SUPREME COURT OF QUEENSLAND

CITATION:	*Attorney-General for the State of Queensland v McCann* [2018] QSC 115
PARTIES:	**ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (applicant) **v** **ELIJAH JAMES McCANN** (respondent)
FILE NO/S:	BS No 6666 of 2011
DIVISION:	Trial Division
PROCEEDING:	Review of continuing detention order
ORIGINATING COURT:	Supreme Court at Brisbane
DELIVERED ON:	24 May 2018
DELIVERED AT:	Brisbane
HEARING DATE:	21 May 2018
JUDGE:	Applegarth J
ORDER:	**Application adjourned for review on 25 May 2018**
CATCHWORDS:	CRIMINAL LAW – SENTENCE – SENTENCING ORDERS – ORDERS AND DECLARATIONS RELATING TO SERIOUS OR VIOLENT SEXUAL OFFENDERS OR DANGEROUS SEXUAL OFFENDERS – DANGEROUS SEXUAL OFFENDER – GENERALLY – where the applicant seeks a review of a continuing detention order made on 6 October 2016 – where the order was made because the respondent required medium to long-term psychiatric treatment for his severe mental illness and that, until this occurred and his substance abuse issues were better addressed, he was not a good candidate for release on supervision – where the order was made on the basis of expert evidence that the respondent required a prolonged admission to a medium secure psychiatric service where efforts could be made to stabilise his mental illness – where during the 20 months the order has operated the respondent has not been treated in a medium secure mental health facility, and has spent most of his time in prison, often in his cell for up to 20 hours a day – whether the respondent should continue to be subject to a continuing detention order or be released subject to a supervision order which includes a requirement that he reside at a secure mental

health facility

COUNSEL: B H P Mumford for the applicant
T A Ryan for the respondent

SOLICITORS: Crown Solicitor for the applicant
Cridland Hua for the respondent

[1] The respondent, a 31 year old indigenous man, suffers a severe mental illness. He should have a bed, care and treatment in a secure mental health facility. Instead, he spends up to 22 hours a day in a prison cell. Is this to be his fate for the indefinite future?

[2] This question arises more than six years after the respondent's sentence was fully served.

[3] The expert medical advice to the Court in recent years was that the respondent required a long period in a secure mental health facility. The Court expected this to occur when, on 6 October 2016, Burns J made a continuing detention order. As is apparent from the reasons of Burns J, that order was made because the respondent "required medium to long-term psychiatric treatment and that, until this occurred and his substance abuse issues were better addressed, he was not a good candidate for release on supervision".[1]

[4] Instead of commencing a lengthy period of treatment in a secure mental health facility which addressed the respondent's complex mental health needs, he was returned to prison. Eventually, he spent only about four months in a secure mental health facility before being abruptly returned to prison. To cope with his mental illness, he confines himself to his cell for most of the day. For all intents and purposes, he is in a form of solitary confinement.

[5] Any transition into the general prison population is likely to end badly. The respondent's fragile mental health will not cope with the noise, the crowding and the stresses of the hostile environment he would face.

[6] Rather than receive the intensive treatment and counselling he needs, the respondent sees a prison psychiatrist every four weeks or so. This situation, if it continues, holds little hope for an improvement in the respondent's mental health, and, with it, a reduction in the risk that he will reoffend. The expert advice is that the respondent is in need of "very active psychiatric treatment" and that the period of four months in a secure mental health facility was not long enough to treat his needs.[2] He needs "close oversight of his compliance with medications, establishment in secure, safe accommodation, ongoing case management and support to assist him to remain abstinent from destabilising substances."[3]

[7] How has the system failed to provide the treatment and accommodation that is essential to reducing the respondent's risk of reoffending, and thereby to promote protection of the

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1 Reasons of Burns J, 6 October 2016 at p 4, ll 43-45.

2 Report of Dr Sundin dated 26 March 2018 at ll 295-296.

3 Ibid at 306-308.

community? The short answer is that the system finds it easier to find a bed for the respondent in a prison than the bed he needs in a mental health facility.

Background

[8] The respondent:

(a) had a severely disadvantaged childhood, displayed behavioural problems and did not respond to treatment for diagnosed ADHD;

(b) engaged in inappropriate sexual activities before he was a teenager and may have been sexually abused as a youth;

(c) has a long history of severe alcohol and substance abuse, as well as inhalant abuse from sniffing paint and petrol;

(d) demonstrated a significant anti-social personality disorder; and

(e) suffers from schizophrenia, the symptoms of which first manifested themselves in 2013 and require anti-psychotic medication.

[9] The respondent's parents separated when he was six months old, and his mother re-partnered on numerous occasions. As a child, he apparently witnessed severe domestic violence. He displayed poor concentration, distractibility and rebelliousness, with multiple school suspensions and expulsions. His behaviour deteriorated further as an adolescent and he was aggressive towards his mother. She could not handle him so he went to live with his father in Brisbane. However, this was unsuccessful, and the respondent started living on the streets at the age of 12.

[10] The respondent's encounters with the criminal justice system began as a teenager, and included youth detention. His criminal history includes numerous property offences and street offences. Prior to 28 November 2005, his only sexual offence was a minor one for indecent exposure of his genitals to passing vehicles. This occurred when he was intoxicated by alcohol and inhalants.

[11] By November 2005 he was living an unstable, homeless existence and surviving by stealing and other acts of dishonesty. On 28 November 2005 he had been sniffing paint. He encountered a woman, who was walking her dog along a suburban, bushland track. She was aged in her early 50s. He followed her, probably intending to rob her phone, and grabbed her from behind. She fell heavily to the ground and sustained severe injuries to her knee. The respondent showed her no sympathy and climbed on top of her. He reached inside her underwear and used his fingers to penetrate her vagina. A nearby resident heard the victim and approached the scene. The respondent backed away, but then tried to put his arm around his victim and kiss her. He was apprehended by police not long afterwards. His victim required knee reconstruction surgery.

[12] On 9 March 2007, the respondent appeared in the District Court of Brisbane and pleaded guilty to one count of grievous bodily harm, one count of rape, one count of common assault and one count of receiving stolen property. He received a head sentence of six years' imprisonment.

[13] Close to the end of his sentence, the Attorney-General applied for an order under the *Dangerous Prisoners (Sexual Offenders) Act* 2003. On 15 December 2011, Byrne SJA made an order under Division 3 of the Act that the respondent be released from custody on 23 December 2011, subject to the requirements of a supervision order, until 24 December 2016.

[14] In 2013, contravention proceedings were brought against the respondent over an act of wilful damage to an electronic monitoring device. On 26 August 2015, he was released on an amended supervision order which included numerous additional requirements. He was required to comply with any order made under the *Mental Health Act*, attend appointments with community mental health services and participate in other forms of treatment. Unfortunately, the respondent's severe problem with inhalant abuse meant that it was not long before he inhaled petrol. On 8 September 2015, QCS officers detected that he had inhaled petrol. The respondent freely admitted this, and he was detained in custody. The contravention proceeding was heard by Burns J on 15 August 2016. Justice Burns had the advantage of reports from Dr Grant and Dr Sundin and heard witnesses.

[15] On 6 October 2016, Burns J gave his reasons for ordering the supervision order made on 15 December 2011, as amended, be rescinded and that the respondent be detained in custody for care, control or treatment.

[16] Dr Grant and Dr Sundin have had extensive experience in assessing the respondent. Justice Burns made particular reference to the concerns expressed by Dr Grant and Dr Sundin about whether the respondent was capable of being managed in the community. It is appropriate to quote two paragraphs of Dr Grant's report dated 11 July 2016:

> "If Mr McCann is considered sufficiently unstable to be managed in the community at this stage he could be subject to a continuing Detention Order and continue to receive treatment in custody from the Prison Mental Health Service. In effect he would be being detained in custody for treatment of a mental illness and in my opinion that is not the most appropriate way of managing a mental illness. Prison is containment but nevertheless can be a stressful environment and it appears that Mr McCann, from his account, is having ready access to illicit drugs.
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> An alternative process would be for Mr McCann's mental illness to take priority at this stage, which in my opinion is necessary. **I believe he would benefit from a prolonged admission to a medium secure psychiatric service where efforts could be made to stabilize his mental illness.** Once he is stabilized, his illness is better controlled, and a future treatment plan is in place, he could return to the community at that stage on a continuing Involuntary Treatment Order but possibly also under the auspices of the DPSOA Supervision Order which would need to be extended." (emphasis added)

[17] Dr Sundin supported Dr Grant's suggestion about a long stay in a medium secure psychiatric facility. As she observed in her addendum report dated 8 August 2016, admission to a psychiatric facility would seek to attain better control of the respondent's psychiatric condition. The respondent had been "able to fly under the radar in prison with regards to the extent of his psychotic illness. Dr Grant and I have now both had experiences with this man initially presenting partially intact but then decompensating over a prolonged interview and

displaying florid psychotic symptoms. While prison mental health does its best, they are not a substitute for a psychiatric treatment centre."

[18] It was these important expert opinions which Burns J relied upon in making the orders which he did on 6 October 2016. He directed that copies of the reports of Dr Sundin and Dr Grant, together with the transcript and his reasons for judgment, be supplied to the Prison Mental Health Service to assist in the assessment of the respondent's future treatment needs.

[19] Justice Burns found it unnecessary to make any formal recommendations about the respondent's treatment or that Corrective Services consider providing regular psychological treatment to the respondent whilst he was in custody. Justice Burns did not think it appropriate to make that recommendation because he assumed that persons detained under the Act would receive "appropriate psychiatric and psychological treatment".

[20] One might have expected, given the considered views of Drs Grant and Sundin and the judgment of the Court that acted upon them, that shortly after 6 October 2016 the respondent would begin to receive psychiatric treatment in a secure mental health facility, rather than in a prison. This was not to be, despite a diagnosis of schizophrenia and well-documented psychotic behaviour whilst in custody. Instead, the respondent had to wait in prison for several months until a bed became available at the High Secure Inpatient Service, which is also known as "The Park".

[21] The respondent was transferred from the Townsville Correctional Centre to the Brisbane Correctional Centre in January 2017, and came under the care of Dr Schramm, a psychiatrist with the Prison Mental Health Service. I have had regard to the respondent's medical record from the Prison Mental Health Service, which runs to several hundred pages.

[22] As early as November 2016, the respondent had expressed his ongoing frustration about the lack of progress in relation to the court decision, since he expected to be transferred to a secure unit for treatment. The respondent was deemed unsuitable for engagement in therapy with psychology staff due to alleged inappropriate thoughts and comments involving female psychology officers. Notes of interviews with the respondent showed that he had a good insight into his own needs. He understood that he needed treatment and that he would not be released on a supervision order until he had received the right treatment. He apprehended that he had a year to do this, and this required treatment and counselling for alleged abuse in his past. Documents recording the respondent's thoughts also note how being in the general prison population made him mentally unwell and prompted flashbacks about certain violent incidents.

[23] By April 2017, the respondent's frustration had grown, with the realisation that if he did not receive treatment and "get cleared by Mental Health I'll have to wait another year …" Eventually on 22 May 2017, the respondent was admitted to The Park. Unsurprisingly, he preferred its environment to that of the prison. The respondent's complex pathology and possible cognitive impairment presented what Dr Schramm described as a "diagnostic dilemma". In any event, he began to receive treatment in a mental health facility in May 2017.

However, he was returned to prison in October 2017. This was unplanned and seems to have happened "out of need to create a bed".[4]

[24] Even when the respondent was in The Park high secure unit, he suffered an acute decompensation that resulted in his being placed in seclusion on 30 August 2017. This deterioration appears to have coincided with changes in his medication.

[25] On 4 December 2017, the Attorney-General applied, pursuant to s 27(2) of the Act, to review the continuing detention order made on 6 October 2016. Orders were made for Drs Grant and Sundin to review the case and to interview the respondent. These interviews occurred in February 2018.

[26] By January 2018, the respondent was experiencing elevated levels of anxiety, having witnessed a number of fights. He reported hearing "voices" and was struggling to maintain his mental health. He may have informed medical staff that he was having thoughts of self-harm, when he did not intend to self-ham. At one stage he explained "I just wanted to get help".

[27] The respondent explained to Dr Grant in February 2018 how he had been transferred within the prison from different units. His psychiatric condition did not allow him to cope with the very noisy situation in which he had been accommodated in a 70-man unit. His mental health plan required him to be in a quieter environment and he had been transferred to a 25-inmate unit, in which he had his own room. He said that he spent 22 hours a day in his room, being released for two hours each day to share a yard with five other inmates. He preferred to be left alone in his own room, since being around people was difficult. Being around a lot of people was said to trigger his schizophrenia.

[28] The respondent told Dr Grant on 22 February 2018 that he was no longer hearing any voices and was not preoccupied with previous delusional ideas or thoughts about being a ninja. He remained concerned about people referring to him as a sex offender. He frankly admitted to Dr Grant that he had been breached since returning from The Park. This included use of buprenorphine. He also was breached for inhaling some paint which he and other inmates took from a cupboard on 30 December 2017. The respondent explained that drug use was part of the culture in prison. He recognised that illicit drug use or inhalants would be the biggest risk if he left custody on a supervision order. He anticipated that he would be tested three times a week under a supervision order, would have to remain "clean" and maintain a positive life style.

[29] The respondent expressed concerns to Dr Grant about how he would cope in the future and access appropriate help. He wondered how he would be able to access a medium secure unit, assuming that he would not be able to go back to the high secure unit. He understood that he might not be offered a hospital admission and that he would need to be able to cope at "the precinct" if he was released on a supervision order. He had some doubts about how that would work out for him and whether he would get the appropriate level of support.

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[4] Dr Schramm, 20 March 2018 at p 2.

[30] The respondent had found the structure, activities and therapy that were offered to him at The Park very helpful.

Dr Grant's report dated 2 March 2018

[31] Dr Grant noted the respondent's ADHD symptoms as a child and that he might have some residual symptoms affecting his behaviour in adult life. The respondent was diagnosed by Dr Grant as having a significant Antisocial Personality Disorder. According to Dr Grant, the respondent suffers quite severe chronic schizophrenia which first became evident in 2013.

[32] Dr Grant concluded there was no definite evidence of a sexual paraphilia. During his stay in custody and in hospital the respondent had displayed quite significant sexual preoccupations and made inappropriate sexual comments towards females. These tended to be more severe when he was unwell. However, the respondent's sexual offending "did not have any strong connection to his schizophrenia but the recent report suggested that when unwell he may have significant increases in sexual preoccupation and a tendency towards inappropriate sexual behaviour".

[33] In terms of risk assessment, Dr Grant gave the following opinion:

> "Mr McCann has a combination of very significant factors that together contribute to risk for sexual re-offending and general re-offending. Those factors include past history of ADHD with possible residual symptoms, a very significant Antisocial Personality Disorder, a history of chronic substance and inhalant abuse which is an ongoing issue, previous social instability and lack of social structure and support, and in recent times a very significant factor involving his severe Schizophrenia which has not completely resolved on treatment. In my opinion, it is now evident that when unwell he is more likely to be sexually inappropriate and disinhibited and the Schizophrenia is therefore a significant factor in potential for future sexual re-offending.
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> Whilst Mr McCann's Schizophrenia now seems under better control on his current medication regime, the fragility of his state of mind and ability to control his behaviour is indicated by the fact that he is currently being cared for in a prison unit where he is alone in his cell for 22 hours of the day. He finds that situation more comfortable than being around a noisy environment. Since his return from High Secure he has had at least one formal breach for the use of Buprenorphine and he reports in fact more than one use of Buprenorphine and another use of inhalants in the company of other prisoners. His inability to control substance abuse was apparently one of the reasons why he was transferred to the current prison environment where he is away from temptations.
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> My assessment is that Mr McCann presents a moderate-to-high risk for future sexual re-offending and a similar risk for general offending if released into the community. I am concerned about the fragility of his mental state, how easily he can be destabilized by a stressful environment, and how readily he can be persuaded to return to illicit drug use or inhalant abuse. Since the last review Mr McCann's mental illness was sufficiently severe to warrant a prolonged

> admission to High Secure and during that admission he required a period in seclusion because of the severity of his symptoms and the perceived threat to those around him. Whilst his mental status is now more stable, he appears at risk of undergoing decompensation with fairly minimal stress in his life. Recent incidents of substance abuse in custody only accentuate the possibility of further use of substances, particularly if he is feeling stressed or anxious.
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> Under these circumstances, I seriously doubt that Mr McCann could be safely managed in the community on a Supervision Order designed to reduce his risk. I believe that even with close supervision it would be very likely that Mr McCann would develop more severe symptoms of Schizophrenia and probably relapse into substance abuse.
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> If Mr McCann were released into the community he would need very close intensive treatment and supervision through a combination of the DPSOA requirements and monitoring, along with close mental health service follow-up and treatment.
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> If Mr McCann was able to maintain a period of wellness and abstinence from the use of any illicit substances whilst in custody over a period of at least six to 12 months I would be more confident that he might be ready to cope with the stresses of life living outside of prison in the precinct with appropriate treatment and support. He needs to develop a greater degree of resilience and determination to remain substance free if he is going to be able to succeed in the community, even with the full benefit of a Supervision Order and psychiatric treatment."

Dr Sundin's report dated 26 March 2018

[34] Dr Sundin interviewed the respondent on 16 February 2018 and, it seems, the respondent's symptoms were worse than when he saw Dr Grant six days later. The respondent told Dr Sundin that his auditory hallucinations continued and that he also heard voices. He expressed concern about the risk of being harmed by prisoners.

[35] From Dr Sundin's review of all of the material with which she was briefed, she concluded that the respondent suffers from a primary serious mental health disorder in the form of schizophrenia, paranoid type, chronic, treatment recalcitrant. That psychiatric condition occurred in the setting of a man with a lengthy history of substance use disorder, and a past history of antisocial personality disorder. At the time of her interview with the respondent, he was seeing Dr Schramm every three or four weeks but was not seeing a psychologist for counselling.

[36] Dr Sundin gave the following assessment:

> "Mr McCann's risk for sexual reoffending has been assessed in the moderate to high range with the risk of offending exacerbated by any acute exacerbation of his chronic psychotic illness, abuse of disinhibiting substances including opioids or inhalants and by any emotional collapse or social disintegration. The material supplied from both Prison Mental Health Services and The Park secure mental health facility suggests that Mr McCann's schizophrenia remains somewhat

treatment recalcitrant. He continues to be plagued by paranoid delusional ideas, ideas of reference and auditory hallucinations. He has continued to demonstrate fluctuant levels of behaviour with untriggered irritability and aggressiveness at times and continuing inappropriate approaches and conversations with female staff. He has gained some insight into some of his more grandiose delusional ideas and accepts that he does suffer from schizophrenia but the extent of his insight at this stage remains reduced.

My concern with Mr McCann is that his primary risk for recidivism appears to revolve around his mental health and associated substance use difficulties. Despite being on high doses of antipsychotic medication, he continues to experience psychotic symptoms. He has continued to seek inappropriate solutions to his ongoing psychotic symptoms as exemplified by his repeated requests for Subutex in 2017. The material provided does not explain the reason why Mr McCann was returned to prison after four months at The Park mental health facility. It may have been that bed pressure caused staff to prioritise his needs as lower than other patients. Unfortunately, however, this does not assist Mr McCann, who appears to have still been suffering psychotic symptoms at the time of discharge and certainly was continuing to have psychotic symptoms at the time of my review of him. Dr Grant and I have both previously recommended a long term psychiatric admission to a medium secure facility. In my opinion, four to five months has not been sufficient. Mr McCann is in my opinion in need of very active psychiatric treatment. I would hope that a trial of clozapine would be given consideration, given that mainstream antipsychotic medications thus far have proven to have only limited efficacy.

At the moment Mr McCann is being detained primarily for the safety of others and is receiving only limited psychiatric treatment in the form of antipsychotic medications. The reality of the institutional setting is such that there is little else that Prison Mental Health Services can offer to an individual such as Mr McCann.

The risk that Mr McCann poses to the community could be reduced by measures such as close oversight of his compliance with medications, establishment in secure safe accommodation, ongoing case management and support to assist him to remain abstinent from destabilising substances. Close liaison with community correctional services and community mental health services would be essential if Mr McCann were to be returned to the community. If he remained complaint with treatment and remained abstinent from disinhibiting substances, both licit and illicit, the risk of sexual offending would be moderated to low. The presence of his current involuntary treatment order will help facilitate compliance with treatment and oversight of community treatment by community mental health services.

In my opinion, the primary focus of management to reduce Mr McCann's risk to the community continues to be focused on treatment of his primary psychotic disorder and strategies to try and ensure his abstinence from illicit substances.

…

> Unfortunately, taking all of these factors globally, I have serious doubts that Mr McCann can be adequately supervised under the auspices of a DPSOA supervision order at this time, given that his psychotic illness remains active and he remains vulnerable to impulsive acts."

[37] Dr Sundin provided an addendum report dated 26 April 2018 after she was provided with additional requested material; and confirmed her earlier advice.

Dr Schramm's report dated 20 March 2018

[38] Dr Schramm, a consultant psychiatrist with the Prison Mental Health Service, began to treat the respondent in January 2017 and saw him over several months in custody until a bed became available in the High Secure Inpatient Service. Dr Schramm's report dated 20 March 2018 recounts unusual aspects of the respondent's presentation which might have been explained by "fantasy or primitive thinking rather than definitive psychosis". However, Dr Schramm's assessment was that:

> "… in addition to a primitive and damaged personality and possibly some mild cognitive impairment, there has been a long history of convincing enough psychotic symptoms such that schizophrenia is an apt diagnosis. He does not appear to be actively psychotic currently. Despite his compliance, I doubt that this is driven by insight but by a wish to be perceived as cooperative in order to appease those that hold his fate in regards his DPSOA and release from custody in their hands. I'd be advocating a continuation of his Treatment Authority long term. He should remain on depot antipsychotic medication long term. If released he would be referred to a community mental health service for case management follow-up (he does not require hospitalisation currently)."

Dr Wagner's neuropsychology report dated 21 March 2018

[39] Any future treatment of the respondent would be well-informed by Dr Wagner neuropsychology report dated 21 March 2018. It contains a comprehensive account of the respondent's background, as well as the results of various tests administered to assess the respondent's cognitive status. The tests were undertaken in August 2017 when the respondent was a resident at The Park. Dr Wagner recommends that any treating team should be aware of the respondent's cognitive strengths and weaknesses. Whilst the report identifies a number of areas of significant cognitive difficulty, there are several areas of intact functioning in his cognitive profile.

Overview of the respondent's presentation to treating psychiatrists during his period under the Continuing Detention Order

[40] Dr Schramm has remarked upon the "diagnostic dilemma" presented by the respondent who during his period in custody under the Continuing Detention Order reported various psychotic-like symptoms. The diagnoses of Dr Grant and Dr Sundin confirm that the respondent has chronic schizophrenia, which first became evident in 2013, and which has been treated in the past at a suboptimal level. However, he appears to have improved significantly on his current medication regime, with the reduction or resolution of auditory hallucinations and some of the more severe features of his condition. The respondent's treatment is complicated by the fact

that he does not simply suffer from schizophrenia which is somewhat resistant to treatment. He has been diagnosed with antisocial personality disorder and polysubstance abuse. Even assuming his schizophrenia can be treated with appropriate medication in an environment in which his symptoms will not flare, his problems with substance abuse will remain. Some of his neurological deficits and cognitive impairments may be the result of chronic long-term use of inhalants. However, he has sufficient cognitive ability to engage with treatment and rehabilitation strategies.

[41] The Integrated Offender Management System ("IOMS") records seem to indicate that during his time at the Brisbane Correctional Centre he was residing in a secure unit, either on a safety order or as a sensible administrative arrangement to accommodate him in an environment which presented less risk of exacerbating his mental illness than accommodation in a large, general section.

[42] The respondent returned a positive test on 27 November 2017 for buprenorphine and this test was confirmed on 8 December 2017. He was breached for wilfully consuming or inhaling something to induce an intoxicated state on 30 December 2017 when he and another inmate were found to have obtained a tin of paint without authorisation and to have inhaled it for the purpose of inducing intoxication.

[43] Dr Schramm noticed some improvement of the respondent's mental state after his period in The Park. Some persecutory ideas had abated and the respondent did not appear to be as fearful or hallucinated. When Dr Schramm saw the respondent after his return to prison from The Park, he did not appear to be as distressed, fearful or hallucinated as in the past. He still, however, held certain old delusional ideas.

[44] In Dr Schramm's view, assessment of the respondent was clouded by his clearly having "an agenda of saying what he thinks he should (to expedite his release from custody) almost whenever we meet and/or turning discussions to complaints that he should be given the treatment he needs so he can get out of prison". There was some evidence of inconsistent answers about past psychotic concerns. The respondent forcefully reiterated to Dr Schramm his need for "counselling" for his sexual offending and for having been sexually abused.

The respondent's transfer to Woodfood Correctional Centre

[45] The decision was made on 2 January 2018 that the respondent be transferred to the Woodford Correctional Centre. The transfer was to occur after his appointment with Dr Grant on 22 February 2018. The decision to transfer him was because the Brisbane Correctional Centre is a reception centre. The respondent retains a high security classification.

[46] I have read the IMOS for the period after he transferred to Woodford on 26 February 2018. However, the copies on the Court file cease on 29 March 2018. They record the respondent wanting to be waitlisted for an available course that would assist him with his recent illicit substance use whilst at the Brisbane Correctional Centre.

[47] The respondent appeared by video-link from the Woodford Correctional Centre at the hearing before me on 21 May 2018. Because not much was known about his circumstances there, with the consent of Counsel I asked the respondent about his circumstances and have had regard to this unsworn evidence.

[48] The respondent was supported during his appearance by Mr Andrew Cummins, who is with the Indigenous Mental Health Intervention Project. This initiative seeks to link individuals into rehabilitation programs before they are released. Mr Cummins also deals with the Prison Mental Health Service in case managing indigenous inmates.

[49] The respondent explained that whilst the unit he is in at Woodford is a larger unit than the unit he was in in Brisbane, it was quieter. He said that he could not do courses because he is a "red tag". He sees a psychiatrist from the Prison Mental Health Service about once a month. The prison has psychologists who assist inmates to cope with anxiety, and the respondent needs to see such a psychologist about once a week. However, the prison psychologists do not provide counselling for sexual offending or childhood trauma. The respondent thought there had been some changes in his medication for schizophrenia since he had been transferred to Woodford.

Dr Grant's oral evidence

The respondent's schizophrenia

[50] Dr Grant gave evidence that the respondent continues to have "some low grade symptoms of his schizophrenia despite the treatment that he is on".[5] Active symptoms of schizophrenia were still present. The respondent's inappropriate sexual comments to female staff in prison were more evident when he was very unwell. Dr Grant explained that the respondent's schizophrenia was a factor, but not in a direct way, to his risk for sexual reoffending. He explained:

> "It's a factor in a non-specific way in that his schizophrenia doesn't result in delusions or hallucinations that are relevant to sexual offending or pushing him towards sexual offending, but in his disorganised and thought disordered behaviour when he is unwell, he seems to be more sexually disinhibited. Schizophrenia may be affecting his sexual drive as well. So it's certainly a connection, but I'm not saying it's a kind of – a delusional drive towards sexual offending. It's more to do with the general kind of influence of him being unwell."[6]

[51] Dr Grant observed that people with schizophrenia find it difficult being in a noisy, stressful environment. It was an indication of the severity of the respondent's schizophrenia that, even during his time at The Park, he required a time in seclusion. The respondent's schizophrenia had not responded well to treatment, and this raised the question of other forms of treatment. Dr Grant agreed with Dr Sundin that the respondent should be trialled on clozapine, which is a drug used for treatment-resistant schizophrenia. Such a trial would need to be undertaken as an inpatient.

Risk Assessment

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[5] Transcript 21 May 2018, T1-16, l 19.

[6] T 1-16 ll 47 - T 1-17 ll 6.

[52] Under cross-examination, Dr Grant agreed that if the requirements of the supervision order were complied with, so that the respondent did not use any illicit substances, continued his treatment with anti-psychotics and attended treatment, as required, then this would have a significant effect on reducing the risk of committing a sexual offence involving violence. However, the problem identified by Dr Grant in both his reports and his oral evidence relates to the prospects of the respondent complying with the requirements of a supervision order if he was allowed to live in the general community, without close supervision. The problem with compliance is highlighted by the fact that the respondent was not able to abstain from using inhalants for very long the last time he was released on a supervision order, and also by the fact that he inhaled paint in the controlled environment of a prison on 30 December 2017.

[53] Dr Grant thought that it would be a challenge for him to remain substance-free, and although the respondent had some insight into his illness, he is not fully insightful. He recognised that substance abuse was a major risk for him, but the respondent did not inspire much confidence that he had strategies or an ability to avoid that risk.[7]

Systematic issues

[54] Because of the respondent's suboptimal treatment for schizophrenia and his substance abuse problem, Dr Grant and Dr Sundin both had recommended in 2016 that the respondent receive treatment in a medium secure mental health facility. However, there are systemic problems with his getting that kind of long-term treatment because of the way in which health services are organised and the availability of beds. Because of the respondent's security classification, he eventually went to a high security facility and there was no clear pathway from the high secure facility to a medium security facility because they are run by "different parts of the system".[8] There was no pathway into the general mental health system.

[55] According to Dr Grant, if the respondent was in the general community and "unwell enough to be in hospital", he might be admitted to an acute unit or a medium secure unit. However, as Dr Grant says, they are notoriously difficult to get into, because they are always a shortage of beds. There are a number of medium secure units in the metropolitan area and there is also one at The Park which is related to the forensic service. Beds in these units rarely become available. This appears to be a resourcing problem with individuals with severe mental illnesses, possibly more serious than the respondent's mental illness presently is, occupying available beds in medium secure units. A person who is managing a mental illness in a community setting, with supported accommodation, is unlikely to be admitted to a medium secure unit.

[56] The problem which the respondent presents is that whilst it is possible to imagine his schizophrenia being managed in a supportive situation in the community, his situation is complicated by his substance abuse, the fact that he is subject to the Act, and his anti-social personality disorder.[9]

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[7] T1-22, l 47.

[8] T1-23, l 44.

[9] T1-25, l 20.

[57] The end result is that the system has failed the respondent and the community because the respondent cannot get or keep a bed in a secure unit. To the extent his condition improved whilst in the high secure unit at The Park he was seen to be less needy than someone else who needed a bed there.

[58] According to Dr Grant, there is little else that the Prison Mental Health Service can offer the respondent as far as any treatment is concerned to improve his condition, other than being trialled on clozapine.

[59] Unless the respondent's condition deteriorates, it is unlikely that the Prison Mental Health Service will be persuaded to return him to the high security unit, assuming a bed becomes available.

[60] After Dr Grant gave his oral evidence, Dr Sundin was not required for cross-examination.

What is to be done?

[61] The system over the period of about one year and eight months since the Continuing Detention Order was made has not provided a pathway for the respondent to enter a medium security mental health facility, as Dr Grant and Dr Sundin recommended in mid-2016.

[62] At a review hearing under s 30 of the Act, the Court may affirm a decision that the respondent is a serious danger to the community in the absence of a Division 3 order. If the Court affirms the decision it may order, under s 30(3), that he:

(a) continue to be subject to the continuing detention order; or

(b) be released from custody subject to a supervision order.

[63] In deciding whether to make an order under subsection 30(3)(a) or (b), the paramount consideration is the need to ensure adequate protection of the community, and the court must consider whether adequate protection of the community can be reasonably and practicably managed by a supervision order.

[64] It is unnecessary to address in detail each of the matters listed in s 13(4) of the Act in assessing whether the respondent is a serious danger in the absence of a Division 3 order. The psychiatric evidence and all of the other evidence establishes that he is, and the respondent's Counsel does not contest that the evidence supports a finding that the decision that he is a serious danger in the absence of a Division 3 order be affirmed.

[65] The issue is how the discretion conferred by s 30(3) should be exercised. Should he continue to be subject to a continuing detention order or be released subject to a supervision order?

[66] Both options present difficulties. If a continuing detention order is made then the Court seemingly cannot order that a place in a secure mental health facility be provided. Yet, treatment in such a facility was the essential rationale for making a continuing detention order on 6 October 2016. On the basis of what has happened since 6 October 2016 and what I infer from the evidence about available places, I should not assume that if I make a continuing detention order the respondent will be given a place in the high security unit at The Park. He will remain in prison, with some possible improvement in his schizophrenia if clozapine is

trialled in an inpatient setting and proves successful. While he remains in prison, he will need to remain in something akin to a form of self-imposed solitary confinement. Transition into the general prison population is very likely to exacerbate his mental illness, and it will also give him greater access to illicit drugs or inhalants, which he is at risk of using at times of stress.

[67] The respondent is hardly to be criticised for having an "agenda" of receiving counselling and treatment so as to enhance his prospects of being placed on a supervision order. Counselling and treatment is, after all, what the Court contemplated in 2016. Presently, it seems that the respondent is not accommodated in a place in which he can receive intensive counselling about sexual issues from a psychologist. It is understandable that he prefers the environment of The Park since his condition improved somewhat during his truncated stay there.

[68] Within the correctional system, the high security unit at The Park seems to be the only place for a prisoner with the respondent's security classification to receive the mental health treatment which the experts say he needs. However, with resourcing demands due to forensic orders and prisoners with mental illness more acute to that which the respondent presently suffers, he seems to have little prospect of receiving treatment in that high security unit. Also, if he happens to be admitted to it he remains at risk of being "bumped", without notice, back to the prison, as occurred in October 2017.

[69] Because of his security classification, he is seemingly deemed unsuitable for treatment at a medium security mental health facility.

[70] It remains the fact, however, that the respondent remains subject to a Treatment Authority under the *Mental Health Act* (formerly described as an Involuntary Treatment Order).

[71] It is remarkable that there can be a systemic failure of the kind which has occurred in this case. The respondent is subject to concurrent regimes, each of which is supposed to provide him with essential treatment for his severe mental illness. Yet neither seems capable of finding him a place in a secure mental health facility.

[72] In the short-term, the respondent should be trialled on clozapine in an inpatient setting, as recommended by the two experts. Also, in the short-term, the two bureaucracies which have responsibility for treating his mental illness should secure a place for him in a mental health facility which is adapted to his needs and is able to cope with the risks he presents. This includes controls upon his ability to access substances, including inhalants, and close monitoring of his condition to ensure his abstinence from such substances.

[73] Simply to make a supervision order without ensuring such a place is available to the respondent would risk repeating what happened the last time the respondent was released subject to a supervision order. Without appropriate management, the respondent will follow the usual course of someone who is released subject to a supervision order. He will be taken to what is described as "the precinct". Whilst he would be supervised there and subject to many requirements, including a curfew and restrictions on his movements, there is a high probability that, before long, he would react badly to his environment and being accommodated for a long time with numerous sex offenders at the precinct. He probably would be able to access petrol, paint or some other intoxicant, contravene the requirements of the supervision order and find himself liable to be returned to custody awaiting the

outcome of a contravention proceeding. Even with an understanding approach to minor breaches of a supervision order, it is hard to see how those supervising the respondent at the precinct under a supervision order could tolerate a situation in which the respondent's mental health and his substance use disorder led him to access intoxicants.

[74] Neither community protection nor the rehabilitation of the respondent is advanced by the respondent simply being placed on a supervision order, after which he goes to the precinct, becomes stressed, his mental illness flares, he accesses an inhalant or some other intoxicant and thereby breaches the order. A supervision order which sends the respondent down this pathway should be avoided, if possible.

[75] In the circumstances, I am presently minded to make a supervision order which requires the respondent to reside at a secure mental health facility, unless otherwise directed by the Court.

[76] The respondent would remain subject to any existing or renewed Treatment Authority under the *Mental Health Act*. He would be subject to the kind of requirements which the previous supervision order contained. These would require him to comply with any orders made under the *Mental Health Act* save to the extent they are inconsistent with the provisions of the supervision order.

[77] It will be for those with responsibility for the administration of any such supervision order and for the implementation of his Treatment Authority to map out a pathway. Steps along the pathway would seem to include the trial of clozapine as an inpatient. If the high security unit at The Park is unsuitable as a place for the respondent's ongoing treatment, or no place is available at that facility, then the authorities will need to find a medium security mental health facility.

[78] As indicated by me on 21 May 2018, I have adjourned the matter so that the authorities can consider the problem which the respondent presents and come up with a better solution than they have over the past 20 months in terms of accommodation in a mental health facility. The parties agreed that the hearing should be adjourned so that these matters can be explored and, if necessary, an appropriate additional respondent be joined.

Concluding observations

[79] I am conscious that this case is symptomatic of wider systemic problems which include:

(a) The burden of prisoners with severe mental health problems;

(b) Too few places in facilities like The Park, with the Prison Mental Health Service having to prioritise the most acute cases for such a facility;

(c) Secure mental health facilities face the burden of widespread mental illness in the general community;

(d) "Temporary" accommodation at "the precinct" of individuals subject to supervision orders under the Act is, in reality, a place of long-term accommodation because individuals who are subject to orders under the Act struggle to find appropriate and approved accommodation in the general community.

[80] The precinct is not a place that an individual with a mental illness, such as the respondent, who does not have a sexual paraphilia, should be for very long, if at all. His accommodation there is likely to exacerbate his mental illness, which will prompt a decline into misbehaviour and substance abuse.

[81] It is not my role as a judge to devise solutions to systemic problems. My role is to review the respondent's continuing detention order. It is apparent that the order is not working. It is not working as the Court and the experts expected it to when the order was made in October 2016. It is not working to reduce the risk of the respondent re-offending because he is not receiving the treatment, counselling and supervision which he requires. Subject to a trial of clozapine, his schizophrenia is presently being treated as best it can be in difficult circumstances by the Prison Mental Health Service. There is not much more that the Prison Mental Health Service can do for him for so long as he remains accommodated in a prison cell, rather than a secure mental health facility.

[82] Because the continuing detention order is not working, as intended, as a means of ensuring the respondent is detained for care and treatment, the making of a supervision order is urged by Counsel for the respondent. However, a supervision order that simply transports the respondent to "the precinct" is unlikely to work well for either the community or the respondent. A supervision order which, both in words and in its practical operation, ensures the respondent resides in a secure mental health facility is the best solution. As presently advised, it is more likely than a continuing detention order to provide the respondent with treatment and care in an environment which he needs to stabilise his mental health and begin to address his long-standing problems of substance abuse.

[83] The Court can devise the words of a supervision order. It can refer, in terms, to a requirement that the respondent reside at a secure mental health facility. However, the Court does not provide those facilities; the Executive Government does.

[84] Before making a supervision order with such a requirement or some similar requirement, I expect the corrective services authorities and mental health authorities to have a plan for the respondent's treatment, care and accommodation. Neither part of the system is currently providing the respondent with the treatment, care and accommodation which he obviously needs. Whilst he remains a "prisoner" (despite having completed his sentence more than six years ago), the respondent is the responsibility of the Department of Corrective Services. Yet he is also subject to a Treatment Authority under the *Mental Health Act*. I expect that the relevant government officials will overcome whatever bureaucratic obstacles stand in the way of the respondent transitioning to a secure mental health facility for treatment and care.

[85] Presently a Continuing Detention Order does not provide a pathway for the respondent to enter a high security mental health facility, let alone transition to a medium security mental health facility. A suitably worded supervision order which is implemented in accordance with a plan worked out by both corrective services and mental health authorities may provide a pathway for the respondent's future treatment and long-term rehabilitation. The application is adjourned so that the authorities can find a place for the respondent in a secure mental health facility without further delay.