A PROFILE OF FORENSIC PATIENTS IN NEW SOUTH WALES AND AN ASSESSMENT OF THE ROLE OF THE MENTAL HEALTH REVIEW TRIBUNAL IN EFFECTING THEIR RELEASE

Robert Hayes
Michael Sterry
Tony Ovadia
Bernard Boerma
and
William Greer
Mental Health Review Tribunal
New South Wales

The Mental Health Act 1990 (NSW) and the Mental Health (Criminal Procedure) Act 1990 (NSW) (hereafter, the forensic review legislation), provide mechanisms for dealing with mentally and developmentally disabled people while they are detained in accordance with criminal law. Under the forensic review legislation, such people are called ‘forensic patients’.1 The purpose of this paper is to profile these patients, while protecting their identities, and to assess the effectiveness of the forensic review mechanisms.

1 For the sake of clear exposition, the complex set of legal rules have been simplified in this paper.
In New South Wales, as at October 1991, there are eighty-six forensic patients whose lives are governed by the forensic review legislation. This represents only a small percentage of those currently detained in prison in New South Wales, whether before or after trial, who may be mentally ill or suffering from some kind of mental disability, or who may have a developmental disability. Many lawyers and psychiatrists working within the criminal justice system of New South Wales seek to prevent their patients or clients from falling within what are perceived to be the traps of the forensic review legislation. Furthermore, quite apart from any perception of the malodorous nature of forensic patient status, much mental illness, mental disability, and developmental disability simply remains undetected (Herrman et al. 1991), or non-addressed. This arises from a lack of resources within the criminal justice and corrective services systems, which are not equipped to deal with the problems posed by the mentally or developmentally disabled. Consequently, this paper deals with groups which are not representative of the general population of persons suffering from these types of disabilities.

Forensic Patients in New South Wales: Who Are They?

Of the eighty-six forensic patients in New South Wales, as at October 1991, sixty-five have been found not guilty on the grounds of mental illness; nine are 'unfit to be tried'; and twelve received forensic status after having been transferred to a mental hospital, having become mentally ill whilst in a prison (see Table 1).

<table>
<thead>
<tr>
<th>Type of Sentence or Reason for Detention</th>
<th>Number of Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Transferees'</td>
<td>12</td>
</tr>
<tr>
<td>Fixed term sentences</td>
<td>6</td>
</tr>
<tr>
<td>Limiting term sentences</td>
<td>2</td>
</tr>
<tr>
<td>Awaiting trial (remand)</td>
<td>3</td>
</tr>
<tr>
<td>Life sentence</td>
<td>1</td>
</tr>
<tr>
<td>Unfit to be tried</td>
<td>9</td>
</tr>
<tr>
<td>Not guilty on the ground of mental illness</td>
<td>65</td>
</tr>
<tr>
<td>Total</td>
<td>86</td>
</tr>
</tbody>
</table>

These forensic patients are in New South Wales prisons or hospitals, or living in the community on conditional release. Table 2 shows the locations of these eighty-six forensic patients.
A Profile of Forensic Patients in New South Wales

Table 2

Location of Forensic Patients as at October 1991

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prisons</td>
<td>10</td>
</tr>
<tr>
<td>Public mental hospitals</td>
<td>39</td>
</tr>
<tr>
<td>Community</td>
<td>19</td>
</tr>
<tr>
<td>Prison mental hospital</td>
<td>18</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>86</strong></td>
</tr>
</tbody>
</table>

Demographic data

Of these eighty-six persons, seventy-two (83.7 per cent) are men and fourteen (16.3 per cent) are women. This is higher than the ratio of men to women in custody in New South Wales prisons which in 1989 was 93.6 per cent: 6.4 per cent (New South Wales. Department of Corrective Services 1990). It is not clear whether this is due to women forensic patients remaining in the system for a longer period, or because women are more easily identified in the criminal justice system as being mentally ill. There are three Aboriginal forensic patients (3.5 per cent) and twenty-six who were born overseas, twenty-two of whom are from a non-English speaking country (25.6 per cent). Aboriginal and persons from a non-English speaking background appear to be over-represented when compared to their proportion in the general population.

The patients range in age from nineteen to sixty-nine, the average age being 40.7 years (mean is 40.7, standard deviation is 11.40 years). They have been forensic patients on average for 5.8 years. Some of them have been under detention for one year or less, and one person, who is serving a life sentence, has been a forensic patient for over thirty years. This patient had not been found not guilty on the ground of mental illness, but is a transferee from prison. A detailed analysis of the years detained is presented in Table 3 and Figure 1.

Table 3

Number of Years Patient Detained as at October 1991

<table>
<thead>
<tr>
<th>Number of years detained</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of forensic patients</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Number of years detained</td>
<td>16</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
<td>22</td>
<td>23</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
<td>29</td>
<td>30</td>
</tr>
<tr>
<td>Number of forensic patients</td>
<td>8</td>
<td>6</td>
<td>6</td>
<td>11</td>
<td>9</td>
<td>7</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Previous history

Some sixty-four (fifty-three male and eleven female) forensic patients (that is, 74 per cent), had a previous psychiatric history: there appears to be no difference between men and women in this area.

A previous history of drug addiction was present in twenty-four (28 per cent) forensic patients, twenty-three (27 per cent) had a previous history of alcohol addiction, thirty-seven (43.8 per cent) had a criminal record, and forty-two (48.8 per cent) had a history of violence. Details of these are shown in Table 4.

Thus, the forensic patients mostly had both a psychiatric and criminal history and over one quarter of them had a history of substance abuse.

Of those patients who had a previous psychiatric history, most had multiple admissions to hospital. Eleven had one admission, and one person had thirty-eight admissions. The average number of admissions was three. The number of admissions is represented graphically in Figure 2.

Diagnoses at the time of committing the offences were as shown in Table 5. The term 'offence' is used to describe the incident leading to forensic status, but of course, persons not guilty on the grounds of mental illness have committed no offence.
Table 4

Previous History of Forensic Patients* as at October 1991

<table>
<thead>
<tr>
<th></th>
<th>% Male patients</th>
<th>% Female patients</th>
<th>Total Number</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric history</td>
<td>53</td>
<td>72</td>
<td>64</td>
<td>74</td>
</tr>
<tr>
<td>Criminal record</td>
<td>31</td>
<td>42</td>
<td>37</td>
<td>43</td>
</tr>
<tr>
<td>Violence</td>
<td>37</td>
<td>50</td>
<td>42</td>
<td>49</td>
</tr>
<tr>
<td>Drug addiction</td>
<td>20</td>
<td>27</td>
<td>24</td>
<td>28</td>
</tr>
<tr>
<td>Alcohol addiction</td>
<td>19</td>
<td>26</td>
<td>23</td>
<td>27</td>
</tr>
</tbody>
</table>

* This table is based on eighty-six patients (seventy-two male, fourteen female) but the criminal history of one male has not yet been investigated.

Figure 2

Number of Admissions to Hospitals as at October 1991
Table 5

Provisional Diagnosis at the Time of the Offence as at October 1991

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number of Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major psychosis</td>
<td>68</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
</tr>
<tr>
<td>Drug/alcohol dependence</td>
<td>5</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>10</td>
</tr>
<tr>
<td>Developmental disability</td>
<td>9</td>
</tr>
<tr>
<td>Organic psychosis</td>
<td>1</td>
</tr>
<tr>
<td>Transient organic psychosis</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>97</td>
</tr>
</tbody>
</table>

Note: Several patients had two provisional diagnoses.

The offence

Of the eighty-six forensic patients, twenty-two were charged with having committed at least two offences, and ten patients with having committed three offences. The types of offence with which people were charged is shown in Table 6 below; the classification used is the recently adopted Australian National Classification of Offences.

Table 6

Details of Offences as at October 1991

<table>
<thead>
<tr>
<th>Offence Category</th>
<th>Number of Offences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offences against person</td>
<td>108</td>
</tr>
<tr>
<td>Murder</td>
<td>43</td>
</tr>
<tr>
<td>Attempted murder</td>
<td>7</td>
</tr>
<tr>
<td>Manslaughter</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>55</td>
</tr>
<tr>
<td>Robbery and extortion</td>
<td>3</td>
</tr>
<tr>
<td>Breaking and entering and other offences involving theft</td>
<td>2</td>
</tr>
<tr>
<td>Property damage and environmental offences</td>
<td>4</td>
</tr>
<tr>
<td>Offences against good order</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>118</td>
</tr>
</tbody>
</table>
Of these offences 55.8 per cent were committed in the home of the alleged perpetrator. The rest occurred in diverse places, from trains to psychiatric hospitals (see Table 7).

Table 7

Locations Where Offences Committed
as at October 1991

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of Offences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private home</td>
<td>48</td>
</tr>
<tr>
<td>Public place</td>
<td>22</td>
</tr>
<tr>
<td>Psychiatric hospital</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>86</td>
</tr>
</tbody>
</table>

Note: Some patients committed offences against more than one person at a specific location.

The victims of the offences were varied: wives, children and strangers were among the victims. The relationships of offenders to their victims are set out in Table 8.

Table 8

Victim Categories—Offences Against the Person
as at October 1991

<table>
<thead>
<tr>
<th>Victim Category</th>
<th>Number of Victims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>7</td>
</tr>
<tr>
<td>Parent</td>
<td>13</td>
</tr>
<tr>
<td>Child</td>
<td>13</td>
</tr>
<tr>
<td>Other relative</td>
<td>7</td>
</tr>
<tr>
<td>Stranger</td>
<td>60</td>
</tr>
<tr>
<td>Friends</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
</tr>
</tbody>
</table>

Thus, the offences were committed equally against friends or family members (fifty-two) as against strangers (sixty).
Judicial Role of the Mental Health Review Tribunal (MHRT) in Releasing Forensic Patients

People who are mentally or intellectually unable to undergo a criminal trial

Mental or developmental disabilities might make a person unfit to be tried for the offence(s) for which he or she has been charged. When an especially empanelled jury has so found, the judge may order the person's detention in a prison or hospital, and must refer the issue of ongoing unfitness to the Mental Health Review Tribunal (MHRT).

In relation to persons found unfit to be tried, those persons whom the MHRT determines will become fit during the period of twelve months after the finding of unfitness may be made subject to a court order that they be detained, in a hospital or other place, for a period not exceeding twelve months. The MHRT must, as soon as practicable after the making of the court order, review the case and determine whether the person has become fit to be tried, and whether the safety of the person or any member of the public will be seriously endangered by the person's release. If the MHRT is of the opinion that the person has not become fit to be tried and is satisfied on the available evidence that the safety of the person or any member of the public will not be seriously endangered by the person's release, the MHRT must make a recommendation to the Minister for Health for the person's release (s. 80 Mental Health Act).

When an accused person has been found unfit to be tried by both the court and MHRT, the Attorney-General may direct that a special hearing be conducted. The 'special hearing' process should be made the subject of separate and detailed analysis. Suffice it to say, however, that it is conducted similarly to a criminal trial and if the person is found not guilty of the offence charged, the person is no longer a forensic patient. Where a special hearing results in a qualified finding of guilty, a 'limiting term' may be imposed, with an order for detention in a hospital or other place. As with the previous class of case, the MHRT must review the matter and determine whether the person has now become fit to be tried, or if not, whether that person could safely be released (s. 80 Mental Health Act).

Even though a person has been exposed to the entire process and has received a limiting term, the fitness of the patient to be tried for an offence is re-examined at each subsequent six monthly review by the MHRT (s. 82(1)(b) Mental Health Act). Where the MHRT is of the opinion that the patient has now become fit to be tried, it must notify the Attorney-General accordingly (s. 82(3) Mental Health Act). The MHRT it would seem, as a consequence of the same review, could also make a recommendation to the Minister for Health as to the patient's conditional or unconditional release (s. 82(1)(c) Mental Health Act), but only where the MHRT is satisfied about the safety of any release (s. 82(4) Mental Health Act). The Attorney-General and the Director of Public Prosecutions would then be notified by the Minister for Health of the recommendation for release (s. 83(1) Mental Health Act). Presumably, where the recommendation for release is made by the MHRT, this may have some influence on the decisions of the Attorney-General and the Director, concerning the possibility of further
proceedings against the person (s. 29 Mental Health (Criminal Procedure) Act). Where a
decision is made to institute further proceedings, the Attorney must request the court which
held the initial unfitness inquiry to hold a further inquiry as to the person's unfitness.

Notwithstanding a finding by the MHRT that a person has become fit to be tried,
the Attorney-General has a discretion to advise the Minister for Health that no further
proceedings will be taken against the person. In such cases the 'prescribed authority'
may release the person, after having informed the Minister for Police of the date of the
person's release (s. 84 Mental Health Act as amended by the Statute Law
(Miscellaneous Provisions) (No. 2) 1990).

Prescribed authority is defined by clause 20 of the Mental Health Regulation 1990
to mean basically the Governor, where a person has been found not guilty on the
grounds of mental illness, the Governor-General, where the person is detained by an
order of the Governor-General, or the Minister for Health, in relation to all other
persons.

The MHRT must also review the cases of persons found not guilty by reason of
mental illness, including where the person's primary and continuing problem is
developmental disability, and where the mental illness finding was made after a special
hearing. Following such a finding, where a court orders the person to be detained in
strict custody in a hospital or other place, the MHRT must as soon as practicable make
a recommendation as to the person's detention, care, or treatment, or, if the MHRT is
satisfied that it will not be dangerous to do so, may make a recommendation as to the
person's conditional or unconditional release (s. 81 Mental Health Act).

People who are detained following a finding of unfitness to be tried under this
process must, as forensic patients, be reviewed by the MHRT at least once every six
months. If the MHRT determines that any such person has become fit to be tried, it
must notify the Attorney-General and Minister for Health accordingly (s. 82 Mental
Health Act). The possible outcomes of such a notification are discussed below.

The general forensic review provision is set out in s. 82 of the Mental Health Act.
It provides that the MHRT may at any time, and must, at least once every six months,
review the case of every forensic patient and make a recommendation to the Minister:

(a) as to the patient's continuing detention, care or treatment in a hospital, prison
or other place; or

(b) in the case of a patient subject to a determination that the patient is unfit to be
tried for an offence, as to the fitness of the patient to be tried for an offence;

or

(c) as to the patient's release (either unconditionally or subject to conditions).

In the case of a person with a limiting term who has become fit to be tried and found
by the MHRT to pose no risk on release, the MHRT may make a recommendation to
the Minister for the person's release. However, there is
nothing in the legislation which states that the Minister must release such a person. It seems that such a person can be kept in limbo.

People who lack criminal responsibility because of mental illness or other mental conditions

A person accused of crime who is found not guilty by reason of mental illness will become a forensic patient, and must be reviewed by the MHRT as soon as practicable after the court order for his or her detention, and at least six monthly thereafter. The MHRT may make recommendations to the Minister as to the patient's continuing care or treatment in a hospital, prison or other place, and may make recommendations for conditional or unconditional release if the patient is not dangerous (s. 81 Mental Health Act).

Ordinary prisoners who manifest mental illness in gaol

Under ss. 97 or 98 of Mental Health Act, ordinary prisoners may be transferred to mental hospitals where the Chief Health Officer of the Department of Health, acting on medical certificates, by two practitioners, considers that the prisoner is mentally ill or has a mental condition which is treatable in a hospital and that the prisoner consents to the transfer. As soon as practicable after the transfer, the MHRT must review the prisoner (now a forensic patient) and make recommendations to the Minister as to the person's continued detention, care or treatment in hospital. The transferred prisoner remains a forensic patient for so long as he or she remains in hospital and is not reclassified by the MHRT, or remains on conditional release as ordered by the prescribed authority. As such a person's period in hospital is to be treated as a period in prison, the expiry of the transferee's fixed term of imprisonment while in hospital will terminate his or her forensic status. If the transfer is for longer than six months, the patient will be systematically reviewed by the MHRT under s. 82 of the Mental Health Act at least once every six months.

Where the Chief Health Officer orders transfer, but it is not effected within a period of two weeks, the MHRT must informally review the prisoner's case each month until such time as the person is transferred to a mental hospital or until such time as the MHRT recommends that the person not be so transferred. The MHRT must also make a recommendation to the Minister as to the person's detention, care or treatment (s. 87 Mental Health Act).

The MHRT may have a role in the release of mentally ill ordinary prisoners where they have been transferred to a hospital and may even impose community counselling orders upon prisoners with psychiatric problems but who are not in a hospital. It should be noted that the MHRT's role with forensic patients, and in making determinations for the courts in relation to fitness to be tried, represents only two of its eleven broad heads of jurisdiction (Mental Health Review Tribunal 1990, 1991a).
Approach of the Mental Health Review Tribunal to Its Role

The MHRT's forensic role is a curious one, in so far as it is largely recommendatory. The MHRT has no determinative role in any significant areas, such as transfer from prison to hospital, transfer to open ward, movement from detention to conditional release in the community, discharge from conditional to unconditional release.

The MHRT is enjoined by the Mental Health Act to be as informal as possible. In the pursuit of its review functions in relation to forensic patients, and indeed in relation to its full jurisdiction under the forensic review legislation, the MHRT is not bound by the rules of evidence, but may inform itself of any matter in such manner as it thinks appropriate, as the proper consideration of the matter before it permits (s. 267 Mental Health Act). In performing its functions relating to forensic patients, the MHRT must be chaired by the President or Deputy President, and as with its jurisdiction generally, the legal member sits with a psychiatrist and other suitably qualified member, in a panel of three. The MHRT can set its own procedure for the conduct of its business. The forensic patient whose case is being reviewed must be represented by a barrister or a solicitor, unless the forensic patient declines to be represented. The MHRT may approve representation by another person of the forensic patient's choice (s. 274 Mental Health Act).

The MHRT does not sit as a judge between two adversarial parties. The Mental Health Advocacy Service, established to advocate the rights of mentally ill people and forensic patients, generally argues at each review for a reduction in the existing restrictions on the forensic patient in question. This encourages the patient's gradual progress from prison, through to hospital, and out into the community on conditional, and ultimately unconditional release. The Advocacy Service may produce evidence in the form of prison or hospital staff reports, and if appropriate, independent psychiatric reports supporting a reduction in the currently prevailing restraint on the liberty of the patient under review. But there is never a clearly defined opposing party, producing contrary material, with the resulting conflict being adjudicated upon by the MHRT. The Advocacy Service advocates to the MHRT the case for less restrictive restraints, on a set of medical, social work, nursing, prison officer (if the forensic patient is being detained in a prison), and other reports and evidence, and the MHRT, using material, including that supplied by the Advocacy Service, then takes up the case, analyses it, asks questions of the witnesses, incorporates its own and other especially commissioned expertise, and presents it in writing to the Minister. There is never a party in forensic patient proceedings before the MHRT who is duty-bound to carry the burden of justifying the continuance of the currently prevailing restraint on the liberty of the forensic patient, much less, advocating a further tightening of that restraint.

The MHRT has appointed a Liaison Officer to assist it with its review of forensic patients, and in particular cases, it has directed the Liaison Officer to make detailed investigations and reports about the patients. The work of the Liaison Officer is aimed at finding something better for patients, within the prison, health, and community health or probation and parole systems, than
those systems, on their own initiatives seem able to produce. The investigative process is not secret and is conducted with the knowledge of the Mental Health Advocacy Service. The results are made available to the Advocacy Service for comment, and alternative suggestions and criticisms are actively sought.

The MHRT indeed actively supports the development, by the Advocacy Service, by the hospital where the forensic patient is being detained, or by any other responsible organisation which should or might have an interest, of conditional release programs for forensic patients. In one recent case, the Aboriginal community of a particular area offered to take an Aboriginal forensic patient under its wing. The MHRT seized upon, and developed the offer into a coherent conditional release plan, using supplementary governmental supports.

Conditional release, monitored community treatment, and the availability of ongoing review with a prospect of gradual de-escalation of restraints upon the patient's liberty, on the one hand, and in appropriate circumstances, revocation of existing liberties on the other, provides an appropriate balance between the public interest in protection of society, and individual rights and freedom. The approach of the MHRT to its forensic review function indeed reflects the approach of the Supreme Court of New Jersey, in *State v. Fields* (390A 2d 584 [1978]). In that case the court said:

If at any periodic review proceeding the State is unable to meet its burden of justifying the continuance of the currently prevailing restraint on the liberty of the patient, it becomes the task of the reviewing judge again to 'mould' an appropriate order. The new order should provide for the least restrictive restraints which are found by the judge to be consistent with the well-being of the community and the individual. However, even where the [patient's] condition shows marked improvement, only the most extraordinary case would justify modification in any manner other than by a gradual de-escalation of the restraints upon the [patient's] liberty.

The difference between the system for forensic review currently prevailing in New South Wales and that which apparently prevails in some jurisdictions in the USA is immediately apparent from the above judicial extract. The court referred to the 'State' meeting its 'burden of justifying' the continuance of the current prevailing restraint on the liberty of the patient. As already emphasised, the state of New South Wales does not undertake this burden.

As the MHRT is both an advocate of, and adjudicator upon, the case of each forensic patient for a progressively less restrictive environment, it has actively involved itself in liaison and other representative committees concerned with advancing the welfare of forensic patients in New South Wales. The main inhibitors on the welfare and progress of forensic patients have been bureaucratic practices and procedures in the mental health and prisons systems. Two of such committees have a highly significant potential for improving the lot of forensic patients. The first committee to be mentioned is a standing liaison committee, comprising a representative from the Department of Corrective Services, a representative of the Mental Health
Branch of the Department of Health which, amongst other things, is responsible for the welfare of forensic patients, a representative of the Mental Health Advocacy Service, and representatives from the MHRT. The MHRT, through its representatives on this standing liaison committee, is actively promoting the following developments:

- initial assessment of new forensic patients at Long Bay Prison Hospital by an expert team, to formulate and implement an appropriate rehabilitation program;
- modification of existing Corrective Services classifications systems when they are applied to forensic patients, allowing forensic patients hospital-style leave outside the prison, hospital-style day and weekend leave outside the prison, and immediate movement in appropriate cases to work release programs;
- involvement of both Corrective Services and Department of Health representatives in assessment processes for forensic patients; and
- initial placement of female forensic patients in the Long Bay Prison Hospital.

The psychiatrist, medical, nursing, custodial and other staff of the Long Bay Prison Hospital in 1991, and the planners of this unit, are to be commended for the improvement in the condition of forensic patients transferred to this unit—most now show a readiness for conditional release which was not apparent before.

The other committee which has relevance to this area is the Mental Health Act Implementation Monitoring Committee set up by the Minister for Health. This committee, as the name suggests, is monitoring all provisions of the new legislation and is particularly looking at any problems that arise with the forensic patient provisions.

The MHRT has also actively pursued the innovation of preliminary case conferences which take place prior to the hearing by the Tribunal of forensic cases, to determine the progress of each patient, and to ensure that the patient's case is not left to lie dormant in the six-month period between s. 82 reviews.

The preliminary case conferences are chaired by the Registrar of the MHRT but do not involve the President, Deputy President, and other Members who sit on forensic case reviews. Any reports produced at these conferences are made available to the Mental Health Advocacy Service and are tendered to the Tribunal at each review for its consideration. The Mental Health Advocacy Service has a representative present at each preliminary case conference. The MHRT, through its processes, becomes a mixture of advocate, counsel assisting, investigator, expert witness, and finally, Royal Commissioner, in ultimately making periodical recommendations to the Minister about each forensic patient. At least each six months it has to form a fresh view about the appropriate next step for each forensic patient, which is
then articulated, in the form of recommendations with accompanying reasons, and it proceeds to advocate that view, both formally, and sometimes informally, to the Minister, and to the departmental officers who provide ministerial advice.

Twists in the Release Path for Patients

*Mandating treatment for people who remain dangerously ill*

How might a forensic patient attain release? The answer to this question can be very complicated, sometimes desirably, sometimes not. Many obstacles can be placed in the release path.

An ordinary prisoner who became a forensic patient on becoming mentally ill or otherwise disordered, and was transferred to a mental hospital, must be released from hospital at the end of his or her prison sentence, unless classified as a continued treatment patient by the MHRT within the final six months of that sentence (s. 89 Mental Health Act). To receive this status, the person must of course be a 'mentally ill person' under the civilian patient provisions of the Mental Health Act. The MHRT can, at the end of prisoner's term make that person the subject of a community treatment or counselling order, depending on the prisoner's location, such orders mandating medication, treatment, and appropriate support facilities. This feature of the Mental Health Act is much too complex a subject to allow discussion here (for more details see Mental Health Review Tribunal 1991b).

A person who was found unfit to be tried and who received a limiting term of imprisonment following a special hearing, must also be released at the expiry of that limiting term, again, *unless* classified as a continued treatment patient by the MHRT in the sixth months prior to the expiry of the limiting term. Again, the person, who was unfit to be tried must be a 'mentally ill person' under the Act for this civilian continued treatment status to be conferred. As most recipients of limiting terms are developmentally disabled, not mentally ill, this means of continuing their detention after the expiry of their terms will seldom be available, notwithstanding that in some cases they might be highly dangerous people.

The New South Wales Attorney-General recently set up a committee to identify areas of concern in the operation of the criminal justice system. One of the issues placed by the Attorney before the committee was that of the release of persons with a developmental disability after the expiry of their limiting terms imposed in special hearings, notwithstanding the fact that such developmentally disabled people, in individual cases, might possess antisocial traits which make them potentially dangerous to others. The committee, which included a representative from the Department of Community Services, and from other governmental and non-governmental areas, finalised its recommendations, which went to the Attorney early in 1991. The whole area has now been referred to the New South Wales Law Reform Commission.

Any prisoner or forensic patient, close to the expiry of the prison sentence or limiting term, may be made the subject of a Guardianship Order by the
Guardianship Board where the applicant for an order (who may be a Corrective Services or Health Department official with a genuine concern for the welfare of the person) believes that the prisoner or patient would be incapable of managing his or her own affairs without supervision. These orders also provide a mechanism for indirect control in appropriate circumstances.

Guardianship orders, of course, cannot be made against a person about to be discharged from prison or hospital simply because that person is potentially dangerous. The person must meet the legal requirements of the *Disability Services and Guardianship Act 1987* (NSW) for a guardianship order, and the practical guidelines that the Guardianship Board imposes on itself in determining those persons for whom it will assume a guardianship review responsibility. The combined effect of these legal rules and practical guidelines mean that potentially dangerous forensic patients and ordinary prisoners with one of the following kinds of disabilities could be made the subject of Guardianship Orders under the Disability Services and Guardianship Act 1987 on the expiry of their terms: intellectual disability; psychiatric disability; dementia; brain damage from an accident or from the abuse of alcohol or drugs; disability from advanced age; and physical or sensory disability. The disability must be severe enough to mean that the person requires 'supervision or social habilitation' in 'one or more major life activities'. The person must be 'totally or partially incapable of managing his or her person' and must need the order.

*Releasing patients who are unfit to be tried*

We have already noted that a person found to be unfit to be tried and given a special hearing with the consequent limiting term may, immediately after the imposition of the limiting term, be considered by the MHRT to be fit to be tried (under s. 80 of the Mental Health Act) and may be either exposed to a further court hearing about unfitness, or released by the Minister for Health on the advice of the Attorney-General (s. 29 Mental Health (Criminal Procedure) Act).

The cases of persons found unfit to be tried, and who have subsequently been found by the MHRT to be unlikely within twelve months after the finding of unfitness to become fit to be tried, are referred to the Attorney-General who on advice from the Director of Public Prosecutions, may direct that a special hearing be conducted or may decide that no further proceedings will be taken (s. 18(b) Mental Health (Criminal Procedure) Act).

In the case of an unfit person with a limiting term, who is found by the MHRT during one of its six-monthly s. 82 reviews to have become fit to be tried, the Attorney-General on being notified of this (under s. 82(3) of the Mental Health Act), may direct the trial of that person. The trial may lead to a finding of not guilty, with the result that the forensic patient is discharged.

Where the MHRT makes a determination that a person previously found unfit to be tried has now become fit, regardless of when that determination is made, the MHRT must notify its determination to the Attorney-General (ss. 80(3), 82(3) Mental Health Act). Such notification may result in an order for the person's release (s. 29(3) Mental Health (Criminal Procedure) Act). Alternatively, the
finding may result in a further inquiry as to the person's unfitness (s. 29(1)(a) Mental Health (Criminal Procedure) Act), a finding by the court that the person is now fit (s. 30(1) Mental Health (Criminal Procedure) Act), and a recommencement of the proceedings against the person. The former forensic patient may, of course, be found not guilty in these proceedings.

The MHRT must recommend to the Minister the release of a person who has not become fit to be tried, where the safety of the person or any member of the public would not be seriously endangered by the person's release. These recommendations are made after reviews conducted by the Tribunal under s. 80 of the Mental Health Act, of persons recently ordered by a court to be detained, following proceedings arising from their unfitness (s. 80(4) Mental Health Act).

Releasing forensic patients who were (and possibly remain) mentally ill

Forensic patients who were found not guilty by reason of mental illness, whether in special hearings or after ordinary trials, may only be conditionally or unconditionally released on recommendations of the MHRT after a s. 81 or a s. 82 review. The MHRT may not recommend the release of a forensic patient unless it is satisfied:

that the safety of the person/patient or any member of the public will not be seriously endangered by the person's release (s. 81(2)(b), 82(4) Mental Health Act).

Notices of recommended releases are referred to the Minister for Health, who must then notify the Attorney-General of the recommendation, and at the same time furnish a copy to the Director of Public Prosecutions. The Director of Public Prosecutions must, within twenty-one days after the date of any such notification, indicate to the Attorney-General whether the Director intends to proceed with criminal charges against the person concerned (s. 83(2) Mental Health Act).

Recommendations for conditional or unconditional release made immediately following verdicts of not guilty by reason of mental illness are referred to the Minister for Health under s. 81 of the Mental Health Act. However, unlike recommendations under s. 80 or 82 for conditional or unconditional release, the Minister does not have an obligation to notify the Attorney-General, under s. 83 of the Mental Health Act, of such a recommendation.

Attorney-General's role

When the Attorney-General receives a release recommendation, under s. 80 or s. 82 of the Act, whether unfit to be tried, not guilty on the grounds of mental illness, or a mentally disturbed prisoner in a mental hospital, the Attorney-General has thirty days to indicate an objection to the person's release (s. 84 Mental Health Act). The Attorney's objection to conditional or unconditional release may be on the ground that:
• the person has served insufficient time in custody or under detention; or,
• the Attorney-General or the Director of Public Prosecutions intends to proceed with criminal charges against the person.

If such an objection is made, then the person may not be released.

Facts and Fantasies About Forensic Patients

There is a view abroad that the MHRT is unnecessarily conservative in its approach, inhibiting the return of forensic patients, from prison, through mental hospital, back into the community.

The forensic review legislation requires that forensic patients be legally represented. Generally, they are represented by the Mental Health Advocacy Service, an experienced and well-qualified group of mental health lawyers. Since the re-establishment of the MHRT under the 1990 Act, in September 1990, the Mental Health Advocacy Service has advocated conditional release of eleven forensic patients. One of the patients was recommended twice for release, having been rejected on one occasion, and the case is again under consideration by the Minister. In relation to all eleven forensic patients, the MHRT has found itself persuaded by the evidence that monitored conditional release of the patient was appropriate. The MHRT has submitted to the Minister, in respect of each of the eleven patients, a comprehensive program for the patient's safe treatment in a monitored community treatment program. The Minister has rejected the MHRT recommendations in one of the cases, but accepted them at a subsequent review, and has accepted the recommendations in relation to six of the other patients in question, and these six have been conditionally released at the time of writing. One of the patients is awaiting repatriation to his country of birth when his affairs are settled in Australia. The MHRT is now monitoring the progress of those patients released into the community. Each has been provided with a comprehensive community program which effectively mandates the provision of appropriate counselling, treatment, and other support. In relation to the four outstanding patients, their cases only went to the Minister recently and are still under review.

Prisoner A: diminished responsibility and guilty of manslaughter

The progress of the eleven forensic patients who have been or might soon be, conditionally released, and indeed, of the bulk of the forensic patients detained in New South Wales prisons and hospitals, is in marked contrast to that of a prisoner sentenced recently by Justice Matthews in the Supreme Court. In Her Honour's judgment (No. 70419/90, Friday 21 June 1991), she explained why she felt it necessary to sentence a man, Prisoner A, clearly 'most disturbed at the time of the killing', who pleaded not guilty of murder but guilty of manslaughter, on the basis of diminished responsibility. The plea was accepted by the Crown in full discharge of the indictment, however, Her Honour sentenced the prisoner to a minimum term of imprisonment of five-and-a-half years, and an additional term, to commence on the expiry of the minimum term, of a further eleven-and-a-half years. Her Honour said:
[One] of the primary considerations when sentencing a disturbed offender who has committed an indiscriminate killing such as this is the protection of the community, so long as the ultimate punishment is not excessive to the offence. But how can a sentencing judge predict when an offender might cease to be a danger to the public, and reflect this in a determinate sentence . . . ?

. . . [The] only course available to me is to ignore the proportions envisaged by [s. 5 of the Sentencing Act], and to impose a sentence in which the minimum term will bear roughly the same proportion to the total sentence as did many non-parole periods in the pre-Sentencing Act days. In other words, I propose to impose a relatively short minimum term and a very substantial additional period. This will give the prison and medical authorities a large area of discretion as to when the prisoner should be released according to his mental state at the time. In the interests of the community the total sentence will have to be a long one. For there will be no discretion as to his release when it expires. He will have to be released, no matter what his mental condition is at the time and this is a matter of considerable concern to me. However, it is very much to be hoped that the prisoner will have shown himself to be safe for release well before the expiration of his sentence. I repeat that the length of the sentence is attributable only to my concern that the prisoner might continue to present a danger to the public for a considerable time to come. Following a killing as serious as this the sentence I am about to impose is, I believe, well within a sentencing judge's discretion.

Justice Matthews found that had the matter proceeded to trial on issues other than sentence, there would have been a real possibility that the prisoner might have been acquitted on the ground of mental illness.

Prisoner A was charged in mid-1990. He was sentenced in mid-1991. At this time he is being detained in the Reception Centre of Malabar Correctional Centre. He is not a forensic patient and is not within the jurisdiction of the Tribunal. Accordingly, the authors do not know whether he is showing symptoms of mental illness, and whether he is receiving appropriate treatment. Prisoner A has a long history of schizophrenia, and has been receiving specialist treatment since 1984. His condition remained under control until late 1987, when a bizarre incident occurred. He had multiple admissions to mental hospitals, and at the time of the offence, was regularly attending hospital to receive moderate injections. We venture the opinion that the Reception Centre is an inappropriate place for the maintenance of a mentally ill person like Prisoner A.

Patient B: mentally ill and not guilty of wound with intent to murder

Prisoner A's case is in marked contrast to that of Patient B. Patient B was acquitted on the ground of mental illness of the offence of wound with intent to murder, in late November 1989. He was conditionally released in mid-1991. The conditions for his conditional release mandate the services of a qualified psychiatrist, Patient B's local medical practitioner, a community nurse, and a local community health centre. Following this acquittal on the ground of mental illness, Patient B was detained in the Long Bay Prison
Hospital for only some three weeks before being transferred to a cottage in the grounds of a mental hospital.

While both Prisoner A and Patient B have been given diagnoses of paranoid schizophrenia, it is inappropriate and unfair to compare their respective situations, because, in the words of one of the expert psychiatrists who gave evidence before the MHRT in patient B's case:

Paranoid schizophrenia anyway is simply a description of symptoms, it is not a diseased state as such.

Dr. X said:

Single isolated psychotic episodes [such as that experienced by Patient B] which recovers [sic] very well with medication and rehabilitation are unusual. I would question the diagnosis of paranoid schizophrenia and discard it.

Notwithstanding this obvious difference between Prisoner A and Patient B, a comparison between their respective fates must be salutary for those who are apparently still saying that forensic patient status should be avoided at all costs, by the defence seeking to hide mental illness behind a plea of guilty to a lesser offence than that for which the client was charged.

**Legal and ethical problems in hiding mental illness**

There are two other matters that need to be mentioned in this context. First of all, the ethics of such an approach from the defence would in some circumstances be questionable. Secondly, the High Court recently held in *R v. Falconer* ([1990] 171 CLR 30), that *the prosecution* may raise the issue of mental illness. In the words of Justices Deane and Dawson:

Nowadays it is often in the interests of the prosecution (or, at all events, the community) to raise the question of insanity, rather than in the interests of the accused. It used to be said that it was for the defence to raise a plea of insanity and not for the prosecution. That is probably still the case, but we think that the position has now been reached where it is only realistic to recognise that, if there is evidence of insanity, the prosecution is entitled to rely upon it even if it is resisted by the defence . . . It may be anomalous for the prosecution to raise the matter initially because the prosecution should not commence proceedings if it is seeking an acquittal, even on the grounds of insanity. The responsibility for the protection of the community in those circumstances lies elsewhere than in the criminal law. But we can see no reason why, if there is evidence which would support a verdict on the grounds of insanity, the prosecution should not be able to rely upon it in asking for a qualified acquittal as an alternative to conviction.

It is reported from Victoria that prosecuting authorities there are now commissioning independent psychiatric assessments of accused persons prior to their trials with a view to bringing the issue of mental illness before the court.
In this context, we again emphasise our opinion that the development of conditional release programs for persons acquitted on the ground of mental illness is to be encouraged and supported.

**Assessment of the Forensic Release System**

The current system for release of forensic patients is working well. But it will work well only while there is a Minister for Health who is prepared to review MHRT recommendations for release within the boundaries of the evidentiary and legal framework within which they were made. Consideration within this framework will mean that most recommendations for conditional release will be automatically approved, with some being sent back to the MHRT for its further consideration, based on queries or concerns which the Minister might hold about gaps in the evidence, relevant unresolved issues, and relevant issues which the MHRT has missed but which ought to be addressed before a recommendation for release could safely be implemented. The Tribunal has, in the year ending September 1990 under the 1990 Act, made 167 recommendations for relaxation in the prevailing restraints on the eighty-six patients reviewed: 119 have been approved, thirty rejected, and eighteen are still under consideration (see Table 9). The system also relies on the Minister promptly attending to the MHRT's recommendations. The MHRT recommendations are currently being quickly expedited. The system, nevertheless, has the inbuilt flaw of being vulnerable to ministerial abuse of discretion, and denial by a Minister of natural justice.

**Table 9**

**Outcome of Recommendations for Relaxation* in Prevailing Restraints made by Tribunal During the Period 3 September 1990–2 September 1991**

<table>
<thead>
<tr>
<th>Number of recommendations</th>
<th>Number approved by Minister</th>
<th>Number rejected by Minister*</th>
<th>Number still under consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td>167</td>
<td>119</td>
<td>30</td>
<td>18</td>
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</table>

* Some of these recommendations were subsequently approved on re-submission.

There is as well the overlay of discretion in the Attorney-General to determine that a forensic patient found to be no longer dangerous by the MHRT has 'served insufficient time in custody'. There is nothing in the legislation to guide an Attorney-General, acting bona fide, and determined to accord natural justice, as to the factors which are appropriately taken into account in determining whether a forensic patient has served 'sufficient time in custody'. The wide and unfettered discretion afforded an Attorney-General
by this legislation gives scope for mala fides on the part of an Attorney. There may one day in New South Wales be an Attorney who allows political factors to influence his or her discretion. There may one day in New South Wales be an Attorney who is fearful and ignorant about mental illness, and who allows his or her emotions to predominate in the exercise of his discretions. So broad and ill-defined is the Attorney's veto power, that an improper decision to refuse release might well conceal its impropriety, and prove unchallengeable before a court.

These mechanisms for ministerial veto, which in our view, make the forensic system inherently flawed, were obviously politically inspired. It is important to note that, through the entire course of the protracted and vigorous community and parliamentary debate over the draft mental health bill prior to its passage, with little amendment and assent, through both Houses of State Parliament, hardly a breath was spent or a drop of ink spilt on the forensic review provisions, even by those lawyers and psychiatrists who have, over the past decade, been intimately involved with the care, treatment, and disposition of forensic patients. Those in the community who, with us, see the forensic review system as fundamentally flawed, seem muted by the thought that the public, and politicians, are not yet ready to allow decisions about release back into the community of mentally ill people who have done dangerous, bizarre and frightening things, to be left to a body which cannot be voted out of office if it makes a mistake.

There is a discernible trend, derived from constitutional, United Nations, or European Community bills, covenants or charters of human rights, towards requiring access by persons who are unfit to be tried or who have been found not guilty on the ground of mental illness, to a decision-making body which is independent from the executive, and with determinative powers. The Law Reform Commission of Victoria has recommended that the rights of such detainees should be determined by an independent tribunal, rather than by executive decision-making. Jurisdictions in the USA have relied on guarantees in the Bill of Rights to afford access by forensic patients detained in prisons or institutions for the criminally insane to a definitive judicial determination of their right to be released. Expressing the trend in broad terms, it is viewed as unacceptable that a person who has never proved mentally fit to be tried, or who was found not guilty on the ground of mental illness, should be held for some indeterminate period, at the whim of a political figure. The growing mood in the Human Rights arena is well expressed in the case of Thynne, Wilson and Gunnell v. The United Kingdom (25 October 1990) when the European Court of Human Rights held that the United Kingdom had breached the European Convention of 1950 by reason of the absence of a judicial procedure for testing the continued lawfulness of their detention.

While highlighting the fundamental flaw in the New South Wales forensic review system, we must, nevertheless, chauvinistically point out that New South Wales is light years ahead of most other Australian jurisdictions, and indeed, most other common law jurisdictions throughout the English speaking world, in its approach to the release of people who have committed violent and dangerous acts while mentally ill. Some other Australian jurisdictions will be doing very
well, over the next ten years, to bring their systems for forensic review up to anything like the benchmark set by this State.

References


