I currently work as a consultant psychiatrist at Thomas Embling Hospital (Forensicare). In addition, I hold the positions of Associate Professor at Swinburne University and Senior Lecturer in Forensic Psychiatry at Monash University. I also have a busy private practice, which includes forensic work. I have been involved in working with patients subject to the CMIA since 1998 and have produced numerous reports relevant to various stages of the CMIA, from initial hearings to final revocations of Orders over the past 15 years. I have also appeared before the FLP and the Courts on many occasions and have produced reports for both the OPP and defence lawyers. I have also published several research and opinion papers on related matters (see appendix).

This submission reflects my own views rather than those of any organisation with which I am affiliated.

Pages and Qs refer to the CMIA Review Document

Page 48: 3.103: I believe that it is problematic that private practitioners may be assumed to be responsible for 'monitoring' for compliance with NCSOs; this is beyond the capacity of private practitioners, and is an uneasy fit with the essentially voluntary nature of their relationship with clients.

Q 1: there may be merit in a tighter 'threshold' than the current 'disordered mental processes'. In particular, stating that certain conditions/mental states (for example states of heightened emotion or pure personality disorder) would NOT be sufficient grounds may be of some help.

Q7—Option (a) is best in my opinion; we do need some clarity about how to proceed where delusional disorders are affecting clients' instructions and understanding of court processes; currently there seems to be a lack of clarity. My view is that the criteria should include the capacity to *rationally* instruct a lawyer.

Q11: Providing support /education for people who are just 'below the bar' for fitness is a humane and progressive option, already working in some places.

Q21: The law in Victoria seems to have a strangely ambivalent, perhaps even sceptical, approach to the role of the jury in CMIA hearings. If really we really believe that juries have little to offer then it would be far preferable in my opinion to adopt the 'Mental Health Court' model from Queensland: that is an inquisitorial system for cases where there is no contest as to the facts that the defendant actually carried out the offence. It involves judges and barristers who have developed expertise in the relevant field and having psychiatrists who are independent assisting the judge. It is a more efficient and arguably fairer and more transparent model.

Question 31: The current approach of allowing case-law to develop and evolve with respect to the boundaries of what constitutes a disease of the mind has worked well. There are some boundary issues around drug associated psychoses, particularly for example when people with established psychotic illnesses intentionally abuse substances and therefore become acutely psychotic. It is very difficult to establish clear boundaries in these matters[1] but at the very least some guidance, along the lines of the Queensland legislation, excluding those cases where substance use has clearly been a major aetiological factor would be appropriate.
I would be very concerned with any expansion into personality disorder: the limits on this are far from clear; a more useful approach would be to specifically exclude cases where the only diagnosable mental disorder is a

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[1] "Drug-associated psychoses and criminal responsibility". Carroll, A., McSherry, B., Wood, D. & Yannoulidis, S. *Behavioral Sciences & the Law* 26: 633-653, 2008

personality disorder. It is notable that those jurisdictions that have gone down this route such as the Northern Territory and the ACT are exactly those jurisdictions that lack any facilities whatsoever for actual rehabilitation. Forensic services in the United Kingdom do indeed cater to severe personality disorder: however the UK has 5 times more forensic beds per capita than Victoria (notwithstanding our superior GDP per capita). The reality is that any such expansion of the concept of disease of the mind would result in many CMIA patients residing in prisons and/or would result in non-mentally ill patients occupying beds as Thomas Embling Hospital, a facility which is ill-equipped to manage severe personality disorder in the absence of mental illness.

With acquired brain injuries, clearly severe cases might qualify if there is a clear severe neurocognitive deficit, but it must be borne in mind that a huge percentage of offenders have some level of acquired brain injury.

Question 37: The problem of course with the term 'moderate degree of sense and composure' is that there is very poor interrater reliability as to how 'moderate' is measured. In practice, this addition to the MacNaughton criteria can be used to argue for those who lack impulse control for any reason. Thus far, this has not resulted in any greater number of problematic cases but the vagueness of this term is surely undesirable. That said, a 'strict' purely cognitive standard as in many USA jurisdictions would also be undesirable, excluding many seriously psychotic individuals who are surely not morally responsible for their offences. Perhaps a better form of words is needed; no easy task.

Question 41: See earlier comments regarding possibility of a mental health court along Queensland lines.

Question 50: All the high-minded talk of therapeutic diversionary measures at the Magistrates Court level is irrelevant in the absence of adequate resources.

Public mental health services are currently quite unable to provide adequate acute inpatient service or community-based care for the most severely ill. It would be inappropriate and a recipe for conflict to give magistrates the power (as in Western Australia) to admit directly into hospital beds or to impose community treatment orders. The power to impose forensic orders at the magistrate level would be similarly unhelpful unless backed up by a commensurate reallocation of resources, which appears to be most unlikely in the current climate. The current court based programs such as CISP and ARC, which require the cooperation of the offender, appear to work fairly well based on my experience in seeing such offenders in private practice. The kinds of problems that such offenders display are unlikely to be well managed within a coercive framework involving treatment orders and compulsory servicing by public mental health: in practice, they do better with voluntary engagement with psychosocial disability workers and substance use workers etc.

Question 62: The nominal term is totally irrelevant to outcomes and misleading to many. We have many patients who have been detained beyond the expiry and conversely many patients who have been freed from their orders well before the nominal term. In my opinion, the nominal term figure simply serves to confuse the patients in the early stages of their forensic journey, giving them false hope (often supported by lawyers) with respect to time frames of detention. If we are serious about nominal terms then I would support them becoming limiting terms whereby at the expiry date the forensic order simply lapses, and consideration is then given to treatment under the Mental Health Act. This approach could be problematic where homicide offenders are concerned: in practice, such offenders do appear to be treated differently and it would be arguably more honest and transparent for the law to reflect this, perhaps by way of an 'indefinite' limiting term. Another sensible option could be to remove nominal terms altogether but to mandate court reviews at fixed intervals.

Question 65: In practice, many sensible lawyers now avoid raising these issues where factors such as personality dysfunction and substance use feature heavily. Most lawyers have now learned that such factors mean that patients may well end up in hospital for many, many years even where the offence has not been grave.

Question 70 & 88 & 92: A problem we have at the moment is that when considering discharge from hospital psychiatrists are understandably very risk averse. The extent to which this conservatism is driven by the courts and the extent to which it is driven by clinicians is unclear: there is no doubt a dialectic between the two. What currently happens is that, for good reasons, we are very keen to ensure adequate integration into the community: structured activities during the day, supportive friends and family, ability to cook and shop adequately (or reside in a place where these needs met) etc. Although there is a relationship between these factors and future risk of reoffending, it does mean that we are sometimes setting the bar very high when considering discharge. The contrast in how the State of Victoria chooses to manage non-forensic but probably more high risk mentally disordered offenders in the community, who struggle to get inpatient stays of adequate length or adequate community support, is very stark. The underlying legal problem is that, unlike with Mental Health Act patients (whereby there needs to be risk secondary to mental illness to warrant detention), for forensic patients evidence of risk for any reason is sufficient. Apart from anything else, this means that patients with mental illness are held up to a quite different standard with respect to preventative detention than other offenders. The approach would seem unlikely to be consistent with contemporary human rights standards although I will leave it to others to decide whether this means that the act is not compliant with the Victorian Charter.
The solution is not simple however. If we were to go down the route of requiring risk to be linked to the disease of the mind that led to the custodial

order in the first place, then this might lead to the release of a small but significant number of highly dangerous individuals who, because of co-morbid severe personality disorder or sexual paraphilic disorders, would pose a serious and imminent risk to the public.
At the very least however I would advocate:

- the removal of the need to concern ourselves with risk of harm to self: this risk is usually better managed in a non-coercive framework ; if it is secondary to mental illness, it can be managed by the Mental Health Act in any case; judges have previously revoked orders where this is the issue (Justice Kellam on Koritnik).
- consistency throughout the CMIA for how the issues of risk are dealt with: currently, there appears to be a difference between criteria for apprehension and criteria with respect to discharge
- clear statements about the kinds and severity of risks envisaged: to justify ongoing preventative detention, in my view these risks should be serious in nature and amount to more than simply the risk, for example, of poor self-care.

Question 74 and 78: I would advocate major changes with respect to administration and oversight of leave. At forensic leave panel level the current process involves micromanagement and an incredible amount of inefficiency and cost. A useful model is that of South Australia where, as I understand it, teams need only obtain permission from the authorities at times of major transitions for example when moving to unescorted leave from escorted leave, and the fine details of leave planning are left to the discretion of the treating team: the authorities merely have to be comfortable with the broad parameters set. The added benefits would be that this would free up time for the Panel to focus efforts on high risk cases.

Question 79 and question 80: I was involved with the NCSO program in its very early days; others will obviously have more up-to-date experience and

be able to comment better than I on how it currently functions. I have some concerns about the current process though. It is important to note that much of what goes on is not driven by what is in the CMIA but by practice that has developed, usually at the behest of the Department of Health, over the years. I have long had concerns about the curious model whereby Forensicare has supervisory legislative *responsibility* but this is split from day to day management. Whether the treating service is a private psychiatrist or a public mental health service, I find this division problematic both practically and medicolegally. A more satisfactory model in my view, would be that treatment and supervision are linked to the same service and that the NCSO program, as with its equivalent in Queensland, provides expert support and advice in the form of frequent consultations and education of the treating services. This has the benefits of both clarifying roles and also allowing forensic resources to be freed up for actually upskilling the treating services rather than engaging in a monitoring relationship, which was infamously described by one (now retired) local AMHS Director of Clinical Services as a " master and slave relationship".

Question 83: I think the relevant issues are well outlined in the paper that Tom Dalton, myself and others put together some years ago. At the end of the day, it is a typically Australian problem with interstate politics being the barrier. From a clinical perspective, I would have no doubt that the relevant service directors would be only too happy to collaborate and develop up a joint memorandum of understanding. There are now some good examples of interstate transfers but the need to involve the politicians means that these are inevitably subject to long drawnout procedures. If the Federal and State governments are serious about their commitment to Recovery based mental health policy then this is an important area since current arrangements often compromise patients' access to family support.

Question 93 to: The role of treating psychiatrists in providing medicolegal reports for their patients is an issue which divides Australasian forensic psychiatrists. In general, I am of the school of thought that believes that the roles should be separated. Ideally therefore for example, the risk assessment for extended leave applications would indeed be done by a an entirely independent psychiatrist, obviously with access to the clinical files etc.. In practice, the costs of this would be prohibitive. Experience since the CMIA came in suggests that in practice the dual role of the treating psychiatrist is not a great problem in practice: the key reason for this I would suggest is that the "rules of engagement" are very clear to all parties throughout the treatment relationship. Patients are well were, certainly at the rehabilitation end of the hospital, that their treating psychiatrist may one day be called upon in court to provide a risk assessment. This fact permeates the treatment relationship but in my (completely biased) opinion does not poison that relationship. That said, it would be helpful if patients could more readily access high-quality 2nd opinions from independent forensic psychiatrists in the event that they are unhappy with the views of their treating doctor.

Question 106: I can well understand the arguments in favour of open access and reporting of court cases. In practice however without suppression orders it would be **quite impossible to safely rehabilitate many of our patients**. Open reporting would result in a media circus with the inevitable publicising and sensationalising of our patients' lives having a profoundly detrimental effect on their social adjustment and mental health. The public do not in general appreciate that CMIA patients are not criminal offenders, and any reporting would inevitably be prejudicial to good long-term outcomes.

Andy Carroll

[redacted]

22 August 2013

Appendix: relevant publications

"Community outcomes of mentally disordered homicide offenders in Victoria

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Ong, K., Carroll, A., Reid, S. & Deacon, A.

Australian and New Zealand Journal of Psychiatry, 43(8): 775-80, 2009

"Forensic Mental Health Orders: Orders without Borders".

Carroll, A., Scott, R., Green, R., Dalton, T., Brett, A. & McVie, N.

Australasian Psychiatry, 17(1): 34-37, 2009

"Risk assessment and management in practice: the Forensicare Risk

Assessment and Management Exercise"

Carroll, A.

Australasian Psychiatry, 16 (6): 412 -417, 2008

"Drug-associated psychoses and criminal responsibility".

Carroll, A., McSherry, B., Wood, D. & Yannoulidis, S.

Behavioral Sciences & the Law 26: 633-653, 2008

"The evolution of mental disorder as a legal category in England and Wales".

Forrester, A. , Ozdural, S., Muthukumaraswamy, A. & Carroll, A.

Journal of Forensic Psychiatry & Psychology, 19(4): 543 – 560, 2008

"Treatment and security outside the wall: diverse approaches to common

challenges in community forensic mental health"

A. Brett, A. Carroll, R. Green, P. Mals, S. Beswick, M. Rodriguez, D. Dunlop & C. Gagliardi

International Journal of Forensic Mental Health, 6(1): 87-99, 2007

"Depressive Rage and Criminal Responsibility"

A. Carroll & A. Forrester

Psychiatry, Psychology & Law 12(1):36-43, 2005

"Clinical Hopes and Public Fears in Forensic Psychiatry"

A. Carroll, M. Lyall & A. Forrester

Journal of Forensic Psychiatry & Psychology 15 (3):407-425, 2004

"Insight and Hopelessness in Forensic Patients with Schizophrenia"

A. Carroll, C. Pantelis & C. Harvey

Australian and New Zealand Journal of Psychiatry 38(3):169-73, 2004