Criminal Justice and Public Health

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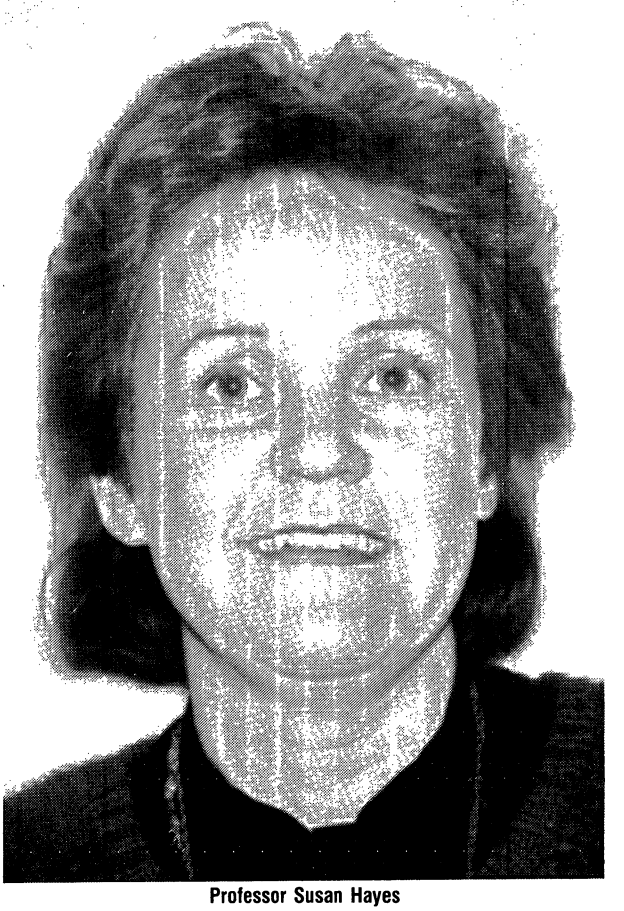

Professor Susan Hayes

THE husband and wife team of Dr Robert A. Hayes and Professor Susan Hayes presented a paper to the Adelaide conference on "Criminal Justice and Public Health." It was a most interesting paper, presented with considerable verve by the male member of the team. It is with great pleasure that we reproduce that paper here.

Dr Robert Hayes is a lawyer. He has been Associate Professor of Law at the University of New South Wales and also a member of the Australian Law Reform Commission. Two of the major projects upon which he has worked for the Commission are the Report on Privacy and the Report on Spent Convictions. He has done a great deal of work on medico-legal problems and, with his wife, is the co-author of two books relating to the problems of the intellectually disabled offender in the criminal justice system.

Professor Susan Hayes is a psychologist and is head of the Department of Behavioural Sciences in Medicine at the University of Sydney. Her professional work has included periods as Honorary Psychologist at the Royal Alexandra Hospital for Children and the Westmead Centre. She has been a member of the Intellectually Handicapped Persons Review Tribunal Panel and a part-time Commissioner of the Corrective Services Commission (NSW). She has very considerable experience, both in Australia and overseas, and she has devoted much of her time to honorary work.

The Hayes family includes four children and, with all their various activities, it seems little wonder that one of the principal interests of the parents is in physical fitness!

They have combined to produce a most thought-provoking paper.

Paper presented at Conference on
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jointly convened by the Australian Crime Prevention Council; International Prisoner's Aid Association and the World Society of Victimology,
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THE thrust of this paper will be the significant gaps in the criminal justice system which appear when it is called upon to deal with persons of less than full health. The gaps, and the difficulties which arise for those working in the criminal justice system — lawyers, medical practitioners and other expert witnesses, judges and magistrates, police, mental health personnel, prison medical services, and correctional staff in custodial settings as well as in probation and parole — occur in two identifiable areas:

1. Court proceedings
2. Disposition of offenders.

This paper will examine the kinds of difficulties occurring in these areas, and the competing pressures based on society's norms and expectations which render decision-making so vexed. Lastly, some directions for reform, and resulution of the competing dilemmas will be presented for consideration.

THE COMPETING PRINCIPLES

Before we examine those areas of the criminal justice system which are fraught with difficulty, it is important to realise that in the areas which are the focus of this paper — mental illness, intellectual handicap, behaviour disorder, drug and alcohol addiction, and sexually transmitted diseases — there is no clear and shining star to follow. A whole galaxy of stars shed a glimmer of light. When choosing one to steer by, the others cannot be ignored. One of the virtues of the criminal justice system is its ability to balance competing interests in an individual case; whereas one of its frustrations is that it might not provide much light to guide the travellers in the next caravan.

What are the important principles?

(a) A person should not be punished for being in a state of ill health. Contradicting this principle are quarantine laws enabling the incarceration of a person suspected of having an infectious disease; as well as laws providing sanctions and punishment for persons who wilfully spread disease.

(b) Hospitals should not be institutions of social control. However, for offenders who are unable to take responsibility for their actions owing to ill health, hospital admission may not only be humane and desirable for the individual, but also necessary for the protection of society.

(c) Persons who are unable to take responsibility for their actions should not suffer criminal penalties. But how can society excuse those individuals whose self-inflicted impairment (eg through drugs or alcohol) results in harm to others?

(d) Information about an accused's emotional and personal problems, mental health, intellectual abilities, physical health, and infectious diseases are important to the sentencing process, as well as their management in a community or prison setting. Nevertheless, an individual's right to privacy must be respected. An example is the intellectually handicapped prisoner who is reluctant to be identified as having deficits, and to be singled out for special programmes, preferring instead to survive in the best way possible in the prison mainstream.

(e) Similarly, the individual's rights, including the claim to privacy, are sometimes in conflict with the principle of the common good. This issue was resolved for the common good in relation to diseases such as tuberculosis and syphilis . . . . screening tests and mandatory treatment were seen as acceptable and desirable. The same dilemma is less clearcut for AIDS sufferers because of the lack of recognised treatment or cure. Resolution of this conflict appears to be in the direction of treating **all** of the population as being potentially AIDS antibody positive and taking appropriate precautions.

(f) The principles of normalisation (ie making available to intellectually handicapped people the norms and patterns of everyday living) and integration into the community are to some extent subverted by the need for special programmes and services. Resolution of this dilemma is by making normalisation a goal rather than a means to an end — special services may be required in order to bring the individual closer to the ultimate goal of normalisation.

(g) The principle that the least restrictive alternative should guide treatment is in the correctional setting, set in opposition to the need for protection of society.

THE corrosive effect of competing community expectations is illustrated by the fact that one error in classification leading to re-offending by a convicted killer or sex offender, for example, completely obliterates the hundreds of successful *"risks"* in rehabilitation of offenders, and is exploited unmercifully by Opposition Members of Parliament for their own selfish ends of embarrassing the Government. Totally obliterated in this war of words are the individuals (and their families) who suffer the backlash and are placed under a level of security which is not warranted, nor which in the end is helpful or productive for society.

As the issues in health and the criminal justice system are discussed, these competing principles and expectations constantly resurface.

THE DIFFICULT AREAS

1. Court Proceedings

Criminal justice, as a dynamic, evolving system, has had to cope with new problems and challenges which were simply unknown a century or even 50 years ago. Many of the new problems have arisen from advances in medical knowledge, eg greater sophistication of diagnosis, or differential diagnoses of conditions which were heretofore treated in the same way. Difficulties also arise from changes in society's values and expectations about treatment. One hundred years ago, it was considered humane and caring to incarcerate imbeciles and lunatics in asylums to protect them from exploitation in the community and to provide a calm, stress-free environment. Now, removal from the mainstream of society is viewed as segregationist, discriminatory, and a dangerous infringement of civil liberties.

Areas where health becomes an issue in the court proceedings include the following situations:

(a) Cases where a person's physical health is relevant to pleading, or sentencing.

Examples might include where the accused has a heart condition which would affect decisions about whether or not a custodial sentence would be appropriate. Or a physical disability such as being wheelchair-bound may rule out some sentencing options including a prison with no disabled access, or some kinds of community service order which the disabled person would find difficulty in fulfilling owing to environmental problems. A further example is where the accused's physical disability could be relevant to *mens rea,* eg an epileptic who commits a violent assault during a fit or during a period of amnesia following a seizure.

This problem area does not rate a high profile, except perhaps with the accused and with the judge who must decide how the issue of physical health is relevant. Comparatively few cases occur, and where they do, the range of sentencing options available to judges can be utilised in a flexible way. The major issues to be addressed are (a) to what extent is the physical disability a mitigating or contributing factor, and (b) which sentencing option will best meet the requirements of justice and

protection of the community, but at the same time not further impair or cause actual harm to the offender?

(b) Cases where a person's intellectual or psychiatric handicap is relevant to pleading or sentencing.

We have expressed our views elsewhere [1] on the discrimination, misunderstanding and mistreatment which befalls an intellectually handicapped person who becomes involved in the criminal justice system. Others have described the problems of mentally ill people in this context. [2] The Law Reform Commission of Western Australia has recently issued a discussion paper which raises the issues pertinent to the criminal process and persons suffering from mental disorder, and calls for public discussion. [3]

Problems facing the mentally disordered offender (to use an umbrella term) during progress through the criminal justice system include:

- lack of recognition by police during apprehension and questioning, sometimes resulting in curtailment of pretrial rights, erroneous evidence being led, or misleading confessions;
- lack of automatic pretrial or presentence multi-disciplinary assessments and reports to assist the court;
- lack of recognition of the presence of mental disorder by lawyers and judges, which can result in inadequate representation, and in proceedings eg, cross-examination in court, being conducted in an unfair and prejudicial way;
- the de facto onus being placed on the accused to raise the issue of mental disorder;
- lack of appropriate services in the community and in custodial institutions, so that even where the presence of mental abnormality is recognised the judge may not be able to locate suitable resources and is forced to sentence the offender to a more restrictive alternative than is desirable;
- the possibility of diversion out of the criminal justice system into a security hospital, until the accused is fit to plead; or on the grounds of being found not guilty on the ground of insanity.

A brief digression is appropriate to discuss the implications of what is in effect an indeterminate sentence, ie where the accused is found unfit to plead, or not guilty on the ground of insanity (the terminology varies according to the jurisdiction). Recent amendments to the NSW Crimes Act 1900 provide a useful model. Under the new part XI A of the Act, there is a comprehensive scheme for dealing with an accused person who is unfit to be tried.

The first stage, when the issue of fitness to be tried is raised in a Court enquiry as to fitness. If the accused is found unfit, he or she must be referred to the Mental Health Review Tribunal for determination as to whether he or she will be fit to be tried within 12 months. If the Tribunal finds that the person will not be fit to be tried, then the Court which conducted the enquiry must conduct a special hearing, the purpose of which being to decide, on the basis of the available evidence, whether the person committed the offence charged, or whether he or she was not guilty of the offence charged. It is also open to the Court to find the person not guilty on the ground of mental illness. Where the Court makes a qualified finding of guilt, this does not amount to a conviction. The Court must nominate an appropriate *"limiting term"*, being the best estimate of the head sentence appropriate to a conviction on the charges. The accused is then referred back to the Mental Health Review Tribunal for determination of whether he or she is mentally ill, or suffering from a mental condition for which treatment is available in a hospital. If the person is mentally ill or consents to medical treatment for his or her condition, the Tribunal must order that the person be detained in a hospital. The Mental Health Tribunal has a continuing role in the assessment of an accused, and may request that a further enquiry be held if it believes that a person is fit to be tried. (There are separate procedures for determining fitness in respect of a person tried summarily, but space prevents details being given here.)

A *"trial of the facts"* such as is possible under the NSW Crimes (Mental Disorder Amendment) Act 1983 is one solution to the very grave consequences which can arise when a mentally abnormal accused is held for an indeterminate period at the Governor's Pleasure, and suffers not only a longer period of incarceration than would have occurred had sentence been passed, but also from being outside the mainstream of penal reform.

(c) Cases where infectious disease (eg AIDS) or self-inflicted impairment of physical and mental abilities (eg through alcohol or drugs) is relevant to criminal responsibility.

The criminal justice system is unfortunately the system which collects those individuals for whom all other systems in society have failed. So far it has confined its husbandry mainly to mentally ill and intellectually handicapped offenders. Other categories — including AIDS sufferers, and drug and alcohol addicts — are likely to be added to the list of those for whom the criminal justice system is the last and sometimes the only resort. There is a fine but highly significant line between providing appropriate treatment and resources, and forcing individuals to undergo treatment for *"deviant"* behaviour. The criminal justice system is an agent for social control. What needs careful consideration is **how** the social control is undertaken; **who** is to be socially controlled; and to **what extent** are the individual's civil liberties to be allowed to be curtailed, for the so-called good of society.

These competing principles have already been mentioned. At this point, it is appropriate to look at some of the social control functions already accepted in the criminal justice system.

The social control function is available only in cases where an individual has breached the law — with the proviso that over the years, *"illegal"* behaviour has varied.

> *"Criminal law should only be used as an instrument of social control, if at all, on the basis of a conviction. Once a person has been found not guilty of a criminal offence, for whatever reasons, the criminal justice system should not deal with that person,"* [4]

The Law Reform Commission of Victoria, having taken the high moral ground by reaffirming the basic doctrine, even for those unable to control their actions because of gross self-induced intoxication, that a person is not guilty of a crime unless the act was done voluntarily or intentionally, takes solace from the fact that there have been few acquittals, that a trial judge need only open the possibility to the jury in cases of extreme intoxication, and that in any event juries are reluctant to accept that an offender was so grossly intoxicated as not to have acted voluntarily and intentionally. [5] This is rather like the housekeeper who takes a soft line with the children knowing that the parent will have the last, harsh word.

The limitations of a defence based on self-inflicted ill health are seen in the public's and the Court's attitude that in such a situation the accused cannot be seen as completely blameless. Gibbs J. (as he then was) in **O'Connor** [6] stated that:

> *"Crimes of violence committed by persons while intoxicated have never been uncommon, and the increase in drug-taking in the community today has made the problem evem more serious. The law would afford quite inadequate protection to the individual, and would rightly be held in contempt, if persons completely under the influence of drink or drugs could commit crimes with impunity."*

The Law Reform Commission of Victoria endorsed the principle that the jury should consider whether the Crown had proved beyond reasonable doubt that the accused acted voluntarily and intended to commit the offence. It then went on to consider whether changes in sentencing options were needed to deal with possible criminal acts which were involuntary or unintentional owing to gross intoxication. [7]

One option canvassed was the detention of the perpetrator for treatment, similar to a *"not guilty but insane"* finding. The Commission sensibly rejected this. The concept of indeterminate *"sentences"* at the Governor's Pleasure has wrought sufficient havoc for the intellectually handicapped or mentally ill accused without introducing it into the drug and alcohol arena.

There is no doubt that a close correlation exists between drug and alcohol consumption and criminal activity. [8]

One study found that alcohol/drug involvement in a sample of prisoners amounted to 94%. Nevertheless, the superficially attractive notion of compulsory treatment has many pitfalls — invasions of individual rights, problems with motivation and genuine participation, and questions as to whether such compulsory treatment is properly a health or corrective services responsibility (each with its attendant limitations of the "contract" with the offender and possible conflict of interest).

Hospital or guardianship orders are one possibility for sentencing such offenders. Hospital orders authorising detention of an offender in a specified institution exist in one form or other in Victoria, Queensland, South Australia, Tasmania, Western Australia and the Northern Territory. The major difficulty lies with the conflict between punitive and treatment goals. In reality, the punitive goal overwhelms the other, because the individual loses his/her liberty and some civil rights. [9] It is essential that rules securing natural justice be developed for the administration of treatment and medication. Mechanisms are required for review, transfer and release, so that the *"punishment"* does not exceed that which is an appropriate sentence for the crime.

Guardianship orders place the individual under the guardianship of a board (if one exists) or an individual, and exist in Tasmania and NSW. The possible infringements of natural justice and civil liberties which can occur with hospital orders are less likely to occur with guardianship orders because the offender is in the community and therefore has available the normal checks and balances against inhumane, illegal, or unnecessary interference with the offender's rights. Guardianship orders can allow the court to impose appropriate treatment, supervision and residential conditions, and therefore are appropriate particularly for groups who would be at risk in prison, eg intellectually handicapped, or young offenders. The imposition of restrictions on freedom of movement and choice, however, require that a system of review be established.

The criminal justice system is currently grappling with the new phenomenon of criminal liability where there have been deliberate attempts to infect another person with AIDS. In NSW there is a case pending of an accused charged with allegedly attempting to murder two policemen by biting them. In Los Angeles, a man who allegedly knowingly sold his AIDS infected blood to a blood bank has been arrested on suspicion of attempted murder. [10] A hospital order hardly seems appropriate, since there is only palliative or symptomatic treatment and no cure. A guardianship order does not meet society's need for protection from such deliberate acts of spreading infection. It seems once again that the prison system (and in particular, the prison medical service) will provide the final repository.

2. *Disposition of Offenders*

Despite sentencing options which can divert offenders into community-based punishment, hospitals, or periodic detention, the fact still remains that a number of offenders are sentenced to prison terms when either (i) prison is an inappropriate placement (eg intellectually handicapped and mentally ill offenders), (ii) the prison placement is made very difficult for the custodians, because of commitant diseases (eg AIDS) or behaviour problems needing special management. Some of these issues are discussed below:

(a) The AIDS Problem

(i) **Prison Health:** A further grave problem for prison administrators is management of AIDS among offenders. The prison population is a very high risk one because of the sharing of intravenous drug needles, the occurrence of homosexual intercourse and rape, and the possibility of violence leading to blood spills. The problem is exacerbated by the rapid passage of offenders — although the NSW prison population is a little over 4000 at any given time, an estimated 15,000 proceed through the system annually and are exposed to the AIDS risk factors mentioned above. A proportion of these people upon release then engage in further risky activities — bisexuality, promiscuous behaviour, and intravenous drug use — which then place their sexual contacts at risk. Thus the ripples spread.

Some prison systems have opted for compulsory testing for the AIDS virus; some have opted for voluntary testing; some, including NSW, do not have large-scale testing programmes. Not one has satisfactorily resolved the issue of what to do with identified AIDS carriers or sufferers. In NSW, there is a small AIDS unit separated from the mainstream of the prison. The disadvantage of such a unit is that prisoners miss out on some of the freedoms and privileges of the normal discipline stream, and so it is an esentially unattractive approach.

As the AIDS problem in prisons grows, the spectre arises of whether it will become necessary, if segregation of AIDS offenders is the chosen route, to have two parallel prison systems to cater for the various categories of sentenced and unsentenced prisoners, and the different security classifications. This would then beg the question of how to treat the non-AIDS strand, since at any given time a fair proportion could be developing the AIDS antibody.

Some other management problems include:

- industrial issues, including selection of custodial staff to work in the *"AIDS prisons"*; and on the other hand, the willingness of officers to distribute condoms;
- possible victimisation of known AIDS sufferers;
- possible attacks by AIDS sufferers on other inmates or on custodial officers;
- reducing the amount of illegal drugs entering gaols, an almost impossible task if contact visits with family and friends are maintained:
- the question of whether or not to issue needles in gaols, thus reducing the risks of sharing needles but effectively condoning illegal practices;
- health education and introduction of preventive programmes for prisoners;
- reduction of violence, and homosexual practices, the latter being achievable only if the goal of one prisoner per cell can be attained.

Some steps have already been taken, and certainly the level of awareness of the risk of AIDS is high amongst custodial staff and inmates. The complex moral and philosophical issues remain largely unresolved, however, and it is up to prison administrators and medical services to do the best they can in a *"band-aid"* situation.

(ii) **Public Health:** An overriding issue is the extent to which the criminal justice system can and should be used to protect public health. According to the *New York Times* [11] Mississipi State

officials recently issued a quarantine order against a male prostitute who is AIDS positive. The order forbidding the man to have sexual relations without informing his partner that he has been exposed to AIDS, came after a grand jury refused to indict him on a felony sodomy charge resulting from his arrest with a prominent businessman in the State capital. Violating provisions of the quarantine, which is of indefinite duration, would make the man subject to a prison term. What are the implications of this for Australia?

There is no doubt that a similar order could be made in Australia, under existing public health, *"disorderly house"* venereal diseases and quarantine legislation. Such legislation enables public health administrators to exercise wide-ranging powers to prevent the spread of infectious diseases. Whilst the powers vary in respect of particular diseases, they extend to detention of infectious persons. [12] In Queensland, the Northern Territory and Western Australia these powers have already been extended to apply to persons suffering from AIDS, [13] and could be introduced in other jurisdictions. For example, existing legislation has been amended to accommodate compulsory medical testing. The only jurisdiction where compulsory medical examinations for suspected AIDS sufferers does not exist is in Victoria. [14]

The existence of provisions like that in s.5ON of the Public Health Act 1902 (NSW) should also be noted. That section makes it unlawful for an AIDS sufferer to have sexual intercourse with another person unless prior to the sexual act the partner has been informed of the risk of contracting AIDS and has voluntarily agreed to accept that risk. Failure to inform a partner of the risk makes the person subject to $5,000 fine. [15]

WHILE one point of view would be that it should not be a crime to be sick, there is already a precedent in the attempts of nearly a century ago to control venereal disease. Public opinion strongly supported VD legislation, notwithstanding its intention of controlling the behaviour of the infected person and the treating practitioner. AIDS differs from VD in the very important fact that there is no cure and therefore no point in compulsory medical treatment, or even quarantine from general social activities. Education for preventive measures is the only option. Nevertheless, as education about the spread of AIDS and safe sexual practices becomes more widespread, the community is likely to seek strong sanctions against those who wilfully flout safe practices and thus place others at risk. The necessary legislation is either in place or can easily be implemented — governments predictably use it to reflect community values. Inevitably, we will find that more AIDS sufferers are present in prison populations. It is important that custodial services in conjunction with prison medical services take a proactive rather than a reactive stance, preparing to put in place a range of options to cater for the different offences committed by AIDS sufferers.

(b) Behaviourally Disordered Offenders

Issues raised by the behavioural disorder are vexed, primarily because of the umbrella nature of the term. It can be used to encompass intellectually handicapped offenders who cannot cope in the prison system, or mentally ill offenders, or sociopaths, or people who are uncooperative and unable to be managed through normal discipline. Whatever the aetiology, it is clearly unfair to custodial staff, fellow prisoners, persons with a behavioural disorder, and the prison medical service to allow the situation to drift on in circumstances where all deny responsibility, but custodial staff are left to cope with problems beyond their levels of expertise and training.

One solution is to create special units, such as the Special Care Unit in the Malabar Correctional Complex at Long Bay.

Specially chosen and inducted custodial staff operate in parallel with mental health expert staff, and inmates have "contracts" with the Unit. The Unit has an impressive record.

It does not, however, cater for intellectually handicapped behaviourally disordered offenders, nor is it large enough to cope with the numbers who need such a service, particularly inmates serving short sentences.

There seems to be evidence that correctional services are proceeding towards increasing numbers of specialist populations — small units with a variety of characteristics need to be established for young offenders, fine defaulters, protection prisoners, segregation prisoners, sex offenders, and those suffering from AIDS, or mental illness, or intellectual handicap. Within each category is the need to provide flexibility and a range of security classifications. This is indeed a multifactorial problem for custodial services, as well as for probation and parole services. Nevertheless, those who establish and run special units and services must never lose sight of the following important principles:

- normalisation
- integration
- the need for the least restrictive alternative
- the requirements of natural justice
- appropriate mechanisms for review of placement and appeal against placement.

DIRECTIONS FOR REFORM

Directions for reform can be seen in two distinct areas of the law itself, and of existing correctional options.

Legislative changes need to incorporate the following:

- curtailment throughout Australia on a uniform basis of indeterminate sentences through introduction of the NSW system of a trial on the facts if an accused is unfit to be tried; and mechanisms for regular review;
- following the Butler Committee recommendations, [16] the possibility of sentencing orders for inpatient and outpatient hospital treatment, and guardianship orders, for mentally abnormal offenders;
- mandatory presentence reports for all first offenders, the reports being based on multidisciplinary assessment, [17] covering the offender's physical and mental health, cognitive abilities, and social and adaptive skills.

In the area of practical sentencing alternatives, the range available to the Courts and to classification services as correctional systems must include:

- the option for differential management of mentally ill and intellectually handicapped offenders;
- increased resources for special education; psychiatric, psychological and behaviour management services; appropriate budgeting and social skills training, sexual and human rela-

tionships programmes, and general *"habilitation"* programmes;

- increased use of community-based disposition, including community service orders, reparation programmes and home-based detention, to provide more meaningful and appropriate punishment without removing a vulnerable offender from his or her community and family support services;
- community-based hostels and *"halfway"* accommodation, staffed by custodial personnel expert in the field of protection both for the vulnerable or ill offender and the community;
- the opportunity for flexibility and revision of sentencing options in the light of changing circumstances and the offender's changing needs;
- small special purpose units within the mainstream of the prison which can cope with the special needs of mentally abnormal offenders, and those in need of protection, without total removal from the general thrust of prison reform, discipline and privileges (the disadvantages of segregated goals for mantally abnormal offenders have been canvassed else-where.) [18]

SUMMARY

It is apparent that the difficulties for society, the criminal justice system and correctional services in dealing with offenders who have mental or physical impairments are destined to increase in future years. There are no easy avenues. Many reforms will confront community values. Changes which seem in the public interest might infringe human rights and civil liberties. Courts and correctional services are compelled to weigh up the competing interests and decide where to draw a line, and this process must be conducted with openness and full acknowledgement of the difficulties and potential dangers.

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5. Ibid., paras 43 and 77.
6. R. v O'Connor (1981) 146 CLR 64, 93.
7. Op cit, section 3, para 44ff, p. 18ff.
8. Op cit footnote 4, para 46, page 19.
9. Potas, op cit, pp 13-14.
10. *Sydney Morning Herald,* 30 June 1987.
11. 13 February 1987, p B4, cd 6.
12. See ACT: Public Health (Infectious and Notifiable Diseases) Regulations, r.7; NSW: Public Health Act 1902, s.32A; NT Notifiable Diseases Act 1981, s.13(2)(a); QLD: Health Act 1937, s.56(2); SA: Health Act 1935; TAS: Public Health Act 1962, s.28; VIC: Health Act 1958, s.128; WA: Health Act 1911, s.323D.
13. Queensland: Health Amendment Act (No.2) 1984, s.2 extends the definition of "venereal disease" to include AIDS, so that a person suffering from AIDS may be dealt with under S.56(2) of the Health Act 1937. Northern Territory: AIDS has been declared by the Minister to be "notifiable disease" within Schedule 3 of the Notifiable Disease Act 1981, so that all the powers in respect of "infected persons", including the power of detention, apply. Western Australia: By virtue of the Health Amendment Act (No.2) 1985 which introduced specific provisions in respect of AIDS, powers of detention were given under s.323D.
14. Diseases Notification Regulations do not declare AIDS to be an infectious disease, only a notifiable disease. Powers in respect of compulsory medical examinations exist only in relation to infectious diseases.
15. See also Health Act 1937 (Qld) s.54(12), which creates a similar offence, penalty being 2 years imprisonment and/or a $10,000 fine.
16. Report of the committee on mentally abnormal offenders, CMND 6244, 1975 (UK).
17. Op cit footnote 1, pp. 89-92.
18. Op cit footnote 1, pp. 139ff.