I would like to provide comment on the operation and outcomes of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (CMIA).

I have been involved with this Act since its inception. I contributed to the workings of the committee that reviewed the previous process of Governor's Pleasure under the Crimes Act. I worked as a consultant psychiatrist in forensic services from 1991 to 1998. I have provided expert opinion to the Supreme Court in hearings related to initial disposition, applications for Extended Leave and Revocation on many occasions. More recently, as Chief Psychiatrist I have been a member of the Forensic Leave Panel, and have been involved in inquiries following critical incidents involving persons detained under the CMIA. In my current role as Executive Director, NorthWestern Mental Health, I have overall responsibility for a number of persons who are in the community under Orders imposed through the CMIA.

I think it is hard to separate the review of the CMIA from the context in which it exists and the services which it depends upon. Victoria currently has a single forensic mental health facility - the Thomas Embling Hospital (TEH) - which was opened in 2000 and which has 116 beds, of which 100 are within a high security environment. TEH is expected to respond to the acute mental health needs of prisoners as well as to those under a Custodial Supervision Order (CSO) under the CMIA. With the growth of the prison population this means that there is a very real tension between responding to the acute mental health needs of remanded and sentenced prisoners, and to those who may be sentenced under the CMIA. I acknowledge that the government is proposing to increase the capacity of mental health response within the prison system, however at present those who are unwilling or unable to consent to treatment and who meet other criteria under mental health legislation can only be treated in a hospital setting, and this is only provided at TEH.

In my view, the CMIA has achieved a number of its proposed objectives. Decisions in relation to leave, extended leave and ultimate release have shifted to the FLP and judiciary in a way that has mostly been to the advantage of the individual while retaining a consideration for community concern and community safety. There are however some areas which I believe require further refinement and consideration.

1. There is a block in the step between the FLP and extended leave approval. The FLP can only approve leave for a limited amount of time. The Courts appear to require a high level of reassurance in approving extended leave. this means that persons who have extensive leave to the community still require a bed at the forensic service resulting in an exit block. I am aware that this is in part the consequence of very limited forensic inpatient services, and have been promoting the need for a medium secure unit and step down units for some time. However, in the context of the current very limited services, this gap between the threshold set by the FLP and that set by the Court results in (in my view) unnecessary utilisation of high cost, limited availability services to the detriment of other persons who need those services. I think there should be a step between that currently set by the provisions for the FLP and the original Court.

2. The other significant area of concern in my view are the provisions in relation to Non-Custodial Supervision Orders (NCSO). I understand that in order to be found not guilty by reason of mental impairment there should be a nexus between the offending behaviour and a treatable mental illness. In my experience, persons have been found not guilty and been made subject to a NCSO where the main issue was not a mental illness, but behaviour more closely linked to an underlying personality disorder or substance abuse. These carry different expectations in relation to treatment and recidivism. I believe some persons who have been found not guilty and placed on a NCSO have been highly unlikely to be able to comply with the requirements of the NCSO and thus have subsequently been placed on a CSO with the result that they are detained for a much longer period than the original offence would have required. This is a situation that the CMIA was explicitly endeavouring to avoid. My view is that any person who is considered for disposition under the CMIA must have a very clear argument that the offending behaviour was related to the mental illness and the risk of recurrence will be reduced if not entirely mitigated by treatment of that illness. Issues of personality disorder or substance abuse are not so amenable to treatment and in my view should not be included under the CMIA since they lead to a greater risk of extended detention verging on preventative detention, for which our system is not designed and is not capable of meeting.

I hope I have been able to illustrate some of the major concerns in relation to the CMIA. As noted above, in my view it has functioned well and has been an improvement on the earlier regime. A major issue is the lack of step down medium secure facilities to support a more graduated release program.

Please do not hesitate to contact me if you would like further discussion on the above.

Kind regards

Ruth

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