Submission made by the Office of the Public Advocate

to the

REVIEW OF THE MENTAL HEALTH ACT (1996)

and the

CRIMINAL LAW (MENTALLY IMPAIRED DEFENDANTS) ACT (1996)

1. INTRODUCTION

The Office of the Public Advocate (the Office) welcomes the Review of the *Mental Health Act 1996* and the *Criminal Law (Mentally Impaired Defendants) Act 1996,* while at the same time recognising the improvements that have been made in relation to mental health service provision in Western Australia since the implementation of the two Acts.

This Review provides an opportunity to identify issues that require a legislative response:

- based on practical experience since the application of the *Mental Health Act 1996* and the *Criminal Law (Mentally Impaired Defendants) Act 1996*, and

- that reflect the principles and standards that underpin ongoing developments in treatment practice in Mental Health, for example, the United Nations Principles for the Protection of Persons with a Mental Illness, the Mental Health Statement of Rights and Responsibilities and National Standards.

The Review also provides an opportunity to identify issues that may be best addressed by changes in policy and practice across all of the agencies involved in the delivery of services that impact on the lives of people with decision-making disabilities, their carers and families who are affected by the *Mental Health Act 1996* and the *Criminal Law (Mentally Impaired Defendants) Act 1996.*

Issues include the need:

- for effective interagency collaboration,

- for service providers to be well informed about all relevant legislation and to have a shared understanding about functions and responsibilities across agencies,

- for system wide policies and procedures in identified areas,

- for an adequately resourced range of services to support people with decision-making disabilities,

- for education for people with decision-making disabilities, carers, families and service providers,

- to address issues and special requirements that impact on, for example, Indigenous people, people from culturally and linguistically diverse backgrounds, people who live in remote and isolated areas, and young people and children, and

- for a process to be developed and implemented to achieve continuous quality improvement in all mental health facilities and services.

The focus of this submission is on:

- the interface between the *Guardianship and Administration Act 1990* and the *Mental Health Act 1996* and the *Criminal Law (Mentally Impaired Defendants) Act 1996* and the impact of both Acts on people with decision-making disabilities,

- strengthening safeguards in the legislation, and

- incorporating improvements in best practice and improving accountability through improved service performance.

This submission is not exhaustive and does not reflect the full range of issues that various stakeholders may have in relation to the existing legislation. Nor does this submission purport to reflect the full extent of legislative amendments required. Rather this submission does reflect the Office of the Public Advocate's experience with the legislation since 1996 and key areas for improvement arising from that experience.

This submission is one component to the Office of the Public Advocate's involvement with the review process. The Office is also represented on the Stakeholder Committee and will continue to actively participate in the review process as recommendations are further developed and refined.

2. THE GUARDIANSHIP AND ADMINISTRATION SYSTEM

2.1 The Guardianship and Administration Act 1990

The *Guardianship and Administration Act 1990* (the Act) established a Guardianship and Administration system which aims to protect the best interests of adults who are unable to make reasoned decisions for themselves. The decision-making disability may occur because of dementia, mental illness, intellectual disability or acquired brain injury.

The Act allows for the appointment by the Guardianship and Administration Board of a substitute decision-maker to make decisions about personal, medical or lifestyle decisions (called a Guardian) or financial decisions (called an Administrator) on behalf of the person.

2.2 The Public Advocate

The Public Advocate is an independent statutory officer appointed under the *Guardianship and Administration Act 1990* to protect and promote the rights of people with decision-making disabilities.

Broadly speaking the Office of the Public Advocate provides six major services:

- information and advice on how to deal with concerns, problems or conflicts which impact on the quality of life of people with decision-making disabilities,
- investigation of complaints or allegations that the well being of a person with a decision-making disability may be at risk or is being abused,
- advocates on behalf of people with decision-making disabilities as to whether a guardian or administrator should be appointed by the Guardianship and Administration Board,
- acts as a guardian of last resort where there is no other person who is willing or able to be appointed as a guardian,
- conducts community education and training in regard to the guardianship and administration system in Western Australia, and
- advocates for improvements in services, policies and programs for people with decision-making disabilities in the community.

The Public Advocate has a separate and independent role from the Guardianship and Administration Board.

2.3 The Guardianship and Administration Board

The Guardianship and Administration Board is an independent statutory tribunal established under the *Guardianship and Administration Act 1990*. An application can be made to the Board to appoint a Guardian or Administrator.

The Board decides:

- whether the person has a mental disability that affects his or her ability to make decisions (a decision-making disability). The Board is concerned with the person's competency at the time of the hearing,
- whether he or she needs a Guardian or Administrator,
- who should take on the role of Guardian or Administrator. The Board may appoint a family member or friend to take on this role. If there is no one else available or suitable, the Board may appoint the Public Advocate as Guardian or the Public Trustee as Administrator, and
- the term of the order, up to a maximum of five years.

2.4 Principles applicable to decision-making by the Guardianship and Administration Board

The *Guardianship and Administration Act 1990* contains five principles that must be taken into account by the Guardianship and Administration Board when considering any application for the appointment of a Guardian or Administrator before making an Order.

i. **Presumption of competence**. The Guardianship and Administration Board requires evidence that the person has a decision-making disability before it proceeds. The Board is concerned with the person's current competence, but is able to respond to someone who has a cyclic illness.

ii. **Best interests**. The Guardianship and Administration Board is bound by what is in a person's best interest, not that of family members, service providers or other interested parties.

iii. **Less restrictive alternative**. The Guardianship and Administration Board requires evidence that other less restrictive alternatives have failed or are not appropriate before it will consider making an Order. For example, in the case of medical treatment, s119 (3) of the *Guardianship and Administration Act 1990* describes a hierarchy of persons, who must have a close personal relationship with the person, who can consent to medical treatment without the need for Guardianship.

iv. **Limited versus plenary orders**. The Guardianship and Administration Board is required to make a Guardianship or Administration Order only where there is a need for a substitute decision-maker and will not make a total or Plenary Order if a Limited Order, covering only one or two areas of authority, will be sufficient. The Guardianship and Administration Board is required to make orders that impose the least restrictions on the person's freedom of decisions and actions.

v. **Current wishes/previous actions**. The Guardianship and Administration Board must take account of, but need not be bound by, the wishes of the person, as expressed by them or gathered from their previous actions.

The Public Advocate has also adopted these principles in undertaking her responsibilities.

2.5 Authority of Guardians

Guardians appointed by the Guardianship and Administration Board can be given plenary or limited powers. These may include one or more of the following:

- where the represented person is to live, whether permanently or temporarily,
- with whom the represented person is to live,
- with whom the represented person is to associate,
- consent to medical treatment or health care,
- whether the represented person should work, the nature or type of work, who the person should work for and other matters related to work, education and training, and
- matters relating to legal proceedings, acting as a guardian ad litem or legal next friend.

3. THE MENTAL HEALTH ACT (1996)

3.1 Background

The objects of the *Mental Health Act (1996)* are to:

- ensure that persons having a mental illness receive the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity
- ensure the proper protection of patients as well as the public, and
- minimise the adverse effects of mental illness on family life.

3.2 Issues

While there are many specific issues of particular concern, it is important that any changes are developed within an overall framework. It is the Office of the Public Advocate's view that there are a number of key elements, which will be important to the development and operation of effective mental health legislation. These include:

- the legislation must be in 'plain English',
- there must be well developed policies and procedures consistent with the legislation to guide practice,
- people should be provided with information about their rights and status and the capacity to access records about their care and treatment,
- effective independent internal review processes should be developed in important areas such as treatment, access to records, whether a person is 'voluntary' or 'involuntary', and transfer from one facility to another, and
- effective independent external review processes should be established in regard to important areas such as treatment, access to records, whether a person is 'voluntary' or 'involuntary', and transfer from one facility to another.

While it is recognized that the operation of the *Mental Health Act (1996)* (the Act) was a significant legislative reform and contributed towards improvement in the delivery of services and the safeguarding of the rights of people with a mental illness, the Review provides an opportunity to further enhance the treatment of people with a mental illness.

3.2.1 Statement of Objects and Principles

Since the Act came into effect there have been significant developments in mental health legislation in other States and Territories and national scrutiny of existing legislation. The inclusion of a set of principles varies throughout Australia, however, it is worth noting that the Northern Territory legislation includes a comprehensive set of principles. This includes principles relating to:

- the provision of treatment and care,
- involuntary and voluntary admission and treatment,
- care and treatment of Aborigines and Torres Strait Islanders,
- rights of carers, and
- rights and conditions in approved treatment facilities.

It has also been indicated above that the current *Guardianship and Administration Act (1990)* contains a set of guiding principles.

Recommendation 1 It is recommended that Statements of Principles are set out clearly in any amended legislation consistent with current best practice. It is noted that the Northern Territory legislation provides a comprehensive model.

3.2.2 Medical treatment

There is currently a concern about the provision of medical treatment (as distinct from psychiatric treatment) for involuntary patients. Section 110 of the Act provides that medical treatment may be given to a person who is in an authorised hospital as an involuntary patient or a mentally impaired defendant. The Crown Solicitor has advised that the proper construction of the provision is:

- that consent can only be provided where the patient is incapable of providing consent themselves,
- that such consent can only be provided by the Chief Psychiatrist or his delegate (not other staff),
- that the Chief Psychiatrist cannot consent where a Guardian has been appointed by the Guardianship and Administration Board and is available, and
- that consent can be provided by either the Chief Psychiatrist (or his delegate) or a person authorised under section 119 of the *Guardianship and Administration Act (1990)*.

While this opinion has been widely circulated there exists some uncertainty among mental health practitioners as to their authority in relation to medical treatment and the authority of a legally appointed guardian. The current legislation is not clear, and there is a view that there are a number of aspects in regard to medical treatment for involuntary patients that require clarification.

First, the Act should define 'medical treatment'. The current legislation is silent on this. It is noted that the Victorian and Northern Territory legislation defines 'psychiatric' and 'non psychiatric' treatment. There is also a need to distinguish between 'minor' medical treatment and 'major' medical treatment. Particular issues such as whether contraception is medical treatment or not need to be clarified.

Second, the Act should specify who has the authority to make medical treatment decisions both 'major' and 'minor' in relation to an involuntary patient. Currently consent for medical treatment may be given under the *Mental Health Act (1996)* or section 119 of the *Guardianship and Administration Act (1990)*. Under the current section 110 of the *Mental Health Act (1996)* this would be, in the following order: the patient if able to consent, if not the legally appointed guardian and then the Chief Psychiatrist or his delegate. Section 119 of the *Guardianship and Administration Act (1990)* may also apply to a person who has a mental illness.

Section 119 of the *Guardianship and Administration Act (1990)* provides that a hierarchy of people can provide consent to dental and medical treatment for people with a decision-making disability.

There is a view that an involuntary patient in an authorised hospital should be treated in exactly the same manner as any other person with a decision-making disability and that the Chief Psychiatrist should not have the power to make medical treatment decisions in regard to involuntary patients in an authorised hospital.

Recommendation 2 It is recommended that section 110 of the Act be amended consistent with the *Guardianship and Administration Act (1990)* to establish a hierarchy of persons who can consent to medical and dental treatment.

Recommendation 3 It is recommended that 'medical treatment' be defined in the legislation consistent with legislation in other States and Territories.

<u>Recommendation 4</u> **It is recommended that medical treatment be defined providing that consent for 'minor' medical treatment may be given by a person listed in the proposed hierarchy and that for all 'major' treatment decisions an application must be made to the Guardianship and Administration Board.**

3.2.3 Community Treatment Orders

The Mental Health Act (1996) (the Act) requires that for a person to be made an involuntary patient, they must meet the requirements of section 26. Under the provisions of the Act, a patient can either be detained in an authorised hospital or live in the community subject to a Community Treatment Order (CTO).

The current process, which allows for extension of a CTO after 3 months and then a new order to be written after 6 months, can be distressing for some people with long term mental illness who may be required to remain on CTOs. This is because many patients who are placed on a CTO believe that they will be discharged after the initial three-month period. However, for long-term patients this is often not the case. It would be more humane for an individual to know that the initial CTO is for a three month period and that this can be extended or renewed on a 6 monthly basis if the psychiatrist is satisfied that the involuntary criteria continue to be satisfied.

<u>Recommendation 5</u> **It is recommended that the Act be amended to require that an individual be informed that an initial CTO is for a period of up to three months and that this can be extended or renewed on a 6 monthly basis if the treating psychiatrist is satisfied that the involuntary criteria continue to be met. The information should be clearly set out on associated forms, and strict accountability requirements maintained.**

There has been a tension as to whether a CTO could or should specify where a person who is subject to the CTO is to reside. Some mental health practitioners have refused to specify where a person shall live even though it is integral to the person's treatment. This has in some cases resulted in applications to the Guardianship and Administration Board for the appointment of the Public Advocate as a guardian so that decisions can be made about the person's accommodation. This can be daunting for the person affected and an unnecessary duplication of resources.

In the Supreme Court decision of "MM", Scott J was considering an appeal from a decision of the Mental Health Review Board. Scott J found that the word 'treatment' of a person's mental illness should be interpreted widely in the context of the statute in order not to subvert the intent and purpose of the provision. In this instance 'treatment' could include not only anti-psychotic medication but also supervision and a safe environment in which to live.

It is noted that the Victorian mental health legislation provides that *'a community treatment order may specify where the patient must live, if this is necessary for the treatment of a patient's illness'.*

<u>Recommendation 6</u> **It is recommended that a treatment plan, which includes accommodation, be specified in a CTO.**

3.2.4 Independent second opinions

Section 111 of the Act provides that an involuntary patient in an authorised hospital may request an opinion regarding treatment from another psychiatrist who has not previously considered the matter. In practice there has been concern that for patients in hospital, the second opinion is usually obtained from a psychiatrist in the same hospital. This is not perceived as independent and presents the psychiatrist with a conflict of interest.

Similarly section 76 of the Act provides that an involuntary patient on a CTO may request that their treating psychiatrist, who is proposing an extension of the CTO, obtain a second opinion as to whether the order should be extended. However, for similar reasons outlined above there is a perceived lack of independence.

<u>Recommendation 7</u> It is recommended that where a second opinion is requested, that this is obtained from a psychiatrist outside of the mental health facility from which the person is receiving treatment.

3.2.5 Voluntary and involuntary patients

The Act in the main applies to 'involuntary patients' including people detained in authorised hospitals and people subject to Community Treatment Orders. A hospitalised involuntary patient may be treated differently from an involuntary patient on a CTO. For example under section 110 of the Act, the Chief Psychiatrist may make medical treatment decisions in regard to an involuntary patient in an authorised hospital. However, the Chief Psychiatrist does not have the power to make medical treatment decisions for an involuntary patient who is subject to a CTO.

There is a concern that the Act should make provision for the treatment of voluntary patients. Voluntary patients may confront barriers in accessing the services intended to support and/or protect vulnerable people with mental illness. A person's legal status can also change throughout a period of time. That is a person may move from being a voluntary patient to an involuntary patient, in an authorised hospital or on a Community Treatment Order. The Act needs to recognize the continuum of care required by a person with a mental illness. There is a need for the rights of both 'voluntary' and 'involuntary' patients as consumers of the mental health system to be addressed. It is noted that the Northern Territory legislation includes provisions specifically in relation to the treatment of voluntary patients.

<u>Recommendation 8</u> It is recommended that access to treatment for both 'voluntary' and 'involuntary' patients be reflected in the Act.

<u>Recommendation 9</u> It is recommended that voluntary patients be informed in writing of their rights including the right to refuse treatment and the right to leave hospital.

<u>Recommendation 10</u> It is recommended that the Act be amended to enable voluntary patients to make a complaint to the Council of Official Visitors, to access their records, to obtain a second opinion as to treatment and the right of review by the Mental Health Review Board.

3.2.6 Discharge planning

Effective discharge planning is an important issue for consumers, their carers and/or family and the whole community. The requirement to undertake adequate discharge planning could be addressed through legislation, as in the Northern Territory, or through policies and procedures at departmental and hospital levels. Should consideration be given to the development of a continuous quality improvement process for mental health service providers, discharge planning could be one of the essential components included. Service providers already subject to an external accreditation process should not be required to participate in an additional process.

<u>Recommendation 11</u> It is recommended that consideration be given to the inclusion of a requirement to develop viable discharge plans either, in the Act, or through the introduction of a continuous quality improvement process for mental health service providers.

3.2.7 The role of carers and families

There is a need to recognise the role of carers and families while maintaining a balance with the rights of consumers to confidentiality.

<u>Recommendation 12</u> It is recommended that the role of carers and families be formally recognised in the Act.

The Mental Health Review Board

The Mental Health Review Board (MHRB) currently performs important functions, which should be maintained and strengthened.

There is a concern that the MHRB has narrowly construed its role, in the main to determining whether a person meets the requirements to be an involuntary patient under section 26 of the Act. This is despite current provisions in the Act (see s112, s142 and s145 of the *Mental Health Act* (1996)), which promote a much wider role in relation to a range of matters. It is proposed that there be greater clarity regarding the functions and duties of the Board.

In particular it is noted that the MHRB has an important role in externally reviewing a number of decisions made by mental health practitioners. An effective MHRB has a critical role to play in safeguarding the rights, treatment and liberty of a person with a mental illness.

It is proposed that the MHRB have a role in externally reviewing a range of decisions made in relation to a person with a mental illness. This may include decisions in regard to treatment, whether a person is an involuntary patient, where a person has been denied access to records in relation to their treatment, the terms of a CTO and the transfer of patients from one mental health facility to another. It is noted that the Northern Territory legislation provides for a wide range of matters to be determined by the Board.

The Government has announced that the State Administrative Tribunal (SAT) will commence on 1 January 2004. The inclusion of the MHRB within the SAT has the potential to enhance the operation of the MHRB. Advantages include greater transparency and accountability in the functioning and procedures of the Board, independence from the Health system, improvements in administrative support, recruitment of suitable members from a wider range of suitably qualified professionals, access to ongoing training for members and consistency in decision making.

It is noted that the MHRB currently has legal, psychiatric and community members. This promotes increased accountability and independence in decision-making. The use of multi member Boards is a positive feature of the MHRB.

It is important that persons appearing before the MHRB continue to have access to representation by specialist legal centres such as the Mental Health Law Centre and that the processes of the MHRB remain informal.

An important issue of concern has been the right of patients to access medical information or be provided with reports provided to the MHRB. It is noted that the Victorian legislation, requires that copies of reports provided to the MHRB also be provided to the person for whom the MHRB is making a decision, unless the MHRB is satisfied that there is a reason not to provide a copy.

Conflict of interest is also a matter of concern. It is noted that the Victorian legislation provides that a person for whom the MHRB is making a decision, can object to a particular member of the MHRB hearing a matter as they may have a conflict of interest. This is of particular concern in Western Australia, as members of the MHRB who are psychiatrists may have treated the person appearing before the Board.

Currently, involuntary patients must be reviewed by the MHRB within 8 weeks of the initial order. There is concern that this timeframe is too long. It is noted that the Northern Territory legislation requires that a review be conducted within 7 days.

There has been some concern about the Board's procedures and transparency of those procedures. It is proposed that the legislation be amended to reflect procedures consistent with other administrative review tribunals.

<u>Recommendation 13</u> It is recommended that the Act be amended to specify that the Mental Health Review Board (MHRB):

- **is bound by the rules of natural justice,**
- **is not bound by the rules of evidence,**
- **is not required to conduct proceedings in a formal manner,**
- **may inform itself on any matters that it considers fit, and**
- **should conduct proceedings in a speedy and timely manner while at the same time allowing for proper consideration of matters.**

<u>Recommendation 14</u> In matters being considered by the MHRB, it is recommended that:

- **a person appearing before the MHRB be advised of their right to be represented by a qualified advocate or another person,**

- **a person appearing before the MHRB or their represented person should be able to object to a member of the Board hearing their matter, particularly as there may be an apprehension of bias. Patients should be informed of this right, and**

- **a person appearing before the MHRB or their represented person should have access to all records and reports prior to a hearing unless the Chief Psychiatrist applies to the Board to deny access. In this circumstance, the Board must be satisfied as to a number of factors including that access to the documents would cause serious harm to the person's health or the safety of another person. The Victorian legislation includes a similar provision.**

<u>Recommendation 15</u> It is recommended that a review of an involuntary patient be carried out by the MHRB within a period significantly less than 8 weeks of the initial order.

<u>Recommendation 16</u> It is recommended that the MHRB have a role in externally reviewing:

- **the treatment of both a voluntary and involuntary patient,**
- **whether a person is an involuntary patient,**
- **the terms of Community Treatment Orders,**
- **the transfer of a patient from one facility to another, and**
- **access to patient records and reports.**

3.2.9 The Council of Official Visitors

The Council of Official Visitors is an important independent service established under the Act to ensure affected persons' rights are observed and to investigate complaints. Members of the Council of Official Visitors are drawn from the general community and are appointed by the Minister for Health.

<u>Recommendation 17</u> It is recommended that the role and powers of the Council of Official Visitors in inspecting, monitoring and reporting be maintained and strengthened.

The Council of Official Visitors plays an important 'watchdog' role for people who are defined as 'affected persons'. The current definition excludes a range of people who are in the mental health system and thus denies them access to the Council's services.

<u>Recommendation 18</u> It is recommended that the definition of 'affected persons' be broadened in order to provide the protection afforded by the Council of Official Visitors to voluntary and involuntary patients in public and private hospitals, on Community Treatment Orders and in psychiatric hostels.

<u>Recommendation 19</u> It is recommended that the Council of Official Visitors' role includes advocacy (as distinct from legal representation) for affected persons before the MHRB.

4. THE CRIMINAL LAW (MENTALLY IMPAIRED DEFENDANTS) ACT 1996

4.1 Background

Currently the Public Advocate is advised when a person is found unfit to stand trial or acquitted on account of unsoundness of mind and placed on a Custody Order. The Public Advocate is required to "investigate whether the person is in need of an administrator of his estate and take such other action as he considers appropriate". It has been the experience of the Office that, particularly for defendants with an intellectual disability or acquired brain injury, they are often detained for extended periods in mainstream prisons, with limited assistance, little impetus for release planning and no coordinated effort to find the resources to effect release options.

While a number of specific issues in relation to the current legislation are discussed below, there is considerable concern about the general operation of the Criminal Law (Mentally Impaired Defendants) Act (the MID Act) particularly in relation to people with a decision-making disability.

It is noted that there have been significant developments in other States since the introduction of the MID Act in 1996. In particular the Victorian Parliament in 1995 conducted an *Inquiry Into Persons Detained at the Governor's Pleasure.* This provided a framework for a major overhaul of the existing legislation and resulted in the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997. The Inquiry canvassed similar issues to those of concern in Western Australia. It also reviewed existing legislation in each of the other States. The Northern Territory has now followed the Victorian reforms. It is this Office's view that the existing MID Act will need to be substantially amended to reflect current best practice.

4.2 Issues

4.2.1 Mental illness vs Intellectual Disability or Acquired Brain Injury

The *Criminal Law (Mentally Impaired Defendants) Act* (the MID Act) does not differentiate in its provisions between people with intellectual disabilities or acquired brain injury and people with mental illness. The needs of people with intellectual disability and acquired brain injury are very different from those of people with mental illness. There is a fundamental difference in the two types of condition.

Mental illness is a condition that affects people of all intellectual abilities and may be episodic, temporary or cyclical. Intellectual disability is a learning deficit. While people who are experiencing mental illness may display extreme irrationality, people with intellectual disability are usually rational within a limited range of ability. People with a mental illness often respond to treatment, and once the treatment has been provided will be able to take their place in the community. The 'detain-treat-release' model of the MID Act may be an appropriate one for someone with mental illness but has no relevance for someone with a stable, lifelong intellectual disability or acquired brain injury.

There is also a concern that there is an absence of culturally appropriate assessment tools.

Recommendation 20 **It is recommended that the MID Act take account of the different characteristics and needs of people with intellectual disabilities or acquired brain injury and people with mental illness as well as cultural differences.**

4.2.2 *Assessment of people with dual diagnosis*

The requirement of the MID Act for assessment within a specified timeframe does not take account of the extensive time it takes to accurately assess a person with a dual diagnosis of intellectual disability and mental illness. This issue needs to be recognised in the legislation.

<u>Recommendation 21</u> It is recommended that a realistic timeframe and mechanism be developed for inclusion in the MID Act for the appropriate assessment of people with intellectual disability and a mental illness, including cultural differences.

4.2.3 No interim alternative to a Custody Order

Once found unfit to stand trial under the MID Act, the court can only discharge the defendant unconditionally, or if the penalty for the offence includes a prison term, can impose a Custody Order. Under these circumstances the court cannot access interim sentencing options from the Sentencing Act such as are available to the court for a person found of unsound mind.

<u>Recommendation 22</u> It is recommended that a wider range of sentencing options be available for people found unfit to stand trial.

4.2.4 No alternative to prison

Although there is legislative provision for a mentally impaired defendant to be detained in a 'declared place', no such place exists, and it is understood that there has been no progress in establishing one or more 'declared places'. Consequently, a mentally impaired defendant who is not considered suitable for treatment (for example, a person with an intellectual disability, acquired brain injury, dementia or an untreatable mental illness) will not be admitted to an authorised hospital but will be placed in a mainstream prison for the duration of their Custody Order. It is noted that the Northern Territory legislation provides that a person may be placed on a custodial supervision order in an 'appropriate place'.

This requires the active involvement of government agencies in the proactive development of appropriate support services.

<u>Recommendation 23</u> Consideration should be given to provision of an option for a Supervised Custody Order which would allow a mentally impaired defendant to be supervised in the community and only placed in custody if they do not comply with the supervisory regime.

4.2.5 No limit on the length of a Custody Order

Although there are clear provisions for the review of the Custody Order, the person essentially remains in custody until a viable release plan is developed. If the person has an intellectual disability or acquired brain injury their disability may be such that they require on-going supports in order to maintain a lawful lifestyle. Without the resources to provide appropriate supports, the person will remain in custody. It appears that mentally impaired defendants with intellectual disability or acquired brain injury spend longer periods in custody than other persons found guilty of the same offence.

<u>Recommendation 24</u> It is recommended that the MID Act require a limiting term for any Custody Order, so that people with an intellectual disability or acquired brain injury do not spend longer periods in custody than other people found guilty of the same offence. Consideration could be given to other jurisdictions, such as the Northern Territory, Victoria and New Zealand, which have introduced limitations on the period of custody.

4.2.6 Limited specialised programs

It is apparent that there are few specialised rehabilitative programs available to mentally impaired defendants to assist them to address their offending behaviour.

<u>Recommendation 25</u> It is recommended that mentally impaired defendants have access to appropriate rehabilitative programs.

4.2.7 The Mentally Impaired Defendants Review Board

The MID Act provides for review of mentally impaired defendants by the Mentally Impaired Defendants Review Board (MIDRB). The MIDRB carries out paper reviews in the same way as the Parole Board. Defendants do not appear before the Board and are not represented. Currently there is no agreed cross-agency process to develop release plans for consideration by the MIDRB. Where the Public Advocate has been appointed Guardian by the Guardianship and Administration Board for a mentally impaired defendant, a major component of the Guardian's role has generally been to advocate that relevant stakeholders give priority to the development of a release plan.

Presently a mentally impaired defendant for whom the MIDRB is making a decision does not appear before the MIDRB. Nor does their advocate or legal representative should there be one. A major criticism is that the review process is not transparent and does not provide for procedural fairness or accord the person affected natural justice.

A release plan requires the endorsement of the MIDRB, the Attorney General and the Governor in Executive Council before it can be affected. Other States have established review processes that are separate from that of Executive Government. For example in Victoria and the Northern Territory reviews of release orders are conducted by the judiciary.

In 1995 the Victorian Parliamentary Report, the *Inquiry Into Persons Detained at the Governor's Pleasure* considered a wide range of possible models ranging from establishing a specialist administrative review body to review by the judiciary. The Inquiry, after considering all of the arguments, recommended that a court based model was the most appropriate. The Northern Territory and Victoria currently have court based release systems.

While there are many advantages to a specialist review body being established there are also advantages in the judiciary having that responsibility. In particular the public interest in ensuring that the system is fair and open to public scrutiny adds weight to the judiciary assuming that responsibility.

<u>Recommendation 26</u> It is recommended that the Criminal Law Mentally Impaired Defendants Review Board be abolished and an alternative system of review be established. The new review body should:

- **be bound by the rules of natural justice,**
- **be required to review custody orders within a set time period,**
- **provide that an application can be made by a mentally impaired defendant for a review of a custody order, and**
- **provide that a mentally impaired defendant can appear before the review body and be represented by an advocate or legal representative.**

4.2.8 Interstate Transfers

The MID Act does not currently address the issue of interstate transfers. The value of people affected being in reasonably close proximity to family and support networks cannot be underestimated.

<u>Recommendation 27</u> It is recommended that the MID Act make provision for the interstate transfer of MID prisoners.

5. RECOMMENDATIONS

The Mental Health Act (1996)

Recommendation 1	It is recommended that Statements of Principles are set out clearly in any amended legislation consistent with current best practice. It is noted that the Northern Territory legislation provides a comprehensive model.
Recommendation 2	It is recommended that s110 of the Act be amended consistent with the *Guardianship and Administration Act (1990)* to establish a hierarchy of persons who can consent to medical and dental treatment.
Recommendation 3	It is recommended that 'medical treatment' be defined in the legislation consistent with legislation in other States and Territories.
Recommendation 4	It is recommended that medical treatment be defined providing that consent for 'minor' medical treatment may be given by a person listed in the proposed hierarchy and that for all 'major' treatment decisions an application must be made to the Guardianship and Administration Board.
Recommendation 5	It is recommended that the Act be amended to require that an individual be informed that an initial CTO is for a period of up to three months and that this can be extended or renewed on a 6 monthly basis if the treating psychiatrist is satisfied that the involuntary criteria continue to be met. The information should be clearly set out on associated Forms, and strict accountability requirements maintained.
Recommendation 6	It is recommended that a treatment plan, which includes accommodation, be specified in a CTO.
Recommendation 7	It is recommended that where a second opinion is requested, that this is obtained from a psychiatrist outside of the mental health facility from which the person is receiving treatment.
Recommendation 8	It is recommended that access to treatment for both 'voluntary' and 'involuntary' patients be reflected in the Act.
Recommendation 9	It is recommended that voluntary patients be informed in writing of their rights, including the right to refuse treatment and the right to leave hospital.
Recommendation 10	It is recommended that the Act be amended to enable voluntary patients to make a complaint to the Council of Official Visitors, to access their records, to obtain a second opinion as to treatment and the right of review by the Mental Health Review Board.
Recommendation 11	It is recommended that consideration be given to the inclusion of a requirement to develop viable discharge plans either in the Act, or through the introduction of a continuous quality improvement process for mental health service providers.
Recommendation 12	It is recommended that the role of carers and families be formally recognised in the Act.

Recommendation 13 — It is recommended that the Act be amended to specify that Mental Health Review Board (MHRB) in its procedures:

- is bound by the rules of natural justice,
- is not bound by the rules of evidence,
- is not required to conduct proceedings in a formal manner,
- may inform itself on any matters that it considers fit, and
- should conduct proceedings in a speedy and timely manner while at the same time allowing for proper consideration of matters.

Recommendation 14 — In matters being considered by the MHRB, it is recommended that:

- a person appearing before the MHRB be advised of their right to be represented by a qualified advocate or another person,

- a person appearing before the MHRB or their represented person should be able to object to a member of the Board hearing their matter, particularly as there may be an apprehension of bias. Patients should be informed of this right, and

- a person appearing before the MHRB or their represented person should have access to all records and reports prior to a hearing unless the Chief Psychiatrist applies to the Board to deny access. In this circumstance, the Board must be satisfied as to a number of factors including that access to the documents would cause serious harm to the person's health or the safety of another person. The Victorian legislation includes a similar provision.

Recommendation 15 — It is recommended that a review of an involuntary patient be carried out by the MHRB within a period significantly less than 8 weeks of the initial order.

Recommendation 16 — It is recommended that the MHRB have a role in externally reviewing:

- the treatment of both a voluntary and an involuntary patient,
- whether a person is an involuntary patient,
- the terms of Community Treatment Orders,
- the transfer of a patient from one facility to another, and
- access to patient records and reports.

Recommendation 17 — It is recommended that the role and powers of the Council of Official Visitors in inspecting, monitoring and reporting be maintained and strengthened.

Recommendation 18 — It is recommended that the definition of 'affected persons' be broadened in order to provide the protection afforded by the Council of Official Visitors to voluntary and involuntary patients in public and private hospitals, on CTOs and in psychiatric hostels.

Recommendation 19 — It is recommended that the Council of Official Visitors' role includes advocacy for affected persons before the MHRB.

The Criminal Law (Mentally Impaired) Defendants Act 1996

Recommendation 20 — It is recommended that the Criminal Law (Mentally Impaired Defendants) Act (the MID Act) take account of the different characteristics and needs of people with intellectual disabilities or acquired brain injury and people with mental illness as well as cultural differences.

Recommendation 21 — It is recommended that a realistic timeframe and mechanism be developed for inclusion in the MID Act for the appropriate assessment of people with intellectual disability and a mental illness, including cultural differences.

Recommendation 22 — It is recommended that a wider range of sentencing options be available for people found unfit to stand trial.

Recommendation 23 — Consideration should be given to provision for an option of a Supervised Custody Order, which would allow a mentally impaired defendant to be supervised in the community and only placed in custody if they do not comply with the supervisory regime.

Recommendation 24 — It is recommended that the MID Act require a limiting term for any Custody Order, so that people with an intellectual disability or acquired brain injury do not spend longer periods in custody than other people found guilty of the same offence. Consideration could be given to other jurisdictions, such as the Northern Territory, Victoria and New Zealand, which have introduced limitations on the period of custody.

Recommendation 25 — It is recommended that mentally impaired defendants have access to appropriate rehabilitative programs.

Recommendation 26 — It is recommended that the Criminal Law Mentally Impaired Defendants Review Board be abolished and an alternative system of review be established. The new review body should:

- be bound by the rules of natural justice,
- be required to review custody orders within a set time period,
- provide that an application can be made by a mentally impaired defendant for a review of a custody order, and
- provide that the person affected can appear before the review body and be represented by an advocate or legal representative.

Recommendation 27 — It is recommended that the MID Act make provision for the interstate transfer of MID prisoners.