Director. Accordingly, Forensicare submits that s 54A(1)(a) be amended to reflect this practice.

Under section 54, the Panel can grant leave for a maximum of six months and impose any conditions it considers appropriate, including a condition that the person comply with any direction of the authorised psychiatrist. In practice, the Panel produces detailed leave determinations which set out details of all categories of leave granted to the person and the conditions to apply, such as the frequency, purpose and location of the leave granted and whether the leave is to be escorted by clinical staff, accompanied by family members or unescorted. These determinations are set out on the 'FLP 1' form. Leave is generally granted for the six month maximum period, after which the person is required to make a new application.

At 30 June 2013, there were 70 forensic patients at Thomas Embling Hospital. The requirement for minimum six monthly applications for leave results in a minimum of 140 detailed applications and determinations annually. Given that the average length of stay of forensic patients is generally several years, many of these applications will be renewals of leaves previously considered and granted by the Panel. As the number of forensic patients grows, this will be an increasing trend.

The composition of the Panel, including the presence of a higher court judge, makes it well placed to consider the potential rehabilitative benefits of the proposed leave and determine whether the leave should be granted on risk grounds. However, whether each subsequent grant of leave to the same person on the same conditions merits such high level consideration is less clear. Further, there have been occasions when hearings have been cancelled due to a lack of judges available to sit on the panel. As noted in the consultation paper, the consequence of this for forensic patients whose grant of leave is due to expire is that the leave ends and cannot be resumed until a new grant of leave is applied for at the next hearing of the Forensic Leave Panel. The consequences of this can be significant for patients who are attending education and employment whilst on leave.

For these reasons, Forensicare submits that consideration should be given to changes to the law and practice of the Panel so that it is focused on major leave transition points without the need to return for renewal of leaves in the same terms as those already granted. Major transition points would include the first grant of escorted off ground leave, first grant of unescorted off ground leave, and the first unescorted overnight off ground leave. In this system, the finer details of leave planning would be left to the treating team. The treating team could provide

regular reporting of the person's progress on leave, say on a six monthly basis to allow the Panel to monitor whether the person was accessing the leaves that had been granted and any concerns that might arise. At the point where the person wishes to seek further leaves or leaves of a different nature, an application could then be made to the Panel. Similarly, if the treating team had concerns in regard to the leave progress such that it was considered appropriate for a change to be made, this could be brought before the Panel for reconsideration.

Such a system would allow the Panel to place a greater focus on the more significant issues of rehabilitation and risk, rather than the finer details of leave. It would also reduce the amount of administrative resources involved in the application and determination process without undermining the role of the Panel in risk assessment and oversight of leave. The current level of detail required in leave determinations can lead to errors which cannot be quickly and easily rectified because of the need to reconvene the Panel.

It is also likely to reduce the unnecessary stress of frequent leave applications for forensic patients and better focus clinical and administrative resources where they are most needed.

Extended Leave
In regards to the provision dealing with suspension and revocation of extended leave, Forensicare submits that section 58(6) would benefit from clarification. The current provision creates confusion regarding the types of leave that can be granted to a person during the period of suspension of their extended leave. For example, it is not clear whether a person whose extended leave has been suspended be granted special leave of absence under the CMIA for the purpose of receiving medical treatment during the period of the suspension.

<u>Monitoring people subject to supervision orders</u>

Forensicare considers that there is sufficient clarity in the arrangements for monitoring people subject to non-custodial supervision orders. While much of these arrangements are not contained in the CMIA, there are policies and procedures in place that clearly set out the responsibilities of the various agencies that may be involved in the supervision, management and treatment of people subject to non-custodial supervision orders. This has created a strong and well-accepted structure, particularly between Forensicare and area mental health services, for the supervision, management and treatment of people subject to non-custodial supervision orders.

Forensicare does not see a need for these arrangements to be legislatively prescribed and would be concerned that any such prescription might hinder the ability to put in place management and treatment plans that take into account individual treatment needs.

<u>Breaches of supervision orders</u>

Forensicare considers that there is no need for guidance on failures to comply with or breaches of supervision orders. While the current provisions in sections 29 and 30 do not set out the extent of the non-compliance before action must be taken under the CMIA to either apply for variation of the order (section 29) or apprehend the person (section 30), Forensicare considers that the non-specific terms of the provisions permit a decision to apprehend a person or apply for a variation of their order to be guided by clinical discretion and informed by an understanding of a person's individual circumstances. While any attempt to further define the extent of non-compliance required before action must be taken under the CMIA may be helpful in some cases, it risks creating circumstances where Forensicare is legislatively required to apprehend a person or apply for variation of their order despite a clinical view that the person remains manageable on a non-custodial supervision order.

While Forensicare supports the retention of the current provisions setting out the circumstances in which action must be taken under the CMIA in response to a failure to comply with a non-custodial supervision order, Forensicare submits that the process following apprehension of a person under section 30 could benefit from some changes. In particular, Forensicare considers that the introduction of a power to hold a person's non-custodial supervision order in abeyance for a period of time following their apprehension before requiring that an application to vary the order to a custodial supervision order be made would be beneficial. Under the current provisions, an application for variation of a person's non-custodial supervision order to a custodial supervision order must be made within 48 hours of apprehension and the hearing of the application must then be heard by the court as soon as possible. This process is artificial and inappropriate as it does not provide sufficient time for the treating team to form a clinical view as to whether variation to a custodial supervision order is indeed required. Additionally, any variation to a custodial supervision order at such an early stage after apprehension may not necessarily accord with the least restrictive principle enunciated in section 39 as the person subject to the non-custodial supervision order may only require a relatively short period of inpatient treatment before, once again, being able to be appropriately managed in the community under a non-custodial supervision order. A variation to a custodial supervision order would effectively set the person back two stages in that, once on a custodial supervision order, the person would need to go through the graduated process of applying for extended leave before regaining a non-custodial supervision order.

The restrictive process imposed by the current provisions has, in practice, been addressed by requesting that the court adjourn the hearing for a period of time to allow for a reasonable period of assessment and treatment. Occasionally, a number of rolling adjournments have been required. Forensicare considers that this same outcome could be better achieved by the introduction of a more transparent legislative process that requires the court to be notified of a person's apprehension within 48 hours but then allows for the person's non-custodial supervision order to be placed in abeyance following their apprehension for three monthly periods up to a maximum of 12 months without requiring a court hearing. In Forensicare's experience, in the majority of cases, a period of three months is likely to be sufficient to allow the treating team to form a clinical view as to a person's risk and treatment plan and, therefore, whether the person can be discharged back to the community on a non-custodial supervision order or whether variation to a custodial supervision order is required. However, in other more complex cases, up to 12 months may be required to establish an appropriate treatment and management plan. If reinstatement of a non-custodial supervision order can be achieved within this time period, placing a non-custodial supervision order in abeyance, even for a period of 12 months, is more consistent with the principle of least restriction that underpins the Act and preferable to early variation of a non-custodial supervision order to a custodial supervision order without full assessment of a person's risk and treatment needs.

Regardless of whether the current provisions regarding the apprehension of people subject to non-custodial supervision orders are retained or whether a new process allowing for a person's non-custodial supervision order to be placed in abeyance following their apprehension is introduced, Forensicare notes that the CMIA does not make clear whether or not Forensicare has the power to discharge a person back to the community on a non-custodial supervision order at any point following apprehension. Forensicare notes that section 58 which deals with the suspension and revocation of extended leave explicitly provides that the Chief Psychiatrist must lift the suspension immediately if the reason for the suspension no longer exists. In practice and in accordance with the principle of least restriction, Forensicare has, on occasion, discharged people back to the community on a non-custodial supervision order following apprehension and prior to the court hearing an application to vary the order to a custodial supervision order (at the point at which it is considered the person is again manageable in the community). Forensicare submits that a provision similar to that applying to the suspension of extended

leave, that accords the power to lift the suspension of the non-custodial supervision order to the Authorised Psychiatrist, would assist in clarifying the matter.

Interstate transfers

Rehabilitation and recovery rely on a person being able to access social and family support. Whilst the CMIA recognises the need to allow a person on a supervision order in another state to return to their state of origin, it does not appear that these provisions have been used effectively or frequently to effect interstate transfers.

There have been a very small number of interstate transfers of people on supervision orders since the enactment of the CMIA.[4] All of these have involved the transfer of persons to Victoria; there has not been any transfer of a person from Victoria to a participating state.

Forensicare is aware that the process for the interstate transfer of people on supervision orders is lengthy, bureaucratic, and likely to take several years, despite the fact that interstate transfers can be beneficial for the person subject to the supervision order. However, Forensicare considers that the reasons why transfers are difficult to effect relate less to barriers in the CMIA provisions than to the lack of complementary provisions across jurisdictions and the inaccessibility of the process to people subject to supervision orders and those treating and supporting them. Whilst intergovernmental agreements have been identified as a possible mechanism for overcoming these barriers, there has been limited progress in pursuing these.

There appears to be limited political will to resolve this issue. It is particularly unfortunate that there are not clearer arrangements in place between Victoria and its two neighbouring states - New South Wales and South Australia – given the potential for people to be drawn into the CMIA regime by an accident of geography and then finding themselves forced to remain in a state with which they have no practical connection, such as family and social supports, accommodation and employment. This situation is not conducive to the rehabilitation and recovery of the person.

Decision making and interests under the CMIA

Application of the principles and matters the court is to consider

Forensicare submits that, if the risk-based approach of the CMIA is retained, clear legislative guidance should be provided regarding the meaning of the term "serious endangerment" which underpins decisions to make, vary or revoke a supervision order, or to grant extended leave. While the recent decision of *NOM v DPP* [2012] VSCA 198 has provided some guidance on the meaning of "endangerment", the understanding of what constitutes a risk of serious endangerment in the current provisions remains open-ended and ambiguous, covering both criminal and non-criminal conduct, and harm to self as well as others. This is in contrast to other statutory contexts, such as the reckless endangerment offences in the *Crimes Act 1958* (Vic) which specifies the relevant gravity of the risk as either serious injury or death. Forensicare submits that clarifying what is meant by the term "serious endangerment" would reduce the subjectivity associated with the concept, both for the courts and for clinicians providing expert opinion, and establish clearer thresholds for court intervention at different stages of transition through the CMIA.

Additionally, Forensicare submits that the same threshold of endangerment should apply throughout the CMIA. It seems curious that the relevant risk to be considered throughout most of the CMIA is that of the risk of "serious endangerment", with the exception of decisions to revoke a supervision order which may take into account only the likelihood of endangerment as

[4] Forensicare is aware of only one interstate transfer.

expressed in section 40 of the Act. As noted by the Supreme Court in *NOM v DPP* [2012] VSCA 198, the concept of "serious endangerment" is different to that of likelihood of endangerment. Forensicare submits that consistency regarding the nature of the risk to be considered at any stage at which a person's status can be changed under the CMIA would assist in reducing the subjectivity and elasticity of the notion of endangerment.

Forensicare notes that the language in section 40(1)(c), which requires that the court have regard to the likelihood of endangerment when deciding whether or not to make, vary or revoke a supervision order, is also problematic. In particular, Forensicare submits that there should be some guidance as to what degree of likelihood is required. The recent decision of *NOM v DPP* [2012] VSCA 198 stated that an assessment of the likelihood of the risk materialising required an assessment of whether or not the risk is more than merely possible. Forensicare notes that, in clinical terms, risk is expressed along a continuum from low to medium to high. Guidance regarding the relevant threshold of risk would assist in reducing the subjectivity associated with the concept.

Regardless of the approach taken to the meaning of risk in the CMIA, Forensicare agrees with the New South Wales Law Reform Commission's view that the likelihood of a person endangering themselves should not form part of the criteria for making, varying or revoking a supervision order, or granting extended leave. Forensicare submits that it is inappropriate for a person who only poses a danger to themselves and has not been convicted of a crime to be managed under the coercive processes of CMIA. Additionally, from a clinical perspective, while such persons are more appropriately managed in a non-coercive framework, they can, if required, be managed by the mainstream psychiatric system under the *Mental Health Act 1986* (Vic). Forensicare notes that there have been a handful of cases where the court has been prepared to revoke a person's supervision order despite there being a clear, ongoing and current risk of the person posing a danger to themselves.

Other models of decision making

Forensicare acknowledges that there are a number of strengths associated with a decision making model involving an independent court or tribunal that are theoretically attractive. These strengths are well summarised in the Consultation Paper. However, as recognised in the Paper, the current judicial model also has significant strengths, including an established procedural framework and safeguards, appropriate provisions for public scrutiny, and a 'degree of authority' that may confer community confidence. Accordingly, Forensicare submits that, before abandoning the current judicial model of decision making, a thorough examination of any proposed alternatives models and the degree to which those models address the weaknesses of the current system in practice is required.

Suppression orders

Forensicare acknowledges the importance of the principle of open justice and understands that the public has a legitimate interest in being informed of the outcome of proceedings under the CMIA which often involve significant harm to victims. However, significant negative consequences for both the person subject to the supervision order and the general community may flow from open proceedings in matters determined under the CMIA. These negative consequences are associated with the fact that mental illness continues to be a highly stigmatising diagnosis which poses significant challenges in terms of recovery and community reintegration. For persons subject to supervision under the CMIA, these challenges are further compounded by their forensic status.

Forensicare submits that there are important reasons why the balance between therapeutic considerations (pointing to suppression) and open proceedings (pointing to publication) should

be heavily weighted towards the former. These reasons are well summarised in the Consultation Paper. In particular, exposure to the stress of media publicity may increase the likelihood of relapse and impede a person's motivation to engage in rehabilitative processes as people may be more reluctant to engage with organisations in the community if they regard the community as potentially hostile towards them. Additionally, if members of the wider community become aware of a person's offence, the stigma associated with mental illness may make it more difficult for the person to engage with community services, gain employment and form relationships. The presence of good community integration, particularly employment, is well recognised as a factor that reduces a person's long-term risk of engaging in violence.[5] While any impediment to the process of recovery and community reintegration is clearly not in the interests of the person subject to supervision under the CMIA, factors that threaten community integration may also serve to increase the risk of harm to the community in the long term and, therefore, not be in the public interest.

Forensicare notes that the general community is not naïve to the association between mental illness and violence. Indeed, this link is commonly portrayed in artistic and news media. However, while research notes that the risk of violent offending in the population of people supervised under the CMIA is low,[6] the popular view usually overestimates the magnitude of the risk of harm posed by those with a mental illness. Publication of details of specific cases (as opposed to actual population data) is likely to increase what is already an overestimation of this risk and is a poor method of increasing community understanding of the general association between mental illness and offending. Accordingly, Forensicare submits that the public interest in the successful reintegration of a person subject to supervision under the CMIA into the community will almost always outweigh the public interest in being informed of the details of a particular case.

Given the vulnerability of persons subject to supervision orders and the fact that they have not been found guilty of a crime, Forensicare submits that it is appropriate for the CMIA to adopt a wider test for the granting of suppression orders than that applying in other proceedings. The 'public interest' is an appropriate threshold which can take into account both the potential consequences of open proceedings for both the person subject to the supervision order and, in turn, the general community.

However, it appears that the public interest test only applies in relation to suppression orders sought 'in any proceeding before a court under [the CMIA] Act'(see section 75). In practice, in practice, this has meant that a person who is made subject to a supervision order is not protected from publication in regard to their circumstances unless and until a new application of some kind is made in relation to their supervision status. This can be significant for those subject to custodial supervision orders with long nominal terms who do not return to court for a proceeding under the CMIA until they make an application for extended leave, generally some years after the original order is imposed. In the intervening period, they are afforded no protection from publication of the details of their offence or their current circumstances, regardless of the public interest or otherwise of such publication. It is unclear whether this arises from a practice of not seeking orders at the criminal trial or an interpretation of section 75 as not being available at this stage. For these reasons, Forensicare submits that consideration should be given to clarifying the circumstances in which suppression orders can be made under the Act, so that protection from publication of identifying information is provided from the time that the supervision order is made.

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[5] Andrews, D.A. & Bonta, J. (1995). *The Level of Service Inventory – Revised.* Toronto: Multi-Health Services. Finn, P. (1999). Job Placement for Offenders: A Promising Approach to Reducing Recidivism and Correctional Costs. *National Institute of Justice Journal, July 1999,* 2-11.

[6] Ong, K., Carroll, A., Reid, S. & Deacon, A. (2009). Community outcomes of mentally disordered homicide offenders in Victoria. *Australian and New Zealand Journal of Psychiatry, 43*, 775-780.

Conclusion

Forensicare welcomes the opportunity to provide input into this review and would be happy to discuss the issues covered in this submission in more detail with the review team at any time.