

Treatment and care of mentally ill offenders pursuant to Part 5 of the *Sentencing Act* 1991 and Parts 3–4 of the *Mental Health Act* 1986

Discussion paper

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Contents

Executive summary	1
Making a submission	2
Introduction	3
General	3
The Vincent review	3
<i>Sentencing Review</i> and <i>Pathways to Justice</i> report	4
Changes in service delivery—their significance for legislative reform	5
Considerations concerning mental illness and its relevance to sentencing	7
Chapter 1 Proposed amendments to s.93(1)(d)	9
1.1 Hospital orders	9
1.2 Restricted community treatment orders	15
1.3 Proposals for amendment	19
1.4 Summary of issues for consideration	27
Chapter 2 Proposed amendments to s.93(1)(e)	29
2.1 Hospital security orders	29
2.2 Retaining s.93(1)(e)—clarification required	31
2.3 Summary of issues for consideration	35

Executive summary

This paper proposes amendments to s.93(1)(d) and s.93(1)(e) of the *Sentencing Act* 1991 (Vic) and parts 3-4 of the *Mental Health Act* 1986. It has been developed by the Mental Health Branch, Department of Human Services in collaboration with Legal Policy, Department of Justice.

In relation to s.93(1)(d) of the Sentencing Act, the most significant of these proposals would:

- permit a court to make an order for involuntary community treatment on the advice of the responsible authorised psychiatrist, without requiring the person to be admitted to an inpatient service
- permit courts to make s.93(1)(d) orders only in circumstances where a non-custodial disposition is being contemplated
- align the criteria for making of a s.93(1)(d) order with the criteria for 'civil' involuntary commitment, but permit additional conditions to be placed on the order by the responsible authorised psychiatrist where necessary because of the relationship between the person's mental illness and offending behaviour
- give courts greater guidance concerning the matters to be considered prior to making of orders
- streamline and simplify the administrative provisions for managing orders under the Mental Health Act.

In relation to s.93(1)(e) orders, it is proposed to amend these provisions to clarify:

- the criteria under which they should be made and revoked
- the consequences of discharge to prison on the operation of the order
- issues concerning granting of parole from an inpatient mental health service.

The introduction to the paper sets out the reasons for the review and provides historical context for legislation in the area. It identifies relevant considerations which the courts have identified when sentencing mentally ill offenders, and describes related dispositions for persons with mental illness who come before the courts. Chapter 1 proposes amendments to s.93(1)(d) and related provisions in the Mental Health Act, and chapter 2 sets out proposals for amendment to s.93(1)(e).

Making a submission

Input is welcomed from stakeholders on all of these proposals and any other issues which might be relevant to the effective operation of the provisions. Submissions should be forwarded to:

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no later than **6 February 2004**.

Introduction

General

Part 5 of the *Sentencing Act* 1991 enables Victorian courts to make hospital orders¹ and hospital security orders² for persons found guilty of offences who require involuntary treatment and care for mental illness. Parts 3–4 of the *Mental Health Act* 1986 provide a mechanism for community treatment of hospital order patients, set out the circumstances in which this should occur, and provide for discharge from orders when certain legislative criteria are no longer satisfied.³

The need to review these provisions arises from two principal sources: the *Report of the review panel appointed to consider leave arrangements for patients at the Victorian Institute of Forensic Mental Health*⁴ undertaken by the Honourable Justice Frank Vincent and the *Sentencing Review Discussion Paper* and *Pathways to Justice* report of Professor Arie Freiberg.⁵ In addition, stakeholders working in the area have raised issues relevant to the effective operation of these provisions which are also addressed in the paper.

The Vincent review

In May 2001, the Honourable Justice Frank Vincent chaired a review panel to consider leave arrangements for patients at the Victorian Institute of Forensic Mental Health ('the Vincent review'). The review followed a number of security related incidents at the Institute in 2000–2001.

The Vincent review made a number of recommendations concerning leave for security and involuntary patients at the Institute. It also recommended that s.93(1)(d) of the Act not be used in matters where a serious crime has been proven, and that greater legislative guidance be given for determining when such orders should be made by the courts and subsequently discharged by the Chief Psychiatrist or Mental Health Review Board. The Minister for Health accepted these recommendations but determined that amendments to implement them should be held over until the results of the Sentencing Review were known.

1 Section 93(1)(d) *Sentencing Act* 1991.

2 Section 93(1)(e) *Sentencing Act* 1991.

3 Only those provisions in parts 3–4 relating to hospital orders and hospital security orders are subject to review in this paper.

4 The review panel reported to the Minister for Health in June 2001.

5 Freiberg A, *Sentencing Review Discussion Paper*, August 2001; Freiberg, A, *Sentencing Review: Pathways to Justice*, March 2002.

Sentencing Review and Pathways to Justice report

In October 2000, the Victorian Government commissioned Professor Arie Freiberg of the University of Melbourne to conduct a review of Victorian sentencing laws. The terms of reference included the desirability of making any changes to existing sentencing options (including suspended sentences, combined custody and treatment orders, intensive correction orders and youth training centre orders) with special reference to the procedures and consequences following breach of such orders.⁶

The *Sentencing Review Discussion Paper* did not directly address the operation of Part 5 of the Sentencing Act, but raised general questions about the effectiveness of substituted sentences which can be said to include the hospital security order.⁷

The final report of the review, entitled *Pathways to Justice*, made extensive recommendations concerning reform of Victorian sentencing law. It proposed the introduction of more individualised and flexible sentencing options for those offenders who do not require immediate terms of imprisonment, and the establishment of formal mechanisms by which the community can inform the sentencing process and be informed about sentencing.

Key recommendations included the:

- establishment of a Sentencing Advisory Council
- reform of substituted sentences, such as the suspended sentence and intensive corrections order
- abolition or revision of the combined custody and treatment order
- renaming of the community based order as the 'community corrections order' and its division into separate orders including an assessment and treatment order.

The *Sentencing (Amendment) Act* 2003 was passed in the Autumn 2003 Parliamentary session. The amendments provide for the establishment of a Sentencing Advisory Council and empower the Court of Appeal to give guideline judgements.

⁶ *Discussion Paper*, *ibid.*

⁷ At p. 66.

Changes in service delivery– their significance for legislative reform

General

In reviewing the operation of hospital orders and hospital security orders, it is important to acknowledge the very significant changes in service delivery that have occurred since these legislative provisions were developed. These changes are critical in considering how the legislation should be amended.

At the time the hospital order provisions were incorporated in the *Mental Health Act 1959*, treatment and care for serious mental illness occurred in large stand-alone institutions. Persons subject to hospital orders could be expected to remain in these institutions for very long periods of time, with limited or no access to ongoing treatment in the community.

In the late 1950s and early 1960s, new psychotropic medications began to be developed and the focus of treatment for mental illness commenced a shift away from inpatient care to community treatment. Following these developments, and consistent with changes throughout the Western world, large stand-alone institutions in Victoria began to close. By the early 1990s, and following large scale national and state policy reform, mental health services began to be ‘mainstreamed’ with general health services. As part of this process, inpatient services formerly provided by large stand-alone institutions were co-located with general hospitals.

In 1994, twenty one area mental health services were established across Victoria to underpin service delivery. As part of this process, a broader range of community treatment services were developed in each service area, including Mobile Support and Treatment teams (MSTs) and Crisis Assessment and Treatment teams (CATs). In addition, community care units and secure residential extended care units were developed to provide residential treatment options for people with serious mental illness. Specialist statewide services were also developed, with a dual role in service delivery and provision of expert advice and assistance to area mental health services where required. These statewide services include the Victorian Institute of Forensic Mental Health (VIFMH), a dual disability service for treatment of people with substance abuse disorders and mental illness (SUMITT) and a service to support the treatment of individuals meeting the criteria for a diagnosis of borderline or severe personality disorder (SPECTRUM).

As a consequence of these reforms, the majority of treatment and care for mental illness now occurs in the community. In the ‘mainstream’ or civil context, services may be provided voluntarily, or involuntarily pursuant to a community treatment order under s.14 of the *Mental Health Act 1986*. Inpatient care is provided through the co-located services described above and the objects of the Mental Health Act require that patients be treated in the least restrictive manner possible. As such, these units do not operate as locked wards, though each unit has a small number of secure high dependency beds which are intended for short term use only. Inpatient stays are relatively short and, in accordance with the above principles, a key goal

of inpatient treatment is to enable the person to return to community living as soon as possible.

Forensic mental health services have been significantly expanded as part of the redevelopment of Victorian mental health services described above. In 1999, a secure 100 bed facility for treatment and care of mentally ill offenders was opened at the Thomas Embling Hospital in Fairfield. The facility is operated by the VIFMH and provides services to:

- remanded or sentenced prisoners suffering from acute episodes of mental illness who are transferred from prison under s.16(3)(b) of the Mental Health Act
- forensic patients found unfit to plead to an offence or not guilty on the grounds of mental impairment under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic)
- hospital security order patients under s.93(1)(e) of the Sentencing Act
- hospital order patients under s.93(1)(d) of the Sentencing Act who are referred from area mental health services or from the courts
- involuntary patients whose needs are complex and who are referred to VIFMH by area mental health services.

The VIFMH also provides community mental health services to persons considered to require ongoing specialist forensic mental health services.

Effects of service reform

The effects of the above reforms are particularly significant for persons subject to hospital orders. Inpatient stays for this group of patients are likely to be much shorter than in the past and the focus of treatment is on rehabilitation and reintegration into the community. The majority of hospital order patients are likely to be treated by area mental health services rather than the specialist forensic mental health service and when inpatient care is required, this will generally be provided in inpatient services co-located with general hospitals. For hospital security order patients, treatment and care will occur at Thomas Embling Hospital.

Related legislative changes

While there have been significant changes in the way mental health services are provided in the last two decades, there have also been significant legislative reforms concerning seriously mentally ill people who appear before the courts. The most significant of these is the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic), which radically reformed the law relating to persons found unfit to plead or not guilty by reason of mental impairment. It enables the Supreme and County Courts to make custodial and non-custodial dispositions for the treatment and care of persons with a mental impairment, and provides a scheme for gradual rehabilitation and reintegration into the community.

At the other end of the dispositional spectrum, it should also be noted that the hospital order provisions discussed in Chapter 1 of this paper pre-date the current community based order (CBO) and intensive corrections order (ICO) under the Sentencing Act. Under these orders, conditions may be attached concerning psychiatric assessment and treatment.

Considerations concerning mental illness and its relevance to sentencing

Prior to considering specific issues relating to amendment of the hospital order and hospital security order provisions, it is useful to consider recent Victorian case law which has dealt with the interrelationship between mental illness and offending behaviour. The most significant case for the purposes of this discussion is *R v Tsiaras* [1996] 1 VR 398. In *Tsiaras*, the Victorian Court of Appeal suggested there are five ways in which serious psychiatric illness—not amounting to the legal test for insanity⁸ is relevant to sentencing:

- First, it may reduce the moral culpability of the offence, as distinct from the prisoner’s legal responsibility. Where that is so, it affects the punishment that is just in all the circumstances and denunciation of the type of conduct in which the offender engaged is less likely to be a relevant sentencing objective.
- Second, the prisoner’s illness may have a bearing on the kind of sentence that is imposed and the conditions in which it should be served.
- Third, a prisoner suffering from serious psychiatric illness is not an appropriate vehicle for general deterrence, whether or not illness played a part in the commission of the offence. The illness may have supervened since that time.
- Fourth, specific deterrence may be more difficult to achieve and is often not worth pursuing as such.
- Finally, psychiatric illness may mean that a given sentence will weigh more heavily on the prisoner than it would on a person in normal health.

Following the Court’s decision in *Tsiaras*, the above have been adopted as guiding principles in sentencing mentally ill offenders whose illness falls short of mental impairment.⁹

In adopting the *Tsiaras* principles, courts find themselves balancing the person’s need for treatment against community expectations that a person who commits a crime should be punished. As *Tsiaras* reflects, this involves inherent tensions: whilst it is clearly undesirable that people be punished for suffering a mental illness, the existence of mental illness should not automatically override requirements that a person who commits a crime be punished. The severity of the illness and seriousness of the crime are therefore key factors.

8 Since this decision, the defence of insanity has been replaced by the defence of mental impairment in the Crimes (Mental Impairment and Unfitness to be Tried) Act.

9 See *R v Vukovic* [1999] VSC 225 and *DPP v Che Kien* [2000] VSC 376.

In this context, the following discussion endeavours to examine what kinds of dispositions hospital orders and hospital security orders should be and how they should operate. The department considers that the goal of any reforms should be to ensure:

- effective treatment and care for individuals with mental illness where this is necessary either for their health or safety or for the protection of the community
- flexibility in the kinds of dispositions available to the courts, which should be consistent with current models of service delivery described above
- transparency and clarity of operation for the courts, offenders, service providers and the community
- fair procedures for dealing with offenders.

In view of the above, particular attention will be given to:

- how the use of hospital orders might be restricted to matters other than those where a serious crime has been proven (as recommended by the Vincent review)
- what legislative criteria might be introduced to guide decisions concerning the making of hospital orders or hospital security orders and, similarly, what matters should be considered in determining whether to discharge these orders
- how the current provisions should be amended to improve their operational effectiveness.

It should be noted that while provisions in ss.90 and 91 relating to diagnosis, assessment and treatment orders are not dealt with as part of this paper, stakeholders are welcome to identify issues concerning their operation in responding to the proposals that follow.

Chapter 1 Proposed amendments to s.93(1)(d)

1.1 Hospital orders

Hospital orders are created under s.93(1)(d) of the Sentencing Act. The order is made following a finding of guilt and instead of passing sentence, which means that no other sentence may be imposed at the same time.¹⁰ A hospital order requires that a person be admitted to and detained in an approved mental health service as an involuntary patient.¹¹

Although proof of a connection between the illness and the crime is not stated as a requirement in the Act, it is assumed that such a connection is present prior to the making of an order.¹² A hospital order may only be made following ‘a trial’, which means that it is only available in relation to persons found guilty of indictable offences in the Supreme or County Courts.¹³ It should be noted, however, that the provision does not appear to have been interpreted in so limited a way by Victorian Magistrates’ Courts: more than half the orders examined by the department in preparing this paper were made by Magistrates’ Courts.

1.1.1 Background

An equivalent of the hospital order was contained in s.51 of the Mental Health Act 1959. Patients subject to these orders were treated as recommended or approved patients, as the case required. Significantly, they were not ‘security patients’.¹⁴ The consultative committee appointed to review the 1959 Act commented that the judiciary had been reluctant to use s.51 because it placed no limit on discharge by the superintendent of the psychiatric service.¹⁵

To overcome this difficulty, the committee agreed with a proposal by the Law Reform Commissioner that the courts be given power to impose a restriction order in addition to a hospital order.¹⁶ The proposal made by the committee was that the restriction order would require the court that committed the offender to review the case on the advice of the hospital superintendent prior to release. The purpose of recommending the restriction order in Victoria was to address the situation posed by a dangerous offender who required treatment, but who remained dangerous regardless of successful treatment for mental illness.¹⁷

When passed in 1986, the Mental Health Act 1986 contained the hospital order, which was a version of the provision in the 1959 Act. The new section did not introduce the concept of the restriction order, but provided that discharge could only be undertaken by the Minister for Health. The provision was amended shortly after its passage to permit the Chief Psychiatrist or Mental Health Review Board to discharge the person, rather than the Minister.

10 Fox R and Freiberg A, *Sentencing: State and Federal Law in Victoria*, 2nd ed., 1999, p. 800.

11 The *Mental Health Act 1986* provides for three patient statuses: involuntary, security and forensic. Security patients are persons transferred from prison under s.16(3)(b) or subject to a hospital security order under s.93(1)(e) of the *Sentencing Act 1991*. Forensic patients are persons subject to custodial supervision orders under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*.

12 Fox and Freiberg, above, n10, p. 799.

13 *Ibid*, p. 797.

14 Section 50 Mental Health Act 1959.

15 Citing *R v Rapke ex parte Curtis* [1975] VR 641 where the offender was given an order under s.51 but was not admitted because the authorities at Royal Park Hospital came to the view that there was no treatment that they could provide. See Myers D, Fitzgerald D, Ball R, *Report of the Consultative Council on Review of Mental Health Legislation*, December 1981.

16 The restriction order was available under mental health legislation in the United Kingdom.

17 Myers et al, above, n15, pp. 109-110, 112-15.

Section 15 of the 1986 Act requires that prior to making an order, the court be satisfied:

- (i) that the person appears to be suffering from a mental illness that requires treatment; and
- (ii) that the treatment can be obtained by admission to and detention in a psychiatric in-patient service; and
- (iii) that the person should be admitted as an involuntary patient for her or his health or safety or for the protection of members of the public.

A person detained under this provision is detained as an involuntary patient.

In 1988, the report of the Victorian Sentencing Committee concluded that these provisions were 'adequate to deal with this category of offender'. It recommended that provisions to the same effect be introduced into the new Penalties and Sentences Act. In coming to this decision, the Committee said:

The courts generally proceed on the basis that deterrence has little role to play in the sentencing of offenders who are suffering from significant mental illness or intellectual disability, where such disability or mental illness contributes to the commission of the offence. In those circumstances the courts have generally looked for options of a non-custodial nature wherever possible to deal with the offenders.

The *Sentencing Act 1991* moved the substantive provisions concerning hospital orders from the Mental Health Act to the new Sentencing Act, as recommended by the Victorian Sentencing Committee.

1.1.2 Case law

In the little case law that exists, the courts have expressed caution in relation to the use of hospital orders. In *R v Carlstrom* [1977] VR 366, the Full Court of the Supreme Court held that an order under s.51 (1) (the predecessor of the hospital order) would only be made 'where the court is satisfied in all the circumstances that the making of an order under the section is *preferable* to passing sentence'.¹⁸ In *R v Cummins* [1991] 1 VR 44, the Victorian Court of Criminal Appeal expressed a view that section 15 of the Mental Health Act was 'still something of a novelty'.¹⁹ The court:

noted that the section does not appear to allow the court to retain control of a prisoner once such an order is made and it may regain it only in the limited circumstances to which the section refers.²⁰ Nor does there appear to be power to impose any particular time limit for the operation of the order, and the length of its life would appear to depend entirely upon the determination of the psychiatrist in charge of the prisoner's programme. In these circumstances, the court would require to exercise the very greatest care before determining that the appropriate manner with which to deal with

¹⁸ At p. 368, emphasis added.

¹⁹ At p. 45.

²⁰ Following a three-month assessment order.

a prisoner was the grant of his release pursuant to a hospital order into a psychiatric in-patient service facility. This is so even though the prisoner is to be an involuntary patient.²¹

The court endorsed the view of the Court of Appeal in *R v Robinson* [1975] VR 816 in relation to s.13 of the *Alcoholics and Drug-dependent Persons Act 1968* which contained a similar form of order. In the court's view:

even though all the jurisdictional facts as required under s.13 have been established, it will be seen that there is still a discretion conferred upon the court as to whether or not it will exercise the powers conferred under the section. This discretion should be exercised only for the purpose of rehabilitating suitable accused persons who fall within the description of s.13(1)(a) and (b) and who, it may be reasonably assumed, can be reclaimed.

The legislation does not take away from the court the ordinary discretion conferred upon a court to impose the appropriate punishment on a guilty offender. The various factors which are material to punishment must still be considered but because of the provisions of s.13 a new factor should be added to the existing relevant material. Where a serious crime has been committed and is of a prevalent nature calling for general deterrent penalty, then in our opinion the discretion conferred under s.13 should not be lightly exercised to relieve the offender from correctional custody which deservedly should be imposed on him as a punishment for his wrongdoing. This consideration must be borne in mind in cases where the crime has become or is becoming much too common and offends against contemporary attitudes to the conduct constituting the crime.²²

The decision of the court in *Cummins* suggests some of the factors that should be taken into account in deciding whether to impose a hospital order. In *Cummins*, the applicant had suffered from schizophrenia for a considerable period and relied on a suggestion in a psychiatric report provided to the court that he would be suitable for a disposition under s.15 if the relevant statutory requirements relating to availability of treatment could be met. Nevertheless, the court held that 'the gravity of the crimes committed and the seriousness of the circumstances attending their commission' were such as to make an order under s.15 untenable. The crimes in question were aggravated burglary, armed robbery and false imprisonment. The crimes were planned thoroughly and had involved the applicant and three others breaking into the victims' home, binding the victims and stealing a number of paintings and artefacts. The court confirmed the sentences of imprisonment imposed on the offender.

In the case of *M²³*, the offender entered a plea of guilty to a charge of intentionally causing serious injury, having initially been charged with attempted murder. *Cummins* J found it 'notable that a hospital order is a therapeutic entity, not a sentence, and that it is indeterminate in length'.²⁴ He emphasised that the decision

21 At p. 49.

22 At p. 49.

23 (1996) 88 ACrimR 387.

24 At p. 389.

to impose a hospital order was for the judge alone, and did not flow from any particular recommendation by expert witnesses. He stated that:

A court must look to all relevant considerations. Whilst in cases of illness, therapeutic considerations are most prominent because of the reduced moral culpability of the offender and because of the importance of cure and rehabilitation, the court must also look in particular to the matter of community safety, including that of the family of the offender. The therapist essentially looks to the care of the individual; the court looks both to the individual and to the community.²⁵

While not spelt out expressly, relevant factors taken into account in *M* appear to be that:

- the psychosis experienced at the time of the offence, although precipitated by marijuana use, was a symptom of underlying schizophrenia, not cannabis-induced psychosis
- the offender expressed guilt and remorse, and entered a plea of guilty
- the offender had an understanding of, and insight into, his illness
- inpatient treatment for schizophrenia was likely to be necessary for a significant period
- there was support for a therapeutic disposition from the victim (the offender's mother).

Cummins J noted that expert psychiatric evidence supported a therapeutic disposition and that considerations of community safety (including that of the defendant's family) did not militate against it.²⁶

1.1.3 Vincent review

The Vincent review panel expressed the following concerns about the hospital order provisions in the Act:²⁷

The consideration of leave for patients admitted under s93(1)(d) of the Sentencing Act 1991 raises a wider range of issues relating to the use of this section by courts as a means for the disposition of offenders. An order under s93(1)(d) is an indeterminate order of a court. However, interventions to release the person into the community and indeed discharge the person from the order are administrative actions, being a decision of either the Chief Psychiatrist or the Mental Health Review Board.²⁸

Any consideration of the use of s93(1)(d) should include consideration of Restricted Community Treatment Orders, to which s93(1)(d) provides a gateway.

²⁵ At p. 390-91.

²⁶ At p. 392.

²⁷ At p. 22-3.

²⁸ Leave decisions for patients admitted under s93(1)(d) orders are made by the authorised psychiatrist. Decisions concerning discharge from orders are made by the Chief Psychiatrist or Mental Health Review Board.

The Review Panel believes that the use of s93(1)(d) of the Sentencing Act 1991 should be reconsidered. The panel believes that this section is not suitable for the disposition of persons who have been found guilty of serious crimes and that the Sentencing Act 1991 should be amended to provide criteria governing its use.

The panel went on to recommend:

That the Attorney-General consider the use of s93(1)(d) of the Sentencing Act 1991 and amend the legislation to provide criteria for the circumstances in which it should be used, and that these criteria reflect that s93(1)(d) should not be used in matters where a serious crime has been proven.

The panel also commented that:

The use of section 93(1)(d) of the Sentencing Act 1991 has been brought to the panel's attention. Of particular concern is the fact that detention under s93(1)(d) is indeterminate, there being neither a maximum nor minimum period. The detention of patients under s93(1)(d) is reviewed annually by the Mental Health Review Board, and patients may appeal to the Board against their detention at any time. The Chief Psychiatrist may also discharge a patient detained under s93(1)(d).

The panel is concerned that patients detained under s93(1)(d) may be discharged earlier than they would have been released had they been sentenced by the court. This has potential to undermine confidence in the courts. The panel is also concerned that patients under s93(1)(d) may spend periods in detention much greater than they would have spent had the court sentenced them.²⁹

The Review Panel is of the view that legislative guidelines for determining when patients detained under s93(1)(d) should be discharged should be provided to the Chief Psychiatrist and the Mental Health Review Board. The panel believes that the Minister for Health should consider amending the Mental Health Act 1986 to include criteria for determining when patients detained under s.93(1)(d) should be discharged.

The panel recommended:

That legislative guidelines be provided to the Chief Psychiatrist and the Mental Health Review Board for when a person on a s93(1)(d) order should be discharged from that order. That the Minister for Health consider amending the Mental Health Act 1986 to include criteria for determining when patients detained under s93(1)(d) of the Sentencing Act 1991 should be discharged.

²⁹ At p. 29. The same observation is made in the 1999 *Report of the Expert Committee, Review of the Mental Health Act 1983*, concerning the existing law in the United Kingdom.

The Minister for Health accepted these recommendations but agreed, on advice from the Department of Justice, that given the complexity of the issues raised and the need for immediate action concerning other recommendations, their implementation would be best considered in the context of amendments to the Sentencing Act that were likely to flow from the review of that Act being conducted by Professor Freiberg.

1.1.4 Use of s.93(1)(d)

Data analysis - use by courts, gender, age, diagnosis, offending history, and prior contact with mental health services

In order to inform this review, the department has undertaken an analysis of 59 orders³⁰ made between July 1991 and June 2002. The results of this analysis are summarised below.

Of the 59 orders reviewed, approximately 55 per cent were made by Magistrates' Courts, 28 per cent by the County Court and 10 per cent by the Supreme Court. Of the total sample, approximately 76 per cent were made in metropolitan areas and 20 per cent in regional areas.³¹ The vast majority of orders concerned males with a history of psychosis.³² Evidence of prior offending was identified in documentation relating to 74 per cent of orders.

Forty-nine per cent of orders examined related to offenders under the age of 30 at the time of the offence. Of the remainder, 34 per cent were aged between 30–40 and 17 per cent were aged 40 and above. Of the total sample, 83 per cent had prior contact with mental health services.³³

Thirty-three of the 59 orders reviewed had been discharged by the Chief Psychiatrist or Mental Health Review Board. The average period subject to orders was two years and 11 months. However, it should be noted that 19 per cent of those discharged had been subject to orders for longer than five years, with the longest period being 10 years.

Fifteen of the 59 orders reviewed related to persons who are currently subject to orders. Of those, just over half (53 per cent) have been on orders for longer than six years. Their original offences vary in seriousness from assault to armed robbery and attempted murder. Two persons have been subject to orders for over 11 years, the longest period being 11 years and three months.

30 It should be noted that this number does not necessarily reflect the total number of orders made during the 12 year period. Orders were excluded from the research where insufficient data was available for the purpose of analysis.

31 Approximately 2 per cent of orders were made in the Children's Court and in 3 per cent the originating court could not be ascertained.

32 Ninety five per cent of orders examined related to males. Of those males, 97 per cent had a primary diagnosis of psychosis.

33 This research would appear broadly consistent with research published in 1995 which found that of 41 people subject to hospital orders, all but two of the 41 concerned males. In that study, the majority were diagnosed with schizophrenia, and two thirds were aged between 18 and 35. The majority had had lengthy contact with the criminal justice system, with one third having more than 20 previous convictions extending over a ten year period. Past contact with the mental health system had occurred in the majority of cases, with the contact involving a number of admissions to inpatient mental health services. See J Mulvaney, 'Professional Conflict and the Sentencing Process: the Case of Hospital Orders' (1995) 18(1) *International Journal of Law and Psychiatry* p. 101–115.

1.2 Restricted community treatment orders

1.2.1 Background and legal framework

A person may be made subject to a restricted community treatment order (RCTO) only if:

- a hospital order applies to the person
 - the person appears to be mentally ill and to require treatment for the illness
 - the treatment can be obtained by making the person the subject of an RCTO
 - because of the person's mental illness, the person should be made subject to the RCTO for their health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public
 - the person is, in the opinion of the authorised psychiatrist, suitable for treatment subject to an RCTO
- and
- the Chief Psychiatrist is satisfied that the person to whom the application relates is suitable for treatment subject to an RCTO.

The RCTO is made by the Chief Psychiatrist, on the recommendation of the authorised psychiatrist of the approved mental health service. The order does not take effect unless and until it is approved by the Mental Health Review Board. Throughout this process, the person remains an involuntary patient for the purposes of the Mental Health Act.

The RCTO must specify:

- the psychiatrist who is to supervise the treatment of the patient
- where the patient is to receive the treatment
- the intervals at which the patient must attend the psychiatrist for treatment
- the intervals at which the psychiatrist must submit a written report concerning the treatment of the patient to the Chief Psychiatrist
- the duration of the RCTO
- any other conditions that the Chief Psychiatrist considers appropriate.

³⁴ Section 36(2A)(a) *Mental Health Act 1986*.

³⁵ Section 15B(5) *Mental Health Act 1986*.

³⁶ Section 15C(2) *Mental Health Act 1986*. An extension of RCTO must not exceed 12 months.

³⁷ Section 36(2A)(b), s37(2), s15B *Mental Health Act 1986*.

In circumstances where the person has failed to comply with the order, or requires inpatient treatment and care, the order can be revoked by either the Chief Psychiatrist or the Board.³⁴ an RCTO may be varied by the Chief Psychiatrist,³⁵ and there is no limit to the number of times an RCTO may be extended.³⁶ Where a person no longer satisfies the criteria for an RCTO or for inpatient treatment and care, they must be discharged as an involuntary patient by either the Board or the Chief Psychiatrist.³⁷

1.2.2 Case law

Mental Health Review Board decisions

A brief overview of reported decisions of the Mental Health Review Board during the 1990s indicates that RCTOs have been an important mechanism for provision of treatment and care to offenders with serious mental illness. Individual decisions also reflect:

- use of long periods of leave of absence prior to making of RCTOs³⁸
- reluctance by the Board to approve an RCTO in circumstances where the patient had little insight into their illness and an expressed intention to continue using illicit drugs³⁹
- willingness by the Board to discharge a person from an RCTO where they had shown steady, gradual improvement without medication over a period of 12 months⁴⁰
- some confusion at service level concerning the operation and effect of RCTOs as compared with CTOs.⁴¹

Administrative Appeals Tribunal decision 1995

In 1995, the Administrative Appeals Tribunal made a determination concerning the effect of imprisonment on hospital orders and RCTOs.⁴² The Tribunal determined that in circumstances where a person subject to a hospital order had committed further offences and been transferred from prison to hospital under s.16(3)(b) of the Mental Health Act, the original hospital order continued to have effect following the expiry of the s.16(3)(b) order. In making its determination, the presiding member stated that:

The Act contemplates a balance between provision of care for the mentally ill and the protection of members of the public. Considering the circumstances of the case such as these, it would seem a capricious result that persons subject to involuntary patient status with supervening security orders made in relation to events not connected with their involuntary status, should be released from the system simply by the effluxion of the time of the operation of the security orders and without any psychiatric assessment.

For these reasons I prefer an interpretation of the legislation that provides for the continuation of a hospital order. I do not accept the submission that the making of the later security order extinguishes the earlier hospital order, particularly given that there is nothing in the legislation providing for such extinguishment.

The applicant's order was therefore found to continue after his prison sentence expired, and he was subsequently placed on an RCTO.

³⁸ *In the appeal of ALB (1991) 2 MHRBD (Vic) 19.* This is supported by the data analysis set out above.

³⁹ *In the review of PGS (1991) 2 MHRBD (Vic) 6.*

⁴⁰ *In the review of ES (1994) 2 MHRBD (Vic) 172.*

⁴¹ *In the review of KC (1994) 2 MHRBD (Vic) 118.*

⁴² *In The Matter of The Secretary to the Department of Health and Community Services and the Mental Health Review Board and JC; In The Matter of FA and the Mental Health Review Board and The Secretary to the Department of Health and Community Services (17 January 1995).*

1.2.3 RCTOs—use and current practice

1.2.3.1 Leave of absence

As described in the introduction to this paper, most people subject to hospital orders spend a relatively limited time in the inpatient setting. Once a treatment regime is established, the person is usually placed on leave of absence (subject to conditions) by the authorised psychiatrist,⁴³ in preparation for eventual placement on an RCTO. Placement on leave is only undertaken after appropriate clinical assessment by the authorised psychiatrist.

Conditions on leave are usually the same as those recommended for inclusion in an RCTO, and give the authorised psychiatrist an opportunity to ascertain whether the conditions are appropriate to maintain community safety and address the person's treatment needs in the community. Should the person require readmission during this time, the leave of absence is revoked by the authorised psychiatrist and the person returns to the inpatient service.

The Office of the Chief Psychiatrist has indicated that these provisions have resulted in some people being subject to lengthy periods of leave of absence pursuant to s.41 of the Act prior to approval of RCTOs. This view is supported by the data analysis, which reflected an average of 2 years and three months between the making of a s.93(1)(d) order and approval of an RCTO by the Board. In the vast majority of cases, the person was receiving treatment and care in the community on leave of absence during this period, with intervening periods of inpatient care when required. However, because the provisions for making of an RCTO require three separate levels of authorisation, leave of absence is used in the interim as the authorised psychiatrist can place the person directly into the community under these provisions and ensure their prompt return to an inpatient service should this be necessary.

1.2.3.2 Making of an RCTO by the Chief Psychiatrist and approval by Mental Health Review Board

When considered clinically appropriate, the authorised psychiatrist forwards a proposed RCTO to the Chief Psychiatrist, who assesses the patient. If satisfied the criteria are met, the Chief Psychiatrist makes an RCTO,⁴⁴ then forwards it to the Mental Health Review Board for approval. The Board schedules a hearing and, if satisfied the criteria are met, approves the order.⁴⁵ In most cases, the initial order is for a period of 12 months, though there is no statutory limit on the period for which the initial order may be made. As indicated above, there is no limit on the number of times an RCTO may be extended.

43 Sections 40–41 *Mental Health Act 1986*.

44 Section 15A(3) *Mental Health Act 1986*.

45 Section 15A(3) and 36(2A)(c) *Mental Health Act 1986*.

1.2.3.3 Revocation–return to inpatient service

Should a person subject to an RCTO require inpatient treatment for their illness, the Act requires that the RCTO be revoked by the Chief Psychiatrist or Board. When this occurs, the person must return to the approved mental health service for inpatient treatment and care. In the context of episodic mental illness, readmission in this way is not uncommon and, in most cases, the inpatient stay is relatively short.

When considered clinically appropriate by the authorised psychiatrist, the person returns to the community on leave of absence, and the process for approval of an RCTO begins again. A new draft order with appropriate conditions must be developed by the authorised psychiatrist and the person must be reviewed by the Chief Psychiatrist prior to making of the order. The new order must then be forwarded by the Chief Psychiatrist to the Mental Health Review Board for approval. In practice, this process is extremely cumbersome and may take many months to administer.

1.2.3.4 Kinds of conditions placed on RCTOs

Conditions placed on RCTOs may be very broad and may:

- require abstinence from alcohol or use of illicit drugs and/or restrict contact with certain people or geographic areas relating to the offence
- require the person to reside in a certain place in order for treatment and care to be provided
- set out the nature of the cooperation required with case managers and treating teams.

These conditions are usually developed by the responsible authorised psychiatrist and forwarded to the Chief Psychiatrist prior to the making of the order. The Chief Psychiatrist may modify the conditions if considered necessary. In practice, this is uncommon.

1.2.3.5 Current data on RCTOs

Current data concerning use of RCTOs indicates that:

- There are three people currently subject to RCTOs, which represents a significant reduction since 1999, when 16 people were subject to RCTOs. Of those three people, two have been subject to s.93(1)(d) orders for longer than six years;
- There are currently five people on leave of absence awaiting approval of an RCTO. Of these, four have been subject to s.93(1)(d) orders for more than six years, with the longest period being 11 years.

1.3 Proposals for amendment

In implementing the Vincent review recommendations concerning restriction of s.93(1)(d) to less serious offences, a timely opportunity exists to improve the operational effectiveness of these provisions.⁴⁶ The goal of these proposals would be to:

- emphasise the diversionary aspects of the s.93(1)(d) order
- ensure consistency of the order with current frameworks for involuntary admission and mental health service provision
- ensure flexibility in place of treatment
- streamline current administrative requirements to remove duplication and increase clarity and transparency of operation.

In proposing changes of this nature, it is also considered that an amended legislative framework would be more responsive to judicial and community expectations concerning effective treatment and care of people with a mental illness who are found guilty of less serious offences.

The proposals are set out in detail below and would:

- remodel s.93(1)(d) to create a single ‘restricted involuntary treatment order’, which would enable community or inpatient treatment immediately following the making of an order, depending on clinical need
- align the criteria for making of such an order with the civil commitment criteria for involuntary detention but enable conditions to be placed on the person’s treatment and care when considered necessary for effective management of the mental illness
- permit these orders to be made only in relation to offences where the court is not considering imposing a custodial sentence
- provide greater guidance for the courts concerning matters to be considered prior to making of these orders, explicitly requiring them to have regard to the person’s current mental state, their medical, psychiatric and forensic history and social circumstances
- clarify that **primary** legal authority for decisions concerning treatment rests with the authorised psychiatrist of the responsible service
- enable the person to be discharged from the order to a s.14 CTO by the Chief Psychiatrist or Mental Health Review Board, or to be discharged from involuntary status altogether if they no longer meet the statutory criteria
- enable the authorised psychiatrist, Chief Psychiatrist or Mental Health Review Board to bring about inpatient admission where clinically necessary
- ensure leave of absence provisions cannot be used for community treatment for extended periods

⁴⁶ As indicated above, the Sentencing Act currently permits conditions concerning psychiatric treatment and care to be attached to Community Based Orders and Intensive Corrections Orders. However, there is no detailed data available concerning use of these orders with psychiatric conditions. As such, it is not possible to evaluate their effectiveness, and/or ascertain whether there are gaps in the legislative framework for sentencing of mentally ill offenders which may need to be addressed via amendments to Part 5 of the *Sentencing Act 1991* or Parts 3-4 of the *Mental Health Act 1986*.

- require regular reporting on the progress of all restricted involuntary patients by the authorised psychiatrist to the Chief Psychiatrist at regular intervals
- make miscellaneous amendments to ensure broad operational consistency of these orders with CTO provisions in the Mental Health Act.

1.3.1 Options for restricting the application of s.93(1)(d)

Two options for implementing the Vincent panel recommendations and restricting the use of hospital orders are:

- **Restricting the making of s.93(1)(d) orders to cases where the court is not considering a term of imprisonment. Where a term of imprisonment is being considered, s.93(1)(e) could be used.**

The department favours this option, which retains as much flexibility as possible for the courts and hinges on the kind of penalty the court is considering imposing. This option would dovetail neatly with the requirement that the court be considering a sentence of imprisonment before making a hospital security order under s.93(1)(e), and would not prevent use of this disposition by higher courts where appropriate.

- **Restricting the making of s.93(1)(d) orders to a defined group of crimes.**

This option may give greater certainty on the face of the legislation as to which offences may result in a s.93(1)(d) order. Such a definition could be linked to the hierarchy of penalties contained in the Sentencing Act.⁴⁷ Alternatively, a definition could limit the making of orders to summary offences and indictable offences heard summarily.

1.3.2 Remodelling s.93(1)(d)–RCTO

Currently, Part 5 of the Sentencing Act only permits courts to make orders for hospital treatment of a person's mental illness. As outlined earlier in the paper, these orders can be traced back to the Mental Health Act 1959 and continue to reflect the institutional setting in which services were provided at that time. Input is therefore sought concerning whether the hospital order provisions should be remodelled as set out below to facilitate effective treatment, clarify the intended consequences of the order and better reflect the way mental health services are now provided.

1.3.2.1 Flexibility of treatment—community or hospital

A key aspect of proposals for reform of s.93(1)(d) is to provide the courts with a more flexible disposition whereby involuntary community treatment can be provided immediately following the making of the order. It is therefore proposed that the Act be amended to provide for making of a 'restricted involuntary treatment order'. Subject to this order and the process set out below, a person could be provided with inpatient or community treatment immediately following the court order, depending on their clinical needs.

⁴⁷ See s109 *Sentencing Act 1991*

In circumstances where inpatient admission is considered unnecessary immediately following the order, the authorised psychiatrist would be required to advise the court that the person meets the criteria for community treatment pursuant to an RCTO, that services are available for their treatment and supervision, and that these can be provided under the order. The RCTO and associated conditions (if any) would be provided to the court. If the court goes on to make the restricted involuntary treatment order, it would form the legal basis for the person's involuntary treatment in the community subject to an RCTO. If inpatient care is subsequently required, the RCTO would be revoked and the person would then be admitted for inpatient treatment pursuant to the restricted involuntary treatment order.

This proposal would be intended to increase the flexibility of dispositions for the courts, reflect the changes in service provision which have occurred over the last decade and ensure a person's appropriate placement within the mental health service system immediately following the order.

1.3.2.2 Criteria for making and discharging s.93(1)(d) orders

The department considers that any reformulation of the law in this area should strongly emphasise the diversionary nature of the s.93(1)(d) order, with its purpose being the involuntary treatment of mental illness. In taking this view, it is considered that the current s.93(1)(d) criteria outlined at 1.1.1 above may result in people being treated subject to a more restrictive regime than is clinically necessary,⁴⁸ because they do not explicitly require that consideration be given to whether treatment can be provided in a less restrictive manner.⁴⁹ Such an outcome may contribute to prolonged periods subject to orders which are outlined above. Consistent with the criteria for civil commitment, a person who is involuntarily detained should be treated in the least restrictive manner necessary to ensure the safety of the community and provision of effective treatment.

In view of the above, and the proposal that these orders be used only where the court is not considering a custodial disposition, the department considers that the criteria for making and discharging of s.93(1)(d) orders should be broadly equivalent to the civil commitment criteria for involuntary detention. The fundamental difference between these orders and 'mainstream' involuntary provisions should be a capacity to impose additional conditions on the person's treatment where considered necessary because of the interaction between the person's mental illness and offending behaviour.

Such a structure would also permit the Chief Psychiatrist or Mental Health Review Board to discharge a person to a less restrictive s.14 CTO when additional conditions are no longer clinically necessary, but where the person continues to require involuntary treatment for their mental illness. Amendment of the criteria in this manner would, of course, also permit the person to be discharged completely from involuntary status by the Chief Psychiatrist and Board where treatment and care is no longer necessary.

48 A less restrictive regime would be pursuant to a community treatment order under s14 of the Act, or via treatment as an informal patient.

49 See the data analysis referred to at 1.1.4 above.

It is important to note that the indeterminate nature of these orders is considered inappropriate by some writers in the area, who consider that orders should be of fixed duration and proportional to that which would have been imposed in the absence of mental illness. It has been argued that this would provide a form of ‘safety net’ to avoid unnecessarily prolonged orders.

In the context of the Victorian regime for involuntary treatment and care, potential drawbacks of a time-limited order may be that:

- the person’s treatment and care may be primarily driven by the duration of the order rather than clinical need, and this is inconsistent with the existing treatment-focused regime in the Mental Health Act
- where effective treatment requires an additional level of conditions because of the interaction between the person’s mental illness and offending behaviour, a time limited order may result in poorer outcomes for the patient as the legislative capacity to place conditions on the person’s treatment and care would cease on expiry of the order. In circumstances where the conditions are central to the person’s compliance with, and the success of, treatment, expiry of the order may therefore make effective treatment and care more problematic.

The department considers that amendment of the criteria as proposed above is likely to address concerns associated with prolonged periods subject to orders and is preferable to time-limiting orders, but welcomes stakeholder views on the issue.

1.3.2.2 Increased guidance prior to making of an order

In considering whether to make such an order, it is proposed that the Act be amended to explicitly require the court to consider the person’s current mental state, their medical, psychiatric and forensic history and social circumstances prior to making an order. This is consistent with the findings of the Vincent review, which recommended that greater legislative guidance be given to courts concerning the circumstances in which such orders should be made.

1.3.2.4 Responsibility for provision of ongoing treatment and care

Under this proposal, clinical and legal responsibility for provision of ongoing treatment, care and supervision would rest with the authorised psychiatrist. As is currently the case, the primary focus of such an order (and its point of differentiation from other Sentencing Act orders such as the CBO and ICO) would be treatment and care for mental illness. As set out above, the order would operate as a complete diversion from the criminal justice system.

1.3.3 Making of an RCTO by the authorised psychiatrist following inpatient admission

1.3.3.1 Responsibilities of the authorised psychiatrist

In view of the restriction of s.93(1)(d) to less serious offences, it is arguably unnecessary for three statutory authorities (the authorised psychiatrist, Chief Psychiatrist and Mental Health Review Board) to be involved in decision making concerning a person's transition to community treatment following inpatient admission. In addition, as discussed above, the cumbersome nature of the current RCTO provisions has resulted in use of leave of absence to manage a person's transition to community treatment. This does not clearly or transparently reflect the decision making undertaken by the authorised psychiatrist prior to a person's transition to the community.

Consistent with the above proposals, it is therefore proposed that the existing RCTO provisions be modified to permit the authorised psychiatrist to make an RCTO (as opposed to the Chief Psychiatrist and Board as is currently the case). In making this recommendation, it is acknowledged that the authorised psychiatrist or their delegate currently undertakes the clinical assessment prior to a person's transition to the community and, in doing so, bears responsibility for the person's ongoing management. Should this proposal proceed, it would be broadly consistent with responsibilities imposed on the authorised psychiatrist by non-custodial supervision orders in the Crimes (Mental Impairment and Unfitness to Be Tried) Act. Under this regime, the authorised psychiatrist has responsibility for ongoing treatment and care of the patient and for making decisions concerning the necessity for inpatient treatment and care.

1.3.3.2 Duration of the RCTO and status

An RCTO could be made for a maximum period of 12 months. As is currently the case, there would be no limit on the number of times an RCTO could be extended. The person would be an involuntary patient subject to an RCTO for the purposes of the Act. As such, the Mental Health Review Board would be required to undertake an annual review and the person could appeal their continued detention at any time.

1.3.3.3 Minimising leave of absence

In streamlining the process as outlined above, it would be intended that the use of the leave of absence be minimised. Trial leave to ascertain the appropriateness of certain conditions may be appropriate for a number of days; however, it is proposed that any longer period of community treatment must be undertaken pursuant to an RCTO.

1.3.4 Reporting to, and oversight by, the Chief Psychiatrist

The authorised psychiatrist would be required to report to the Chief Psychiatrist immediately following the making of an RCTO and on a regular basis for all persons subject to these orders within the service. Importantly, the Chief Psychiatrist would have the capacity (and responsibility) to revoke an RCTO and require the person's readmission to hospital if of the view that the legislative criteria for community treatment were not satisfied.

1.3.5 Variation of RCTOs

Consistent with the proposals above, the authorised psychiatrist should have the power to vary an RCTO, with a requirement for statutory reporting of the variation to the Chief Psychiatrist and Board. This would ensure that as a person's treatment and care needs alter, the RCTO can be modified promptly. It is considered that the Chief Psychiatrist should retain the existing power to vary an RCTO.

1.3.6 Streamlining of revocation process

A person's readmission to an inpatient service currently results in the revocation of the RCTO. In turn, when a person's mental state has stabilised and they no longer require inpatient treatment and care, the lengthy process for making of an RCTO begins again.

Where the criteria for inpatient admission are met and revocation is considered necessary, the authorised psychiatrist should be permitted to revoke the RCTO. Readmission as a restricted involuntary patient would result. A new RCTO would be made by the authorised psychiatrist when inpatient treatment and care are no longer required and the criteria for making of an RCTO are met.

1.3.7 Discharge by the Chief Psychiatrist or Board

1.3.7.1 Who can discharge?

It is considered that discharge from a restricted involuntary treatment order or RCTO should continue to be restricted to the Chief Psychiatrist or Mental Health Review Board. Any such amendment should provide that a person can be discharged from an RCTO to a less restrictive s.14 CTO in circumstances where they meet the involuntary criteria but do not require additional conditions on their treatment and care.

1.3.7.2 Guidelines for Chief Psychiatrist or Board

The Vincent review recommended that greater guidance be provided concerning discharge of hospital orders and RCTOs. It is considered that in addition to the current legislative criteria, the Act should be amended to explicitly require the Chief Psychiatrist or Board to have regard to the person's current mental state, their medical, psychiatric and forensic history and social circumstances in considering whether to discharge a person subject to a restricted involuntary treatment order or RCTO.

1.3.8 Review of CTO provisions—miscellaneous amendments

The CTO provisions in the Mental Health Act have recently been amended to improve their operational effectiveness, address issues that have arisen in clinical practice, and clarify and uphold the rights of involuntary patients.⁵⁰

The CTO provisions in the Act have been amended to:

- require a treatment plan to accompany a CTO and provide for review of the plan by the Mental Health Review Board
- clarify that a CTO is unenforceable while a person is serving a prison sentence or is being held in custody on the order of a court in a prison [a prison (for the purposes of determining where a CTO may not operate) includes a remand centre, youth residential centre or youth training centre within the meaning of s.249 of the *Children and Young Persons Act 1989* and a police gaol within the meaning of the *Corrections Act 1986*]
- clarify that a CTO does not need to be revoked if the person requires treatment that can only be provided in an inpatient setting
- clarify that a person subject to a CTO should be able to seek and receive non-psychiatric treatment at a general hospital that has been proclaimed as an approved mental health service without the need to revoke the CTO
- clarify that a person must not be prevented from leaving an approved mental health service unless they have been readmitted as an inpatient and the CTO revoked
- clarify that the death of a person subject to a CTO is a reportable death for the purposes of the Coroner's Act.

The above recommendations are considered relevant to the effective operation of RCTOs and it would be proposed to apply them in any amendments made as a result of this review.

⁵⁰ Further detail on the background to these proposals is contained in *Community Treatment Orders – Background and Discussion Paper*, Department of Human Services, February 2003.

1.3.9 Expiry of RCTOs—the consequences

The CTO provisions in the Mental Health Act have also been amended to provide that involuntary status is automatically discharged when a CTO expires without being extended. This proposal results from the decision of the Victorian Supreme Court in *Wilson v Mental Health Review Board*⁵¹, in which the court determined that a person's involuntary patient status ceases if their CTO expires without having been extended.

While there are significant similarities in the statutory regimes governing CTOs and RCTOs and broad consistency between the regimes is desirable, it is considered that:

- the RCTO results from the order of a court, not an administrative order
- Parliament has shown a clear intention to ensure people subject to a s.93(1)(d) order are assessed at a number of different levels before discharge
- there is currently no specified time limit for an RCTO when it is first made, but a CTO may only be made for a period up to 12 months
- the Act acknowledges the potential for other factors to be relevant in effectively managing a person subject to a s.93(1)(d) order. An order of this nature may arise from a variety of offences and the offending behaviour may not be solely the result of mental illness. For example, substance abuse or another disorder or disability may also play a part. In these circumstances, when a person is placed in the community on an RCTO and, as outlined above, the Act permits a wider range of conditions (such as drug testing) to be applied to the RCTO.

Given Parliament's and the court's intention that a person be reviewed at a number of levels prior to discharge, it would seem inconsistent with this intention that a person be automatically discharged because their RCTO has expired without being extended. On this basis, it is not proposed to amend the Act to provide that an RCTO is automatically discharged if it expires without having been extended. It is proposed that the Act be amended to clarify that the person's underlying involuntary status subject to the original order of the court does not cease. However, a clear statutory process would be required to be undertaken by the authorised psychiatrist, including notification of the person and advice to them concerning the processes undertaken by the authorised psychiatrist to rectify the error and make a new RCTO. The making of the new RCTO would result in a review of the person's status by the Mental Health Review Board.

As is currently the case, the Act would continue to provide for automatic discharge in circumstances where the person cannot be located and has been absent from a service without leave for a continuous period of 12 months.⁵²

51 [2000] VSC 404.

52 Section 42.

1.4 Summary of issues for consideration

1.4.1 Options for restricting the use of the hospital order

Two options for implementing the Vincent review recommendations and restricting the use of hospital orders are:

- Restricting the making of s.93(1)(d) orders to cases where the court was not considering a term of imprisonment. Where a term of imprisonment is being considered, s.93(1)(e) could be used.
- Restricting the making of s.93(1)(d) orders to a defined group of crimes.

Comments on either of these options are requested.

1.4.2 Making of orders by the court

- Should s.93(1)(d) be remodelled to create a 'restricted involuntary treatment order', whereby a person becomes an involuntary patient whose treatment and care pursuant to the Mental Health Act would be subject to additional conditions aimed at effective treatment of their mental illness? Should there be a duration limit on such orders?
- Should courts be explicitly required to have regard to the person's current mental state, their medical, psychiatric and forensic history and social circumstances in considering whether to make an order requiring involuntary treatment?

1.4.3 RCTOs

Making RCTOs

- Should the Sentencing Act enable a person to receive community treatment immediately following the making of a restricted involuntary treatment order, where the legislative criteria for community treatment are satisfied and in circumstances where hospital admission is considered clinically unnecessary by the authorised psychiatrist? How should this occur?
- Should the authorised psychiatrist be permitted to make an RCTO (rather than the Chief Psychiatrist and board as is currently the case) where the legislative criteria for community treatment are satisfied?

Readmission/revocation

- Should the authorised psychiatrist be able to revoke an RCTO?
- Should the Mental Health Act prevent prolonged use of leave of absence provisions for people subject to restricted involuntary treatment orders?

Reporting and monitoring

- Should reports on the progress of all restricted involuntary patients be provided to the Chief Psychiatrist by the authorised psychiatrist?

Variation

- Should the authorised psychiatrist be permitted to vary an RCTO where necessary for the person's treatment and care?

Discharge

- Should the Act permit a person to be discharged from an RCTO to a CTO in circumstances where additional conditions are no longer required for effective involuntary treatment?
- Should the Mental Health Act explicitly require the Chief Psychiatrist or Board to have regard to the person's current mental state, their medical, psychiatric and forensic history and social circumstances in considering whether to discharge a person from a restricted involuntary treatment order?
- Should the Mental Health Act be amended to ensure broad consistency between RCTO and CTO provisions?
- Should the Mental Health Act be amended to clarify that a person's involuntary status does not automatically cease on expiry of an RCTO?

1.4.4 Other amendments

- Are any other amendments required to ensure effective operation of these provisions?

Chapter 2 Proposed amendments to s.93(1)(e)

2.1 Hospital security orders

Hospital security orders are created under section 93(1)(e) of the Sentencing Act and require that a person be admitted to and detained in an approved mental health service as a security patient. The order is made by way of sentence. A hospital security order cannot be made:

- unless, but for the mental illness, the court would have sentenced the person to a term of imprisonment (s.93(2))
- for a period longer than the period of imprisonment to which the person would have been sentenced had the order not been made (s.93(3)).

Although proof of a connection between the illness and the crime is not stated in the Act, it is assumed that such a connection is present before a s.93(1)(e) order is imposed.⁵³ A hospital security order may only be made following ‘a trial’, which means that it is only available in relation to persons found guilty of indictable offences in the Supreme or County Courts.⁵⁴ It is possible to make a hospital security order in respect of one offence and to pass a sentence of a different kind in respect of another at the same time, provided that it is possible for both sentences to be given effect in respect of the offender.⁵⁵ A hospital security order may be grafted onto an indefinite sentence under the Sentencing Act.⁵⁶

2.1.1 Background

The hospital security order was first introduced in the 1991 Sentencing Act. Although introduced with the amendments arising from the 1988 Victorian Sentencing Committee, the hospital security order was not recommended by the Committee. The second reading speech does not provide any policy justification for, or guidance concerning the interpretation of, the hospital security order. The legislative intent underlying the hospital security order must therefore be distilled from the provisions themselves.

The Act provides that if the person is discharged as a security patient, the order has effect as a sentence of imprisonment for the unexpired portion of the order.⁵⁷ The court is required to set a non-parole period,⁵⁸ which only comes into effect on discharge as a security patient.⁵⁹

⁵³ Fox and Freiberg, above, n10, p. 799.

⁵⁴ *Ibid*, p. 797.

⁵⁵ *R. v Jolly* [1994] 1 VR 446 at 450.

⁵⁶ Fox and Freiberg, above, n10, p. 803.

⁵⁷ Section 93(5) *Sentencing Act* 1991.

⁵⁸ Section 93(4) *Sentencing Act* 1991.

⁵⁹ Section 93(6) *Sentencing Act* 1991.

2.1.2 Case law

The hospital security order has not been discussed at any length in case law. In *R v Jolly* [1994] 1 VR 446, the Court of Appeal considered a hospital security order of 15 years, with a non-parole period of 10 years, following a plea of guilty to one charge of murder and one charge of intentionally causing serious injury. The offender had suffered from mental illness for many years and it was not contested that he was mentally ill at the time of the offences. In finding this order to be ‘manifestly inadequate’ and re-sentencing the offender to an order for the term of his natural life (with a non-parole period of 16 years), Brooking J (with whom Teague and Coldrey JJ agreed) commented that:

*The order made does not sufficiently reflect the crimes committed. The protection of the public outweighs in this case the other sentencing considerations.*⁶⁰

Jolly makes it clear that, as with the hospital order, therapeutic considerations are to be balanced against the other considerations in sentencing—including protection of the public—when making a hospital security order.

In *R v Bannon*,⁶¹ the defendant suffered from schizophrenia and shot and killed his mother while acutely psychotic. In making the order, Vincent J stated that:

The crime of murder is...for practical purposes, the most serious known to the law. Its significance arises from the fundamental importance that is attributed in our society to the life of each of those who dwell within it. Accordingly, the courts must endeavour through the sentences which they impose to deter those who may contemplate its commission and to effect just retribution upon perpetrators. They must also reflect in their response to the commission of this offence the seriousness which it is regarded by our society and the actual adherence by our community to its stated values. Nevertheless, each occasion and each offender must be viewed in the light cast by all the circumstances relevant to the individual offence and perpetrator. In [the defendant’s] case...[the] level of culpability must be regarded as much lower than that which is normally encountered in relation to the crime of murder.

*...The courts have many times expressed the view that in the cases of persons who suffer from such conditions, concepts of general and specific deterrence assume less significance as sentencing considerations than might otherwise be the case. A similar approach must be taken when levels of culpability and the degree of importance to be attached to the retributive function of the sentencing process are considered.*⁶²

The defendant was ordered to be admitted to and detained in an approved mental health service for a period of 11 years. A non-parole period of seven years was fixed under s.93(4) of the Act.

⁶⁰ At p.453.

⁶¹ [1999] VSC 186.

⁶² At p.189.

2.1.3 The Sentencing Review

The *Sentencing Review Discussion Paper* referred to the hospital security order in passing⁶³ in the context of a discussion of substituted sentences. The paper identified that:

- There are conceptual difficulties inherent in equating sentences that involve little or no incarceration for a sentence of imprisonment. The concept of substituted sentencing assumes that such sentences can be equated.
- One of the aims of substituted sentences is to divert offenders from imprisonment. The ICO (and other substituted sentence options) has not resulted in the diversion of significant numbers of offenders from prison.

The paper suggested that substituted sentences be abolished or reduced to a minimum in Victoria's sentencing hierarchy, and that a sentence should be presented in its own right with a clear set of prescriptions and punitive or therapeutic values which are self-referential and not linked—other than in the broadest fashion—with a sanction in a different form.

The *Pathways to Justice* report recommended that substituted sentences be reduced to a minimum in the Victorian sentencing hierarchy. The Government is considering this and other associated recommendations, with a view to ensuring sufficient flexibility is maintained to target individual offenders whose specific conditions need to be addressed via these forms of sentences.

2.2 Retaining s.93(1)(e)—clarification required

The hospital security order requires detention in an approved mental health service, which, insofar as it involves detention, has clear parallels with imprisonment. Any unexpired portion of the order must be served as a sentence following discharge from an approved mental health service. Hence, the requirement that the court would, but for the mental illness, have sentenced the offender to imprisonment is a rational requirement; that is, it is a true substituted sentence.

Furthermore, the hospital security order already has a clear set of therapeutic values that are self-referential. The punitive value of the order is less clear. To this extent, it meets the criteria proposed in the Sentencing Review for being an independent order. In its current form, however, it is unclear whether the hospital security order is intended to divert offenders from prison. The requirement that the unexpired portion of the order be served as a sentence suggests that this is not its primary purpose.

The department is of the view that s.93(1)(e) should be retained in the Sentencing Act. It serves an important and significantly different function from s.93(1)(d) and provides the courts with a mechanism to ensure treatment and care are provided to a person in a secure therapeutic environment. Some specific issues associated with its operation are considered below.

2.2.1 Forensic Health Legislation (Amendment) Act 2002

The Vincent review considered the criteria by which prisoners are transferred from correctional facilities to approved mental health services for treatment under s.16(3)(b) of the Sentencing Act. In considering the issue, the panel stated that:

the criteria that determine when a patient should be returned to prison should be defined more closely. The statutory criteria give both the Board and the Chief Psychiatrist a wide discretion when deciding when security patients should be returned to prison. The beds at Forensicare are a limited resource that should be used wisely to treat the most seriously ill patients. In this context, prevention of relapse is an important goal. The focus of treatment for security patients at Forensicare must be the acute phase of illness, after which treatment may be able to proceed within the prison system. Furthermore, the period that security patients spend outside the prison system should be as short as possible. From both correctional and mental health perspectives, it is important that security patients should return to prison unless continued treatment at Forensicare is necessary and can be justified.

The panel believes that the Chief Psychiatrist should formulate criteria for deciding when a patient should be returned to prison based on these principles to be used by Forensicare, the Chief Psychiatrist and the Mental Health Review Board. The Minister for Health should give consideration to amending the Mental Health Act 1986 to reflect these criteria.

The panel went on to recommend:

that the process by which prisoners are transferred to Forensicare and returned to prison remain unaltered but that the Chief Psychiatrist work with the Mental Health Review Board and the Correctional Services Commissioner to formulate criteria for deciding when a patient should be returned to prison based on these principles to be used by Forensicare, the Chief Psychiatrist and the Mental Health Review Board. That the Minister for Health give consideration to amending the Mental Health Act 1986 to reflect these criteria.

The *Forensic Health Legislation (Amendment) Act 2002* amended the Mental Health Act to implement the Vincent review recommendations concerning admission of prisoners to approved mental health services and their discharge back to prison. As a consequence, the requirement in s.16(2)(a)(i) of the Act that:

the person appears to be mentally ill and to require treatment for that illness

in order to be transferred to or discharged from a mental health service became that:

*the person appears to be mentally ill and to require **immediate** treatment for that illness.*

Because s.93(1)(e) patients are security patients for the purposes of the Act, the consequence of this amendment is that the criteria for their admission in s.93(1)(b)(i) of the Sentencing Act remain unchanged (and do not require that the need for treatment be immediate), but the criteria for their discharge in the Mental Health Act are in accordance with the above amendment.

This inconsistency raises the issue concerning the nature of s.93(1)(e) orders: are they intended to be for short term treatment and prompt discharge back to prison, or are they intended to have a stronger rehabilitative focus? The limited case law would suggest that orders under s.93(1)(e) are qualitatively different from short term s.16(3)(b) transfers from prison. Forensic clinicians support this view. They have indicated that in their experience, when courts are considering making such orders, it is not their intention that the focus be simply on acute stabilisation with a view to return to prison. Rather, it appears that sentencing judges endeavour to ensure that vulnerable individuals with severe mental illness are placed in a secure hospital environment where they can receive appropriate stabilisation of illness **and** ongoing rehabilitation with a view to a smooth transition to community-based care at the expiry of their sentence.

The department considers that the legislation should provide a mechanism for ongoing care, treatment and rehabilitation at an approved mental health service as opposed to short term treatment. It is considered that amending s.93(1)(b)(i) to insert a notion of 'immediacy' would limit the discretion of the court to make such orders where the acute phase of the person's illness had passed by the time of sentencing, and would also mean that patients subject to hospital security orders could only be treated in an approved mental health service during an acute phase of an illness. For the reasons set out by Vincent J in *Bannon*, it is considered that such an outcome would be highly undesirable.

It is argued that the criteria for admission and discharge of s.93(1)(e) patients should be consistent, thereby requiring amendments to the current provisions in s.44 of the Mental Health Act to separate discharge of s.16(3)(b) security patients from those detained pursuant to s.93(1)(e) orders.

2.2.2 Effect of discharge to prison on s.93(1)(e) order

Confusion also arises concerning the status of a s.93(1)(e) order when a person is discharged to prison, subsequently become unwell and then requires transfer back to an approved mental health service. It is not clear whether the s.93(1)(e) order comes to an end on the person's initial return to prison – thereby requiring them to be transferred back to the mental health service under s.16(3)(b) of the Mental Health Act – or whether the s.93(1)(e) order is reinstated and forms the legal basis on which they return to the mental health service.

The department considers it desirable for the reasons set out above that persons subject to a s.93(1)(e) order by a court should be able to return to the mental health service under the original order and not pursuant to the short term transfer provisions in s.16(3)(b).

2.2.3 Parole

The court is required to set a non-parole period when making a hospital security order (s.93(4)), but parole may only be considered if the person subject to the order has been discharged as a security patient and returned to prison.⁶⁴

As a consequence of this, the Adult Parole Board cannot consider the granting of parole to a s.93(1)(e) patient while they continue to be detained in an approved mental health service. It is considered that the Parole Board should be able to consider parole for patients sentenced under s.93(1)(e) while they are still detained in an approved mental health service. The extension of a parole entitlement to people subject to s.93(1)(e) would allow reintegration with the community directly from the Thomas Embling Hospital rather than requiring discharge to prison. Allowing the Parole Board to make orders in these cases would enable greater continuity of treatment and stronger referral linkages with community forensic mental health services.

The proposal would also enable better integration into the community of patients whose sentences end while at Thomas Embling (and who therefore must be discharged) and who do not meet the criteria for detention under s.12 of the Mental Health Act. Any such extension of the jurisdiction of the Parole Board would be dependent on the service agreeing to the discharge of the patient into the community prior to the expiry of their sentence.

2.3 Summary of issues for consideration

2.3.1 General

- Should s.93(1)(e) be retained as a sentence substituted for a term of imprisonment?
- Should the admission criteria in s.93(1)(b)(i) be amended to be consistent with the criteria in the Mental Health Act for transfer of mentally ill prisoners, or should they permit longer term rehabilitation?

2.3.2 Parole issues

- Are there any foreseeable problems in extending the jurisdiction of the Parole Board to include patients subject to s.93(1)(e) who are detained in an approved mental health service?

2.3.3 Effect of discharge to prison on operation of s.93(1)(e) order

- What effect should discharge to prison and subsequent readmission to a mental health service have on operation of a s.93(1)(e) order?

