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JUST DESERTS FOR THE MAD

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For Nadia,
Jason and Michael

Preface

Some years ago I came across a particularly interesting trial involving a plea of diminished responsibility. I was concerned to note that although the plea was successful, the offender was sentenced to penal servitude for life – the same sentence that he would have obtained had he been convicted of murder. This was despite the fact that the circumstances of the offence and the background of the offender contained weighty mitigating factors which, under ordinary sentencing principles, clearly justified a more lenient sentence. Of particular significance was the fact that the prisoner was thought to have permanent brain damage. The maximum penalty was imposed not because it was deserved but because, in the view of the trial judge, the prisoner presented a continuing threat to the safety of the community and could not be released while his mental infirmity remained. Presumably, as the prisoner's prognosis suggested incurability, he could not realistically hope to be released within his lifetime – a consequence more devastating than a normal sentence of life imprisonment.

This decision did not seem right and while I was busy considering my objections to it, the prisoner, Veen, appealed to the High Court of Australia. By majority the Justices of the High Court held that wrong sentencing principles had been applied. The Court, among other things, emphasised the importance of ensuring that sentences should not exceed the punishment merited by the offence. I was particularly impressed by the judgment of Murphy J. who considered that it was inconsistent with the aims of the criminal law, indeed 'a distortion' of the criminal law, to sentence offenders to longer terms than deserved on account of their mental illness or diminished responsibility. His Honour added that if the community required additional protection from the offender than that afforded by imposing the deserved punishment, then this

should be achieved, if it could lawfully be achieved, by methods outside the criminal justice system.

In this book I attempt to resolve some of the major practical and conceptual difficulties presented by the mentally disordered offender in the criminal justice and correctional systems. My arguments are based on a belief that both the community and the judiciary have developed a false or unrealistic expectation of the ability of the criminal justice system to effectively protect the community through its sentencing policies. So long as the limits of the criminal justice system as a means of protecting society fail to be recognised, unnecessarily harsh penalties will continue to be imposed without commensurate gains in the quality of life.

Throughout this book therefore, I examine, in greater or lesser depth, the dividing line, between the bad and the mad, between treatment and punishment, between concepts of responsibility and non-responsibility, between non-culpability and culpability, between civil commitment and criminal punishment, and in general terms, between utilitarian and retributive constraints upon the quest for community protection. Particular consideration is given to the power of the courts to deal with mentally disordered offenders and to the adequacy (or inadequacy) of facilities or penal institutions assigned with the task of containing and/or treating them. An attempt is made to explain how the penalty commensurate with the gravity of the offence can, or should be determined without seriously jeopardising either the attempt to meet the offender's mental health requirements or the legitimate demands of the community to see that justice is done.

The view of just deserts advocated here is not an inflexible one that trades concern for the individual for that of crass uniformity of punishment. It is a view of 'just deserts' that is treated as a limiting rather than as a defining principle of punishment. It attempts to promote uniformity of approach in sentencing by focussing upon the degree of culpability or blameworthiness of the offender, giving due regard to the circumstances of the particular offence, and to the subjective considerations pertaining to the individual offender.

It is self-evident that a just and humane society is bound to temper justice with humanity. Equally such a society should apply humane principles justly. *Just Deserts for the Mad* may therefore be seen as my attempt to describe an approach for dealing with

mentally disordered offenders within the bounds of conventional criminal justice concepts. It purports to provide a basis for the development of a flexible dispositional system that functions in a way that is just and humane, honest and fair, for those persons who find themselves at the interface of criminal law and mental health procedures.

I. Potas
October, 1981

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1 Introduction

In its Sentencing Reference the Australian Law Reform Commission was asked, *inter alia,* to examine the adequacy of existing laws providing alternatives to imprisonment. In this task the Commission was asked to collaborate with the Australian Institute of Criminology. The present book grew from its original purpose of providing a discussion paper for the Australian Law Reform Commission to a more comprehensive document which was thought worthy of publication in its own right. If special consideration is given to the criminal justice and mental health systems of the Australian Capital Territory, it is partly in order to accommodate the Australian Law Reform Commission's growing interest in this area, and even more importantly because the Australian Capital Territory has the unenviable distinction of being the most backward of Australian jurisdictions in this area of the law.

The aim of this book is however, to highlight Australia-wide issues relating to the disposal of mentally disordered offenders with the object of stimulating debate and more importantly, with the object of identifying many of the inadequacies that surround this most delicate and critical area of civil liberties and social control. Throughout this book important legal and procedural modifications are advocated with the aim of pricking the conscience of the community and stirring the lethargic machinery of law reform into action.

The scope of this book is broad. It is broad because it has been found necessary to go beyond an examination of sentencing *simpliciter* in order to allow the issues to be presented in a proper perspective. Inevitably the present analysis touches on procedural law, encompassing topics such as unfitness to plead and the insanity defence. Reference is made to the problems of providing treatment for those who become subject to criminal proceedings and in this

regard issues relating to the provision of adequate facilities designed to accommodate the needs of forensic patients are considered. Reference is also made to civil commitment procedures in an effort to explore the relationship of punitive and non-punitive modes of disposal.

Indeed the topics referred to and the problems they present would suggest that the whole area would benefit greatly from a discrete and thorough examination of mental illness and the law. The subject deserves a special reference to the Australian Law Reform Commission as well as to other state Law Reform bodies. At the present time there are such glaring inadequacies in the present system that reform should not wait for a final all-embracing blueprint before it can proceed. There is much reform that can and should be effected immediately. To procrastinate further is but to perpetuate obvious inadequacies in the present system.

What emerges from the present study is that in the realm of criminal justice systems generally, and particularly with regard to sentencing, the disposition of mentally disordered offenders presents not only a difficult, but also an oft neglected, segment of penal policy and practice. The difficulty stems partly from the subject matter itself so that the dilemmas of the forensic patient are left to languish unheeded, deposited, so it seems, in the too-hard basket of political priorities.

Until attention is drawn to the importance of the problem, nothing will be done to alleviate the suffering of the silent minority of mentally disordered persons – a minority for whom the general public spares little understanding, sympathy or concern.

In the normal course of events, sentencing involves an assessment of the objective circumstances of the offence, together with an assessment of the responsibility attributable to the actor. The task for the sentencer is to determine the degree of culpability and therefore quantum of punishment that is deemed appropriate. This is achieved, not only by reference to the offence, but also by taking into account all the circumstances of the particular case.

One such circumstance relates to the offender's mental condition at the time that the offence is committed. As shortly to be demonstrated, the provision of proper weight to this factor, is no simple task. In extreme cases the proven existence of a mental illness may negate the commission of an offence altogether, as in the case of a verdict of 'not guilty on the ground of insanity'. More usually

however, offenders are found to be criminally responsible even though they may be considered to have been mentally ill (in a clinical rather than in a legal sense) at the time of offending.

It is in these circumstances, except where the prescribed penalty is mandatory, that the question of mitigating the otherwise appropriate punishment arises. Whether a court will reduce the otherwise appropriate penalty, and if so the extent to which the court is likely to reduce the penalty, depends to a large extent upon the offender's diagnosis and prognosis. The reliability of such evidence by psychiatrists and psychologists, and indeed the concept of 'dangerousness' which is commonly imported into the assessment of sentence are themselves highly subjective and tenuous ingredients in the recipe for disposal. The problems are such that it is easier to ignore the issue of mental illness during the sentencing process and hope that other agencies will pick up the tab.

The neglect in resolving the problems of the mentally ill offender is explained but not excused by the difficulties that these problems present. Indeed there are so many categories of mentally disordered offenders that no single solution can be appropriate. Thus special considerations are presented by those who are held unfit to plead or to stand trial, those who are fit to stand trial but who are subsequently found to be insane (according to the legal test of insanity), and those who are found guilty but who nevertheless are considered, because of some mental infirmity, to be of diminished responsibility.

There is also a category of offenders who have been held fully responsible for their crimes but who subsequently, often while serving a sentence of imprisonment, suffer from mental illness during their confinement. Further complications relate to determining whether or not persons, who have committed serious offences and who are suffering from mental illness, are amenable to treatment, whether they can be trusted to remain in the community and undergo treatment designed to help them cope with their problems, or whether they should be held in secure custodial conditions on account of the gravity of their crimes or seriousness of their mental disorder.

Often when treatment and security objectives clash the result is an unhappy compromise. On the other hand consideration is given to the element of community protection even though this often

creates a conflict between treatment and security goals. There are however limits beyond which in justice, protection of the community may not be taken – a topic which is to be developed more fully in the latter part of this book. Difficulties also relate to determining the conditions under which forensic patients should be detained. Should mentally disordered offenders be held in psychiatric hospitals or prisons, should they be detained in prison-hospitals (hospitals inside prisons) or hospital-prisons (locked wards within the precincts of mental hospitals). The answer to these questions may differ depending on the category of offender under consideration, the treatment needs of individual offenders and the community interest in ensuring that those considered dangerous are contained in secure institutions while they continue to be, or at least while they continue to be considered to be, a substantial threat to the safety of others.

Further difficulties presented include definitional problems such as finding an answer to the question: 'What is mental illness?'. Then there are specific labelling problems which may affect the way in which the labellee is to be treated. Answers to the following questions are of vital importance: 'Is the particular offender mentally ill?' and 'What is the nature of the illness?'. Issues are complicated further by the fact that psychiatrists, psychologists, social workers, judges and juries are called upon to make judgments relating to the state of mind of an accused person, or convicted prisoner awaiting sentence, at a time long after the events in question. Thus, given that certain symptoms or manifestations of behaviour indicate that the offender is, or was, suffering from mental illness, the question becomes: 'Was the offender mentally ill at the time of the commission of the offence and if so, to what extent?'. Next, problems of prognosis and treatment arise. There will be cases where there is no cure for the patient's mental disorder. The question: 'Is the offender's condition amenable to treatment?' is a critical step in determining the range of options that may be open to the sentencer. Once the enquiry proceeds to examine the prisoner's treatment needs, ethico-legal considerations are brought to the fore.

There are issues relating to prisoner's rights to have and to refuse treatment. Then there are considerations relating to treatment resources, for unless there are appropriate medical facilities and psychiatric services available the offender's needs cannot be

accommodated. No doubt there are cases within prison walls where mentally disordered persons who might otherwise benefit from treatment go unidentified and ignored. How are the interests of these persons to be catered for? Ultimately and despite all these considerations, the sentencer when presented with evidence relating to mental disorder, is placed in an unenviable position in that the assessment at the point of disposal often draws upon expert medical opinion which itself is controversial, inferential and speculative.

TOWARDS COMMUNITY BASED TREATMENT

Punishment and treatment have never been happy bed-fellows under the auspices of criminal justice systems. Correctional authorities have not always seen eye to eye with health services, and understandably so, as the approach and philosophies of these agencies may at times be diametrically opposed to each other. For example, the need to detain an individual in a prison may be contra-rehabilitative from a mental health perspective, but perfectly acceptable from, for example, a 'just desert' model of corrections. What may be best for the individual may not necessarily be best for the community and *vice versa.*

In Australia the administration of mental health 'care' is towards community-based treatment; the trend away from institutionalisation is of comparatively recent date. Indeed the new philosophy and the change of attitude towards the mentally ill which this new philosophy heralded, appears to have established itself in England by about the mid-1950s. The British Royal Commission on the law relating to mental illness and mental deficiency,[1] (the Percy Report) which was set up to examine its *Lunacy and Medical Treatment Acts,* 1890-1930 and the *Mental Deficiency Acts,* 1913-1938, resulted in altering substantially the way in which those certified 'insane' were to be treated and set the tone for a more humane attitude.

The Commission had regarded earlier legislation as attaching moral blame to those labelled insane. The change meant that from now on impairment of the mind was to be equated with that of

1. 1954-1957 Report Cmnd. 169 (1957).

physical illness. The recommendations of the Percy Report, which formed the basis of the *Mental Health Act* 1959 of England and Wales, had a profound effect not only in Britain but also beyond its shores. Its influence spread quickly throughout parts of North America, Africa and the Commonwealth, including Australia.[2] In the United States in 1955 for example, there were 558,000 people in mental hospitals. By 1980 this figure had dropped dramatically to 150,000.[2A]

Indeed, the object of the legislation intended to cover compulsory commitment to mental institutions, as set out at paragraph 136 of the Percy Report, may even today be accepted as the guiding principle for mental health legislators in Australia. It states as follows:

> In our view, as in the view of almost all our witnesses, individual people who need care because of mental disorder should be able to receive it as far as possible with no more restriction of liberty or legal formality than is applied to people who need care because of other types of illness, disability or social or economic difficulty. But mental disorder has special features which sometimes require special measures. Mental disorder makes many patients incapable of protecting themselves or their interests, so that if they are neglected or exploited it may be necessary to have authority to insist on providing them with proper care. In many cases it affects the patient's judgment so that he does not realise that he is ill, and the illness can only be treated against his wishes at the time. In many cases too it affects the patient's behaviour in such a way that it is necessary in the interests of other people or of society in general to insist on removing him for treatment even if he is unwilling. This makes it necessary to have compulsory powers to override the normal personal rights of individuals in certain circumstances. **Special legislation is necessary (a) to define the circumstances in which such powers may be used and to provide safeguards against their abuse; (b) to protect patients' property when they are incapable of managing**

2. Larry O. Gostin, 'The Merger of Incompetency and Certification: The Illustration of Unauthorised Medical Contact in the Psychiatric Context', (1979) 2 *International Journal of Law and Psychiatry* 127.

2A. What has happened to the difference? It seems that some 400,000 persons are now being supported by community mental health or mental retardation services or are in correctional institutions. R. Kiel, 'Mental Health for the Convicted Offender: A model that works', (January/February, 1981) *Corrections Today* 24.

> **their own affairs; and (c) in connection with criminal cases. In our view these are the only purposes for which special mental health legislation is still needed.**
>
> **(Emphasis added).**

A contemporary view of the philosophy and approach towards the mentally ill was given recently in a paper presented by the Director of the Mental Health Branch of the Australian Capital Territory's Health Commission at a public seminar held in Canberra in 1975. The view expressed was that:

> Today a mentally ill person is likely to need hospital care only during his more serious relapses. Throughout his periods of remission he is likely to be able to resume his place in his family, and in society, although sometimes at a reduced level of social competence. There is now an emphasis on therapeutic and social support for the patient in the community and mental health workers are beginning to concern themselves with genetic, family, social and environmental factors in the cause and control of mental disorders. Thus mental health care is no longer a purely medical prerogative, but a cooperative responsibility of medical, psychological, social and lay workers. This medico-social model of care, with its necessary involvement of diverse professional and lay counsellors, needs to be reflected in the regulating and controlling functions of [the proposed new Mental Health Ordinance for Territory].[3]

The emphasis is clearly on out-patient care where this alternative is reasonably available, in preference to hospitalisation. This 'open-door' policy is tied to the belief that rehabilitation is more effective in the community. In relation to this there can be seen a parallel approach in criminal justice circles, with the growing view that imprisonment itself should be used as a sanction of last resort, and further that rehabilitation in prison is seldom likely to be effective.

LIMITING STATE INTERFERENCE

Contemporary mental health policies share with developing penal policies of criminal justice agencies, the belief that compulsory institutionalisation should be avoided in so far as this is

3. From an unpublished paper by Dr Mickleburgh presented at a seminar on a proposed Mental Health Ordinance for the Australian Capital Territory, Canberra, 26-27 September, 1975.

possible. Thus mental health workers advocate voluntary treatment on an informal basis where harm to the patient, or to other persons or property, are not unduly put at risk. On the other hand, mental health professionals also demand the mechanism for enabling them to deal with cases where voluntary treatment is not practicable. The right or just amount of interference, or coercion in a particular case might best be viewed as a continuum where the appropriate degree of compulsion is determined by a delicate balancing of interests – those of the patient, those of society and also those of the intervening medical practitioner or therapist.

What is abundantly clear is that given a choice, an order that a person should receive psychiatric treatment or attend a therapeutic program while permitting that person to remain in the community is to be preferred to an order requiring the involuntary commitment of a person at an institution for the mentally ill. As the patient's ability to adequately function in the community decreases, the State's authority to interfere with the individual's autonomy increases. Built into any such system a high level of tolerance is demanded, allowing individuals an optimum degree of freedom of expression or of behavioural eccentricity. At a point where the patient becomes violently destructive of persons or property, the right of the mental health or criminal justice authority to intervene arises. As a general rule the guidelines provided in s.9 of the *Mental Health Act* 1976 of South Australia provides a useful statement of policy to be followed. It states that 'restrictions upon the liberty of patients, and interference with their rights, dignity and self respect' should be minimised 'so far as is consistent with the proper protection and care of the patients themselves and with the protection of the public'.

The degree of compulsion to be used in any individual case should therefore be consistent with the minimum amount of interference necessary to achieve the desired degree of control. The actual level of control in any given society will depend on that society's capacity or willingness to tolerate deviant behaviour, and upon the procedural and administrative mechanisms in that society for enforcing such control. With regard to criminal matters the degree of compulsion measured from the standpoint of punishment needs to be balanced against the gravity of the offence and *inter alia,* against the mental condition of the offender. Hence the nature, quality and duration of any proposed treatment have

relevance, but as expounded in the Australian Law Reform Commission's discussion paper number seven, and as discussed later in this book, the severity of the coercive component employed should not exceed the gravity of the offence.[4]

If more therapy is required than is commensurate with the gravity of the offence, either in duration or kind, this must be achieved through channels outside the specific precincts of the criminal law. It must nevertheless be achieved within the boundaries of the general law if order is to be maintained. In severe cases involuntary commitment procedures, hospital orders or imprisonment may be the only appropriate responses for the management and control of offenders presenting a danger to the community. These issues will be expanded upon in the ensuing pages. For the present it should be noted that it is a fundamental principle, and indeed an assumption underlying the arguments contained in this book that treatment within the community is generally to be preferred to institutional care, and that the use of the latter should be reduced to an absolute minimum.

A further, and recurring theme is that although the present study relates to the disposition of mentally disordered criminal patients, humane considerations demand that these persons be afforded the same opportunities for treatment and the same rights to decline treatment as are available to the general public.

Rehabilitation of the mentally ill offender in so far as this goal is achievable, is for obvious reasons, both in the interests of the offender and of the community. Where the offender is serving a term of imprisonment and there is a conflict between a treatment program, which advocates returning the offender to the community as a necessary or even desirable part of treatment and, on the other hand, continuing the custodial measure in order to ensure that the offender is not released (on grounds of community protection, or because the offender has not served the minimum term of imprisonment commensurate with the gravity of the offence), it may be appropriate to sacrifice the potential benefit that early release may have upon such an offender for the purpose of community protection.

4. I. Potas, *Limiting Sentencing Discretion: Strategies for Reducing the Incidence of Unjustified Disparities*, (Australian Law Reform Commission, Sydney, 1979), pp. 69-71.

However, unless the offender is sentenced under legislation requiring preventive detention, or unless the offender is certifiable under laws applying to civil commitment, she/he should be released no later than the expiry date of the sentence. This theme also will be developed later where it will be argued that the role of the criminal law in protecting the community is a strictly limited one. Penal law should not be permitted to trespass into the province of civil law, which also serves to protect the community. Thus it follows that several principles of general application are applicable to the handling of mentally disordered offenders. For example, where the term of imprisonment fixed by the court (less remissions) has expired, and the offender's condition is such that further in-patient treatment is considered necessary by the appropriate authorities, the proper course would be to place the offender in precisely the same position as any other citizen who is being dealt with in accordance with ordinary civil involuntary commitment procedures. In this regard an adequately represented Mental Health Review Tribunal should be constituted for the purpose of ensuring that all proper procedures are followed and in particular, for ensuring that the interest of individual offenders, who invariably are in a position of weakness, are adequately protected against unfair or arbitrary decision-making. One of the functions of such a tribunal would be to ensure that persons detained involuntarily are not forgotten by the bureaucracy and allowed to languish unnecessarily in institutions. Legislatively sanctioned regular reviews of detainees would be one means for ensuring that mentally disordered offenders are not forgotten or otherwise unfairly treated.

Furthermore, adequate appeal provisions against involuntary commitment orders, and in turn appeals to the Supreme Court, where such appeals are not presently available, should be made available, in order to allow challenges to be made with regard to unfavourable determinations of the Tribunal. It goes without saying that the right to be legally represented at such appeals, as indeed at all judicial hearings affecting the liberty of the individual, should be considered a fundamental right, and enshrined in legislation. A useful precedent for the structure and role of such a Tribunal is contained in ss.35-38 of the *Mental Health Act* 1976 (South Australia).

For reasons already expressed the present study will concentrate

mainly on the problems faced by the Australian Capital Territory – a jurisdiction which uses New South Wales institutions for incarcerating offenders – whether this incarceration relates to ordinary imprisonment or to involuntary commitment of mentally ill persons to mental institutions. In the course of discussing the problems and issues in the Australian Capital Territory, other jurisdictions will be briefly examined and compared with a view to providing a set of broad principles of general application to all jurisdictions. It is in this way that the material to be presented has relevance to all jurisdictions. Indeed all Australian States, the Commonwealth and the Territories have their own systems for dealing with mentally disordered offenders. They are all based on the English common law system so that it is not surprising to find that these jurisdictions have more in common with each other than differences. What is increasingly clear is that some jurisdictions have more sophisticated and flexible criminal justice and mental health systems than do others, thereby enabling them to cope more effectively with mentally ill offenders. The disparity of systems in Australia is a mixed blessing for the law reformer because it is possible to study and to select or isolate the best features of each system, discard the worst and present them in a parcel of recommendations aimed at making improvements in the status quo.

THE HOSPITAL ORDER

Thus one of the principal issues to be pursued is to consider whether Australian courts have adequate powers to sentence or otherwise dispose of cases in those circumstances where it is clear that the ordinary principles of punishment seem inappropriate for dealing with the offender's mental disorder (whether this disorder exists at the time of the offence, or at any later stage prior to disposal), and some form of treatment appears to be required.

For example, in England under s.60 of the *Mental Health Act* 1959, courts are empowered to make orders authorising the admission of a person to be detained in a hospital provided that they are satisfied, on the evidence of two medical practitioners, that the offender is suffering from a mental illness (or other abnormality

defined in s.4 of the Act),[5] and that the nature or degree of the disorder warrants the detention of the person in a hospital. Before making a hospital order the court must be satisfied of a number of matters including the fact that a hospital order is the most suitable method of disposal, and that there is an institution that will receive the offender. Some of the more serious cases are sent to one of the four special hospitals: Broadmoor, Rampton, Moss Side or Park Lane, which are run as hospitals for criminally violent persons who require special security. Other offenders subject to hospital orders are placed in ordinary hospitals run by the National Health Service. Where such an order is made, the court may not pass a sentence of imprisonment in respect of that offence. In short, a hospital order is imposed in lieu of a sentence of imprisonment.

Discharge from hospital under a hospital order is a matter for the doctor or the Mental Health Tribunal except where the order

5. Section 4 provides as follows:

> **(1)** In this Act 'mental disorder' means mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of mind; and 'mentally disordered' shall be construed accordingly.
>
> **(2)** In this Act 'severe subnormality' means a state of arrested or incomplete development of mind which includes subnormality of intelligence and is of such a nature or degree that the patient is incapable of living an independent life or of guarding himself against serious exploitation, or will be so incapable when of an age to do so.
>
> **(3)** In this Act 'subnormality' means a state of arrested or incomplete development of mind (not amounting to severe subnormality) which includes subnormality of intelligence and is of a nature or degree which requires or is susceptible to medical treatment or other special care or training of the patient.
>
> **(4)** In this Act 'psychopathic disorder' means a persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to medical treatment.
>
> **(5)** Nothing in this section shall be construed as implying that a person may be dealt with under this Act as suffering from mental disorder or from any form of mental disorder described in this section, by reason only of promiscuity or other immoral conduct.

is coupled with a restriction order under s.65 of the Act. A restriction order may be imposed at Crown Court level (but not below) and may either involve the specification of a fixed term, in which case the offender may not be released (discharged) from hospital before that term expires, or alternatively the order may be 'without limit of time', that is, it may be indefinite. In the latter circumstances the restriction cannot be lifted without the consent of the Home Secretary. Once the restriction order is lifted or the restriction otherwise expires, the case is treated as a hospital order *simpliciter.*

The rationale for imposing a restriction order is that an offender who is considered likely to commit (further) acts of violence or aggravated sexual offences should be kept out of circulation for a period of time in order to protect the community. Implicit in the need for such an additional measure is the fear that doctors may for whatever reason exercise their discretion and release a person prematurely. The principal criterion for the application of a restriction order is that of dangerousness. It would appear that the English courts favour the use of an indefinite restriction except where it is clear that a cure can be brought about within a fixed period.[6]

RESERVATIONS RELATING TO HOSPITAL ORDERS

To assume that a hospital order is not punitive is to misconceive the object of this sanction. It shares with imprisonment the consequences of depriving an individual of his or her liberty. Like imprisonment it affords protection to the community by separating inmates from normal societal intercourse. Unlike imprisonment however, the aim of this disposition is to provide remedial action in the form of medical or psychiatric treatment in an attempt to rehabilitate or to retard the deterioration of a mentally disordered person. It is here that the object of rehabilitation assumes most

6. *Gardiner* [1976] 1 All E.R. 895 *Toland* (1973) 58 Cr. App. R. 453. For useful description of the operation of hospital, guardianship and restriction orders, see Sir Rupert Cross, *The English Sentencing System,* (2nd ed., Butterworths, London, 1975), pp. 63-66. For greater detail see *Report of the Committee on Mentally Abnormal Offenders,* Chairman, Lord Butler (hereafter The Butler Report) Cmnd. 6244 (H.M.S.O., London, October, 1975), esp. ch. 14.

meaning. Unfortunately, it is here also that the rights and liberties of individuals are at greatest risk. It is therefore imperative that adequate provision be made for ensuring that the potential for abuse of such a sanction is minimised.

Indeed the dangers of treatment in an institutional context are well documented and have been brought to the attention of the general public through books and films such as *A Clockwork Orange*[7] and *One Flew Over the Cuckoo's Nest*.[8] In *A Clockwork Orange* for example, society's response to violence lay in the use of drug-induced treatment. This was the Ludovico technique of aversion therapy, the aim of which was to make patients violently ill by the very thought of violence. The consequences of such a cure are horrific. In the novel it destroyed the personality of the protagonist by reducing him to a malleable, zombie-like state. Under such a treatment-oriented regime is seen a far more insidious and cruel form of social control than is acceptable to any society which boasts humanitarian principles. A similar warning comes from *One Flew Over the Cuckoo's Nest* where the decision to 'rehabilitate' a troublesome as opposed to a sick patient through psychosurgery presents a far more terrifying fate than that of imprisonment.

The potential for abuse of chemical and surgical forms of treatment, especially with regard to those persons who are held in prisons or mental institutions, calls for the highest level of vigilance. This is so in order to ensure that basic human rights are not infringed by those in power – particularly the white-coated diagnosticians and prognosticians, the wielders of the hypodermic needle and the manipulators of the surgeon's knife. It is the law that must provide the framework for reducing the incidence of abuse by declaring the limits beyond which treatment should not go, and by providing the procedural checks and balances to ensure so far as possible that the vulnerable are protected to the full extent of the law. Within this framework, the ethics of the medical profession must also play a significant part by respecting the autonomy of the individual and guarding against experimentation, neglect or improper treatment which endangers the health, the life and the liberty of the patient.

7. A. Burgess, *A Clockwork Orange*, (Heinemann, 1962).
8. K. Kesey, *One Flew Over the Cuckoo's Nest*, (Methuen & Co. Ltd., Great Britain, 1962).

That any measure involving involuntary or partially coercive hospitalisation should be carefully designed to cater for a specific category of offender only, and that the treatment conditions should be carefully controlled, monitored and reviewed not only by the medical profession into whose care the recipient is entrusted, but also by legal and civil libertarians, are vital preconditions for the introduction in Australian jurisdictions of any treatment or hospital order type of disposition. Equally the duration of the incarceration, and the mechanism for release from such incarceration must be carefully designed to ensure that in cases involving a punitive component, the term served on account of the punitive component is neither too long nor too short.

Where the prisoner can no longer be benefited by hospitalisation, but the punitive component of the sentence imposed has not been satisfied and there is a restriction operating to prevent the hospital authorities from determining the premature release of the prisoner, the appropriate course would be to transfer the prisoner to prison for the balance of the appropriate term. This would be a departure from the English system of hospital orders where the measure imposed is in lieu of sentence, but would accord with the Tasmanian system, which in most other respects replicates the English model.

Indeed Tasmania has a system of hospital orders, modelled on the British Act but with some distinguishing features to be considered in some detail below. New Zealand also seems to be more advanced than most Australian jurisdictions, because it too has a system of court ordered hospitalisation.[9] Interesting variations of disposal also exist in Queensland, Victoria and the Northern Territory, and these too will be briefly discussed. For present

9. See *Criminal Justice Act*, 1954 (N.Z.) ss.39B, 39G, 39J, 47A and the *Summary Proceedings Act*, 1957 (N.Z.) s. 171(3). Also under the *Mental Health Act*, 1969 (N.Z.) ss.42 and 43 there are provisions for the hospitalisation of special patients (persons needing hospitalisation when entering the criminal justice system). For voluntary and involuntary civil commitment proceedings see ss.15 and 24 of the *Mental Health Act*, 1969 (N.Z.) respectively. Canadian provisions are also of interest, see generally the *Canadian Criminal Code* ss.465, 541, 608 and 738. Provincial mental health legislation also contains psychiatric remand legislation, for example, see Ontario Mental Health Act ss.14 and 15. Complications arise in Canada on account of overlapping federal and provincial law, discussed in M. Schiffer, *Mental Disorder in the Criminal Trial Process*, (Butterworths, Toronto, 1978), p. 51.

purposes it should be noted that a hospital order option is not readily available in most jurisdictions, including the Australian Capital Territory and under Commonwealth laws generally. The options for dealing with 'mentally ill' offenders, that is offenders found unfit to plead, or found not guilty on the grounds of insanity will also receive separate attention.

INADEQUACY OF OPTIONS

For the present it is submitted that existing laws under the Commonwealth and under the laws of the Australian Capital Territory are grossly inadequate when it comes to dealing with offenders who, upon their trial or prior to sentencing, exhibit clear symptoms of mental disorder. This is particularly obvious in circumstances where treatment rather than punishment appears to be the more appropriate response. For example, where a mentally disordered person has been convicted of an offence the present practical options in the Australian Capital Territory are limited essentially to a sentence of imprisonment coupled with a recommendation that the offender should receive psychiatric treatment appropriate to his or her needs while in prison (possibly with an expectation that the prisoner will be transferred from prison to an appropriate mental institution should the treatment available in prison prove to be inadequate), or to an order (recognisance) under which the offender is released into the community on condition, *inter alia,* that he or she, as the case may be, agrees to undertake a course of treatment as an out-patient at a clinic or hospital.[10]

Similar dispositional limitations are seen to apply in all States that do not have a system of hospital orders. The problem to be considered therefore is whether there is a need for new laws providing an alternative to both outright incarceration in a penal institution and conditional release in the form outlined. In other words an answer is sought as to whether there ought to be a sentencing option (in those jurisdictions that do not possess such

10. Similar practical limitations apply under Commonwealth laws and to the laws of most of the other Australian States. In order to contain the discussion, references to these jurisdictions are kept at a minimum.

option) where the essence of the disposition is that the offender is 'sentenced to receive help' in a psychiatric institution rather than sentenced in the ordinary course of events to a term of imprisonment in a conventional prison.

2 The Meaning of 'Mental Illness'

Being tagged a mentally ill person is often enough to provide the threat, justification or excuse for depriving an individual of many of his or her normal civil rights. This is so whether the person concerned has committed an offence or not. For this reason it is necessary to understand what is meant by concepts such as 'mental illness', or 'insanity' or 'mentally ill person'. Unfortunately these questions are easier to ask than to answer satisfactorily.

According to a study in 1966 conducted at the Rozelle Admission Centre at Callan Park Hospital in Sydney, there exists a dramatic overuse of involuntary admissions. The study revealed that from a sample of 100 patients involuntarily admitted to that hospital, only about 34 committals were considered to be appropriate admissions within the meaning of the *Mental Health Act* 1958 (New South Wales).[11] This disturbing statistic may be explained at least in part by the inadequate guidance in the Act relating to those who are eligible for involuntary commitment, which in turn stems partly from the vagueness of the terms 'mentally ill' and 'mentally ill person' as defined in the Act. Section 4 of the *Mental Health Act*, 1958 (New South Wales) states as follows:

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11. O.V. Briscoe, 'The Meaning of 'Mentally Ill Person' in the Mental Health Act, 1958-1965 of New South Wales', (1968) 42 A.L.J. 207. See also *In the Matter of an Alleged Incapable Person*, (1959) W.N. (N.S.W.) 477 and also *R. v. Veen* 6 August 1977, unreported decision of the N.S.W. Court of Criminal Appeal, per O'Brien J. discussed in I. Potas, *Sentencing Violent Offenders in New South Wales*, (Law Book Company, Sydney, 1980), p. 1047ff., particularly at pp. 1053, 1054. Overuse of admissions to hospital is not restricted to New South Wales, for example, refer to the Directory of Mental Health Services in Victoria (1976) where the Mental Health Authority states that in the majority of cases admission to hospital is not necessary, *ibid.*, p. 6.

> 'Mentally ill person' means a person who owing to mental illness requires care, treatment or control for his own good or in the public interest, and is for the time being incapable of managing himself or his affairs and 'mentally ill' has a corresponding meaning.[12]

The definitions have been described as being circular: "mentally ill' is defined in terms of itself – that is a 'mentally ill person' is one suffering from mental illness of defined severity, a statement which does not solve the problem of what the Act means by mental illness'.[13] There is no definition of the term 'mental illness' itself although it is probably intended to have a 'pragmatic and commonsense meaning'.[14] Another commentator has described the definition of a 'mentally ill person' as dubious, circular, vague and therefore capable of embracing persons 'who ought never to be caught by the Act'. The commentator adds the following observations:

> We might well wonder, whether we be legal or medical practitioners, just what is meant by these elements of the definition 'care', 'control', 'for his own good', 'in the public interest', 'incapable of managing himself', not to mention what is 'mental illness'. We might well ask how to define, and who defines 'for his own good', and whether 'the public interest' in the context of the Mental Health Act means the same as it does in the context of, say, public law.
>
> A variety of possibilities come to mind in relation to defining 'mental illness'. Incapacity resulting from a stroke? Alcoholism? Homosexuality? Psychosis? Neurosis? Incapacity arising from old age? Surely this definition needs to be clarified. For it is on the basis of whether or not a person is assessed as being a 'mentally ill person' that the rest of the Act comes into effect.[15]

FLUCTUATING MEANINGS

Freiberg, in a comprehensive article relating to the disposition of mentally disordered persons involved in criminal proceedings, also refers to the difficulties inherent in current definitions of 'mental illness' and related concepts, noting that the definition

12. Cf. *Mental Health Act*, 1959 (England and Wales) s.4, *supra*, n.5.
13. O.V. Briscoe, *op. cit.*, p. 209.
14. *Ibid.*
15. Pat O'Shane, 'Comment: *Mental Health Act*, 1958 (N.S.W.)' [1978] 2 U.N.S.W.L.J. 398, 399.

'seems to change chameleon like, with each stage of the criminal process'.[16] Undoubtedly this observation is intended as a criticism of current definitions. However there is a lesson to be learned here, namely, that there can be no single satisfactory all-embracing definition. Instead this revelation should constitute an acknowledgement that the term 'mental illness' is a complex concept best defined in broad terms in order to permit the individual meaning to be derived from the context and according to the purpose for which it is used. Nor should the vagueness of the definition imply a humpty-dumpty approach of allowing 'mental illness' to mean whatever the user intends it to mean. Rather it implies that the term should have a consistent meaning when it is used for similar kinds of purposes.

Thus, restricting the definition for present purposes to forensic patients, the meaning may change according to whether it is used in connection with:

(a) persons found to be unfit to plead or who are otherwise found to be insane on arraignment or during trial,[17] or;

(b) persons acquitted on the ground of insanity,[18] or;

(c) persons serving prison sentences who warrant transference to mental institutions for treatment.

A fourth and discrete category positioned between (b) and (c) may be added to this classification. For convenience this may be labelled (d).

(d) persons convicted of an offence, but owing to their mental condition are considered primarily to require treatment rather than punishment, or at any event, are entitled to have

16. A. Freiberg, 'Out of Mind, Out of Sight: The Disposition of Mentally Disordered Persons involved in Criminal Proceedings', [1976] 3 Mon. Law Rev. 134, 137.
17. See *R.* v. *Podola* [1960] 1 Q.B. 325; *R.* v. *Presser* [1958] V.R. 45; *Ingram* v. *A.G. for the Crown* [1980] 1 N.S.W.L.R. 190; *Golobic* v. *Radau* (1981) 33 A.L.R. 61.
18. *R.* v. *Porter* (1933) 55 C.L.R. 182.

their mental conditions taken into account in determining sentence.[19]

Thus to qualify as being mentally ill for the purpose of determining whether the accused is fit to plead or stand trial is different from determining whether the offender is to be acquitted of the crime on the grounds of insanity under the M'Naghten Rules. The M'Naghten criteria considered in the following chapter should be compared with the criteria for unfitness to plead given by Smith J. in *Presser*.[20] His Honour said:

> [The accused] needs, I think, to be able to understand what it is that he is charged with. He needs to be able to plead to the charge and to exercise his right of challenge. He needs to understand generally the nature of the proceedings, namely, that it is an inquiry as to whether he did what he is charged with. He needs to be able to follow the course of the proceedings so as to understand what is going on in court in a general sense, though he need not, of course, understand the purpose of all the various court formalities. He needs to be able to understand, I think, the substantial effect of any evidence that may be given against him; and he needs to be able to make his defence or answer to the charge. Where he has counsel he needs to be able to do this through his counsel by giving any necessary instructions and by letting his counsel know what his version of the facts is, and, if necessary, telling the court what it is. He need not, of course, be conversant with court procedure and he need not have the mental capacity to make an able defence; but he must, I think, have sufficient capacity to be able to decide what defence he will rely upon and to make his defence and his version of the facts known to the court and to his counsel, if any.

Category (c) appears to imply a straight medical definition of mental illness, suggesting treatability, and not involving notions relating to culpability or blameworthiness. Care needs to be taken however, lest at this juncture the medical model is used only as a pretext to remove troublesome prisoners from the prison environment.

Category (d) offenders present the most difficult class of offenders because they are not sufficiently mentally ill to be absolved from responsibility for their actions, but these same persons may nevertheless appear to present a need for treatment. Somehow the clinical diagnosis that the offender is mentally

19. *Veen* v. *R.* (1979) 53 A.L.J.R. 305; *Channon* v. *R.* (1979) 20 A.L.R. 1.
20. [1958] V.R. 45.

disordered is taken to mitigate or detract from the degree of blameworthiness that would otherwise be attracted as a consequence of the commission of the crime.

Again the determination of mental illness is essentially a clinical one, although it may also involve a legal component as in the case of diminished responsibility. For example, it may be that the accused is not in fact mentally ill, but is able to persuade a jury to the contrary, thereby securing a more favourable verdict. It is important to recognise that responsibility as a legal concept should be distinguished from the fact that the offender may also be mentally ill. Thus in order to allow mental disorder to operate as a mitigating factor it is necessary to show that the mental disorder affected the offender's behaviour in a material way. Unless this can be shown, mental illness cannot validly be used as a basis for diminishing the offender's responsibility for the act.

The more usual response in category (d) cases is for the court to impose a bond or probation order with a condition that the offender should submit to psychiatric treatment. If the offence is of a high order of gravity the court may sentence the person to imprisonment primarily as a means of protecting the community. The court may sentence the person to imprisonment also with the hope or expectation that the prisoner will receive the necessary psychiatric treatment in prison, or failing this in the hope that the prison authorities will transfer the person to a mental institution when and as required. Unfortunately, as already indicated in most jurisdictions, a court has no power other than to recommend that an offender sentenced to imprisonment should receive treatment. Further, prison must be the least satisfactory environment in which to achieve improvements in the mental health of an individual. Indeed it would appear that in most prisons, treatment needs are ignored or go undetected.[21]

There is therefore in category (d) cases, a need to identify such cases and in some cases at least, provide a disposition that is primarily non-punitive and treatment orientated, yet at the same

21. For example, refer to the criticisms relating to health care in N.S.W. prisons in the *Report of the Royal Commission into N.S.W. Prisons*, (The Nagle Report), (Govt. Printer, Sydney, 1978), ch. 24, pp. 272-281. Discussed *infra*. p. 115ff.

time one intended to keep the prisoner for reasons of community protection, under lock and key. This involves the addition to the sentencing armoury of a hospital order form of disposal.

Other possible (desirable) solutions include the establishment of half-way houses for persons needing treatment but who can otherwise function adequately in the community and a treatment or psychiatric probation order that would replace the recognisance or ordinary probation order. Further consideration of these issues are discussed in the ensuing pages.

At this stage two points are stressed. First, whatever improvements may be made in definitions relating to mental illness, it is submitted that terms encompassing this concept should remain sufficiently vague to enable them to accord with improvements in psychiatric knowledge. Equally the definitions should not be so vague as to render them meaningless or uncertain. The task is to strike the right balance – a balance that may not, indeed probably will not, satisfy all factions of the community.

Second, it should be conceded that the same term, mental illness, is likely to have a different meaning according to the application for which it is used. For example, it is recognised that mental illness for the purposes of the insanity defence is intended as a test of responsibility, an ethico-legal definition and not a medical one. Thus, there is no contradiction in holding that a person at a particular point in time was mentally ill but may properly be held accountable for his or her actions. This is because the offender may satisfy the cognitive test of knowing the nature and quality of the act and knowing that the act was wrong, even though at the same time the offender was suffering from an identifiable mental illness. There are ample examples of such cases.[22] It is particularly well illustrated in the application of the special defence of diminished responsibility – a defence which acknowledges the joint presence of severe mental disorder and culpability on the part of the offender.

22. See for example, *R.* v. *Nell* (1969) 90 W.N. (Pt. 1) (N.S.W.) 91; *R.* v. *Kocan* (1966) 84 W.N. (Pt. 1) (N.S.W.) 588. Discussed in I. Potas, *op. cit.*, n. 11, p. 1047ff.

MODELS OF MADNESS

In the context of discerning the object for which the definition of mental illness is intended, the use of models, or summaries of the way in which mental illness may be viewed, is instructive. Thus, Mickelburgh and Porritt advocate a 'medico-social model', rather than a 'social-deviance' model.[23] In their view the former model acknowledges the existence of mental disorders, while the latter is concerned primarily with 'labelling segregation and control that locks the deviant person into the role of patient' but at the same time refuses to recognise the existence of mental disorder. A person acquitted on the grounds of insanity and subsequently detained at the Governor's pleasure may fall into either of these alternative models, yet in practice it is the latter that is applied. Bates has identified the following models, each of which provides a different emphasis or slant on proposed definitions of mental illness:

1. The classical medical or disease model.
2. The disease model modified by the inclusion of the 'sick role'.
3. Community psychiatry, a medico-social model.
4. Sociological models, which regard madness as a deviant social role.
5. Antipsychiatry, a conspiratorial model with legal overtones.
6. The educational model.
7. The self-help model.[24]

Bates comments *inter alia* that the acceptance of one or other of these models has important implications for the way in which people labelled mad will be treated. She writes:

23. 'Translating Madness Theory into Legislation' in *Mental Disorder or Madness: Alternative Theories*, Bates and Wilson (eds.), (University of Queensland Press, St Lucia, 1979), p. 57, esp. p. 59.
24. 'Alternative Thories of Madness', *ibid.*, p. 21. See generally E. Bates, *Models of Madness*, (University of Queensland Press, St Lucia, 1977).

> If, for example, 'mad' people are seen as being sick, they will go to doctors for a cure, and the doctors will use drugs in hospitals where nurses will care for these patients. If, on the other hand, it is society or the family which drives people mad, these unfortunate victims of their environment may get together and fight the system, leaving their families and their society and perhaps developing new types of social living such as communes. Or, if madness is seen as merely a legal construct to get disturbed people out of the way, then changes in the law would solve the problem.[25]

The search for an appropriate definition of mental illness would certainly be simplified if all could agree upon the application of a single model. However the models tend to overlap and merge with one another and as already discussed, the definition should vary according to the purpose for which it is intended. Indeed it is likely that the definition is derived partly from the treatment or response deemed appropriate for a particular individual. It is worth labouring this point: it is not only that a person is labelled mentally ill on account of his or her irrational or deviant behaviour, the ascription of madness may equally be derived from the treatment or response that is deemed appropriate when such behaviour is manifested.

That this should be the case is not so much a criticism of the concept but a reminder or warning of the need to exercise extreme caution in order to avoid unjustifiable classification of persons as mentally ill. With regard to the criminal law and to sentencing it is important that the mental illness label should have relevance for the purposes of assessing responsibility and determining punishment. In particular, it should be used in such a way as to show that the offender's disorder (whether it amounts to insanity under the law, or to a lesser impairment of mental functioning) bears on the offender's responsibility (or lack of responsibility) for the offence or offences in question. If it does not, although the offender may be mentally disordered, that fact is irrelevant for the purposes of determining the gravity of the offence and the corresponding severity of the sentence. It should not therefore be assumed that the offender's mental illness is to be ignored altogether. It may be highly relevant for choosing the kind of sentence that is ultimately imposed, but it is submitted it should not necessarily

25. 'Alternative Theories of Madness', *op. cit.*, p. 21.

affect the quantum. The relationship of treatment to punishment will be explored more fully when examining the principles of sentencing the mentally disordered offender (Chapter 10).

Thus the legal model of mental illness (and here reference is omitted to unfitness to plead and post-sentencing procedures) is concerned with concepts of responsibility and culpability. These concepts invoke a highly moralistic component into criminal law administration, that essentially calls for answers to the following questions: 'to what degree, if at all, should one in fairness attribute blame to the actor in consequence of his or her having committed the proscribed act or acts?' and, if blame is attributable, 'to what degree, having regard to prescribed penalties, and to the principles and the practice of sentencing, should the actor be brought to account for the act or acts of which he or she has been convicted?'.

MENTAL DYSFUNCTION

It is beyond the scope of this book to tender a definition of mental illness. Indeed the term 'mental illness' itself is losing favour. The Butler Committee's preference for 'mental disorder' over both 'mental illness' and 'mental abnormality' provides a commendable substitute.[25A] Shortly something will be said about the M'Naghten Rules, the current test (as opposed to the definition) of legal insanity. Meanwhile something more needs to be said concerning the way in which the clinical (ordinary) meaning of mental illness may be considered. Thus under a proposal for a new Mental Health Ordinance for the Australian Capital Territory it is 'mental dysfunction' that has found favour and is likely to be substituted for 'mental illness'.

The new term places emphasis on the unnatural working of the mind rather than on the concept of a structural or organic disease of the brain so often implied by the words 'mental illness', 'mental abnormality' and even 'mental disorder'. It therefore appears to be a more accurate term to use when referring to the mental illness phenomena. It may be that 'mental dysfunction' as a replacement

25A. *The Report of the Committee on Mentally Abnormal Offenders,* (The Butler Report) Cmnd. 6244 (H.M.S.O., London, 1975), para. 1-18. Also discussed by Freiberg, *op. cit.*, n. 16, pp. 135-139.

term for 'mental illness' may not find community acceptance readily. Indeed, if introduced, the new term would probably not be accepted in common parlance for some time. Yet in view of the term's connotations, and therefore its potential educative effect regarding the nature of mental illness, it would appear to be an improvement on previous terminology.

There is a danger, at least in the short term that this new word would simply add to the list of terms that are already in use thereby contributing to, rather than reducing, the stigma that currently attaches to the 'mental illness' label. Thus to say a person has a mental dysfunction may be a more euphemistic way of saying that he or she is mentally ill, or mentally disordered or less kindly, that he or she is 'mad', 'nuts', 'out of their mind' or simply 'insane'. What can be said with a degree of confidence is that total replacement of previous terms used to describe the phenomena of irrational behaviour cannot be achieved by legislation alone. Be that as it may, in the proposal for a new ordinance for the Australian Capital Territory, the following definition has been advocated:

> 'Mental Dysfunction' means a disturbance or defect of disabling degree of perception, comprehension, reasoning, judgement, learning, memory, motivation, emotion or other mental function.

This definition is just as vague, open-ended and circular as are the more usual definitions relating to mental illness. Thus mental dysfunction means little more than a defect or disturbance of mental functioning. The definition however could include a blind or deaf person who was otherwise normal – that is, a person who suffers from a defect of perception of disabling degree – a consequence to which the framers of the definition would surely object. One advantage of the definition is the discovery of the term mental dysfunction itself, for it eliminates the need to refer to a mythical illness and instead directs attention to the concept of a disturbance or defect in mental functioning. The definition, it is submitted, would be improved by expanding upon what is meant by 'a disturbance or defect of disabling degree' a concept which should also be sufficiently vague as to allow it to vary according to the purpose for which it is used. For example, if voluntary commitment to a mental institution is under consideration, the criteria could include a requirement that the person should be detained

only if the dysfunctional disturbance or defect is sufficiently serious to warrant that the person should be detained 'for his own protection or the protection of others'.

With regard to determining whether the offender is fit to be tried, or whether he (or she) should be considered not guilty on the grounds of insanity, or whether he should be given a hospital order, or whether while in prison, he should be transferred to a mental institution, the meaning of 'mental dysfunction' and more particularly, the assessment of whether the person suffers from 'a disturbance or defect of disabling degree' would vary according to the state of psychiatric and psychological knowledge, the remedies, and the facilities that are available for dealing with the disorder. Any attempt to fuse all the objects for which the term may be employed into a single all-embracing definition is bound to fail, and hence a degree of circularity, ambiguity or vagueness will inevitably be an essential part of an acceptable definition. The alternative is to have no definition at all.

NARROWING THE DEFINITION

The definition of 'mental dysfunction' as it relates to involuntary admissions, whether this relates to civil or criminal proceedings, could be further qualified by adopting some of the recommendations of the New South Wales *Mental Health Act* 1958 Review Committee.[26] The Committee recognised the desirability of narrowing or better defining the class of persons who may be considered mentally ill in order to prevent the wrongful detention of political prisoners, sexually promiscuous persons and frequent drug takers, unless they also exhibited mental illness.[27]

This kind of approach has been adopted in the Northern Territory in its recent *Mental Health Act* 1979. No definition of mental illness is given in that Act, but certain forms of behaviour are identified as constituting an insufficient basis upon which to hold that a person is mentally ill. Thus under s.4 of the Act, the definitional section, the following subsections are included:

26. *Report of the N.S.W. Mental Health Act (1958) Review Committee,* is hereafter referred to as the Edwards Committee. Its Report is published in 22, *Proceedings of the Institute of Criminology,* (Sydney, 1975).
27. *Ibid.*, p. 14-15.

> (2) A person shall not be considered to be a mentally ill person by reason only that he expresses or refuses or fails to express a particular political, anarchic, religious, irreligious, legal, illegal, moral, or immoral opinion or engages in or refuses or fails to engage in a particular political, anarchic, religious, irreligious, legal, illegal, moral or immoral activity.
>
> (3) Evidence of the taking of or addiction to a drug or psychotropic substance is not of itself evidence of mental illness, but a biochemical or psychological effect of a drug or psychotropic substance may be an indication of mental illness.

While s.4(2) would suggest a very wide category of exemptions – at first blush it would appear to rule out almost any form of self-expression, act or omission – these exemptions are qualified by the words 'by reason only'. Presumably the terms of the section mean that the offender must, in addition or despite the manifestation of any one of the forms of behaviour referred to in the subsection, also exhibit symptoms of mental illness. However as already indicated, no definition of 'mental illness', 'mental disorder' or 'mentally ill person' appears in the Act.

To shirk a positive definition of mental illness has its attractions. Yet it is submitted that it is preferable to have a circular definition than none at all. The addition of exclusionary factors (negative definitions) through a process of elimination help further to focus the meaning that is sought to be defined. Hence, the combination of positive and negative definitions, coupled with a clear statement of the purpose for which the term is employed, serves to restrict and focus the meaning of the concept to a point where it is possible to determine with a degree of confidence that a person falls within or without the definition.

Some desirable strategies of the kind referred to by the Edwards Committee for restricting the definition may also be noted briefly. For example, the requirement that a mentally ill person should only be detained 'for his own protection or for the protection of others' is further qualified. The phrase 'for his own protection' may be defined to cover the situation where the person has attempted either to kill himself (or herself) or to cause serious bodily harm to himself, or where there is a belief on reasonable grounds that he is likely to do so. Similarly the phrase 'for the protection of others' may be defined to include a recent attempt (or recent act) of inflicting grievous bodily harm upon any person, or a recent act of violence or some other act that would reasonably

indicate that the person is likely to inflict serious harm upon another person, or that the behaviour would create a nuisance likely to lead to a breach of the peace of a kind or magnitude that no reasonable person would tolerate. Many of these critical issues are not purely medical considerations and therefore it follows that these questions should not be left exclusively to be decided by the medical profession.

Another important reform to be recommended is to place an onus on the medical practitioner who certifies the person as mentally ill to be satisfied 'that involuntary admission and detention is necessary and that no alternative means for dealing with the person is reasonably available'.[27A] This requirement would also be in conformity with the general principle of sentencing that imprisonment should be a sanction to be used only as a last resort.[28]

A condition precedent for the application of a hospital order would be that the offender had either pleaded guilty or had been convicted of a criminal offence. Otherwise the means of the offender's disposal would remain subject to civil procedures only. This proposal is developed more fully later. For the present it should be noted that the definition of mental illness, and the consequences of labelling a person as such for purposes of the criminal law, or with the object of satisfying the criteria of involuntary civil commitment, involve not only clinical judgment but also ethical considerations of great moment. For this reason the medical profession should not alone be expected to exercise the power of deciding who should and who should not be labelled mentally ill.

27A. *Ibid.*, p. 22.

28. See I. Potas, *Limiting Sentencing Discretion: Strategies for Reducing the Incidence of Unjustified Disparities*, (A.L.R.C., Sydney, 1979), pp. 29-30.

3 Disposal of Insane Persons

HISTORICAL DEVELOPMENT

Apart from the relatively recent development of statutes providing for strict liability, the common law principle that a person who commits a prohibited harm does not thereby attract liability to punishment unless that person can also be regarded as being morally blameworthy for the act, is still the prevailing philosophy of the criminal law: *actus non facit reum nisi mens sit rea.*[29] Even so persons found unfit to plead or unfit otherwise to stand trial or who have been acquitted on the ground that they were insane at the time that the offence was committed, often attract custodial dispositions which may be indistinguishable from the dispositions of those who, in the ordinary course of events, are found guilty and convicted of some of the most serious offences known to the criminal law. That is, they may find themselves detained for an unspecified period of time in circumstances that might readily be compared with a sentence of life imprisonment. For the purposes of understanding this development it is sufficient if the discussion commences with *Hadfield,*[30] decided at the very beginning of the nineteenth century in England.

On 11 May 1800, James Hadfield attempted to shoot George III at the Drury Lane Theatre. Although he fired a shot at the King,

29. According to Brett and Waller, *Cases and Materials in Criminal Law,* it was recognised in the reign of Edward I (1272-1307) that a person who was insane at the time the offence was committed ought not to be convicted. The rule was recognised by Coke in his *Third Institute* and restated by Hale in *Pleas of the Crown.* Hawkins (1 P.C., Book 1, Chapter 1) and Blackstone (4 Comm. 21, 24-26) also concur that one cannot be guilty of a crime 'unless the will joins with the act. . . an idiot or a lunatic, since he is defective in his understanding, therefore cannot be guilty of a crime.'

30. *R.* v. *Hadfield* (1800) 27 St. Tr. 1281.

the ball missed the King's head by about a foot. In due course Hadfield was put on trial for his life. The unchallenged evidence at the trial revealed that while the accused undoubtedly intended to kill the King, he had done so while suffering under the delusion that he was required to die in order to save the world. In preference to committing suicide he hoped to achieve his aim by being convicted of treason and so allow himself to be executed. In this way Hadfield believed he was committing a good rather than an evil act.

However, in accordance with principle the court held that it was inappropriate to convict him. Instead the jury was asked to acquit the accused but in so doing it was directed to provide the reason for its verdict. This resulted in the qualified acquittal, a practice which has persisted in all Australian jurisdictions to the present day. Lord Kenyon in deciding what options were available to the court, considered that Hadfield could only be remanded to the confinement from which he came (Newgate Gaol). At the same time his Lordship was adamant that Hadfield should not be discharged saying:

> . . . this is a case which concerns every man of every station, from the king upon the throne to the beggar at the gate; people of both sexes and of all ages may, in an unfortunate frantic hour, fall a'sacrifice to this man, who is not under the guidance of sound reason; and therefore it is absolutely necessary for the safety of society that he should be properly disposed of, all mercy and humanity being shown to this most unfortunate creature.[31]

The *Trial of Lunatics Act* of 1800 (39 and 40 Geo. III c.94) was passed about a month after Hadfield was acquitted. It was made to apply retrospectively, thereby giving statutory authority for the procedure which was followed in that case. Henceforth in all cases of treason, murder or felony where there was evidence of insanity, the jury was to determine (i) whether the person was insane at the time of the commission of the offence and if so, (ii) to declare whether such person was acquitted by them on account of such insanity. Later still, following a number of incidents involving Queen Victoria shortly after her coronation, the application of the special verdict was extended to include non-capital offences

31. *Ibid.*, p. 1356. For a more detailed discussion see the judgment of O'Brien J. in *R. v. S.* [1979] 2 N.S.W.L.R. 1, 30ff. See also N. Walker, *Crime and Insanity in England*, vol. 1, (University Press, Edinburgh, 1968), ch. 4.

(misdemeanours), (3 and 4 Vic. c.54 1840).

A second important feature of this early Act was that in the event of an acquittal on the ground of insanity, the trial judge was empowered to order the acquitted person to be held in strict custody before handing him over to the King, who in turn 'could give such further order for his safe custody during his pleasure as may seem fit'.[32] Even during this early period the onus of proving mental incapacity lay upon the accused.[33]

The English *Lunacy Act* of 1800 applied in the Colony of New South Wales and continued to apply until 1 March 1878 when the *Lunacy Act* of 1878 (New South Wales) came into effect.[34] The latter consolidated and amended the law relating to insane persons so far as it applied in New South Wales, and it re-enacted in substantially similar terms the provisions in the earlier Act relating to persons acquitted on the ground of insanity. This re-enactment was contained in s.58 of the *Lunacy Act* of 1878, which in addition provided for the disposal of persons found to be insane on arraignment or during the trial.

The next development of relevance was the *Criminal Law Amendment Act* of 1883 (46 Vic. No. 17), which was the precursor of the *Crimes Act,* 1900 (New South Wales). Section 415 of the Act referred to orders for the disposal of any person who was indicted for an offence but acquitted on the ground of insanity. When the *Crimes Act,* 1900 (New South Wales) was passed it replaced s.415 with s.439. Thus the present position is that s.439 applies both to New South Wales and to the Australian Capital Territory – the latter having adopted the provisions of the New

32. See *R.* v. *S.* [1979] 2 N.S.W.L.R. 1, 32, per O'Brien J. The precise terms relating to disposal of a person acquitted on account of insanity were contained in s.1 of Act 39 and 40 Geo. III c.94 and expressed *inter alia* as follows:

> **The Court before whom such Trial shall be had shall order such person to be kept in strict Custody, in such Place and in such Manner as to the Court shall seem fit, until His Majesty's Pleasure shall be known; and it shall Order for the safe Custody of such person during his Pleasure, in such Place and in such Manner as to His Majesty shall seem fit.**
>
> **(Emphasis added)**

33. See particularly *R.* v. *S.* [1979] 2 N.S.W.L.R. 1, 45ff., where O'Brien J. methodically examines the authorities relating to the onus of proof in insanity cases.

South Wales *Crimes Act* in 1909. It now provides as follows:

> **Disposal of insane persons.**
>
> **439.** Where a person, indicted for any offence, is acquitted on the ground that he was insane at the time of committing such offence, or is on arraignment found to be insane, he shall be dealt with in the manner in such case provided by the Lunacy Act or Acts in force for the time being.

The 'Lunacy Act or Acts' to which the present section refers in the Australian Capital Territory is the *Lunacy Act* of 1898 (New South Wales) and the *Lunacy Ordinance* 1938.[35] In New South Wales however, the *Mental Health Act* 1958 (New South Wales) replaced the *Lunacy Act* of 1898, but despite a change in terminology, s.23(2) of the new Act, which dealt with the special verdict, was to retain the same legislative directive as in the earlier Acts, dating all the way back to 1800. In short, for a period spanning almost two centuries where insanity has been pleaded as a defence, the primary function of a judge and jury has been, and still continues to be, to determine whether the offender is to be held criminally responsible for his or her deed and not whether the offender is insane,[36] or (more accurately) whether the offender

34. Note however, that there were other N.S.W. Acts dealing specifically with lunatics. The first important N.S.W. statute dealing specifically with the mentally ill was the *Dangerous Lunatic Act*, 7 Vic. No. 14 of 1843. For a discussion of the early legislation see McLemens and Bennett, 'Historical Notes on the Law of Mental Illness in New South Wales', [1962] 4 Syd. Law Rev. 47.

35. The *Lunacy Ordinance*, 1938 (A.C.T.) merely imported a new provision (s.72A) dealing with the power of the Governor-General to release on licence a person detained under s.65 of the *Lunacy Act* of 1898 (N.S.W.).

36. See generally *R. v. S.* [1979] 2 N.S.W.L.R. 1, 39ff., per O'Brien J. Note also that neither New South Wales nor the other Australian Colonies followed the English departure of 1883 when the special verdict was changed from 'acquittal on the ground of insanity' to 'guilty. . . but insane'; *Trial of Lunatics Act*, 1883 (Imp.). This change was precipitated as a consequence of violent acts against Queen Victoria (discussed in N. Walker, *op. cit.*, p. 188ff.). Indeed the Queen insisted upon the change after one, Maclean, who had fired a pistol at her at Windsor Station was, following his trial for treason, acquitted on the ground of insanity. While the change in terminology made no difference to the treatment that the prisoner received, Walker states that the word 'guilty' had such a hypnotic effect that this was overlooked (*ibid.*, p. 192). Following a long sleep and after universal condemnation the former verdict was restored in 1964.

was considered to be insane (mentally ill) at the time that the offence was committed.

The legal test of insanity was to be enunciated later, in the so called M'Naghten Rules, (to be considered shortly) but for present purposes it should be noted that the Australian Capital Territory is still subject to the provisions of the old *Lunacy Act* of 1898 (New South Wales). The issues are further complicated by the fact that the Territory has no facilities – that is, no prison or hospital for the detention or treatment of the mentally disordered offender, including the criminally insane (to use the terminology of the vintage) and complicated arrangements, sometimes of tenuous legality, are made for the detention and care of such persons in New South Wales State institutions.

DISPOSAL OF FORENSIC PATIENTS IN THE A.C.T.

The following figures provide schematic representations of the procedures in the Australian Capital Territory for dealing with offenders charged with indictable offences who are either:

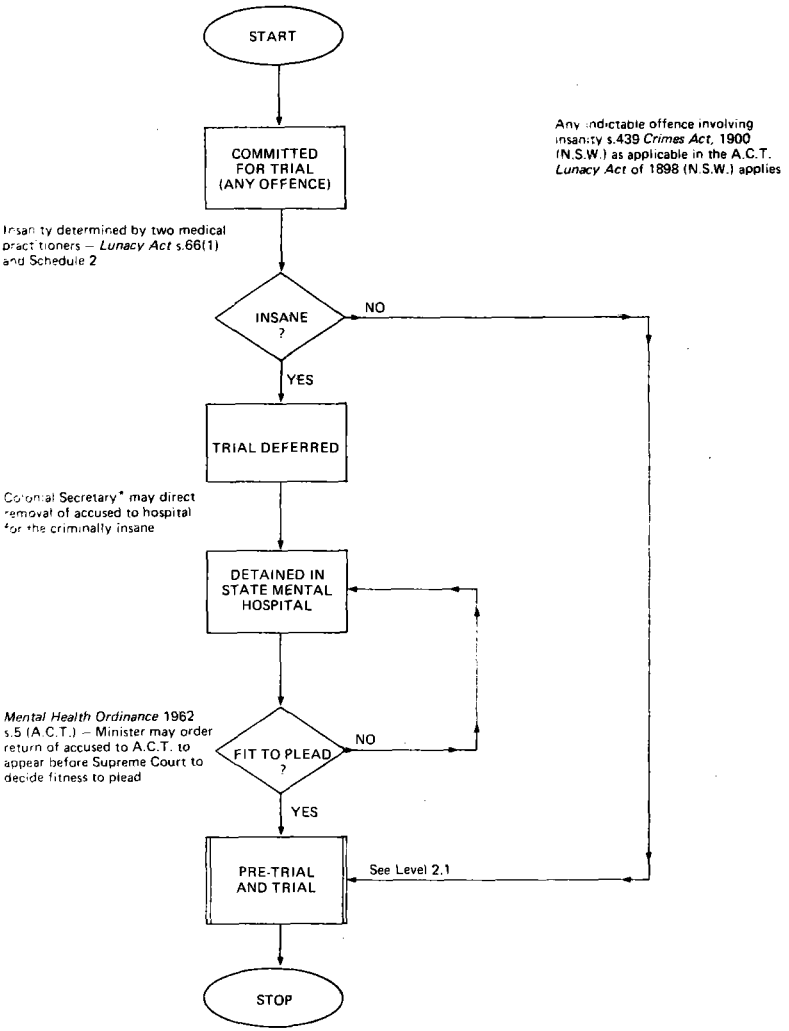
(1) acquitted on the ground of insanity;

(2) found unfit to plead or otherwise unfit to stand trial; or

(3) committed for trial and certified insane by two medical practitioners in accordance with Schedule 2 of the *Lunacy Act*.

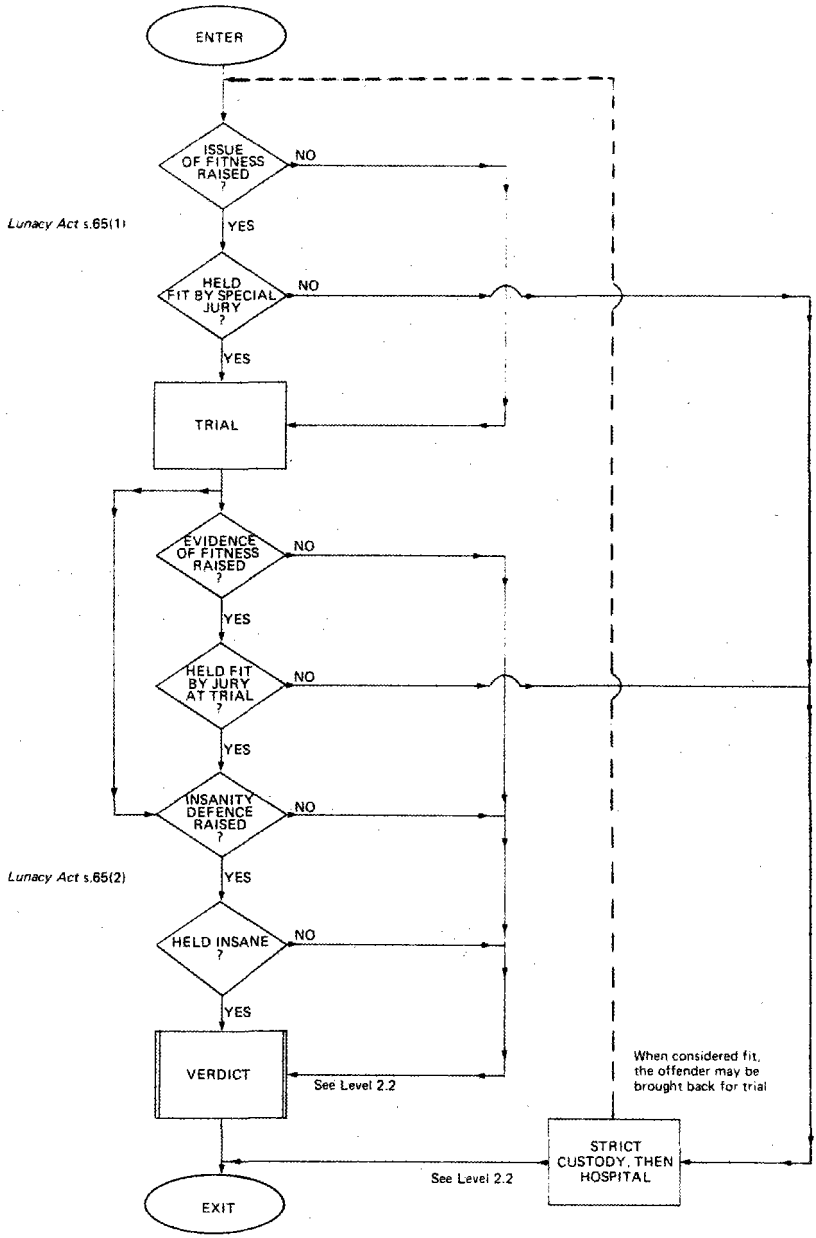
These figures show that in the Australian Capital Territory where the detainee has been acquitted on the ground of insanity it is the Governor-General who assumes the ultimate authority for determining the terms and conditions for release. In the case of persons falling into categories (2) or (3) the *Lunacy Act* gives the Colonial Secretary the power, and therefore the responsibility for ensuring that the offender is detained in a hospital for the criminally insane, and then returned to gaol and trial when certified fit. Before considering who in the Australian Capital Territory assumes the authority of the Colonial Secretary, it is again pointed out that there are no hospitals for the purposes of detaining the criminally insane in the Territory, nor indeed is there a gaol. Accordingly, the powers exercised by the person standing in the shoes of the

LEVEL 1.1 – INSANITY AND UNFITNESS TO PLEAD OR STAND TRIAL IN THE AUSTRALIAN CAPITAL TERRITORY

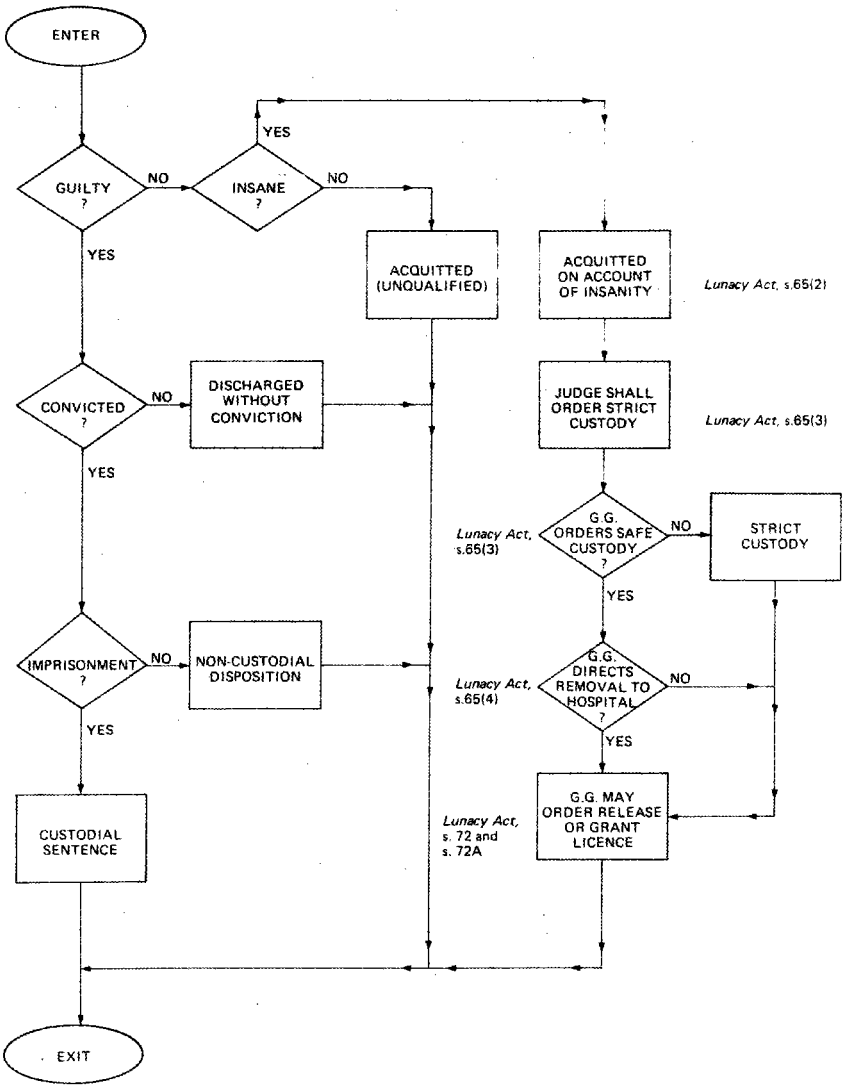


* As to who exercises the power of the Colonial Secretary, see text

LEVEL 2.1 – PRE-TRIAL AND TRIAL PROCEDURES



LEVEL 2.2 – VERDICT



Colonial Secretary, must, if the terms of the legislative directives are to have meaning, exercise such powers consistently with arrangements for the disposal of persons to mental institutions and gaols outside the Territory.

An arrangement, struck pursuant to the terms of the *Insane Persons and Inebriates (Committal and Detention) Ordinance* 1936-1937, provides for 'the reception, detention and maintenance in institutions in the State of New South Wales of insane persons and inebriates committed to those institutions' from the Australian Capital Territory. The details of the arrangement are to be found in an agreement contained in the Schedule to that Ordinance and is executed by the then Minister for Health of the State of New South Wales and the Minister of State for the Interior (now Minister for the Capital Territory). This agreement was entered into on behalf of the State and the Commonwealth respectively. A supplementary agreement was entered into in 1961, which was found necessary following the repeal in New South Wales of the *Lunacy Act* and the substitution thereof of the *Mental Health Act,* 1958 (New South Wales). The supplementary agreement is now contained in the *Mental Health Ordinance,* 1962.

Section 5 of the Ordinance is of particular interest for it empowers the Minister to order the return of a person who has been committed to take his trial but who has been held unfit to plead and therefore committed to and detained in a State institution. Once returned to the Territory the person must be brought before a magistrate 'as soon as practicable' and the magistrate may order that the person be detained in such custody as he thinks fit. Meanwhile the Supreme Court of the Australian Capital Territory has the responsibility of determining whether or not the person is fit to plead. If it determines that the accused is fit, the case will proceed to trial. If the Court decides that the accused is not fit to plead, the Minister 'may order that the person be recommitted to the institution in which he was detained before being returned to the Territory.'[37] The Minister, for the purposes of the Ordinance, is the Commonwealth Minister for Health.[38]

37. *Insane Persons and Inebriates (Committal and Detention) Ordinance,* 1936-1937, s.5(4).

38. *Seat of Government (Administration) Ordinance,* 1930 (A.C.T.) discussed *infra,* p. 41.

THE COLONIAL SECRETARY

Who then exercises the power of the Colonial Secretary? According to the Crown Prosecutor's office it is the Commonwealth Attorney-General, but the authority for this proposition has not been discovered. One hypothesis is that the Commonwealth Attorney-General has inherited a similar power to that exercised by the State Attorney-General under the *Mental Health Act*, 1958 (New South Wales). Under s.26 of that Act, the State Attorney-General is empowered to order that a person charged with an offence and held in a mental hospital be transferred to prison and thence put on trial in order to determine that person's fitness to plead. Is it possible that this power is shared by other Ministers of the Commonwealth or of the Australian Capital Territory?

It appears that in 1898 the Colonial Secretary was a Minister in the Colony of New South Wales – an officer often associated with the Premier. J.D. Bunker was the Colonial Secretary at that time. The *Interpretation Act* of 1897 (New South Wales) implies that the Colonial Secretary (New South Wales) was a Minister for running the Chief Secretary's Department and that Department according to the *Appropriation Act* of 1897 (New South Wales) appropriated certain sums for the maintenance of lunacy hospitals (the Master of Lunacy) and therefore was the same person referred to in the *Lunacy Act* of 1898 (New South Wales). By virtue of s.6 of the *Seat of Government (Acceptance) Act*, 1909 the *Lunacy Act* was applied in the Australian Capital Territory.

Section 45 of the *Interpretation Ordinance* 1967 which repealed earlier ordinances, provides that a reference to a continued State law, to a Minister of the Crown other than the Attorney-General of the State of New South Wales, shall be read as a reference to a Minister for the time being administering the *Seat of Government (Administration) Act*, 1910-1965 unless express provision is made to the contrary. Section 10 of the *Seat of Government (Administration) Ordinance*, 1930 (Australian Capital Territory) provides that except as provided by that section, the Ordinances of the Territory shall be administered by the Minister of State for the Capital Territory.

The exceptions are contained in the Second Schedule of that Ordinance where it is provided that various Ministers shall administer certain Ordinances. Among the Ordinances administered by the

Commonwealth Minister for Health (see Part 2 of the Second Schedule) are the *Insane Persons and Inebriates (Committal and Detention) Ordinance,* 1936; and the *Mental Health Ordinance,* 1962. Both these Ordinances vary the provisions of the *Lunacy Act,* even though on the face of it that Act does not refer to the Minister for Health.

Interestingly enough, Part 1 of the Second Schedule provides that the *Lunacy Ordinance* 1938 is administered by the Attorney-General. No mention is made of the *Lunacy Act* of 1898. Thus it would appear that the latter is administered, *de jure,* by the Minister of State for the Capital Territory. It seems however that the matter does not rest there, for as discussed earlier the Commonwealth Minister for Health, pursuant to s.5 of the *Mental Health Ordinance,* 1962, has power to recall a person held in a State hospital for the purpose of bringing him or her before the Supreme Court to determine the question of that person's fitness to plead. Furthermore, the same Minister has power to return that person to the State institution from whence he or she was brought if that person is again found unfit to plead. Thus it seems that the power of disposal formerly exercised by the Colonial Secretary is shared by both the Minister for the Capital Territory and the Minister for Health.

The foregoing conclusion is tentative, and its complicating features have been highlighted in order to demonstrate the complexity and corresponding uncertainty that prevails in this area of the law. It calls out for urgent legislative clarification.

LITTLE PROGRESS IN THE A.C.T.

The law on insanity as a defence and the law relating to the procedures for dealing with persons found unfit to plead or to otherwise stand trial in the Australian Capital Territory are still largely based on New South Wales laws of last century. As has been seen, the 1898 *Lunacy Act* of New South Wales can itself be traced all the way back to *Hadfield's* case in England and to the *Trial of Lunatics Act* of 1800. Indeed the New South Wales *Lunacy Act* was repealed in that State and replaced by the *Mental Health Act* 1958, an Act which itself has undergone a thorough

review by the Edwards Committee,[39] and proposals for substantial amendments to it are currently being drafted.

By comparison to other jurisdictions which are themselves often slow to respond to change, the Australian Capital Territory has made little progress towards amending its mental health legislation. Although at the present time there is a proposal for a new mental health ordinance which is intended to bring the requirements of the law up to date with modern developments in the philosophy and treatment of the mentally ill, snails pace progress has left little basis for believing that reform is imminent. The wheels of justice are slow to recognise the plight of the mentally ill and like the prisoner sentenced to a term of imprisonment, the forensic patient and the involuntary civil patient, all are transported to New South Wales institutions.

While this system of disposal may have been satisfactory when the Australian Capital Territory had a relatively small population, that population has now reached (at the time of writing) approximately one quarter of a million people. It is time that the citizens of Canberra accepted responsibility for looking after the mental health of its own residents and set to work to make provision for an enlightened system of mental health care for those who live and work in the Territory.

TERMINOLOGICAL AND PROCEDURAL VARIATIONS

There are few differences among the Australian criminal justice systems with regard to procedures for dealing with persons acquitted on the ground of insanity, for each jurisdiction bears remarkable similarities to the original procedures laid down in the *Trial of Lunatics Act* of 1800. The terminology varies slightly. For example, the relevant provisions in Victoria,[40] the Northern Territory[41] and the Australian Capital Territory[42] refer to the offender as being

39. *Report of the N.S.W. Mental Health Act (1958) Review Committee,* (Edwards Committee), 22 *Proceedings of the Institute of Criminology,* (Sydney, 1975).
40. *Crimes Act,* 1958 (Vic.), s.420.
41. *Criminal Law Consolidation Act and Ordinance,* 1876-1960 (N.T.), s.381.
42. *Lunacy Act* of 1898 (N.S.W.) as amended, in its application to the A.C.T., s.65.

'acquitted on account of insanity'. Queensland[43] and Western Australia[44] use the phrase 'acquitted on account of unsoundness of mind'. The Commonwealth[45] varies this to 'acquitted by reason of unsoundness of mind', while South Australia[46] and Tasmania[47] employ the phrase 'acquitted. . . on the ground of insanity'. The New South Wales[48] formula is again slightly different, requiring the jury to declare that the person was 'acquitted. . . on the ground that he was. . . mentally ill'. While this appears to be an attempt to avoid the stigma of labelling the person 'insane', the section goes on to define 'mentally ill' as meaning 'so insane as not to be responsible, according to the law, for the act or omission the subject of the charge'.

The dispositional stage in the procedure is almost identical with that prescribed by the *Trial of Lunatics Act* of 1800.[49] In all jurisdictions except for Tasmania and the Northern Territory, the court is obliged to order that the person who is subject to the qualified acquittal is to be held in strict custody until the Governor's pleasure is known.[50] The procedure in Tasmania will shortly be considered. In the Northern Territory, by virtue of transitional provisions contained in s.7 of the *Criminal Law Consolidation Act* (No. 2) 1978, a person held in custody pursuant to s.381 of the *Criminal Law Consolidation Act* at the Governor-General's pleasure, is henceforth to be held in safe custody at the Administrator's pleasure. The Northern Territory also has a number of unique features relating to the power of the Supreme Court to deal with persons unfit to plead, and this will also be considered shortly. Meanwhile it is worth noting that other variations in terminology although present are fairly inconsequential. For example, in New South Wales it is the judge rather than the court who orders strict custody until the Governor's pleasure is known. In Queensland

43. *Criminal Code Act*, 1899 (Qld.), s.647.
44. *Criminal Code*, 1913 (W.A.), s.653.
45. *Crimes Act*, 1914-66 (Cth.), s.20B.
46. *Criminal Law Consolidation Act*, 1935-1975 (S.A.), s.292.
47. *Criminal Code Act*, 1924 (Tas.), s.381(1).
48. *Mental Health Act*, 1958 (N.S.W.), s.23.
49. Discussed *supra*, p. 32.
50. In Western Australia the Governor, in the name of Her Majesty, may give the order for safe custody during his pleasure, *Criminal Code* (W.A.), s.653.

and Western Australia, Her Majesty's Pleasure is the term substituted and used in preference to Governor's pleasure, while under Australian Capital Territory and Commonwealth laws it is the Governor-General's pleasure that is substituted.

Variations also exist with regard to the place where the Governor (or his counterpart) may order that the person should be detained during his pleasure. Most jurisdictions leave the place of confinement unspecified. Thus in Queensland and Western Australia, reference is made merely to 'a place of confinement', in Victoria reference is made to 'a place designated', in South Australia reference is made to 'a place thought fit', and under Commonwealth law the Governor-General may order in writing the safe custody of the offender 'in a place specified'. In the Northern Territory reference is made to 'a hospital, prison or other place', and in the Australian Capital Territory the relevant provision merely refers to 'a gaol, or other place of confinement'.

New South Wales provides a more restrictive formulation – the 'Governor may order safe custody during his pleasure in a prison'. In order to shift the offender to a mental hospital, the Governor must obtain two medical certificates, but thereafter it seems that the person may be detained there during the Governor's pleasure indefinitely. The fact that in the first instance a Governor's pleasure detainee is held in prison rather than a hospital demonstrates the incongruity of the 'not guilty on grounds of insanity' verdict. It demonstrates that a person may no longer be considered to be mentally ill but must nevertheless be detained in an institution designed for the containment of convicted criminals.

While the rationale for the continued incarceration of these persons may be based on the need to protect the community, it is submitted that those who are acquitted should be detained, if at all, in secure facilities which are not identified with persons whom the courts have adjudged culpable for their actions. Unfortunately, as will be revealed, practice and theory are poles apart.

JUDICIAL DISCRETION AND THE QUALIFIED ACQUITTAL

A common feature found in most Australian criminal justice systems is that the trial judge's discretion is unnecessarily curtailed after an insanity verdict has been returned by the jury. The judge

has no option but to order that the defendant be kept in strict custody. This can lead to unnecessarily harsh consequences as evidenced in the case of *R.* v *Butterworth*[51] where the accused had been allowed bail for 10 months preceding the verdict. Following the insanity verdict and qualified acquittal, the trial judge was precluded from doing what in His Honour's view was the appropriate course to be taken, namely to release the defendant either conditionally or unconditionally into the community. Instead he was obliged to order that the defendant be held in strict custody in prison.

This unfortunate state of affairs fails to give cognisance to the fact that some persons who are acquitted on grounds of insanity may have suffered only a temporary lapse of mental health at the time that the offence was committed. These same persons may be in excellent mental health at the time of the trial, and may not present a threat to the safety of the community even if permitted to go at large.

Is it not ironical that, except where the penalty is fixed by law, a judge may release a person into the community rather than sentence him or her to a term of imprisonment after that person has been convicted of a serious offence? Yet if that same person would have been acquitted on the ground of insanity of the same offence or even of a less serious offence, the judge's hands would have been tied. The trial judge is obliged to order that the acquitted party be detained in strict custody, and the 'prisoner' must await the Governor's pleasure before there can be any hope of release. Surely the law should enable the trial judge without further ado to order release of the acquitted party when the circumstances would indicate that such a course is warranted. Such a course would also be consistent with the view that imprisonment is to be used as a last resort, and with the view of mental health authorities that treatment in the community is to be preferred to hospitalisation.

A further, and related problem particular in the context of Commonwealth and Australian Capital Territory detainees, is the administrative delays inherent in obtaining the Governor-General's

51. Unreported decision of the New South Wales Court of Criminal Appeal, referred to in the *Report of the Royal Commission into New South Wales Prisons* (The Nagle Report) (Sydney, 1978), p. 320. The case is also referred to in P. Winch, *Governor's Pleasure Prisoners in New South Wales,* Masters thesis, (Sydney Institute of Criminology, 1977), p. 16.

authority for dealing with the offender. This delay may arise in relation to obtaining transfers from strict custody (prison) to 'safe custody' as the Governor-General thinks fit, and the delay involved in obtaining the Governor-General's terms for release. The very notion of 'Governor's pleasure' connotes a blanket authority that purchases administrative convenience at the cost of acquiring an increased potential for the abuse of civil liberties. It is an anachronism more appropriate of application under a Divine Right of Kings doctrine. It is submitted that at the very least the trial judge ought to have the power of deciding whether, if at all, a person who has been acquitted on the ground of insanity should acquire the status of a Governor's pleasure detainee. It is further submitted that in appropriate circumstances the trial judge should be empowered to order an absolute discharge of a person who has been acquitted on the ground of insanity.

UNFITNESS TO PLEAD IN THE NORTHERN TERRITORY

The *Criminal Law Consolidation Act* (No. 2) 1978 of the Northern Territory, introduced into the *Criminal Law Consolidation Act* a welcome measure of judical discretion for the disposal of persons who are unfit to plead in that jurisdiction. Section 382A.(1) of the Act provides that:

> **382A.(1)** Where a person charged with an offence is, from want of comprehension of the nature of the circumstances alleged or of the proceedings, found by the court before whom he is charged to be unfit to plead that court may order that the person be (a) discharged; (b) remanded on bail; or (c) remanded in custody.

If remanded on bail or in custody by a magistrate, the person must be remanded to appear before the Supreme Court.[52] The Supreme Court may then order that the person be absolutely discharged, conditionally released, or detained in safe custody (i) at such place; (ii) for such periods; and (iii) subject to such conditions, as the Supreme Court thinks fit.[53]

Where a person is remanded in custody under subsection (1) he

52. *Criminal Law Consolidation Act* (No. 2) 1978, s.382A.(2).
53. *Ibid.*, s.382A.(3).

(or she) may apply to the Supreme Court for bail, at any time.[54] Where he has been conditionally released he may apply at any time for a variation of the conditions or apply to be absolutely discharged from custody.[55] Similarly he may at any time apply to the Supreme Court for a variation of the conditions applying to the order for his detention in safe custody, and may also apply for conditional release or absolute discharge.[56] In each case the Supreme Court 'may make such order in relation to the person as it thinks fit'.[57] In particular, where the Supreme Court has ordered either that the person be conditionally released or detained in safe custody it may at any time order that the person be tried for the offence for which he was found to be unfit to plead.[58]

What distinguishes this procedure from the more conventional approach is that the judiciary, rather than the executive arm of government has the power and responsibility for determining the fate of the person found unfit to plead. This is an admirable innovation, but it is marred by poor draftsmanship. In particular, there does seem to be some ambiguity or uncertainty in the procedure for determining whether a person is or is not unfit to plead. This is because s.382 of the *Criminal Law Consolidation Act and Ordinance* 1876 to 1960, which *inter alia* had provided for a jury to determine the question of unfitness to plead in indictable matters (similar to the procedure just outlined for the Australian Capital Territory) was repealed.[59] The decision is simply given to 'the court' to determine whether or not the person is fit to plead.

This, therefore, at least *ex facie,* suggests that an accused has lost the right to have the matter of fitness to plead determined by a jury. It is not at all certain whether this result was intended, or more importantly, whether such an omission is desirable. Further, there appears to be a drafting error in that most of the dispositional powers of the Supreme Court appear to be activated only after a magistrate has remanded the offender to appear in the Supreme Court. This implies that the powers and procedures of the Supreme Court where unfitness to plead is raised in the first instance at the

54. *Ibid.*, s.382A.(4).
55. *Ibid.*, s.382A.(5).
56. *Ibid.*, s.382A.(6).
57. *Ibid.*, s.382A.(7).
58. *Ibid.*, s.382A.(8).
59. *Criminal Law Consolidation Act* (No. 2), s.6.

trial proper are in need of clarification.

The preceding discussion is aimed not so much as a criticism of the Northern Territory's provisions, but as a vehicle for highlighting the need for the introduction of some general reforms which would inject a greater degree of certainty into the area of unfitness to plead cases. Further, the new legislation of the Northern Territory does have a number of positive features, the most radical of which is to give the court a degree of judicial discretion in the disposal of unfitness to plead cases. Of significance also is the fact that the legislation of the Northern Territory provides ample provision for the review of orders adversely affecting the offender. This recognises a continuing right on the part of the detainee to challenge the circumstances to which he or she may be subjected. Most significantly it provides a means for bringing otherwise easily hidden issues into the public arena thereby helping to avoid the back-door system of justice and the pitfalls of administrative and bureaucratic decision-making that may so easily become subject to abuse.

R. v. *GOONRINGER*

A recent illustration of the flexibility of s.382A of the *Criminal Law Consolidation Act* 1978 (Northern Territory) is given in *R.* v *Goonringer.*[60] Goonringer, an Aborigine, had been charged before a magistrate with assault occasioning actual bodily harm, and break enter and steal. The magistrate had determined that the accused was unfit to plead by reason of his inability to comprehend the proceedings or the nature of the offence, and accordingly had remanded the offender to the Supreme Court to be dealt with in accordance with s.382A of the *Criminal Law Consolidation Act.* The accused had a long history of mental illness and among other things had been found to be incapable of giving instructions for his defence. He had over 24 admissions to hospital for psychiatric treatment and on at least two previous occasions had been certified insane and had spent time at Hillcrest Hospital in Adelaide. Further

60. Unreported decision of the Supreme Court of the Northern Territory 25 October 1979, before Gallop J.

there was evidence that the accused could not tolerate being locked up.

According to the senior specialist psychiatrist who had been treating him, excessive medication was required in order to bring the patient under control when he was locked up in hospital or gaol. He became aggressive when told he could not leave the ward, was generally aggressive to the nurses and other patients, and did not seem to appreciate the wrongness of such behaviour. According to the evidence led on behalf of the accused, the best course was to release the offender to his own environment with a requirement that he should be provided with medication (stellazin tablets) on a regular basis under the supervision of the Health Department. There was no cure for his condition but the prognosis was that if he were to take medication as prescribed there was a realistic hope that he would not behave aggressively towards other people.

A further consideration was that the community from which the accused had come, at Bamyili, an Aboriginal settlement near Katherine, was prepared to accept him back and support him. He would attend a clinic there for daily medication.

After considering all the evidence, the judge held that incarceration was inappropriate. His Honour felt that in view of the offender's mental disorder he could not properly be released conditionally because he would be unable to comprehend the nature of his commitments ('what is the good of me imposing conditions, especially as I say in circumstances where the man is *non compos mentis*'). Accordingly the matter was considered to be a social and medical problem rather than a legal one and the court ordered an absolute discharge.

THE TASMANIAN APPROACH

The Tasmanian procedure is singularly different from other jurisdictions. In that State, in pursuance of s.382(1) of the Criminal Code, the judge 'shall make an order that the accused person be dealt with as a mentally disordered person who has become subject to the criminal process'. This order authorises a person acting under the authority of the Attorney-General to convey the detainee at any time during a period of two months to a hospital specified

by the Attorney-General.[61] Meanwhile the judge may give such directions as he thinks fit for the conveyance of the person to a gaol or a place of safety pending that person's admission to hospital.[62] Persons admitted to a hospital under this scheme are then treated as if they had been admitted in pursuance of a hospital order together with a restriction order.[63] The same procedure applies to persons who are found by a jury to be incapable of understanding the proceedings. Indeterminacy of detention then becomes the order of the day.

STATUTE OF LIMITATIONS FOR UNFITNESS TO PLEAD

The indeterminate nature or consequence of the application of unfitness to plead provisions, coupled with the threat of a pending trial are objectionable features of most criminal justice systems. As already seen, the Northern Territory has gone some way towards remedying some obviously unsatisfactory features in the law. Similarly the Edwards Committee has proposed for New South Wales the adoption of elaborate provisions enabling a 'special trial' to be held in order that, at least where insufficient evidence exists against the accused, the matter can be disposed of despite the incapacity of the offender.[64] However a general criticism (one which relates to all Australian jurisdictions) is the failure of legislatures to provide a formula limiting the duration for which a person held unfit to plead may be detained for the purposes of criminal prosecution. In short, there are presently no time limits either for launching a prosecution or for holding a person in custody while he or she continues to be classified as unfit to plead. To remedy this situation it is proposed that a Statute of Limitations to deal with the problem should be enacted. Such a statute might take the following form:

(1) No person may be detained in custody on account of his unfitness to plead for a term which would exceed the

61. *Criminal Code Act*, 1924 (Tas.), s.382(2).
62. *Ibid.*, s.382(3).
63. *Ibid.*, ss.382(4), (5) and (6).
64. Edwards Committee, *op. cit.*, n. 39, pp. 50-57.

maximum term of imprisonment, less remissions, that the person would otherwise have served if he were to have been convicted of the offence or offences as charged.[65]

(2) No person may be prosecuted for the offence or offences in question after serving a term of detention equal to the term referred to under (1) on account of his unfitness to plead, even though he may be considered fit to plead at some later date.

(3) No person (other than a person who is charged with an offence carrying a penalty of life imprisonment) may be prosecuted for any offence in respect of which he has been detained after he has served a term of two years in custody for that offence or offences on account of his unfitness to plead.

(4) No person may be prosecuted for any offence in respect of which he has been detained after he has served a term of five years in custody on account of his unfitness to plead.

(5) The period allowed for prosecution referred to under (3) and (4) may be extended if, and only if, application is made to the court within the time allowed for prosecution, and the Crown is able to establish that the extension of time is in the public interest.

(6) Where a person has served a term in custody on account of his unfitness to plead, but has recovered sufficiently to be tried within the specified period, and is subsequently prosecuted and convicted for the offence or offences in respect of which he was previously held to be unfit to

65. *Ibid.*, p. 60 where the adoption of a more elaborate provision of a similar import is advocated. The main consideration for having such a provision is to ensure persons are not forgotten in the system. *Ibid.*, p. 61. The Edwards Committee also favours the term 'unfit to be tried' in preference to 'unfit to plead' and advocates separating the rules relating to fitness to plead from the insanity defence provisions, *ibid.*, pp. 46-49. For all forensic patients the Committee advocates annual reviews by a Mental Health Tribunal. The Tribunal would then be required to make a recommendation to the Governor as to the necessity for the continued detention of such persons in a mental institution. Cf. *Mental Health Act*, 1974, No. 2 (Qld.).

plead, any sentence imposed will take into account the time served during which he was held in custody as unfit to plead.

Nothing referred to above should be taken as derogating from the power of the Attorney-General to terminate criminal proceedings against the accused. For example, s.358(1) of the *Crimes Act*, 1900 (New South Wales) enables the Attorney-General 'in respect of any person under committal for trial, and in all cases in which any person is remanded in prison' to exercise his discretion not to proceed with the case. This requires the transmission at any time, of a certificate to the Judges of the Supreme Court. Thereupon a Judge of the Supreme Court 'may' by warrant direct the gaoler to discharge the person from custody in respect of the offence mentioned in such warrant.[66]

The reader should be left with one further thought. There are many more crimes committed than are reported to the police. There are many more reported crimes than criminals brought to trial. Principles of parsimony, humanity and justice do not require that all those caught in the criminal justice sieve be brought inevitably to trial. In appropriate cases diversion is a far more sensible policy than insistence on a verdict as to the guilt or non-guilt of each and every individual.

66. Cf. *Mental Health Act*, 1974, No. 2 (Qld.), ss.32 and 33 discussed *infra*, p. 160.

4 The Insanity Defence

THE M'NAGHTEN RULES

The legal test of insanity for the purposes of the 'special defence' was enunciated by the House of Lords in 1843 in the so called M'Naghten Rules. These Rules which continue to apply to all common law jurisdictions in Australia and also apply with slight modification in the Code States provide, *inter alia,* as follows:

> . . . that the jurors ought to be told in all cases that every man is to be presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction; and that to establish a defence on the ground of insanity, it must be clearly proved that, at the time of committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.[67]

Countless judicial decisions have been concerned with the proper construction meaning and application of the M'Naghten Rules,[68] and they have withstood the test of time as providing the criteria for determining when a person should be held not responsible and therefore acquitted of the offence because he or she was suffering from a 'disease of the mind' at the time that the offence was committed.

The M'Naghten Rules have been and continue to be the subject of trenchant criticism and debate. They have been criticised for

67. (1843) 10 Cl. and Fin. 200, 210. 8 E.R. 718, 722, per Tindal C.J.
68. For example, see *R.* v. *Kemp* [1957] 1 Q.B. 399; *R.* v. *Porter* (1933) 55 C.L.R. 182; *Stapleton* v. *The Queen* (1952) 86 C.L.R. 358; *Willgoss* v. *The Queen* (1960) 105 C.L.R. 295; *R.* v. *S.* [1979] 2 N.S.W.L.R. 1.

placing inordinate weight upon intellectual factors while ignoring factors relating to emotional and volitional impairment.[69] Formulated about 140 years ago, the Rules have been criticised for not keeping abreast with modern developments in psychology and psychiatry. They have been criticised as being too 'polar' in that 'the accused has to be very mad to come within their ambit'.[70]

Even reformulations of the M'Naghten Rules such as the Durham formula which holds that 'the accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect',[71] or the American Law Institute's Model Penal Code formulation, under which the accused must demonstrate that 'as a result of mental disease or defect' the accused lacked substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law, have been shown to possess drawbacks that suggest little advancement upon the well trodden path of the M'Naghten criteria.[72] Indeed the M'Naghten Rules have survived partly because of their simplistic nature enabling juries to understand and apply them.[73] They have also survived because of a recognition that medical opinion cannot, or should not replace the jury's ultimate responsibility for making the moral judgment relating to the guilt of the accused.

According to the Committee on Mentally Abnormal Offenders (England) (hereafter referred to as the Butler Report) the following requirements should be included in any proposed reformulation of the insanity defence. The defence should:

(a) avoid the use of medical terms about which there may be disputed interpretations or whose meaning may change with the years; and

(b) be such as to allow psychiatrists to state the facts of the defendant's mental condition without being required to pronounce on the

69. Goldstein, *The Insanity Defense*, (Yale University Press, 1967), p. 46. Note however, that in Australia the test is interpreted fairly widely. See particularly *R.* v. *Porter* (1933) C.L.R. 182 per Dixon J.

70. Milte, Bartholomew and Galbally, 'Abolition of the Crime of Murder and of Mental Condition Defences', (1975) 49 A.L.J. 160, 163.

71. *Durham* v. *United States* (1954) 214 F 2d 862 (D.C. Circuit).

72. For a criticism of these reformulations see *Report of the Committee on Mentally Abnormal Offenders*, (The Butler Report) Cmnd. 6244 (H.M.S.O., London, 1975), p. 220 *et seq.*

73. Kuh, 'The Insanity Defense – An Effort to Combine Law and Reason', (1962) 110 U. Pa. Law Rev. 771, 783-785.

extent of his responsibility for his offence. Degrees of responsibility are legal, not medical, concepts.

Moreover, to the extent that the question of 'insanity' is to remain one for the jury to decide, the defence must:

(c) avoid the use of words and expressions which may confuse the jury; and

(d) be capable of being the subject of a clear direction by the judge.[74]

The Butler Report goes on to propose its own reformulation by advocating a verdict of 'not guilty on evidence of mental disorder',[75] that is based on a two tiered approach, covering the *mens rea* portion of the rules in the first instance, and then permitting an exception from conviction if it is determined that the offender was suffering from severe mental illness or severe abnormality when he committed the offence.

It is significant that in Australia there does not seem to have been any serious attempt to abandon the M'Naghten Rules. Thus in New South Wales the Edwards Committee has merely stated that no alterations should be made to the M'Naghten Rules: 'if they are not to be completely abolished, they ought to be left alone'.[76] Minor modifications of the Rules were considered to be pointless and the Committee was partly able to justify its decision by pointing in New South Wales to the existence of the defence of diminished responsibility.[77] This special defence would provide an alternative to an insanity plea, if it could be established within the meaning of the relevant provision in the *Crimes Act,* 1900 (as amended), that the accused was mentally disordered at the time of the offence.[78]

The Mitchell Committee of South Australia, while recommending against the introduction in that State of a defence of diminished responsibility, supported in substance the retention of the M'Naghten

74. The Butler Report, *op. cit.*, n. 72, para. 18.17.
75. *Ibid.*, para. 18.18 *et. seq.*
76. *Report of the N.S.W. Mental Health Act (1958) Review Committee,* (Edwards Committee), 22, *Proceedings of the Institute of Criminology,* (Sydney, 1975), p. 48.
77. The defence of diminished responsibility was introduced in 1974, see s.23A *Crimes Act,* 1900 (N.S.W.).
78. See for example *Veen* v. *The Queen* (1979) 53 A.L.J.R. 305.

Rules noting at the same time that 'We [the Committee] do not for one moment suggest that the M'Naghten Rules are particularly satisfactory.'[79] The Committee however advocated the abandonment of all references to delusions,[80] criticised the unduly intellectualised component in the rules and recommended that South Australia adopt the first paragraph of the insanity test as laid down in the Queensland and Western Australian Criminal Codes.[81] Section 27 of these Codes presently provides as follows:

> **27. (Insanity).** A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission he is in such a state of mental disease or natural mental infirmity as to deprive him of capacity to understand what he is doing, or of capacity to control his actions, or of capacity to know that he ought not to do the act or make the omission.
>
> A person whose mind, at the time of his doing or omitting to do an act, is affected by delusions on some specific matter or matters, but who is not otherwise entitled to the benefit of the foregoing provisions of this section, is criminally responsible for the act or omission to the same extent as if the real state of things had been such as he was induced by the delusions to believe to exist.

JUSTIFYING DETENTION OF INSANE PERSONS

What justification is there for detaining persons who have been acquitted on the ground of insanity? Herbert Fingarette, a con-

79. *Criminal Law and Penal Methods Reform Committee of South Australia*, Fourth Report, 'The Substantive Criminal Law', (1977), p. 42.
80. This reference to delusions is not referred to in the passage quoted above. The reference relates to the rule that where the accused was suffering from a delusion, but was otherwise sane, he is to be treated as if his delusions represented reality. Unfortunately the Committee did not provide sufficient reason for their recommendation to abandon this Rule except to state that in practice it could lead to absurd results. It could be argued however, that this Rule ought to be retained as it is consistent with principle that the ascription of responsibility is determined essentially by reference to the actor's *mens rea* or evil intent. See *ibid.*, p. 43. Note however, that the rule relating to delusions is retained in the Criminal Codes of Queensland and Western Australia – see para. 2 of s.27 quoted on this page.
81. *Ibid.*

temporary commentator on the concept of insanity has something to say on this subject.[82]

First, he distinguishes between absence of *mens rea* (and therefore blameability) from the insanity plea. He argues quite rightly that absence of *mens rea* is a claim by a responsible person under the law that he or she acted without guilty intent, whereas the insanity plea is a claim that the person was not a responsible agent at the time of the commission of the relevant act. He suggests that a person who is found to be legally insane is not a fit subject of moral judgment at all. He says:

> Of one who is not even a responsible agent, though we may say he is not guilty, we mean by this not to express a moral judgment of him but to indicate that one must abstain from judging such a person morally.[83]

A child who commits a prohibited act is in a similar position. Fingarette continues:

> . . . the innocence of a person who succeeds with an insanity plea is the innocence of a person who **cannot** be guilty. . . . It is the innocence of one who is held not to have had the capacity to act as a free and responsible citizen.[84]

He therefore concludes that the qualified verdict does not signal absence of moral fault but does signal 'a grave fault in capacity at the time of the offending act, to respond to the requirements of morality and the law'. The fault of incapacity then is, for Fingarette, the condition precedent for the incarceration of legally insane persons. However, whether the fault is one of morals or of capacity the policy of restraining the person is justified in his view on the basis that the community needs to be protected. Fingarette goes on to postulate that there are not two but three fundamentally different verdicts:

(1) responsible under law and innocent of crime;

(2) responsible under law and guilty of crime; and

82. H. Fingarette, *The Meaning of Criminal Insanity*, (University of California Press, Berkeley, 1972).
83. *Ibid.*, p. 132.
84. *Ibid.*, p. 135.

(3) not responsible under the law and hence neither guilty nor innocent.

And so concludes that:

> . . . there is a fundamental and rational legal basis for denying those held not guilty by reason of insanity the immediate freedom that we grant those who are held not guilty *simpliciter*.[85]

If we pause to examine these verdicts we find an unfortunate use of the word 'innocent'. The jury's verdict is not a declaration of the accused person's guilt or innocence – it is the narrow, more technical question of whether the Crown has proven beyond reasonable doubt to the satisfaction of the jury that the accused person is responsible in law for the commission of the offence. The verdict 'not guilty' is not therefore identical with a finding that the offender is innocent. It is only equivalent to a finding that the Crown has failed to discharge the onus of proving that the offender is guilty. Thus it may be more accurate to amend the alternative verdicts to read as follows:

(1) responsible under the law and **not guilty** of crime;

(2) responsible under the law and **guilty** of crime; and

(3) **not responsible** under the law and hence **neither guilty** nor **not guilty.**

Of course when we put the third verdict in this form it is clearly unacceptable because it is a pre-condition of the qualified verdict that the accused be found not guilty. Thus the third verdict cannot logically be interpolated as meaning 'not responsible under law and hence neither guilty nor not guilty'. When all is said and done however, it is a matter of empirical fact that juries do have the power to bring in the qualified verdict, and that what flows from it is sanctioned by law. The real question is whether the procedure that follows a qualified acquittal is really necessary when there are alternative means for disposal outside the criminal law.

If the insanity defence is to be retained as a permanent feature of criminal justice administration, it should be retained in such a

85. *Ibid.*, p. 134.

way as to ensure that the qualified acquittee is treated in the same way as any other citizen who is suspected of being mentally disordered and therefore a threat to the community. There is no adequate justification in modern times for requiring such persons to be detained at the Governor's pleasure.

THE FUTURE OF THE INSANITY DEFENCE

The dilemma of what to do with the person found not guilty by reason of insanity is a problem which finds no simple solution. Caesar for example, has argued that the historical basis for the insanity defence no longer applies. He argues simply that as those found not guilty by reason of insanity present as great a threat to society as the convicted sane offender, the defence should be eliminated or its consequences altered. This would allow the health needs of the defendant to be met without jeopardising the safety of the community.[86] As has been seen the social defence aspect of this approach is presently achieved by the requirement that a person so acquitted should be kept in strict custody, then in safe custody during the Governor's pleasure. The fact that the 'patient' is often obliged at least in some States to serve his or her term in penal institutions is a stark reminder that the time is long overdue for deciding not whether, but how the law should be changed. In particular, the time has come for resolving the apparent paradox of the way persons acquitted on the grounds of insanity are treated.

A recurring theme in this book is that so long as the insanity defence remains, a person acquitted on the ground that he or she was insane at the time that the 'offence' was committed should on no account be held in an institution reserved for persons serving prison sentences.

Further, while it is conceded that such persons may be required to be held in custody while they continue to represent a potential threat to the community at large, they should be given such treat-

86. B. Caesar, 'The Insanity Defence: The New Loophole' in (1979) 25 *Crime and Delinquency* 436. Similar views are held by N. Morris, 'Psychiatry and the Dangerous Criminal', (1968) 41 S. Cal. Law Rev. 514, 517; H.L.A. Hart, *Punishment and Responsibility: Essays in the Philosophy of Law*, (Clarendon Press, 1968), p. 19.

ment or care as their health needs demand, and they should be released at the earliest possible moment that they are considered no longer to be a serious threat to the life, limb or property of others. In short, they should be treated in the same manner as any other person who has been involuntarily detained in a mental institution on account of his or her mental illness.

No attempt is made here to enter the debate as to whether or not the time has come to abandon altogether the insanity defence. To abandon the defence would strike at the very heart of the criminal law and necessitate a radical change in philosophy with far reaching consequences. However Monahan has pointed out that the ranks of the abolitionists are growing, and it may be a question of time before there is a major overhaul of the present system.[87] While the topic relating to the future of the defence of insanity is too large and too complex to embrace here, consideration should be given to including this vital issue in any future reference to the Australian Law Reform Commission on mental illness and the law.

THE SPECIAL DEFENCES

There is a further and related problem, but one which is more easily resolved in terms of conventional criminal law concepts and does not threaten to the same extent fundamental assumptions of the criminal law whenever changes to the rules of insanity are contemplated. This relates to the future of the 'special defences' of provocation and (in two States) diminished responsibility. To this list may be added the defence of excessive self-defence.[88] The

87. J. Monahan, 'Abolish the Insanity Defense? Not Yet', (1973) 26 Rutgers Law Rev. 719. See also Goldstein and Katz, 'Abolish the Insanity Defense – Why Not?', (1963) 72 Yal L.J. 853; Brady, 'Abolish the Insanity Defense – No!', (1971) 8 Houston Law Rev. 629. Others involved in the debate include Halleck, *Psychiatry and the Dilemmas of Crime*, particularly p. 341; Hart, 'Changing Concepts of Responsibility' (Ch. VIII), *op. cit.*; Hart, *The Morality of the Criminal Law*, (1964); Szasz, *Law Liberty and Psychiatry*, (1963), pp. 138-146; Fingarette, *op. cit.*, pp. 1-15; Morris, *op. cit.*, Morris and Hawkins, *The Honest Politician's Guide to Crime Control*, (University of Chicago Press, 1970), esp. p. 175; Packer, *The Limits of the Criminal Sanction*, (Stanford University Press, Stanford, 1978).

88. *Viro* v. *R.* (1978) 52 A.L.J.R. 418. Excluded from discussion are the two defences of sane and insane automatism, see *R.* v. *Quick and Paddison* (1973) 57 Cr. App. R. 722; *R.* v. *Tsigos* [1964-1965] N.S.W.R. 1607.

effect of these defences, if successfully pleaded, is of course to reduce murder to manslaughter, thus enabling the court to exercise its discretion when imposing sentence. This is because in most jurisdictions the penalty for murder is mandatory life imprisonment, whereas the penalty for manslaughter is a discretionary life sentence only.

But, it may be argued, why have these special highly complicated defences? Why not merely let the jury determine whether the offender is guilty of an unlawful homicide? Thus, once it has been determined that the accused may properly be found guilty of an unlawful homicide, it makes a great deal of sense to leave the issue of disposal and the relevance of any evidence relating to provocation or diminished responsibility for evaluation at the sentencing stage.

In the Australian Capital Territory it has recently been held that the penalty for murder is not mandatory – an apparent oversight by the draftsman when the death penalty was abolished.[89] This fortuitous circumstance means that there is no need to introduce the special defence of diminished responsibility and thereby removes the need for courts to engage in 'tortuous circumlocution' in order to avoid a murder verdict.[90] Likewise it might be thought, procedural advantages could be obtained by abandoning the highly technical defences of provocation, and excessive self-defence.

That there has been in recent times a rising tide of dissatisfaction with the mandatory penalty of life imprisonment for murder is clear. A list of arguments against the mandatory life sentence is given in the Butler Committee's Report.[91] Later still, the Serota Committee recommended that the mandatory penalty of life imprisonment for murder should become a maximum penalty only.[92] A similar recommendation was made by the New Zealand

89. *R.* v. *Wheeldon* (1978) 18 A.L.R. 619. Sections 4 and 5 of the *Death Penalty Abolition Act*, 1973 (Cth.) and s.6 *Crimes Ordinance*, 1974 (A.C.T.) had the effect of abolishing capital punishment for murder, substituting imprisonment for life and enabling the court to impose a sentence of less duration where the latter was specified. The usual practice in other States has been to trade death penalty abolition for a mandatory life sentence.

90. Milte, Bartholomew and Galbally, *op. cit.*, n. 70.

91. The Butler Report, *op. cit.*, n. 72, paras. 19.8-19.16.

92. *Sentences of Imprisonment: Report of the Advisory Council on the Penal System*, (Chairperson, B. Serota). (H.M.S.O., London, 1978), ch. 12, pp. 106-115.

Criminal Law Reform Committee,[93] and in Australia there have been rumblings of like effect.

In Australia, Milte, Bartholomew and Galbally[94] have argued quite persuasively for doing away with the mandatory penalty of life imprisonment for murder, doing away with all the mental condition defences and thus allowing the disposition to be determined at the sentencing stage. It is at the sentencing stage, they argue, that the gravity of the offence coupled with the aggravating and mitigating circumstances relating to the offender (including any mental disorder) can be given due weight.

There is however, at least one word of caution against the common sense suggestion advocating the removal of the special defences from the statute books. It is this. It alters the role of the jury in making the primary judgment relating to the moral and legal responsibility of the offender and shifts this fundamental task to the sentencer. As Morse has observed:

> . . . the defendant's degree of moral and legal responsibility should be made in the first instance by the jury, the representatives of society. If the moral difference is expressed only by the low visibility sentencing decision of the judge, the moral educative effect of the criminal law is much diminished.[95]

The retention of the separation between trial and dispositional stages is important not only in order to ensure that the primary decision as to culpability is determined by the jury, but also because it is the jury's decision that sets the parameters of just punishment, particularly the upper limits of punishment that may be imposed in any particular case. However for present purposes, it is submitted that it is not necessary to go so far as to abolish the insanity defence, without consideration being given to the constructive suggestions made by Milte *et al.* The present writer is supportive of the proposal to abolish the mandatory penalty for murder, but at the same time would retain such special defences as would permit or facilitate the jury, rather than the judge, in making the primary decisions as to culpability. To distinguish

93. *Report on Culpable Homicide*, see summary [1978] Crim. Law Rev. pp. 1-4.
94. *Op. cit.*, n. 72.
95. S. Morse, 'Diminished Capacity: A Moral and Legal Conundrum', (1979) Vol. 2, No. 3, *Law and Psychiatry* 217, 289, 290.

between murder and other culpable homicides it would be desirable, it is submitted, to reduce the penalty for manslaughter to a maximum term of imprisonment of 15 years, (as presently obtains in Victoria) and substitute for the mandatory penalty for murder, a discretionary penalty of life imprisonment.

THE UTILITY OF THE INSANITY DEFENCE

There are conflicting opinions as to whether the prisoner is wise to raise the insanity defence. According to South Australian data analysed by George, persons acquitted on the ground of insanity may serve considerably longer terms of enforced detention than those convicted of the offence and sentenced in the ordinary course of events.[96] On the other hand, Knight who has examined insanity acquittals in Tasmania for the period January 1971 to June 1979 has provided statistical evidence suggesting that in that State at least, the periods of enforced detention for persons acquitted on the ground of insanity are generally far shorter than for comparable offenders found guilty and sentenced.[97]

Thus whether it is to the advantage of the accused to raise insanity may depend upon the jurisdiction in which he or she is found. It may also involve a consideration of the nature of the offence, for it would seem foolish to plead insanity unless the risk of being awarded a substantial term of imprisonment is anticipated. In most circumstances insanity is raised to avoid the mandatory penalty of life imprisonment (or to avoid the death sentence) for murder, but this is not always the case.[98]

96. T.S. George, 'Commitment and Discharge of the Mentally Ill in South Australia', (1972) 4 Adelaide Law Rev. 330, 355, 356.

97. S.J.D. Knight, 'The Use of the Defence of Insanity and the Unfitness to Stand Trial Provisions in the Tasmanian Criminal Code', *Criminal Research Project,* (Unpublished, 1979). Knight warns however, that in view of his small sample, the conclusions must be viewed with extreme caution.

98. Only Western Australia retains the death penalty in its legislation. Capital punishment was abolished by the following legislation: *Criminal Code Amendment Act,* 1922 (Qld.), *Crimes (Amendment) Act,* 1955 (N.S.W.), *Criminal Code Act,* 1968 (Tas.), *Death Penalty Abolition Act,* 1973 (Cth.), *Crimes (Capital Offences) Act,* 1975 (Vic.) and *Statutes Amendment (Capital Punishment Abolition) Act,* 1976 (S.A.).

However, Freiberg has produced data showing that for two States, Victoria and New South Wales, the only States in which he was able to obtain meaningful data, the average periods of detention for male persons found not guilty of murder on grounds of insanity and who were in custody on 31 December 1974, were seven years five months and six years two months respectively, calculated from the date of the Governor's order. This was, according to Freiberg, considerably less than the average time served by life sentence prisoners, the difference being about six years in Victoria and 11 years in New South Wales.[99]

More recent data from Victoria confirm the observation that Governor's pleasure detainees who are acquitted of murder on the ground of insanity serve shorter periods of incarceration on average than do convicted murderers. Thus during the period 1970 to 1979, there was a total of 83 Governor's pleasure prisoners 'sentenced' in Victoria. Of this total, 34 were persons acquitted of murder on the ground of insanity. This compares with 87 prisoners convicted and sentenced for murder during the same period. Table 1 which contains data supplied on request from the Victorian Department of Community Welfare Services, suggests that it is still advantageous for the prisoner charged with murder to attempt to obtain an acquittal on the ground of insanity rather than be convicted of murder.

Table 1 – Time Served by Murderers Released Between 1970 and 1979 (Victoria)

	Range		
Number	*Minimum*	*Maximum*	*Mean Time Served*
87 convicted	3 years and 9 months	29 years	13 years and 6 months
34 acquitted on ground of insanity	11 months	17 years and 11 months	9 years and 2 months

99. A. Freiberg, 'Out of Mind, Out of Sight: The Disposition of Mentally Disordered Persons involved in Criminal Proceedings', [1976] 3 Mon. Law Rev. 134, 159.

The interpretation of this table however, must be approached with caution, for the mean time served may be influenced by extreme values at either end of the range.

Freiberg also provides data suggesting that a far higher ratio of insanity verdicts per life sentenced prisoners exist where the jurisdiction has retained capital punishment on its statute books. Writing around the same time as the date of abolition of capital punishment in Victoria, Freiberg implies that with abolition there would be a diminution in the proportion of insanity verdicts compared with guilty verdicts for murder.[100]

Sufficient time has not elapsed since the abolition of the death penalty in Victoria to test this hypothesis. Table 2 provides a breakdown on a yearly basis of the number of convicted and sentenced murderers and the number of murderers acquitted on the ground of insanity for the period June 1970 to June 1980 inclusive. In order to avoid possible ambiguities, data for the year

Table 2 – Persons Acquitted of Murder on Ground of Insanity and Murderers Convicted and Sentenced in Victoria

Year	*No. Acquitted of Murder on Ground of Insanity*	*No. Convicted and Sentenced*	*Total*
Period 1			
1970 June–Dec.	4	4	8
1971 Jan.–Dec.	8	5	13
1972 Jan.–Dec.	1	8	9
1973 Jan.–Dec.	4	2	6
1974 Jan.–Dec.	7	9	16
TOTAL	**24**	**28**	**52**
Period 2			
1976 Jan.–Dec.	5	7	12
1977 Jan.–Dec.	1	9	10
1978 Jan.–Dec.	2	9	11
1979 Jan.–Dec.	3	11	14
1980 Jan.–June	2	2	4
TOTAL	**13**	**38**	**51**

100. *Ibid.*, p. 161.

in which the abolition of the death penalty came into effect (1975) have been omitted from the table. It can therefore be said with reasonable confidence that persons dealt with prior to 1975, or after the commencement of 1976, were aware of the possible consequences of a murder conviction when preparing their defences.

The table clearly shows that while there has been a relatively constant number of disposals over the two periods under consideration (52 and 51), there was a dramatic drop in the number of Governor's pleasure prisoners (from 24 to 13), and a corresponding increase in the number of convicted and sentenced murderers (from 28 to 38) in the period following abolition of capital punishment. Although there may be other explanations for these variations, it is submitted that the data are consistent with the hypothesis referred to above.

In passing it might also be noted that in England, following the introduction of diminished responsibility, there was a marked reduction in the proportion of insanity verdicts.[101] Therefore following similar reasoning it would not be unreasonable to infer that both Queensland and New South Wales would have also experienced a drop in the incidence of insanity verdicts after these States introduced diminished responsibility in their jurisdictions. The advantage of course in pleading diminished responsibility rather than pleading insanity in these States, is that it provides the offender with a means of avoiding the mandatory life sentence for murder. Accordingly, it is submitted that if Victoria were to introduce diminished responsibility a further, perhaps even more dramatic, reduction in the use of the insanity defence would result.

The preceding observations suggest that the insanity defence will be invoked, first, in order to avoid capital punishment and secondly, in order to avoid a mandatory sentence of life imprisonment, particularly where the special defence of diminished responsibility is not also open to the defence. Where the prisoner has the option of using the defence of diminished responsibility (that is, in New South Wales and Queensland), the insanity defence would probably be relegated to a reluctant third choice in any attempt to

101. N. Walker, *Crime and Insanity in England,* vol. 1, (University Press, Edinburgh, 1968), pp. 158-160. Note however, that the defence of diminished responsibility in Australia is available in Queensland and New South Wales only, see s.304 *Criminal Code* (Qld.); s.23A *Crimes Act,* 1900 (N.S.W.).

avoid the inexorable consequences of a murder conviction. However, as indicated earlier, the penalty for murder is not mandatory in the Australian Capital Territory.[102] There would appear therefore to be less incentive on the part of the accused to plead insanity in the Territory than in most other jurisdictions.

Thus in the Australian Capital Territory the insanity defence is of reduced significance. It is unnecessary for use as a means of avoiding the inexorable consequences of life imprisonment for murder precisely because there is no mandatory penalty. On the contrary, courts are empowered to set determinate sentences for murder, whereas Governor-General's pleasure detainees are subject to indeterminate periods of detention. Similarly, the Territory does not need to import from New South Wales the special defence of diminished responsibility, which as discussed earlier, is essentially another device for escaping the mandatory penalty for murder. In short, the only advantages to the accused for raising insanity may be summarised as follows:

(1) to avoid the stigma of conviction. This however would need to be traded against the stigma of being labelled mentally ill ('mad' rather than 'bad');

(2) to avoid the possibility of having the maximum sentence imposed despite the existence of a discretion to impose a shorter sentence. Here the gravity of the offence for which the offender is to be tried must be carefully weighed. Where the offence is particularly heinous, and there are no mitigating circumstances the advantages of an insanity defence could appear to provide an attractive alternative;

(3) where it would be beneficial for the accused to receive psychiatric care in a mental institution rather than in a prison; and in particular

(4) where the offender's mental illness is of a temporary nature and unlikely to recur. In this event, the offender may have a legitimate ground for believing that he or she will be released in a relatively short period of time.

102. *R.* v. *Wheeldon* (1978) 18 A.L.R. 619. See also *supra*, n. 89.

That the issue of insanity is not a dead letter in the Territory has been shown by the recent successful insanity plea by *Taylor*,[103] a case decided after *Wheeldon* and therefore at a time when it was known that the life sentence for murder was not mandatory.

INSANITY UNDER COMMONWEALTH LAW

It should not be forgotten that the insanity defence may be used for offences other than murder. A recent example of this, and one which also suggests that a person may escape a long sentence of imprisonment where the defendant is acquitted on ground of insanity, is the case of Able Seaman Trent. Trent was found not guilty on the ground of insanity, by a Court-Martial, of wilfully destroying six naval aircraft, wilfully damaging another six naval aircraft, and wilfully damaging a hangar at H.M.A.S. Albatross, Nowra in New South Wales. The value of property damage caused by fire was estimated at many millions of dollars. Trent committed these offences on 4 December 1976, and was charged under s.29(C) of the *Naval Discipline Act* (United Kingdom) applied in pursuance of s.34 of *Naval Defence Act*, 1910 (Commonwealth). Following his trial and qualified acquittal of the offences, Trent was ordered on 22 April 1977, to be kept in strict custody at the Royal Australian Navy Hospital, H.M.A.S. Penguin, Sydney, until 18 July 1977. Then he was transferred to the First Military Corrective Establishment at Holsworthy.[104]

Finally in pursuance of s.63 of the *Naval Discipline Act*, the Governor-General declaring his pleasure ordered first, that Trent should be detained in safe custody and second, that he should be released from custody on 20 October 1978, subject to certain conditions, including a requirement that he should place himself under the supervision of a parole officer and that he should submit himself to any recommended psychiatric treatment.

103. *R.* v. *Taylor*, unreported decision of the Supreme Court of the Australian Capital Territory S.C.C. No. 55 of 1977, 19 June 1979 to 26 June 1979.
104. It is understood that the Holsworthy Military Corrective Establishment has now been closed and, although most of those held at Holsworthy have been moved, it appears that the new establishment does not have facilities to house mentally ill offenders. One may question whether an acquitted person should in any event be housed in a penal institution (*infra*, Chapters 6 and 7).

There can be little question that but for Trent's successful insanity plea his period of incarceration would have been considerably longer having regard to the gravity of his deeds. Accordingly, the case shows that there may be advantages in raising the insanity defence in certain circumstances.

A further issue which arises from this case, and one which applies to many jurisdictions including New South Wales, is that often prisoners acquitted on the ground of insanity are detained in penal institutions rather than hospitals. On 16 December 1976, for example, of 51 Governor's pleasure prisoners detained in institutions in New South Wales only 29 were in mental hospitals. Further, of 57 Governor's pleasure prisoners who were released during 1966-1967 slightly fewer than half this number 'had been admitted to a mental hospital at some stage of their detention'.[105]

SUMMARY OF RECOMMENDATIONS AND OBSERVATIONS

Based partly on the observations in the preceding discussion, the following recommendations and observations can be made:

(1) The insanity plea is likely to continue to be raised by the defence in appropriate cases even though the prisoner in the alternative may not be faced with the prospect of a mandatory penalty. In general those acquitted on ground of insanity for murder appear to be released from custody prior to those convicted of murder.

(2) It is preferable to retain in the Australian Capital Territory a system of discretionary penalties for serious crimes including murder,thereby reducing the attraction of insanity pleas and also reducing the need for the introduction of special defences such as diminished responsibility. However, the distinction between murder and manslaughter should be retained, together with the principle that the jury should make the primary decision relating to the culpability of the offender.

105. *Report of the Royal Commission into N.S.W. Prison,* (The Nagle Report), (Govt. Printer, Sydney, 1978), p. 321. These data are also referred to in the Judgment of Jacobs J., in *Veen infra,* p. 116.

(3) Other jurisdictions should also consider the advantages of discarding the mandatory penalty for murder. To distinguish between the penalties for murder and manslaughter, the maximum penalty of the latter should be reduced to 15 years' imprisonment.

(4) Persons found not guilty on the ground of insanity, and also persons who are considered unfit to plead or to stand trial should not be detained in penal institutions. Rather they should be detained in ordinary or special mental hospitals if treatable. If not treatable, these persons should be detained in other institutions or asylums which are sufficiently secure to afford protection to the community but at the same time are also able to provide humane care treatment and consideration.

(5) Where there are no adequate facilities to provide treatment and security in the form outlined, resources should be made available to provide them.

(6) Once a person acquitted on the ground of insanity has recovered sufficiently in order to be released, release should be proceeded with, without undue delay. This may involve a reassessment of the desirability of retaining the present system of Governor's pleasure as the basis of the authority for detention and release. At the very least, the trial judge ought to be in the position of determining whether the defendant should be discharged, either conditionally or unconditionally, or whether his or her future should be determined at the discretion of the Governor.

(7) In the case of a person unfit to plead, a determination should be made within a reasonable time as to whether the charges against the detainee should be proceeded with or dropped. Where the charges are dropped the prisoner should then be subject to the ordinary rules governing involuntary civil commitment. Consideration should be given also to providing a statute of limitations for proceeding against persons who are held in custody on the basis that they are unfit to plead.

5 Involuntary Commitment

Much has been said concerning the concepts of insanity and unfitness to plead or stand trial. Their importance lies not so much in the prevalence with which these matters arise or are contested in the criminal courts, (fortunately they arise infrequently), but rather for their value in delineating the parameters of the criminal law, (including criminal procedure) and for their contribution in leading to an understanding of who are, and who are not, to be held criminally responsible and therefore subject to criminal sanction. Outside the criminal law, civil involuntary commitment of mentally disordered persons to psychiatric institutions remains a primary method of legal constraint. As both civil and criminal procedures have the effect of depriving an individual of his or her liberty, does it make any difference whether this is achieved in pursuance of civil or criminal law? Is it not the case that under either system the aim of protecting the community is promoted? On what basis is one course taken in preference to the other? The answers to these questions are based not on legal or medical considerations but on ethical ones.

FREEDOM FROM INTERFERENCE

A general principle of cardinal significance of criminal justice is that there may be no imposition of a penalty unless and until there has been a conviction.[106] To hold otherwise would open pandora's box of arbitrary power, and subject the citizen's civil liberties to the whims and fancies of those in authority. There are of course many areas in which the citizen's freedom or right to go

106. *Cobiac* v. *Liddy* (1969) 43 A.L.J.R. 257, 259.

about his or her ordinary business may be interfered with or interrupted quite severely. These include where he (or she) is arrested, where he is remanded in custody (denied bail), where he is held unfit to be tried (and detained in custody), where he is found not guilty on grounds of insanity and eventually detained at the Governor-General's pleasure,[107] or where he is otherwise committed or detained at a mental institution involuntarily.

Military conscription and subjecting a person to quarantine may provide less obvious forms of restraint upon liberty. While these types of measures may resemble penal sanctions in their effect, (they are after all coercive forms of state interference that infringe an individual's freedom to go about his or her ordinary business), they are conceptually different. In no way are they intended to be punitive – that is they are not intended to be state-based forms of punishment formally inflicted as a consequence of the proven commission on the part of the actor of discrete acts or omissions identified as being criminal.

This does not mean that an individual experiencing a form of non-punitive state-authorised restriction upon his freedom does not feel he is being punished, or that such interference is necessarily less harsh than a court-imposed sanction following a conviction. It merely means that the interference is not intended to be punitive nor is it intended to be perceived as punitive. Conversely, if it is intended to be punitive then the application of the measure is legally unjustified and morally obnoxious.

The dividing line permitting punitive interference rests upon proving the case against the accused 'beyond reasonable doubt', the so called golden thread of English criminal law that is also shared by all Australian criminal law jurisdictions. As Lord Sankey said in *Woolmington* v. *DPP*:[108]

> Throughout the web of the English criminal law one golden thread is always to be seen, that it is the duty of the prosecution to prove the prisoner's guilt subject to what I have already said as to the defence of insanity and subject also to any statutory exception. If, at the end of and on the whole of the case, there is a reasonable doubt, created by the evidence given by either the prosecution or the prisoner, as to whether the prisoner killed the deceased with a malicious intention, the

107. The nomenclature varies from jurisdiction to jurisdiction, as discussed *supra*, p. 42ff.
108. [1935] A.C. 462, 481.

> prosecution has not made out the case, and the prisoner is entitled to an acquittal. No matter what the charge or where the trial, the principle that the prosecution must prove the guilt of the prisoner is part of the common law of England and no attempt to whittle it down can be entertained.

This golden thread provides a double protection. First it prohibits courts from imposing punishment when all the elements constituting the proscribed act have not been proven to the requisite degree. Second, where an offence has been proven to the requisite degree, the penalty imposed is linked to the statutory provision that specifies the maximum permissible penalty for that offence. Indeed in most cases a sentence less than the maximum will be imposed, and sometimes a different type of sanction may be imposed altogether. However, for present purposes the limiting principle of punishment, which demands that the penalty imposed should not exceed the maximum prescribed penalty, can be seen as affording a degree of protection to the convicted person by ensuring that the punishment does not exceed this limit.

There is no attempt here to belittle the significance or the potential for non-punitive incursions into basic civil liberties. The legal devices and justifications which enable the state authorities to intrude and interfere with the individual's right to do as he or she pleases must be carefully defined, scrutinised and not permitted to exceed the minimum standards that are consistent with the smooth working of a tolerant society. In this regard the standard for the violation of liberty given by John Stuart Mill in his famous essay 'On Liberty', namely, that the only purpose for which power should be exercised over a member of a civilized community against his will is to prevent harm to others – is a useful principle to follow.

Mill went further and suggested that interference was not justified even though it was for the person's own physical or moral good. By implication, Mill's principle is clearly intended to apply to a person's mental health, or mental ill health. However modern involuntary commitment laws, through humane and often paternalistic motives do not support the principle of non-interference to this extent – as in the case of suicidal patients – where treatment is given often against the patient's will. This issue presents a dilemma of social, moral and religious significance with which every society must grapple.

Even so, the consequences of ignoring the rights and responsibilities of the state to regulate or exercise control over the treatment of non-criminals, such as those held in mental hospitals or those detained under pre-trial powers, while at the same time upholding a post-conviction policy that adheres to a carefully regulated regime of judicial and administrative control over an individual offender wherein the degree of interference (or punishment) is strictly limited, invites arbitrary power to operate via the back door. All things being equal, a non-criminal should not be subjected to a greater infringement upon his or her civil rights than one who is convicted. The procedures for achieving involuntary civil detention must be at least as fully delineated by the general law as those applying to the criminal law.

Alas, in all Australian states and territories, the protections afforded against wrongful, mistaken or arbitrary decision-making in the area of involuntary civil commitment lag behind criminal law procedures for protecting accused persons. As a first step towards correcting this anomaly, it is submitted that the onus of proof for effecting civil involuntary commitment to a mental institution, including the procedure for changing the status of a person within a mental institution from a voluntary to a involuntary patient, should be the same as that required under the criminal law, namely, the authorities should be required to establish beyond reasonable doubt that such labelling (and consequent deprivation of liberty) is appropriate. This should be in addition to the recommended requirement referred to earlier (at p. 30 *supra*) that a medical practitioner who certifies a person as mentally ill should be satisfied that admission and detention is necessary and that there are no alternative means for dealing with the person reasonably available.

POLICE AND THE MENTALLY ILL

The exercise of police discretion has a critical bearing on procedure that is likely to be followed in any case involving serious antisocial acts by mentally disturbed persons. The question often faced by the police is whether to proceed with a prosecution or divert the offender into the mental health system. In general the attitude taken by police is that where there are obvious manifest-

ations of mental disorder, and the offences are not of a high order of gravity, the decision to take criminal proceedings may be abandoned in preference to placing the person under the care of mental health authorities. No doubt a significant proportion of persons involuntarily committed to mental institutions are persons who but for the exercise of police discretion might have been prosecuted for a criminal offence.

In the United States, the President's Commission on Law Enforcement and Administration encouraged the approach that persons requiring special therapeutic treatment should be diverted as soon as possible from criminal proceedings.[109] While such policy emanates from commendable humanitarian considerations it may overlook the potential protections that are afforded by criminal proceedings. As Kittrie has noted, the implementation of the rehabilitation ideal, and in this regard, the emphasis on social defence or community protection may leave the individual offender unable to protect himself or herself from the authority of the therapeutic state.[110] Before, during and after criminal proceedings, it is always desirable to keep in mind the potential alternatives to which a mentally disordered person may be subjected. Treatment or diversion to mental health authorities may not always be the appropriate course to follow despite the manifestation of dysfunctional behaviour.

A recent study conducted at Orange County, California, involving 100 randomly selected police officers, 50 of whom had just arrested a person and 50 of whom had petitioned a person for involuntary civil commitment, were interviewed immediately after they had taken their respective courses of action. The aim was to examine the decision-making process of the police involving the mentally ill. Among other things, the study showed that about one-third of the committed cases could have involved an arrest, while from those arrested a similar proportion could have been made subject to civil commitment procedures. Yet despite this overlap, which led support to the thesis 'that criminal justice and mental health function as interchangeable systems of social regulation', there was

109. *The Challenge of Crime in a Free Society*, (U.S. Government Printing Office, Washington, 1967), p. 134.
110. N. Kittrie, *The Right to be Different: Deviance and Enforced Therapy*, (John Hopkins University Press, Baltimore, 1971), p. 401.

little evidence suggesting that the seriously mentally ill were being 'criminalised' by being sent to prison, or that serious law-breakers were being diverted to hospitals. In short, the police were found to have done 'a surprisingly accurate job of triage along the dimensions dictated by official public policy'.[111]

In Australia, so far as the writer is aware, there have been no studies which have focussed on the exercise of police discretion in the handling of mentally disordered persons.[112] A study in this area is urgently needed if for no other reason than to uncover the nature and form of screening that takes place prior to diversion (why are some diverted from the courts and others not?), and to discover whether there is a consistency of approach in the exercise of this discretion. If present systems were to reveal unjustifiable disparities in the exercise of this discretion, consideration could then be given to formulating guidelines for decision-making at this level.

AUSTRALIAN FEDERAL POLICE ESCORTS

In the Australian Capital Territory the Australian Federal Police have the task of escorting mentally ill detainees from courts or the remand centre of the Territory to hospitals where they may be detained for the purposes of psychiatric assessment or treatment. In addition a high proportion of escorts relate to persons who have been detained by the police in pursuance of powers under the *Lunacy Act* and who are then scheduled in accordance with the *Mental Health Ordinance*. They may then be taken directly to a mental institution without at that stage, requiring the *imprimatur* of a judicial officer.[113]

111. Monahan, Caldeira and Friedlander, 'Police and the Mentally Ill: A comparison of Committed and Arrested Persons', (1979) 2 *International Journal of Law and Psychiatry*, p. 509, esp. p. 517.

112. For a useful Canadian study on the exercise of police discretion see R.G. Fox and P.G. Erickson, *Apparently Suffering from Mental Disorder*, Research Report, (Centre of Criminology, University of Toronto, 1972). The Report also contains a useful bibliography.

113. 98A Section 4(1) *Mental Health Ordinance*, 1962 is discussed *infra*, p. 79ff.

Table 3 reveals the number of police escorts of mentally ill persons in the Australian Capital Territory and their destination for the period from June 1975 to June 1980. It is seen that by far the majority of scheduled patients are sent to Kenmore Hospital at Goulburn, New South Wales. While daily average figures are not available it is anticipated that most committals are for short term stay, measured in days, weeks or months rather than in years. The numbers suggest however that there are sufficient patients to warrant a special psychiatric unit, if not a small self-contained institution,to handle these cases in the Australian Capital Territory.

Table 3 – A.C.T. Mental Patient Escorts*
Breakdown from June 1975 to June 1980

	New South Wales		*Australian Capital Territory*		
	Kenmore (Goulburn)	*Bloomfield (Orange)*	*Canberra Hospital*	*Woden Valley Hospital*	*Total*
1975 (from June)	8	4	–	–	12
1976	48	18	9	2	77
1977	70	–	6	8	84
1978	53	1	7	4	65
1979	62	1	3	3	69
1980 (to June)	27	–	–	1	28

* Source: Australian Federal Police, General Policing, A.C.T.

ADMISSION PROCEDURES IN THE A.C.T.

There are many organisations which are completely dissatisfied with present laws governing involuntary commitment, and with compulsory treatment that is usually concomitant upon such commitment. The better known organisations include MIND, the Council for Civil Liberties, and the Citizens' Committee on Human Rights. In Western Australia, a group calling itself FACT (Foundation for the Abolition of Compulsory Treatment) was recently formed. It is an organisation committed to the principle that an individual should have a right to choose or reject medical or psychiatric treatment, and has constantly lobbied the State

Government pending a review of its Mental Health Act.[114] Legislative changes are also imminent in New South Wales (shortly to be considered), Victoria[115] and the Australian Capital Territory.

It is beyond the scope of this book to examine the pros and cons of involuntary commitment procedures. Here attention is restricted to procedures that are relevant or could become relevant to residents of the Australian Capital Territory. The relationship of the Territory's laws to those of New South Wales soon becomes apparent. By virtue of s.3 and particularly cl.6 of the Schedule to the *Mental Health Ordinance*, 1962 (Australian Capital Territory), once a person is admitted to an institution in New South Wales the detainee becomes subject to New South Wales law. Clause 6 provides as follows:

> 6. A person admitted to an admission centre in pursuance of clause 4 or clause 5 of this agreement shall be deemed to be subject to the provisions of the Mental Health Act and any act, matter or thing may be done or performed with respect to that person, in all respects as if the person had been admitted to and detained in the admission centre in pursuance of subsection (1) of section 12 of the Mental Health Act.

Thus amendments to the *Mental Health Act*, 1958 (New South Wales) may materially affect the way in which persons sent from the Australian Capital Territory into New South Wales institutions are to be treated. In this regard proposed amendments to s.12 of the *Mental Health Act*, 1958 (New South Wales) are of particular significance because it is under that section that admission and detention procedures for 'involuntary patients' are set out.[116]

114. A. Blanchard, 'Mental Health Laws: Proposed Changes in W.A.', (1981) 6 *Legal Services Bulletin* 27.

115. The Victorian Health Commission has recently published a position paper on mental health legislation but at the time of writing, it has not been seen by the author.

116. Section 12(1) of the *Mental Health Act*, 1958 (N.S.W.) provides as follows:

> **12.** (1) A person may be admitted to and detained in an admission centre –
> (a) upon the certificate of a medical practitioner who is of the opinion that such person is a mentally ill person;
> (b) upon a written request to be so admitted and detained made by him to the superintendent of such admission centre;
> (c) upon a written request for him to be so admitted and

Reform in New South Wales is, of course, also relevant as a guide to Australian Capital Territory legislators concerned with the future directions of mental health matters in the Territory. The Edwards Committee did in fact advocate a number of important amendments to s.12 of the Act, being particularly concerned with the problem of ensuring that only appropriate persons should be detained. Some of these amendments will be considered shortly.

In the Australian Capital Territory, s.4 of the *Mental Health Ordinance* deals with the required procedure for certification and conveyance of a person to an admission centre in New South Wales. The procedure, *inter alia*, requires that two medical practitioners independently of each other should personally examine the patient,[117] form the opinion that the person is mentally ill and

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detained made to the superintendent of such admission centre by a relative or friend of such person;

(d) where he is taken to such admission centre by a member of the police force and a copy of an order, relating to such person, made by a justice under subsection (2) or (3) is handed to the superintendent of such admission centre by such member of the police force;

(e) where he is taken to such admission centre by a member of the police force who in writing informs the superintendent of such admission centre that such member believes such person to be a mentally ill person and that such member found such person wandering at large or committing some offence against the law or in circumstances which reasonably led him to believe that such person was about to commit some offence against the law;

(f) where he is escorted to such admission centre by a welfare officer who in writing informs the superintendent of such admission centre that such welfare officer believes such person to be a mentally ill person.

Provided that a person admitted to or detained in an admission centre pursuant to paragraph (b), (c), (d), (e) or (f) shall be examined by the superintendent or a medical officer attached to such admission centre as soon as practicable after his admission thereto and shall not be detained therein after such examination unless such superintendent or medical officer certifies that in his opinion such person is a mentally ill person or ought to be detained therein for observation or treatment.

117. There is provision for the admission and detention of an A.C.T. resident in a State admission centre for observation and treatment upon the certificate of one registered medical practitioner, but this procedure is not generally followed. *Mental Health Ordinance*, 1962 Schedule, Cl.4.

that he 'is a suitable case for admission to an admission centre in the State' and also have formed the opinion that police assistance 'is desirable for the conveyance of the person to the admission centre'. The certificates are required to be in accordance, or substantially in accordance with the forms set out in Part I and Part II of the Schedule to the Ordinance. These forms are reproduced on the opposite page.

In New South Wales, a person may be involuntarily detained in a mental institution upon the certificate of one medical practitioner, which is the most common form of admission.[118] Admissions may also be made upon written application of a relative or friend, a member of the police force or a welfare officer who 'believes the person to be a mentally ill person.' A person may also be admitted by order of a justice of the peace.[119] The Edwards Committee recommended against increasing the number of medical practitioners (to two) on the ground that in many cases urgent and immediate treatment is necessary and requiring the production of two certificates as the basis for involuntary commitment is impracticable. It did however, advocate that before signing the certificate, the medical practitioner should be satisfied that 'involuntary admission and detention is necessary and that no alternative means for dealing with the person is reasonably available'.

With regard to the procedures to be followed in the Australian Capital Territory, reference should also be made to the *Lunacy Act* of 1898 (New South Wales) as amended in its application to the Territory. Part I of the Act is subtitled 'Proceedings by which persons of unsound mind may be placed under restraint' and proceeds to authorise the apprehension of persons who fall within its very broad provisions. Thus 'upon information on oath before a Justice that a person deemed to be insane is without sufficient means of support, or is wandering at large, or has been discovered under circumstances that denote a purpose of committing some

118. *Mental Health Act*, 1958 12(1) *supra*, n. 116. See also *Report of the N.S.W. Mental Health Act (1958) Review Committee*, (Edwards Committee), 22, *Proceedings of the Institute of Criminology*, (Sydney, 1975), p. 22.
119. The Edwards Committee has advocated the deletion of the provision relating to the power of a justice to order that a person should be apprehended and taken to the nearest convenient admission centre on the ground that this power is superfluous. *Ibid.*, p. 26.

SCHEDULE

PART I

I, ...
(Name in full)
of ..... Medical Practitioner.
(Address)
do hereby certify that on the ..... day of .....
19....., at .....
(Address of place where examination took place)
I personally examined .....
(Name of person in full)
of .....
(Address of person examined)
independently of any other medical practitioner and I am of the opinion that the said person is a mentally ill person and is a suitable case for admission to the Admission Centre at .....
.....
(Name of institution)
for observation and treatment.

In my opinion the person examined is*—

(a) suicidal;
(b) dangerous to others;
(c) unable to care for himself;
(d) not under proper care and control.

The facts and other matters upon which I have formed these opinions are as follows:—

The following treatment and medication (if any) have been administered in respect of the mental illness of the person examined:—

So far as I am aware—

(a) the bodily health and condition of the person examined is .....; and
†(b) the person examined has not suffered any recent injury; *or*
†(b) the person examined has suffered a recent injury of which particulars are as follows:—

‡Signed this.....day of ..... 19.....

Signature.....

PART II

I am of the opinion that the assistance of a member of the Police Force is desirable in conveying the person examined to the Admission Centre at .....
(Name of institution)
The facts and other matters upon which I have formed this opinion are as follows:—

Signed this.....day of ....., 19.....

Signature.....

* Strike out and initial any of the conditions that are not applicable.

† Strike out words inapplicable.

‡ Omit when the form in Part II of the Schedule is used.

offence against the law', the Justice may order the apprehension of that person for the purpose of bringing him before two Justices.[120] In fact Justices (which under the *Lunacy Act* means Justices of the Peace), have very limited powers in the Australian Capital Territory and it is the stipendiary magistrate who assumes the authority and has the responsibility for determining whether a person should be certified.

Similarly, if 'any constable. . . has knowledge that any person deemed to be insane is not under proper care and control, or is cruelly treated or cruelly neglected by any relative or other person having or assuming the care or charge of him' the constable is obliged **forthwith** to 'give information thereof to a Justice'. In turn the Justice must either visit and examine that person and inquire into the case himself, or authorise 'some medical practitioner' to do the same and report his opinion to him in writing. If then it appears to the Justice that 'such person is insane and not under proper care and control, or is cruelly treated or cruelly neglected by any relative or other person. . .', the Justice may by order require the police to bring that person before two Justices (that is, in practice, before a magistrate).[121]

Except in the case of an emergency where the magistrate may act on one medical certificate,[122] the magistrate is required to call two medical practitioners 'who have previously examined such person apart from each other and separately signed certificates' in accordance with Schedule Two of the Act. Then, following a hearing of all relevant evidence, and where the magistrate is satisfied that the person is insane and:

(a) is without sufficient means of support; or

(b) was wandering at large; or

(c) was discovered under circumstances that denote a purpose of committing some offence against the law; or

(d) is not under proper care and control; or

(e) is cruelly treated or neglected by any person having or assuming the charge of him.[123]

120. *Lunacy Act*, 1898 (N.S.W.), s.4, as applicable to the A.C.T.
121. *Ibid.*, s.5.
122. *Ibid.*, s.5.
123. *Ibid.*, s.6.

And further where the magistrate is satisfied that the person 'is a proper person to be taken charge of and detained under care and treatment', he may make the appropriate order for that person's conveyance to a mental institution.[124] The breadth and vagueness of these criteria and their implications are self evident.

At this point the *Insane Persons and Inebriates (Committal and Detention) Ordinance,* 1936-1937 becomes relevant, for it is under its provisions that the Australian Federal Police are empowered to transport insane persons to New South Wales. There they are handed over and received into the custody of the State Police and finally conveyed to a mental hospital in accordance with the order.[125] In practice the handing over of patients into the custody of the State police is dispensed with and patients are generally escorted directly to the relevant mental institution.

One commentator has observed a flaw in the procedures for committal of Australian Capital Territory persons to New South Wales institutions under the *Lunacy Act.* Indeed a similar oversight has also been observed in procedures under the *Inebriates Act,* 1900 (New South Wales) as applied in the Territory, as commitment to State institutions under that Act also involves application of the *Lunacy Act.* Under the schedule to the *Insane Persons and Inebriates (Committal and Detention) Ordinance,* it was contemplated that persons committed to New South Wales institutions from the Australian Capital Territory were to be made subject to the provisions of the *Lunacy Act* and any amendments thereto, as they applied in New South Wales. However, by section 3 of the *Mental Health Act,* 1958 (New South Wales) 'the Lunacy Act and the New South Wales Act which ratified the State's agreement with the Australian Capital Territory' were repealed. If this argument is correct it created a gap in the law.[126] It would seem therefore that the only proper procedure for committing (that is, properly admitting), Australian Capital Territory residents into New South Wales institutions are those which accord also with current New

124. *Ibid.*

125. See particularly s.5 of the *Insane Persons and Inebriates (Committal and Detention) Ordinance,* 1936-37. Note also the schedule to the ordinance. Data showing the number of police escorts are referred to *supra,* p. 77.

126. H. Gamble, 'Mental Health' in *A.C.T. Supplement to Legal Resources Book,* (N.S.W.), (ed. N. Seddon) (Law Faculty, Australian National University, 1979), p. 18.2-18.3.

South Wales admission and detention requirements.

In summary, once admitted to an institution in New South Wales, the patient, as soon as practicable after admission, must be examined by two medical practitioners separately and apart from each other.[127] If they find that the patient does not require further observation and treatment the person must be discharged from the admission centre.[128] If two medical practitioners do feel that further observation and treatment in a mental hospital is necessary, the superintendent of the hospital shall cause the matter to be brought before a stipendiary magistrate 'as soon as conveniently may be'.[129] The magistrate is then required to hold an inquiry, and if he determines that the person is mentally ill he must then direct that the person be detained in an admission centre or a mental hospital, or authorised hospital for such period not exceeding six months as may be specified therein, or he must discharge the person 'to the care of any relative or friend who satisfied' the magistrate that the person will be taken care of.[130] If the magistrate is not satisfied that the person is mentally ill he must order that the person be discharged from the admission centre. The magistrate has power also to suspend the execution of any direction or order for up to, but not exceeding fourteen days.[131]

The Edwards Committee recommended a number of minor changes to s.12(9), the most important being that the magistrate's power to order detention should be exercised 'if no appropriate alternative means of disposition is reasonably available.' It also recommended that adjournment of any hearing should be for a period not exceeding ten days. These are important recommendations strongly supported by the present writer.

Where after the expiration of six months, the person is still detained, a tribunal consisting of a psychiatrist, medical practitioner and a barrister and solicitor appointed by the Minister has the task of deciding whether:

(a) the person should be reclassified as a continued treatment

127. *Mental Health Act*, 1958 (N.S.W.), s.12(4).
128. *Ibid.*, s.12(5).
129. *Ibid.*, s.12(6).
130. *Ibid.*, s.12(9).
131. *Ibid.*

patient (to be detained for further observation and treatment);

(b) the person should continue as a temporary patient (for a period not exceeding three months); or

(c) whether the patient should be discharged.

With regard to (b) after the expiration of the period referred to therein, the tribunal is required to determine whether to reclassify the patient in terms of (a) or to discharge the patient in terms of (c) above.[132] Under s.15 of the Act the superintendent must ensure that all continued treatment patients are medically examined 'at such intervals as may be prescribed' in order to determine whether their continued detention is necessary. The Edwards Committee recommended that all long stay involuntary patients should be brought before the tribunal every 24 months at least, lest they become 'forgotten' in a mental hospital.[133] Where the superintendant is of opinion that the patient no longer requires further observation and treatment, he may discharge him. He is obliged to discharge the patient where there is an order by the tribunal, an authorised officer, the court or a stipendiary magistrate. He may also discharge the patient pursuant to an application by the patient, or by a relative or friend of the patient.[134]

REFORM REQUIRED

The present laws governing the Australian Capital Territory's system of mental health disposals constitutes a patchwork of antiquated New South Wales laws still applicable in the Territory, coupled with a number of *ad hoc* ordinances of the Territory designed *inter alia*, to define the arrangements for transportation to and detention in New South Wales institutions of involuntary Australian Capital Territory psychiatric patients. At a time when New South Wales and the Territory shared a common law (the *Lunacy Act* of 1898), such an arrangement was likely to prove

132. *Ibid.*, s.14.
133. Edwards Committee, *op. cit.*, p. 40.
134. *Ibid.*, s.16.

reasonably satisfactory. However, with the repeal in 1958 of the *Lunacy Act* in New South Wales, the paths of the two jurisdictions began to draw apart. The *Mental Health Ordinance,* 1962 made an attempt to draw the two jurisdictions closer together but in fact achieved little in terms of clarifying or repealing earlier legislation.

It is, however, becoming increasingly clear that it is no longer appropriate to salvage the mental health system of the Australian Capital Territory by piecemeal legislative review. In the first place, it is clear that the *Lunacy Act* must go. Next, the choices are two in number. The first is to determine whether or not the Territory desires to proceed with the arrangement for transportation and detention of Australian Capital Territory residents to New South Wales institutions. If so, it is desirable that mental health legislation in the Territory should be carefully attuned to developments in New South Wales and not allowed to fall out of step in terms of philosophy and approach.

The second choice and, it is submitted, the one to be preferred, is for the Australian Capital Territory to enact legislation of its own. It is envisaged that this legislation would make provision for the detention and treatment of involuntary patients within, rather than without, the boundaries of the Australian Capital Territory. It would have advantages canvassed elsewhere in this book. In particular it would have the advantage of cutting the umbilical cord with New South Wales, thereby avoiding the need for legislation prescribing complicated arrangements of the type that currently exist between the two jurisdictions. More important than this however, the Territory's legislature could make provision for the way in which involuntary patients are to be treated in the Territory and ensure that the interests both of the patient and the community are adequately safeguarded.

In a relatively small community such as the Australian Capital Territory, there is an excellent opportunity for establishing a model system of psychiatric health care that could be emulated by other states. The establishment of such a model will inevitably demand financial commitment on the part of the Federal Government. This, however, is not a sufficient justification for avoiding the moral responsibility all communities have of providing adequate health care and treatment facilities that cater for the needs of its own citizens.

Indeed a policy decision has already been made to repeal the

following Acts and Ordinances, (all of which are relevant to mental health administration in the Territory), and replace them with a new Mental Health Ordinance:

> *Lunacy Act*, 1898 of New South Wales in its application to the Australian Capital Territory, *Lunacy Ordinance*, 1938 (Australian Capital Territory).
>
> *Inebriates Act*, 1900 of New South Wales in its application to the Australian Capital Territory, *Inebriates Ordinance*, 1938 (Australian Capital Territory).
>
> *Insane Persons and Inebriates (Committal and Detention) Ordinance*, 1936;
> *Mental Health Ordinance*, 1962.

TREATMENT ORDERS FOR THE A.C.T.

According to the Capital Territory Health Commission, mental health legislation for the Australian Capital Territory should provide for compulsory treatment where the person needing treatment refuses voluntary treatment and at the same time satisfies the criteria laid down for compulsory treatment. The following criteria for compulsory treatment has been proposed:

(a) the person is suffering from a mental disorder;

(b) by reason of that disorder:
  (i) the person has engaged, or is likely to engage in behaviour representing a danger to the physical well-being of himself or another person; or
  (ii) the person is in a state of social breakdown;

(c) the person is not likely voluntarily to undergo or cooperate in adequate treatment for that disorder.

In turn, the term 'social breakdown' is defined as a lack of capacity to:

(a) obtain and use the goods and services essential to the

support of life; and

(b) engage in the social transactions essential to an independent life – so that the person suffers severe distress and deprivation.

It is also proposed that judges and magistrates should have the power to make treatment orders. These orders would not necessarily provide for compulsory detention so that a person subject to such an order might only be required to attend for outpatient treatment. The least restrictive form of treatment which would appear likely to deal with the condition would be the cardinal principle for determining the degree of interference deemed appropriate. Similarly, in cases involving unfitness to plead, the court would be empowered to make treatment orders, or a series of treatment orders. With regard to Governor's pleasure detainees, the policy is unclear, although it would appear that the spirit of the new proposals favours the exercise of judicial rather than executive authority over such persons. The present writer would certainly support the extension of judicial power in this area.

Important considerations relate to the conditions attaching to treatment orders. It is proposed that an initial treatment order would not exceed 21 days in duration. A subsequent order made by the judge who reviewed the initial order could then be made within the period of the initial order. This would extend the period by up to three months, provided that the person was still found to be mentally dysfunctional. Further orders, within the term fixed by the preceding order, could then be made subject to the same criteria, but this time for a period not exceeding six months.

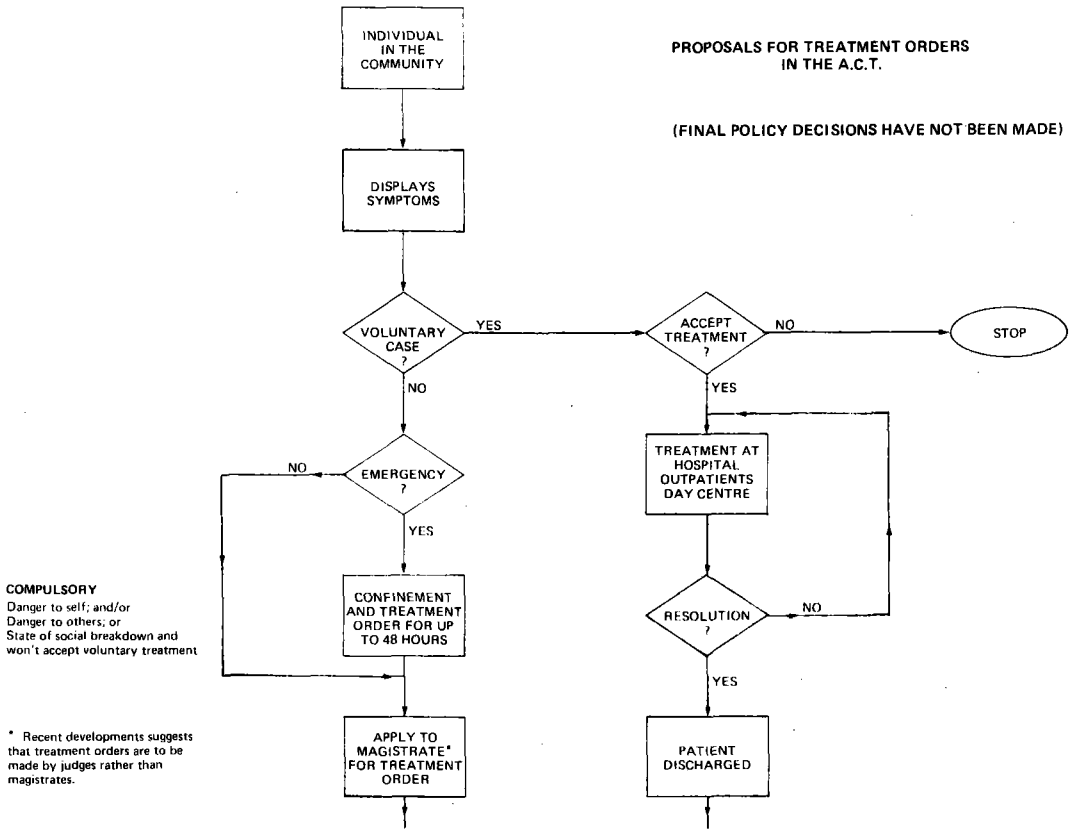
As already stated, in each case the judge or magistrate would be required to ensure that the order and the conditions attaching thereto were the least restrictive forms of disposal appropriate in the circumstances. It is proposed that the new legislation would protect persons under treatment orders from being subject to treatment which produces irreversible physical lesions (such as castration) although psycho-surgery could be ordered subject to guidelines. Other prohibited forms of treatment would include compelling a person to submit to acts that are abhorrent to the patient, treatment which inflicts undue distress or deprivation, or treatment which may be described as experimental, new or un-

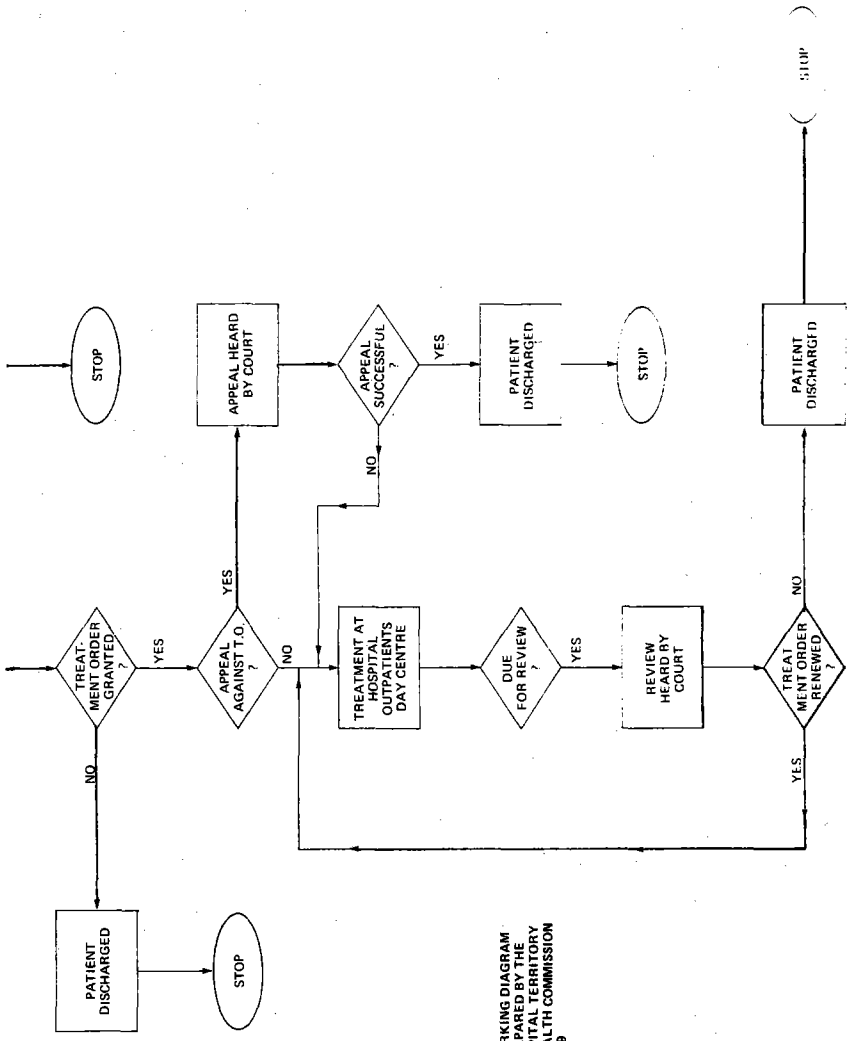
orthodox. Examples of prohibited forms of treatment would include what may broadly be referred to as 'brainwashing' techniques, some forms of aversion therapy and trial of new drugs.

It is also being proposed that provisions be made for enabling a person to appeal from the Supreme Court to the Federal Court against a treatment order and in any such appeal new evidence tending to justify termination of the order could then be introduced. Further, where the condition of a person subject to a treatment order has improved sufficiently, the responsible medical practitioner would be empowered to relax or remove any conditions of the order, or indeed terminate the order as the case may require. Furthermore, once the order expired or was otherwise terminated, the person could nevertheless choose to continue with treatment on a voluntary basis if so inclined. The draft flow-chart that follows, produced by the Capital Territory Health Commission, provides an insight into the way in which it perceives the new ordinance should operate.

Of particular significance are the Health Commission's views with regard to mentally disordered persons and criminal proceedings. These views have been expressed thus:

> It is considered that in all cases the system for voluntary treatment and compulsory treatment should be substantially the same for all persons whether or not they are involved in criminal proceedings. It is therefore considered that in no case should a court be able to order compulsory treatment as a substitute for any other penalty.
>
> The mental health legislation should provide that a person who is undergoing a criminal penalty and who becomes or is mentally disordered may receive voluntary treatment in the place where he is undergoing the penalty on the same basis as if he were not undergoing such a penalty. Such a person should only be given compulsory treatment if a treatment order is obtained in respect of that person on the same basis as for any other person. Such a mentally disordered person, if subject to a treatment order, should be treated in a place directed by the [judge] who makes the order. The period of treatment should be considered to be time served for the purpose of any penalty of imprisonment if the treatment is given during any period of imprisonment.
>
> It is proposed that where a person appears by reason of mental disorder to be unfit to plead the judge or magistrate should be able to make a treatment order subject to the previously stated criteria.


PROPOSALS FOR TREATMENT ORDERS
IN THE A.C.T.
(FINAL POLICY DECISIONS HAVE NOT BEEN MADE)
INDIVIDUAL IN THE COMMUNITY
DISPLAYS SYMPTOMS
VOLUNTARY CASE ?
YES
NO
ACCEPT TREATMENT ?
NO
STOP
YES
EMERGENCY ?
NO
YES
TREATMENT AT HOSPITAL OUTPATIENTS DAY CENTRE
RESOLUTION ?
NO
YES
CONFINEMENT AND TREATMENT ORDER FOR UP TO 48 HOURS
APPLY TO MAGISTRATE* FOR TREATMENT ORDER
PATIENT DISCHARGED
COMPULSORY
Danger to self; and/or
Danger to others; or
State of social breakdown and won't accept voluntary treatment
* Recent developments suggests that treatment orders are to be made by judges rather than magistrates.


STOP
TREAT-MENT ORDER GRANTED ?
YES
NO
APPEAL AGAINST T.O. ?
YES
NO
APPEAL HEARD BY COURT
APPEAL SUCCESSFUL ?
YES
NO
PATIENT DISCHARGED
STOP
TREATMENT AT HOSPITAL OUTPATIENTS DAY CENTRE
DUE FOR REVIEW ?
YES
REVIEW HEARD BY COURT
TREAT MENT ORDER RENEWED ?
NO
YES
PATIENT DISCHARGED
STOP
PATIENT DISCHARGED
STOP
WORKING DIAGRAM PREPARED BY THE CAPITAL TERRITORY HEALTH COMMISSION 1979

DISTINGUISHING CIVIL AND CRIMINAL ORDERS

While there is no argument with the proposition that persons involved in criminal proceedings should be entitled to treatment in terms similar to those which apply to non-offenders, the proposal implicit in the passage quoted, namely, that a court should not be able to order treatment in lieu of some other penalty, presents some difficulties. This is particularly true in the case of the convicted offender who obviously requires treatment and at the same time deserves punishment. The acceptance of the principle that time served while undergoing treatment, should count for the purposes of calculating time served for imprisonment, leads logically to the proposition that in some cases treatment may in fact be substituted for imprisonment.

It will shortly be shown that there is indeed a need for a sanction which attempts to satisfy both goals, those of treatment and punishment. However, it is submitted that the form of disposal of civil and criminal patients should be distinguished, and this can be achieved by reference to the type of order that is applied. Therefore, it is submitted that the term 'hospital order' should be applied to offenders who at the point of sentence are considered to be so mentally disordered that psychiatric treatment or detention in a hospital rather than in a prison is the most appropriate form of disposal.

Accordingly, the term 'treatment order' and its corresponding meaning as outlined earlier, should be the form of order applying to civil patients and also to offenders who are subject to the criminal processes but who have not proceeded beyond the point of sentence. In short, it is considered that the presumption of innocence should apply to persons subject to criminal proceedings, and in turn these persons should be entitled to be treated in the same way as civil patients. The only occasion when a hospital order should be used is where it signifies a punitive component. Meanwhile, a further and related matter concerns the issue of mental health facilities in the Australian Capital Territory. This is considered next.

6 Sentencing Options and Facilities in the A.C.T.

A flexible system of sentencing alternatives is of little consequence if it is not supported by adequate facilities for ensuring that alternative measures may be applied in practice. For example, there is little point in giving courts the power to order hospitalisation in lieu of imprisonment if institutions refuse to take persons referred to them, or if appropriate facilities are otherwise unavailable. Nor is it a sufficient answer to say that mentally disturbed persons will receive psychiatric care in prison when in fact treatment facilities in prisons are either nonexistent or else fall far short of providing an environment conducive to humane care and treatment. An effective therapeutic environment must be, *inter alia*, safe, clean, within the sight and hearing of trained medical personnel (or health trained correctional personnel), and incorporate special medical programs that are tailored to individual needs.

The theme of treatment within prisons or psychiatric institutions is developed more fully in the following chapter. In this chapter, attention once again is drawn to the Australian Capital Territory's method for dealing with mentally disordered persons. In addition, issues relating to the adequacy of facilities for the treatment and containment of the mentally ill in the Territory are addressed.

At a seminar entitled 'Corrections in the Australian Capital Territory', conducted by the Australian Institute of Criminology in December 1978, the then Director of Community Welfare, Mr Hemer, said:

> . . . there is no local Australian Capital Territory secure mental health facility. There are wards in each of the two hospitals, psychiatric wards, but they have virtually no holding power and is very much on a voluntary basis. There is also the possibility of certification in New South Wales mental institutions, but again the certification that moves them from the Territory into New South Wales has no force of law – a

person can sign himself out from whichever New South Wales facility he is landed in.[135]

The matter is particularly complicated in the case of an offender who is not sufficiently mentally disordered to warrant certification and commitment to a mental institution, but at the same time is not bad enough to warrant imprisonment. The answer is usually and often unsatisfactorily resolved by releasing the prisoner on a recognisance, conditioned *inter alia* that he or she should reside as directed as a voluntary patient at an institution in New South Wales.

At the same seminar, Mr Nichol, an Australian Capital Territory Stipendiary Magistrate, observed that difficulties of a similar nature could also arise at the remand stage. He cited a case in which an adult offender, (prior to the availability of the Belconnen Remand Centre) had been held for about four months in the police station holding cells and was taken daily in custody to the hospital for psychiatric treatment. He concluded that 'quite apart from what you might do after assuming somebody has come to court with a psychiatric problem but has also committed a crime, whether you are going to have a hospital order type situation, there is certainly a case for considering attaching to a hospital, despite all the problems with it, some secure psychiatric ward for both adults and young people. . .'.[136]

The completion of the Belconnen Remand Centre has brought with it a better deal for remandees in the Territory. In most cases where a psychiatric, psychological or other assessment of the detainee is required, either by order of the court or upon request of defence counsel, this may now take place at the Remand Centre itself. Occasionally some detainees are escorted from the Remand Centre to Ward 12B of Woden Hospital for outpatient treatment or assessment. At the hospital more sophisticated tests may be carried out such as electro encephalograms. In addition, detainees may be taken from the Remand Centre to Kenmore Hospital in Goulburn if they are certified as mentally ill while on remand.[137]

135. Unpublished transcript, Australian Institute of Criminology, Canberra, 4-5 December 1978.

136. *Ibid.*

137. In general police escort mentally ill prisoners to and from court to the Belconnen Remand Centre, and also to institutions in New South Wales. On the other hand, escorts from the Remand Centre to the psychiatric ward at

POWER TO REMAND FOR PSYCHIATRIC ASSESSMENT

An issue that arises under the topic of psychiatric assessment is whether courts have power to order psychiatric assessment even though the person is held in custody. Where the offender is not in custody he (or she) may agree to undergo an examination as a condition of a recognisance. It may be that under the inherent jurisdiction of the Supreme Court, there is authority to direct that an individual subject himself or herself to psychiatric examination, but the matter is not so certain in the case of magistrates.

A magistrate may remand a person in custody, but is probably not authorised to order clinical examination of the offender and an accused person may refuse to submit to such an order or request if it is against his or her wishes.[138] That there should be specific authority to remand a person in custody (or otherwise) for the purpose of psychiatric examination is not in dispute. The form such an order should take, could be similar to a treatment order as described previously, except that a shorter time limit would need to be specified. It is submitted that ten days would be an adequate maximum period for such an order with the proviso that extensions or further orders could be made at any time for persons held in custody where this was believed to be desirable in the circumstances of the particular case.

Not only is it desirable that courts be given specific powers authorising them to remand the accused for the purposes of psychiatric examination (such remand to be available at any time prior to sentence), but it would be desirable that there should be explicit legislative directives indicating the purpose for which the examination is intended. For example, Lindsay citing Swadron has noted that a psychiatric examination may be intended to cover one or more of the following purposes:

(i) to determine fitness to stand trial;

(ii) to provide evidence upon which a defence of insanity may be raised;

Woden Valley Hospital are undertaken by officers of the Remand Centre.

138. A magistrate's power to remand a person in custody is given in s.70 of the *Court of Petty Sessions Ordinance*, (A.C.T.). No mention is made of a person's obligation to submit to psychiatric examination, and as a magistrate's powers are creatures of statutes it follows that he has no power to order such examination.

(iii) to provide the court with information that may be relevant to the issue of sentencing;

(iv) to provide information that will assist in determining the advisability of commencing procedures for the civil commitment of the accused.[139]

Consistent therefore with the earlier suggestion that the meaning of the term 'mentally ill' may alter according to the purpose for which it is used, it is also desirable for the purposes of psychiatric examination and report to specify the object for which the psychiatrist or psychologist is asked to express an opinion.

DEPORTATION TO NEW SOUTH WALES

Despite the preference for community treatment there still remains a need to compulsorily detain for psychiatric treatment a small percentage of persons needing care and attention for mental disorder. Estimates vary, but it would seem that about 3 per cent of those identified as needing psychiatric treatment are required to be detained for more than a short period. As already indicated, the practice has been to transport many of these persons to New South Wales institutions – usually Kenmore Hospital at Goulburn because of its proximity – but sometimes also to Bloomfield Hospital at Orange.[140] A mentally disordered offender who has been convicted and sentenced in the Australian Capital Territory, is first escorted to Goulburn Gaol for classification. If the prisoner is considered to be dangerous yet requires treatment over and above that which can be offered by the prison service, he may be transferred to Morisset or Gladesville where there are maximum and medium security wards. Now transportation and separation of those considered mentally ill, whether involving criminal or non-criminal persons, presents hardship not only to the patient, but also to relatives and friends of the patient. Clearly therefore, it is desirable

139. P. Lindsay, 'Fitness to Stand Trial in Canada: An Overview in Light of the Recommendations of the Law Reform Commission of Canada', (1977) 19 *Criminal Law Quarterly* 314, 330. See also Swadron, *Detention of the Mentally Disordered*, (1964), pp. 262-4.

140. For data giving the number of police escorts from the Territory, *supra*, p. 77.

to offer appropriate treatment facilities for mentally ill patients requiring in-patient care within the Australian Capital Territory.

Before turning to consider the problems inherent in the provision of appropriate facilities for the containment and treatment of mentally ill offenders, the following two decisions of the Supreme Court of the Australian Capital Territory are included in order to illustrate how these cases are presently handled in the Territory.

R. v. RILEY[140A]

The case of *Graham Lindsay Riley* presents a good illustration of the apparent failure of the Morisset Hospital to provide the level of security deemed necessary for the containment of forensic patients. The issue of security is even more fully developed in the next chapter when the Cribb and Munday episode is considered. In the present case, attention focuses essentially upon the Supreme Court's response for dealing with a compulsive sex offender.

On 22 August 1977, Riley, allegedly posing as a doctor, indecently assaulted an eight year old boy in the children's ward of the Woden Valley Hospital. Riley had a long history of sexual offences involving young boys, dating back to 1971, when at the age of 24 he had been convicted and sentenced to 12 months' imprisonment for sodomy. Apart from a number of similar offences, he had been sentenced by the Australian Capital Territory Supreme Court as recently as April 1977, to two concurrent terms of three years' imprisonment for indecently assaulting two boys, and had recently been released on parole when he committed the offences at Woden Valley Hospital.

Instead of imposing a term of imprisonment, the Supreme Court released Riley on a $50 eight year good behaviour bond. Among other conditions of the bond was one which required that Riley should admit himself as a voluntary patient at Morisset Hospital. He also undertook as a condition of the bond to accept the guidance of the medical superintendent of the Hospital. He was admitted to Morisset on 3 October 1978, where he was first

140A. Unreported decision of the Supreme Court of the Australian Capital Territory, 3 October 1978. See also case note [1979] 3 Crim. L.J. 27.

placed in a maximum security ward. Shortly afterwards he was transferred to an open ward of the institution.

On 21 November, in breach of the terms of his recognisance, Riley left the Hospital in the company of another inmate. *The Canberra Times*[141] quickly headlined the incident as 'sex criminal walks out of hospital' sending the usual shock-waves and angry responses that such sensationalism normally carries throughout the community.

It was not long however before Riley was recaptured and once again brought before the Supreme Court of the Australian Capital Territory. The sentencing Judge was faced with the difficult task of determining the disposition in the present case. During the course of the hearing the Crown Prosecutor outlined the sentencing options of the court referring as he did so to the near obsolete *Habitual Criminals Act* of 1905 (New South Wales). This Act still applies in the Australian Capital Territory despite its repeal and replacement in New South Wales by the less severe, yet still infrequently used, *Habitual Criminals Act,* 1957. The effect of the former Act is that a person who is formally declared to be an habitual criminal is subject to being sentenced to imprisonment for an indeterminate period – a disposition that might easily be equated with a sentence of life imprisonment.

The Crown Prosecutor pointed out that apart from this provision, the maximum sentence that could be imposed for Riley's offence was five years' imprisonment. On the other hand, defence counsel argued that inmates absconding from Morisset Hospital were not unusual occurrences, and that the superintendent of the hospital believed that Riley could be helped if given a further opportunity to remain at the institution. It was submitted that Riley would emerge from Morisset a more responsible member of the community than if he were sent to prison.

McGregor J.'s answer to the dilemma involved the use of the partly suspended sentence (split sentence). His Honour sentenced Riley to imprisonment for three and a half years, but ordered that he be released after serving six months of that period provided that he entered into a $100 good behaviour bond and undertook to remain at Morisset Hospital as a voluntary patient for eight years. In addition to this order, his Honour recommended that

141. *The Canberra Times,* 29 November 1978.

Riley should be kept in a closed ward for at least 12 months, and that he should not be permitted to live in a halfway house for at least a further 12 months. A further recommendation was that Riley should receive psychiatric treatment during that part of the sentence that he served in prison.

There were a number of other conditions associated with the bond, but for present purposes these need not be listed. One observation however should be made. The sentencing Judge was obliged to use what appears to be a very circuitous and clumsy method of doing what could have been achieved were he empowered to make a hospital order coupled with a restriction order and were there in existence appropriate facilities which could provide what was no doubt foremost in his Honour's mind, both security to the community and treatment for the offender during the period of his confinement. A little later the theme of what is to be done with mentally ill offenders who seem to fit neither in a mental institution nor in a conventional prison will be further considered.

R. v. *SMITH*[142]

Another recent example illustrating the difficulties of managing the mentally ill offender in the Australian Capital Territory is contained in a case which for reasons of anonymity is simply referred to as *Smith*.

Smith was convicted of maliciously wounding her boyfriend (a man of advanced years). The circumstances of the offence were that Smith and the victim of the offence had contemplated marriage. He then rejected her, an action so hurtful and provocative to her that she attacked and stabbed him several times with a pair of scissors. The wounds turned out not to be serious, and he was able to go to the Woden Valley Hospital and receive treatment in the outpatients' department. Apparently the victim suffered no permanent injury as a result of this incident.

At the time of the offence Smith was 29 years of age. She had suffered from epilepsy from her childhood days, had missed a

142. Unreported decision of McGregor J. in the Supreme Court of the A.C.T. S.C.C. No. 9 of 1977, 2 November 1978. See also case note [1979] 3 Crim. L.J. 40.

great deal of schooling, and in fact had left school at 14. Although she had worked temporarily, she had not worked since 1969. Since that time she had been in receipt of an invalid pension. According to a psychiatric report she had had five prior admissions to Kenmore Hospital, one in 1973, one in 1974, and three in 1977, all under the terms of s.12(1)(a) of the *Mental Health Act*, 1958 (New South Wales).[143] The present offence was committed after she had absconded from the last admission.

The diagnosis of the psychiatrist accepted by the sentencing judge included the assessment that the accused was an epileptic, with schizophrenic-like psychosis of epilepsy, that she was of borderline intellect (an I.Q. of about 70) and had a personality disorder of the explosive type. She was considered to have an innate deficiency in the capacity for controlling her behaviour. His Honour proceeded to place emphasis on the importance of protecting the community, and referred to a decision of the New South Wales Court of Criminal Appeal[144] in which the English decision of *Reg.* v. *Hodgson*[145] was quoted with approval.

In her favour there was evidence that she was a person of good character with no prior convictions, that she had already suffered as a result of her act, and that she could be assisted if psychiatric treatment were to be given to her during a period of restricted liberty. This, his Honour said 'may improve her self control and tendency to drug default'.

Psychiatric evidence suggested that her prognosis was dependent upon her taking anti-psychotic and anti-epileptic medication under supervision. Without constant medication she would be likely to experience seizures and be in constant risk of becoming dangerously violent. Kenmore Hospital was prepared to accept her as a patient for an indefinite period of time. It was considered that in time her condition would plateau, and improve, that she would be able to visit her family for holidays or weekends and that she could spend time at Watson Hostel when this was deemed appropriate.

His Honour then said that little could be gained by a 'lengthy sentence of imprisonment' and that the interests of the community could be served best by returning the accused to Kenmore Hospital

143. *Supra*, n. 116.
144. *R.* v. *Felshaw*. Unreported decision, N.S.W. Court of Criminal Appeal, 21 October 1977.
145. (1968) 52 C.A.R. 113, 114, referred to *infra*, p. 202.

for the continuation of her treatment. His Honour continued:

> I recognise the plausibility of the submission that it may not be fair to her, under the guise of assisting her, to require that she remain in custody for even longer than the maximum gaol sentence which her offence could attract; particularly when there are good reasons to argue that her crime does not warrant the maximum sentence. But one must pay due regard to her own requirement of rehabilitation, and, as I have said, the safeguarding of the public.

His Honour added:

> Even so, I do not understand that any Order made here would bind those in charge at Kenmore Hospital to retain her there longer than they considered her condition warranted.

McGregor J.'s order read as follows:

1. The accused is convicted.
2. I sentence the accused to imprisonment with light labour for a period of 18 months.
3. I direct that she be released forthwith upon her entering into a recognisance herself in the sum of $100 with one surety of $100 and subject to the following conditions, namely, she will:
   (i) be of good behaviour for five years;
   (ii) return forthwith to Kenmore Hospital by such transport as is provided for her, and remain there or at such other mental hospital, authorised hospital in New South Wales or the Australian Capital Territory, admission centre or half-way house (all of which places are hereafter referred to as 'institution') to which she may be transferred by a Mental Health Tribunal or other competent authority until properly discharged;
   (iii) during the time she is at any such institution, accept and cooperate in receiving treatment as shall be directed, prescribed or given by the superintendent, person in charge thereof, or such other person as he or they shall nominate;
   (iv) not absent herself from such institution without the consent previously obtained of the superintendent or person in charge;
   (v) during any period she is in any such institution, comply with such rules and regulations thereof as shall apply to her;
   (vi) if permitted to take leave for any time outside any such institution in the Australian Capital Territory or elsewhere will, during the period of her absence, obey such reasonable directions as to treatment, medication and otherwise as she will be given by the superintendent, person in charge, or such other officer as the

superintendent or person in charge shall nominate and will, at the expiration of any such time, return to the said institution;

(vii) whilst in the Australian Capital Territory, and on leave, be subject to the supervision of any Welfare officer appointed by the Director of the Welfare Branch of the Department of the Capital Territory, and obey all reasonable directions of that officer.

4. The recognisance referred to in (3) above may be taken before a Justice of the Peace who is an officer of this Court or the Court of Petty Sessions of the Australian Capital Territory.

5. The period of five years referred to in 3(i) above is to commence from today.

What emerges from both *Riley* and *Smith*, is that the recognisance, in conjunction with a partly suspended sentence, or in conjunction with a fully suspended sentence, proves to be a very flexible tool that can be tailor-made to the individual offender. One reservation is that the use of recognisance in combination with imprisonment (suspended or otherwise) attempts to turn an essentially voluntary disposition into a coercive one. To this extent these sanctions appear to be highly artificial devices for achieving 'voluntary' treatment. At the same time the 'voluntary' nature of the recognisance introduces uncertainties with regard to other goals, particularly that of community protection.

The sanctions employed in both these cases place considerable responsibility into the hands of the treatment authorities. On the one hand, there is the open-door policy of mental health institutions which favours returning individuals as soon as possible back into the community. On the other hand, there is an incentive in the case of mentally disturbed offenders not to release such persons prematurely. If such persons are seen to breach their recognisance following release into the community that is an admission of failure, and therefore mental health authorities are more likely to err on the side of caution and detain persons longer than necessary in order to shield themselves from public criticism. Thus there is the danger that the period of detention at the mental institution, pursuant to the terms of the recognisance, may require that the offender should remain an in-patient for a term exceeding that dictated by the term of imprisonment that would otherwise have been deemed appropriate having regard to the gravity of the offence. In other words, the period of straight imprisonment could in terms of the proportionality principle turn out to be the lesser

of two evils.

There is no dispute that in general sending a person to prison may not satisfy the prisoner's needs or even provide the best hope for reducing the incidence of future criminality. This is particularly true in the case of a mentally disordered offender. However, as will be discussed a little later, the prevailing principles of sentencing in Australia are geared to ensuring that a person is not punished beyond a measure which is deemed to be commensurate with the gravity of the offence.[146]

In the long run, a recognisance of five or eight years duration holds over an offender the spectre or potential of long term 'voluntary' incarceration in a mental institution. Alternatively, if for whatever reason the terms of the recognisance are not complied with, (and the longer the period the more unrealistic the expectation that the terms of the recognisance will not be breached), the prisoner faces the prospect of further imprisonment or detention in respect of the same offence. Thus a recognisance cannot always be relied upon as being in the long term, a less punitive measure than a term of imprisonment, nor in the short term, as providing the necessary community protection that the court so obviously attempts to achieve.

The problem seems to stem from the difficulty of separating the elements of culpability and therefore blame, from that of rehabilitation and the need to treat the offender. What has been suggested and further argued in the concluding chapter of this book is that the punitive component should be limited, and related strictly to the offender's culpability for the offence. Over and above this limit, rehabilitation should be achieved if it can be achieved either through voluntary means or, where the appropriate civil involuntary commitment criteria are satisfied, in accordance with the normal prescripts for such commitment. The recognisance may prove to be either too lenient or too harsh a device, depending on the circumstances, and in any event may often be intended to achieve a result which may have very limited promise of success. It is submitted a firmer, more specific sanction should replace this flexible but somewhat uncertain dispositional device. One replacement to be considered under the heading 'Role of Probation in Mental Health' is the probation order requiring treatment along

146. See particularly Ch. 10, *infra*, p. 175ff.

similar lines to that provided by s.3 of the *Powers of Criminal Courts Act*, 1973 (United Kingdom). The other also to be discussed in greater detail is through the introduction and use of hospital orders. The first is a non-custodial measure, the second a custodial, alternative to imprisonment.

If treatment orders, psychiatric probation orders and hospital orders are to be viable alternatives to the present system of 'voluntary' transportation and detention in New South Wales mental institutions, the Australian Capital Territory should provide facilities of its own. Only in this way can the alternative sanctions be effectively evaluated, only in this way can the courts obtain a satisfactory level of feedback as to the success or otherwise of its sentencing options, only in this way can there be adequate supervision and control over what happens to those who are 'sentenced' to rehabilitation programs or treatment regimes in the Territory.

A PROTECTIVE CARE WARD FOR THE A.C.T.

The Capital Territory Health Commission has recognised the need to bring the law and the provisions of mental health facilities up to a standard commensurate with the requirements of Canberra's expanding population. During the year 1978-79, the Mental Health Branch reported 3,639 new case referrals with a 4 per cent increase in attendances to 35,871.[147] Much of the branch's work has provided assistance in the community, through its community mental health teams, and particularly through its special terms working with children and adolescents, intellectually handicapped and alcohol and drug dependent persons.[148]

The Commission has proposed the establishment of a medium security Protective Care Section for psychiatric patients in Ward 12 at the Woden Valley Hospital. At the time of writing there exists some 26 beds at Woden Valley Hospital for voluntary

147. Capital Territory Health Commission Annual Report 1978-1979, (Australian Government Publishing Service, Canberra, 1980), p. 30.

148. *Ibid.* With regard to the Alcohol and Drug Dependence Unit, an Alcohol Education Program of six weeks duration was conducted repeatedly for persons involved with drink-driving charges. According to a spokesperson for the Commission, the courts were not referring enough cases to them although the program itself appeared to be relatively effective.

in-patients psychiatric treatment but there are no facilities for involuntary patients whether they be criminal or otherwise. It has been suggested that about one-third of these beds could be taken for a medium security protective care section which would house short term involuntary psychiatric patients. While negotiations are still proceeding for the acquisition of this facility it is clear that its physical layout is unsatisfactory because it does not permit the necessary surveillance of patients. This is a serious inadequacy. Without proper viewing facilities, suicidal patients or patients liable to be assaulted could not be adequately cared for or protected.

There is a further concern relating to the detention in general hospitals of psychiatric patients deemed dangerous. There is a clear reluctance to accept such persons within general hospitals because they are considered to be disruptive, to threaten the safety of other patients and because of the stigma associated with the mental illness label. It evokes the 'good idea so-long-as-it-is-not-in-my-community' response of local residents and hospital authorities and leaves the mentally ill person grossly disadvantaged in comparison to his physically ill counterpart. Despite these concerns it is considered desirable and recommended that:

(i) The Australian Capital Territory should have its own, self-sufficient, mental health treatment and custodial facilities.

(ii) The facilities should be sufficiently large to cater for involuntary as well as voluntary patients.

(iii) The law should be amended to permit, within strict guidelines only, detention of mentally ill persons within the Territory for the purposes of psychiatric treatment and assessment. This requires new legislation relating to psychiatric remand, treatment orders and hospital orders.

(iv) Until other more appropriate facilities can be made available, part of the Woden Valley Hospital should continue to provide psychiatric care and treatment for unconvicted mentally disordered patients. Such expansion or alterations should be made to the existing building as will enable the provision of a medium security protective care section to be fully operational as soon as possible.

(v) Consideration should also be given for the provision of separate or adjoining medium and minimum security facilities for holding mentally disturbed offenders. In addition, consideration should be given to the establishment of a short term maximum security assessment treatment or holding unit in the Territory for those persons involved in criminal proceedings who are considered to be severe security risks.

(vi) Only where long term patients require maximum security facilities should the procedure for transferring them to New South Wales institutions be continued. This is based on the belief that such offenders would be so few in number that the provision of a special institution would be unjustified, and also in the belief that special treatment would be more readily available in New South Wales.

The policy advocated here is to work towards the provision of Mental Health care for Australian Capital Territory residents in the Territory itself so that reliance on mental health facilities outside the Territory may be reduced to an absolute minimum. The possible methods for achieving this are enlarged upon below.

POSSIBLE LOCATIONS FOR A MEDIUM SECURITY WARD

A number of possible locations for a medium security protective care ward for psychiatric patients are under consideration by the Director of Mental Health. These include a ward at Calvary Hospital, two 10 bed wings at Watson Hostel, a ward at Royal Canberra Hospital and several other wards at Woden Valley Hospital.

The most favoured short term solution is to convert Ward 11B of Woden Valley Hospital. This ward has the advantage of being on the ground floor, with access to an outside recreational area. It has provision for good surveillance and requires little alteration.

One proposal involves the construction of a free standing building on the grounds of Woden Valley Hospital, which would appear to be the most expensive solution, and from the inmates point of view would probably attract the greatest stigma. However there is no reason why voluntary psychiatric patients could not be treated under separate arrangements in the main part of the

hospital, and only forensic patients cared for in the special facility designed for this purpose. Indeed the separate building could also have a small maximum security facility to house the 'dangerous' mentally ill offender for short periods of time. This could be used where the prisoner is awaiting trial or is appealing against an adverse decision and is considered to be both extremely dangerous and requiring psychiatric treatment.

Principally however, this facility would operate as a medium and minimum security institution for detaining forensic patients only – ensuring that other involuntarily committed patients, and other voluntary patients are not associated and therefore identified with forensic patients. In this facility it would also be desirable to have specially trained psychiatric nurses with the perimeter of the building controlled by custodial officers.

To sum up, the transportation of mentally ill persons from the Territory can no longer be justified. In particular, with the recent opening of the Calvary Hospital in the Belconnen area, making a third large general hospital for the region, Canberra has placed itself in the embarrassing position of providing an oversupply of hospital beds and facilities. Despite this, the majority of mentally ill persons are sent out of the jurisdiction, away from family and friends into New South Wales mental hospitals. It is difficult to sustain the argument that the community is serious in its efforts to rehabilitate these persons. It is submitted that it is no longer appropriate that this state of affairs should continue, and positive steps should be taken to alleviate the present position, *post haste.*

Priority should be given to acquiring an appropriate facility within the Australian Capital Territory for treating involuntary psychiatric patients who have not committed serious offences. These persons constitute a larger group than forensic patients and therefore have a far stronger case for demanding treatment at a location that is not too distant from family and friends.

WATSON HOSTEL

There is in the Australian Capital Territory a psychaitric hostel, Watson Hostel, which is mainly used for long-stay voluntary psychiatric patients. Watson Hostel also houses a small percentage of short-term patients who use the facility as a half-way house

after returning to the Territory from a period of treatment at Kenmore. The hostel which is set in the foothills of Mt Majura, consists of four separate buildings (or villas) each with a 10 bed capacity. At the time of writing a spokesperson for the institution indicated that there were only 20 beds occupied at the hostel because of staff shortages. He indicated that while the number of inmates could be expected to fluctuate, under normal circumstances the hostel would be expected to have a daily population of about 30 patients. He was also of the opinion that a number of persons who might otherwise be held there were detained at Kenmore Hospital.

A pamphlet published by the Capital Territory Health Commission states that the object of Watson Hostel is to provide:

(a) continued psychiatric care for those patients suffering long term (chronic) disorders who cannot be cared for at home;

(b) continued psychiatric care for those patients who at the present time are residents of Mental Hospitals outside the Australian Capital Territory and whose support network (that is, family and friends) are residents of Australian Capital Territory;

(c) 'half-way' house care for those patients who have been hospitalised and not deemed ready to cope with stresses of the community;

(d) rehabilitation and training for those patients who would be employable if suitable employment could be found;

(e) a support system for those patients who have already found employment and require time to readjust to this;

(f) emergency (overnight) accommodation for community crises, for example, a depressed parent during family crisis;

(g) relief accommodation for the patient living at home to give the family a rest; and

(h) to provide a home (sanctuary or asylum) for the psychiatric patient who has a chronic condition requiring continuous supervision and who has no outside support system.

In addition, the aim of Watson Hostel is to provide an assessment of the patient and determine the extent to which the patient's family can be involved with the patient. It is believed that families have a right to decide whether they wish to become involved with the patient and equally whether the patient wishes to become

involved with members of their family.

In the short term the hostel aims to engage patients in carefully planned programs relating to self care, work, leisure habits and community involvement. In the long term, it aims to improve the patient's relationship with family members and/or the community, to promote a higher degree of independence in the patient, and ultimately to provide the patient with a 'more meaningful and enriched life style'.

The hostel however, is concerned with the possible introduction of disruptive patients. It is believed that such patients would not only disrupt programs or disturb residents, but would also precipitate unfavourable community reaction to the hostel and its residents. The managers of the hostel feel that they should not be expected to take responsibility for these residents, and that such persons should remain in hospital until they have regained 'a sufficient level of functioning acceptable to the community'. This is explained in the hostel's pamphlet:

> Hostels are part of the community and need to be socially integrated with it if they are to perform the socially rehabilitative function required of them. They are not extra mural chronic hospital wards to be shunned and isolated.
>
> Whilst talking about the rights of the individuals, there is also a need to consider the rights of the community. Residents should not be placed in hostels if they are unlikely to be able to fit in reasonably well with community living.
>
> The community attitude is much better than it was some years ago and many local communities accept the hostels very well, and are actively supportive and involved.
>
> We wish to keep community goodwill by carefully considering what a community can accept and tolerate. If this is ignored the present continuation and future development of the community could be lost.

An important consideration for establishing adequate facilities within the Australian Capital Territory is so that the legal and mental health authorities of the Territory are able to retain control over the patient. However, it would seem clear that the Watson Hostel would not provide an appropriate institution to hold involuntary or disruptive patients and any attempt to introduce such patients to the hostel could jeopardise its valuable contribution to the community. Equally it is clear that there is a need for a

facility which would cater for involuntary committals within the boundaries of the Australian Capital Territory.

It is submitted that as well as a facility for holding civil patients, there should also be provision made for holding and treating forensic patients within the Territory. The two facilities could be adjacent to each other, but the patients separated to distinguish the two groups in such a way as to avoid adverse labelling. In short, it is advocated that there should be three categories of psychiatric patients and facilities in the Australian Capital Territory.

First, the voluntary pschiatric patient who should be cared for without any requirements as to security or special observation. Second, the involuntary civil patient who should be segregated from the voluntary patient by being held, treated or observed in a protective care environment. Third, the forensic patient who would require similar but separate facilities from the involuntary civil patient, with a marginally greater emphasis on security.

7 Facilities and Standards of Treatment

There is an ever increasing awareness of the need to provide proper treatment facilities for the mentally disordered person. This is so whether the treatment is given in prison, in a mental institution, in a special institution which combines both prison and hospital, in a half-way house, or in, or under the auspices of less coercive regimes, be they custodial, semi-custodial or non-custodial in nature.

A reconsideration of the open-door policy of mental institutions provides a useful medium for introducing the problems that beset the search for adequate facilities for the containment and the treatment of mentally disordered offenders.

THE DISPLACEMENT EFFECT OF OPEN-DOOR POLICIES

The impact of the open-door policy of mental institutions is important for determining the kind of institutions that may be needed in the future. England, Canada, the United States of America and Australia have witnessed a general abandonment by mental hospitals of their asylum role, it becoming increasingly popular to treat mental patients in the community. It is believed that this open-door policy has had a displacement effect with the result that courts in dealing with mentally disordered offenders are using imprisonment more frequently.[149]

149. B.T.H., 'The Meaning of May – A Review of One Aspect of the U.K. Prison Inquiry', [1979] 143 *Justice of the Peace* 647, 648. For example, it was previously noted that in the U.S.A. the numbers in mental hospitals have been reduced from 558,000 in 1955 to 150,000 in 1980. R. Kiel, 'Mental Health for the Convicted Offender: A model that works', *Corrections Today*

This is despite observations such as those of Lawton L.J. in *Clarke*,[150] that 'Her Majesty's courts are not dustbins into which the social services can sweep difficult members of the public'. It seems that psychiatric hospitals and, where they exist, psychiatric prisons are unwilling or unable to accommodate certain categories of offenders. They may be unwilling because they do not believe that they are able to treat the offender with any degree of success or alternatively (in the case of general hospitals), because they cannot provide the degree of security necessary to guarantee protection – whether this protection relates to hospital staff, to other inmates or to the general community.

In the United States the gaol has been described as 'a revolving-door psychiatric ward' and as 'a second rate mental hospital'.[151] Wilson, an American commentator, has attributed the increase of mentally ill inmates in United States prisons to the policy of state mental health hospitals releasing inmates as soon as possible. He states that:

> While psychotics used to spend years hospitalized, many are now sent instead for a few days to community mental health centers. If they end up in state hospitals, they may remain there for as little as 30 days. Some observers believe that many of these go on to commit crimes, and thus end up in the prison population.

24, (January/February (1981). For an Australian study which has concluded that where mental hospital populations are high, prison populations are low, and *vice versa;* see D. Biles and G. Mulligan, (July, 1973), *Brit. J. of Crim.* 275. This study is somewhat superficial and does not distinguish adequately, among the various categories of psychiatric patients. It would for example, be useful to know whether there is a significant relationship between prison populations and populations of psychiatric patients who are involuntarily detained in mental hospitals. Data which would allow such comparisons are not readily available.

150. [1975] 61 Cr. App. Rep. 320. But see *R.* v. *Arrowsmith* [1976] Crim. Law Rev. 636 where a sentence of three years' imprisonment imposed upon a mentally disturbed offender following a breach of her probation order was upheld although it was out of proportion to the offence she had committed. In *R.* v. *Tolley* 58 Crim. App. Rep. 423, the decision in *Clarke (supra)* was preferred to that of *Arrowsmith* by the English Court of Appeal.

151. See generally R. Wilson, 'Who will care for the 'Mad and Bad'?', *Corrections Magazine,* (February 1980), particularly p. 14.

> While it is tempting to correlate the increase in mentally ill inmates with mental hospital release policies, there are no hard data available to support the notion that prisons are actually absorbing the mental health releasees in this way.[152]

He proceeds to point out that Henry Steadman, with the financial assistance of the Law Enforcement Assistance Administration of the United States, is to study the movement of inmates through mental health and correctional systems over a 10 year period.[153]

That a similar study should be undertaken in Australia in an attempt to gauge the impact of the open-door policy of mental institutions upon prison populations is beyond dispute. If it is found that neither prisons nor hospitals provide the proper environment for some persons, consideration should be given to some sort of institution which provides no more than asylum for certain untreatable categories of patients. As the size of the problem is not known, it is pointless in speculating further upon this issue. In the interest of the search for more humane and efficient forms of dispositional devices, however, it is recommended that research be conducted to trace the plight of offenders who are not acceptable for treatment at mental institutions and who (apparently for this reason) end up in prison and *vice versa.*

PSYCHIATRIC SERVICES IN N.S.W. PRISONS

At present in the New South Wales prison system, adequate psychiatric treatment has not been provided despite the efforts of the Prison Medical Service. While it is not unusual for recommendations to be made at the time of sentence that the prisoner should receive psychiatric treatment while in prison, it would appear that such recommendations are often ignored.

Yet it is not even necessary for a court to order or recommend medical treatment while the offender is serving a sentence of imprisonment, as there is a right to free treatment in certain circumstances. Thus s.16(1) of the *Prisons Act,* 1952 (New South Wales) provides:

152. *Ibid.*, p. 6.
153. *Ibid.*

> Every prisoner shall be supplied at the public expense with such medical attendance, treatment and medicine as in the opinion of the medical officers is necessary for the preservation of the health of the prisoner and of other prisoners and of prison officers, and may be so supplied with such medical attendance, treatment and medicine as in the opinion of the Commissioner will alleviate or remedy any congenital or chronic conditions which may be a hindrance to rehabilitation.

The following extract from the judgment of Jacobs J. in *Veen* v. *R.*[154] provides an insight into psychiatric services in New South Wales prisons. The extract follows Jacobs J.'s observations that New South Wales has neither a system of hospital orders, nor a special psychiatric prison of the kind that exists in England. His Honour said:

> The most that can be said is what O'Brien J. [in the New South Wales Court of Criminal Appeal in the present case] stated:
>
> 'If an offender is mentally disordered but not mentally ill within the purview of the Mental Health Act, psychiatric treatment is available if appropriate within the prison system from the Prison Psychiatric Service.' In a later case than the present one: *R.* v. *Page*, [1977] 2 N.S.W.L.R. 173 in which the principle enunciated in the present case was referred to and applied (although the sentence in that case was regarded as appropriate irrespective of the application of this particular principle), Street C.J. said, at p. 176: 'There is not the slightest reason to doubt that he will receive, whilst in custody, such psychiatric attention and treatment as may now or hereafter be available for his specific malady. His Honour could hardly have used more emphatic terms in expressing his concern regarding the appellant's psychiatric difficulty.'
>
> However, it is clear that the psychiatric services available in respect of a prisoner such as the present one are very limited indeed even if they can be said to exist at all. The trial judge in *R.* v. *Page* was Maxwell J. and that same judge has had occasion to say more recently in *R.* v. *Jessop* (29th March, 1978 unreported) when pronouncing sentence: 'I interpolate to state that according to my information and experience there is no way in which prisoners serving sentences in New South Wales can be afforded appropriate psychiatric treatment.' We were informed during the hearing of this matter, and it was not in any way challenged as a correct statement, that the applicant has not received any psychiatric treatment since his sentence. Yet in the meantime he has once attempted suicide.

154. (1979) 53 A.L.J.R. 305, 313-315. This case is discussed in Ch. 10, *infra*, p. 200ff.

Any doubts which might otherwise be left about the unavailability of any extensive psychiatric treatment in New South Wales prisons are resolved by the recent report of Nagle J. as Royal Commissioner appointed to enquire into New South Wales prisons. Having stated that medical services in New South Wales prisons are not operating satisfactorily, and having referred to the fact that part-time general practitioners and medical specialists supplement full-time services of Health Commission officers, Nagle J., *Report of Royal Commission into New South Wales Prisons* (Government Printer, 1978), at p. 335, said:

'If medical treatment is not available within the prison system, then it must be acquired from outside. . . Both logic and justice dictate that an imprisoned person should be provided with proper medical treatment.

The cost of such a provision is no answer to its necessity. The Department attempted to answer it in that way. But it is wrong.

If imprisonment is to be retained, society must accept the responsibility for ensuring that prisoners do not incur any physical or mental deterioration which can be cured or treated during their confinement. To achieve this objective, a suitable prison medical service must be provided.' He then turns his attention to the Observation Section at the Malabar prison complex; and it is there, if anywhere within the prison system itself, that psychiatric care and treatment (apart from visits to outside psychiatry specialists) would be given. At pp. 335 et seq. Nagle J. says:

'One of the most disturbing aspects emerging from the Commission's inquiries into the medical services of the Department has been the condition and use of the Observation Section at the Malabar Complex. The Section was originally designed for the containment and treatment of prisoners who were psychiatrically disturbed. All parties at the hearings of the Commission unanimously condemned the building and its facilities.'

. . .

The cellular conditions in the Observation Section are appalling. Some cells still have toilet tubs for use by occupants.

This practice is both unhygienic and dehumanizing. Some cells have no provision for beds and the occupant, whether sane or insane, is contained in a bare room. On the outside in the attached yard, there is scant cover for prisoners when it rains.

Apparently, various attempts and proposals have been made in the past to renovate the Section. Its continual use is an indictment on the prison system, its administration and the people of New South Wales. The situation should not have been allowed to continue and its replacement should be a first priority in any future building programme.

The Consultant Psychiatrist to the Prison Medical Service, Dr W.E. Lucas, describes the Section with a note of exasperation: 'One can only describe the Observation Section as Dickensian. Physically, it appears much the same as when I first saw it in 1968. However, it appears utterly durable. Cellular confinement of 16-17 hours per day is totally unacceptable for psychiatric patients. There are no psychiatrically trained staff and the inmates there are now predominantly psychiatrically disturbed. Whilst my knowledge is confined to since 1968 in the period since plans to provide alternatives have consistently foundered.'

It was universal practice to house all people charged with capital crimes in the Observation Section at Long Bay before their trial, whether or not any psychiatric illness was indicated. This could perhaps have been justified if a genuine attempt at psychiatric assessment was to be made on a remand prisoner. This was not the case. . .

Prisoners, if convicted of capital crimes, were sent back to the Observation Section. Again, this practice is difficult to justify unless it was to carry out a thorough examination and assessment of the prisoner to assist in his programming. But that has not been the history of the Observation Section: rather it has been used as a half-way house to acclimatize such prisoners to prison life.

. . .

It is clear from the evidence that, in the past, the Observation Section had been used to subdue or discipline recalcitrant prisoners. This is a more important criticism.

. . .

The Observation Section has for a long time had the reputation of being a punishment unit. This use is completely inimical to the concept of an Observation Section or psychiatric assessment unit. It has no legislative warrant.'

Some further insight into the lack of conditions for any extensive treatment of the mentally disordered can be got from Ch. 29 of the Report, which deals with prisoners found not guilty on the grounds of mental illness and ordered to be detained – the so-called 'Governor's Pleasure Prisoners'. Having related the statutory provisions and their constricting effect, he states at p. 393 et seq.:

'As a consequence, many of those acquitted by the jury on the ground of mental illness are never admitted to a mental hospital. Of fifty-one Governor's Pleasure prisoners detained on the 16th December, 1976, only twenty-nine were in mental hospitals. Of the fifty-seven Governor's Pleasure prisoners released during 1966-76, only twenty-six had been admitted to a mental hospital at some stage of their detention.

Many Governor's Pleasure prisoners who urgently need psychiatric treatment, but who do not qualify for admission to a mental hospital,

are thus deprived of the treatment they could otherwise have obtained as voluntary patients in such hospitals. The psychiatric treatment available in the penal institutions, such as it is, does not measure up to what those prisoners need and deserve.'

'. . . it is most desirable that the procedures for reviewing each prisoner's case should be placed into the hands of people with expertise in psychiatry and psychology, and that firm guidelines should be laid down to assist in the assessment of each case.

This is not so under the present system.

. . .

The circumstances under which Governor's Pleasure prisoners are detained in themselves arouse some cause for concern. It is difficult for the public to appreciate the uncertain and frustrating future contemplated by a person who has been imprisoned for an indeterminate period. The obsession which, it has been suggested elsewhere, prisoners, sentenced to imprisonment for a fixed period, have with a release date is not available to the Governor's Pleasure prisoner. The indeterminate nature of the sentence, coupled with an absence of rights on the part of the prisoner to do anything to procure his or her own release, is the source of much unhappiness.' If this can be said of prisoners found by a jury to be mentally ill it is equally true of any prisoner suffering from severe mental disorder and undergoing life imprisonment. It is a bleak picture which Nagle J. concludes to be in need of urgent reform. If and when that reform should be effected it would be time to consider the adoption of the English development. [155]

AN UNEASY DIVISION OF RESPONSIBILITY

Perhaps the most undesirable and neglected feature of prison treatment relates to the handling of Governor's pleasure detainees. The Nagle Report cites examples of Governor's pleasure detainees, despite recommendations to the contrary, failing to be transferred from prison to mental hospitals.[156] The Commission found an uneasy division of responsibility between the Health Commission and the Department of Corrective Services with regard to Governor's pleasure prisoners admitted to mental institutions. In brief the arrangement provides that the Principal Adviser of Mental Health is responsible for placing and treating Governor's pleasure

155. *Ibid.*
156. *Report of the Royal Commission into N.S.W. Prisons,* (The Nagle Report), (Govt. Printer, Sydney, 1978), p. 320-1.

detainees in mental hospitals. The prison psychiatrist also has a role to play, and makes regular visits to the institution to which the detainee has been transferred.

Meanwhile, the superintendent of the mental hospital is required to examine the detainee from time to time in order to determine whether he or she is mentally ill within the meaning of the Mental Health Act. After six months the Mental Health Tribunal is also required to make a determination as to whether the detainee should be kept in a mental hospital.

Where the detainee is no longer considered to be mentally ill and therefore where there is no ground for further detaining the person in a mental hospital, 'the prisoner is either released or, more frequently returned to prison'.[157] In the latter circumstance, the detainee must surely be in a most unhappy predicament, continued detention being justified neither on grounds of mental illness nor culpability but presumably upon the ground that the detainee is dangerous. One may be excused for thinking that such detainees are more often held for reasons of political expediency. Why rock the boat? The criterion of dangerousness as the presumed ground for release is perhaps more realistically summed up by the cautious phrase 'if in doubt, don't'.

It is always safer, it seems, for those in authority to detain the person for a longer period than normally considered necessary in order to avoid adverse publicity or criticism. Fortunately there is a growing awareness of the practice of detaining persons without adequate justification and in this regard prisoners' action groups and civil libertarians have directed and will continue to direct attention against this abuse.[158] Once returned to prison, the sole responsibility for the management of the detainee reverts to the Department of Corrective Services. The Nagle Report points out the lack of, and need for, appropriate criteria for release of Governor's pleasure detainees. It found no justification for an acquitted person's detention on grounds of retribution or deterrence (although it opined that here could be on grounds of dangerousness), and

157. *Ibid.*

158. The classic case is that of Sandra Willson who had served some 18 years in New South Wales institutions before a successful and concerted campaign by activists to bring her plight into the open. See Sandra K. Willson, 'Prisons, Prisoners and the Community' in *Women and Crime*, (eds., S.K. Mukherjee and Jocelynne A. Scutt), (George Allen & Unwin, Sydney, 1981).

that there ought to be firm guidelines for assessing each case.[159]

One may however question the need for special guidelines. There are already guidelines for detaining civil patients against their will and it is submitted that these ought to be the guidelines applicable to those acquitted on the ground of insanity.

RECOMMENDATIONS OF THE NAGLE REPORT

Following an observation that many Governor's pleasure detainees spend most of their time in prison and that 'to many observers, it is quite inappropriate that a person who has been acquitted because of a mental disorder should be in prison at all', the Report goes on to make a number of important recommendations. It recommends *inter alia*, that Governor's pleasure detainees should be removed from the responsibility of the Department of Corrective Services and placed entirely in the hands of the Health Commission, that the existing procedures relating to the admission and release of prisoners to mental hospitals should be revised and that in most cases where a person has been acquitted on the ground of mental illness, there should be an adjournment in order that psychiatric evidence of the person's mental state may be obtained. Consistent with the above philosophy, the Report recommends that during the period of remand for psychiatric assessment, the person should be detained in a mental hospital, although the judge should also have the power in exceptional cases to allow the person to be at large during this period.

Once evidence relating to mental condition has been heard '. . . the judge should have a discretion as to his or her disposition. This should include ordering committal to a mental institution, release on conditions and unconditional release'.[160] Where the Governor's pleasure prisoner is finally admitted to a mental hospital, the Report recommends that the person should be treated

159. A forthcoming study by G. Wardlaw, criminologist of the Australian Institute of Criminology is to consider the issue of dangerousness and release criteria.

160. *Op. cit.*, p. 323. As discussed previously the legislation of the Northern Territory goes some way towards satisfying these recommendations, *supra*, p. 46ff.

in the same way as any other patient who has been compulsorily detained, thus becoming classified as a 'temporary patient' within the meaning of the Mental Health Act and therefore becoming eligible for review by the Mental Health Tribunal after six months.

The Commission recommends some variations to the present procedure for releasing Governor's pleasure prisoners. It recommends that a certificate of the superintendent of the hospital indicating the fitness of the detainee should be obtained. The certificate would then be filed at the original court of commitment. Unless there was an objection to the release by the court itself or by any other person, the prisoner would be released. Otherwise a hearing would be held to determine whether on the balance of probabilities 'the release of the prisoner would present a substantial risk of serious bodily injury or serious property damage to another person'.[161] If the court were not persuaded of such a risk the prisoner would be released.

The Nagle Report also makes a number of important observations relating to the disposition of mentally disordered offenders who fail to satisfy the legal requirements of insanity, but who nevertheless are considered to be sufficiently mentally disordered to warrant hospitalisation and treatment. In this regard it advocates an expansion of judicial discretion in order to enable the trial judge in appropriate circumstances to commit a convicted prisoner directly to a mental hospital. The Report envisages that this power would be modelled along the lines of hospital orders under the English *Mental Health Act*, 1959.[162]

Since the Nagle Commission Report, and since *Veen*, there continue to be instances demonstrating the failure of the Corrective Services Department to meet adequately its obligations in providing care for inmates housed in its institutions.[163]

161. *Ibid.*, p. 323.

162. See particularly s.60-65 inclusive of the Act. These are briefly discussed *supra*, pp. 15-17.

163. The case of Barry King, a Parramatta prisoner, who was injured by shotgun pellets provides a good illustration. King was reported to have had 18 shotgun pellets in his head, neck and arms six weeks after he had been shot by prison officers, despite requests for treatment, and orders by magistrates that he should have the pellets removed. See G. Zdenkowski, 'Medical Treatment in Prison', (1981) 6 *Legal Services Bulletin* 45, where this and the responsibility of prison authorities to provide medical treatment are discussed.

No doubt the new prison hospital being built at Long Bay will provide a vastly improved deal for both prisoner and public alike. It should also open the door for the introduction of hospital orders in that State. It must be stressed however, that the success or failure of any new institution depends upon the calibre and training of staff who are charged with the duty of providing the day to day administration of its services. The provision of new buildings and facilities need to be matched with an enlightened and humanitarian administration if the inadequacies of the past are to be rectified. In this regard also, it is desirable that there should be standards specified and met if progress is to be made. Before turning to consider the kind of guidelines that would assist in promoting a better deal for the mentally disordered prisoner, something further needs to be said concerning the type of institution that is best able to serve the dual prupose of treatment and punishment in a custodial environment.

THE PSYCHIATRIC PRISON HOSPITAL

Queensland's Security Patients' Hospital at Wacol prison, South Australia's Northfield Security Hospital, adjoining Yatala Prison, and Tasmania's Special Institution, which is annexed to Risdon Prison, are institutions which have been designed to provide both treatment and protective security for forensic patients.

J Ward of Ararat Prison is Victoria's maximum security mental hospital for the criminally insane and holds about 30 men. The first three institutions referred to however, are the only penal institutions designed specifically to house, care for and treat mentally disordered offenders in Australia. In the majority of cases the choices are either to ignore the prisoners' psychiatric needs, to provide treatment on an *ad hoc* basis while the prisoner is serving his or her sentence in prison or to transfer the prisoner from a penal to a mental institution for more intensive or specialised treatment.

The Security Patients' Hospital at Wacol is the largest institution of its type in Australia, and in 1979 had a daily average number of 62 patients, about twice the number held at South Australia's Northfield Security Hospital. The Tasmanian Institution rarely contains more than a few individuals at any one time, and despite the fact that it is well equipped and served by specially trained

personnel, its cramped and claustrophobic surroundings provide a lesson in how not to design such an institution.

Although there are in New South Wales a number of hospital facilities which contain wards with differing levels of security to house mentally ill patients, including the criminally insane patient, a psychiatric facility within the precincts of Long Bay Gaol is presently being built. One facility that has already been referred to, and to which mentally ill offenders from the Australian Capital Territory are sometimes sent is Morisset Psychiatric Hospital. This hospital is situated near Newcastle and holds about 800 patients of whom only a small proportion are criminal. At present it contains the main maximum security facility for holding and treating mentally disordered offenders sent from New South Wales prisons. That this facility has failed to provide adequate security has been demonstrated by the apparent ease with which offenders are able to walk out or escape from the institution. This has been demonstrated in *Riley*,[164] and perhaps even more convincingly in Cribb and Munday.

In April 1979, the Premier of New South Wales, Mr Wran, questioned the appropriateness of allowing the admittance to Morisset Psychiatric Hospital of potentially dangerous persons such as John Ernest Cribb, who was awaiting trial for the triple murders of a woman and her two small children, and William John Munday, who was convicted of kidnapping, rape and armed robbery, and was serving a sentence of 30 years' imprisonment. The pair had recently escaped from the maximum security wing of Morisset Hospital for the criminally insane, triggering what was to be described by the news media as the State's biggest manhunt since 1959 when the police sought the recapture of Simmonds and Newcombe after their escape from Long Bay Gaol. Cribb and Munday were said to be desperate and extremely dangerous.

Until their recapture their escape was accompanied by publicity which obviously evoked considerable fear in the community. This fear was further precipitated following the abduction and rape by the escapees of two 17 year old school girls, and police were advising young women to stay off the streets, for the general public to lock homes and cars, and for families to exercise caution when answering knocks on their doors. The press reported widely

164. Discussed *supra*, p. 97ff.

the following statement of Premier Wran, 'But two people such as these with a proven track record of such animal behaviour should not be anywhere but behind bars in the most strict custodial institution.'[165]

The maximum security facility at Morisset (Ward 21) is separated from the rest of the hospital buildings. It is surrounded by a high stone wall. If the patient is serving a prison sentence and his condition improves, he may be returned to prison but more probably he will first be transferred to a closed ward (Ward 19) within the institution. On further improvement, he may then be returned to prison or else may graduate to becoming a patient on 'parole-in-company' under the supervision of staff. In some cases he may be transferred to an open ward, mix with non-criminal patients and be able to move freely about the hospital grounds. Eventually, he may even be released from the hospital.

One criticism of this system has related to the speed with which potentially dangerous criminals are processed through the system. The nursing staff of the hospital have claimed that 'it is common practice for prisoners convicted of murder or violent sexual crimes to be unconfined in open wards within two years of entering the hospital' and that 'most criminally insane patients spend less than a year in Ward 21.'[166] The main concern of the nursing staff is their belief that they are at considerable risk when patients are transferred prematurely from the maximum security wing to Ward 19. In addition, they have complained that Morisset 'has become a dumping ground for overcrowded prisons' and have even threatened industrial action by refusing to accept Ward 21 patients into other wings of the hospital until these patients had completed their non-parole period, or in the case of Governor's pleasure or life sentence prisoners[167] until they had served 10 years in maximum security.

A major overhaul and review of Morisset Psychiatric Hospital followed the Cribb and Munday episode. The number of referrals from penal institutions to the maximum security wing began to decline. Whether this relates to the inadequacy of security or a

165. *The Canberra Times*, 18 April 1979. Riley's case also represents a recent example of the lack of security at Morisset Psychiatric Hospital. This case is discussed *supra*, 97ff.
166. *Newcastle Morning Herald*, 14 December 1978.
167. *Ibid.*

tighter screening of offenders is not known. Certainly immediate steps were taken to improve (in terms of security) the physical layout of the ward. Extra precautions were taken, including the installation of additional bars on the windows of the maximum security wing. Inside the perimeter of the grounds surrounding this ward, Israeli type fencing and electrical alarm systems were installed. Extra staff, particularly during the night shifts were provided and improved telephone communication facilities and lighting systems were added. However the most significant policy change precipitated by the Cribb and Munday affair was the long term one advocating the construction of a separate institution to house mentally disordered offenders requiring maximum security facilities.

It is important that the escape of Cribb and Munday should not be taken as providing the sole justification for this new policy. In fact some 12 months prior to these escapes, the Nagle Report had recommended that the construction of a special maximum security unit to house the criminally insane should be considered by the State Government. The effect of these escapes may be seen as serving to influence and hasten the Government's decision to construct a special psychiatric hospital within the precincts of the prison complex at Long Bay.

At an estimated cost of 10.5 million dollars, the new hospital is expected to contain 160 beds. Forty of these beds will be set aside as a maximum security psychiatric ward for male patients and is anticipated to replace the maximum security wing in other psychiatric institutions. It is planned that a further 40 beds will be used as a general psychiatric ward, 30 of which will be used for male and 10 for female patients. Finally, the last 40 beds are expected to be used as a general medical ward for male patients. The facility would also contain a kitchen, an out-patient's department, an administration centre and amenities for staff.

The administration and staff of the hospital would be run by the Health Commission of New South Wales, but the hospital itself would be surrounded by a security wall with custodial accommodation and watchtowers manned by custodial officers from the Department of Corrective Services.

The maximum security ward would, however, be separated from the rest and have its own walled enclosure. According to the Minister for Health, the new hospital would take about two years

to build, and therefore would probably not be fully operational until 1982.[168]

To assume without further argument that the prison hospital somehow provides the solution to the plight of the mentally ill may be somewhat simplistic. For example, Janette Hartz-Karp who has examined the appropriateness of constructing a special psychiatric prison hospital in Western Australia, has recommended against the construction of such an institution in that State.[169] She points out, *inter alia*, that the construction of a special psychiatric prison hospital is based on two propositions. First, that the Mental Health Services cannot adequately cater for mentally ill offenders, and second, that the mentally ill offender cannot be adequately looked after in a prison setting.

She argues that the inevitable outcome of incarcerating a person in a special psychiatric prison hospital is to label that person as 'mad' as well as 'bad' and therefore is possibly the least efficacious and most problematic means of catering for mentally ill offenders.[170] She advocates a decentralised approach to the problem in which responsibility for disordered offenders are split effectively between legal, mental health and correctional authorities. This she suggests, avoids the hybrid status of 'mad' and 'bad' and the administrative problems that this group of prisoners presents. Indeed she discloses a deep distrust of psychiatrists and the tendency to classify troublesome prisoners as mentally ill. Given a choice she seems to favour the use of imprisonment rather than the prospects of handing prisoners over to the mental health authorities. Even so she recognises that some prisoners may require treatment which is not available in prison and these persons she concedes should not be denied the right to accept or refuse treatment.[171]

168. *Grapevine*, April 1980, the Official Newsletter of the New South Wales Department of Corrective Services. Janette Hartz-Karp, 'The Mentally Ill Within the Criminal Justice System', *Research and Information Series No. 19*, (Western Australian Department of Corrections, Perth, September 1979).
169. *Ibid.*, p. 6.
170. If we accept that some people are 'bad', and others are 'mad' would it not be reasonable to suppose that there are people who are both 'mad and bad' and for whom neither hospital nor prison seem appropriate institutions for their containment and treatment? If this is the case then we can neither avoid labelling some persons as mad and bad nor at the same time refrain from providing adequate facilities for such persons.
171. *Ibid.*, p. 61-63.

There is much in Hartz-Karp's paper that is commendable and well argued. However she does not, in the present writer's opinion, tackle the very problem upon which the need for a psychiatric prison-hospital is based. The psychiatric prison-hospital provides a greater degree of security than does an ordinary psychiatric hospital.

Even a maximum security wing in a mental institution such as Morisset has shown itself to have fallen short of providing adequate security. This is well illustrated in the autobiography of William John Munday where he describes how he 'conned' his way into Morisset in order to plan his escape from prison.[172] He states:

> I ran around the jail talking to anyone and everyone who had been to Morrisett. [sic] They told me of all the possible escape routes and I began to act crazy. I had spoken to John [Cribb] briefly and he decided that if I got to Morrisett we would escape together. You know, I must have been so convincing. Even JB thought I was going nuts. I would walk around talking to myself, telling screws to get stuffed or I'd cut their heads off. I would always get charged with telling off a screw and when I fronted the VJ, I'd say 'I don't remember doing it.'
>
> I'd call a lot of witnesses and have the charge dismissed. One day a Doctor Darcy from Morrisett came to visit me. I conned him well and good. He really thought I needed help quick and it was on his recommendation that I was transferred to Morrisett. Three months passed and I still wasn't there. Then one day I was talking to John through a gate and a screw told me to move or else he'd move me physically. I told him to take a walk and he rushed me. I smashed him, and screws appeared from nowhere. I was put into the pound and flogged but it was worth it because a few days later I was moved to Morrisett.
>
> I laughed all the way there in the paddy waggon. I thought they were real suckers. Now I wonder who was the sucker, me or them? They're on the outside and I'm in here doing 58.[173]

This kind of manipulation of the system is well known to prison administrators. Sometimes it manifests itself in overt acts of self-abuse, particularly attempted suicide, self-mutilation and other forms of self-induced injury such as the swallowing of sharp objects. In these circumstances the nature of the prisoner's complaint is readily verifiable either by direct visual examination or

172. W. Munday and M. Attard, *58 Years*, (C. Murphy, Sydney, 1980).
173. *Ibid.*, p. 108.

with the aid of x-ray equipment. In cases of mental illness however, the prison psychiatrist is often left to distinguish between genuine and feigned illness without the aid of hard evidence of the kind just referred to.[174] That the psychiatrist will be tricked or mistaken on many occasions is beyond dispute. Even so, this is not a reason for removing the psychiatrist from the prison service.

Apart from genuine cases of mental illness, which must surely be the role of the psychiatrist to diagnose, the very presence of a prison medical service and the promise of adequate treatment even if this means transferring prisoners beyond the walls of their present confinement, constitutes a positive rather than a negative influence upon the mental health of all prisoners. In this regard it is of no serious consequence if a few manage to manipulate the system in order to remove themselves from the immediate environment in which they find themselves. That prisoners will wish to manipulate the system in this way serves only to highlight the inadequacies of institutional life. No doubt the lengths to which prisoners will go in order to attract the notice of prison administrators is but one measure of the prisoner's sense of hopelessness and despair.

These are often taken as signs of mental disorder, but as already indicated, feigned and genuine mental disorder are not easy to distinguish. Indeed there is no inconsistency in finding that a person who sets out to manipulate the system by feigning mental illness is in fact mentally disordered and would benefit from treatment.

However from the description given by Munday, there is no reason to believe that his behaviour was anything other than rational. Thus Munday further describes how he was able to manipulate the authorities in order to plan his escape. He explains how he decided 'to act crazy a little longer' so that he could 'check things out' for himself. He describes how he and Cribb began to plan their escape from the first day of his arrival:

> They put me into a dormitory with these ten guys who were nice and crazy and my whole stay there was freckled with incidents that would make the sanest man insane. Every night at 6 pm we went to bed. Before you went to your dormitory you were stripped and searched. You walked into your ward naked and put on your PJ's there. My first

174. Discussed *infra*, p. 171ff.

> night there I checked all the windows. But there was no way you could get out of them. They were shackled with iron bars and mesh.
>
> Finally, after much scheming John was moved into the same dorm as me. The next move was to have all the other loonies removed. That was the easiest of all because all we had to do was threaten them. I did the standing over. One at a time they all moved.
>
> One of the nut cases told the nurses I was standing over the others and I was dragged into the office. I walked in dragging my feet along the ground like I was stoned. Believe it or not they actually flog people in there. I was flogged that day. I have seen them bash men then stick a needle into them and throw them into solitary to recover. They can get away with it because they're under the guise of the Health Commission and not the Department of Corrective Services.[175]
>
> They threatened me that day with shock treatment. I kept my cool even though I was dying to flare up. I just mumbled something and shuffled my way out of the office and back to the loonies' ward. John and I soon decided on our means of escape. It had to be the windows. So we smuggled in hacksaws. I can't, for legal reasons tell you how or who helped us, but it wasn't very hard.
>
> It took us three days to saw through the first set of iron bars and a further three days to get through the outside set. Each night we would paste them back together so no-one would notice what we had done.[176]

The new measures at further securing Morisset which were introduced following the successful escape of Cribb and Munday would now make escape more difficult. Yet Morisset would still fall short of being able to provide the degree of security that is found in maximum security penal institutions. In the first place the kind of special maximum security unit that is to be built within the precincts of the Long Bay Prison Complex would probably reduce attempts by prison inmates to seek admission with the sole object of escaping from prison. Further, by being situated at Long Bay, it would reduce the problem associated with transportation of the prisoner from prison to prison-hospital. After all, the Long Bay Prison Complex is by far the largest penal institution in New South Wales and therefore already accommodates the largest

175. Note the accusation relating to the use of illegal force to effect compliance and the view that it is easier to get away with it under cloak of a treatment rather than a punitive authority. That this could be so highlights the need to provide safeguards in order to minimise such abuse.
176. *Ibid.*, p. 109.

number of potential customers. The hospital's proximity to the general prison population would facilitate short term committals and offer treatment and adequate surveillance of patients by specially trained staff.

It is important however, that the hospital should not appear to be part of the ordinary prison. It must have a completely different administration and not be subject to the rigours of prison rules and regulations. In summary, it is security which is the primary concern of prisons and of prison officers who are the experts in this field. If hospitals could provide equivalent security to that of a prison there would be less objection to a dual rather than tripartite arrangement. The psychiatric prison-hospital is the logical compromise of security and treatment and allows for the development of a regime which is different from the other two.

GUIDELINES FOR TREATMENT

Granted that some convicted offenders may require medical or psychiatric treatment, what principles should apply to the prisoner's right to have, or abstain from having, treatment? Australian Discussion Paper 4, prepared by the Australian Criminal Sciences Committee for the Sixth United Nation Congress on the Prevention of Crime and the Treatment of Offenders,[177] states that the principles proposed by Nigel Walker find considerable support in Australia. The conditions proposed are as follows:

(1) that the prisoner must consent;

(2) that it must not involve greater restriction on freedom than that to which the prisoner would have been subject if sentenced ordinarily;

(3) that the resources for treatment already exist and do not have to be provided at considerable cost for a small number of offenders; and

177. D. Biles, *De-institutionalisation of Corrections and its Implications for the Residual Prisoners,* Australian Discussion Paper, Topic 4, (A.G.P.S., Canberra, 1979), p. 26.

(4) that prospects of success really are substantial.[178]

The Australian Discussion Paper adds a fifth condition – that the offender may withdraw from treatment at any time – but this condition could be interpreted as being included in Condition 1. The issue of consent is further complicated when it comes to compulsory treatment and it is here that adequate guidelines are required to ensure this exception to the general rule is not abused. Next, Condition 3 is somewhat of limited application for it seems to preclude the possibility of introducing new treatment facilities until such time that there is a substantial demand for them. On humanitarian grounds alone it would seem that whenever treatment is needed,whether on short term or on a continuing basis by even a comparatively small number of individuals, every attempt should be made to provide appropriate facilities to meet this need. This is the approach for the treatment of physical illnesses, and likewise it ought to be the approach for those suffering from mental illness.

Surely few would argue with the proposition that all citizens regardless of social status deserve the benefits of a minimum standard of medical care and attention, and that the community is duty bound to do its best in meeting this standard. If it can improve on the minimum standard so much the better. While it is not suggested that the state should do more than is reasonable, having regard to humanitarian considerations, it is recommended that at the very least no prisoners should be denied treatment available to the general public.

The only, and important consideration, shared by both the criminal and the non-criminal, relates to the problem of security – sometimes referred to as the principle of social defence. It is in these circumstances that the interests of the individual may be relegated to a position secondary to that of the community.[179] This accords with the general principle and aim of imprisonment, namely, the protection of the community under which all the usual objects of deterrence, retribution, rehabilitation and denunciation are said to fall.

178. N. Walker, *Treatment and Justice in Penology and Psychiatry*, the Sandoz Lecture, (The University Press, Edinburgh, 1976), pp. 127-132.
179. This is not to derogate from the possibility and hope that those undergoing treatment will benefit from treatment and emerge rehabilitated and hence no longer a serious threat to the community.

Finally, with regard to Condition 4, it is debatable whether only those who have a substantial prospect for successful treatment should be entitled to have it. Rather the emphasis should be upon whether the offender needs treatment and might benefit from it. In any event the concept of 'success' might imply that the offender has a substantial chance of full recovery, or equally the term may be interpreted as indicating some or any improvement in the offender's condition. Where there is a need for treatment with a corresponding expectation of some improvement in the prisoner's condition, then it would seem that the opportunity to enable that improvement to take place should be provided to the prisoner as of right.

Within reason, neither the cost nor the number of offenders who require treatment should preclude the provision of proper medical or psychiatric support. On the contrary, if the State is prepared to interfere with an offender's liberty it would seem appropriate to suggest that it is morally bound to make any necessary treatment available to the detainee. Having assumed custody of an individual, the State cannot then abrogate its responsibilities towards that individual. To deny care when it is needed is to compromise upon humanitarian principles.

A THERAPEUTIC BILL OF RIGHTS?

It is unrealistic to expect that a small minority of persons such as the mentally ill, the chronic recidivist, the alcoholic or drug addict, will all accept society's judgment and happily submit to such treatment programs as may be deemed necessary by the authorities. Some degree of coercion or control is inevitable. Therapeutic programs, as indeed prisons, are likely to remain a fact of life in the struggle to preserve peace and good order in the community. To ensure that there is a restrained and consistent approach to the problem, that the systems operate in a just and fair manner, general principles are required which balance the intrinsic evils of compulsory therapeutic intervention with the overall advantages of such intervention. Kittrie writes:

> Until we face the issue of the therapeutic state's right to confine even when it cannot treat and develop and implement standards and procedures for such admittedly social-defense measures, we will find

> progress past the deficiencies of the criminal model of social controls either strewn with new dangers to individual liberty or else totally unacceptable to meet the needs of social defense.[180]

In order to protect individuals from deficiencies in the present system, but at the same time in order to retain the potential benefits of a therapeutic approach to corrections, thereby giving the therapist a chance to serve his noble purpose, Kittrie has offered a set of principles which he has dubbed the Therapeutic Bill of Rights. His principles are as follows:

1. No person shall be compelled to undergo treatment except for the defence of society.

2. Man's innate right to remain free of excessive forms of human modification shall be inviolable.

3. No social sanctions may be invoked unless the person subjected to treatment has demonstrated a clear and present danger through harmful behavior which is immediately forthcoming or has already occurred.

4. No person shall be subjected to involuntary incarceration or treatment on the basis of a finding of a general condition or status alone. Nor shall the mere conviction of a crime or a finding of not guilty by reason of insanity suffice to have a person automatically committed or treated.

5. No social sanctions, whether designated criminal, civil, or therapeutic, may be invoked in the absence of the previous right to a judicial or other independent hearing, appointed counsel, and an opportunity to confront those testifying about one's past conduct or therapeutic needs.

6. Dual interference by both the criminal and the therapeutic process is prohibited.

7. An involuntary patient shall have the right to receive treatment.

8. Any compulsory treatment must be the least required reasonably to protect society.

9. All committed persons should have direct access to appointed counsel and the right, without any interference, to petition the courts for relief.

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180. N. Kittrie, *The Right to be Different: Deviance and Enforced Therapy*, (John Hopkins University Press, Baltimore, 1971), p. 400.

10. Those submitting to voluntary treatment should be guaranteed that they will not be subsequently transferred to a compulsory program through administrative action.[181]

THE A.M.A. GUIDELINES

Many of these principles expressed perhaps in different forms are to be endorsed. Complementary to these principles is the need to uphold a minimum standard of mental health in penal institutions, and for this purpose guidelines of the form advocated by the American Medical Association in March 1979, for psychiatric care in prisons and jails should be adopted. These include the following:

- All correctional personnel should be trained by medical staff 'to recognize signs and symptoms of chemical dependency and emotional disturbance and/or developmental disability, particularly mental retardation.'
- Every new inmate should be interviewed by a psychologist and referred for psychiatric evaluation within 14 days if mental illness is suspected.
- Psychiatric problems identified either at screening or after admission must be followed up by medical staff. The urgency of the problem determines responses. Suicidal and psychotic patients are emergencies and require prompt attention.
- Inmates awaiting emergency evaluation should be housed in a specifically designated area with constant supervision by trained staff. Inmates should be held for only the minimum time necessary but no longer than 12 hours before emergency care is rendered.
- Before any diagnosed psychiatric patient is assigned housing or programs, has disciplinary measures taken against him, or is transferred, prison administrators should consult with the psychiatric staff.
- The policy should be that 'patients with acute psychiatric and other illnesses who require health care beyond the resources available in the facility are transferred or commited to a facility where such care is available. . .' If treatment is to be provided in the prison, it must be in a 'safe, sanitary humane environment. . . [have] staff within

181. *Ibid.*, pp. 402-404. In the text Kittrie expands on each of the principles *per seriatim.*

sight or sound of all inmates. . . [and have] trained personnel available to provide treatment and close observation.'

- Inmates are to be informed, orally and in writing, of procedures for access to medical treatment.

- A 'special medical program. . . for inmates requiring close medical supervision' should be devised. Psychotic or suicidal inmates are included in this group. An individual treatment plan must be developed by a physician, and must give specific instructions to health-trained correctional staff.[182]

When guidelines such as these are coupled with a system of inspection and accreditation, appropriate standards are more likely to be encouraged and maintained.

Whether such a system could be initiated on a national level in Australia is highly debatable in view of the constitutional arrangements for the sharing of powers, the suspicion with which the States often regard initiatives of this kind by the Federal Government, and also by examining the history of uniform cooperation in other spheres. However this should not prevent the States themselves developing their own systems of inspection and accreditation and promoting and declaring their own standards, and of course comparing their own standards with those of other jurisdictions.

Further, there is no reason why the Australian Capital Territory should not develop its own treatment facilities in Canberra, and at the same time declare the standards and provide a system of inspection and accreditation that could serve as a model for other jurisdictions. Certainly the declaration of standards alone may not be a sufficient protection to inmates, and regular inspection and accreditation would ensure that treatment standards are maintained. This would also promote a better public image and help break down the image of mental and correctional institutions as being nothing more than warehouses for forgotten souls and dubious practices, a bag of worms which must remain hidden from the public eye.

182. R. Wilson, *op. cit.*, n. 151, p. 17.

8 Extending the Options

A number of contemporary judicial decisions relating to mentally disordered offenders suggest there is a need for custodial or semi-custodial alternatives to both civil commitment and imprisonment in a very small, but nevertheless significant, number of cases. *Riley*[183] and *Smith*[184] have provided two illustrations of the gap that exists in the Australian Capital Territory for dealing with offenders who do not fit satisfactorily into any of the dispositional alternatives presently available to the courts. This problem is not unique to the Australian Capital Territory for other jurisdictions also suffer from this 'yawning gap' of dispositional options, as the following Victorian decision clearly demonstrates.

R. v. *TUTCHELL*[185]

In *Tutchell* the Full Court of the Supreme Court of Victoria had occasion to consider the options which were available to courts in Victoria for the disposal of convicted offenders requiring urgent psychiatric and psychological assistance. Tutchell had pleaded guilty and had been sentenced, in the County Court on 7 June 1978, in respect of the following offences:

indecent assault of girl under 16 years;

indecent assault of boy under 16 years;

buggery with a woman;

buggery with a boy under 14 years;

183. *Supra*, p. 97.
184. *Supra*, p. 99.
185. [1979] V.R. 248.

buggery with men (two counts);

buggery with animals (two counts);

assault occasioning actual bodily harm; and

stealing a pocket calculator.

For these offences the trial judge sentenced Tutchell to a total effective sentence of seven years' imprisonment with a non parole period of five years. In addition the trial judge requested, *inter alia*, that Tutchell should be given 'such psychiatric or psychological assistance as may be available in G division at Pentridge'.[186]

Among the several grounds of appeal against the severity of the sentences imposed, there was one which claimed that the trial judge had failed to give proper weight to evidence indicating that the applicant required treatment which could not be given in gaol. Indeed an original, but amended ground of the appeal made by the applicant had been that 'Drs Bartholomew and Myers and psychologist Crewdson told the Court that the treatment I require cannot be given in gaol. They recommended probation for teatment at Mont Park Psychiatric Hospital.'[187] A further ground of appeal was that the trial judge had 'failed to give proper consideration to aspects of rehabilitation'.[188]

For the Full Court, the first question was whether there was any error involved in the imposition of sentence. The Court held that the trial judge was in error because he had made an excessive estimate of the aggregate sentence. The Court therefore felt justified in deciding for itself the appropriate length and type of disposition it would substitute.

The Court took the fairly unusual course of agreeing to hear additional evidence on the matter in order to determine whether or not the applicant required treatment, whether treatment would assist him in avoiding future sexual offences and whether there was a practicable way of providing him with treatment. Detailed evidence was in fact given by psychologists Crewdson and Montgomery (the latter being in charge of the psychological clinic at La Trobe University) and psychiatrist Dr Bartholomew. The matter was then adjourned in order to obtain further evidence and for

186. *Ibid.*, p. 249.
187. *Ibid.*
188. *Ibid.*, p. 250.

this purpose, Dr Bartholomew undertook to convene a conference of experts 'whose participation would be essential to the successful carrying out of the proposals' for treatment of the offender.[189] A report of the conference with its conclusions was presented to the Court by Dr Bartholomew. The Court then proceeded to evaluate the evidence before it.

First the Court considered that if the offender were to undergo a prison sentence without receiving any treatment he would resume a similar pattern of behaviour following release. That is, the Court was 'satisfied that if the applicant receives no treatment it is likely that he will again commit sexual offences against children.'[190] A further observation of the Court related to the applicant's adjustment to imprisonment. It noted that the prisoner had informed on other prisoners and therefore had to be confined for his own protection. Apparently he had been sexually assaulted by a group of men and already had attempted suicide on one occasion. It was considered that there was a substantial risk that the prisoner would make further attempts at taking his own life.

In giving consideration to the dispositions which were available to the Court in cases such as the present one, reference was made to the suspended sentence. This sanction in Victoria applies to those sentenced under the *Alcoholic and Drug-Dependent Persons Act*, 1968, s.13, but not to offenders generally (including the applicant).[191] Then the Court considered a provision which has some resemblance to a hospital order. Under s.51 of the *Mental Health Act*, 1959, a court has the option of sending an offender to an appropriate State institution where it is satisfied that the person is either mentally ill or intellectually defective. Section 51 provides as follows:

189. *Ibid.*, p. 253. Included in the conference were Dr Stephens, Dr Cameron and Mr R.D. Stanley, (Melbourne Centre for Forensic Psychiatry), Dr Montgomery and Dr Stevenson, (Psychiatrist Superintendent of Mont Park Hospital). The public solicitor, the counsel for the applicant and the probation officer were also present. Prior to the conference Dr Stevenson and a number of his colleagues at Mont Park Hospital had also interviewed the applicant.

190. *Ibid.*, p. 254.

191. Had a similar case been brought before a court of the Australian Capital Territory, the offender could have been dealt with by way of a suspended sentence. One may question however, whether a suspended sentence affords any greater protection to the community than a probation order. Cf. *Riley* discussed *supra*, p. 97 and see also *infra*, p. 141ff.

> 51(1) Where a person is convicted of any criminal offence by a court of competent jurisdiction the court on being satisfied by the production of a certificate of a medical practitioner or by such other evidence as the court may require that such person is mentally ill or intellectually defective may in lieu of passing sentence order such person to be admitted into an appropriate State institution to be named in the order and the person shall forthwith be conveyed to and upon the production of the order and certificate shall be admitted into and detained in such institution accordingly.
>
> (2) Any such person shall be for all the purposes of this Act deemed to be admitted as a recommended patient or approved patient (as the case may be) under the appropriate provision of Division 2 of this Part and the superintendent shall take such further action under that Division as the case requires.

The Court referred to *R.* v. *His Honour Judge Rapke; Ex parte Curtis* (1975) V.R. 641 and *R.* v. *Carlstrom* [1977] V.R. 366 as demonstrating the problems of using s.51 of the *Mental Health Act,* 1959. It noted that if it exercised powers under s.51, the superintendent of the institution was then empowered to decide how long the person was to be detained. Further, it noted that there was no guarantee that a person so sentenced would receive treatment.

Next the Court referred to the bond (or bind-over) power under which it was empowered to release the offender on a recognisance with a requirement that he undergo treatment and come up for sentence when called upon. The Court was of the opinion that in the case of a serious sexual offence, probation,[192] where an officer was assigned 'to assist and supervise the offender during treatment', was generally to be preferred and that probation 'may in some cases' be a viable option in such cases. It required the consent of the offender to undergo the necessary treatment, and failure to comply with the terms of the order would render the offender liable, in the terms of s.516(4) of the *Crimes Act,* 1958, to be dealt with 'in a manner in which the court could deal with him if he had just been convicted before that court of that offence'.

The Court then referred to *R.* v. *Dole*[193] in which McInerney J. had lamented the fact that Victorian legislation had no counterpart to s.20 of the *Crimes Act,* 1914-1973 (Commonwealth) (the

192. Under s.509 of the *Crimes Act,* 1958 (Vic.).
193. [1975] V.R. 754.

split sentence) under which it was possible to impose a sentence of imprisonment but, at the same time, specify that the prisoner be released on a recognisance during the unexpired part of the sentence.[194] The recognisance could then be subject to a condition requiring him to undergo psychiatric treatment until his sentence had expired.[195] The Court observed however, that a similar result could be achieved under s.190 of the *Social Welfare Act*, 1970 (Victoria). Under that section the sentencing court could specify a non-parole period and after the minimum term had expired, the Parole Board could then release the offender on parole on condition that he agreed to undergo any necessary treatment.

What were the pre-conditions for granting the applicant treatment? The Court felt that it had to be satisfied first, that the prisoner in an informed and free manner, consented to be placed on probation and agreed to submit himself to the proposed course of treatment. Second, that those entrusted with the appellant's treatment agreed to fulfil their responsibilities. On the latter aspect the Court required 'direct evidence from the persons and authorities' involved in the treatment program, that they were 'fully aware' of the offender's condition and background and that they accepted 'the responsibilities proposed for them'.[196]

In the result the Mont Park Hospital authorities were unable to provide the necessary assurance to the Court. The main problems related to 'security, safety and notification'. The applicant could only be admitted as a voluntary patient,[197] would not be confined in secure conditions and could virtually without notice, abandon the treatment and walk out of the hospital at any time. Further, it

194. This form of disposition was used in *Riley* discussed *supra*, p. 97.
195. *Ibid.*, p. 770. In *R.* v. *Dole* the Victorian Full Court substituted a custodial sentence in lieu of a bond upon an offender who had been convicted on three counts of indecent assault of a girl aged nine. He had a long history of sexual offences. The bond had been granted in order to provide the offender with an opportunity (indeed a further opportunity) for treatment. However the majority of the Court (Gowans and Nelson JJ.) considered that the trial judge's discretion had miscarried, because added weight had to be given to the principle of general deterrence and to the seriousness of the offences themselves. Even so, the Court was prepared to fix a relatively short non-parole period of nine months, after which time the prisoner could be released on parole on condition that he submit to a course of curative treatment.
196. (1979) V.R. 248, 256-257.
197. Under s.41 of the *Mental Health Act*, 1959 (Vic.).

was considered that the 'relative freedom of movement' which he would enjoy as a voluntary patient meant that other patients would be at risk of sexual attack or abuse. Accordingly, the Court held that the Mont Park Hospital was not a suitable institution at which the proposed plan of treatment could be implemented. The only alternative left was imprisonment. The Court said:

> There being no practical way of having the applicant treated in the manner proposed, there is no alternative to sentencing him to imprisonment. For his own protection he is likely to be kept in G division at Pentridge where he can be protected as well as in many psychiatric and mental hospitals. There are at present two female occupational therapists there who engage in a considerable amount of psychotherapy of various types. The report suggests that it is possible that the applicant could be helped by their efforts. The report confirms that endeavours are presently being made to improve psychiatric treatment facilities in G division. It is proposed that some behaviour modification programme be introduced, although it is unlikely to be comparable to that at La Trobe University for many years. The dilemmas of this case demonstrate the need for such a programme. We will recommend that such psychiatric or psychological treatment as is available to prisoners be made available to the applicant.[198]

The Court then proceeded to impose a total effective sentence of five years' imprisonment with a non parole period of three years and six months.

From the perspective of rehabilitation the decision in *Tutchell* is highly unsatisfactory. The strong medical opinion led the Court to conclude that unless the prisoner received appropriate treatment for his problems he would recidivate. The program of treatment advocated by the experts could not be implemented for the reasons given, and the Court was constrained to fall back on imprisonment

198. *Supra*, n. 196, pp. 257-8. At the time of writing, another case reminiscent of *Tutchell*, has been reported in South Australia: *R.* v. *Clay* [1979] 22 S.A.S.R. 277. In this case the appellant was convicted on five counts of rape and one of indecent assault, the sentences effectively covering a period of seven and a half years. The Supreme Court felt that if there were a regime in which the appellant could be made to take his medication and closely supervised, it would not be necessary to send him to prison. The court held however, there was no option but to dismiss the appeal. See particularly the judgment of Mitchell J. who held *inter alia*, that although the appellant was diminishingly responsible for his offences, he was nevertheless responsible because he had chosen not to take his medication and, while probably also affected by liquor, vented his anger by committing the offences of which he was convicted.

coupled with an exhortatory recommendation for treatment. In terms of holding out any real prospects for rehabilitation of the offender, the decision could best be described as little more than a display of wishful thinking on the part of the Court. Certainly the conditions for psychiatric treatment in Victorian penal institutions would need to be considerably superior to those applying in New South Wales prisons where, as has already been observed, psychiatric treatment 'such as it is, does not measure up to what those prisoners need and deserve'.[199] This surely is a severe indictment of our criminal justice and penal systems.

THE ROLE OF PROBATION

Probation has been the subject of a separate research paper of the Australian Law Reform Commission and while its general recommendations cannot be fully discussed here, some of the recommendations are relevant to the use of probation as it relates to mentally disordered offenders.[200] In keeping with the general tenor of that research paper it is submitted that probation should not be seen as a lenient measure but be a sentence in its own right.[201] Further, the duration of a sentence of probation should be limited to a maximum term of two years with the possibility of a further extension of two years if sanctioned by a court. It would also seem appropriate that the breach of the terms of a sentence of probation should attract a specified maximum penalty,[202] subject of course to the usual discretion of a court to impose a lesser penalty or no penalty at all. Furthermore, the type of conditions that may be attracted under the sentence of probation should be clearly set out in legislation.[203]

The partly suspended or split sentence illustrated in *Riley*[204]

199. *Report of the Royal Commission into N.S.W. Prisons,* (The Nagle Report), (Govt. Printer, Sydney, 1978), p. 321. See also Ch. 7 *supra,* p. 115.
200. Jocelynne A. Scutt, *Probation as an Option for Sentencing,* Sentencing Research Paper No. 8. (Australian Law Reform Commission, Sydney, 1979). See also I. Potas, *Legal Basis of Probation,* (Australian Institute of Criminology, Canberra, 1974).
201. Jocelynne A. Scutt, *op. cit.,* paras. 74-83.
202. *Ibid.,* paras. 84-90.
203. *Ibid.,* para. 91.
204. *Supra,* p. 97.

should be retained until a more appropriate sanction is devised. It is submitted that like the sentence of probation it should be of a limited duration, and should not be imposed in respect of sentences in which the actual time spent in prison would exceed 12 months. Nor, it is submitted, should the suspended part of such a sentence exceed two years.[205] This sanction should not detract from the availability of totally suspended sentences and both these sanctions should enable a condition of supervision or other specified conditions to be attached to them. Like the partly suspended sentence, the (totally) suspended sentence should contain a specified list of conditions that may be imposed. It should also be limited in duration. A suspended sentence of three years would appear to be an adequate maximum sentence for such a disposition, as any suspended sentence exceeding three years would suggest that the offence was sufficiently grave to warrant a term of immediate imprisonment.

Parole and release on licence are other mechanisms for placing offenders under forms of restricted liberty. As these measures have been discussed elsewhere and are not strictly speaking sentencing options they are not considered here.[206] This should in no way be taken as diminishing the importance of these administrative devices for reducing the negative effects of imprisonment nor their importance for encouraging community reintegration following an offender's release from prison.

How then should probation be used when sentencing the mentally disordered? It has already been advocated here and also in discussion papers of the Australian Law Reform Commission, that wherever possible, non-custodial sanctions should be used in preference to custodial ones. The probation officer has in this regard an important role to play. First, probation officers prepare pre-sentence reports, a service that has proved to be of great assistance to sentencers in the deliberation of their sentencing decisions.[207] Of course the probation officer's duties go beyond advising courts as to the offender's potential for rehabilitation.

205. *Op. cit.*, paras. 93-100.
206. See M. Richardson, *Federal Parole Systems*, Sentencing Research Paper No. 6. (A.L.R.C., Sydney, 1979).
207. S. White, 'The Effect of Social Inquiry Reports on Sentencing Decisions', (1972) 12 *British Journal of Criminology*, p. 230.

Their other main role involves the supervision and guidance of offenders who have been referred by the courts to the probation service.

These tasks of reporting upon and supervising offenders are well recognised within the punitive boundaries of Australian criminal justice systems. One English commentator has recently advocated that the probation service should play an even greater role in identifying those in need of psychiatric assessment.[208] His thesis is that the decision to seek a psychiatric assessment of the offender, and indeed the decision as to whether an assessment should be made at all, are crucial issues which need to be based upon proper information. He warns against relying solely upon court behaviour as an indication of mental disorder and, *inter alia*, proposes that social enquiry reports – equivalent to pre-sentence reports in Australia – should be prepared before deciding whether or not a medical assessment is considered desirable. In Australia the usual practice is that where the pre-sentence report indicates the desirability of medical remand, the sentencing procedure is deferred in order to obtain the benefit of psychiatric opinion. This not only increases the chances of offering treatment to those in need but maximises the effectiveness of providing treatment.

However the rush to obtain psychiatric reports should be approached with caution. Criminal behaviour is largely behaviour engaged in by normal people who have had the misfortune of being caught and prosecuted. In most serious cases a pre-sentence investigation will provide adequate information upon which to supplement the ordinary information available to the sentencing court, and a witch-hunt for mental abnormality may produce more harm than good. Furthermore, even when mental abnormality is predicted, courts should be wary of the dangers of too readily accepting medical opinion – for as Lord Normand in *Carraher* v. *H.M. Advocate* warned in a diminished responsibility case, 'the court has a duty to see that trial by judge and jury according to law is not subordinated to medical theories'.[209] The same warning extends to courts of summary jurisdiction where the magistrate,

208. P. Lewis, 'Shall we ask for a Psychiatric Report?', (1979) 143, *Justice of the Peace*, 518.
209. 1946 S.C. (Ct. of Judiciary) 108, 117.

standing in the shoes of the jury, is also open to the temptation of too readily accepting expert opinion as conclusive proof of the prisoner's mental state.

Veen's case[210] also highlights the importance of expert medical opinion and the weight to be given to it in the sentencing process. In that case the High Court Justices were in unanimous agreement that the psychological and psychiatric examinations of the prisoner were superficial, premature and totally inadequate. Some of the Justices warned of the dangers of predicting future behaviour particularly when based on sparse evidence and when the implications for the prisoner's future were serious.[211]

Equally important is the proper assessment of a mentally disordered offender when it comes to decide whether, in a particular case, the prisoner should be released conditionally into the community, or whether the prisoner should be incarcerated. If released, the sanction most often employed is the recognisance or probation order, under which the offender agrees to undergo a course of treatment in the community. With shades of options along the lines discussed in *Riley* and *Smith,*[212] the most usual back-stop is that of imprisonment. This is so even where, as illustrated in *Tutchell,* it is clear that imprisonment is not a desirable alternative but no other adequate option appears to satisfy the practical difficulties that the case presents.

THE PSYCHIATRIC ORDER

In keeping with the general philosophy of the Australian Law Reform Commission's Sentencing Reference and also with the approach towards probation outlined above, it is recommended that the system of placing offenders on a recognisance should be abandoned in favour of a disposition that is designed specifically for ordering psychiatric or therapeutic treatment of the kind adopted under the English *Powers of Criminal Courts Act,* 1973.

210. *Veen* v. *The Queen* (1979) 5 3 A.L.J.R. 305.
211. *Ibid.*, p. 307, 308. The case is discussed in Ch. 10 *infra,* p. 200ff. See also the analysis of *Veen,* in I. Potas, *Sentencing Violent Offenders in New South Wales,* (Law Book Company Limited, Sydney, 1980), pp. 1056-74 esp. paras. 1-230 to 1-233 inclusive.
212. Discussed *supra,* pp. 97-104.

Section 3 of that Act provides that where the court is satisfied on proper medical evidence that the mental condition of the offender 'is such as requires and may be susceptible to treatment' (but the offender's condition is not such as would warrant a hospital order) it may include in a probation order a requirement:

> . . . that the offender shall submit, during the whole of the probation period or during such part of that period as may be specified in the order, to treatment by or under the direction of a duly qualified medical practitioner with a view to the improvement of the offender's mental condition.

The only alteration to be made to this general power would be that it should, like the recommendation relating to the reform of probation, be a sentence in its own right and not a sanction imposed in lieu of a sentence of imprisonment. Breach of the terms of such a disposition would then invite penalties for the breach rather than for the original offence.[213] Where the offender objects to treatment, a matter to be discussed more fully below, he or she should have the right to refuse to be subjected to a psychiatric order. Where the appropriate consent is not forthcoming, the court would be obliged to choose an alternative method of disposal.

THE ISSUE OF CONSENT

The relationship between supervision under the probation service and treatment under the auspices of a mental health agency should be clearly distinguished in that the former does not necessarily rely on the offender's desires or motivation to successfully complete the period of probation. Like it or not, the probationer is obliged to report to the probation officer and comply with the other terms of the bargain or suffer the consequences of not doing so. Mental health agencies on the other hand generally require the cooperation of the offender to subject himself or herself to the treatment program. Only in this way, it is believed, is the aim of curing or affecting an improvement in the offender's malady

213. I. Potas, *op. cit.*, n. 200, pp. 42-44. I. Potas, A.L.R.C. Research Paper No. 7, June 1979, pp. 38-39. Jocelynne A. Scutt, *op. cit.*, n. 200, p. 4ff.

optimised. Successful treatment generally demands internal cooperation not merely external compliance. Indeed the philosophy of treatment is inimical to the coercive nature of punishment.

Implicit in any form of treatment also is the individual's common law right to accept, or (its corollary) refuse, treatment and strong objections could be raised where an individual is obliged to undergo, or even to continue to undergo, treatment to which he or she objects.[214] Unless such treatment is sanctioned by law it amounts to an assault.

Furthermore, while it may be argued that a person who enters into a recognisance, or indeed is subject to an order or sentence under which there is an obligation to undergo psychiatric treatment, is in fact 'freely' consenting, this consent could be vitiated if it is not what is commonly referred to as informed consent – that is, if prior to nominal consent being given, there is no clear explanation of the purpose, nature and risk of the proposed course of treatment. Under the present proposal it is recommended that the offender should be informed beforehand of the requirements of the psychiatric order and, as indicated above, be given an opportunity of refusing to accept its terms. The problem of consent looms larger as the possible consequences of treatment increasingly encroaches upon an individual's autonomy and also as the capacity of the individual to consent is reduced or vitiated.[215]

There can be no real objection for leaving the decision to terminate treatment at the discretion of those responsible for providing the treatment. In general therefore it is recommended that the treatment authorities be given the right to terminate

214. There may be statutory exception to this right to refuse treatment as in the case of compulsory treatment of alcoholism, drug use or the ordering of mental examination. The Canadian Law Reform Commission has recommended 'that treatment shall not be administered against an individual's refusal, unless there is a finding of incompetence or an exception recognised by law'. See *Medical Treatment and the Law,* Working Paper 26, Law Reform Commission of Canada, Ottawa, 1980.

215. There comes a point where the patient is unable to consent. The paradigm cases are the incompetent patient and the patient who is subjected to emergency procedures. For the justification for proceeding without consent see Larry O. Gostin, 'The Merger of Incompetency and Certification: The Illustration of Unauthorised Medical Contact in the Psychiatric Context', (1979) 2 *International Journal of Law and Psychiatry* 127, 141.

treatment at any time prior to the expiration of the period specified by the court. With regard to extending the original period it would seem desirable that this should be undertaken only in exceptional circumstances, and then only with the approval of the court.[216] As previously stated, the maximum period of an extended term should not exceed two years, and there should be allowable only one such extension.

This raises again the problem of consent to treatment, and in this regard it may be useful to distinguish between two types of treatment, one which would not involve the need to obtain informed consent, the other which would. It would seem reasonable, for example, that special consent should be unnecessary where treatment involves educational rather than clinical treatment programs. Thus, for example, if the 'treatment' involves attending a series of lectures which is unlikely to impose upon the recipient adverse psychological or physical harm, then informed consent would not seem to be a necessary prerequisite. On the other hand informed consent would be required where the offender may be subjected to any form of aversion therapy, to psychotherapy, to pharmacotherapy, to electro-convulsive therapy and to psychosurgery or any other form of surgical procedure. In some cases it may be difficult to decide whether informed consent is appropriate, and in such circumstances it would be preferable to disclose fully the nature of the program to the prisoner in order to give him or her an opportunity to object before the sanction is imposed.

Ultimately it may be desirable to distinguish between the legitimate coercive (penal) component of a sanction, and the therapeutic, or treatment component, ensuring that neither the former nor the latter should exceed in the aggregate the just deserts limit for the offence. Where, however, no added interference of an offender's civil liberties are threatened by the course of treatment and where the alternative would be a term of imprisonment there is no reason why treatment to this extent may not be coercive. To put it another way, so long as the treatment is contained within the bounds of deserved punishment and providing that the offender accepts the treatment as within those bounds, or as ancillary to those bounds, there can be no objection to treatment.

216. This should not prevent the offender agreeing to undertake further treatment on a voluntary basis.

However, as a matter of principle it is desirable as already pointed out that the offender be given the option of opting out of treatment and accepting an alternative sanction where the treatment is found to be objectionable. Again, in principle it is also desirable that treatment be accepted voluntarily if possible as motivation is a vital ingredient for maximising treatment prospects.

THE PROBLEM OF COMMUNICATION IN THE A.C.T.

In the Australian Capital Territory there is a particular problem that relates to the fairly common practice of releasing persons upon their own recognisance on condition *inter alia,* that they agree to undergo psychological or psychiatric treatment or counselling for a stated period of time. The problem arises where the court sends the person for treatment without consulting or notifying the responsible agency – in this instance without consulting or notifying the Mental Health Branch of the Australian Capital Territory Health Commission. A representative of the Commission complained that this often placed it in an awkward situation 'because occasionally we do get someone from the courts sent over. . . [T]hey have said "here I am, I have been sent over to see you for the next 18 months" [but] . . . we have not been consulted about it beforehand.' Then referring to the issue of the offender's prospects for rehabilitation, the same speaker continued 'we are landed with a client [who has] quite a range of motivations and our primary concern is that if we are going to achieve some sort of change in his behavioural attitude then that person has to wish to change in some way. If that [motivation] is missing, I don't really feel that we can get very far. . . This is the crucial dilemma for us.'[217]

Then turning to consider the topic of duration of treatment, the same speaker continued 'As far as the treatment itself goes, I don't think we have a problem – the courts send us someone for 18 months and [if] we feel that within a period of four months, or six months, we have achieved what is to be achieved. . . we leave

217. Statements from an unidentified speaker at the seminar entitled 'The Future of Corrections in the Australian Capital Territory', (from a transcript of the proceedings) Australian Institute of Criminology, August, 1978.

the treatment there and we feel that we have achieved the necessary requirements as far as that person goes.'

Apparently the same difficulty does not arise under the Commission's pre-planned course for alcoholics. This course is an alcohol education program of six weeks duration aimed at early intervention in problem cases. A significant number of referrals are made to that program from the courts, although sometimes referrals of alcoholics are not made because the accused has progressed beyond the point where early intervention can be of benefit. This program is principally designed for persons who are brought before the courts for drink driving offences and is essentially a form of diversion and alternative to imprisonment.[218]

The program is such that both the referring agency and the receiving agency have a clear understanding of its aims and objectives. The less specific form of disposal, which merely requires the offender to be of good behaviour for a stated period of time and accept the directions of the Capital Territory Welfare Branch, or more particularly, requires the person to undergo psychiatric treatment for a stated period of time, but in either case where no notice or communication of this requirement is given to the treatment agency by the court, is plainly an unsatisfactory method of disposal.

Clearly it is not sufficient to make such directions unless the receiving agency is fully informed and is given adequate notice of the court's order. Further the treating agency should participate in the court's decision by informing it of the kind of program that the offender is likely to undergo. This would assist the court in reaching its decision, and also provide the offender with an insight into the nature of the program that is being contemplated. It is only with a properly explained program that the offender is in a position to give informed consent and, as previously outlined, the degree of explanation required may vary according to the nature and duration of the treatment proposed.

Of course it may not always be possible to outline in detail either the precise nature of treatment or the quantum or duration of treatment believed necessary to obtain optimum success in treating the offender. Each case will vary and there is little point in denying that within a fairly broad framework, psychiatric

218. See the *Motor Traffic (Alcohol and Drugs) Ordinance*, 1977 (A.C.T.).

treatment involves other than a fair share of guesswork, with a 'trial and error' and 'wait and see' methodology. Those treatment methods which appear to produce positive results are pursued or reinforced and those which appear to produce negative or nil results are abandoned. Accordingly, the kind or quantum of therapy cannot always be delineated in advance and must be varied to accord with each individual under a 'treat as you go' approach.

Despite these difficulties it is desirable nevertheless to inform the offender with a sufficient degree of specificity what the treatment may entail so that the offender has some knowledge of, and therefore can properly consent to, the proposed course of treatment. Further, by limiting the duration of the treatment program the offender is protected from having to undergo excessively long periods of treatment and in these circumstances also the consent to treatment is more meaningful. Thus it is desirable to require the treatment authorities to outline the parameters only of the kind of treatment contemplated, leaving sufficient discretion within the boundaries specified to vary or terminate treatment.

The requirement that the treatment authorities should outline the proposed course of treatment will also mean that they must make practical and responsible submissions and not just vague ones. For example, a recommendation that the prisoner could be benefited by psychiatric treatment if placed under the care of the Health Commission is too vague and should be further qualified by a statement relating to the nature, quality and duration of the treatment.

From the offender's point of view the advantage of doing this is not only to enable 'informed consent' to be given for contemplated treatment, but that it provides a ground for objecting to any variation in treatment when it is found to be objectionable and outside the proposed program.

Indeed a more detailed description of the proposed course of treatment during the sentencing stage also assists the court in deciding upon the appropriate disposition. It places the court in a better position to evaluate the potential benefits of any proposed treatment program while also ensuring that the program does not exceed the punitive component of the sentence measured in terms of the proportionality principle. As already discussed it is important that the court's aim of benefiting the offender should not assume paramountcy and therefore lead to an increase in the other-

wise appropriate sentence.

The foregoing may be summarised in the form of a series of recommendations:

(1) In all cases involving a treatment or therapeutic component, the treatment authority should specify in as much detail as practicable, the nature and maximum duration of the treatment it feels would benefit the prisoner. Thus where there is already a course of treatment in existence, such as the six weeks alcohol education program a general statement explaining the nature and duration of the course and also the extent of the anticipated participation of the offender in the program should be provided. This could be accomplished simply by employing a general proforma statement that could be given to the offender and to the court during, or immediately prior to, the dispositional stage of proceedings.

Where a more individualised scheme of treatment is proposed, the Health Commission or the medical practitioner, as the case may be, should provide a statement setting out the nature and duration of the proposed treatment, the offender's participation in the scheme, and the anticipated benefits for the offender from the scheme.

(2) The proposed treatment should be specified with sufficient particularity to enable the offender to provide a meaningful or informed consent to it, but it should not be so detailed as to prevent the treatment authorities from exercising a degree of discretion necessary to adjust or modify the program of treatment in accordance with the perceived needs of the offender.

(3) Where the proposed course of treatment is varied and is considered to be objectionable and outside the course of treatment as outlined by the treatment authority, the offender should have a right to refuse such treatment. In case of dispute the matter should be referred back to the sentencing court for clarification or resolution. The offender should be made aware of this right to refuse or object to treatment.

(4) The treatment authority should have a right to terminate or reduce in intensity the prescribed course of treatment prior to the expiration of the term set by the court.

In any event, no psychiatric order should exceed in duration a term of two years with a possible further extension of two years if approved by the court.

(5) The court should ensure that adequate notice is given to all parties that are associated with the disposition of the court. Furthermore, vague conditions requiring the offender to 'accept such treatment as may be necessary' or 'present herself for assessment and treatment if necessary' are too uncertain and therefore should constitute no part of a criminal sanction.

(6) The sentence including sentences that incorporate conditions relating to treatment, should always be limited in accordance with the principle of just deserts, as outlined in Chapter 10. It should never be permitted to exceed the penalty that is commensurate with the culpability of the offender and the seriousness of the offence.

9 The Hospital Order

Two points have been made repeatedly. The first is that in most jurisdictions the judiciary lack adequate range of sentencing or dispositional options for dealing with mentally disordered offenders. The second point, intimately linked with the first, is that most jurisdictions lack adequate facilities for the care and treatment of mentally disordered offenders. In these circumstances, courts must choose between non-custodial sanctions on the one hand, which often places the offender's interest before those of the community and in serious cases offends the principle of commensurate or just deserts, and imprisonment on the other hand, where the prospect of rehabilitation or the provision of adequate treatment for the offender is less than favourable.

Unfortunately, sometimes a court has no choice but to impose a sentence of imprisonment even though it is patently obvious that such a disposition is manifestly inappropriate.[219]

This problem is seen most frequently in the case of sex offenders. Thus the Canadian Law Reform Commission which stated that rehabilitation should be taken into account in sentencing only after the criminal process had imposed its sanctions, was prepared to recognise the special problems presented by the sex offender.[220] The Commission said:

> The sentencing of sex offenders is perhaps more problematic than the sentencing of most other offenders. Sex offences differ in severity and may therefore be subject to the whole range of sentencing options. One reason may be that the criminal law operates on presumptions of normalcy and freedom of choice. These presumptions form the basis

219. [1979] V.R. 248. See also *Veen, infra,* p. 200.
220. Law Reform Commission of Canada, Working Paper 22, Criminal Law, *Sexual Offences,* Canada, 1978, pp. 43-46.

> for concepts of responsibility and culpability which justify the imposition of such sanctions as fines and imprisonment. For some sexual offences, however, traditional sanctions will not be appropriate. The reason is that some sexual offences may be regarded as the result of abnormal and irrational behaviour.[221]

Special problems are also presented by the social nuisance and other categories of mentally disordered or inadequate individuals. The principles for determining the appropriate disposition for these persons will be considered in the following chapter. For present purposes let it be acknowledged that there are some categories of offenders who require both custodial and therapeutic care, and that the courts should be in a position to make orders that satisfy these requirements. The hospital order is of course the sanction that attempts to do just this.

THE ATTITUDE OF THE JUDICIARY TO HOSPITAL ORDERS

It would seem that the judiciary perceive the need for a hospital order type of disposition. In a recent survey, commenced in December 1978 and conducted by the Law Foundation of New South Wales with the assistance of the Australian Law Reform Commission, judicial officers throughout Australia were asked, *inter alia*, whether in their jurisdiction they had available to them the power to impose hospital orders.[222] The term 'hospital order' was broadly described as a sanction which enabled the court to incarcerate an offender in a treatment environment or hospital rather than in prison. Of a total of 322 respondents, 225 or 69.9 per cent indicated that no such disposition was available in their jurisdictions. Of these 225 respondents, a further 154 or 68.4 per cent considered that hospital orders should be made available in their jurisdictions.

Another question related to whether the hospital order should be available specifically as an alternative to imprisonment. Of a total of 154 respondents who answered this question, 111 or 72.1 per cent considered that hospital orders should be available as

221. *Ibid.*, p. 44.

222. The Law Reform Commission, *Sentencing Federal Offenders*, Report No. 15 (Interim) (A.G.P.S., Canberra, 1980), Appendix B.

such an alternative. In other words, the majority of respondents were in favour of introducing hospital orders and introducing them as an alternative to imprisonment rather than as a sentence in its own right.

With the exclusion of diversionary programs, hospital orders, or a form of hospital order,exist in Victoria (s.51 *Mental Health Act,* 1959 and s.13 of the *Alcohol and Drug Dependents Persons Act,* 1968); in Queensland (ss.32 to 39 inclusive of the *Mental Health Act,* No. 2, 1976); in South Australia (s.77a *Criminal Law Consolidation Act,* 1935-75) and in Tasmania (s.47 Div. 4 *Mental Health Act,* 1963 and also s.30(1) *Alcohol and Drug Dependency Act,* 1968). In Western Australia reference should be made to the *Convicted Inebriates Rehabilitation Act,* 1963 regarding the availability of treatment orders. In the Northern Territory special provisions allowing the judiciary to order the forced hospitalisation of mentally disordered offenders are contained in sections 24 and 25 of the *Mental Health Act,* 1979.

The nature and form of hospital orders vary markedly from jurisdiction to jurisdiction. The Victorian formula has been considered in *Tutchell*'s case and some of its inadequacies noted. An overview of the relevant provisions in Tasmania, Queensland and Northern Territory follows.

TASMANIA

Tasmania's system of hospital, guardianship and restriction orders is modelled on the provisions of the *Mental Health Act,* 1959 of England and Wales.[223] The key provisions are contained in sections 48 and 49 of the Tasmanian *Mental Health Act,* 1963, as amended.

Section 48(1) provides that where a person has been convicted of an offence which is punishable by imprisonment and the Supreme Court has power to pass sentence it may, in addition or instead of passing sentence, make a hospital order or a guardianship order in respect of that person.[224] Under subsection 2 of

223. *Op. cit.,* pp. 14-15. For a summary of the English provisions see *Report of the Committee on Mentally Abnormal Offenders,* (The Butler Report), Cmnd. 6244 (H.M.S.O., London, 1975), pp. 185-202.

224. Clearly in order to make a guardianship order it would not be possible

section 48, the Supreme Court may also couple the hospital order with a restriction order where it appears to the Court 'having regard to the nature of the offence, the antecedents of the offender, and the risk of his committing further offences if he is set at large at any time during the continuance of the hospital order, that it is necessary for the protection of the public so to do'.[225]

The power of a court of petty sessions to make a hospital order is somewhat more complex in that it may make a hospital or guardianship order where the offender is convicted, or in certain circumstances, charged with an offence, but it is then precluded from imposing a sentence of imprisonment or a fine in respect of the offence. In addition, courts of petty sessions are precluded from exercising these powers simultaneously with those prescribed under the following Act or provisions:

(a) *The Probation of Offenders Act*, 1934;

(b) Paragraph (c) of subsection (3) of section 71 of the *Justices Act*, 1959; and

(c) Paragraph (a) of subsection (1) of section 23 of the *Child Welfare Act*, 1960;

but in other respects it may make orders the court is normally empowered to make.

Subsections (4) and (5) of section 49 relate to the power of courts of petty sessions to refer the matter to the Supreme Court for disposal.

The Tasmanian Supreme Court, unlike the English equivalent, is empowered to impose a sentence (including a term of imprisonment) in addition to making a hospital order. The Tasmanian court of petty sessions does not have this additional power,[226] although it may refer the case to the Supreme Court to be dealt with by that Court.[227] The Supreme Court also has the power, not shared with the court of petty sessions, to impose a restriction

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to also pass a sentence of imprisonment unless of course the sentence was suspended. See *Mental Health Act*, 1963 (Tas.), s.55(5).

225. The effect of a restriction order is to prevent the premature release of the offender. The discharge of the offender is subject to the restrictions contained in Division IV of the same Part of the Act.

226. *Mental Health Act*, 1963, s.49(3).

227. *Ibid.*, s.49(4) and (5).

order. The effect of a restriction order is to prevent premature release or transfer of the offender from hospital without first obtaining the approval of the Attorney-General.[228] Under normal circumstances the termination of a hospital order is a matter for the medical authorities.

Under the terms of s.51 of the *Mental Health Act*, the power of the Court to make hospital and guardianship orders is circumscribed. The section provides that no hospital or guardianship order shall be made unless the Court is satisfied, on evidence of two medical practitioners:

> (i) that that person is suffering from mental illness, psychopathic disorder, subnormality or severe subnormality; and
>
> (ii) that the mental disorder is of a nature or degree that warrants his detention in [an institution] for medical treatment. . .; and
>
> . . . the court is of opinion, having regard to all the circumstances, including character and antecedents of the person concerned and (if the order is to be made in respect of his conviction for an offence) to the nature of the offence, and to the methods available for dealing with him, that it is expedient that a hospital order. . . should be made in respect of him.

Where the Supreme Court has made a hospital order,[229] it is prohibited from making a restriction order or passing a sentence of imprisonment upon the offender unless the medical practitioners give oral evidence coupled with certain other criteria,[230] and the Court is satisfied 'that arrangements have been made' for the patient's admission to the hospital within 28 days commencing from the date that the order is made.[231] The order must also specify 'the form or forms of mental disorder (in accordance with s.51(1)) that the offender is found to be suffering from, and the

228. *Ibid.*, s.67; see also s.68 (which deals with patients whose discharge is subject to restrictions); s.69 (which relates to procedures for transferring patients subject to restriction to gaol or other places); and s.70 (which relates to discharged persons subject to restrictions).
229. For the present purpose it has been decided to limit the discussion to hospital orders only, although in general the principles that apply to hospital orders apply equally to guardianship orders.
230. *Mental Health Act*, 1977, s.6, s.51(2).
231. *Ibid.*, s.6(3).

Court is precluded from making the order if the medical practitioners' diagnoses do not overlap or are otherwise not in substantial agreement.[232]

The *Mental Health Act,* 1977 (Tasmania) amended the 1963 Act in some respects, and in particular it amended s.48 by inserting a new subsection. This was subsection (1A) which defines a hospital order simply as 'an order authorising the detention of the person to whom it relates in the institution specified in the order. . .'.[233] The term 'institution' means a hospital or special institution and 'special institution' means a place declared to be a special institution under s.6A.[234] The effect of s.6A is to enable the Minister to declare a place to be a special institution, provided that he is satisfied that it is a suitable place for the accommodation and treatment of detainees who, 'in the interests of their own health or safety or for the protection of other persons, need to be so detained in conditions of special security'.[235] The Minister may declare a prison or part of a prison to be a special institution,[236] in which case the superintendent of the prison becomes the controlling authority and the prison officers are included in the staff of the special institution.[237]

In order to accommodate the requirements of the Act, Risdon Prison in Hobart was extended with the object of providing a prison hospital. This extension to the prison has been declared a 'special institution' and it is designed not only to cater for hospital order detainees, but also for mentally or physically ill prisoners who may be transferred from the main prison. When the writer visited the prison, the superintendent expressed concern about the difficulty of transferring persons ordered to be detained in the special institution back into the prison.

One of the disadvantages of being detained in the hospital section is that a detainee is not able to participate in work programs conducted by the main prison. It was suggested that the whole

232. *Ibid.*, s.51(5).
233. *Mental Health Act,* 1977 (Tas.), s.4. The same subsection defines a guardianship order as 'an order placing the person to whom it relates under the guardianship of the Board or the person named in the order'.
234. *Ibid.*, s.2.
235. *Ibid.*, s.6A(1).
236. *Ibid.*, s.6A(2).
237. *Ibid.*, s.6A(3) and (4).

prison should be declared a 'special institution' thereby facilitating transfers within the prison complex. While this may have some clear advantages of a therapeutic nature, it also has the disadvantage of mixing the 'mad' with the 'bad'. The converse, that is, the mixing of the 'bad' with the 'mad' occurs anyway, when prisoners in the main gaol are transferred for treatment to the hospital annex. Thus the result of declaring the whole complex a 'special institution' would tend to make Risdon Prison no more than a prison with good medical and psychiatric facilities.

Howsoever the present dilemma may be resolved, the current situation appears unsatisfactory. If, as a primary aim of creating this 'special institution' it was hoped to create an environment which would segregate detainees in order to prevent the counter-therapeutic effect of labelling the 'mad' as 'bad' and *vice versa*, the experiment to this extent has failed. A further criticism relates to the size and claustrophobic atmosphere of the hospital. While in principle the concept of a special institution provides the key to the provision of treatment in a secure environment, it is vital that the environment should be so designed as to minimise any semblance of a prison – at least in so far as this is possible. In this regard it is desirable to provide facilities containing a graded level of security, that is, maximum to medium to minimum security in an environment which is conducive to the proper care, treatment and rehabilitation of the offender. The special institution at Risdon Prison does not, it is submitted, comply with these requirements.

Despite these criticisms, which relate more to the facilities than to good intentions, the Tasmanian legislation has attempted to reduce the stigma that may attach to a person detained in a special institution which is or forms part of a prison. Thus although the Prison Regulations are generally applicable to such detainees, they are deemed 'not to be confined or to be detained in that prison' for other purposes.[238] Indeed the Attorney-General may, by directions in writing to the superintendent of the prison, modify or exclude the operation of the Prison Regulations with regard to persons so detained.

Further the superintendent of the prison is obliged to ensure that 'as far as possible effect is given to the directions or requirements of the responsible medical officer with respect to the

238. *Ibid.*, s.6A(5).

treatment of a patient liable to be detained in that institution'.[239] It is a genuine attempt to give paramountcy to humanitarian considerations without relaxing security objectives. In practice however, the special institution at Risdon Prison falls short of being a satisfactory environment for the purpose for which it was designed.

QUEENSLAND

Part IV of the *Mental Health Act*, 1974, No. 2, of Queensland applies to 'patients concerned with criminal and like proceedings' although it is to be read in addition to, but not in derogation of, the Queensland Criminal Code.[240] Section 31 of the Act sets out the procedure for removing persons serving a term of imprisonment from prison to a hospital for treatment for mental illness, but it is sections 32 to 39 that are particularly relevant to the present discussion.

Section 32 relates to persons charged with simple offences (that is, offences indictable or not, punishable on summary conviction before a Magistrates Court, 'by fine, imprisonment or otherwise'). In the course of a hearing, where the defendant is before justices, and they are satisfied on the evidence of two medical practitioners, that the defendant is mentally ill, they may authorise his or her admission to a hospital (other than a security patients hospital) that is prescribed by the regulations and specified in the order.[241] This is referred to as a 'court order' and authorises the conveyance and the admission of the patient to the hospital specified in the order.[242]

The patient is then treated in accordance with the provisions relating to the admission and detention of patients generally (pursuant to Division II of Part III of the Act) and may be detained at the hospital 'as if the authority for his detention had been renewed' for '12 months from the date of the court order'.[243] The

239. *Ibid.*, s.6A(7).
240. *Mental Health Act*, 1974, s.28.
241. *Ibid.*, s.32(2). This of course is a form of civil commitment.
242. *Ibid.*, s.32(3).
243. *Ibid.*, s.32(4).

complaint is adjourned 'to a date to be fixed'.[244]

Within seven days of the making of the order, the Director of Psychiatric Services is required to arrange for the psychiatric examination of the patient. The examining psychiatrist must have regard to:

(a) the mental condition of the patient;

(b) any relationship between the mental illness of the patient and the alleged offence the subject of the complaint;

(c) the likely duration of the mental illness and the likely outcome of treatment;

(d) any other matter likely to assist the Governor in Council in determining, pursuant to this section, whether the hearing of the complaint against the patient should continue; and

(e) any other matter prescribed.[245]

The examining psychiatrist must then forward his report to the Director of Psychiatric Services, who in turn is required to make a report to the Minister for Justice for submission with the report of the psychiatrist, to the Governor in Council.[246]

At this stage the Minister for Justice is required to make a recommendation to the Governor in Council as to whether the complaint against the patient should continue.[247] If the Governor in Council orders that the hearing should not proceed further, the complaint 'shall be deemed to be dismissed'.[248] The Governor in Council may order that the hearing of the complaint should proceed where the patient is no longer detained, or no longer requires detention.[249] If the hearing proceeds, evidence previously heard is disregarded and the matter is heard *de novo*.[250] If within three months from the date of the court order, the Governor in Council has not made an order under section 32, the complaint is deemed to be dismissed.[251]

244. *Ibid.*, s.32(5).
245. *Ibid.*, s.32(7).
246. *Ibid.*, s.32(8).
247. *Ibid.*, s.32(9).
248. *Ibid.*, s.32(10).
249. *Ibid.*
250. *Ibid.*, s.32(14).
251. *Ibid.*, s.32(15).

Section 33 relates to persons charged with indictable offences. Where, 'upon examination of witnesses by justices' they are satisfied that the defendant is mentally ill (on the evidence of two medical practitioners) and they consider that there is sufficient evidence to put the defendant on trial, they are required to commit the defendant for trial and also make a 'court order' authorising the patient's admission to a security patients' hospital.[252] Once the justices make a 'court order' under s.33, they may not make an order relating to custody or bail.[253] The court order is sufficient authority for the conveyance to, admission and detention of the patient at the security patients' hospital.[254] The Director of Psychiatric Services must then arrange for the psychiatric examination of the person and that examination must have regard to:

(a) the mental condition of the patient;

(b) any relationship between the mental illness of the patient and the alleged offence the subject of the charge and, in particular, the mental capacity of the patient at the time of the alleged offence, having regard to the provisions of section 27 of *The Criminal Code*;

(c) the likely duration of the mental illness and the likely outcome of treatment;

(d) any other matter likely to assist the Governor in Council in making a determination pursuant to this section;

(e) any other matter prescribed.[255]

The report of the examination is then to be forwarded to the Director, who in turn is required to make a report to the Minister for Justice for submission with the report of the psychiatrist, to the Governor in Council.[256] The Minister for Justice is also required to make a recommendation within three months from the date of the court order, to the Governor in Council, 'concerning the continuation or otherwise of proceedings of the charge against the patient'.[257] After consideration is given to these reports and

252. *Ibid.*, s.33(1).
253. *Ibid.*, s.33(3).
254. *Ibid.*, s.33(4).
255. *Ibid.*, s.33(6).
256. *Ibid.*, s.33(4).
257. *Ibid.*, s.33(6).

recommendation, the Governor in Council may do one of three things:

> (a) order that the patient be not further proceeded against in respect of the charge against him;
>
> (b) order that proceedings be continued against the patient forthwith; or
>
> (c) before making an order referred to in paragraph (a) or paragraph (b), defer a determination with respect to the matter for a period not exceeding twelve months within which period he shall further consider the matter at least once, and, before making an order as aforesaid, may after any such further consideration defer a determination for further periods not exceeding twelve months at a time, and within each such further period he shall further consider the matter at least once.

Subsections (a) and (b) are clear and require no comment. However subsection (c), while it may appear to provide ample review and protection to the patient to ensure that he or she is not lost or otherwise overlooked in the system, does contain some undesirable features. In the first place it would be desirable to reduce the maximum period from 12 months to six months before the first postponement of the determination. Thereafter there is no objection to a subsequent period of 12 months maximum within which time a reconsideration should take place.

However, it would seem desirable to place an upper limit on the number of such deferrals. To refrain from so doing is to import into the criminal justice system the concept of preventive detention, a concept which has no place in a sentencing system based on commensurate deserts.[258] It is therefore submitted that, where the period of time spent in custody threatens to exceed the period of any sentence that would have been imposed upon the offender found guilty of the offence, the Minister of Justice should make a statement to that effect in his report, together with a recommendation in favour of dropping all charges against the accused.

Where the person is charged with a sentence which carries with it a sentence of life imprisonment, it is recommended that a statute

258. The principle of commensurate, or 'just' deserts is considered in Ch. 10. Note however, that at this stage the offence has not been proved and therefore strictly speaking there has been no sentence.

of limitations should apply, so that in any event no charges may be brought against the person after a period of five years from the date of the court order. This recommendation for reform would be in keeping with the more detailed proposals relating to the disposal of persons found unfit to plead referred to previously.[259]

Section 33 goes on to provide that where pursuant to an order that the patient should not be further proceeded against, the patient should not thereby be discharged but should be deemed to have been admitted to the hospital pursuant to Division II of Part III of the Act, as if the authority for detention had been renewed for a period of 12 months following notification of the change of status. In addition the person is deemed to be a restricted patient in accordance with the terms of section 50 of the Act, shortly to be discussed.

Section 34 applies to persons on remand whether in custody or not, for indictable offences, and section 35 applies to mentally ill persons after they have been committed for trial or sentence. The procedures for admission to the Security Patients' Hospital under these sections are similar. In the case of sentenced prisoners, the patient must be seen within three days by a psychiatrist who must certify that the person is mentally ill. If he does not so certify, the patient is returned to a prison. If certified, review of the patient's condition takes place at least once every 12 months or upon his discharge date whichever comes first, although 14 days before or seven days after the discharge date, the psychiatrist is required to make a recommendation as to whether the patient should be detained beyond the expiration of the sentence.[260]

The Director then decides whether to discharge, transfer or declare the patient to be a restricted patient. Under the terms of section 50 of the Act, restricted patients can either be civilian patients who are considered to be a danger to themselves or persons who are detained beyond the expiration of their sentence. They are subject to reviews initially within the first six months of the

259. *Supra*, p. 50-51.

260. This for the reasons already stated is an objectionable provision and offends against the principle of just deserts. It is also objectionable on the ground that it reposes power in the opinion of one person, even though the ultimate decision is made by the Director. If such power is to be exercised, it should be exercised, it is submitted, by a Tribunal which in turn should obtain judicial approval for its decision.

determination and thereafter every 12 months. All determinations are reviewed by the Director, who has the power to release or transfer a restricted patient. However, provided that the Director gives written permission, leave of absence may be granted by a medical practitioner. Such leave is also reviewable at regular intervals. Patients may also apply to the Mental Health Review Tribunal to have their circumstances reviewed, but such applications are restricted to one per year.

Other powers of interest include those under section 36 of the Act under which persons found to be of unsound mind by a jury and ordered by a Court to be kept in strict custody in prison may be ordered by the Minister of Health, to be kept in a security patients' hospital. The court also has power to order the detention of such persons in a security patients' hospital directly, whereupon the usual post admission procedures previously outlined, take effect. Section 37 applies to Queens' Pleasure detainees, and once again the Court or the Minister may order that the person be held in a security patients' hospital. Each such case is reviewed annually and the Governor in Council issues his determination as he sees fit. Discharge of patients is upon the recommendation of two medical practitioners nominated by the Director who may, with the consent of the Governor in Council, order their release.[261]

Section 39 refers to persons detained under section 18 of the *Criminal Law Amendment Act* and relates to persons unable to control their sexual instincts. Upon finding the offender guilty of an indictable offence the judge may order an inquiry as to whether the offender's mental condition is such that he is capable of controlling his sexual instincts. This determination is made by a medical practitioner and a psychiatrist. If the decision is adverse to the offender the judge may order that he be kept at Her Majesty's Pleasure.[262] The judge may also impose a sentence of imprisonment in addition to this determination. The prisoner is then detained in any institution in accordance with the direction of the Governor in Council. Medical reviews for this class of offender are then carried out every three months.

It is difficult to go beyond this provision without comment. The procedure discloses a potentially draconic power which would

261. S.38.

262. Cf. *Mental Defectives (Convicted Persons) Act*, 1939 (N.S.W.) *R. v. Combo* [1971] 1 N.S.W.L.R. 703.

enable a convicted sex offender to be incarcerated for an indefinite period which, in individual cases, could far exceed the punishment that is considered commensurate with the gravity of the offender's crime. The power that allows the trial judge to impose a concurrent sentence of imprisonment only serves to show how the concepts of culpability and punishment may be confused and confounded with those of treatment. Unlike the usual presumption of innocence that surrounds an insanity verdict, the sex offender labelled under this section may indeed be considered to be both 'mad' and 'bad'. As stated previously, there may in fact be such persons, but as shortly to be argued, it is important to separate the concepts of help (treatment) and censure (punishment). Thus indeterminacy of detention imported into a sentencing decision in this fashion serves only to cloud the delicate line that is drawn between the proper ascription of responsibility and non-responsibility for an act, between culpability and non-culpability, between criminal punishment and civil commitment.

THE SECURITY PATIENTS' HOSPITAL AT WACOL

In this regard also, a comment should be made about Queensland's Security Patients' Hospital at Wacol Prison. Unlike Hobart's special institution at Risdon Prison, the Security Patients' Hospital is distinctly separated from the main prison even though it is situated within the prison grounds. It functions separately from the main gaol and has a dual administration. The Prisons Department is responsible for the security of the total establishment so that the Hospital Administrator is a Prisons Department superintendent. However, the Medical Director and his staff are responsible for the treatment and physical well being of the inmates. The Director has a staff of approximately 65 and most of the senior staff are specially trained to cope with the management of psychiatric patients. Many are qualified psychiatric nurses.

The inmates are referred to as patients, and a first name basis staff-to-patient relationship is developed. As in other hospitals no weapons or batons are carried within the institution. The hospital has a maximum security facility for dangerous offenders and a medium security facility for improved patients. A minimum security area has yet to be opened, the delay being attributed to

staff shortages.

At the time of writing there were 60 patients being held at the Security Patients' Hospital. This figure included some 15 non-forensic patients sent from other psychiatric hospitals (principally Wolston Park). These patients had been transferred to the institution because they had become unmanageable, disrupted other patients or generally were thought to require close attention in secure surroundings.

The institution has occupation therapy areas where patients do such things as leather work, copperwork, mosaics, carpentry, pottery, gemstone cutting, and making stuffed animals and rugs. They can purchase their own goods, see films or plays, play snooker or table tennis. The Security Patients' Hospital is autonomously run, although the cooking is not done by the patients but by 10 prisoners from Wacol Prison who are brought in to do it. In short, this institution contains many of the features lacking in the 'special institution' at Risdon Prison. The latter is less able to offer such benefits because it does not have sufficient inmates.

The Security Patients' Hospital suffers from the problem of mixing the non-criminal with the criminal detainee and as such offends the principle of segregating the mad from the bad. It is, a highly objectionable practice to incarcerate difficult or uncooperative mentally ill civil patients in an institution designed to house mentally disordered offenders. Such a policy may be interpreted simply as punishing those who have not been charged or convicted of a crime. It is submitted that if a person has not been convicted of a crime, (and this includes those persons who are acquitted on the ground of insanity and may therefore qualify for the category of forensic patient), he or she should not be held or allowed to mix in an institution which holds convicted criminals. This in no way should be taken as implying that some non-forensic patients should not be contained in secure custodial facilities. It merely calls for the provision of separate facilities in order to maintain the symbolic distinction between the mad and the bad, and also to reduce the unjustifiable incidence of labelling people as criminal when in law they have not been so declared.

Finally the description given by Foley-Jones, a senior officer in the Western Australian Department of Corrections, suggests that Queensland's Security Patients' Hospital is far from satisfactory. He states that:

> The new 'cage' living and recreation area. . . is somewhat reminiscent of a zoo. Apart from its physical inadequacies, the Security Hospital is laden with the additional burden of accommodating dangerous or otherwise unwanted civil mental patients, e.g., mental defectives who are being channeled inappropriately into the criminal justice system.[263]

Whatever may be the merits of Foley-Jones's first observation, one cannot help but agree that it is quite inappropriate to house troublesome civil patients in an institution designed principally for forensic patients. Such a practice is even more obnoxious than the practice of detaining persons acquitted on the ground of insanity in prisons, a practice that time and apathy have condoned.

THE NORTHERN TERRITORY

The power of courts of the Northern Territory to deal with persons who are unfit to plead has already been considered in some detail.[264] Its simplicity may be contrasted with the more elaborate procedures that apply in Queensland. Under the *Mental Health Act*, 1979 of the Northern Territory, specific power is given to the court or magistrate to suspend the execution of a sentence, or to release a person upon condition provided that the defendant voluntarily submits 'to care, treatment or control for a mental illness'.[265]

Similarly, under s.23 there is power to make certain orders with regard to offenders in custody, whether or not they are under a sentence of imprisonment. A precondition for the use of this power is that the person is 'in need of care, treatment or control for a mental illness'. Any such order may include the following conditions – that the person be kept locked up, be kept under close guard or be allowed freedom to leave the hospital where he or she is receiving treatment. Further conditions may include the

263. J. Hartz-Karp, 'The Mentally Ill within the Criminal Justice System', *Research and Information Series No. 19*, (Western Australian Department of Corrections, Perth, 1979).
264. *Supra*, p. 46ff.
265. *Mental Health Act*, 1979, s.22(1)(c), but this power falls short of what is taken here to be a hospital order.

requirement that the person should not be subject to prison regulations while hospitalised, that the person be released on parole prior to the expiration of the specified non-parole period, that the person be granted additional remissions of sentence, and that the person be released while receiving care, treatment and control, and that this period should count as part of the sentence.[266] In addition, any order or any condition of an order made in pursuance of s.23 may be varied or revoked at any time.[267] No care, treatment or control order may be made under section 23 unless the patient consents.[268] Little can be said in criticism of the general intendment of this section.

Under ss.24 and 25 of the Act however, there is power to deal with persons without their consent. This power comes closer to what is envisaged as a hospital order, although like s.23 it applies equally to whether or not the person is under a sentence of imprisonment. Section 24 enables a court or magistrate:

> where it is made to appear. . . after reasonable enquiry that a person who is in custody,
>
> (a) by reason of a mental illness: (i) requires care, treatment or control; and (ii) is incapable of managing himself or his affairs;
>
> (b) is not, or is not likely, upon his release, to be under adequate care and control; and
>
> (c) is likely, by act or neglect, to cause death or serious bodily harm to himself or another person,

to call for reports from the Chief Medical Officer and the Secretary of the Department responsible for the person's custody.[269]

After receiving these reports, the court or magistrate may order that the person be 'cared for and controlled without his consent for a mental illness for a period while he is in custody'.[270] Normally, no such order is to exceed six months,[271] during which period the Chief Medical Officer and the Secretary of the Department responsible for the person's custody are required to appear before a court

266. *Mental Health Act*, 1979 (N.T.), s.23(2).
267. *Ibid.*, s.23(5).
268. *Ibid.*, s.23(6).
269. *Ibid.*, s.24(1).
270. *Ibid.*, s.24(2).
271. *Ibid.*, s.26(3).

or magistrate to make such reports as may be necessary under the terms of subsection (2) of section 24.

In his report, the Chief Medical Officer must give consideration to the mental health of the person in custody, the nature of care and control that is exercised over the patient, and the treatment, if any, given to the patient. With regard to the treatment, the Chief Medical Officer must indicate whether the treatment was given as recognised standard treatment, with proper authority or in an emergency.[272]

Guidelines for the preparation of reports by persons other than the Chief Medical Officer are also prescribed.[273] Orders cease to be in force by effluxion of time, and also in the event of revocation or release of the person from custody otherwise than in pursuance of an order under s.23.[274]

While an order under s.24 is in force the court or magistrate may with respect to the person who is subject to that order authorise:

(a) a treatment that may be given to that person;

(b) an operation that may be performed on that person;

(c) a procedure that may be carried out in respect of that person;

(d) a method of control that may be exercised over that person; or

(e) the removal of that person from one hospital or place to another hospital or place (including a place outside the Northern Territory).[275]

A duty is also placed on the Chief Medical Officer to disallow:

(a) a particular treatment to be given to;

(b) an operation to be performed on;

(c) a procedure to be carried out in respect of;

(d) a method of control to be exercised over; or

(e) the removal from a hospital of,

a person who is the subject of an order made under section 24, unless:

(f) it has been authorized by a court or magistrate;

272. *Ibid.*, s.24(5).
273. *Ibid.*, s.24(6).
274. *Ibid.*, s.24(7).
275. *Ibid.*, s.25(1).

(g) by reason of an emergency, it is not practicable to delay the treatment, operation, procedure, control or removal; or

(h) in the case of a treatment – it is, in the opinion of the Chief Medical Officer, a recognized standard medical treatment.[276]

Two further subsections restrict the power of the court or magistrate. Thus an order under s.25(1), (a) or (b) may not be made for the purpose of treating an illness, and a court or magistrate may not authorise sterilization, 'for the reason only that the person is mentally ill'.

LIMITATIONS OF PSYCHIATRY

A very real and perplexing problem is to determine who should and who should not be made subject to a hospital order. Assuming that legislative criteria can readily be agreed upon,it is then necessary to determine whether a particular person falls within that criteria. A leading forensic psychiatrist, Dr Bartholomew, has pointed out that if psychiatry has anything significant to offer the criminal process it is that it can make a reliable diagnosis.[277] Unfortunately, he adds that as mental illness is most often typified by psycho-pathology rather than somato-pathology there is very little hard evidence that can be brought before a court.[278] Factors which influence diagnoses are most often based on the patient's own statements and behaviour, as for example, indicated in the case of Sam.

Sam was a New Australian and lived alone. He had had some difficulty with debt collectors. One day he was approached by two men from the Council on some perfectly innocent matter, unrelated to tax and debt collection. However, acting under a delusion Sam shot them. In due course he was arrested and put in prison where he continued to hear tax and debt collectors chatting about him outside the prison walls. He was soon given some treatment for his condition, and some time later the psychiatrist

276. *Ibid.*, s.25(2).

277. Allen A. Bartholomew, *Psychiatry, the Criminal Law and Corrections*, Eighth Summer Judicial Conference, University of Queensland, 24 January 1978 (unpublished), p. 6.

278. *Ibid.* This point was also made earlier in relation to Munday's escape from prison, *supra*, p. 126ff.

asked Sam whether he could still hear the voices, to which he replied 'No'. While the psychiatrist was congratulating himself on such a rapid cure, Sam added 'because they have gone away'.[279] Once it is accepted that diagnosis depends largely on the patient's statements (either that the patient has been hallucinating or that the patient has a symptom which correlates with a psychotic state) it becomes a difficult task to distinguish the genuine from the feigned psychotic state.[280] Add to this evidence which suggests that the place where the psychiatrist receives his training has an influence on the frequency of diagnosis of schizophrenia cannot but lead to undermine confidence in the reliability of so-called expert psychiatric opinion.[281]

The problem of diagnosis prior to sentencing is no less important and no less difficult than diagnosis towards the end of the term of the sentence where consideration is given to determining whether the offender is 'cured', or if not 'cured' whether he or she continues to present a threat to the community. A failure to predict future behaviour has also been a reason for the disillusionment with parole.

Perhaps, as Bartholomew notes, when quoting the following passage from Linder,[282] the main question posed for the psychiatrist is 'can the person benefit from treatment?' That is:

> Doctors do not have a clearly formulated concept of disease, and that the answer they give to the question 'is this a disease?' is really a covert answer to the quite different question 'should this person be under medical care?'.[283]

279. I am indebted to Dr Wetherley, psychiatrist, of the Royal Hobart Hospital for this anecdotal material.

280. Research using patients illustrates the ease with which sane patients may be diagnosed insane by merely stating that they hear voices. See D. Rosenhan, 'On Being Insane in Insane Places', (1973) 179 *Science* 250; L. Goldman, 'Will the Next Pseudo Patient Please Come In?', (1975) *Modern Medicine in Australia* 7.

281. There is evidence suggesting that American psychiatrists diagnose schizophrenia some 10 times more frequently than their British counterparts from Maudseley Hospital. See M. Katz *et al.*, 'Studies of the Diagnostic Process: The Influence of Symptom Perception, Past Experience and Ethnic Background on Diagnostic Decisions', (1969) 125 *Amer. J. of Psychiatry* 937. See also Bartholomew, *op. cit.*, n. 277, p. 5.

282. R. Linder, 'Diagnosis: Description or Prescription? A Case Study of Diagnosis', (1965) 20 *Perceptual and Motor Skills* 1081.

283. Bartholomew, *op. cit.*, n. 277, p. 18.

This question itself may raise similar or related problems of perplexity and disagreement on the part of psychiatrists. For example, it may be considered that pseudo patients require medical care when they do not. Equally the question of the kind of treatment, the intensity and duration of treatment are likely to be contentious issues.

That there is and will continue to be uncertainty in this field of law and medicine is clear. It accordingly means that practitioners in both professions must tread cautiously to ensure that there is a minimum of unnecessary interference with the offender's autonomy. Equally clear is that some individuals, not readily identified, do require treatment in order to help them cope with life. Some of these persons will also have committed criminal offences. The fact that they have committed criminal offences is no reason to deny them treatment. Similarly, the fact that diagnosis is often contentious and unreliable does not mean that the endeavour to identify and treat those suffering from mental illness should be abandoned.

Thus given that there are some individuals who require treatment (even though these persons are not easily identifiable) it would seem that there should be room for a treatment or hospital order sanction, which is distinguishable from imprisonment, even though it may share one of its main attributes – the restriction of freedom as a punishment. To ensure that freedom is not restricted beyond the term that would have been imposed were the offender sentenced to imprisonment, it should be provided that a term of imprisonment commensurate with the gravity of the offence should be specified, but suspended on condition that the person serve the term at a mental institution 'for so long as he needs treatment' within the period of the suspended sentence.

If the person fails to 'recover' within the specified period he or she should be committed (if certifiable) to an ordinary mental institution, under the same rules that apply to all citizens. If the person recovers prior to the termination of the sentence and no restriction order has been specified by the court, the mental health authorities should be authorised to release the person unconditionally, or conditionally, on parole. If a restriction order is specified, the offender should have the option of spending the balance of the sentence in prison. There should also be a mechanism which enables a restriction order to be lifted by allowing application to

be made to a court.

The essence of a hospital order should be that it is a form of imprisonment that is served in a therapeutic environment rather than in a conventional prison. Its goals are inevitably humanitarian intended to reduce the harshness of imprisonment without detracting from either the punishment concept or the aim of protecting the community from the offender.

The addition of hospital orders to the judicial armoury of dispositional options is not all that is required. The nature of the facilities that must inevitably complement the use of such a sanction is of vital importance. It must not be used as a means for dumping undesirables or misfits. Indeed, unless on balance the hospital order proves to be a more humane method of disposal then that of imprisonment, and in this regard the nature of the treatment facility and the rights of patients are of critical importance, it would be better that it should remain a dead letter. It is better to have no such disposition than find the object of the sanction is inevitably frustrated by a system that has not been designed to meet its ends.

10 Commensurate Deserts

The main concern of this chapter is to identify the principles that apply to the sentencing of persons who have been found guilty of an offence, but who nevertheless are found to be mentally disordered. The issues discussed include considerations relating to the sentencing of persons for rehabilitation or cure, the relevance of the offender's mental condition to the determination of the sentence, and the manner in which sentencing alternatives may be applied in respect of persons who require some form of psychiatric care or other therapeutic intervention while they are subject to the processes of the criminal justice system. The present chapter holds that a system of hospital orders is a desirable addition to current sentencing options and that the apparent conflict between treatment and punishment objectives that this kind of sanction seems to present can in fact be reconciled by application of ordinary sentencing principles.

Before proceeding, two propositions are emphasised. The first is that in a very small number of cases there is a need to ensure that the prisoner is kept out of the community, and at the same time that he or she is placed in a secure therapeutic environment that is not a conventional prison. This is because it is the common experience that in prison, treatment commensurate with the needs of a prisoner and complying with humanitarian considerations is not forthcoming. On the other hand, for the reasons given previously, containment in a locked ward of a mental institution cannot always provide the desired degree of security so that in some cases a special institution, both humane and secure, is required to house forensic patients.

The second proposition supported by judicial authority, is that while in some situations it is proper to give particular emphasis to the element of rehabilitation when sentencing a mentally disordered

offender, neither the fact that the prisoner would benefit from an extended term of imprisonment, nor the fact that the prisoner is likely to reoffend some time in the future is the imposition of a term of imprisonment longer than that which is deserved, justified.[284]

In other words the principle of just deserts, variously referred to as retribution, retribution as practised under the law, the principle of proportionality and the principle of commensurate deserts should apply to set the limits, particularly the upper limits of punishment, that are both legally and morally appropriate. The severity of the offence and the culpability of the offender must put upper bounds on just punishment. To go beyond these limits would simply be unfair.[285] The first of these propositions has been discussed at length, the second requires further elucidation.

JUST DESERTS

The just deserts approach to sentencing has taken the United States by storm.[286] Commentators have pointed to the gross inequities arising from the exercise of sentencing discretion in that country, to the prevalence and use of indeterminate or semi-

284. I Potas, *Limiting Sentencing Discretion: Strategies for Reducing the Incidence of Unjustified Disparities*, (A.L.R.C., Sydney, 1979), pp. 69-74.
285. N. Morris, *The Future of Imprisonment*, (University of Chicago Press, Chicago, 1974), pp. 59-61. Limits of just punishment may also be determined by application of utilitarian principles, as Beccaria and Bentham noted in their writings, for example, see E. Monachesi, 'Cesare Beccaria' in *Pioneers in Criminology*, (ed. H. Mannheim) (2nd ed. Paterson Smith, Montclair, New Jersey, 1972), p. 41. See also in the same edition G. Geis, 'Jeremy Bentham' in which Bentham's contribution to criminology is discussed with reference to Bentham's cautionary advice, 'never use a preventive means of a nature to do more evil than the offence to be prevented', *ibid.*, p. 61. This is not of course the same as saying that the limits under deserved punishment coincide with the limits under a utilitarian based model. What is suggested however, is that the upper limit is governed by the just deserts formulation, but a less severe sentence is perfectly acceptable, indeed desirable if utilitarian considerations so indicate.
286. For example the proposed *Criminal Code Reform Act* of 1977 (U.S.) introduced at the 95th Congress, 1st Session, S.1437 (4 August 1977) is based on a broad just deserts model. Advocates of just deserts include: A. Von Hirsch, *Doing Justice — The Choice of Punishments*, (Hill and Wang,

determinate sentencing models and to the lack of sentencing review procedures.[287] This movement towards greater fairness and certainty in sentencing has also been promoted by the belief that rehabilitation (including reformative and therapeutic approaches of disposal) has failed to be any more successful in reducing recidivism than the direct punitive approach.[288] Various 'just deserts' models have been proposed. These vary from systems of flat, or mandatory sentencing models, where the court is given no option as to penalty, to presumptive sentencing schemes, where the court is given a (usually) legislatively based range of penalties under which the sentence is located and finally pinpointed after certain aggravating and mitigating factors are taken into account.[289]

A modified version of the latter is the judicial guidelines model,[290] a model which involves the least amount of departure from current sentencing practice.[291] While great variations exist in these sentencing models and indeed while the term 'just deserts' may mean different things to different people, Von Hirsch's formulation is the one adopted here. It states as follows:

> The severity of the penalty carries implications of degree of reprobation. The sterner the punishment, the greater the implicit blame: sending someone away for several years connotes that he is more to be condemned than does jailing him for a few months or putting him on probation. In setting penalties, therefore, the crime should be sufficient-

New York, 1976); D. Fogel, *We are the Living Proof: The Justice Model of Corrections*, (W.H. Anderson, 1975); E. Van Den Haag, *Punishing Criminals*, (Basic Books, 1975); *Task Force on Criminal Sentencing; Fair and Certain Punishment*, Report of the Twentieth Century Fund, (McGraw Hill, 1976); R. Singer, *Just Deserts: Sentencing Based on Equality and Desert*, (Ballinger, Cambridge, Massachusetts, 1979).

287. M. Frankel, *Criminal Sentences – Law without Order*, (Hill and Wang, New York, 1973), p. 76.

288. R. Martinson, 'What Works? Questions and Answers about Prison Reform', *The Public Interest*, No. 35 (Spring, 1974) 9; Martinson, Upton and Wilks, *The Effectiveness of Correctional Treatment*, (New York, Praeger, 1975); J.Q. Wilson, *Thinking About Crime*, (New York Basic Books, 1975), pp. 168ff.; Van Den Haag, *op. cit.*, p. 188ff.

289. These are more fully considered in I. Potas, *op. cit.*, n. 284, pp. 83-96.

290. L. Wilkins *et al.*, *Sentencing Guidelines: Structuring Judicial Discretion*, (U.S. Department of Justice, 1978); L. Wilkins, 'Sentencing Guidelines to Reduce Disparity?', [1980] Crim. Law Rev. 201.

291. I. Potas, *op. cit.*, n. 284, pp. 89-94.

> ly serious to merit the implicit reprobation. . . . Where an offender convicted of a minor offense is punished severely, the blame which so drastic a penalty ordinarily carries will attach to him – and unjustly so, in view of the not-so-very-wrongful character of the offense. . . . [Conversely] imposing only a slight penalty for a serious offense treats the offender as less blameworthy than he deserves.[292]

Seriousness for Von Hirsch is not restricted merely to the harm done or risked by the act, but also includes an assessment of the culpability of the actor.[293] This inclusion is of vital importance for it ensures that just deserts is not solely concerned with the objective circumstances of the offence. It invites into the assessment, considerations personal to offenders, such as their character, antecedents, age, health and mental condition.[294]

An examination of sentencing decisions of Australian superior courts reveals that sentencing practice has always reflected a broad just deserts policy. Von Hirsch's formulation therefore is

292. Von Hirsch, *op. cit.*, n. 286, p. 70. In similar vein, Morris has stated that:

> No sanction should be imposed greater than that which is 'deserved' by the last crime, or series of crimes, for which the offender is being sentenced. Nor should a sanction be imposed which is so lenient that it unduly depreciates the seriousness of the crime.

However it is clear that Morris' lower limit of desert is not as clearly defined as his upper limit, for elsewhere he states that the concept essentially 'is one of a retributive maximum; a license to punish the criminal up to that point and no more.' See generally Morris, *op. cit.*, n. 285, pp. 73-77. That the lower limit is less certain is understandable also by application of another principle that he applies to the decision to imprison, namely, the principle of parsimony which states that:

> The least afflictive (punitive) sanction necessary to achieve defined social purposes should be imposed.

Ibid., pp. 60-62. The principle that imprisonment, as indeed any form of compulsory institutionalisation, should be used as a last resort may also be seen as an application of this principle of parsimony.

293. *Op. cit.*, n. 286. Seriousness of an offence for Von Hirsch also embraces the defendant's prior criminal record, including the number of prior convictions and the seriousness of previous offences. Thus all things being equal, a first offence is deserving of less punishment than a second or subsequent offence.

294. Hyman Gross has described culpability of criminal conduct as depending upon the seriousness of the harm it threatens, the degree of risk of the harm occurring, the actor's control over the harm-threatening aspects of his conduct, and the legitimacy of the conduct under the circumstances. *A Theory of Criminal Justice*, (Oxford University Press, New York, 1979), pp. 74-82.

neither particularly new nor particularly elucidatory, although it does sound a reminder to sentencers to pull in their utilitarian belts, in order to ensure that punishment under the law is used neither as a sledge-hammer nor as a feather-duster.

Thus, utilitarian principles, such as deterrence and rehabilitation, are constrained by the application of principles of justice and of fairness, a prerequisite being that the penalty 'should be such as, having regard to all the proved circumstances, seems. . . to accord with the general moral sense of the community.'[295] This principle also demands that the penalty should be neither excessively lenient nor excessively severe. In the oft quoted passage from *Radich*[296] for example, it is said that a court fails in its duty if it is 'weakly merciful, and does not impose a sentence commensurate with the seriousness of the crime'. Similarly in *Dole*,[297] Gowans J., citing a passage from *Williscroft*,[298] endorsed the view that where an offender receives a good behaviour bond or is placed on probation for an indictable offence, it is implicit that the circumstances of the offence are 'sufficiently lacking in heinousness as to permit all other considerations to be treated as subsidiary to the prospect of the offender's rehabilitation'.[299]

Furthermore, although it is generally accepted that the purposes of punishment are 'manifold' assuming 'a different significance not only in different crimes but in the individual commission of each crime', the elements of general deterrence and retribution assume greater importance 'when the crime in question is a serious one, has been committed in a particularly grave form, and its contemporary prevalence is the cause of considerable community disquiet'.[300]

At the same time commentators upon penal theory have warned against exceeding the deserved level of punishment. For example, Norval Morris argues that the punishment which is viewed by the community at the relevant time as exceeding that which is deserved is a form of tyranny,[301] and Sir Rupert Cross submits that 'the

295. *R.* v. *Geddes* (1936) 36 S.R. (N.S.W.) 554, per Jordan C.J.
296. [1954] N.Z.L.R. 86, 87.
297. [1975] V.R. 754.
298. [1975] V.R. 292, 299-300.
299. [1975] V.R. 754, 761.
300. *Ibid.*
301. N. Morris, *op. cit.*, n. 285, p. 76.

infliction of punishment although tending towards crime reduction is unjustified if it is not also morally deserved'.[302] A passage from the judgment of O'Brien J., in the New South Wales Court of Criminal Appeal decision of *Veen*[303] discloses just how closely the declared general principle of sentencing reflects a just deserts approach. His Honour, *inter alia*, said:

> The court should reserve the maximum sentence for the worst examples of the offence concerned, and otherwise impose a term which, having regard to the maximum, is in all the circumstances in fair proportion to the gravity of the offence with which it is dealing. In reaching that proportion the court should have regard to the background of the offender in determining whether or not leniency is warranted and if so, in what degree. Included in that background are such matters as previous offences committed by the offender especially if they indicate he is a persistent offender in the same or similar kinds of offence, for then he would normally forfeit any claim to leniency. A sentence should not, however, inflict heavier punishment by way of a sentence longer than bears a fair proportion to the gravity of the offence assessed against the background of the offender because of the likelihood of his commission of further such offences. Whether this likelihood be determined from his record of previous convictions or from a disposition otherwise shown to the further commission of such offences, a heavier punishment would be to punish him for offences for which he had already been punished or for offences he had not committed. All punishment for offences is fundamentally for the protection of the community and the court should not impose a longer sentence than is otherwise fairly proportionate to the gravity of the offence considered upon the background of the offender in order that the community will thereby be afforded greater protection from his crime.

Crime reduction as an object of sentencing is often aligned with the principle of social defence. As such it encapsulates the desire to protect the community from crime through the application of criminal sanctions that are said to be essentially retributive, deterrent or rehabilitative in emphasis.[304] However, as already discussed, the just deserts or retributive model sets the limits of just punishment under the criminal law, and to this extent only is

302. R. Cross, *The English Sentencing System*, (2nd ed.), (Butterworths, London, 1975), p. 118.
303. *R.* v. *Veen*, unreported decision, 6 August 1977.
304. *R.* v. *Goodrich* (1952) 70 W.N. (N.S.W.) 42; *R.* v. *Cuthbert* (1967) 86 W.N. (Pt. 1) (N.S.W.) 272, 274. For the discussion on preventive detention see *infra*, p. 190ff.

the object of community protection through the application of utilitarian objects acceptable.

Thus, leaving aside the issue of strict liability, the commission of the *actus reus* (the physical prerequisites of the offence) is a necessary, but insufficient, ingredient for invoking culpability and assigning consequent commensurate punishment under the law. It has already been seen that persons lacking in capacity, such as the legally insane or infants, are exculpated.[305] Similarly, persons who commit non-intentional or accidental acts or omissions, short of criminally negligent acts or omissions, and persons who, although accused of an offence, have been declared not guilty under the formal processes of the law, are outside the legitimate reach of criminal punishment.

In brief, just punishment is determined by reference to the gravity of the proven offence and by reference to the culpability of the offender. Just punishment is determined also by reference to the statutory penalties available for the offence, as modified by sentencing practice. In evaluating culpability or degree of blameworthiness of the offender, and in determining the consequent commensurate punishment for the offence, certain aggravating and mitigating factors are weighed in the balance. In this regard the offender's mental condition, or more specifically the offender's degree of control over the harmful or harm-threatening aspects of the proven proscriptive conduct, provides one of a number of highly relevant considerations in the assessment of just punishment under the law.[306]

REHABILITATION

Humanitarianism, enmeshed in the medical model of corrections, has aimed at mitigating the harshness of the criminal law by promoting an individualised approach to sentencing. It has attempted to shift the focus in sentencing from the offence to the offender and to some extent, it has succeeded. However, rehabilitation, the catch-cry of criminologists of past decades, has ended in disillusionment.[307] It has left in its wake indeterminate and semi-determinate

305. Chapters 3 and 4, *supra.*
306. Hyman Gross, *op. cit.*, n. 294.
307. D. Lipton, R. Martinson, J. Wilks, *The Effectiveness of Correctional*

sentencing systems designed among other things to mitigate the harshness of imprisonment by encouraging early release from prison at an optimum point in an offender's stated period of incarceration through the introduction and use of such devices as licences and parole. This modified system of sentencing, that has grown like topsy by replacing the rigidity of the law with a more flexible discretionary sentencing system, was thought to benefit the offender as well as the community. However, despite its philanthropic intentions, rehabilitation as an object of punishment has emerged as little more than an utilitarian dream.

Rehabilitation as a general policy was doomed to fail not only because it categorised crime as an illness but also because it could neither adequately diagnose the illness nor prescribe the cure. It placed an unwarranted faith in the capacity of the penal system to reform offenders and inevitably failed to prove its efficacy and consequently its value as a guide to sentence decision-making.[308] Instead its influence has left the criminal justice system in a mild state of confusion uncertain as to whether it is punishment or treatment that is required. To help clarify the situation, attention has been drawn once again to the less than popular retributive model. This has resulted in the articulation or re-articulation of the general principle that punishment is to be based on the principle of commensurate deserts. Just deserts like a phoenix is emerging triumphant from the ashes of the rehabilitation ideal.

If the truth be known the philosophy of rehabilitation has never really dislodged the primary principle that the punishment should fit the crime. Indeed some commentators have suggested that rehabilitation has never really been tried.[309] Certainly sentencing has become more individualised and indeterminate, particularly

Treatment: A Survey of Treatment Evaluation Studies, (Praeger Publishers, New York, 1975).

308. *Ibid.*

309. Marvin Frankel, *op. cit.*, n. 287, p. 93 has observed for example that the sentence of imprisonment that purportedly is 'tailored to the cherished needs of the individual turns out to be a crude order for simple warehousing'. He also comments that characteristically there are no treatment facilities of any substantial nature in prisons. The same criticism applies to Australian corrective institutions, for example, see the *Report of the Commission into N.S.W. Prisons*, (The Nagle Report) (Govt. Printer, Sydney, 1978), and also J. Braithwaite, *Prisons, Education and Work*, (Australian Institute of Criminology, Canberra, 1980).

with the introduction in the last decade or two of a spate of measures designed to reduce the incidence of imprisonment. Parole is perhaps the single most important innovation in this regard, and indubitably has contributed significantly to the level of indeterminacy in sentencing. Yet it still remains true that sentencing is essentially offence rather than offender based. Thus, although circumstances relating to the offender as well as circumstances relating to the offence allow discretionary judgments on sentence to be made, legislatively prescribed maximum penalties still attach to the type of offence rather than to the type of offender.

Penalties given by statute are arranged, broadly speaking, in a way in which it may be said that the more serious types of offences carry heavier penalties than the less serious. Sentencers have also followed the general rule that the more serious the offence the heavier the penalty. In this respect also just deserts if not articulated as such, has always been part and parcel of criminal law and of sentencing, despite utilitarian intrusions that have added to the complexity and uncertainty of the process.

The legacy of rehabilitation has seen the development of a more humane and individualised sentencing system. The abandonment of rehabilitation as a sentencing goal (that is as a basis for measuring the appropriate amount of punishment), must be achieved in a way that enables the humanitarian and individualised approach to sentencing to be retained. The just deserts philosophy, if properly understood and applied, contains the seeds of a fair and relatively certain system of punishment that is both individualised and humane. On the other hand, while rehabilitation alone does not justify the resort to extra punishment or imprisonment,[310] imprisonment itself should not preclude the desirability of attempting to rehabilitate the offender.[311] The two are not interdependent, and it is this fact that provides the ground for admitting into the sentencing armoury of the courts, a hospital order form of disposal.

After all, the hospital order, if applied as a sentence in its own

310. Canadian Law Reform Commission; *A Report on Disposition and Sentence in the Criminal Process Guidelines*, 1977, para. 14. See also *Channon* and *Veen* discussed *infra*, pp. 187ff and 200ff respectively.

311. Norval Morris in a lecture entitled 'Punishment, Desert and Rehabilitation', given at the University of Denver College of Law, Colorado, 12 November 1976, as part of the U.S. Department of Justice Bicentennial Lecture Series. U.S. Govt. Printing Office, 1976, said:

right, maximises humanitarian goals without offending the principle of just deserts. The hospital order should therefore be recognised as a punitive measure, and its duration should be limited according to the principle of commensurate deserts. It should not be renewable (indeterminate in duration) although there is no objection for enabling early release of the offender on therapeutic grounds except where a restriction order has been imposed by the courts. In general, treatment under a hospital order should not be compulsory but should be 'entirely facilitative'.[312]

PAROLE AND JUST DESERTS

Parole has been attacked, not only on the basis of its failure to reduce recidivism, but also for contributing to the uncertainty and consequent disparity that it has introduced into sentencing practice. The inability of parole boards to predict dangerousness, or less controversially, to predict future criminality on the part of individual offenders, has also been the subject of severe criticism that has resulted in calls for parole abolition.[313]

In similar vein the Australian Law Reform Commission has boldly advocated the abolition of parole, claiming that this would create 'an opportunity for the sentencing process to become not only fairer but also simpler and more easily understood and accepted by the general community for whose protection it is ultimately designed'.[314] Lamentably, the Commission, as indeed

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> Power over a criminal's life should not be taken in excess of that which would be taken were his reform ***not*** considered as one of our purposes. Rehabilitative programs in prison must not define either the duration or the conditions of incarceration; prison programs must be entirely facilitative, never coercive.

312. *Ibid.*

313. For example see Von Hirsch and Hanrahan, *Abolish Parole?* Report submitted to the U.S. Department of Justice, 1977. In fact a number of states have already abolished parole including Maine, Indiana, Arizona, Illinois and New Mexico. In a large number of other jurisdictions guidelines have been developed to ensure greater consistency in parole decision-making. See generally, Australian Law Reform Commission, *Sentencing of Federal Offenders,* Report No. 15, (A.G.P.S., Canberra, 1980), p. 211; Tomasic and Dobinson, *The Failure of Imprisonment,* (George Allen and Unwin, Sydney, 1977), pp. 75-90.

314. *Ibid.*, p. 212.

most proponents of just deserts, has placed too much emphasis on the failure of parole to rehabilitate offenders and has omitted to recognise that a system of conditional release may be seen as playing a positive role within a general system of punishment based on just deserts.

Elsewhere the writer has advocated a system that does away with the indeterminate and predictive elements that presently apply to parole decision-making but retains the concept of conditional release prior to the expiration of the sentence.[315] This is achieved by the simple expedient of making conditional release a right, and one that is calculated to take effect after a fixed proportion of the sentence has been served. In this way the date of release is known as soon as sentence is imposed. It has been suggested that the ratio of the duration of imprisonment to the duration of conditional release should be two to one, thereby ensuring that the sentence remains primarily one of imprisonment and that excessively long periods of conditional release are not possible.[316]

Only the sentence of life imprisonment would be an exception to this scheme. A sentence of imprisonment would ordinarily mean that the first two-thirds of the sentence would be served in custody, and the last one-third of the sentence would be served in the community. This formula would only be varied upon the proven misconduct of the prisoner. Provided that the same formula or meaning were given to all sentences of imprisonment, there would be a firm basis upon which to build a more equitable and certain sentencing system than presently obtains. Such a system would be more readily acceptable to the public and to the prisoner alike and would greatly simplify the task of the sentencer and the prison administrator.

Conditional release, it should be added, is a most useful mechanism of control whether it be used prior to or following imprisonment and, although it may or may not be an effective vehicle for the rehabilitation of the offender, it is more humane, cheaper, and at the same time continues to satisfy the punitive objectives of the criminal law. Particularly in the case of the mentally disordered

315. I. Potas, *op. cit.*, n. 284, Appendix B.

316. Under present parole systems the period of conditional release often exceeds the non-parole portion of the sentence. See I. Potas, 'Parole Review in Australia', (1979) 12 A.N.Z.J. Crim. 177, 180.

violent offender, a system of conditional release requiring supervision or surveillance of the prisoner immediately after release, coupled with the added threat of returning him or her to prison for the balance of the unserved portion of the sentence in the event of serious breach of conditions, is not only an acceptable but a desirable means of disposal. The concept of graduated steps from full custody to unconditional liberty is one of the positive achievements of modern penal administration and needs only to be rationalised. Conditional release clearly is reconcilable with a just deserts model of punishment if applied uniformly to all prisoners in accordance with the scheme just outline.[317]

ADDITIONAL PUNISHMENT FOR THE OFFENDER'S OWN GOOD

There is clear authority for the proposition that it is not proper to increase an otherwise appropriate sentence of imprisonment merely for the purposes of rehabilitating or treating the offender. This is in strict accordance with the limiting characteristic of the just deserts principle referred to earlier. Indeed, according to an opinion expressed by Brennan J. in the Federal Court of Australia appeal decision of *Channon* v. *R.*,[318] the general principle is that 'the limits of a proper sentence' are determined 'without taking into account the treatment of psychiatric abnormality'.[319] His Honour, *inter alia*, said:

> A sentence within those limits will be proper punishment, and no part of that sentence can be either excessive or referable merely to the treatment of the abnormality. When the sentence is fixed within those limits 'to enable a cure to be undertaken', the various objectives of sentencing are properly evaluated, including the interests which society and the offender have in his psychiatric rehabilitation. A proper balance is struck, and punishment is limited accordingly.[320]

317. The desirability of retaining some degree of control over offenders after release from prison is well illustrated in *R.* v. *Combo* [1971] 1 N.S.W.L.R. 703.
318. (1979) 20 A.L.R. 1; see also *Veen* v. *R.* (1979) 53 A.L.R.J. 305, discussed *infra*, p. 200ff.
319. (1979) 20 A.L.R. 1, 9.
320. *Ibid.*

Brennan J. considered that psychiatric treatment could nevertheless be taken into account in determining a period of imprisonment where:

> (1) the offender suffers from a mental abnormality which contributed to the relevant offence;
>
> (2) psychiatric treatment for that abnormality is likely to be made available to the offender during imprisonment;
>
> (3) the offender is likely to avail himself of that treatment; and
>
> (4) there is a reasonable prospect that the treatment will reduce or eliminate the abnormality.[321]

In the writer's opinion, the first factor, (whether the mental abnormality contributed to the offence), is relevant for determining the degree of culpability. It is a vital consideration in seeking the just limits of punishment for the particular offence. The three other factors on the other hand do not impinge upon an assessment of the intrinsic evils of the offence. Their relevance relate not to determining the quantum of the sentence, but rather to determining the nature or kind of sentence that may be deemed appropriate in all the circumstances. These three considerations will weigh heavily upon issues of community protection and rehabilitation, but these must surely be subsidiary considerations that cannot in fairness influence the upper limits of just punishment.

In some cases they may bear upon the lower limits of punishment. Thus where the object of community protection is pursued it may function so as to preclude mitigation, while in the case of rehabilitation or treatment objectives it may, in certain circumstances, allow mitigation of penalty for humanitarian reasons. Sometimes a penalty may be reduced below the range dictated by just deserts, in which case the result may be described as an act of mercy. Mercy should also play a part in criminal justice but its overuse will lead to a weakening of the just deserts principle. It should be used sparingly and always with good reason.[322]

In *Channon,* Brennan J. considered that where his four conditions were satisfied, it would be proper to take into account the

321. *Ibid.*, p. 10.
322. I. Potas, *op. cit.*, n. 315, p. 76.

offender's prospects for cure, provided that the term of imprisonment did not thereby exceed the maximum period of punishment otherwise considered appropriate. Earlier in his judgment Brennan J. made a similar point when he stated that imprisonment is 'only imposed to the extent necessary to protect society' and that 'it cannot be imposed or prolonged merely to serve the supposed psychiatric needs of the offender'.[323]

A similar approach was adopted by Deane J., who, *inter alia*, was of the opinion that:

> . . . it is no part of the function of a criminal court to impose, either within or outside what are seen as the 'permissible limits' of a sentence, a longer term of imprisonment than would otherwise have been imposed for the end of ensuring that the person being sentenced receives psychiatric treatment which would be available, and availed of by, him in prison (but not otherwise) and which would be generally beneficial to his overall health or life. A sentence of imprisonment must be regarded as a punishment (*Power* v *R* (1974) 131 CLR 623 at 627; *subnom Lyons* v *R* (1974) 3 ALR 553 at 555-6). It can only properly be imposed on the basis that it is the appropriate punishment for the particular offence in the particular circumstances.[324]

The reasoning of Toohey J. is also instructive:

> As to the principle, one thing is clear enough. Whatever may be seen to be the object of punishing for a criminal offence, it is not a proper exercise of the sentencing process to impose a term of imprisonment for the sole purpose of holding a prisoner for psychiatric treatment. Not only is such an approach contrary to authority but it is subversive of the role of the courts. History and contemporary events point up only too well the dangers of using imprisonment to secure psychiatric processes.
>
> But it does not follow that the existence of a psychiatric condition and the prospects of treatment are irrelevant when dealing with an offender shown to have a psychiatric disturbance that played some part in the commission of the offence. Where an offender is, by reason of a psychiatric abnormality, a danger to the community the existence of that condition will ordinarily be an important consideration in determining an appropriate penalty.

323. *Ibid.*, p. 7. See also *Veen* v. *R.* (1979) 53 A.L.R.J. 305.
324. (1979) 20 A.L.R. 1, 21. Note also that Power *supra*, also supports the point made earlier that Australian courts accept the principle of fitting the punishment to the crime as the primary consideration in determining sentence.

His honour then turned his attention to consider the extent to which the existence of a psychiatric condition and the treatment of it were relevant in determining sentence. His honour said:

> Speaking of the purposes of punishment it has been said that 'all purposes may be reduced under the single heading of the protection of society, the protection of the community from crime' (Herron CJ in *R* v *Cuthbert* (1967) 86 WN (Pt 1) (NSW) 272 at 274). There is nothing in that statement making it inappropriate for a court to have regard to the availability of a cure for a condition that has caused or contributed to the offence in question. Such a cure may well play its part in the protection of society from the particular offender if seen only as an aspect of rehabilitation.**But such a consideration may not operate to justify the imposition of a sentence of imprisonment longer than would otherwise be a proper sentence.** '. . . the court must first determine what are the limits of a proper sentence in respect of the offences charged. Within those limits it may be perfectly proper to increase the sentence in order to enable a cure to be undertaken whilst the prisoner is in prison. But on the authority of *Ford, supra,* it is clear that it is not correct to increase the sentence above that within the appropriate range for the offence itself, merely in order to provide an opportunity to cure' (*R* v *Moylan* 53 Cr App R at 594).
>
> As to the words 'to provide an opportunity to cure', in the absence of any statutory authority empowering a court to direct that psychiatric or any other treatment be undertaken, the most that it can do within the limits of a proper sentence is to provide the opportunity for treatment if the offender wishes to avail himself of it.
>
> There may be a logical difficulty in first excluding from consideration what has been referred to as the curative element and then bringing it into account. Such an approach may be justifiable only on pragmatic grounds, but it does, I think, represent a workable solution to a difficult problem and one likely to safeguard the interests of the prisoner concerned.[325]
>
> **[Emphasis added]**

The issue of sentencing mentally disordered offenders who have committed offences carrying sentences of life imprisonment will be considered shortly. First, however, a closer examination of the proportionality principle and how the element of mental disorder operates to modify sentence, follows.

325. *Ibid.*, pp. 28-29.

PREVENTIVE DETENTION

In normal circumstances it may be appropriate to reduce the level of a sentence below the ceiling indicated by the gravity of an offence in order 'to reflect the presence of mitigating factors in the offender's character or personal circumstances' and in general no penal objective justifies a sentence which exceeds that ceiling.[326] This general principle emerges quite clearly from the cases in the preceding pages. However, David Thomas has identified a number of special cases in which the English courts have refused to make allowances for mitigating factors.

These include cases where the courts have made use of the exemplary sentence,[327] where the prisoner is labelled a dangerous offender,[328] where the prisoner is considered to be a social nuisance,[329] or a persistent offender,[330] or in circumstances in which it is considered that the prisoner is likely to benefit from treatment in prison.[331] It is stressed that while these categories constitute examples of where the court may refuse to take into account the usual mitigating factors, they have not been held to justify increasing the severity of a sentence beyond that required by application of the proportionality principle.[332]

326. D.A. Thomas, *The Principles of Sentencing*, (2nd ed.) (Heinemann, London, 1979), p. 35.

327. The 'exemplary sentence' refers to a sentence which serves the purpose of general deterrence by being referrable strictly to the facts of the offence and makes no allowance for mitigating factors. See *ibid.*, p. 36.

328. The dangerous offender is one who by virtue of his offence, his prior history and his mental condition, is considered likely to commit violent crimes in the future. See *ibid.*, p. 37.

329. The social nuisance is one who has a long history of minor offences and suffers from a mild form of personality disorder with 'a history of intermittent stays in mental hospitals'. He will generally have shown himself to be unresponsive and uncooperative with social welfare and criminal justice agencies. See *ibid.*, p. 39. Thus, it has been held that the fact that the offender is a social nuisance for whom the health and social services authorities are unable or unwilling to provide is no justification in itself for a long sentence; see *R.* v. *Tolley* [1979] Crim. Law Rev. 118 following *R.* v. *Clarke* disapproving *R.* v. *Arrowsmith* [1976] Crim. Law Rev. 636. *R.* v. *Westell* [1979] Crim. Law Rev. 191. *R.* v. *Jenkins* [1977] Crim. Law Rev. 49. See also A. Samuels, 'The Relevance of Previous Convictions on Sentencing', (1979) 143 J.P. 446.

330. D.A. Thomas, *op. cit.*, p. 41ff.

331. *Ibid.*, p. 44ff.

332. This general principle is consistent also with the passages quoted from *R.* v. *Veen* and *Channon* v. *R. supra*, and is supported by the recent High

The exception to this general principle is contained in special recidivist provisions which empower courts to impose sentences beyond the level that is commensurate with the gravity of the offence. These special provisions attempt to identify the bad risks and isolate them from the community for longer periods than the law would otherwise allow in order that the community may be afforded additional protection. It has long been recognised that the probability of further imprisonment increases with each term of imprisonment and extended periods of detention of dangerous or recidivist offenders was thought to be a sure way of reducing crime.[333] In England,[334] and almost contemporaneously in Australia, Canada and New Zealand, various systems of preventive

Court decision of *Veen* v. *R.* discussed *infra*, p. 200. In the United States it is usual to challenge disproportional punishment on the basis that it constitutes cruel and unusual punishment in violation of the eighth amendment to the United States Constitution. In *Weems* v. *United States* (1910) 217 U.S. 349, the Court held that it was a 'precept of justice that punishment for crime should be graduated and proportioned to the offense', *ibid.*, p. 367. Cf. *Gregg* v. *Georgia* (1976) 428 U.S. 153, *Coker* v. *Georgia* (1977) 433 U.S. 584 following *Furman* v. *Georgia* (1972) 408 U.S. 238. In *Hart* v. *Coiner* (1973 4th Cir.) 483 F. 2nd 136, **cert. denied** (1974) 415 U.S. 9183, the Fourth Circuit Court adopted a four pronged test for the proportionality of a sentence: (1) the nature of the offence; (2) the legislative purpose behind the punishment; (3) punishments imposed in other jurisdictions for the same offence; and (4) punishments available in the same jurisdiction for other offences. See *Constitutional Law – Texas Habitual Offender Statute Does Not Violate the Eighth Amendment. Rummell* v. *Estelle* (1980) 8 Am. J. Crim. Law 209.

333. The Gladstone Committee in 1895, C.7702, para. 28, published the following statistics showing how the probability of further prison sentences increases with the number of prior prison sentences:

	per cent
after first imprisonment	30
after second imprisonment	48
after third imprisonment	64
after fourth imprisonment	71
after fifth imprisonment	79

While statistics of this kind are still the common experience, incapacitation as a means of reducing crime has been shown to be surprisingly ineffective; S. Van Dine, J. Conrad and S. Dinitz, *Restraining the Wicked: The Incapacitation of the Dangerous Criminal*, (Lexington Books, 1979). S. Brody and R. Tarling have also concluded that 'the overall number of convictions could be reduced by imposing more severe sentences, but only at the cost of substantial increases in the use of imprisonment'. They also claim that a

detention, either semi-determinate or indeterminate, were introduced.[335]

The English experience suggests that special recidivist provisions have not proved satisfactory.[336] Under the *Prevention of Crime Act* of 1908, 'double track' sentencing was introduced in England. The 'habitual criminal' who fell within the provisions of this Act would effectively receive two sentences, a retributive one (one for the offence) and a second one which was purely for the protection of society. Although Gladstone had intended that the second part of the sentence should be indeterminate, so that the habitual criminal would be released at the discretion of the Executive in the same way as a person serving a sentence of life imprisonment, the Parliament substituted a semi-determinate form of sentence adding between five and 10 years to the normal sentence of those subject to its provisions.

In 1948, the double-track system was replaced by a blanket sentence of between five and 14 years, but even so its provisions, like those of its predecessors, were seldom invoked. For example, Hammond and Chayen reported that in 1956, of 1,384 men who were eligible for preventive detention, only 13 per cent actually

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modest reduction in the lengths of prison sentences (for example, by increasing the remission entitlements from one-third to one-half) would not result in a large number of additional convictions but 'would significantly decrease the size of the prison population'. See *Taking Offenders out of Circulation*, (Home Office Research Study No. 64, London, 1980), p. 17. But Cf. J.Q. Wilson, *op. cit.*, n. 288, pp. 172-3.

334. *Prevention of Crime Act*, 1908 (Eng.).

335. M. Daunton-Fear suggests that the New South Wales *Habitual Criminals Act*, 1905 was the legislative progenitor of similar provisions in each of the other Australian States and New Zealand. See M. Daunton-Fear, 'Sentencing Habitual Criminals in Australia' in *The Australian Criminal Justice System*, (ed. Chappell and Wilson), (Butterworths, Sydney, 1972), 571, pp. 578, 579. See also *Habitual Criminals Act*, 1907 (S.A.); *Indeterminate Sentences Act*, 1908 (Vic.); *Criminal Code*, 1913 (W.A.); *Indeterminate Sentences Act*, 1921 (Tas.); *Criminal Code*, 1899 (Qld.); *Crimes Act*, 1908 (N.Z.).

336. For a brief history of preventive detention in England see the Report of the Advisory Council on the Penal System; *Sentences of Imprisonment — A Review of Maximum Penalties* (The Serota Committee) (H.M.S.O., London, 1978), paras, 84-115. See also N. Morris, *The Habitual Criminal*; and M. Daunton-Fear, *op. cit.*, n. 335. For a history of Canadian Preventive Detention Law see MacDonald, 'A Critique of Habitual Criminal Legislation in Canada and England', (1979) 4 Univ. of British Columbia Law Rev. 87.

were sentenced to it. Furthermore, of those that were given preventive detention, only a very small proportion were sentenced to a term exceeding the old maximum of 10 years.[337]

In *Grimwood*[338] the English Court of Criminal Appeal reduced a sentence of eight years' preventive detention to one of two years' imprisonment. The offender had been convicted of stealing 14 shillings from a gas meter in his home, and the Court commented that 'a sentence particularly one of preventive detention, ought really to have relation to the gravity of the crime itself'.[339] The courts were reluctant to use the legislation in the way it was intended. The Serota Committee quotes statistics showing how the use of preventive detention declined from about 2 per cent of the prison sentences imposed by higher courts in 1957, to 1.7 per cent in 1961, to 0.6 per cent in 1963 and to 0.3 per cent in 1964.[340]

The Committee state that the typical preventive detainee:

> . . . was not a skilled professional robber or burglar, nor a sexual molester, nor a man of violence, but an incompetent petty swindler or pilferer, whose dishonesties cost society little more – and in some cases less – than his maintenance in prison.[341]

In short, the legislation was failing to identify and detain the so called dangerous offender – the offender who presented a serious threat to the safety and well being of the community.

In 1967, in an attempt to overcome this criticism, the extended sentence was introduced.[342] Its use increased by trickles until it reached a peak in 1970 when a total of 129 extended sentences were imposed. Then it began to decline until in 1976 there were only 14 such sentences passed.[343] Not only were these sentences fewer in number, but their lengths were decreasing to the point

337. W.H. Hammond and E. Chayen, *Persistent Criminals,* (H.M.S.O., London, 1963), cited in the Serota Committee Report *op. cit.*, n. 336, p. 49.
338. *R.* v. *Grimwood* [1958] Crim. Law Rev. 403.
339. See Serota Committee, *op. cit.*, n. 336, p. 49.
340. *Ibid.*, p. 50.
341. *Ibid.* See also Hammond and Chayen, *op. cit.*, n. 337, p. 35.
342. Under the *Criminal Justice Act* of 1967 (England) s.37.
343. The Serota Committee, *op. cit.*, n. 336, p. 50. The English extended sentence, is a good illustration of the harshness of recidivist provisions where the principle of community protection in effect condones a form of double punishment. Thus s.28 of the *Powers of Criminal Courts Act,* 1973 (U.K.) provides that where the protection of the public so requires, and the offence

where some two-thirds were for five years or less.[344] The Serota Committee concluded that the courts' attitude towards long sentences for less serious crimes was leading to the demise of the extended sentence and that it should be abolished.[345]

Meanwhile the search for a satisfactory formula continues with the Butler Committee's recommendation for a 'reviewable sentence', a disposition particularly apposite, it might be thought, for mentally disordered offenders whose treatment needs cannot be predicted in advance.[346] This disposition enables the prisoner to be detained for as long as it is deemed necessary, but requires mandatory reviews to be undertaken every two years. On release the offender would continue under compulsory supervision, although this period also would be subject to mandatory review. The reviewable sentence would only apply to certain specified offences, and is thought to be an improvement on the indeterminacy of the life sentence.[347]

In Australia, while most jurisdictions have legislative devices such as habitual criminal laws permitting sentences of preventive detention to be imposed, the concept of life imprisonment as a merciful sentence has been rejected.[348] Unless the offender is caught within the four walls of a recidivist statute, the sentence

itself attracts a penalty of imprisonment of two years or more, and fewer than three years have elapsed either since the previous convictions or the release of the offender from prison, and where the offender has at least three convictions all imprisonable for two years or more, and the total length of previous sentences amounts to at least five years, including: (a) one sentence of three years; or (b) two sentences of two years. Then, (i) if the maximum sentence is less than five years, it may be raised to five years; or (ii) if less than 10 years, it may be raised to 10 years. The leading case on extended sentences is *D.P.P.* v. *Ottewell* [1968] 3 All E.R. 153.

344. *Ibid.*, p. 54.

345. *Ibid.*

346. *Report of the Committee on Mentally Abnormal Offenders*, (The Butler Report), Cmnd. 6244 (H.M.S.O., London, 1975), pp. 71-73.

347. In England the life sentence has been used both as a merciful sentence (the idea being that a mentally disordered person is to be released at the earliest possible moment he or she is considered cured or no longer a threat to the community) and as the ultimate punitive, deterrent and denunciatory sanction know to the law. Clearly both objects are frustrated while the life sentence has these antithetical roles.

348. *Veen* v. *R.* (1979) 53 A.L.J.R. 305, pp. 312, 313 per Jacobs J. discussed *infra*, p. 200ff.

may not exceed the penalty that is commensurate with the gravity of the offence.[349]

A careful analysis of an article by Mary Daunton-Fear reveals that many of the criticisms that have applied to English habitual criminal legislation apply with equal force to Australian jurisdictions. She concludes by suggesting that in some circumstances there may be a need for such special legislation and recommends the adoption of a form of sentence which upon proof of the relevant criteria enables the legislatively prescribed maximum penalty to be extended by a further five years. She softens the blow by recommending that under her scheme habitual criminals would be entitled to remissions of sentence and be eligible for conditional release (on licence rather than parole) in the same way as ordinary prisoners.[350]

Unfortunately her scheme fails to overcome the general objection that habitual criminal legislation, as indeed all legislation concerned specifically with recidivism, punishes offenders for their status rather than for their crimes, or alternatively punishes offenders for crimes they are thought likely to commit rather than for crimes they have committed. Ultimately it is a highly selective and potentially discriminatory exercise of dubious efficacy and morality.

In the end one cannot but agree with the following statement contained in the Australian Discussion Paper prepared for the Sixth United Nations Congress on the Prevention of Crime and the Treatment of Offenders:

> Opportunities for the formal labelling of individual offenders in Australia are limited to relatively few oddities in the criminal law which are seldom used. Thus, the Criminal Code of Tasmania in section 392 provides for persons to be proclaimed as 'dangerous criminals' and section 77(a) of the South Australian Criminal Law Consolidation Act

349. For example, in *Langley* (1970) 70 S.R. (N.S.W.) 403 the Court of Criminal Appeal reduced a sentence of six years' imprisonment to one of three years because the original sentence was held to contain an element of preventive detention for which there was no statutory authority. See also *Veen* v. *R. supra,* as discussed in I. Potas, *Sentencing Violent Offenders in New South Wales,* (Law Book Company, Sydney, 1980), pp. 1060-8. On the Canadian attitude towards sentencing dangerous offenders see C. Ruby, *Sentencing,* (2nd ed.) (Butterworths, Toronto, 1980), pp. 112-7.

350. M. Daunton-Fear, *op. cit.*, n. 335, pp. 594-7.

> provides for persons deemed 'incapable of exercising proper control over (their) sexual instincts' to be detained for extended periods. All other jurisdictions retain provisions which enable courts to declare offenders as 'habitual criminals', but these provisions are very rarely used and are widely regarded as anachronistic. It is predicted that most of these provisions will be either repealed or fall into complete disuse in the foreseeable future.[351]

Accordingly it is recommended that all such preventive detention devices should be abolished, and it is further recommended that the search for a better system of preventive detention be abandoned. There is, in general, adequate scope under conventional sentencing powers to ensure that those with prior criminal records (bad risks), should serve longer terms in prison by application of the principle that such persons lose claim to leniency. In addition, such persons are generally disadvantaged by being entitled to less favourable remissions (comparable sentence lengths inevitably favour first time prisoners), and less favourable parole eligibility entitlements. In some cases parole is denied at the point of sentence, in other cases parole boards defer or deny release of those considered bad risks. Recidivists are adequately punished without resort to concepts of extra punishment. Nor should mentally disordered offenders be penalised by the application of indeterminate sentencing devices merely on the basis of their psychiatric condition.

TO MITIGATE OR NOT TO MITIGATE?

If, as has been argued, the concept of preventive detention as an object of criminal punishment is placed outside the legitimate parameters of the criminal law and of sentencing, it follows that an offender's mental disorder may influence sentence in one of three ways only:

(1) as a mitigating factor;

(2) as a bar to mitigation; or

351. D. Biles, *De-institutionalisation of Corrections and its Implication for the Residual Prisoners,* Australian Discussion Paper, Topic 4, (A.G.P.S., Canberra, 1979), p. 20.

(3) as relevant for determining the kind (as opposed to the quantum) of sentence.

How are these to be reconciled under a just deserts approach to sentencing? It is clear that the principle of just deserts and the measurement of seriousness (or culpability) does require an assessment of the part played by the offender's mental disorder in the commission of the offence.

Thus for the purposes of determining sentence there should be a clear distinction made between mentally disordered offenders whose criminal acts are demonstrated to be connected with their mental disorder and mentally disordered offenders whose criminal acts are shown not to be a consequence of their mental disorder. Where there is shown to be a connection between mental disorder and the act, it may seem appropriate to permit the mental condition of the offender to operate as a mitigating factor, and, as described above, provide a rationale for reducing the otherwise appropriate sentence. Here the degree of responsibility, and indeed culpability, attributed to the actor and the corresponding level of punishment considered appropriate for the crime may be adjusted downwards.[352]

Conversely, where there is no demonstrable connection of the offence with the offender's mental abnormality, it would seem wrong, except on compassionate grounds, to reduce an otherwise appropriate sentence. To do so would detract from the principle of commensurate deserts – the principle that the penalty should be commensurate with the gravity of the offence and culpability of the actor – and so provide the misleading impression that the offender's behaviour is somehow justified or partially excused by reason of mental disorder.

In determining the measure of punishment in such cases it is not intended that humanitarian considerations should be ignored. Such treatment as is available should be offered to the prisoner, but the treatment should be ancillary to the general object of

352. This general rule is subject to the principle enunciated in *Veen* v. *R.* (1979) 53 A.L.J.R. 305. Where the offender's mental condition is such that he presents a continuing threat to the community (and to himself?) it may not be appropriate to mitigate the otherwise appropriate sentence. See I. Potas, *op. cit.*, n. 349, pp. 1072-4.

punishment.[353] If during incarceration it appears that treatment is inadequate in prison then arrangements to treat the offender in a custodial environment outside the prison should be arranged.[354] However the concepts of responsibility and punishment,which are the concern of the criminal law, and those of treatment and cure which are the concern of the medical profession, should be carefully distinguished. The first task must surely be to identify whether any connection exists between the criminal act and the offender's disorder.

In this regard it has recently been said that where behaviour is serious, but unconnected with a mental disorder:

> . . . both should be dealt with by separate determinations of causation and appropriate disposals. So long as the penal system adheres to treatment ideals, there is no objection to the therapist undertaking the task of dealing with both behaviour and disorder, although it may be particularly helpful here if the actual trial process (at the sentencing stage) were clearly set out to stress that the objectives are twofold. To allow offenders who happen to be mentally disordered at the time of sentence or commission of a criminal act which is not caused by the disorder [to evade responsibility for the act] is detrimental not only to the aims of the penal system but also, at times, to treatment prospects. To allow such an offender to pass off responsibility for his offence onto the disorder is about as logical as excusing offenders who are suffering from common colds at the time of the trial.[355]
>
> **(Words in square brackets added)**

This dichotomy is also important from the point of view of the non-criminal mentally disordered patient, where the stigma and denunciatory elements that are associated with, and inevitably form part of the administration of criminal law and criminal punishment, are to be avoided. For example, detaining in prisons rather than in mental institutions those found not guilty on grounds of insanity is an unjust and damaging practice. It confuses concepts of guilt, responsibility, culpability and punishment with those of innocence, non-culpability and treatment.

353. See *supra,* pp. 10-12, esp. Morris, *op. cit.,* n. 285.

354. All jurisdictions have provision for transfer of prisoners from prison to treatment facilities. See A. Freiberg, 'Out of Mind, Out of Sight: The Disposition of Mentally Disordered Persons involved in Criminal Proceedings', [1976] 3 Mon. Law Rev.

355. R. Steadman, Allen and Davis, 'Psychiatric Models and the Treatment of Offenders', (1978) 142 *Justice of the Peace* 355, 357.

Of course it may not always be possible to determine whether there is or is not a link between the criminal act and the offender's mental disorder. In general the onus of establishing a connection should be upon the prisoner and the prisoner's witnesses. In such a case it may be preferable to give the prisoner the benefit of any reasonable doubt, including any reasonable doubt as to the extent or gravity of the mental disorder. This would be in keeping with the general philosophy of the criminal law. If the offender's mental disorder is of a kind that is amenable to treatment, whether or not the offender's condition influenced the commission or mode of commission of the offence, such treatment as may be available within the context of the punitive component of the sentence should be made available to the prisoner.

It may be that in severe cases of mental disorder the prisoner may be required to serve time in a mental institution. If so, this time should count as part of the sentence. In some cases it may be that a hospital order provides the best form of disposal. As already illustrated by the two Australian Capital Territory cases of *Riley* and *Smith*,[356] and also by the Victorian case of *Tutchell*, and as shortly to be demonstrated again in the New South Wales case of *Veen*,[357] situations arise where neither imprisonment nor probation appears to satisfy the demands of justice, satisfy the needs of the offender and yet offer a required degree of protection to the community. In such cases, given the availability of appropriate facilities, the hospital order would seem to be the only proper form of disposal. Such an order should not be viewed as a therapeutic sentence but as a punishment to be served in a therapeutic environment.

Finally, if the mental disorder is found to be irrelevant for the purposes of determining the quantum of a sentence that is commensurate with the gravity of the offence, it does not therefore follow that a hospital order may not be an appropriate form of disposal. The **kind**, as opposed to the quantum, of the sentence imposed within the punitive limits of just deserts is not constrained by reference to the offender's mental condition at the time that the offence was committed. Indeed it is the humanitarian and individualised aspect of punishment that enables suitable

356. *Supra*, p. 97ff.
357. *Infra*.

sentencing options to be devised and applied in a way that does not unduly compromise the principle of just deserts.

THE MERCIFUL SENTENCE OF LIFE IMPRISONMENT

Veen's case[358] provides the highwater mark of sentencing mentally disordered offenders in Australia. It raises many issues that impinge upon the problem of sentencing the mentally disordered, including the need to ensure that the judge has adequate evidence upon which to base a finding that the offender is mentally disordered and evaluate the extent of such disorder. For this purpose neither the evidence presented at the trial nor the inferences made from the jury's verdict are sufficient. The case also warns of the unreliability of predictions relating to the offender's propensity for future violent behaviour, and it unequivocally supports the principle that punishment should not be disproportionate to the culpability of the offender, even if, as in that case, the maximum penalty prescribed for the offence is life imprisonment.

This was a case of diminished responsibility, and *Veen* was convicted of manslaughter in pursuance of the terms of s.23A of the *Crimes Act*, 1900 (New South Wales).[359] He was a 20 year old Aboriginal, homosexual prostitute whom the judge believed suffered from incurable brain damage. He had been convicted of stabbing to death a man to whose house he had gone for the

358. For an analysis of *Veen* see I. Potas, *op. cit.*, n. 349, pp. 1047-1074. See also Goodman and O'Connor, 'Diminished Responsibility – Its Rationale and Application', [1977] 1 Crim. L. J. 204. R.S. O'Regan, 'Diminished Responsibility Under the Queensland Criminal Code', [1978] 2 Crim. L.J. 183. R. Tomasic, 'Preventive Detention and the High Court', (1981) 55 A.L.J. 259.

359. Section 23A provides as follows:

> **23A.** (1) Where, on the trial of a person for murder, it appears that at the time of the acts or omissions causing the death charged the person was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for the acts or omissions, he shall not be convicted of murder.

See also s.304A of the *Criminal Code*, (Qld.) which also has a similar provision. These sections are based on Section 2 of the English *Homicide Act*, 1957.

purposes of prostitution. Relevant also was the fact that when *Veen* was 16 years of age he had inflicted multiple stab wounds with a kitchen knife on the landlady of the boarding house where he was staying. At the time of that offence he had been drinking heavily and had informed the police that he was going to kill himself or someone else. Fortunately the landlady was not injured seriously and *Veen* was convicted of malicious wounding only.

In the course of giving reasons for his sentence in the present case, the trial Judge said:

> There can be little doubt that the prisoner, if and when released, will whilst he suffers from this brain damage, be likely sooner or later to kill or seriously injure one or more other human beings. There is no suggestion that his condition is curable, or in any way responsive to treatment. In his case the deterrence theory of punishment expounded in *Radich's* case has no application.[360]
>
> Punishment will not deter him, or likeminded people, for in certain circumstances they have no control over their impulses to kill. The only principle of sentencing that I can apply is that the community is entitled to be protected from violence. No matter when the prisoner is released, whether it be in a few years or many years, there is the probability that he will again commit a crime of serious violence.
>
> Thus the case presents the problem that there is no basis for fixing a term of imprisonment or a non-parole period. The crime of manslaughter admits of many degrees, and the penalty ranges from nominal punishment to penal servitude for life. Normally an acquittal for murder, and a finding of guilty to manslaughter, would carry a lesser punishment than life imprisonment, even where the acquittal is based on diminished responsibility. In that case, **the mental responsibility has been substantially impaired, and punishment would normally therefore be less than life imprisonment.** But in this case I do not think the ordinary principles of punishment apply. Indeed I do not think it can be properly said, as I interpret the jury's verdict, that the prisoner should undergo punishment. He has to be imprisoned for the protection of the community from his own uncontrollable urges. There is no institution I can send him to; and the only alternatives open to me are to release the prisoner or imprison him. The first alternative is of course an impossible one.[361]
>
> **[Emphasis added]**

360. For the discussion of the *Radich* principle see I. Potas, A.L.R.C. Research Paper No. 7, p. 58.

361. I. Potas, *op. cit.*, n. 349, p. 1049.

While the High Court was later to hold that the evidence as to *Veen*'s mental condition was insufficient to support the conclusion reached by his Honour, this passage nevertheless highlights the inadequacy of dispositional options available to the court in such cases. As there was no special institution (nor indeed a hospital order form of disposal) the trial judge felt obliged to sentence the prisoner to penal servitude for life. Veen then appealed against the severity of this sentence, first to the New South Wales Court of Criminal Appeal, and then to the High Court of Australia.

The New South Wales Court of Criminal Appeal rejected the appeal on the basis that the case involved a proper application of the principles applying to mentally unstable persons who had committed offences carrying life imprisonment as the maximum penalty. The Court considered that the English Court of Appeal decision of *R.* v. *Hodgson*[362] laid down the approach to be taken in such cases:

> When the following conditions are satisfied, a sentence of life imprisonment is in our opinion justified: (1) where the offence or offences are in themselves grave enough to require a very long sentence; (2) where it appears from the nature of the offence or from the defendant's history that he is a person of unstable character likely to commit such offences in the future; and (3) where if the offences are committed the consequences to others may be specially injurious, as in the case of sexual offences or crimes of violence.[363]

However, on appeal to the High Court of Australia, the majority rejected both the applicability of the English approach and any suggestion – at least without specific legislation – that a person could be sentenced to a term of imprisonment which exceeded that which accorded with his culpability.[364] Murphy J. stated for example, that the punishment of an offender should never exceed his guilt, that a sentence was 'a once-and-for-all decision, not the

362. (1976) 52 Cr. App. R. 113.

363. *Ibid.*, p. 114.

364. See particularly the separate judgments in *Veen (supra)*, of Stephen, Jacobs and Murphy JJ. In the minority Mason and Aickin JJ. also supported the proportionality principle but held that there was no opposition in the present case between the imposition of the life sentence and the object of community protection. See also *R.* v. *Nell* [1969] 2 N.S.W.R. 563; *R.* v. *Edghill* [1969] 2 N.S.W.R. 570; *R.* v. *Gascoigne* [1964] Qd.R. 539; *R.* v. *Kocan* (1966) 84 W.N. (Pt. 1) (N.S.W.) 588.

progressive examination, assessment and, if possible, treatment' that is appropriate to preventive detention, and that it was wrong 'to impose punishment or greater punishment than is merited because of the lack of non-punitive preventive detention.'[365]

The principal judgment, however, was delivered by Jacobs J. who considered *inter alia,* that the English approach as enunciated in *Hodgson* was inapplicable to New South Wales, because it had developed from a two-fold basis. This was:

(1) that the prisoner would be kept under constant review and treatment so that he could be released if and when he responded; and

(2) that a long sentence was required in order to ensure that the offender would not be released while he continued to be a threat to the community.

Jacobs J. concluded that these two considerations interrelated with one another, and that without both these bases present, there would be a breach of the fundamental principle 'that a man must be given the sentence appropriate to his crime and no more.'[366] His Honour added:

> It is only by regarding the life sentence for a mentally disturbed offender as no more than appropriate because of the potential advantages which it offers the offender – proper treatment and possibly earlier release than would otherwise be open – that the course has been able to be developed in England. It needs to be emphasised that the protection of the public does not alone justify an increase in the length of the sentence.[367]

Jacobs J.'s observation regarding the lack of treatment facilities and review procedures for the mentally ill in New South Wales Prisons has already been described at some length.[368] However his Honour was prepared to concede that once reforms in the new South Wales system were implemented the adoption of the English approach could be considered.

365. (1979) 53 A.L.J.R. 305, 320; see also I. Potas, *op. cit.*, n. 349, p. 1064, 1065.
366. (1979) 53 A.L.J.R. 305, 313.
367. *Ibid.*
368. *Supra,* p. 114ff.

Mason J. with whom Aickin J. agreed, preferred to base his decision on a passage from the judgment of Gibbs J. in *Pedder*[369] in which it was said that where a person found guilty of manslaughter was mentally disordered, and on account of that disorder that person would constitute a danger if he were released then, 'in some such cases', sentences of life imprisonment would be required for the protection of the community. Indeed while the proper place for many such offenders was in a mental hospital rather than in a prison, the court, unlike the English courts, had no power to order that the person be admitted to hospital, nor could it impose a short sentence on the assumption that the prisoner would be transferred to a hospital. Furthermore, Mason J. in the minority, considered that the conditions stated in Hodgson constituted appropriate criteria upon which to base the imposition of a sentence of life imprisonment, despite the fact that there were differences between the English and New South Wales systems of psychiatric treatment and assessment.[370]

There were a number of other issues of importance canvassed in *Veen,* but for present purposes it is sufficient to note that the case may be cited as authority for the proposition that, subject to specific legislation to the contrary, a sentence should not contain an element of preventive detention.

Veen's case also assists in explaining the circumstances under which the mental condition of an offender may operate so as to reduce the otherwise appropriate sentence. This it would seem depends upon whether the offender's disorder is (a) temporary or curable, in which case the sentence may be mitigated; or (b) continuing or permanent in which case the penalty may not be mitigated.

Elsewhere the author has contended that in assessing the relevance of mental disorder to sentence, the sentencer should ask the following questions (i) what is the 'otherwise proper' sentence that should be imposed in consequence of the offender having committed the offence? and (ii) is the offender's mental condition of a kind which may be treated as a mitigating factor or not?

369. *R.* v. *Pedder* (29 May 1974) unreported judgment of the Queensland Court of Criminal Appeal. Passage cited in *Veen* v. *R.* (1979) 53 A.L.J.R. 305, 309.

370. *Ibid.*, pp. 310, 311, refer also to the views of Aickin J., *ibid.*, p. 321.

It was then submitted that (iii) if the offender's mental condition is of a kind which may be treated as a mitigating factor then the 'otherwise proper' sentence under (i) may be reduced to the extent considered appropriate; and (iv) if the offender's mental condition is of a kind which may not be treated as a mitigating factor then the 'otherwise proper' sentence under (i) may neither be reduced nor increased, on account of the offender's mental condition.[371]

The 'otherwise proper' sentence is taken to mean the sentence that would have been considered appropriate if the prisoner had not been suffering from a mental disorder at the time that the offence was committed.

This general formulation probably presents the existing state of the law on the way in which the mental condition of an offender may be taken into account by sentencers. However it does not satisfactorily accord with a just deserts model as presented here. To do so requires further refinement of these guidelines. In the first place, it is important that the primary issue of culpability be determined by reference back to the act and to the mental condition of the offender at the time that the offence was committed. For this purpose it is quite irrelevant whether the offender's mental condition is temporary or permanent, curable or incurable. So long as the offender's mental responsibility for the offence has been impaired it follows that the offender is deserving of less punishment than would otherwise be the case.

In accordance with principle, the limits of just punishment are then circumscribed. However, within these limits there is scope for making further adjustments to sentence – the ultimate sentence being determined by application of utilitarian and humanitarian considerations. This may be described as taking place at a second stage in the sentencing process. For example if, all other things being equal, the offender exhibits signs of genuine remorse for having committed the offence in question, the court would be justified in imposing a less severe sanction than might otherwise be the case.

Conversely, if a particular offence is prevalent and it is felt that a deterrent sentence is justified it would be perfectly acceptable for the sentence to be found in the upper part of the range dictated

371. I Potas, *op. cit.*, n. 349, p. 1073.

by the deserts principle. Thus just as the mental condition of the offender may be relevant for determining the limits of deserved punishment at the time of the offence (stage one) – the mental abnormality of the offender may equally be relevant for determining the actual sentence to be imposed within that range (stage two).

During stage two, the offender's mental condition at the time of the offence is not of immediate concern, but the offender's general mental health is. Thus if the offender's mental condition is incurable (and assuming the offender is considered to be a threat to the community while the abnormality subsists) it may be proper to impose a sentence in the upper portion of the range deemed appropriate at stage one. Further, as well as assisting in the process of fine-tuning the penalty deemed appropriate in all the circumstances, the offender's mental condition may also play an important part in determining the kind of penalty that in justice and humanity is considered appropriate (stage three).

In short, mental disorder of an offender should have a bearing on the determination of sentence in any one or more of three ways.

(1) By affecting the determination of the limits of deserved punishment. (This enquiry is restricted to an evaluation of the gravity of the offence and the offender's culpability for the offence).

(2) By affecting the determination of the quantum of punishment within those limits. (Here factors extraneous to the act and the culpability of the actor may be accorded weight – including utilitarian and humanitarian considerations).

(3) By affecting the determination of the kind of punishment that is appropriate. (Here regard is had to all the circumstances of the case, including utilitarian and humanitarian considerations).

In many ways the resolution in *Veen*'s case is unsatisfactory.[372]

372. For a more comprehensive evaluation and criticism of *Veen*'s case, see I. Potas, *op. cit.*, n. 349, pp. 1051-1074.

The High Court had determined that the evidence relating to Veen's mental condition was totally inadequate, yet by majority the Court was prepared to substitute a sentence of 12 years' penal servitude for the sentence of life imprisonment.

It is unclear to what extent, if at all, the Court in reaching its decision, took into account the mental condition of the offender. If the offender's mental condition was taken into account, then this would have been based on the same meagre evidence that the Court itself had criticised as being totally inadequate. If it did not take into account the mental condition of the offender, but sentenced him on the basis of other intrinsic and extrinsic circumstances relating both to the offence and to the offender, then an adequate assessment of the offender's culpability and degree of blameworthiness could not be made. It would, it is submitted, amount to an error in principle, an error consisting of a failure to take into account a matter that ought to be taken into account – an error that precludes a critical observer from being satisfied that the prisoner had received his just deserts.

Veen is a case, not of denying that justice had been done (12 years may in fact have been an appropriate sentence), but a case of seeing that justice had been done. The fact that *Veen* was returned to prison, to endure the same system that had been so trenchantly criticised in the Nagle Report, criticisms which were supported by Jacobs J. in the present case[373] is a further indication of the unsatisfactory resolution, not only of the present case but of all cases involving mentally disordered offenders who are subjected to the conditions that presently obtain in our penal institutions.

THE LIMITS OF PROTECTION UNDER THE CRIMINAL LAW

It is sometimes said that the policy of allowing the penalty to be reduced on account of the offender's mental disorder is antithetical to the aim of protecting the community. For example, Barbara Wootton has argued that the law of diminished responsibility encourages the policy of allowing those who are more likely to commit further crimes to be returned more quickly to the com-

373. *Supra*, p. 117ff.

munity than those whose criminal propensities are less definite.[374] This criticism presumes that the mentally disordered as a class are more violent or dangerous than 'normal' offenders – an assumption for which there is no empirical evidence.[375] However, even if it were found that mentally disordered offenders did present a greater threat to the peace and good order of the community there is no reason to believe that such persons would necessarily be treated leniently.

It is sometimes forgotten that the concept of desert is concerned not only with the actor's mind, but also with the consequences or end result of the actor's conduct. This is well illustrated in the offence of culpable driving where the consequences of the act – the death or injury of the victim of the offence – will influence the perceived seriousness of the act, even though the mental element remains constant.[376] Culpable driving is a good example because harmful effects of the offender's behaviour may be entirely fortuitous, yet the culpability and commensurate punishment will vary in accordance with the resultant harm. Similarly for any particular assaultive crime, the perceived seriousness increases with the degree of violence threatened or used. In turn the commensurate penalty ordinarily increases to reflect the aggravating features of a crime until the point is reached, at the statutory maximum penalty, where the penalty may not, in justice, be further inflated.

Mentally disordered offenders who commit and are convicted of particularly violent crimes are generally able to set off the element of diminished responsibility against the aggravating circumstances of the offence. This may result in a more lenient penalty than might otherwise be imposed. On the other hand, it may merely neutralise some aggravating feature of the offence yet still result in a severe sentence. So long as the mental condition of the offender is seen as only one, albeit important, factor in determining the

374. Wootton of Abinger, 'Diminished Responsibility: A Layman's View', (1960) 76 L.Q.R. 224, 237.

375. H. Steadman and J. Cocozza, *Careers of the Criminally Insane*, (D.C. Heath and Company, Lexington, Mass., 1974); T. Thornberry and J. Jacoby, *The Criminally Insane: A Community Follow-up of Mentally Ill Offenders*, (University of Chicago Press, Chicago, 1979).

376. In New South Wales for example, culpable driving occasioning death carries a maximum penalty of five years' imprisonment, whereas culpable driving occasioning injury carries a maximum sentence of three years' imprisonment. *Crimes Act*, 1900 (N.S.W.) s.52A.

sentence that is deemed to be commensurate with the seriousness of the offence and in particular, provided that adequate weight is placed on the fact that the offender committed the offence or offences of which he or she is convicted, there need be no fear that the most dangerous are treated most leniently.

The simplicity of the Wootton argument fails to recognise the importance of the objective circumstances of the offence and mistakenly places all the sentencing eggs in the basket marked 'psychological make-up of the offender'.

Little time has been devoted to the question of whether the aim of criminal punishment is essentially retributive or essentially preventive. The question is misleading, for it assumes that the choice of one necessarily excludes the application of the other. The view taken here is that retribution or just deserts, as it is preferred to be called, has a preventive function. As Ross points out 'there can surely be no doubt that awareness that someone will avenge himself, just as much as the awareness that he will defend himself, has a deterrent effect upon the aggressive aims of others'.[377] Indeed if the application of just deserts as a general policy in sentencing did not also have a preventive function then it would not be a policy worth pursuing.

Legislators may have foremost in their minds utilitarian values when defining crimes and prescribing penalties but the sentencer must interpret these primarily through the application of principles of just deserts. Thus the method for achieving the preventive effect of the criminal law is through the application of the just desert principle. To expect the courts as a general policy to adopt any other course is to open the floodgates of discretionary abuse and arbitrary decision-making. Any alternative policy would fail to adequately reflect in the sentencing decision the seriousness of the offence, promote respect for the law and provide consistently fair and relatively certain penalties for those who are unfortunate enough to be confronted by the sentencing court.

If the penalty commensurate with the gravity of the offence is not sufficient how is the community to be protected? It has been argued that the principle of just deserts demands that consideration of dangerousness alone should not prevent the return of

377. A. Ross, *On Guilt, Responsibility and Punishment*, (Stevens & Sons, London, 1975), pp. 29 and 129.
378. Hyman Gross, *op. cit.*, n. 294, p. 10.5.

the prisoner to the community at the expiration of the sentence fixed by the court, and that without further justification, to extend the sentence beyond the just deserts limit is little more than a form of tyranny. Indeed recidivist provisions, that punish offenders not only in respect of their immediate crimes but also on the basis of their past record or upon predictions of further criminal behaviour, have been described most aptly as 'extreme measures at the outer fringes of the criminal law' that are best viewed 'as crude counterparts of civil commitment carried on under the aegis of the criminal law'.[378]

It is submitted that any measure which calls for punishment over and above that which is deserved, though it be for social defence purposes, is foreign to the objects of the criminal law and should therefore not be associated with it. In other words, once punishment has been limited in accordance with 'an evaluation of an offender's moral responsibility for his crime'[379] the opportunities for affording added protection to the community under the criminal law are exhausted.

That this should be so helps to explain the essential difference between punitive and non-punitive forms of coercion. Both forms serve utilitarian ends, but only one applies retributive principles which at once are intentionally symbolic, condemnatory, denunciatory and limited in application. For the reasons given therefore, preventive detention should be relegated to the civil side of the 'protection of the community' ledger, and should no longer constitute an integral part of the criminal law.

Accordingly there is only one way in which it may be proper to detain offenders beyond the expiry date of their sentences, and that is upon condition that they satisfy the involuntary commitment criteria applicable to civil patients. Once the term of imprisonment has come to an end the detainee should be entitled henceforth to be treated in the same manner as any other civilian, with the same obligations, rights and privileges. Furthermore, if the prisoner is certified mentally ill at the end of the sentence, his or her status must change from that of prisoner or forensic patient to that of patient *simpliciter.*

379. *R.* v. *Anderson* [1981] V.R. 155, 161.

If the offender is already being treated in a mental institution at the expiration of the sentence, it may then be desirable that there should be separate enquiry to determine whether continued detention in the mental institution is warranted. Unless the inmate satisfies the rigours of civil commitment criteria, he or she should be released forthwith. The inmate should, of course, always have the option of remaining at the institution as a voluntary patient if further treatment is warranted.

Where ex-offenders have residual mental health problems at the expiration of their sentences but their problems are not sufficiently serious to warrant involuntary hospitalisation, the best solution is to provide them with the opportunity of accepting the sanctuary of a half-way house where the goal of gradual adjustment to the community may be pursued. Therapeutic support may be provided during this critical period, including assistance from parole officers or voluntary agencies. Ultimately such support would depend upon the availability of relevant resources and upon the patient's needs, desires and motivations with respect to these. An institution modelled on the lines of Watson psychiatric hostel[380] is the type of facility that could provide the necessary support for such releasees.

Where civil commitment extends the period of forced detention beyond the expiration date of the sentence, the most careful scrutiny and vigilance is required to ensure that persons subject to this procedure are not detained unjustifiably. In the vast majority of cases however, it will be preferable to release offenders into the community even though in individual cases there may be a high expectation of recidivism, including the risk of future dangerous criminal behaviour.

Those who commit crimes effectively place themselves in a position of vulnerability. For crimes, if proven, provide the State with the authority – the right if not also the duty – to punish those who commit them. However, the level of punishment that may be imposed in respect of a particular crime is strictly limited to that prescribed by legislation, as modified, usually downward, through the proper application of common law sentencing principles. The less severe and repressive the society the greater its tolerance of deviant and idiosyncratic behaviour. This applies to society's

380. Discussed *supra*, Ch. 5.

definition of what constitutes a criminal act, just as it applies to the level of punishment that is deemed appropriate for a criminal act.

Indeed it is principally with the object of maximising freedom from interference that it is considered necessary to have a criminal law at all, with its attendant penal sanctions. The corollary of this proposition is that it is outside the object of the criminal law to impose punishment, whether in degree or in kind, that is outside the limits deemed appropriate for the particular offence. This is so, if for no other reason than that it is plainly counterproductive to the maximisation of individual freedom to use more force than is absolutely necessary. Such a policy would not reduce harm in society but increase it. Rather than promote individual freedom it would threaten and restrict it.

Ultimately, it is the proportionality principle of sentencing that holds the key for limiting the quantum of the sanction that may be imposed upon a particular offender who has been convicted of a particular offence. It is through the application of this principle that justice, consistency and fairness may best be promoted and the delicate balance struck between the proper application of force by the State and the rights and duties of its citizens. The name of the game is the right to be free from interference – a right safeguarded, not only by conferring upon the State power to regulate society in accordance with its prescriptions, but also by ensuring that this power is used only where appropriate, and only to the extent that it is appropriate.

Indeed, unless the authority of the State is limited, carefully defined and controlled, a point is reached where it is not the deviant actor but the State itself that emerges, often imperceptibly as the greatest threat to the liberty of the individual. For this reason the sometimes awesome power of the State should seek to protect, not victimise the weak, the poor, the inarticulate and the mentally incompetent. It should ensure that when power is directed against such persons, as indeed when directed against any citizen over whom it exercises jurisdiction, that it does so reluctantly, cautiously, minimally, even-handedly, and above all with humanity.

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n. refers to running footnotes