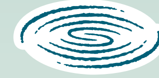

Office of The Inspector of Custodial Services

Mentally impaired accused on 'custody orders': Not guilty, but incarcerated indefinitely

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Inspector's Overview

Custody Orders and the case of Mr B

> *"I just want a date. Everyone else has a date. It's not fair." (Mr B)*

Mr B is a middle-aged Aboriginal man with whom I spent time during a prison inspection a couple of years ago. He repeated these or similar words over and over whenever we met. A softly spoken man with serious cognitive impairments and very limited social skills, his words say so much about the dilemmas and deficiencies of the *Criminal Law (Mentally Impaired Accused) Act* 1996 ('the Act') and the desperation it can generate for some severely impaired people.

In November 2008, due to the severity of his impairments, Mr B was found unfit to stand trial on charges of damage, street drinking and obscene acts in public. He had appeared before the courts on numerous previous occasions, predominantly for lower end alcohol-related public order offences. Previously, however, he had always been regarded as fit to stand trial. He had therefore been convicted and sentenced to fines and short prison terms. His longest prison sentence, imposed almost ten years earlier, had been 12 months' imprisonment for assaulting a public officer. His most recent prison sentence (six months) had been in 2003.

On this occasion, though, the court found Mr B unfit to stand trial. Given this finding, the evidence against him was never formally tested in court and he was never convicted or sentenced. The finding also meant that the court had only two options open to it. These options were polar opposites and highly problematic. The first was to release Mr B straight back into the community without any conditions. This would have offered him no support or supervision despite his impairment-related behaviour bringing him into the courts with monotonous regularity. The only other option was to impose a custody order.

The Act specifically nominates four types of place where a person can be detained under a custody order: an authorised mental hospital, a 'declared place', a prison or a juvenile detention centre. The idea behind 'declared places' was that they would allow people with severe cognitive impairments to be held somewhere other than a prison or detention centre. Given that no declared places had been built, and Mr B was not eligible to be held in an authorised mental hospital, he was only able to be held in prison.

Mr B was given a conditional release order in 2009. This allowed him to live in the community with supervision and support, while being subject to conditions. However, he committed further lower end alcohol-related public order offences within a few months of living in the community and was returned to prison. The Board has been working hard to progress him towards another conditional release order but his cognitive impairments are severe. As prisons go, the prison where he has been kept in

recent years offers a reasonably pleasant physical environment and, at the time I met him, the staff and some prisoners who were family members were looking after him as well as they could. He was also going out of the prison fairly regularly to undertake some community re-socialisation activities. But at the end of the day, this was a prison and he was a prisoner. He was fundamentally out of place and vulnerable to exploitation due to his agreeable nature and poor cognitive skills.

In 2012, Mr B's message to me, and to anyone who would listen, was simple: he knew he had to stay in the prison but he wanted something his fellow prisoners had - a date when his time in prison would end. A poignant and despairing request, but one that nobody could help with.

Two years after I first met Mr B, the Board is still actively monitoring his case. A number of government and non-government agencies are working with him and there are signs of progress. All being well, he will again be able to be released at some point in the future. But some fundamental realities remain: *Mr B is still a prisoner, five and a half years since the custody order was imposed, and two years since he spoke with me. If he had been well enough to be tried and convicted he would not have served anything like this period. He might not have been sent to prison at all. If he had been sent to prison, he certainly would never have been imprisoned indefinitely: he would have had a 'date', and that date would have been some years ago.*

Report Scope

I knew very well that Mr B's circumstances were far from unique: similar cases have been discussed in numerous papers and reports[1] and some have attracted media debate.[2] However, there has never been a full study of the number, profile and circumstances of people held on custody orders. Mr B's comments reinforced my view that we should prioritise such a report as part of our new Research and Audit function.[3]

The Act embraces two distinct groups of defendants. First, there are those like Mr B who are so impaired that they cannot understand enough about what is happening to be able to stand trial. This group comprises people with cognitive impairments or other conditions (such as dementia) which will not improve sufficiently for them to stand trial. The second group is very different, and comprises people acquitted by reason of 'unsoundness of mind' (commonly called the insanity defence). People in this group are well enough to be placed on trial and this means that the evidence against them is tested. At a bare minimum (and unlike cases of unfitness to stand trial) the prosecution

[1] Mental Health Law Centre (WA) Inc. *Interaction with the Western Australian Criminal Justice System by People Affected by Mental Illness or Impairment A Policy and Law Reform Submission: Criminal Law (Mentally Impaired Accused) Act 1996 (WA)* (April 2013); N Morgan and I Morgan, *The Mentally Impaired Defendants Review Board: what is it, what does it do and how can it be improved?* Paper to a seminar hosted by legal Aid (WA) and the Law Society of WA, June 2002: <http://www.health.wa.gov.au/mhareview/resources/documents/MIDRB_paper_Morgans_110902.pdf>.

[2] <http://www.abc.net.au/local/stories/2012/01/09/3404559.htm>; <http://www.theaustralian.com.au/national-affairs/policy/failed-by-offcialdom-rosies-life-locked-up/story-fn9hm1pm-1226852947945#>.

[3] The *Inspector of Custodial Services Amendment Act 2011* (proclaimed in January 2012) expanded and embedded the Inspector's powers to examine specific aspects of a custodial service or a specific custodial experience of an individual or groups of people in custody. They were prompted by the findings of the coroner's inquest into the death of respected Aboriginal elder Mr Ward as a result of a long distance transport.

must prove beyond reasonable doubt that the person did the acts in question. Attention then turns to the person's mental state and they will be acquitted if they were so mentally impaired that they lost the capacity to know what they were doing, to know what they were doing was wrong, or to control their actions.

My legislative jurisdiction extends to prisons, detention centres and a number of other services. It does not extend to mental hospitals or to the workings and role of the courts or the Mentally Impaired Accused Review Board. However, the review would have been incomplete and unhelpful without reflecting on all of these areas. All parties were welcoming, helpful and generous with their time – a clear indicator that they also hold serious misgivings about the current system. I am particularly grateful for the assistance of the Board (who allowed us to access files and hold discussions); the positive engagement and assistance of the Frankland Centre (the state's only secure forensic mental health facility), the Health Department and numerous mental health professionals; and the engagement of judicial officers, including the Chief Justice and the Chief Magistrate.

Relevance, Timeliness and Action

What's been known and what's been done?

Overall this review generally confirmed, quite unequivocally, what many people had suspected. Our current system for managing mentally impaired accused is unjust, under-resourced and ineffective. Appendix A summarises our key findings. Sometimes when reports come out, I am told by the relevant agency that 'there are no real surprises' or 'you're telling us what we know'. Comments of this sort are irrelevant. They simply beg the obvious retort: 'if you *knew* about it, what did you *do* about it?'

Unfortunately, to date, despite everyone agreeing that reform is needed, there has been no action to amend the legislation since 1996, other than to tweak its name so that it now refers, even more pejoratively, to people as 'mentally impaired *accused'* rather than 'mentally impaired *defendants'*.[4] Professor D'Arcy Holman was pessimistic, realistic and prescient when, more than ten years ago, he released a review of the Act with a tortoise on the front cover.[5]

But the positive side is that tortoises do eventually reach their destination. After years of inaction other than meetings, the current government has made a definite commitment to establishing declared places. This is a very positive move, provided full attention is paid to gender, age and cultural diversity and to regional need.

In addition, several government departments are working together to produce a business case to expand forensic mental health services and infrastructure within

[4] *Criminal Procedure and Appeals (Consequential and Other Provisions) Act 2004* s. 82.
[5] Holman CDJ. *The Way Forward. Recommendations of the Review of the Criminal Law (Mentally Impaired Defendants) Act* 1996. Perth: Government of Western Australia, 2003

corrections. If successful, this will greatly improve the prospects for rehabilitation for people on custody orders.

In my view, there is also an opportunity for some immediate pragmatic legislative changes. The responses to this report have shown that there is an appetite for this, with the possibility of more comprehensive changes down the track.

Staging reform

Advocates of reform have generally wanted a complete, ground-up, re-write of the legislation. This is understandable and may well be the most appropriate long term goal. But this goal has also arguably slowed progress in enacting legislative amendments that would have made the Act more workable and flexible pending wholesale reform. In my view, appropriate immediate amendments, include the following:

- Increasing judicial flexibility by allowing people found unfit to stand trial to be released under community supervision and removing some of the current restrictions;
- Providing for a process of regular judicial review of custody orders, even if primary responsibility lies with the executive; and
- Providing a time limit on the duration of custody orders so that unless the most exceptional of circumstances exists, the order cannot run for longer than the alleged offences, if proved, would have justified. Detention after this time could only be on the basis of a court order.

Hitherto, suggestions of this sort have fallen on stony ground but this report could hardly be more timely or relevant. We sent the draft report to relevant stakeholders for comment in January 2014 and requested comments by 26 February 2014. Over that very period, media outlets drew attention to the sad plight of Ms Rosie Anne Fulton. Ms Fulton is a young Aboriginal woman from the Alice Springs area who is currently being held indefinitely in Eastern Goldfields Regional Prison after being found unfit to stand trial on charges of stealing a motor vehicle and driving recklessly. Her life has been marked by disadvantage, deprivation, and abuse. Media scrutiny of her case follows on from the concern that greeted the case of Mr Marlon Noble when it became known four to five years ago.

Labor Party Bill and DotAG Review

In the aftermath of Ms Fulton's case, the State Opposition introduced a Bill that, if enacted, would address one of the concerns mentioned earlier by imposing a time limit on the duration of a custody order.[6]

The Department of the Attorney General (DotAG) has responsibility for the carriage of any changes to the Act and has been reviewing the Act for a number of years. In September 2012, Parliament was informed that a review had been completed and that

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[6] Criminal Law (Mentally Impaired Accused) Amendment Bill 2014 (WA).

there had been broad consultation with 'key stakeholders'.[7] It was also said that a Green Paper would not be released for consultation because there had already been consultation, that Cabinet would consider reform proposals, and that a Bill to amend the Act would be before Parliament by the end of 2013.

In response to our draft report (March 2014), DotAG stated that it had concluded a stakeholder consultation process and will release a discussion paper as part of a public consultation process later this year.

Interestingly, whilst the Act deals with people appearing in the courts, and the judiciary are the 'gatekeepers' of the system, they were not on the list of key stakeholders in 2012. It would also appear that they have not been consulted since then.[8] However, in engaging with this review both the Chief Justice and the Chief Magistrate have indicated strong support for many of the key recommendations, including the need for greater flexibility.

Conclusion: 'I want a Date'

Reform obviously takes time but Professor Holman's tortoise should have reached the finishing line by now. Like Mr B I would like some dates, including a confirmed date at which legislative change will come into effect. This is in no way a comment directed at any political party: the Act has been in force for 17 years through governments of different colours. In fact it is a plea (probably naïve) for party politics to be set aside and for collaborative debate.

Reform can be staged if necessary and it is important not to lose the opportunity to make good practical changes even if comprehensive longer term reform will take longer. The first stage will be to give more discretion to the courts and, at the same time, to action broader reforms to forensic mental health and cognitive impairment.

The number of people held under the Act may be small but as Ghandi put it, and as others have echoed many times: 'A nation's greatness is measured by how it treats its weakest members'. Furthermore, community protection also demands that we all work towards fairer and more effective interventions.

Neil Morgan

17 April 2014

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[7] Hansard, Legislative Council, 11 September 2012, p5423b-5424a.

[8] The parties listed as consulted in September 2012 (see above) were: Mental Health Commission; Disability Services Commission; Department of Corrective Services; Office of the Chief Psychiatrist; State Forensic Mental Health Service; Department of Health; and Mentally Impaired Defendants Review Board.

Recommendations

		Page
1	The government should examine legislative amendments to give greater flexibility to the courts in dealing with people under the Act, including: (i) community based alternatives to custody orders for people who are found unfit to stand trial but require some degree of supervision; and (ii) repealing or restricting the scope of Schedule 1.	10
2	The government should examine legislative amendments to repeal the current 'executive discretion' model and to vest authority for decisions regarding the release of individuals under the Act to: (i) the Mentally Impaired Accused Review Board; or (ii) the courts; or (iii) the Mental Health Review Board.	12
3	The government should increase the number of dedicated forensic mental health beds in hospitals. The increase should, at a minimum, match the increase in prisoner numbers since 1993 and projected future growth in prisoner numbers over the next decade.	25
4	In addition to expanding the number of forensic beds in a hospital setting, the government should develop transitional mental health units at Bandyup Women's Prison and at least one male prison. These units should be evaluated with respect to their uptake and effectiveness, with a view to introducing such units at other prisons.	27
5	The government should continue to progress the establishment of declared places for people with a cognitive impairment held under the Act.	30
6	The government should examine ways to improve the co-ordination of release planning for people held under the Act. Consideration should be given to establishing a multi-agency committee directed by MIARB, which is resourced accordingly.	33
7	The Department of Corrective Services, in collaboration with other agencies, should develop specific policies for managing people under the Act, both in custody and in the community. These should include protocols for enhancing care and treatment, managing challenging	36

	behaviour, initiating leave of absence and developing release plans. Appropriate staff training should also be provided.	
8	The Department of Corrective Services, in collaboration with external providers, should make individual treatment programs available to people under the Act who are not eligible for group programs.	37
9	The Mentally Impaired Accused Review Board, in consultation with the Department of Corrective Services, should document the minimum requirements to be included in treatment completion reports to make them consistent and useful for decision making. The Department of Corrective Services and other agencies should implement these requirements and ensure the reports they make are quality controlled.	37

1 Background

People with a mental impairment in the criminal justice system

1.1 The Western Australian Criminal Code[9] defines the term mental impairment as 'intellectual disability, mental illness, brain damage, or senility'. People who have one or more of these impairments are over-represented in the criminal justice system. This is not to suggest that the impairment itself results in criminal behaviour. Rather, people with a mental impairment are more likely to be of low socio-economic status, unemployed, homeless, have substance abuse issues, and be the victim of physical/sexual abuse. These factors significantly increase the likelihood of contact with the criminal justice system. [10] In addition, research has shown that they face larger barriers in resolving their legal issues due to communication difficulties and limited understanding of legal rights.[11]

1.2 A recent Australian survey of prisoners found that approximately one third had a mental illness[12] and the prevalence of schizophrenia is up to ten times higher among prisoners than the general population.[13] International figures from the US and the UK show that the prevalence of severe mental health disorders among sentenced prisoners is between six and 15 per cent,[14] well exceeding the incidence of these conditions in the general population.

1.3 In Western Australia, the prevalence of mental illness largely matches these national and international comparisons. This Office's 2010 inspection of Casuarina Prison (male) found that close to 50 per cent of the prisoner population was identified as having a mental illness.[15] At Acacia Prison (also male), 40 per cent of prisoners have a mental illness, 10 per cent experiencing active psychosis at any one time.[16] It is generally accepted that the rates of mental illness are even higher amongst female prisoners. A report by the Human Rights and Equal Opportunity Commission concluded that due to the

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[9] *Criminal Code* (WA) s 1.

[10] Hayes S . *Identifying intellectual disability in offender populations - and what then?* Keynote address. Paper presented at the Prison Research Group, Liverpool, UK (February 2004).

[11] Gray A, Forell S, Clarke S. 'Cognitive impairment, legal need, and access to justice' *Law and Justice Foundation – Justice Issues, Paper 10* (March 2009); Australian Human Rights Commission, *Equal before the law: Towards disability justice strategies* (February 2014).

[12] Australian Institute of Health and Welfare (AIHW), T*he health of Australia's prisoners 2010*, cat. no. PHE 149, Canberra: AIHW (September 2011). Viewed June 2013 at: http://www.aihw.gov.au/publication-detail/?id=10737420111&tab=2.

[13] Mullen P, Holmquist C, & Ogloff, J, National forensic mental health scoping study. Canberra, ACT: Commonwealth Department of Health and Ageing (2003); Saha S, Chant D, Welham J, McGrath J 'A systematic review of the prevalence of schizophrenia' (2005) 2(5) *PLoSMed* 141.

[14] Jemelka R, Rahman S, & Trupin E, Prison mental health: An overview. Steadman HJ, Cocozza JJ (editors) *Mental Illness in American Prisons*. (National Coalition for the Mentally Ill in the Criminal Justice System 1993); Birmingham L, Mason D, & Grubin D. 'A follow-up study of mentally disordered men remanded to prison' (1998) 8(3) *Criminal Behaviour and Mental Health,* 202.

[15] Prison Population Statistics for Casuarina Inspection: Report Produced by Strategic and Executive Services Performance and Statistics Branch (2010).

[16] Stokes B, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia* (July 2012).

deinstitutionalisation of mental health services, prison has become a de-facto treatment centre for many people with a mental illness.[17]

1.4 People with a cognitive impairment, such as an intellectual disability or acquired brain injury, are also over-represented in prison. While people with cognitive impairments are no more prone to arrest than the general population, they have a significantly higher rate of re-arrest and are more likely to receive a custodial sentence.[18] In Australia, the prevalence of intellectual disability in prisoners has been noted to be 13 per cent, which is approximately four times the rate in the general population.[19] A recent study of juvenile offenders in New South Wales found that 77 per cent had an IQ that was below average, with 14 per cent of offenders obtaining a score in the extremely low range (<70), indicating a possible intellectual disability.[20] Acquired brain injuries are also very common, with 42 per cent of males and 33 per cent of female prisoners in Victoria being assessed as having an acquired brain injury.[21] People with autism spectrum disorders (ASD)[22] and foetal alcohol spectrum disorders (FASD) are similarly over-represented in the criminal justice system, with FASD particularly prevalent among Aboriginal people.[23]

Fitness to stand trial and unsoundness of mind

1.5 In the 1990's, legislation was introduced in a number of Australian states for the purpose of better addressing the complexities of the interactions with the criminal justice system for people with mental impairments. In Western Australia, the *Criminal Law (Mentally Impaired Accused) Act* 1996 outlines the policies and procedures to be followed in criminal proceedings against people with a mental impairment who are deemed of 'unsound mind' or 'unfit to stand trial'.

1.6 Under the Act, people who are of 'unsound mind' can be acquitted of a crime because at the time of the alleged offence they experienced some form of mental impairment which deprived them of the capacity to control or understand the implications of their actions. People in this category have been found to be well enough to stand trial. The focus of the court is on whether the prosecution can

[17] Burdekin B, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness* (Human Rights and Equal Opportunity Commission, 1993).
[18] Cockram J, 'People with an intellectual disability in the prisons' (2005) 12(1) *Psychiatry, Psychology, and Law*, 163.
[19] Hayes S, & McIlwain D, *The incidence of intellectual disability in the New South Wales prison population: An empirical study* (November 1988).
[20] Indig, D., Vecchiato, C., Haysom, L., Beilby, R., Carter, J., Champion, U., Gaskin, C., Heller, E., Kumar, S. Mamone, N., Muir, P., van den Dolder, P. & Whitton, G. 2009 *NSW Young People in Custody Health Survey: Full Report* (New South Wales Justice Health and Juvenile Justice 2011).
[21] Victorian Department of Justice, *Acquired brain injury in the Victorian prison system*, Corrections Research Paper Series No. 4 (2011).
[22] Hare DJ, Gould J, Mills R, et al: *A preliminary study of individuals with autistic spectrum disorders in three special hospitals in England* (National Autistic Society, 1999).
[23] House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs. *Doing Time - Time for Doing: Indigenous youth in the criminal justice system* (June 2011).

prove that they did the acts in question and had an appropriate mental capacity *at the time of the alleged offence*.

1.7 Conversely, people who are deemed unfit to stand trial are considered unable to follow the course of the trial and, overall, not to be in a position to properly defend themselves. The focus of the courts in such cases is on the person's ability to understand the nature of the charges and the evidence *at the time of the trial*.

1.8 A person's fitness to stand trial can be raised by any of the prosecution, defence, or presiding judicial officer. If sufficient concerns are raised, the case will be adjourned so independent expert advice can be sought (such as a psychiatric report). If, at the next hearing, it is believed that that the individual would become fit to stand trial within six months, then the trial will be further adjourned for this to occur. If not, then the court determines whether to release the individual or to make a custody order

1.9 There are therefore some fundamental differences between those unfit to stand trial, and those acquitted due to unsound mind:

- To have been found not guilty on the grounds of unsoundness of mind, the court must have been satisfied beyond reasonable doubt that the person committed the acts making up the elements of the offence. If this is not proved, the person is entitled to an acquittal and the defence of unsoundness of mind is not relevant.
- In the case of people deemed unfit to stand trial there has been no trial. While a court must have regard to the strength of evidence against the accused, it is never proved beyond reasonable doubt that they actually did the acts in question.
- In the case of people who successfully plead unsoundness of mind, the verdict is one of 'not guilty by reason of unsoundness of mind'. In the case of people who are found unfit to stand trial there can be no verdict: the person has not been placed on trial and is neither guilty nor not guilty.

1.10 However, regardless of whether an individual is acquitted due to unsound mind or deemed unfit to stand trial, the court may impose a 'custody order'.

The courts' options: unfit to stand trial

1.11 Where a person is found unfit to stand trial, the court only has two options open to it.[24] The first is to make an order releasing the person without any conditions ('unconditional release'). The second is to make a 'custody order' which will lead to the person being detained indefinitely in a prison, a juvenile detention centre

[24] *Criminal Law (Mentally Impaired Accused) Act* 1996, ss 16 and 19.

or an authorised hospital. The legislation also refers to the option of a 'declared place' but after 17 years, no such places have been declared.[25]

1.12 In deciding which option to take, the court must consider the strength of the evidence, the nature and circumstances of the alleged offence, the defendant's character, antecedents, health and mental condition, and the 'public interest'. In this context, the 'public interest' essentially means risk to the public.[26]

The courts' options: unsoundness of mind

1.13 In cases of unsound mind heard in the lower courts, the court has the same two options as in cases of unfitness to stand trial – a custody order or unconditional release. Importantly, however, there is a third option, namely, to impose an order requiring the person to be monitored and supervised in the community. Although the person has not been convicted, this order takes the form of a community-based sentence under the Sentencing Act 1995.[27]

1.14 The District and Supreme Courts have the same three options unless the alleged offence falls under Schedule One of the Act. Schedule One consists of a list of offences which Parliament considers so serious that, whatever the specific circumstances, nothing less than indefinite detention will suffice. Schedule One is broad and includes homicide, doing grievous bodily harm, wounding, assault occasioning bodily harm, assaults on a public officer, indecent and sexual assaults, robbery, assault with intent to steal, criminal damage and dangerously driving a stolen motor vehicle.[28]

Place of custody

1.15 People subject to a custody order are held indefinitely until they can re-enter the community without posing an unacceptable risk. This is usually a graduated process that can take a number of years depending on individual circumstances. Subject to assessments of risk, the person will be provided increasing amounts of freedom from their place of custody until they are released.

1.16 This process is overseen by the Mentally Impaired Accused Review Board (MIARB), a statutory body established under Section 41 of the Act, and consisting of the chair of the Prisoner's Review Board, a psychiatrist, a psychologist, and one community member. Under the Act, the MIARB takes decisions on some matters, including place of custody, but many decisions relating to leaves of absence or conditional release require Ministerial and Governor's approval.

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[25] An authorised hospital is a hospital or part of a hospital that has been gazetted to admit, assess, and detain involuntary patients. A declared place is intended to be a secure, supervised, residential style environment; however to date, no declared place has been established.
[26] *GFS* [2001] WASCA 219.
[27] *Criminal Law (Mentally Impaired Accused) Act* 1997, ss 20 and 22.
[28] *Criminal Law (Mentally Impaired Accused) Act* 1997, ss 21 and 22.

1.17 The Act states that people subject to custody orders are to be held in an authorised hospital, a detention centre, prison, or a 'declared place'. Actual placement is determined by the individual's diagnosis and may change during the period of incarceration.

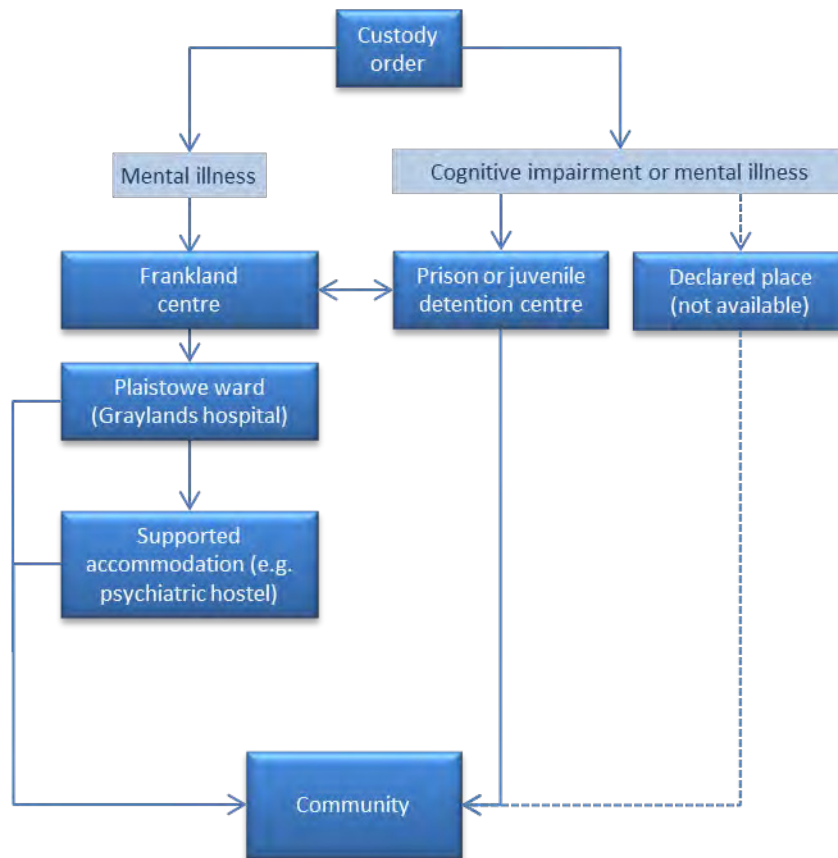

Figure 1

Places of custody for people held under the Criminal Law (Mentally Impaired Accused) Act 1996[29]

1.18 The option of a declared place was envisaged to be a secure supervised environment where the accused could receive appropriate care and treatment; however, to date no declared place has been established. If current plans are implemented two declared places, operated by the Disability Services Commission (DSC), will be established in 2015. Access to these places will be limited to those with a cognitive impairment. There are no current plans to make a declared place available to people with a mental illness.

1.19 The second option is for people on a custody order to be placed in an authorised hospital run by the Department of Health. This option is only available to people who have a *treatable* mental illness and where that illness can only be

[29] Recently, one individual transitioned from prison to a psychiatric hostel, however, this is not a typical release pathway.

satisfactorily treated in a hospital setting (and not in a prison).[30] Such placement is also contingent on sufficient bed space in the hospital.

1.20 People who meet these requirements are initially sent to the Frankland Centre, a high security forensic mental health unit located in the grounds of Graylands Hospital in Perth. The Frankland Centre is a small hospital consisting of just 30 beds and it must cater for adult males, adult females, and occasionally juveniles in one unit. It is operated by the State Forensic Mental Health Service, which is part of the North Metropolitan Health Service, which in turn is part of the Department of Health.

1.21 Given the Frankland Centre's acute rather than rehabilitative focus, stabilised patients may transition to an open (minimum security) ward within Graylands hospital, known as the Plaistowe Ward.[31] This is an eight bed facility and is the only open ward for forensic patients in WA. There is no 'step down' option between the very high security of the Frankland Centre and the low security Plaistowe Ward.

1.22 If necessary, a person placed in Plaistowe can be returned to the Frankland Centre. However, provided the person remains stable and subject to assessments of risk, they may move to supported community accommodation such as a psychiatric hostel which are typically privately run. Alternatively, those who present a low risk to the community and have accommodation available may transition directly to living at home. For the purpose of this report, being placed predominately in any of these facilities throughout the person's custody order is referred to as 'placed in an authorised hospital'.

1.23 The final option is for the person to be placed in prison or, if a juvenile, in a detention centre. Prisons and detention centres are the responsibility of the Department of Corrective Services. People with a cognitive impairment but no mental illness are not eligible to be placed in a hospital because they have no treatable mental illness. As there are currently no declared places, they are automatically placed in a prison or detention centre. People with a mental illness that can be treated in prison may access the Frankland centre from time to time, when needed, but spend most of their time in prison. For the purpose of this report, being placed predominately in a prison throughout the person's custody order is referred to as 'placed in a prison'.

Leave of absence and conditional release order

1.24 The Act makes provision for allowing a leave of absence (LOA) from the person's place of custody. A LOA permits the individual to leave their place of custody for up to 14 days at a time. Restrictions can be placed on the person such as having

[30] *Criminal Law (Mentally Impaired Accused) Act 1996* s 25.

[31] In January 2014, the Plaistowe Ward was closed. A new facility is being identified. Plaistowe Ward patients are currently being accommodated in the Frankland Centre, placing even more pressure on the limited bed places there.

them reside at a specific address or to undertake certain classes which may assist in their rehabilitation or reintegration into the community.

1.25 The Act also makes provisions for people to be granted a conditional release order (CRO). This is a further level of freedom which involves the individual being released from their place of custody. A CRO may have conditions attached, which could include a requirement to abstain from alcohol, to have regular drug tests, or to reside at a specific address.

1.26 People held under the Act are generally able to 'work their way' to lower levels of restriction. Carefully graduated processes apply. There are regular progress reports, risk assessments, and approvals from the MIARB and sometimes the Attorney General and Executive Council.

1.27 The first stage is a LOA from the place of custody. Access to a LOA usually starts slowly. If the person complies with the conditions and is stable, leave can be extended in frequency and duration. Subject to the person's progress, the next stage will be for the Board to consider recommending to the Attorney General that the person be released on a CRO. If the person's behaviour on the CRO indicates that conditions are no longer required, consideration will be given to making an unconditional release order. The effect of an unconditional release order is that the person is no longer subject to the Act.

1.28 The MIARB is central to the system but is often not the ultimate decision maker. Its role is to make recommendations to the Attorney General as to whether the individual should be provided a LOA or a CRO, or be unconditionally released. The Attorney General in turn advises the Governor, as the chair of Executive Council, who ultimately makes the order.[32]

1.29 In deciding whether to recommend the transition of an individual to a lower level of restriction, the MIARB considers the following matters:[33]

- the degree of risk that the release of the accused appears to present to the personal safety of people in the community or of any individual in the community;
- the likelihood that, if released on conditions, the accused would comply with the conditions;
- the extent to which the accused's mental impairment, if any, might benefit from treatment, training or any other measure;
- the likelihood that, if released, the accused would be able to take care of his or her day to day needs, obtain any appropriate treatment and resist serious exploitation;

[32] MIARB requires the Governor's approval before it can grant the first LOA to each person under the Act. After this initial approval is granted, the MIARB are able to cancel or grant new LOAs without seeking further approval. The granting or amendment of a CRO requires the Governor's approval at all times.

[33] *Criminal Law (Mentally Impaired Accused) Act, 1996* s 33 (5).

- the objective of imposing the least restriction of the freedom of choice and movement of the accused that is consistent with the need to protect the health or safety of the accused or any other person; and
- any statement received from a victim of the alleged offence in respect of which the accused is in custody.

1.30 The MIARB bases its recommendations on information contained in reports from those involved in the care or supervision of the accused, including the treating psychiatrist, the individual's case manager, and prison staff. It will usually review cases several times a year and is obliged to report to the Attorney General on each case at least once a year.

The Courts, the Board and the Executive: Balancing Powers and Roles

Powers of the courts

1.31 As previously discussed, the options open to Western Australian courts vary according to whether the accused person has been found to be of unsound mind or unfit to stand trial.[34] If the person is found unfit to stand trial the court has only two options, and they are polar opposites: unconditional release or a custody order. There is no 'intermediate' option which would permit the person to be released into the community subject to supervision, support and monitoring. On the other hand, if the person is acquitted on grounds of unsoundness of mind the lower courts do have the intermediate option of imposing, in effect, a community based sentence. The higher courts also have this option unless the offence is listed in Schedule One.

1.32 In the mid-1990's, the people responsible for developing the Act took the view that it would be wrong in principle to allow the courts to impose an order that required community supervision on a person found unfit to stand trial. They argued that this would be akin to imposing a sentence on a person who had not even been placed on trial. Such legal subtleties are lost on 'consumers' who find they cannot be released under supervision but can be indefinitely incarcerated.

1.33 The absence of an alternative disposition for the courts is also at odds with accepted legal principles that discretion and flexibility are essential in dealing with people with a mental impairment. On occasions, courts have worked around the restrictions by releasing people on bail conditions even after they have been found unfit to stand trial. This use of bail is understandable and pragmatic but arguably breaches the law.[35]

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[34] See [1.11] – [1.14].

[35] See N Morgan and I Morgan, *The Mentally Impaired Defendants Review Board: what is it, what does it do and how can it be improved?* Paper to a seminar hosted by Legal Aid (WA) and the Law Society of WA, June 2002: http://www.health.wa.gov.au/mhareview/resources/documents/MIDRB_paper_Morgans_110902.pdf

1.34 Other states provide greater judicial discretion and more alternatives to custody orders.[36] For example, in New South Wales, Northern Territory, Victoria, Tasmania and South Australia, the court has the ability to unconditionally release the individual, or provide some form of conditional release order, regardless of the offence. In Queensland and the ACT, the court may order the individual to undergo treatment by mental health services, which may take place in the community.

1.35 Western Australia also differs from Victoria, New South Wales, South Australia, and the ACT by not having some form of time limit or 'limiting term' that an individual can be detained under their custody order.[37] As one cognitively impaired prisoner held under the Act poignantly put it: 'I want a date. Everyone else has a date. It's not fair'.

1.36 These issues are compounded by the fact that Western Australia performs poorly compared to other states in providing placement options, in particular for people with an intellectual disability. In Victoria and South Australia, people with an intellectual disability are not to be remanded in prison unless there is no practicable alternative. Instead, they are placed in a residential institution or treatment facility. In Queensland, recent changes to the law mean people subject to a 'forensic order' due to an intellectual disability are placed in a specialised forensic disability service or a mental health service. Prisons are not listed as a potential location to be detained.

1.37 It was suggested to the review team that lawyers in Western Australia avoid entering a plea of unfit to stand trial or of unsound mind due to the lack of options open to the courts, the indefinite timeframes of custody orders, and the absence of placements other than prison or the Frankland Centre. This view is supported by a comparison of the frequency of custody orders in Western Australia with their functional equivalents in other states. In Queensland, New South Wales, and Tasmania, there are many more custody orders provided per capita compared to Western Australia, with only Victoria having a comparable number.[38]

1.38 In summary, flexibility is essential to doing justice and achieving community safety where the accused has a mental impairment. This is especially true where the impairment is so profound that the person cannot even be placed on trial. At present the courts' powers are too restrictive.

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[36] Mental Health Law Centre (WA) Inc. *Interaction with the Western Australian Criminal Justice System by People Affected by Mental Illness or Impairment A Policy and Law Reform Submission: Criminal Law (Mentally Impaired Accused) Act 1996 (WA)* (April 2013).

[37] ibid

[38] While exact like-for-like comparisons are impossible due to legislative differences, Queensland had over 700 individuals whose forensic orders were reviewed by their Mental Health Review Tribunal (2011/12). New South Wales had over 300 individuals reviewed (2011/12), while Tasmania had 31 (2011/12). Victoria had 69 individuals reviewed by the Forensic Leave Panel (2012).

Recommendation 1

The government should examine legislative amendments to give greater flexibility to the courts in dealing with people under the Act, including:

(i) community based alternatives to custody orders for people who are found unfit to stand trial but require some degree of supervision; and

(ii) repealing or restricting the scope of Schedule 1.

Review and release procedures

1.39 As previously discussed, the MIARB is the key reviewing body but it has limited decision making authority.[39] For example, decisions about leaves of absence, conditional release and unconditional release all require approval from the Governor, based on recommendations of the Attorney General. The involvement of a Minister and the Governor can be termed the 'executive discretion' model.

1.40 All other states have removed or greatly reduced the executive discretion component of their legislation, with New South Wales being the last to do so in 2009. The review that informed changes to the New South Wales legislation described the executive discretion process as "…cumbersome, lengthy, overly bureaucratic, resource intensive, operates without transparency or accountability, without conformity to the general principles of mental health legislation, and is liable to administrative challenge".[40] It also suggested that decisions were not always perceived to have been taken strictly in accordance with the legislative requirements. In New South Wales, the Mental Health Review Tribunal has replaced the Governor as the determinative authority for mentally impaired accused. A similar approach for Western Australia has been previously recommended on numerous occasions.[41]

1.41 There are also significant differences in the manner that the mentally impaired accused person interacts with the relevant board or tribunal.[42] In Western Australia the person is able to present a written submission to the MIARB and their advocate is able to present a written submission or appear before the board in person. In most other states the person directly interacts with the board or tribunal and will generally have a lawyer present. In addition, in all states bar Western Australia the person has a right to appeal. In New South Wales for

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[39] See [1.26] – [1.28].

[40] James, G, *Review of the NSW Forensic Mental Health Legislation* (NSW Department of Health, 2007). Retrieved from: <http://www0.health.nsw.gov.au/pubs/2007/pdf/forensic_review.pdf>.

[41] See Holman CDJ. *The Way Forward. Recommendations of the Review of the Criminal Law (Mentally Impaired Defendants) Act* 1996. Perth: Government of Western Australia, 2003; Mental Health Law Centre (WA) Inc. *Interaction with the Western Australian Criminal Justice System by People Affected by Mental Illness or Impairment A Policy and Law Reform Submission: Criminal Law (Mentally Impaired Accused) Act 1996 (WA)* (April 2013).

[42] See Mental Health Law Centre (WA) Inc. *Interaction with the Western Australian Criminal Justice System by People Affected by Mental Illness or Impairment A Policy and Law Reform Submission: Criminal Law (Mentally Impaired Accused) Act 1996 (WA)* (April 2013).

example, people with matters before the tribunal are encouraged to attend the public hearings in person, by phone, or via video-link.[43]

1.42 To date, three main options have been floated with respect to allocating responsibility for reviewing custody orders and taking decisions about progression to release. The first is to retain the existing executive discretion model. The second is to place responsibility directly on the MIARB without the need to refer cases to the Minister and Governor. The third option is to vest responsibility in the Mental Health Review Board which is part of the State Administrative Tribunal.[44]

1.43 It is beyond the scope of this review to examine the merits of the various options in detail. This would require a discrete exercise with broad consultation and many issues would fall for consideration. For example, the relative 'secrecy' of the current system has generated criticism, but on the other hand it does help to preserve a degree of privacy for the parties. However, it is time for the options to be reviewed and for legislative change to be considered. This review should also examine a fourth option, namely, vesting responsibility in the courts.

1.44 At the time the Act was introduced, legal orthodoxy was simple: courts did not get involved in reviewing orders they had imposed, nor did they get involved in decisions to release people from custody. These decisions were seen as matters for the executive arm of government. However, times have changed.

1.45 First, Western Australia now has a number of 'specialist' or 'problem-solving' courts which oversee the progress of a person who is under supervision in the community. These courts set conditions and call for reports from relevant parties as to the person's compliance and progress so they can monitor progress. The best example is probably the Western Australian Drug Court.[45] The state is also currently piloting a mental health court.[46]

1.46 Secondly, the *Dangerous Sexual Offenders Act* 2006 requires the Supreme Court to take decisions about whether people should be detained in prison beyond the end of their sentence on the basis that they pose a risk to the community, or whether they should be released; and if they are to be released, the conditions of such release. This type of legislation survived constitutional challenge in the High Court[47] and the Supreme Court has now developed substantial jurisprudence in

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[43] According to the 2011/12 Annual Report of the NSW Mental Health Review Tribunal, 86% of hearings were attended by the individual who was the subject of the hearing.

[44] This would require some changes to the jurisdiction and operations of the Mental Health Review Board because many of the cases under the Act do not involve a mental illness and because the issues surrounding 'forensic' patients are somewhat different from civil patients.

[45] <http://www.courts.dotag.wa.gov.au/D/drug_court.aspx?uid=5227-1163-1055-5774>.

[46] <http://www.mentalhealth.wa.gov.au/mentalhealth_changes/Mental_Health_Court_Diversion.aspx>. On problem solving courts generally, see <http://www.lrc.justice.wa.gov.au/P/project_96.aspx >.

[47] *Fardon v Attorney General (Qld)* (2004) 223 CLR 575.

the field along with a sharp understanding of the challenges of balancing risks, of risk assessment tools and of the dilemmas of indefinite imprisonment.[48]

1.47 The experience of the courts in overseeing the progress of people on community supervision and in assessing risk for the purposes of release is highly relevant to any consideration of different processes for people subject to a custody order or to community supervision under the *Criminal Law (Mentally Impaired Accused) Act*. They are innocent but are being held under a court order and it would not be inappropriate for the courts to review such orders.

Recommendation 2

The government should examine legislative amendments to repeal the current 'executive discretion' model and to vest authority for decisions regarding the release of individuals under the Act to:
(i) the Mentally Impaired Accused Review Board; or
(ii) the courts; or
(iii) the Mental Health Review Board.

[48] For example: *DPP v Teague* [2010] WASC 58; *DPP v Alvisse [No 5]* [2012] WASC 134; *DPP v McGarry [No 3]* [2011] WASC 134; *DPP v Narkle [No 3]* [2013] WASCA 1.

2 Profile of those under the Act

2.1 As of January 2013, 63 people had received a custody order under the Act since its inception.[49] Thirty-four were still subject to a custody order and were either being held in custody (26) or were subject to a conditional release order (8). Twenty nine had been released unconditionally and were no longer under the supervision of the MIARB. Of those released, three had died while still on a custody order, one from suicide and two from natural causes.

2.2 The demographics of people who have received a custody order are as follows:

- Sixty were male (95%) and three were female (5%). Males and females comprise 91 and nine per cent of the adult custodial population respectively, and so by comparison, females under the Act are slightly underrepresented.
- The ages of people when they received their first custody order ranged from 14 to 63, with a mean age of 31. Five were juveniles when the custody order was imposed and some of these orders are still in force. However, in January 2013, no person under 18 was being held under the Act.
- Eighteen people (29%) were of Aboriginal or Torres Strait Islander origin, while 45 (71%) were non-Aboriginal. Aboriginal people are substantially underrepresented when compared to their numbers in the adult custodial population (41%).
- Out of the 63 people ever held under the Act, 33 (52%) had been acquitted due to unsound mind and 30 (48%) had been found unfit to stand trial.
- Aboriginal people constituted 47 per cent of those unfit to stand trial but only 12 per cent of those acquitted due to unsound mind.

Type of impairment

2.3 Over two-thirds (68%) of people ever held under the Act had solely a mental illness. Eleven (17%) had solely a cognitive impairment and 9 (14%) had both conditions.

2.4 There was a large difference between Aboriginal and non-Aboriginal people under the Act. The vast majority of Aboriginal people (72%) had a cognitive impairment, and this was predominately the result of, or exacerbated by, substance abuse. In comparison, only 16 per cent of non-Aboriginal people held under the Act had a cognitive impairment. Medical records and prison reports of this cohort described them as having very low IQs and most were illiterate and innumerate.

[49] This does not include those who have successful appealed their criminal conviction.

Table 1

Type of mental impairment for people under the Act

Type of Impairment	Aboriginal	Non-Aboriginal	Total
Mental illness	5	38	43
Cognitive impairment	9	2	11
Mental illness and cognitive impairment	4	5	9
Total	**18**	**45**	**63**

2.5 Prison incident reports also indicated the presence of challenging behaviour of varying severity among those with a cognitive impairment. Some demonstrated inappropriate sexual behaviour (such as taking off clothes in front of fellow prisoners) and some demonstrated aggressive behaviour (such as assaulting fellow prisoners or prison officers). One person obsessively cleaned his cell, ripped up his mattress, and was observed eating rubbish and his own faeces.

2.6 Mental illness was far more prevalent among non-Aboriginal people, with 96 per cent of non-Aboriginal people held under the Act having a mental illness. In comparison, 50 per cent of Aboriginal people held under the Act had a mental illness.

2.7 Approximately 70 per cent of people with a mental illness on a custody order have schizophrenia (predominately paranoid type). The behaviour of these people while in custody varied greatly with some demonstrating challenging behaviour, including threatening behaviour and violent outbursts during psychotic episodes while others were completely stable. When stable, these people were fully capable of making rational decisions.

2.8 For the cohort who had both a mental illness and a cognitive impairment, there was similar diversity in individual needs and behaviours. For example, two women had frontal lobe damage making them prone to impulsive, violent outbursts, while others required far less intensive management.

2.9 Over a third of people held under the Act had substance abuse as an explicit aspect of their diagnosis and many more had experienced problematic levels of substance abuse. The majority of mentally impaired accused had a history of alcohol and drug, particularly marijuana, use.

2.10 Over three quarters (77%) of those placed in prison have been supervised, at some point, under the At-Risk Management System (ARMS) due to an acute risk of self-harm or suicide.[50] Two-thirds of mentally impaired accused placed in prison were listed as being a victim or perpetrator of some form of bullying or violence.[51]

2.11 While the prison system houses many people with mental health issues it is important to note that people held under the Act are different in terms of their legal status and needs. They have no set date for possible release (even though they have not been found guilty) and the Board and the Attorney General must have regard to the degree of risk the person presents to the community when making release decisions.

2.12 Extensive support is required in order for these people to show that the risk to the community has reduced from when the custody order was imposed. People in an authorised hospital receive this support but those placed in prison are not treated much differently to the general prison population, making it very difficult to transition to release.

Type of offence

2.13 People have been held under the Act after being charged with a wide variety of crimes, some minor and some very serious. The alleged offence which led to each person's initial custody order is listed in Table 2. Where people were held under the Act for multiple offences, only the most serious offence[52] is reported.

[50] This does not include events where prisoners were automatically placed on ARMS due their transfer from the Frankland Centre. While there were a small number of proactive ARMS referrals (such as when there was a death in the family), the vast majority of these referrals were in reaction to an acute possibility of suicide, such as threats of self-harm, actual-self harm, or perceived deterioration in overall mental health.

[51] This was gauged through the examination of incident reports. The acts ranged from prisoners using the gratuities of mentally impaired individuals to buy cigarettes, to individuals being the victim or perpetrator of physical assault.

[52] The most serious offence was determined by the Department's labelling of 'most serious offence' in the TOMS database. This categorisation scheme also informed the most serious offence for individuals who never went to prison and therefore were not on TOMS.

Table 2

Most serious alleged offence for people under the Act resulting in a custody order

Most Serious Offence	Aboriginal		Non-Aboriginal		Total
	Acquitted due to Unsound Mind	Unfit to Stand Trial	Acquitted due to Unsound Mind	Unfit to Stand Trial	
Wilful Murder	1		13	1	15
Attempted Murder		1	8	1	10
Assault Occasioning Bodily Harm	2		4	1	7
Sexual Penetration of a Child		2		2	4
Assaulting a Public Officer		3			3
Grievous Bodily Harm			1	2	3
Criminal Damage by Fire				2	2
Indecent Dealings		1		1	2
Manslaughter		1	1		2
Robbery While Armed		1		1	2
Aggravated Sexual Assault	1				1
Arson				1	1
Damage Property		1			1
Going Armed in Public				1	1
Indecent Assault		1			1
Kidnapping			1		1
Stalking				1	1
Stealing with Violence		1			1
Threaten to Kill				1	1
Trespassing		1			1
Unlawful Wounding		1			1
Wilful Damage			1		1
Wilful Damage by Fire				1	1
Total	**4**	**14**	**29**	**16**	**63**

2.14 Forty per cent of people held under the Act were accused of committing murder and attempted murder. In all of these cases the person had a mental illness. Most of the people under the Act for murder or attempted murder (88%) were acquitted due to unsound mind, rather than being unfit to stand trial.

2.15 The overwhelming majority of people held under the Act for murder or attempted murder are non-Aboriginal. Only two Aboriginal people have been held under the Act for murder or attempted murder compared with 23 non-Aboriginal people. More generally, Aboriginal people are being held under the Act for less serious offences than non-Aboriginal people.

2.16 All of the individuals whose most serious alleged offence was assault occasioning bodily harm or grievous bodily harm had a mental illness. However in the case of alleged sexual offences, people with a cognitive impairment were over-represented, constituting around 75 per cent of such cases.

Prison or hospital and transition to freedom

2.17 Over half (57%) the people ever held under the Act were placed in an authorised hospital.[53] These people have generally been charged with significantly more serious offences than those held in prison, with more than half of the hospital detainees held for murder or attempted murder. The vast majority of hospital detainees are non-Aboriginal.[54]

2.18 Notably, however, over half of the hospital detainees have been discharged from the Act compared with only a quarter of those placed in prison. In addition, as seen in Figure 2 hospital patients enjoy greater access to LOAs and CROs than the prisoners.

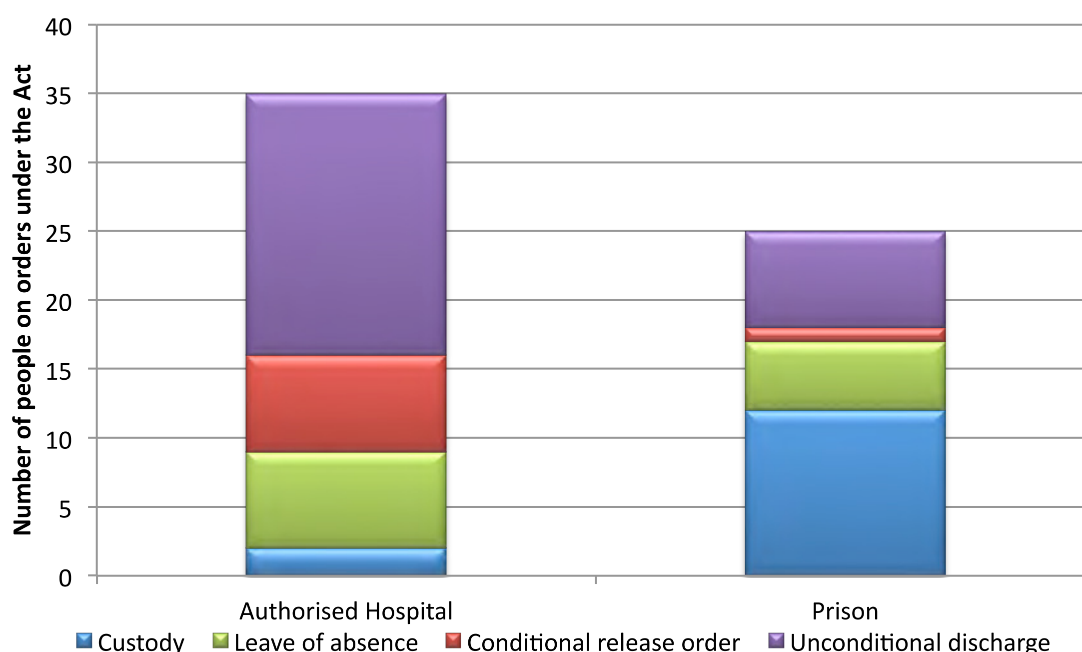

Figure 2
Current order for all people held under the Act

2.19 Of the 35 people placed in an authorised hospital all except two had been granted a LOA or a CRO. These two had only been placed on a custody order in the past year. Nineteen had progressed to discharge and the rest were accessing the community on release orders. This is in stark contrast to those who were placed in prison where almost half were not accessing a LOA or a CRO.

[53] The three individuals who died have not been included in this analysis, nor was the individual who won an appeal of the custody order.
[54] See [2.15] and [2.24]-[2.25].

2.20 Without the establishment of a declared place, there is currently no alternative location for someone with a cognitive impairment other than prison. This puts people with a cognitive impairment at a significant disadvantage given that it is a more difficult, resource intensive and lengthy process for them to access the community. Notably, nine out of the eleven people under the Act with a cognitive impairment are Aboriginal.

2.21 However, this is not the only group that is affected. Those whose mental illness is not as severe, and therefore do not require a hospital for treatment are also at a disadvantage. Comparing people with solely a mental illness who have been placed in an authorised hospital to those held in prison shows a sharp contrast in their degree of freedom.

Table 3

Degree of freedom for those under the Act with solely a mental illness who are predominately placed in either a hospital or prison setting.

Degree of freedom	Hospital	Prison
Custody	2	9
Leave of absence	5	2
Conditional release order	6	
Released	17	
Total	**30**	**11**

2.22 While most people with a mental illness placed in an authorised hospital have been released, those in prison have not. Only two people with solely a mental illness in prison had a leave of absence at the time of the review, and none had accessed a conditional release order.

2.23 It is rare that someone under the Act with a mental illness is released without transitioning through the Frankland Centre. However, places at the Frankland Centre are limited and are taken by those most in need. A person's ability to access the Centre is therefore based not only on the severity of their mental health condition, but also the severity of the needs of others accessing the facility. Prisoners who cannot access the Frankland Centre as their needs are not as severe as others can get 'stuck' in the system. In effect, they are penalised in terms of their placement and access to release for having less severe health needs.

Places of custody for Aboriginal and non-Aboriginal people

2.24 There is a significant difference between Aboriginal and non-Aboriginal people in terms of their custodial placement. Of the 18 Aboriginal people ever held under the Act, only one has been placed in an authorised hospital. Currently Aboriginal people make up 30 per cent of all people under the Act but 60 per cent of those placed in prison.

2.25 These figures can be partially explained by the high number of Aboriginal people under the Act with a cognitive impairment. However, this does not explain why five Aboriginal people with solely a mental illness were predominately placed in prison.

Inappropriateness of the prison environment

2.26 Prisoners with a cognitive impairment are more likely to be exploited by other prisoners and demonstrate deterioration in their mental health and adaptive skills due to the demands of prison life.[55] Sadly, institutionalisation was very common among the cognitively impaired cohort, with one, incarcerated since the age of 14, now referring to prison as 'home' and having great difficulty in making decisions as simple as what to have for lunch. They may also learn a variety of negative institutionalised behaviours such as violence and victimisation through the modelling of peer group behaviour. People with a cognitive impairment are more vulnerable to this occurring since they tend to be aware that they are different and strive to be accepted by others.[56] Imprisoning a person with a cognitive impairment so serious that they cannot stand trial should be a last resort.[57]

2.27 Similar criticisms have been levelled at the imprisonment of those with a mental illness, as there are conflicting cultures and priorities between health and custodial staff within prisons.[58] Mental illnesses can be exacerbated by the unfamiliar and threatening prison environment, and regular psychiatric follow-up can be disrupted when an individual transfers between facilities.[59] The presence of people with an acute mental illness can also affect the entire prison. There is an increased burden placed on staff and an increased risk of self-harm, suicide, aggression, assault, and behavioural disturbance.[60]

2.28 A forthcoming report by this Office has found that prisoners with a mental impairment are greatly over-represented in incidents involving an assault on a staff member. Between 2008 and 2012, prisoners with an identified psychiatric illness or intellectual disability comprised 14 and 2.6 per cent of the daily

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[55] Cockram J. 'People with an intellectual disability in prisons' (2005) 12(1) *Psychiatry, Psychology, and Law*, 170.
[56] Hayes, S., & McIlwain, D, *The incidence of intellectual disability in the New South Wales prison population: An empirical study* (November 1988).
[57] ibid
[58] Butler T, Allnutt S. *Mental illness among New South Wales prisoners* (NSW Corrections Health Service, 2003).
[59] ibid
[60] OICS, *Report of an announced inspection of Hakea Prison. Report* No. 80 (January 2013).

average prison population respectively.[61] However, this cohort accounted for more than half of the assaults on staff.

2.29 The 2003 Holman Report on the operation and effectiveness of the Act recommended that amendments be made to remove references to prisons or detentions centres as a potential place of custody. The review stated that people under the Act should be separated from mainstream prisoners, and placed in facilities appropriate for their detention, care and protection.[62] Inspection of case files indicated that many people under the Act have had their transition to release impeded by their behaviour in prison; however, the prison environment itself undoubtedly contributes to that behaviour occurring in the first place.

Time to conditional release order and leave of absence order

2.30 On average, it took people under the Act approximately one and a half years to be granted a LOA and two years to be granted a CRO (see Table 4).

Table 4
Average time until CRO and LOA for specific cohorts

Cohort	Time Until CRO (years) N= 35	Time until LOA (years) N= 30
Acquitted due to Unsound Mind	1.7	1.0
Unfit to Stand Trial	2.4	2.0
Aboriginal	2.3	3.3
Non-Aboriginal	2.0	1.0
Mental Illness Only	2.1	1.1
Cognitive Impairment Only	2.8	3.6
Comorbid Impairment	0.9	1.6

2.31 The results indicate that people who were unfit to stand trial, Aboriginal people, and those with a cognitive impairment took longer to attain a CRO or a LOA. The differences were most apparent in time to be granted a LOA, with those unfit to stand trial taking twice as long as those acquitted due to unsound mind. Similarly, Aboriginal people took three times as long as non-Aboriginal people to attain a LOA, and people with a cognitive impairment took over three times as long as those with a mental illness. This finding was unexpected, as those who were acquitted due to unsound mind, non-Aboriginal, or with a mental illness faced far more serious offences.

[61] OICS, *Assaults on staff in WA prisons* (forthcoming report). 180 of the assaults over this period assaults were committed by people with an identified psychiatric illness and 69 by prisoners with an identified intellectual disability. Prisoners held under the Act were responsible for three assaults in this period.
[62] Holman CDJ. *The Way Forward. Recommendations of the Review of the Criminal Law (Mentally Impaired Defendants) Act* 1996. (Government of Western Australia, 2003)

2.32 While these results are indicative of the length of time different cohorts take to progress to these stages of release, they should be interpreted with caution due to the limitations of the analysis. These limitations are outlined in the methodology appendix of the review.

Time to discharge

2.33 It is difficult to define the length of time an individual should be in custody based on an alleged crime, given the person has not been found guilty and given the large number of factors that are taken into account when sentencing. However it is clear that some people held under the Act have been in custody longer than their offence would normally warrant. They are typically Aboriginal and placed in prison.[63] Some examples include:

- An Aboriginal man with schizophrenia, polysubstance abuse, and a cognitive impairment who was charged with trespassing and performing an indecent act with intent to insult or offend. He has been in prison for over three years.
- An Aboriginal man with a congenital intellectual impairment who was placed in police custody for street drinking and obscene acts in public. He damaged cells in the police lockup, and has since been in prison for over four years.
- An Aboriginal man diagnosed with organic brain damage who was charged with stealing with violence. He was under the Act for seven years before being unconditionally released.
- An Aboriginal man with an intellectual impairment who was charged with sexual penetration of a child and indecent dealings and was made subject to a custody order in March 2003. He disputed these charges and in 2010 a psychological report concluded that he was now fit to stand trial. He was not given the opportunity to plead not guilty to the charges in court as the Director of Public Prosecutions filed a notice of discontinuance, advising that the period of time he had served in prison already exceeded any sentence a court would reasonably impose.[64] With no avenue to appeal the initial custody order, this man continues to be under the Act. He spent a decade in prison before being granted a conditional release order.

2.34 Table 5 presents information on the time spent in custody by different cohorts of people held under the Act. The first column shows the average time spent under the Act by all 60 people ever held under the Act.[65] Thirty four of these people have not yet been discharged and 26 have been discharged. The second column provides details on the 26 who have been released.

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[63] Mentally Impaired Accused Review Board, *Annual Report for the year ended 30 June 2012* (September 2012).
[64] Robert Cock QC. *Report to the Minister of Corrective Services on Mr Marlon Noble* (June 2011).
[65] Individuals who died while under the Act were excluded from the calculations.

Table 5

Average time under the Act and time to discharge for specific cohorts

Cohort	Time under the Act for all custody orders (Years) N= 60	Time under the Act of those discharged from custody orders (Years) N= 26
Acquitted due to Unsound Mind	6.5	3.7
Unfit to Stand Trial	6.2	4.1
Aboriginal	6.4	3.4
Non-Aboriginal	6.4	4.0
Mental Illness Only	6.7	3.8
Cognitive Impairment Only	4.9	3.2
Comorbid Impairment	6.6	4.8

2.35 People who have been discharged spent, on average, four years under the Act before discharge. It also shows that, among those who have been discharged, people acquitted on grounds of unsound mind have, on average, spent less time under the Act than those who were found unfit to stand trial. Given that the vast majority of people found not guilty by reason of unsound mind have been charged with murder or attempted murder it might have been expected that they would have spent longer under the Act than people who are unfit to stand trial and who are generally facing less serious charges.

2.36 These findings are in sharp contrast to the situation in New South Wales. A 2007 review of New South Wales forensic mental health legislation found that the average time people were a client of the equivalent of the MIARB was eight years for those acquitted due to unsound mind, and 20 months for those unfit to stand trial.[66]

[66] James G, *Review of the NSW Forensic Mental Health Legislation* (NSW Department of Health 2007).

3 Factors impeding release

3.1 This chapter examines the factors that tend to impact on the release of people held under the Act, with a view to identifying areas for improvement.

Factors affecting people with a mental illness

Paucity of forensic psychiatric beds in a hospital setting

3.2 There are only 38 forensic psychiatric beds in Western Australia, 30 in the Frankland Centre and eight in the Plaistowe Ward, at Graylands Hospital. The Frankland Centre is a maximum security facility catering for acute patients, while the Plaistowe Ward is a minimum security 'open ward' catering for non-acute patients. While legislatively it is possible for mentally impaired accused to be accommodated at any authorised hospital in the state, this does not occur, with only the Frankland Centre and the Plaistowe Ward deemed suitable for this cohort.

3.3 At the time of the review, 25 people were being held under the Act because of mental illness. Three were in the Frankland Centre and five in the Plaistowe Ward. Seventeen (68%) were in prison. This is not surprising as the 30 beds at the Frankland Centre are used by any male, female or, very rarely, youth in the custodial system with a mental illness. Bed use is prioritised for those who are most in need of acute hospital care. Adding to these pressures, the Frankland Centre must also accommodate those who have been sent by courts for a mental health assessment.

3.4 The number of forensic beds needs to be placed in its broader local, national and international context. Western Australia's population has increased by over 700,000 since the opening of the Frankland Centre in 1993, and the prison population has increased almost threefold (from 1800 to 5000). However the number of forensic beds has remained static.

3.5 This results in Western Australia having only 1.7 acute forensic psychiatric beds per 100,000 people.[67] This is significantly fewer than New South Wales, Victoria, and Tasmania. Western Australia also has fewer sub-acute beds than New South Wales, Victoria, Queensland, and South Australia (see Figure 3).

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[67] Australian Institute of Health and Welfare (AIHW), *Mental health services in Australia,* Public sector specialised mental health hospital beds per 100,000 population, general population, by program type, states and territories, 2010-11 (March 2013).

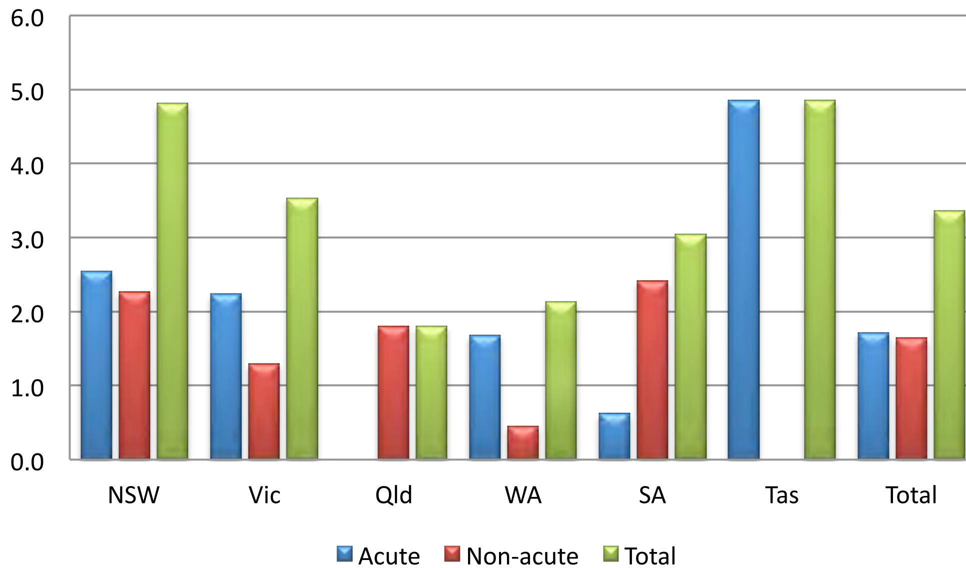

Figure 3
State comparison in public sector forensic beds per 100,000 population[68]

3.6 While Western Australia rates poorly compared to other Australian states, Australia as a whole rates poorly compared to other comparable countries. For example, England and Wales has 6.1 beds per 100,000 population, and some European countries, notably Germany and Belgium, have in excess of 10 beds per 100,000 population.[69] Even so, many of these higher performing European countries still have to use prison as a place of custody for mentally impaired accused to cover the shortfall in forensic beds.

3.7 When countries with ten times the quantity of forensic beds still have to use the prison system as a place of custody, it becomes apparent how chronically under-resourced the forensic psychiatric system is in Western Australia. The lack of forensic beds in Western Australia has been frequently noted in this Office's inspection reports.[70]

3.8 The lack of forensic beds impacts adversely on the provision of health care to mentally impaired accused. The Frankland Centre is constantly at capacity. Only patients most in need of acute care are able to remain there, and if someone is sent to the Frankland Centre via a hospital order from court, another patient will have to be discharged and sent to prison to make room for the incoming person.

[68] Australian Institute of Health and Welfare (AIHW), *Mental health services in Australia,* Public sector specialised mental health hospital beds per 100,000 population, general population, by program type, states and territories, 2010-11 (March 2013). Note: the ACT and the Northern Territory do not have any forensic beds. Queensland and Tasmania do not have any specialised forensic beds for acute and non-acute patients respectively

[69] Joachim Salize, H., & Dressing, H. *Placement and treatment of mentally ill offenders – Legislation and practice in EU member states* (Central Institute of Mental Health, Germany, 2005).

[70] See OICS, *Thematic Review of Court Security and Custodial Services in Western Aus*tralia, Report No. 65 (July 2010); OICS, *Thematic Review of Offender Health Services*, Report No. 35 (June 2006); OICS*, Report of an Announced Inspection of Rangeview Juvenile Remand Centre*, Report No. 50 (April 2008). OICS*, Report of an Announced Inspection of Casuarina Prison*, Report No. 48 (March 2008). OICS, *Report of an Announced Inspection of Bandyup Women's Prison, Report* No. 73 (October 2011); OICS, *Report of an Announced Inspection of Broome Regional Prison*, Report No. 77 (March 2012); OICS, *Report of an Announced Inspection of Hakea Prison*, Report No. 81 (January 2013).

The consequence is that the least unwell individual is sent to prison, even if they still require acute care. As a result their mental health may deteriorate further. Prisoners who are in need of acute care face lengthy delays before a bed in the Frankland Centre is available.[71] Many prisons will now not even attempt to refer unwell prisoners to the Frankland Centre as they know there is no space.[72]

3.9 The problems faced by the Frankland Centre are reflective of broader issues in providing mental health services in Australia. Every year, approximately three million Australians between the ages of 16-85 experience a mental illness,[73] with around 900,000 missing out on mental health services that should be available to them.[74] Western Australian mental health statistics reflect national trends, with the burgeoning state population placing considerable pressure on the mental health system. The number of people admitted for mental health treatment has increased by 24 per cent since 2006.[75] As noted in the Stokes review,[76] increased bed stock is required, particularly in the community rehabilitative setting, and more psychiatrists are necessary. Only the Northern Territory is worse than Western Australia in terms of FTE psychiatrists per 100,000 people.

Recommendation 3

The government should increase the number of dedicated forensic mental health beds in hospitals. The increase should, at a minimum, match the increase in prisoner numbers since 1993 and projected future growth in prisoner numbers over the next decade.

Transitional therapeutic units in prisons

3.10 Too often, unwell patients are being prematurely discharged from the Frankland Centre to a mainstream prison environment due to pressures of numbers. This is a stressful experience due to the stark differences in environment, and is not conducive to mental wellbeing or to an individual's prospects for release.

3.11 It is essential to address the low numbers of hospital-based forensic beds to ensure that people have access to appropriate care and prison-based psychiatric units should not be seen as an alternative to investment in hospital beds. However, transitional units within prisons may also help to address some of the issues faced by those who have returned to the prison from an authorised hospital and as a supplement to hospital-based services. They could serve as a

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[71] Stokes, B. *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia* (July 2012).
[72] OICS*, Report of an Announced Inspection of Bandyup Women's Prison*, Report No. 73 (October 2011). See paragraphs 9.89 – 9.92.
[73] Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing: Summary of results*, Cat No 4326.0. (2008).
[74] National Mental Health Commission, *A Contributing Life, the 2012 National Report Card on Mental Health and Suicide Prevention* (2012).
[75] Stokes, B. *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia* (July 2012).
[76] Ibid.

link not only between the Frankland Centre and prisons but also between prisons and community based services.

3.12 Unlike the Frankland Centre, which focuses on the medical treatment of acute illness, these transitional units would offer rehabilitative services to a more stable cohort. They would need to be staffed by mental health professionals, and to be located at multiple locations to cover both genders (such as Casuarina and Bandyup). Due to their prison-based location, those accommodated in transitional units would be able to benefit from educational or programmatic interventions that are not available at authorised hospitals.

3.13 Transitional units would be particularly beneficial for those people held under the Act who are not able to access the Frankland Centre as they do not have acute enough care needs. They are not able to directly access the non-acute Plaistowe Ward in Graylands and must therefore stay in prison. Here, there is little or no differentiation of regime and they are generally intermingled with other prisoners. A transitional unit would provide a more appropriate environment, dedicated to rehabilitative interventions and assisting their transition to the community. Importantly, transitional units would also have a role to play for the large number of prisoners who are not detained under the Act but have a mental illness, especially in assisting the transition to release.

3.14 State Forensic Mental Health Services believes that there should be at least four of these units. Proposals for such units were developed over a decade ago[77] but did not attract funding. However, promising progress has occurred recently. In 2012, Professor Bryant Stokes published the *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia* ('Stokes Review').[78] The Stokes Review recommended the planning and provision of a full range of mental health services in Western Australian prisons and detention centres. This included dedicated units for women, youth, and Aboriginal prisoners with a mental illness, and for prisoners with an acquired brain injury or intellectually disability. In addition, it was recommended that community services be expanded to facilitate the transition of people with a mental illness from prison. The government supported this recommendation.[79]

3.15 Currently, a planning process is underway involving the Department of Health, Department of Corrective Services, and the Mental Health Commission to develop a business case for the expansion of forensic mental health services and infrastructure in Western Australia. This business case will then be considered by the government. While the expansion of mental health services and

[77] OICS, *Thematic Review of Offender Health Services*, Report No. 35 (June 2006).

[78] Stokes, B. *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia* (July 2012).

[79] Hon Helen Morton MLC, *Western Australian Government response to the report on the Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia* (November 2012).

infrastructure will come at a considerable cost, it will have far reaching benefits and there is clearly scope to better target services in prisons to meet the needs of people with mental health issues.

Recommendation 4

In addition to expanding the number of forensic beds in a hospital setting, the government should develop transitional mental health units at Bandyup Women's Prison and at least one male prison. These units should be evaluated with respect to their uptake and effectiveness, with a view to introducing such units at other prisons.

Access to psychiatric services in prison

3.16 People held in prison under the Act are not treated as a special category in for the purposes of accessing mental health services. Instead, they are treated as any other prisoner with a mental illness, despite their dependence on mental stability for release. As such, they face the same barriers to mental health service access as other prisoners.

3.17 One barrier is the appointment system to access mental health services. For people with schizophrenia (representing 59% of the mentally impaired accused cohort), the illness can decrease their motivation to seek treatment, therefore potentially presenting a barrier to access. As a recent inspection report noted, more assertive processes are required to ensure that patient healthcare service needs are met, and this is particularly the case for the mentally impaired accused.[80]

3.18 The Department does not have full-time psychiatrists at any facility, with psychiatrists instead seconded to prisons on a sessional basis. At Casuarina Prison, the psychiatrist has two sessions a week, with plans to introduce a third session. At Acacia, there is a similar arrangement, with a psychiatrist attending three sessions a week. Other lower security or regional prisons have fewer psychiatric sessions, with Greenough, Karnet, and Wooroloo having one day per fortnight, and isolated prisons such as Eastern Goldfields needing a psychiatrist to be flown in, usually for one day every two months. Psychiatrists have also consulted prisoners by video link at some regional prisons, with one video-link session every six weeks at Roebourne Prison. Regardless of the method of consult, prisoners are referred to psychiatrists via mental health nurses or GPs, so that those who have the most need are given priority.

[80] OICS, *Report of an announced inspection of Broome Regional Prison*. Report No. 77 (June 2012).

3.19 There can be considerable delays in accessing these services, with resources stretched to capacity.[81] Across prisons, overnight mental health care ranges from limited to non-existent, with prisons having to manage very unwell prisoners with minimal staffing.[82] It may take a person a couple of days to a couple of weeks to gain an appointment with a mental health nurse or GP, followed by a further waiting period to access a psychiatrist. In some cases, the psychiatrist may not be available on their scheduled visits, leading to further delays.[83] One prisoner under the Act expressed a desire to the review team to have more regular appointments so that psychiatric reports to the MIARB would be better able to document his mental stability and improve his prospects for release.

Medication compliance

3.20 People with a severe mental illness often have a poor understanding of the need for medication which can lead to poor compliance in taking medication.[84] Many people held under the Act, regardless of whether they had transitioned through the prison system or through the Frankland Centre showed poor compliance in taking medication.

3.21 In prison there is an increased incentive for medication non-compliance due to their high black market value. This commonly results in the secretion of medication, either for trading purposes or in response to stand-over behaviour. A number of people held under the Act had received prison charges for medication secretion.

3.22 People held in the Frankland Centre can be forcibly medicated as an involuntary patient under the Mental Health Act. However, people cannot be forcibly medicated in prison. Hence, some people who are discharged from the Frankland Centre to prison despite not being completely well, and who have questionable insight into their mental health, are being placed in an environment where they are afforded the option of not taking medication.

3.23 There are mixed views on whether to implement Community Treatment Orders (CTOs)[85] in prison to enforce medication compliance. Discussion with State Forensic Mental Health Services expressed concern that a CTO could be used a control device, with prisoners forcibly medicated and with little ability for recourse or review. However, in a report into the suicide of an individual with a

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[81] OICS, *Report of an announced inspection of Hakea Prison*. Report No. 80 (January 2013); OICS, *Report of an announced inspection of Casuarina Prison*, Report No. 68 (November 2010).

[82] OICS, *Report of an announced inspection of Bandyup Women's Prison*, Report No. 73 (October 2011) recommended 24/7 mental health nurse coverage. The Department did not support this recommendation. It claimed that it could ring the Frankland Centre for advice if needed but this was not in fact true. Rather than engaging proactively with the recommendation, it also said that resource limitations did not permit 24/7 coverage.

[83] This was recently the case at Wooroloo, where the psychiatrist did not attend two of their scheduled visits in a row, leading to a significant backlog in appointments.

[84] Kessler R, Berglund P, Bruce M, Koch, J, Laska E, Leaf, P. et al. The prevalence and correlates of untreated serious mental illness. (2001) 36 (6), *Health Services Research*, 987.

[85] A CTO enforces treatment on a person not detained in an authorised hospital and can only be made by a psychiatrist. The person under the effect of the order becomes an 'involuntary patient' under the Mental Health Act 1996. This typically occurs in the community but does not preclude involuntary treatment in prison.

mental illness in Acacia Prison, the Deputy State Coroner regarded CTOs as being in the prisoner's best interest and expressed confusion on why there was such opposition to their provision in prison.[86] This is a highly contentious issue, and more discussion is required to determine the best way to balance these competing ethical concerns.

Factors affecting people with a cognitive impairment

Lack of declared places

3.24 Despite the Act being established in 1996, with a provision for a mentally impaired person to be detained in a declared place, no declared place has been established. This has led to people remaining in the inappropriate prison environment for extended periods of time.

3.25 In June 2013 the Minister for Disability Services announced the establishment of two metropolitan Disability Justice Centres.[87] These centres will function as declared places for people under the Act who are cognitively impaired and will be operated by the Disability Services Commission. The centres are scheduled to open in 2015 and are intended to accommodate up to 20 people between both facilities. The Planning Commission has currently approved the development of these centres.[88]

3.26 The Minister for Disability Services stated that the centres will be secure facilities intended to mitigate risk to the community, while still supporting residents.[89] Staff to resident ratios will be considerably better than staff-to-prisoner ratios, with an aim of one staff member for every two residents during the day and one staff member to every three residents at night. All residents will have an individual development plan that is tailored to rehabilitate and reintegrate them back into the community.[90]

3.27 The Disability Services Commission also intends to provide an in-reach service at all prisons. The in-reach service will provide personalised support (e.g. speech therapy, behavioural management programs) to those under the Act who are clients of the Disability Services Commission. This is a promising initiative for people in regional prisons who are unable to access the Disability Justice Centres. It also ensures that prisoners in metropolitan areas who are unable to access the Disability Justice Centres (e.g. if the centres are full) are still able to receive some

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[86] Vickers EF, *Record of Investigation of Death, Ref 26/11*, Inquest into the death of Declan John Paul Brennan, Coroner's Court of WA (12 June 2009).

[87] The Hon Helen Morton, Minister for Mental Health, Disability Services, and Child Protection, Disability Justice Centres Announced, media statement (12 June 2013).

[88] <http://www.abc.net.au/news/2013-11-29/caversham-centre/5125646>.

[89] The Hon Helen Morton, Minister for Mental Health, Disability Services, and Child Protection, Disability Justice Centres Announced, media statement (12 June 2013).

[90] Draft 8 – Declared Places (Mentally Impaired Accused) Bill 2013 (WA).

specialised assistance. A million dollars has been set aside annually for in-reach services to occur.[91]

> ***Recommendation 5***
>
> *The government should continue to progress the establishment of declared places for people with a cognitive impairment held under the Act.*

Supervision and support

3.28 Currently, those with a cognitive impairment have extremely limited access to rehabilitative activities in prison. Leave of absence activities outside of prison are therefore crucial. Those with a cognitive impairment not only need accommodation in their time away from prison, but also high levels of supervision and support. Given the permanency of cognitive impairments, long-term supervision is typically required. This is a hugely resource intensive process involving the formulation of release plans, and the provision of staff, programs, allied health professionals and accommodation. As noted by the MIARB, finding appropriate supervision and support for this cohort can be very difficult since they commonly lack community and family support. As a result, the MIARB has noted that some people remain in prison even though their charges do not indicate that they present a significant risk to the community.[92]

3.29 The Disability Services Commission (DSC) aims to provide a comprehensive suite of assistance including supervision and accommodation, usually in partnership with non-government organisations such as Outcare, Teem Treasure, or Life without Barriers. Usually, the assistance begins with the non-government organisation developing rapport with the person in prison through visits, and then taking them to supervised activities outside of the prison such as art classes. Depending on behaviour, the person will have greater time periods outside prison, eventuating in them staying in their own house under supervision.

3.30 The DSC has a partnership with the Department of Housing which expedites access to public housing and results in a permanent allocation of a house through the Community Disability Housing Program. Hence, those currently in custody with DSC funding have a house awaiting them once they reach the stage that they can reside in the community.

3.31 To be eligible for this type of support people must be clients of the DSC. In the early years of the Act, there were delays for some eligible prisoners becoming clients, mainly because the DSC was not aware of who they were or that they had been placed in prison. Processes for identifying those in need of support and ensuring they are known to the DSC have since improved. In the early years of

[91] Western Australia Department of Treasury. *2012-13 Budget Statements*, Budget Paper No. 2 Vol. 2 (May 2012).
[92] Mentally Impaired Accused Review Board, *Annual Report for the year ended 30 June 2012* (September 2012).

the Act, there were also delays in obtaining release orders, resulting from a lack of common understanding between the Department, the DSC, non-government agencies providing external support and MIARB on support requirements to enable people to leave the prison. This has also substantially improved in the last five years. People with cognitive impairments who have recently received a custody order have generally been provided support with little delay.

Factors affecting all people held under the Act

Support and management coordination

3.32 Rehabilitating and releasing those under the Act is a complex task that requires extensive co-ordination between numerous stakeholders. Improved co-ordination is required. While each stakeholder is responsible for specific elements of an individual's support and management, no single agency has overall responsibility and authority for the support and management of the mentally impaired accused. This causes problems in both the custodial setting (for example, where people move between the prison system and an authorised hospital) and in developing comprehensive release plans and supports. Conflicting opinions from agencies and professions about what support is needed, as well as when and how the person should be released, add further complexity.

3.33 The MIARB is not itself responsible for developing release plans. In essence, it is a decision making body for the release plans developed by other stakeholders. It can request information from stakeholders and inform them of the reasons why an individual did or did not transition to the next stage of release. The MIARB assesses information from multiple sources such as prison officers, community corrections officers (CCOs), psychologists, psychiatrists, support agencies and appointed guardians and lawyers advocating on behalf of their clients. On the basis of this information, it decides whether to recommend a release order to the Attorney General. The processes differ somewhat between prisons and detention centres on the one hand and authorised hospitals on the other.

3.34 Where the person is being held in a prison or detention centre, the Department is responsible for their day-to-day management. It is also responsible for the development of release plans for consideration by the MIARB. Within the Department, prison officers and to a lesser extent, health staff, will be involved in their day-to-day management and care, and once a year an individual management plan (IMP) will be set and reviewed. An IMP is a report developed by prison staff for all sentenced prisoners. The IMP identifies treatment, program and education needs. It is designed to assist prisoners reaching eligibility for parole, to support their reintegration into the community, and to lower their potential for reoffending. The IMP is used internally within the Department.

3.35 In addition to the IMP, prison officers are responsible for developing a report specifically for the MIARB. This prison report describes the individual's conduct in prison and the officer's opinions regarding release. The MIARB uses this report to get a sense of the person's behaviour in prison and their readiness for release.

3.36 CCOs have responsibility for developing release plans and for providing reports to the MIARB on the status of such plans.[93] These reports focus on identifying the needs of people post-release and require liaison with community agencies to establish support, supervision and accommodation. Typically a request for a report is made each time the MIARB meet to discuss an individual under the Act in prison.

3.37 Authorised hospitals provide a more centralised management system than prisons. In a hospital setting, psychiatrists, in association with other health staff, are responsible for the person's day-to-day management and also for developing release plans and undertaking clinical assessments that inform MIARB decision making. The psychiatrists assist in arranging access to external accommodation, such as a psychiatric hostel. There is also a process of overview as the psychiatric reports provided to the MIARB are prepared by a psychiatrist external to the Frankland Centre and Graylands Hospital.

3.38 A variety of other external agencies are also involved in the support and management of people held under the Act. These include the DSC, which funds supervision and accommodation for people who meet their eligibility criteria. The DSC contracts services out to community organisations such as Outcare, who provide support and supervision outside the prison. Numerous other community organisations provide support and treatment programs for people with a cognitive impairments or mental illness.

3.39 Communication and co-ordination between stakeholders has improved since the commencement of the Act. However, a fragmented release planning process still exists. Agencies continue to operate in silos and this is a significant impediment to release for people under the Act. Despite the failings at a system level, considerable efforts of individual staff within agencies are providing some means of coordination and communication.

[93] The development of release plans are sought early on in the individual's time in prison, and may undergo many revisions over the course of time until a successful pathway to release is identified.

Recommendation 6

The government should examine ways to improve the co-ordination of release planning for people held under the Act. Consideration should be given to establishing a multi-agency committee directed by MIARB, which is resourced accordingly. [94]

Lack of policy in the Department of Corrective Services

3.40 Given the specific needs of mentally impaired accused and their distinct pathways towards release, it would be expected that comprehensive policies and protocols would exist so as to ensure consistency in approach, adequacy of care, and to maximise the prospects for these people being rehabilitated and reintegrated into society. However, this is not the case.

3.41 There are only brief references to the management of mentally impaired accused in Departmental policy documents. These references include:

- Information added in 2006 to Adult Custodial Rule 18 on the need to develop individual management plans (IMPs') for these prisoners.
- An Assistant Commissioner Custodial Operations (ACCO) notice circulated in 2011 stating that mentally impaired accused must be provided with appropriate representation when facing prison charges (an order that was only generated after a critical report on the handling of this issue).
- The CCO operations handbook briefly describes the Act and need to provide reports for the MIARB. It does not provide guidance on how to plan for the release of this complex cohort or how to co-ordinate planning across agencies.

3.42 The lack of policy and guidance hinders the effective management of people in custody and their progress to release, particularly when developing and implementing a leave of absence order.

3.43 Under section 83 of the Prisons Act 1981 a person in custody can be granted an absence permit for compassionate reasons, to access medical services or to facilitate reintegration into the community. A person granted an absence permit remains the responsibility of the prison. The prison assesses the level of risk of the person leaving the facility and sets an appropriate security regime in place to manage the risk.

3.44 This is not the case for a person receiving a leave of absence under the Act. For these people the risk is assessed by MIARB, the supervision regime is developed with the assistance of the not for profit agency providing support and there is little direct involvement from the prison. However the prison still absorbs the

[94] This recommendation is premised on MIARB continuing in its current role as a decision-making body for people held under the Act (refer to Recommendation 2).

risk of the person leaving their secure facility. The person is still considered a prisoner of the facility when they leave, and the prison may be subjected to negative media coverage if the prisoner escapes while on leave.

3.45 The situation is particularly complicated in the privately run medium security Acacia Prison which has been facilitating some absences. First, there are no clear protocols for leave from medium security prisons as such leave generally occurs from minimum security facilities. Secondly, privately run facilities are financially penalised for breaches in security including 'escapes'. Concern over the potential for escape has led to lengthy delays in releasing prisoners on their leave of absence order from Acacia Prison. Dispensation had to be arranged so that if an escape or similar event occurred for someone under the Act, Acacia Prison would not be penalised. These arrangements were of an ad-hoc nature, and only came about due to the determined efforts of staff and management at the prison.

3.46 In July 2013, these escape concerns were validated when a prisoner on a leave of absence order from Acacia Prison escaped from his support workers and was missing for five hours before being recaptured by police.[95] In line with the agreement, Acacia Prison was not fined for this incident. Apprehension in releasing prisoners on their leave of absence order has not been limited to Acacia Prison, with Departmental prisons also demonstrating some reluctance.

3.47 Due to the lack of a leave of absence protocols, staff in all prisons rely on re-integration leave protocols, which involves the individual getting strip-searched and urine tested whenever they return to prison. In addition, to reduce the risk of bullying and stand-over behaviour, the person may be placed in isolation. As a result, one person who engaged in a leave of absence every two to three days, was strip-searched and urine tested approximately 14 times a month. Not only was this process expensive to the State, stakeholders believed that such intrusive protocols act as a disincentive for re-integration into the community, and interfere with rehabilitation.

3.48 These searching and testing protocols may be also be unnecessary and inappropriate. First, in terms of risk management, the conditions of a leave of absence for people with a cognitive impairment typically stipulate that they are to be supervised at all times. Secondly, while the average prisoner would be aware that the measures are designed to avoid the introduction of contraband into prison and to ensure that no illicit substances have been used, people with a cognitive impairment are likely to have little insight into the need for such invasive protocols. In summary, there is no doubt that, because of their mental impairment, this cohort may be subject to manipulation, with the consequential risk of contraband being brought into the prison. However there needs to be a

[95] <http://au.news.yahoo.com/a/17962188/accused-child-sex-offender-gives-carers-the-slip/>.

balance between the mitigation of risk and the facilitation of a rehabilitative process. A more individualised risk management process is warranted.

3.49 Stakeholders noted that there had been confusion as to the type of punishment permissible when an individual under the Act breaches prison rules. Prison staff have been unsure whether people held under the Act are subject to the normal procedures governing prisoner placement and discipline. Prisons need to be safely managed but serious ethical questions arise if prisoners are subjected to adverse consequences for behaviour that may result from mental illness or cognitive impairment (for example, assaulting someone during a period of psychosis) rather than a conscious decision to violate rules.

3.50 One cognitively impaired Aboriginal man from a remote part of the state who had assaulted prison staff spent nearly two years in the Special Handling Unit at Casuarina Prison. He experienced a highly restrictive regime, including a minimum of 21 hours per day locked in cell, and for nearly one year, he was locked down for 23 hours a day. He had no access to education or formal recreation or social activities, and his skills and behaviour deteriorated further. A similar case occurred in the juvenile context to a young male with a mental illness and cognitive impairment. The punishment he received resulted in a marked deterioration in his mental and physical wellbeing.

3.51 The issue of managing poor behaviour is also complicated when the prison seeks to bring charges against a person under the Act for breaching rules while in custody. The only guidance for this situation is provided through a 2011 Assistant Commissioner Custodial Operations (ACCO) Notice which states that the person should be provided with appropriate representation during proceedings where prison charges are made.[96] The notice does encourage Superintendents to use alternative management options rather than prison charges but the fact that charges can be laid is confounding. The mental condition of people found by the court to be unfit to stand trial is most unlikely to improve during incarceration. It therefore seems unreasonable that they can be charged with, and punished for prison charges while in custody. While it is admirable that a notice now exists to provide the person with representation, they would also have had representation for the original offence and this did not alter the court's opinion that they were unable to stand trial. Well documented alternatives to prison charges should be available for this cohort.

3.52 The Department have recently embarked on a process to develop policy. At the time of writing, this process is currently in the working party stage, with some of these areas of policy deficiency identified by the working party.

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[96] Assistant Commissioner Custodial Operations (ACCO) Notice No 12/2011

Recommendation 7

The Department of Corrective Services, in collaboration with other agencies, should develop specific policies for managing people under the Act, both in custody and in the community. These should include protocols for enhancing care and treatment, managing challenging behaviour, initiating leave of absence and developing release plans. Appropriate staff training should also be provided.

Lack of targeted programs

3.53 The MIARB considers programs to be an important component of an individual's transition to release, in particular for developing the necessary social norms and coping skills. However, programs are not meeting the needs of those under the Act. Generic programs available to the average prisoner are not appropriate in addressing the diversity in impairments and treatment needs of this cohort and individually tailored treatment programs are required.

3.54 The Department has adapted two programs for people with an intellectual disability. One is the Legal and Social Awareness Program,[97] and the other is a modified sex offender program. While it is positive that the needs of people with an intellectual disability have been considered, these programs have generally not assisted their progress to release. Most of those with a cognitive impairment displayed only a superficial understanding of the concepts presented, even when undertaking the modified programs.

3.55 For those currently under the Act who have been placed in prison, over half were not assessed for treatment programs or were considered not suitable for programs delivered in a group setting. This occurred for both people with a cognitive impairment and those with a mental illness. In most cases, the person's level of cognitive functioning or mental illness was cited as the reason for exclusion from programmatic interventions.

3.56 Whilst formal group programs are often not suitable for people under the Act, individually tailored counselling is likely to offer some benefit. This was demonstrated when one person under the Act was considered unsuitable for a group substance abuse program but was subsequently provided individual substance abuse counselling. This led to him being granted a leave of absence order.

[97] This program aims to improve understanding of rule and laws, increase moral reasoning, and decrease pro-offender attitudes and beliefs. See Department of Corrective Services. *Offender Services Prison and Community Programs Guide 2009/10* (June 2009).

Recommendation 8

The Department of Corrective Services, in collaboration with external providers, should make individual treatment programs available to people under the Act who are not eligible for group programs.

Poor program completion reports

3.57 Some people under the Act have been able to access programs but the success of these programs was difficult to determine due to poor reporting. When people complete a program, a program completion report is written by the facilitator. Treatment completion reports should describe how the program resulted in the individual adopting more pro-social views or how it affected a change in their behaviour. For a typical prisoner, these reports are forwarded to the Parole Board in support of a parole application, and for mentally impaired accused prisoners, they are forwarded to the MIARB. Program completion reports are one of the few opportunities where a mentally impaired accused prisoner can demonstrate improvement, which may make the MIARB more likely to transition them to release. However, many treatment completion reports forwarded to the MIARB did not provide such information. The following is an excerpt of one such report:

In summary, Mr … was observed to gain a greater understanding of the factors underlying his offending (consent, victim empathy, boundaries). He demonstrated acceptance of responsibility for his behaviour.

3.58 This generalised paragraph was the totality of the description of the person's treatment gains. Given that he was severely intellectually impaired, and was said to communicate predominately via sign, body language, and facial expressions, the report should have provided clear examples and evidence that he could understand such high-level concepts and that he had accepted responsibility for his offending. The lack of evidence made it extremely difficult for the MIARB to determine the benefits of program completion or issues of future risk.

Recommendation 9

The Mentally Impaired Accused Review Board, in consultation with the Department of Corrective Services, should document the minimum requirements to be included in treatment completion reports to make them consistent and useful for decision making. The Department of Corrective Services and other agencies should implement these requirements and ensure the reports they make are quality controlled.

People who do not receive formal support

3.59 People with a mental illness requiring treatment in an authorised hospital currently transition to release through the Frankland Centre and those with a cognitive impairment that meets the DSC's eligibility criteria can access supervision, support and accommodation. [98] DSC support currently takes place via prisons, but will occur from the declared places once they are established.

3.60 However, some people do not fit neatly into these two categories, and have considerable difficulty progressing to release. One person currently under the Act has both a cognitive impairment and a mental illness but does not meet the eligibility criteria to be either a DSC or a mental health services client. He has remained in prison with little support to facilitate release.

3.61 To be eligible as a DSC client for an intellectual disability, an individual must have an IQ under 71, have deficits in adaptive behaviour, and must prove the disability was acquired before the age of 18. This can be difficult, particularly if they have not been in contact with the health system and did not undertake testing in childhood.

3.62 Alternatively an individual can become a DSC client if they have a cognitive impairment which results in a significant decline in functioning. In order to be eligible they need to demonstrate a memory disturbance in addition to other cognitive deficits (e.g. aphasia, apraxia, agnosia, disturbances in executive functions). Again it is often difficult for the individual to demonstrate evidence of a significant deterioration in cognitive functioning as an indication of prior ability is needed to show deterioration. If someone has low cognitive functioning in adulthood (i.e. via substance abuse) but no evidence they were at a significantly higher level of functioning beforehand, they are unlikely to receive support.

3.63 People with a mental illness that is untreatable or that can be treated outside an authorised hospital are also disadvantaged. They are not eligible to be placed in an authorised hospital, and without a disability they are not eligible for support provided by the DSC. Currently they must be placed in prison and they are most unlikely to qualify for placement in a future declared place. This leaves no formal support available to transition out of the prison. Some may be lucky enough to have a supportive family and accommodation available, but for others, there is a less clear path to release. If the individual additionally has a comorbid personality disorder, or a mental illness that presents a lifelong risk, their prospects for leaving prison are further limited.

3.64 For people held under the Act in a prison environment, a focus on improvements in general management of mental health, combined with a positive response by

[98] Western Australian Disability Services Commission, *Eligibility policy for specialist disability services funder or provided by the Disability Services Commission* (January 2012).

government to improvements in policy, forensic beds, transitional units, and support and management co-ordination should improve their treatment in custody and their prospects of progressing to release.

Appendix A: Key findings

Powers of the courts and the executive:

- There are almost certainly many defendants who could invoke the *Criminal Law (Mentally Impaired Accused) Act* but do not do so. Lawyers are probably not invoking the Act due to the risk of custody orders being imposed.
- Discretion and flexibility are essential to doing justice and achieving community safety whenever an accused person has a mental impairment. The Act does not give the courts sufficient flexibility, especially in cases of unfitness to stand trial. Courts should have the option of community based supervision not just unconditional release or a custody order.
- Currently, the procedures for overseeing custody orders lie with the executive arm of government, including the Board, the Attorney General and the Governor. Consideration should be given to streamlining these processes and also to injecting a degree of judicial oversight. Courts could be given the authority to oversee custody orders or, at least, to review them every one or two years.
- Consideration should be given to setting a 'limiting term' when a custody order is made, as in other jurisdictions.

Profile of people held under custody orders:

- Sixty three people were identified as having been held on custody orders since the inception of the Act.
- The vast majority of people held under the Act are male (95 per cent) and adults (92 per cent).
- Around 70 per cent of people held under custody orders have been non-Aboriginal, and 30 per cent Aboriginal.
- The vast majority of Aboriginal people held under the Act (72%) had a cognitive impairment, predominately the result of, or exacerbated by, substance abuse. Only 16 per cent of the non-Aboriginal people had a cognitive impairment; the majority having a mental illness.
- Almost half of the non-Aboriginal people were facing charges of murder or attempted murder. Only 11 per cent of the Aboriginal people faced such charges and Aboriginal people are generally held under the Act for much less serious alleged offences.
- Two thirds of non-Aboriginal people had been found not guilty by reason of unsoundness of mind and one third unfit to stand trial. This compared to 11 per cent of Aboriginal people found not guilty by reason of unsoundness of mind and 89 per cent unfit to stand trial.

Who is held where and why does it matter?

- People with a treatable mental illness may be held in a hospital setting, though many are in prison due to the shortage of secure forensic mental health beds.

- All those with a cognitive impairment are held in prison because there are no other places.
- Over three quarters of those placed in prison were specifically identified as being at an acute risk of self-harm or suicide. Over two-thirds were listed as being the victim or perpetrator of some form of bullying or violence during their stay.
- Given that people on custody orders are seriously impaired and have never been found guilty, prison is an inappropriate place for them to be accommodated.
- People found not guilty due to unsoundness of mind and placed in a hospital tend to progress to release faster than people found unfit to stand trial and placed in prison. This is the case even though their alleged offences are generally more serious.
- Aboriginal people held under the Act are far more likely to be detained in prison than an authorised hospital. In many cases, they are being held far longer than their offence would normally warrant.
- The Frankland Centre, Western Australia's only secure forensic mental health facility was opened with 30 beds in 1993. It still has only 30 beds. The state's prison population has risen almost 300 per cent over the same time frame. Due to the shortage of forensic mental health beds people under the Act are often prematurely discharged from the Frankland Centre to a mainstream prison environment, creating risk and impacting on rehabilitation.
- The number of dedicated forensic mental health beds in a hospital setting must be increased.
- In addition to (not as a replacement for) hospital beds, mental health units should be trialled in selected prisons.
- The government has announced the establishment of Disability Justice Centres. This is a welcome but long overdue development. The Centres are to be established in the metropolitan area but many of the Aboriginal people caught by the Act are from regional and remote areas. Facilities and services must also be established in the regions.

Communication, co-ordination and treatment programs

- Co-ordination and communication between the various stakeholders responsible for planning the release of people under the Act is better in the mental health system than in prisons.
- Co-ordination and communication have improved in recent years for those held in prisons but the release planning process still appears fragmented. It needs to be improved.
- Despite the specific needs, vulnerabilities, and pathways to release for people under the Act, the Department of Corrective Services has yet to develop specific policies on their management or care.
- There are too few treatment programs or one-on-one interventions for people held in prison under the Act.

- The quality of reports generated on prisoners held under the Act is variable. Too many are generalised and lacking the detail and supporting evidence that would be needed by the Board or any other decision maker.

Appendix B: Methodology

People under the Act were initially identified using the Total Offender Management System (TOMS) database. Data was obtained through Structured Query Language (SQL) extractions using the SQL Developer program. The sample consisted of those whose sentence type was listed as 'MIARB' or 'M', indicating that they were under the Act or were deemed unfit to stand trial.

This retrieval method was limited in that it only included people who had entered a custodial facility at some stage while under the Act. If the individual was directly sent to a psychiatric facility after committing the crime and remained there, they did not appear using this retrieval method.

The Mentally Impaired Accused Review Board however kindly provided the review team access to the case files of all people held under the Act, which enabled the identification of the additional cohort of people who never entered prison. These case files included all correspondence to and from the board relating to each individual, such as psychiatric reports, prison reports, and letters from the accused's lawyers or victims.

Medical records of prisoners held under the Act were also examined via the Department's ECHO database to determine any general trends in their conditions and treatment.

In addition, a number of interviews and information requests occurred with a variety of stakeholders, including:

- Department of Corrective Services (including staff at prisons, CYJ, and head office staff);
- Western Australian Department of the Attorney General;
- Western Australian Disability Services Commission;
- Outcare;
- Western Australian Ombudsman;
- Mental Health Law Centre;
- Western Australian Mental Health Commission;
- State Forensic Mental Health Services;
- Mentally Impaired Accused Review Board; and
- A small number of people held under the Act.

Appendix C: Calculation of time under the Act

In the calculation of time to leave of absence and time to conditional release order (CRO), the first leave of absence/CRO of each individual's first custody order was chosen for the calculation of time. It should be noted that in the calculation of years to leave of absence, the first leave of absence with community access was used, given that a leave of absence for emergency medical treatment was not considered reflective of an individual progressing towards release into the community.

People who were in prison before the commencement of the Act were excluded from the calculation of average years to leave of absence/CRO, however they were included in the calculation of average years to discharge and average years under the Act. For this cohort, the Act commencement date was used in the calculation instead of their initial reception date in prison. People who died while under the Act were excluded from the calculation of average years to discharge and average years under the Act, however, they were not excluded from the calculation of average years to leave of absence/CRO. There was also one individual who received a CRO to New Zealand. While not officially discharged from the Act, the MIARB ceased to have jurisdiction over the individual once they left Western Australia and it became an archived case. For this individual the CRO date was considered their discharge date.

These calculations are limited by the small sample size, the difficulties in interpreting events over time due to environmental factors such as MIARB membership, and the fact that no two cases were exactly alike, even within specific cohorts. While these calculations were designed to be as accurate as possible, they should be interpreted with caution.

Appendix D: Stakeholder responses to recommendations

The draft report was provided to the following stakeholders:

- Department of Corrective Services;
- Western Australian Department of the Attorney General;
- Western Australian Disability Services Commission;
- Western Australian Mental Health Commission;
- Mentally Impaired Accused Review Board;
- Western Australian Department of Health;
- Chief Justice of Western Australia;
- Chief Magistrate of the Magistrate Court of Western Australia; and
- Chief Judge of the District Court of Western Australia.

Stakeholders were overall supportive of the recommendations of the report. Some stakeholders addressed specific recommendations, while others provided general comments. Specific responses to recommendations are found in Table 6, while general responses to the report are summarised as follows:

- The Department of the Attorney General stated that it had concluded a stakeholder consultation process to identify the main shortcomings of the Act. A discussion paper will be released as part of a public consultation process later this year.
- The Mentally Impaired Accused Review Board (MIARB) also noted the Department of the Attorney General's forthcoming consultation process. MIARB supported this process and stated that it would provide an opportunity for areas under the Act to be discussed at a wider level.
- The Chief Justice stated that he had no doubt a number of offenders and alleged offenders falling within the purview of the Act are not identified as such by the courts. The Chief Justice stated this was likely due to the draconian consequences that might follow if a person is found unfit to plead or not guilty due to unsound mind. This was considered a significant concern, as people not being able to meaningfully participate in the trial process or who are convicted of offences where they were not criminally responsible at the time of the commission of the offence is a departure from basic standards of justice.

  The Chief Justice believed that offenders under the Act may suffer a greater loss of liberty by reason of their mental impairment than if they were convicted. He stated that it would be desirable if the court was empowered to impose a custody order or a conditional release order for a finite term. This term would not be

longer than the period for which the offender might have received had they been convicted.

The Chief Justice agreed with the report's suggestion that courts should be empowered to release an alleged offender who has been found unfit to plead on a community base alternative to a custody order, such as a conditional release order.

The Chief Justice was not opposed to the executive discretion model, but suggested that that the continuation of a custody order should be reviewed periodically by the courts, perhaps every two years. The Supreme Court was identified as the most suitable court to undertake these reviews given their experience of reviewing those under the Dangerous Sexual Offenders Act.

- The Department of Health reported that clinicians have expressed the view that custody orders contribute to the continued ill health of those subject to them. Clinicians also reported that the current provisions of the Act have numerous negative consequences, criminalising and disadvantaging people with mental disorders who offend. People under the Act were stated to require appropriate treatment so that their condition improves rather than degenerates. WA Health welcomed legislative changes to improve the Act.

Table 6

Stakeholder responses to specific recommendations

Recommendation	Stakeholder Responses
Recommendation 1.	
The government should examine legislative amendments to give greater flexibility to the courts in dealing with people under the Act, including: (i) community based alternatives to custody orders for people who are found unfit to stand trial but require some degree of supervision; and (ii) repealing or restricting the scope of Schedule 1.	**Department of Health** **Supported in Principle** In his draft report, the Inspector recommends amending the legislation so that courts are able to make community based alternatives to custody orders where the accused is found unfit to stand trial. This would be an intermediate option between the current two options: unconditional release or a custody order. This would presumably take the form of a community based sentence that is currently available in the case of a finding of unsoundness of mind in for the lower courts to make, and higher courts if the offence is not a serious one (Schedule 1). Community based sentences are the remit of the Department of Corrective Services. However, given those found unfit to stand trial are likely to have a serious mental health illness, there will need to be appropriate treatment provided for them in the community. WA Health recognises that the strengthening of community mental health services is an area of need in WA. This is something that has been outlined in the Stokes Review and is a priority and key consideration of the MHC. The relevant change to legislation is likely to have a corresponding impact on community mental health services. Whilst WA Health supports treating patients in the community, where appropriate, there will be purchasing implications related with expanding these services. As the MHC is the purchaser of mental health services in WA, service planning and associated impacts for Government's consideration will be driven by the MHC.

<table>
<tr><td></td><td>Disability Services Commission
Supported
The Disability Services Commission (‘the Commission’) supports the concept of greater flexibility to the courts in dealing with people under the Criminal Law (Mentally Impaired Accused) Act 1996 (‘the Act’) as in Recommendation 1.
Chief Magistrate
Endorsed
There is clearly a need for an alternative between release and custody orders. I would favour some form of community mental health order.
I think that the lack of this option means that people in need of treatment and who might potentially pose a risk to themselves or the community without supervision and treatment are released because judicial officers do not want to take the draconian step of making a custody order.
There also needs to be a means of limiting a custody order to a time proportionate to the sentence if they had been found guilty - although I accept that is perhaps difficult.</td></tr>
<tr><td colspan="2">Recommendation 2.</td></tr>
<tr><td>The government should examine legislative amendments to repeal the current ‘executive discretion’ model and to vest authority for decisions regarding the release of individuals under the Act to:
(i) the Mentally Impaired Accused Review Board; or
(ii) the courts; or
(iii) the Mental Health Review Board.</td><td>Department of Health
N/A
The change to review and release procedures is not for WA Health to comment on. However, if the aim is to make the Mental Health Review Board (MHRB) the body responsible for the decision to release a person from the custody order, it should be noted that the MHRB will become the Mental Health Tribunal under new legislation. The Mental Health Bill is currently in Parliament, and if passed will become the new Mental Health Act. One of the aspects of the Mental Health Bill 2013 is to legislate for the creation of a Mental Health Tribunal. The Mental Health Commission is the agency responsible for the establishment of this tribunal, and should be addressed regarding any queries.
Chief Magistrate
Supported
Although it would increase work for the courts I think they provide the adequate level of transparency to any review.</td></tr>
<tr><td colspan="2">Recommendation 3.</td></tr>
<tr><td>The government should increase the number of dedicated forensic mental health beds in hospitals. The increase should, at a minimum, match the increase in prisoner numbers since 1993 and projected future growth in prisoner numbers over the next decade.</td><td>Department of Health
Supported in Principle
The issue of a shortage of Forensic Mental Health Beds is something that WA Health is well aware of and is something that has been identified in the Stokes Review. As the purchaser of mental health services, the MHC provides funding for mental health beds. The MHC is currently developing a Mental Health Service Plan, including the development of a Forensic Mental Health Service plan which will consider the forensic mental health service requirements over the next ten years. The future resourcing/development of forensic mental health services will be considered by Government in its consideration of the plan.
Chief Magistrate
Supported
There is a constant problem in being able to place someone on a hospital order because of the lack of beds. This means that again magistrates may not make the appropriate order because they take this into account and as a result someone in need of treatment ends up in prison.</td></tr>
</table>

Recommendation 4.	
In addition to expanding the number of forensic beds in a hospital setting, the government should develop transitional mental health units at Bandyup Women's Prison and at least one male prison. These units should be evaluated with respect to their uptake and effectiveness, with a view to introducing such units at other prisons.	**Department of Health** **Supported in Principle** The desirability of Mental Health units within prisons is also something that WA Health is aware of and this too, has been identified in the Stokes Review. As this is also within the scope of the Forensic Mental Health Plan the same comments apply as those made to Recommendation 3 above.

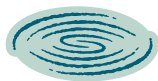
Recommendation 5.	
The government should continue to progress the establishment of declared places for people with a cognitive impairment held under the Act.	**Disability Services Commission** **Endorsed** It is pleasing that the draft report notes the development of a 'declared place' and the range of other services and supports that the Commission provides to mentally impaired accused persons in prison and in the community. As such, the Commission endorses Recommendations 5 and 6, particularly in relations to proposals to improve release planning for people held under the Act.

Recommendation 6.	
The government should examine ways to improve the co-ordination of release planning for people held under the Act. Consideration should be given to establishing a multi-agency committee directed by MIARB, which is resourced accordingly.	**Department of Health** **Supported in Principle** The Inspector has identified the need for improved release planning for people under the Act and recommended the establishment of a multiagency committee directed by the Mentally Impaired Accused Review Board. Whilst the role of WA Health is not clear and requires further clarification, WA Health recognises the importance of good discharge planning in line with the implementation of the key findings of the Stokes Review. Provision around the making of treatment, support and discharge plans, and involving patients in the planning are set out in the Mental Health Bill and apply to patents under the *Criminal Law (Mentally Impaired Accused) Act*. The Chief Psychiatrist will also publish standards and guidelines that will consider aspects of treatment, support and discharge planning for mental health services in WA as per the Mental Health Bill 2013. Furthermore, as the recommendation is regarding multi-agency collaboration, there needs to be clarification of who the committee will be resourced by. WA Health supports and recognises the clear benefits of cross agency collaborations. **Disability Services Commission** **Endorsed** Refer to previous response.

Recommendation 7.	
The Department of Corrective Services, in collaboration with other agencies, should develop specific policies for managing people under the Act, both in custody and in the community. These should include protocols for enhancing care and treatment, managing challenging behaviour, initiating leave of absence and developing release plans. Appropriate staff training should also be provided.	**Department of Corrective Services** **Supported in Principle** The Department has established a working group that will review and examine existing policies and practices for managing people under the *Criminal Law (Mentally Impaired Accused) Act*. Consideration will be given to the development of specific policies and protocols, as well as associated training requirements. **Department of Health** **Supported in Principle** The Inspector's draft report notes that there is a lack of policy in the Department of Corrective Services (DCS). The recommendation is that the DCS, in collaboration with other agencies, should develop specific policies for managing people under the CL(MIA) Act, both in custody and in the community. WA Health mental health policy review is a recommendation of the Stokes Review. Therefore where the DCS policy intersects with WA

	Health policy for the management of prisoners with mental health issues, WA Health is open for discussion with DCS for the update of Health policies. It should however be noted that any change to WA Health policy will need to be in line with the Mental Health Bill 2013. DCS should seek to develop policies that would not be at odds with appropriate standards of mental health care as defined through the Mental Health Bill 2013. **Disability Services Commission** **Endorsed** The Commission is committed to working with the Department of Corrective Services and the Department of the Attorney General to promote equitable outcomes for people with disability in the justice system. The Commission endorses Recommendation 7, and is working closely with the Department of Corrective Services to develop training, procedures and programs for joint clients, including those held under the Act.
Recommendation 8.	
The Department of Corrective Services, in collaboration with external providers, should make individual treatment programs available to people under the Act who are not eligible for group programs.	**Department of Corrective Services** **Supported in Principle** Level of cognitive functioning and mental illness should be taken into account in determining suitability for inclusion to program intervention, whether in a group format or individually tailored counselling. Given the underlying issues associated with those people under the Act, in many cases offence specific program intervention is not relevant because the person lacks sufficient capacity. The need to work more collaboratively with other services, such as health and disability services, to formulate and develop realistic case and risk management plans for those under the Act is supported. The provision of individually tailored counselling to address specific behaviours should be considered when relevant and appropriate to do so. Examination of the resource implications and demand for individual counselling is necessary, Offender Programs is resourced and staffed, based on a group intervention services delivery model. **Department of Health** **N/A** This recommendation addresses the lack of targeted programs for prisoners to address diversity in impairments and treatments needs which may take the form of individually tailored counselling. WA Health can see how such programs would be valuable for offenders. They would not however, appear to fall within the public mental health sphere and therefore are outside the scope of WA Health to comment. WA Health notes however, that Health Services are provided to the Department of Corrective Services under a Memorandum of Understanding which has recently been reviewed and agreed upon. **Disability Services Commission** **Endorsed** The Commission endorses Recommendation 8, that individual treatment programs should be available to people under the Act who are not eligible for group programs. The Commission believes that all people with intellectual or cognitive disability are disadvantaged in prison, not least due to the lack of appropriate treatment and vocational programs. People with cognitive disability held under the Act who also have a mental illness are doubly disadvantaged, and there is an urgent need to ensure that prison staff are skilled in working with a range of disabilities.

Recommendation 9.	
The Mentally Impaired Accused Review Board, in consultation with the Department of Corrective Services, should document the minimum requirements to be included in treatment completion reports to make them consistent and useful for decision making. The Department of Corrective Services and other agencies should implement these requirements and ensure the reports they make are quality controlled.	**Department of Corrective Services** **Supported – Existing Departmental Initiative** The need to improve the quality and consistency of Program Completion Reports across all programs has been recognised by the Department. Staff report writing training has been undertaken over the past 12 months. The Clinical Governance Unit, Operational Support, have prepared new report writing guidelines and report templates as part of the strategy to enhance business capability. Consultation will occur with key stakeholders (e.g. Prisoners Review Board & MIARB) in order to meet necessary requirements. Ongoing reviews will be undertaken following the implementation of new practices, to evaluate the effectiveness of these strategies.



OFFICE OF THE INSPECTOR
OF CUSTODIAL SERVICES

Level 5, Albert Facey House, 469 Wellington Street
Perth, Western Australia 6000
Telephone: +61 8 6551 4200
Facsimile: +61 8 6551 4216

www.oics.wa.gov.au