

Office of the Public Advocate

Response to the following paper:

Sentencing Advisory Council: A Discussion Paper considering the operation of Part 8A of the Criminal Law Consolidation Act 1935 (SA)

7th November 2013

Context

The Office of the Public Advocate puts forward this feedback to the discussion paper in its roles of promoting the right of people who experience a mental incapacity, as well as reviewing programs for people who have a mental incapacity and identifying unmet needs. In providing advice we are also mindful of safety – both the safety of people who have a mental illness or other decision making disability, and the safety of the community in those infrequent instances where such disabilities put others at risk due to behaviour. Overwhelmingly our client group wish to live as independently as possible, and be included in their community. For this to happen housing, clinical services, support services and rehabilitation can be critical to help people attain their goals, and also prevent situations that might lead to risk.

Our Office has individual advocacy and guardianship clients who have been or are on *Criminal Law Consolidation Act 1935* (CLCA) Part 8A limiting terms. We have advocated extensively for service gaps that exist in the provision of forensic mental health and disability areas to be filled. More generally beyond specific services, gaps and unmet need in wider community mental health and disability service provision can put people with a mental illness, intellectual disability, brain injury or autism spectrum disorder at risk of coming before the law. This creates avoidable risk for the person themselves as well as the community.

We note the terms of reference from the Attorney General:

To consider the operation of Part 8A of the Criminal Law Consolidation Act with particular reference to:

- *the test of mental incompetence in section 269C;*
- *the fixing of limiting terms; and*
- *the supervision of defendants released on licence pursuant to section 269O.*

Our Office appreciates that there has been community concern about the operation of these forensic provisions, but careful analysis is needed to determine where the problems arise. It is our observation, based on the issues that we come across with clients and are aware of in the media, that the many problems of concern rest with the care, supervision and follow-up process, and do not rest with the initial court decisions– the current legal tests for mental impairment or how the Courts apply them. This follow-up process could be significantly modified, through the involvement of a Mental Health Review Tribunal. The current review process, in our observation does not adequately look after either the rights and welfare of forensic patients, or the rights and welfare of victims and their families. A move to transfer the current role of the Courts, to a suitably qualified tribunal or specialist Court, should create a more satisfactory system for all participants. We also suggest that consideration be given (subject to the views of victim support groups and the Commissioner on Victim Rights)

to a realignment of roles so that the voice and support of victims occurs through an appropriate victim support service, rather than relying on the current role of the Forensic Mental Health clinical service.

In addition the significant waiting list for forensic inpatient services cannot be simply managed by changing the law. As explained in past Annual Reports of this Office we have limited forensic bed capacity in South Australia, which is particularly severe, when it is considered that our Forensic bed numbers cater not only for people who need a forensic mental health service, but people who require a forensic disability service as well.

When the Sentencing Council's report was released the limited use of the mental impairment defence in the UK where it was said that in 2011 there were 34 successful mental impairment defences (population 63 million) was compared to 50 cases that year in South Australia (population 1.65 million)¹. However in the UK the Courts can use criminal provisions in the UK Mental Health Act 1983. Section 37 of that Act gives the power to the Courts to order a hospital admission or guardianship, and Section 41 the power to restrict discharge. We do not have such provisions in SA. So while mentally ill offenders are more likely to be convicted in the UK, they still receive forensic hospital care, and an extensive system of secure hospital care is available in that country. Furthermore in South Australia there are many prisoners with a mental illness who should now be receiving inpatient hospital treatment but are not. Irrespective of the legislative regime in place people with mental illness or disability in the criminal justice system, will still need care.

As a further point our Office supports the continued availability of this defence for all offences. Although for minor matters, court diversion may be available and should be preferred, there will be occasions where this defence may ensure that a person with a mental illness or disability who may have committed a number of minor offences, receives care and supervision rather than imprisonment.

Question 1.

Should the CLCA be amended to replace reference to 'knowledge' with the word 'understanding'? Should the CLCA be amended to define 'nature and quality of the conduct'? If so, should the definition include 'understanding the physical nature of the conduct and its physical consequences'?

This Office would support replacing the word 'know' with the word 'understand'. We agree as described in the discussion paper, the benefits of the word 'understand' which reflects a deeper appreciation of the effect of the conduct on another (at 2.35).

With respect to the second part of the question, our Office is not in a position to offer informed comment on this change. We note that the paper (at 2.36) reports that the M'Naghten judges "regarded the phrase as "too clear to need explanation"" and that it has been "... interpreted to refer to an individual's appreciation of the physical nature of the act and its physical consequence." If this is indeed the case, then there would seem to be little need to add these words to our statute, if the rule is already seen in this way.

¹ Hunt N (2013) Major review to prompt amendments on mental health loophole as a means of avoiding jail, The Advertiser, <http://www.adelaidenow.com.au/news/south-australia/major-review-to-prompt-amendments-on-mental-health-loophole-as-a-means-of-avoiding-jail/story-fni6uo1m-1226688408208>

Question 2.

Should the CLCA provide for a definition of 'wrongness' based on whether the defendant was able to 'reason with a moderate degree of sense and composure'?

Once again, because we tend to meet clients after the initial trial, we have had little direct involvement with such questions.

We note from the discussion paper that the Porter definition of wrongness is widely used, and once again this suggested law reform, would merely put into statute what is already common practice.

Unless there have been problems reported by the Courts or participants in the process, we would see little point in incorporating this definition into the Act. Doing so could create an impression that something has changed, when in fact it has not.

Question 3.

Alternatively, should the CLCA be amended so as to provide that a consideration of whether there was an ability to reason with a moderate degree of sense and composure be confined to cases of 'frenzy, uncontrolled emotion or suspended reason'?

In this question as well, we feel limited in our ability to respond, because of our Office's lack of direct involvement in such cases at the time of trial.

However the proposition appears worrying. First we do not consider that the discussion document has explained why it might be worthwhile considering limiting this test in this way, or second, explained who might then be excluded from accessing the mental impairment defence, if this was to be done.

While recognising that a formal case review of s269 cases would be needed to estimate the impact of such changes, we would be concerned that many people with significant disability who commit offences without frenzy, might then be less able to mount a mental impairment defence. For example, a person who has severe intellectual disability and hits a person near them, might have acted spontaneously and unpredictably in response to an environmental stimulus, but not be in a state of frenzy or uncontrolled emotion. While this may also be uncontrolled, a person's lack of appreciation of wrongness could be a part of their defence.

Question 4.

Should the CLCA be amended to remove the 'unable to control conduct' component of the defence?

The paper reports that this test is rarely relied on, and is only used by 2% of defendants (at 2.71).

It is our view that this does not provide a reason for removing this defence, and it should remain available to people who have either a psychiatric illness or severe disability who at times be unable to control behaviour.

Question 5.

Should the definition of mental illness in s269A of the CLCA be amended to specifically include hypoglycaemia or exclude hyperglycaemia? Should the definition of mental illness in s269A of the CLCA be amended to specifically include or exclude any other problematic medical conditions?

The broad definition of mental illness that currently exists in the CLCA, is supported. It is similar in many respects to the broad definition used in the *Mental Health Act 2009*

We do not support the naming of specific medical conditions in any definitive way, although there could be benefit in providing an example of a type of condition to illustrate a principle that could be then extrapolated to other conditions. There is a long list of causes for organic mental disorders, both internal and external. It could ultimately be pointless to only definitively mention one metabolic disturbance, in this case hypoglycaemia, as there are so many different other causes of confusion. These include changes in serum electrolytes (for example caused by dehydration), oxygen, carbon dioxide, calcium, endocrine conditions (hypo or hyperthyroidism), infections and the side effects of many drugs.

Our observation is that the problem described in the discussion paper would appear to be the historical artificial division between disorders created by an internal cause and those created by external causes, which creates an anomaly and potential injustice. There does not seem to be any valid scientific, or moral reason to separate such internal and external factors, in considering whether or not a person has a mental illness. For example one person might have mania precipitated by a hyperthyroid state caused by an overactive thyroid gland, while another person has a similar mental state caused by thyroid hormone prescribed by their doctor at too high a dose. If offences are committed in such a state, in both situations a mental impairment defence should be available if the definitions in s269 C are met.

For this reason, rather than definitively naming individual metabolic disorders, if there is a need to eliminate this anomaly, a note could be made in the legislation that a mental illness can be caused or precipitated by internal or external causes, and if it is necessary to name a condition such as hypoglycaemia it could be given as an example.

Question 6.

Should the definition of mental illness in s269A of the CLCA be amended to expressly declare that the objective test formulated by Mason CJ, Brennan and McHugh JJ in Falconer must be applied for the purposes of distinguishing between sane and insane automatism in cases involving dissociation?

This Office has not been directly involved in matters where questions of sane vs insane automatism have been considered.

The objective test for sane automatism put forward by the High Court - how the ordinary person of normal temperament and self control might respond to such a psychological trauma – has been a part of case law for over 20 years, and we understand is now routinely followed in South Australia.

In the absence of controversy about this provision, and with the understanding that the test is currently being used, it is not clear what benefit, if any, there would be in putting this test in the statute.

Question 7.

Should the definition of mental impairment under the CLCA be amended to specifically exclude personality disorder including psychopathy?

This Office would oppose such an exclusion, and would see significant risks if an exclusion were put in place. Because of the evolving nature of psychiatric classification, and the different approaches of clinicians over time it would be unfortunate if specific reference to disorders were made in legislation, particularly when this could be avoided.

In particular we highlight the comment in the discussion paper cited at 2.120 of Wallace J in *Hodges* “[t]he emphasis is not upon the label which a psychiatrist may place upon a prisoner’s personality,” but on the effect of the disorder on that person’s mental functioning.

Because of the three criteria of s269C, we understand that a person with a pure personality disorder is unlikely to be able to mount an effective mental impairment defence, because they will not have the functional impairments in knowledge, judgement and control. For this reason there should be no need for the law to have an exclusion based on diagnosis in addition to the s269 C criteria.

On the other hand a person with a personality disorder might potentially have another superimposed psychiatric illness at the time of the offence, and depending on the nature of the additional illness, and its relationship to the offending, may be able to use an impairment defence at those times.

In this context it is preferable to consider each person’s situation as they arise rather than have specific diagnostic criteria in legislation.

To explain this further, diagnoses of personality disorder are common – a key psychiatric textbook refers to a prevalence of 10-20% in the general population, and that half of all psychiatric inpatients and outpatients have a personality disorder² Many people with another psychiatric diagnosis can have an underlying personality disorder diagnosis

A relevant example affecting mostly women, is borderline personality disorder. 75% of people with this condition are female, and can present with unstable relationships, suicidal behaviour and intense anger. Childhood trauma, in particular sexual abuse, is a common predisposing factor. People with this condition can experience psychotic like symptoms in response to stress, and are also at risk of co-morbid major depression and post traumatic stress disorder. It also responds to specific therapies – in particular dialectic behaviour therapy and some forms of psychodynamic psychotherapy.

Our concern is that a specific exclusion related to personality disorders, could disadvantage such people. In court it might lead to debates as to whether or not co-morbid episodes of psychotic decompensation, dissociation or mood disorder should be considered as additional to the Borderline Personality Disorder diagnosis, and therefore acceptable for a mental impairment defence, or part of the overall presentation; in the latter case an impairment defence would be excluded under this proposal.

Diagnosis can also be uncertain. For example the very term ‘borderline’ as a descriptor for this personality disorder condition reflects its historic position on the borderline between

² Cloninger C and Svrakic D (2009) Personality Disorders in Kaplan and Sadock’s Comprehensive Textbook of Psychiatry, Wolters Kluwer, Philadelphia

schizophrenia and mood disorders. Severe mental illness such as schizophrenia and bipolar disorder can evolve over time, sometimes years, and it is not uncommon for personality disorder diagnoses to be made that are subsequently abandoned when a fully developed syndrome of psychosis or manic depression becomes evident. Conversely it is also not uncommon for people to be given erroneous diagnoses of bipolar disorder, only to have a more accurate diagnosis of borderline disorder made. It is only then that people who have not improved with lithium or other mood stabilisers are finally helped when dialectic behaviour therapy for their personality disorder is provided.

Borderline personality disorder is also being actively researched. For example researchers from the Karolinska Institute in Sweden demonstrated a link in a gene variant involved in the production of the brain chemical serotonin (the tryptophan hydroxylase-1 gene), to impulsivity measured on psychological tests. This study was of a sub-group of women with borderline personality disorder who have attempted suicide and have high scores on a psychological impulsivity test³ As more evidence accumulates our scientific views about what is and what is not a mental illness could change.

These issues are difficult enough for the person with mental illness and their treatment, but could be made worse if there was a diagnosis based exclusion related to personality disorder.

Other examples of the uncertain border between personality disorders and other diagnoses are the DSM IV-TR and DSM-V "Cluster A" personality disorders: paranoid personality disorder, schizoid personality disorder, and schizotypal personality disorder. These conditions, to a greater or lesser degree can be seen as on a spectrum with schizophrenia and other psychosis. People with these personality disorders may never develop a psychotic illness, but can nevertheless be at risk of psychotic decompensation.

Once again the terms of s269 C are the critical differentiator, not an empirical diagnosis based on the presence or absence of certain symptoms of either personality disorder or other conditions.

Lastly the same arguments can apply to the diagnosis of antisocial personality disorder. This is a common diagnosis in prisoners. One again we suggest that the key differentiator are the s269C criteria, because although such people a pervasive pattern of disregarding and violating the rights of others, this is done while knowing the nature and quality of the conduct, knowing that it is wrong, and able to control the conduct.

Overall the law should retain a broad definition of mental illness and allow the M'Naghten criteria to define the use of this defence.

³ Maurex L et al (2009) Emotionally controlled decision-making and a gene variant related to serotonin synthesis in women with borderline personality disorder, *Scandinavian Journal of Psychology*, 50:5-10.

Question 8.

Should the CLCA be amended so that a person charged with an offence would be able to rely on a defence of mental incompetence when, from whatever cause, he or she was unable to understand the nature and quality of their conduct or understand that it was wrong?

This Office is not in a position to comment on this specific proposition because of the complexities of the issues raised. As described in the discussion, with Part 8 Intoxication and Part 8A Mental Impairment, having been developed at different times for different reasons. We do however make the following general comments relevant to questions 8, 9 and 10.

We understand there exists a concern that if a defendant is seen to be responsible for producing a mental illness through their intake of drugs or alcohol, then a moral problem exists if the person is then allowed a mental impairment defence.

However the degree of moral responsibility can vary dramatically depending on the individuals situation.

In spite of broad community education that highlights the risks of drug use a significant proportion of the population continue to use illicit drugs. In 2010, 13.4% of the Australian population over 14 years of age had used drugs in the previous 12 months; with reference to the use of specific drugs the percentages of the population are: 10.3% cannabis, 2.1% amphetamine or metamphetamine, 2.1% cocaine, and 3.0% ecstasy⁴.

In this context a young person who uses drugs, may know of but not really accept the potential catastrophic consequences of drug use that might happen to them, and may not really appreciate this risk until it actually occurs. Should this person commit an offence he or she might meet M'Naghten rules if psychotic.

On the other hand, at the other end of the moral spectrum is the person who knowingly puts others at risk through their drug use, making the decision to use drugs when they have full decision making capacity. For example a person with a past history of drug induced psychosis that placed others at risk, may knowingly take drugs again at later time, even though they are mentally well when making this decision, have capacity, and know that such drug use has put other people at risk in the past and may do so again in the future. If this decision is made because of a blatant disregard for other people and the community, then that person must bear responsibility for the predictable consequences of that decision.

A key issue here is the mental capacity of the person who knowingly takes drugs.

There are of course situations where a person's capacity and judgement may not be clear cut –a person with chronic symptoms of psychosis may have judgement impaired, and be driven to consume caffeine, cannabis and other agents, as part of the overall picture of their illness. Such co-morbidity is common, and access to dual diagnosis treatment programs to address this behaviour is limited. Some people who are manic may resume drug use because of mania. It can be difficult to know if drug use has precipitated mania, or whether the early signs of hypomanic relapse then drove a person to use drugs which make mania worse.

⁴ Australian Institute of Health and Welfare (2011) 2010 National Drug Strategy Household Survey Report, <https://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737421314>

This does not answer question 8 in the paper, except to highlight the need for consideration of individual circumstances by the Court, and the difficulty in making general assumptions about drug induced psychosis.

Question 9

Should the CLCA be amended so that a person charged with an offence would be barred from reliance on a defence of mental incompetence if their inability to understand the nature and quality of their conduct or inability to understand that it was wrong or incapacity for self control was a consequence of the combined effects of mental illness and a state of self induced intoxication?

For the reasons stated above, this Office would not support a change to the law that would have this effect at this time. This is because each individual situation would need careful consideration by the Court. It is not clear from the discussions that the Courts are experiencing difficulties in this regard. As noted in the discussion paper at 2.140, South Australia has already legislated to abrogate the common law on intoxication and criminal responsibility, the so-called O'Connor principle, that still operates in other jurisdictions⁵. From this Office's point of view, taking extra statutory steps with respect to the mental impairment defence have not yet been justified.

Having said this it would be a useful exercise to better reconcile Parts 8 and 8A of the CLCA, given the frequency of "dual diagnoses". In some situations following acquired brain injury there is a "triple diagnosis" pattern that develops of cognitive disability, mental illness and substance use – all interrelated phenomena that need to be considered holistically, and arguably the problem or the resultant behaviours cannot be picked apart.

Question 10.

Should the CLCA be amended so that a person charged with an offence would be barred from reliance on a defence of mental incompetence based on evidence of a mental illness resulting from the use of intoxicants unless the illness is permanent/prolonged/persistent/protracted/enduring?

This is not supported.

By way of context a presumption in all of this is that it is possible with some accuracy to say that a psychotic episode has been drug induced. In practice this is often not the case. As part of early psychosis protocols, it is expected that all young people with first episode psychosis be followed up, because it is often not possible to determine what might be a drug induced psychotic episode compared to the first episode of a developing psychotic illness. Because drug use is prevalent in the community it is not an easy proposition to link a person's psychosis with their drug use – there may be causality but there may also be a coincidental association.

Sometimes psychiatrists have only been able to confidently determine that person has had a drug induced psychosis following a period of prolonged hospitalisation away from illicit drugs, and after antipsychotic medication has been stopped.

So apart from an in principle lack of support for this proposition, there would also be practical difficulties in implementation.

⁵ *The Queen v O'Connor* (1980) 146 CLR 64.

Question 11.

Should the existing provisions on intoxication and mental impairments in the CLCA be retained without change?

For the reasons stated above, we do not consider that the case for change has been made at this time, if the purpose of such a change is to limit access to the mental impairment defence for people who may have a drug induced psychosis.

The Courts need to consider the individual circumstances in each case. There is a risk that any requirement in law to separate out conditions precipitated by drug use, will be beyond the ability of psychiatry and psychology to accurately distinguish between conditions.

Furthermore it is our impression, that much of the controversy about drug use has come about because of instances where people who have been found not guilty of mental impairment, and have used drugs while under community supervision. If this is the problem, then stricter provisions should apply to those people in their limiting who with full capacity use drugs, rather than limit access to the mental impairment defence in the first place to a potentially large group of people, because of the non-compliance of this smaller group.

Questions 12 & 13.

- 12. Should there be a reduction in the number of psychiatric reports required under Part 8A?*
- 13. Should Magistrates and Judges have a discretion regarding the type and/or number of reports to be ordered? If so, what factors should guide the exercise of that discretion?*

This Office would support the court having discretion in how it receives expert evidence. Details of numbers of reports are arbitrary.

Having said this the adversarial process does not always assist the collection and analysis of expert evidence. Even if the arbitrary requirements in law are removed there could still end up being multiple conflicting reports driven by this process.

There is an argument for decisions about competence to be referred to a separate inquisitorial process, that could be run by another Court, or a Mental Health Review Tribunal. The different models in use in other states are referred to in Ian Bidmeade's report *Paving the Way* section 7.

Question 14.

Should the court be provided with additional disposal options to apply to persons found not guilty by reason of mental incompetence? If so, what options should be available to the court?

The Office of the Public Advocate supports the notion that the Courts should have a suite of options, related to supervision, therapy and support, that can be matched to either the care and treatment needs of the person before the court and/or community safety.

The options used in other states and the Commonwealth could be added to this suite.

It would be important that, the option chosen be the least restrictive compatible with the safety of those involved. For example, it would be unfortunate, if a person, say, having committed a minor offence, was then subject to coercive and directed mental health treatment, that would not be applied to a person with such an illness and risk of harm to self or others, under the civil provisions, of the *Mental Health Act 2009*. This does provide a useful comparator, and supports the need for a specialist court or tribunal that is well versed on care and treatment options, and balancing least restrictive options with the prevention of harm.

Finally in any legislation or policy document we suggest that an alternative word to “disposal” be used. We appreciate here that it is used in the context of disposition, however in common use it has other connotations. People with mental illness and disability have been highly stigmatised over the years, and they or the public may not appreciate the subtlety of the legal use of this term. The historical use of the term “bin” to describe specialist psychiatric hospitals is an example of this stigma.

Question 15.

The following options are suggested for consideration:

- (a) Should any of the procedures in the interstate models discussed above be adopted in South Australia?*
- (b) If the court is to retain the power of fixing a limiting term should it be fixed in a way other than by reference ‘to the term of imprisonment that would have been imposed had the accused been convicted of the offence and sentenced in the usual way’?*
- (c) If the court is to retain the power of fixing a limiting term should the court be allowed to take into account a concession by the defence that the objective facts are admitted?*

We appreciate the dilemmas in this section. On one hand, if a person is not guilty by reason of mental impairment, a limiting term based on a sentence for a guilty person is an irrelevant benchmark, as the person requires care and treatment for however long is needed to recover. Yet on the other hand the use of indeterminate sentences in this state in the past, and in other states can remove more rights of a defendant compared to a person who is found guilty, and discourage the appropriate use of such a defence. For this reason it is our view that it is preferable to continue with the concept of a limiting term rather than return to indeterminate sentences. If a person still needs supervision at the end of the limiting term, treating teams have an option to seek orders through the *Mental Health Act 2009* and the *Guardianship and Administration Act 1993*.

In answer to the question of what other reference point should be used, notwithstanding the problematic nature of the current reference point, it is difficult to put forward any meaningful alternatives.

We suspect the notion of a “limiting term” feeds into the notion in many peoples mind that the custodial part of a persons limiting term, is a sanction for committing a crime rather than an order for treatment. Objections to a person’s release into supervised community care may be influenced by the idea that a person has not yet served their time. However it our impression that this problem is not unique to our system of limiting terms. The solutions to this, we think, rest in having an effective method of overseeing key decisions such as hospital discharge during the limiting term.

With respect to the court taking into account a concession by the defence admitting the objective facts of an offence, this is supported. On one hand it is problematic, because once again, this consideration is irrelevant to the treatment needs of a person who is mentally impaired. On the other though a person who is using a mental impairment defence is disadvantaged compared to a person who is not using such a defence if such factors cannot be considered, and for this reason such an amendment is supported.

Question 16.

Should Judges and Magistrates have a discretion in requiring a Victim/Next of Kin reports at all stages of the Part 8A proceedings? If so, what factors should guide the exercise of that discretion?

It is our observation that the current system of supervision does not adequately meet the needs of either victims, or forensic patients.

While we support the giving of Judges and Magistrates the discretion requested, we have concerns about the arrangements in Part 8A proceedings after a finding of mental impairment has been made, related to ongoing supervision (as per 4.20).

The current system does not seem to meet the needs of victims or next of kin, or forensic patients. Arguably, the stress for victims, is not just created by the ongoing need for reports, but the involvement of the original Court in making changes to the supervision order. In contrast if a person is found guilty, the Parole Board has ways of hearing victims views, that does not appear, in so far as we aware, to create the same stress for victims or next of kin.

A further problem with the report process, we suggest, is that some next of kin must not feel that they are being heard in this current process, and recently there has been a trend for victims and next of kin to seek to be heard directly in court hearings to review supervision arrangements.

This could be explored further with victims and next of kin. Should a victim support agency have a role in preparing these reports? Would this specialist victim support involvement reduce the stress of victims and next of kin, and increase a sense of being heard. Improved support to victims would also assist the experience of forensic patients returning to court as the environment might then be less adversarial.

Ultimately we suggest a tribunal or specialist court, overseeing supervision would better be able to meet the needs of all parties.

Questions 17 and 18.

17. *Should the court or supervisory agencies nominate a lead agency to be primarily responsible for supervision of an individual licensee?*
18. *If a lead agency is nominated to be primarily responsible should it instruct the ODPP to determine whether breach proceedings should be instituted?*

While the nomination of a lead agency is superficially attractive, as a strategy in itself, it will not solve the fundamental problems that arise when there is a disagreement between the Department of Correctional Services and Forensic Mental Health Services.

In particular the Parole Board will have expertise in setting limits and responding to breaches by individuals who have regained their capacity following treatment, but for personality and other reasons choose not to comply with their conditions. The Mental Health Services of course will have expertise in assisting a person who relapses or breaches because they are unwell.

It is unfortunate that the Parole Board, in responding to a person with capacity, who wilfully breaches a condition, only has the option of recommending a return of that person to hospital, which creates problems for hospital staff when there is no particular therapeutic reason for such an admission. This is also impacted on by the lack of beds.

Our Office is very concerned that people who have a mental illness or a disability are not disadvantaged in any realignment of roles to create a lead agency for each client. The purpose of a limiting term is to provide therapy and rehabilitation, and the professional judgement and decision making of health and disability staff should not be undermined if another agency is given a "lead" role.

On the other hand the particular skills of the Parole Board are needed to supervise people who have mental capacity and need limits set on behaviour driven by non-illness or non-disability related factors.

For this reason we think that there is benefit in each agency continuing to have its defined role, and that one agency's judgement is not given precedence over the other by arbitrarily assigning a lead role. There can be benefit in these conflicts being heard, not by the ODPP, but by a decision making body - for example a specialist tribunal or Court, could consider the different perspectives before making a determination.

As noted in 4.28 there can be conflict in how breaches are managed related to the use of limited hospital resources. Therefore alternative detention may need to be considered.

Our position is to support a review of alternative detention options. We provide the following suggestions for consideration, although before any were followed through, more consultation would be needed with the relevant groups.

There could be a range of potential options added to a wider range of responses if a breach has occurred.

- If the breach is due to illness, then a return to hospital is needed.
- If a breach is due to behaviours secondary to a disability, then a person could be transferred for a period of time to a closed disability setting that offers positive behaviour support and other specific disability interventions.

- If a person has an underlying drug and alcohol problem which is driving this behaviour then a specific drug and alcohol therapeutic response might be more appropriate. For example an order to undertake, and stay at a residential 'inpatient' program run by the Drug and Alcohol Services at its Glenside Hospital Campus, followed by closer home supervision until it is clear that the person will no longer seek and use the drugs of concern.
- For other people who have capacity, some other form of non-criminal detention, not at James Nash House, may be needed for a period of time until the risk to the community has been lowered. This could be analogous to the non-prison administrative detention used under the *Public Health Act 2011* for people who create a risk of spreading infectious disease. A person could receive in reach drug and alcohol, and mental health interventions if detained in this way.

It is also possible that there will be a small sub-group of people, who with full capacity do not comply with their conditions, and repeatedly and wilfully take actions in defiance of their supervision conditions with disregard to the potential consequences to others. Such behaviour could constitute a criminal offence (see question 21).

Question 19.

Should the shared supervisory role of the Minister for Health and the Parole Board be extended to include the Minister for Disabilities?

The Part 8A provisions define the parameters of the service system for people who are found not guilty by reason of mental impairment. Currently people with a primary disability who come under Part 8A, are assigned to be supervised by the wrong Minister, the wrong department, the wrong service with the wrong training. Everyone loses out: people with disability who could otherwise receive care, supervision and rehabilitation from a disability organisation; people with a primary mental illness who have reduced access to mental health services shared with disability clients without any adjustment for bed numbers; and mental health staff who are expected to manage behaviours of concern secondary to disability without the specialist positive behaviour support programs used in that sector.

There is a strong argument that the legislation sets the parameters that then lead the services to operate the way they do. Changing these legislative parameters – in this case creating a role for the Minister for Disability, may not initially create changes in practice, but over time systems would realign the provision of services into distinct forensic mental health and forensic disability services that each undertake custodial, community and prison in reach services.

For people with a disability, it means that the same Minister would be responsible for care and supervision in custody, as well as in the community. This would provide continuity of care and supervision, and better planning.

For people with disability in custody they could be managed in a Disability run low stimulus environment that meets their needs. Staff would have training in positive behaviour support to prevent and respond to potentially violent behaviour. The care would be cheaper to deliver than hospital care because of the different cost structure. Disability services use disability workers, disability educators and psychologists to deliver a program, and can also efficiently deliver services to smaller cohorts: for example a 10 bed stand alone disability unit could be efficiently run, but in the Health setting a 10 bed hospital unit would be considered by many to be too small to be efficient. (A 10 bed forensic disability unit is needed now).

For people with disability in the community, these changes would allow Disability services to develop specialist expertise in managing risk. This expertise would be available not just to forensic disability clients serving a limiting term in the community, but to other general disability services with behaviours of concern, with the aim to prevent future offending.

With respect to costs, a forensic disability community service would also be more efficient in delivering services to people at risk, compared to the current system of developing one off solutions for individuals through an exceptional needs process. A program response would allow skills to develop and deal with predictable need.

An argument that has been put forward by some for not creating a forensic disability service, and an argument that we would disagree with, is that many forensic clients have dual diagnoses – both a mental illness and a disability and therefore mixing the mental health and disability services is justified. There are also clients with dual diagnoses in the community, and clients are allocated to one or other service, mental health or disability, as a lead service, and the other service will assist. People with disability, who also have a mental illness, also need access to specialist mental health facilities and services for the treatment of those conditions when unwell, just as any other person in the population does. However when a mental health condition has settled it may be better to reside in a disability focussed setting.

A change to legislation now, could lead to positive changes to services in coming years, assisting individuals, and would contribute to community safety.

Question 20.

In the absence of a purpose built facility for individuals found not guilty of an offence due to mental incompetence (or being found unfit to stand trial) on the basis of an intellectual disability or brain injury, what options are available for housing and supporting these individuals whilst on a licence pursuant to s269.

This question can be considered for both people in custody and people on licence in the community. There has been much interest across the sectors in creating such a service, and the Public Advocate has had the opportunity to discuss this issue with government and non-government providers.

For people in custody a 10 person secure residential unit could be established now. Appreciating the limits of funding at the present time, an existing residential setting could be modified. For example at the Oakden sites wards previously occupied by Mental Health Services for Older People could be renovated to become accommodation for a forensic disability service.

The design and ambience of the unit should be as close as possible to a community disability setting. The modern approach to security is to not build prison like buildings as the principal means of security, but rely on a high tech perimeter fence. Inside the ambience should be residential, therapeutic and rehabilitative, rather than custodial.

It is likely that such a facility could be operated by an existing non-government organisation working in the disability area.

There would be a cost in operating such a new facility, as the current mental health beds occupied by people with a primary disability would not close and the existing operating costs would not be transferred. When the existing residents moved to a purpose built disability

facility, there would be mental health patients currently waiting for these existing beds, who would then use this freed up mental health capacity.

While this is a cost, there would also be savings as the Health and Correctional system would not need to pay for the extra marginal costs of looking after clients in the wrong environment (ie the ward or prison cell) which has traditionally created risk and the need for extra staff presence.

The costs could be funded directly by the Government but there are other financing options. Over recent years our Office has put forward the idea of using social impact bonds – an innovative financing method used in the UK and the US – to fund a forensic disability service.

For those in the community, existing resources funded through the disability and exceptional needs unit budget could be pooled to create a specialist forensic disability team. The Senior Practitioner in Disability could oversee the programs and standards of this service. As funds are already spent on these clients through one –off packages of care, it is likely that existing financial resources could be redirected to support this community work, and that this approach would be more efficient..

Finally it is worth commenting on the interrelationship between forensic disability services and the NDIS, because this is relevant to the planning of long term options for this group. It is our view that a forensic disability client should still be eligible for NDIS funding, at least to the level that would be funded if the client was living in the community. It could be reasonable for the State to fund the added care costs due to the security requirements of a CLCA order. This is different to the current situation where all costs are funded by the State.

Question 21.

Should breaches of licence particularly, persistent breaches, be dealt with by way of:

- (a) an amendment to the Mental Health Act 2009 to enable a licensee to be assessed and treated as an alternative to revocation of the licence and returning the person to secure detention at James Nash House; and/or*
- (b) amending the CLCA (and any other ancillary legislation) to provide for home detention where a licensee is either unable or unwilling to comply with the conditions of licence, justifying a higher level of restraint on their liberty, but not requiring inpatient medical treatment; and/or*
- (c) where there is evidence that a breach or persistent breach of licence conditions is not as a result of a mental impairment at the time of the breach, should a breach of licence conditions constitute a criminal offence and attract a criminal sanction?*

This question has already been alluded to in the answers to Question 17 and 18. A range of alternative options for custody have been suggested in the answer to that question.

Mental Health Act 2009

With respect to the use of the *Mental Health Act 2009* order applied to forensic patients, we would consider that this proposal would work more effectively if a Mental Health Review Tribunal supervised the forensic patient rather than a Court.

For example, a Tribunal could make decisions about community supervision and at the same time consider an application from the mental health service for a Level II Community

Treatment Order, if such an order was required. The patients would then have access to a right of appeal over such an order.

There should not be a different threshold for making a *Mental Health Act* Community Treatment Order for a forensic patient, than there would be for any other patient placed on a community treatment order who is not subject to forensic provisions.

In addition to CTOs, It would also be appropriate for a specialist tribunal or a Court to have power to grant a level III Inpatient Treatment Order (ITO) by application or on its own initiative, consistent with the expert evidence before it. The same caveats described above should apply: orders should not be made in situations where an order would not normally be used in general psychiatric settings.

In the South Australian setting, two advantages could be foreseen in giving the Courts this option.

First for forensic patients it would allow inpatient care to be delivered in a wider range of settings in instances where treatment is needed but security is not an issue. Where a forensic patient on a CLCA order can be admitted is tightly defined. Forensic patients in custody are admitted to secure settings only, such as James Nash House, Grove Closed, the Cedars Psychiatric Intensive Care Unit and the Margaret Tobin Centre's Psychiatric Intensive Care Unit. This is irrespective of the clinical need for these secure intensive care settings. There may be situations where a person needs detention but does not require these secure settings. A Mental Health Act order would permit this option when the principal purpose of detention is the delivery of treatment, rather than placing the person in a secure environment.

Second if the court had these powers they could be used to assist people convicted of an offence as well as forensic patients. This situation would be analogous to the use of the UK Mental Health Act 1983 by the courts in that country. A person could receive psychiatric care as an alternative to imprisonment. The court or tribunal should only overturn such orders, once made.

I would note that this Office, when consulted about the CLCA in 2011, opposed the extension of Mental Health Act powers to the court. However on further consideration of the approach used in the UK, and also the numbers of people in prison who have a mental illness – to the extent that the prison system itself could be seen as a mental health system - there could be benefit in the Court having such options for all the people who come before it.

Home detention

Our Office would support Home detention as an alternative to rehospitalisation for a person unable or unwilling to comply with their order but not requiring inpatient care.

Criminal sanction

This Office is open to such a sanction being available to the Courts (or a specialist tribunal) to respond to persistent breaches by persons who have decision making capacity, who show antisocial disregard for the safety of others in their decision to breach licence requirements. This has been mentioned in the answer to Questions 17 and 18. The availability of a criminal sanction needs to be in the context of a range of options.

Having said this, we would wish to better know how other jurisdictions perform, particularly if the creation of a new offence for such breaches is a 'first' in South Australia. In particular

are other jurisdictions managing such situations more effectively, and what options do they use?

If an offence is created, how can this be done in a way that does not disadvantage people with a mental illness or a disability, who may be competent before the law, but are driven in their behaviours by the combined effects of their illness, co-morbid history of substance use (which is more likely to be present than not), and possible financial impoverishment. History of brain injury can also be common. Arguably these are the constellation of problems that lead to people with mental illness to be overrepresented in prisons following convictions for minor offences. A new law should not contribute to this.

A new offence would need to target the small subset of persons who persistently breach for antisocial reasons, and be careful not to inadvertently penalise the broader group; people who are seeking to comply with their orders, who may need tolerance and support, and from time to time have set backs. Any new law would need a review of its operation.

Question 22.

Are additional means of empowering particular agencies (such as the Parole Board) required to deal with non-compliance by licensees?

We have no comment on empowering existing agencies. The case example at 4.59 demonstrates the work of a specialist court or tribunal.

Question 23.

Should the CLCA be amended to allow for administrative detention in the circumstances discussed in R v Draoui? Are there any alternatives to administrative detention in these circumstances?

The Office of the Public Advocate supports the proposed model of administrative detention, on the understanding that it is used on a case by case basis and that this power is a licence condition by order of the Courts.

There needs to be an easy access to an appeal mechanism for the patient should the patient disagree with the detention decision and this mechanism should permit a quick review within one or two days. This review of the Directors decision could be by the Court (or a specialist tribunal).

Questions 24 and 25.

24. (a) *Should there be a statutory provision for police officers or authorised officers in South Australia to take care and control of interstate forensic patients who are found in South Australia and to return them to the jurisdiction that made the orders?*

(b) *Further, should provisions similar to those in Part 7B of the Victorian Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 be enacted in South Australia?*

25. *Are the provisions of Part 7A of the Victorian Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 a suitable model for amendments to the South Australian law to enable transfer of persons under supervision to and from South Australia?*

The Office of the Public Advocate has not had direct involvement in situations where forensic patients from other states have come to South Australia.

We would support provisions that allow the return of people who have left other states without permission, and also allow South Australian people under orders to seek permission to move interstate to live if they wish to.

We support the process of examining the use of warrants, and procedures currently used in mental health legislation to develop a suitable system.

A person affected by such provision, irrespective of their state of origin, should be able to challenge a decision about interstate movement in a South Australian Court or a tribunal.

Question 26.

Are there comments with respect to the Step-Up and Step-Down proposal outlined and being investigated by the Director of James Nash House?

This is an excellent initiative. Our Office has concerns that the Commonwealth Government funding may be time limited. A renewed commitment of funding for Ashton House is required so that it can continue to operate.

We agree that further consideration is needed as to how a step down unit such as this fits within the law.

The Unit still provides detention, in so far that if a person were to leave without permission the police would be called, and the site has security and surveillance measures in place.

It would be reasonable for patients to step down from James Nash House to Ashton House, without the need for permission to be sought by the court.

There is a comparison that can be drawn between the management of prisoners by Corrections and the management of forensic patients by Forensic Mental Health services. After a court has handed a prisoner to Corrections, the Corrections department does not have to go back to the Court to seek permission when it moves a prisoner to a low security prison, or allows a prisoner accompanied leave with staff to attend to some task in the community. In contrast the Forensic Mental Health service cannot make even small changes to a patients regime without Court agreement. The value of this involvement should be questioned. There is an argument that there should be a greater reliance on Forensic Mental Health practitioners to responsibly administer a robust and transparent risk management system.

Changes could be reported to the Court, and subject to review if parties disagreed

We appreciate that Ashton House is new, and its performance is yet to be evaluated. However after this has been done, and it is clear that the model is effective and working, it would be reasonable to give forensic mental health services the discretion for patients to be moved from the medium security environment of James Nash House to the lower security setting of Ashton House, and then notify the Court. This would be different to the current need to seek Court approval.

Question 27.

Should South Australia consider introducing a Mental Health Review Tribunal, Board or equivalent to assist in the supervision of individuals released on licence? If so, what functions and powers would such a Tribunal, Board or equivalent perform?

Throughout this document this Office has referred to the benefit of such a tribunal. We believe that this would deliver better outcomes to patients and victims.

The tribunal could make initial determinations of mental competence, and then routinely supervise patients, taking over the existing role of the Courts.

There is a question to be considered as to whether or not the Tribunal could take over Parole Board functions so that all decisions are made by a single panel. To do this members of the Parole Board would need to be coopted to sit on the tribunal to provide this expertise.

SACAT will be led by a Supreme Court Justice. In serious criminal matters, this Justice could sit with professional assessors to consider questions of mental competence to commit an offence as occurs in other jurisdictions.