The Forensic Patient Population in New South Wales[*]

Tessa Boyd-Caine[1] & Duncan Chappell[2]

Introduction

In NSW, the majority of forensic patients have been acquitted of criminal charges on the grounds of mental illness. The finding of not guilty by reason of mental illness is not a finding of innocence; the Court accepts that the person committed the act as charged, but finds that they did not have the requisite responsibility to be found guilty of the crime because of their mental illness. Mental illness acquitees are generally detained for an indefinite period of time in psychiatric hospitals and prisons throughout the State, ostensibly for the treatment of their mental illness and their subsequent rehabilitation prior to being released to the community.

Despite their interaction with the criminal justice system, there is no data publicly available about forensic patients in NSW. As mental illness acquitees, forensic patients are not counted amongst convicted or offender populations. They are excluded from census data on the prison population, and are largely absent from criminological research. Accordingly, very little is known about forensic patients in NSW. There is also very little published analysis and discussion of the forensic mental health system in this State (Hayes et al 1995 & JARG 1987 are amongst the only previously published work specifically on this topic). In particular, there has been minimal attention paid by Australian criminology to the presence of forensic patients in prisons, and to the detention of forensic patients in general.

In this article we seek to focus attention on forensic patients from a criminological perspective. We begin by considering the NSW forensic system in the context of international principles about the treatment of persons with a mental illness. We then present original data about the forensic patient population in NSW. Using data from the inaugural census of forensic patient files held by the Mental Health Review Tribunal (MHRT), we present basic demographics of the current forensic patient population. These include the number of people on forensic orders in NSW, the locations of their detention, and patterns in decision-making about release. We then take a subset of the forensic

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1 BA (Hons), MCrim. At the time of writing Tessa was the Forensic Team Leader, Mental Health Review Tribunal of NSW. She is currently undertaking doctoral research on the release of mentally disordered offenders at the London School of Economics. <T.Boyd-Caine@lse.ac.uk>.

2 BA, LLB, PhD, President, Mental Health Review Tribunal.

population, those who have been involved in an index offence of homicide, and examine their progress through the forensic mental health system. We discuss the detention of forensic patients and question whether this detention is preventative. Given the lack of publicly available information, some of this discussion requires description of the system itself. Our aim is to raise the spectre of the forensic mental health system in NSW for discussion amongst criminologists and other researchers, with particular regard to the issue of detention in this system.

The Treatment of Persons with a Mental Illness: Best Practice for Decision-Making

International law

The key international principles in this jurisdiction are established in the United Nations 'Principles for the protection of persons with mental illness and the improvement of mental health care' (UN 1991). These principles set out the expected standards for care and treatment; for patient rights; and for decision making in relation to persons with a mental illness. For the purpose of this article, we focus on the decision-making principle. Principle 17 establishes decision-making by review bodies as follows:

> The review body shall be a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law. It shall, in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account (UN 1991: principle 17).

Different jurisdictions apply these principles in various ways, often utilising a combination of court and Tribunal processes. For instance in Canada the *Criminal Code* provides for the court hearing the criminal matter to make dispositional orders in relation to persons who have been found unfit to be tried or not criminally responsible on account of mental disorder. Dispositional orders available include conditional or absolute discharge, or ongoing detention in a hospital. The determinative power to review those orders, or to make such orders where the court has not, lies with the regional Review Boards (*Criminal Code*: s672.38(1)).

In New Zealand, Review Tribunals review orders for compulsory detention and treatment of 'restricted patients'.[3] If the Tribunal determines that a person is no longer in need of compulsory treatment, the patient must be released accordingly [*Mental Health (Compulsory Assessment and Treatment) Act* 1992 (New Zealand): s81(4)(a) & (b)]. However if the Tribunal is of the view that the person continues to require compulsory treatment but no longer need be declared a restricted patient, the ultimate decision about release from restricted status lies with the Minister for Health, in consultation with the Attorney-General [ibid: s81(7)].

Domestic law

In Australia, the principle of judicial or independent decision-making has been reflected in the recommendations of numerous reports and inquiries, most notably in the 1993 report of the Human Rights and Equal Opportunity Commission's 'National Inquiry into the Human Rights of People with a Mental Illness' (the Burdekin Report) (HREOC 1993). The

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3 A restricted patient is one who 'presents special difficulties because of the danger he or she poses to others' as determined by a court [*Mental Health (Compulsory Assessment and Treatment) Act* 1992 (New Zealand): s55].

Burdekin Report recommended that decisions about the discharge of forensic patients should be made by an independent body and not at a political level (ibid; see also Chappell 2004).

In practice, independent and judicial decision-making has been adopted in varying ways in most Australian jurisdictions. In Queensland there are two institutions involved in the decision-making about forensic patients: the Mental Health Review Tribunal (*Mental Health Act* 2000: ss200–207), and the Mental Health Court (ibid: ss288–298). Both bodies are independent and have determinative powers at different points in the decision-making processes for forensic patients.

In Victoria, under the *Crimes (Mental Impairment and Unfitness to be tried) Act* 1997 (Vic) there are a number of decision-making bodies for forensic patients. Decision-makers include the Supreme Court; a panel comprised of judicial officers of the Supreme Court, the chief psychiatrist and other members as required; or the Secretary of the Department of Human Services. Additionally, under the Victorian *Mental Health Act* 1986 the Mental Health Review Board has the power to hear appeals by security patients.[4] In other Australian jurisdictions, courts or tribunals have a range of powers in the decision-making about, and management of forensic patients.

New South Wales: A Legacy of Detention at the Governor's Pleasure

The forensic mental health system in NSW sits in contrast to the principles of independent decision-making established above. However, to understand the decision-making process in NSW, it is first necessary to establish what forensic status is, and how it is attained.

Forensic patients have undergone criminal proceedings in the higher courts, that is the District or Supreme Courts. The criminal proceedings that lead to forensic status are set out in the *Mental Health (Criminal Procedure) Act* 1990 (NSW) (hereafter MHCPA). Once a person has become a forensic patient, they are detained under the *Mental Health Act* 1990 (NSW) (hereafter MHA). Forensic status is established through the following four categories.

i. Not guilty by reason of mental illness (NGMI) (MHA s39)

The Court has accepted that the person committed the act charged, but does not have the capacity to be found criminally responsible due to their mental illness. The finding is an acquittal. There is no conviction recorded, however there is usually a resultant period of detention in a hospital or prison. The court can also release the person to the community, either with or without conditions.[5] For persons found not guilty by reason of mental illness and detained or released on conditions, they receive an indefinite forensic order.

ii. Fitness (MHCPA ss14, 16)

A person may be found by a court to be unfit to stand trial if they are not capable of following the legal proceedings or giving instructions in defence of the charges against them. Fitness patients require a determination from the MHRT as to their likelihood of

4 'Security patients' are persons serving a sentence and transferred into the mental health system for the purpose of compulsory treatment of a mental illness.

5 This recently acquired power is the result of a 2003 amendment to the *Mental Health (Criminal Procedure) Act* 1990 (NSW).

becoming fit within one year. From this determination the matter may be referred to a special hearing or may be kept in obeisance to allow time for the person to become fit.

iii. Persons transferred from prison (transferees) (MHA s97)
A prison inmate, either on remand or sentenced, may be transferred into the mental health system for involuntary care and treatment of their mental illness in a hospital.

iv. Limiting term (MHCPA s24)
Following a special hearing, the Court finds that on the limited evidence available, the person committed the offence. This is a qualified finding of guilt. The person is given a finite period of detention reflecting the sentence the person would have received had they been found guilty of the offence charged in a full criminal trial.

Generally, forensic patients spend an initial period of detention in a secure psychiatric facility. They then move through a process of leave privileges, towards less restrictive conditions of detention, until they are conditionally released to live in the community under the care of a community mental health team. Once a person has demonstrated their ability to reside in the community safely, they may be considered for unconditional release and the ultimate discharge of their forensic order.

The role of the MHRT in this system is to provide ongoing review of the care, treatment and detention or release of forensic patients. Following these reviews, the Tribunal makes recommendations to the Minister for Health. The Minister for Health and the Governor acting on the advice of the Executive Council make the decisions about the conditions of detention and the release of forensic patients in NSW. Thus the forensic patient decision-making process is a political one, where determinations about detention, leave privileges and release are made by the executive. The one exception to this decision-making framework is the area of fitness, in which the Tribunal's jurisdiction is determinative. In all other decisions about forensic patients, the government makes determinations about forensic patients following, although not necessarily in accordance with, recommendations of the MHRT.

This system is unique in Australia, and is a legacy of detention at the governor's pleasure. Even in NSW, the civil jurisdiction of the MHRT is determinative, requiring the Tribunal to make decisions about the involuntary treatment of people with a mental illness in civil hospitals. It is only the forensic jurisdiction that requires decision-making by the executive. As stated above, principle 17 of the UN Principles for the protection of persons with mental illness and the improvement of mental health care requires judicial or independent decision-making about patients detained for compulsory treatment (UN 1991). Moreover, this principle was recommended by the key national inquiry in this area, the Burdekin Report (HREOC 1993). Thus the system of decision-making about forensic patients in NSW contravenes both international law and the recommendation of a national inquiry into the human rights of patients receiving compulsory mental health care.

The Question of Risk

A key principle of the MHA is that detention of people with a mental illness or disorder must be in the least restrictive environment possible to ensure effective treatment (MHA s4(2)(a)&(b)). The intended operating principle underlying the forensic process is that the length of time required for compulsory treatment should be determined by a patient's responsiveness to that treatment, as much as by the nature of their forensic incident and any risk of dangerousness posed by the patient. However, decisions about the release of forensic patients must also take into account that 'the safety of the patient or any member of the

public will not be seriously endangered by the person's release' (MHA s82). In practice, the Tribunal also has regard to risk of dangerousness to the individual or the public in the consideration of leave privileges and less restrictive conditions of detention, as well as in the consideration of release. From our observations the consideration of risk, as represented by the concern for community safety is the dominant factor in the executive decision-making process. Ministerial correspondence, particularly in the form of statements of reasons provided by the Minister for Health, indicate that priority is placed on the nature of the index offence as a determinant factor in how long a patient ought to spend in compulsory treatment.

In recent years, and as a response to the emerging emphasis placed on risk by the executive, the NSW forensic mental health system has become increasingly dominated by the practice of risk assessment. Some psychiatrists have argued that consideration of the dangerousness of their patients has always been an aspect of psychiatric care (Mullen 2002). However there has been an emphasis on a more formal assessment of risk emerging in both the Ministerial correspondence in particular forensic cases in NSW, and at a policy level. In 2003 the Department of Health distributed a policy document outlining how risk assessment should be conducted on forensic patients (NSW Health 2003). The document, a guideline for mental health practitioners involved in the care and treatment of forensic patients, included as an appendix an actuarial tool that may be used in the assessment of risk, and particularly when seeking less restrictive conditions of detention or release. Whilst this guideline was not proscriptive on practitioners, it clearly showed the Government's priority on assessing risk of forensic patients, and the political support for the use of actuarial tools in assessing risk. Increasingly since that time, Ministerial reasons for rejection of Tribunal recommendations have included the lack of an adequate risk assessment as grounds for the rejection, despite the fact that, in the Tribunal's view, adequate attention had been paid to the assessment of risk in each case.

There is a degree of contentiousness about the reliance upon actuarial risk assessment tools, as prioritised over other forms of assessment. Debate abounds amongst practitioners and researchers to this end in both the fields of criminal justice and mental health (Rice et al 2002). Amongst others, John Monahan, who led the key MacArthur study on mental disorder and violence, has argued that actuarial assessment of risk is more reliable and less subject to human error than clinical assessment of risk (Monahan et al 2001; see also Ogloff 2002). Others have contested this, pointing to the distinction between calculating risks posed by whole populations (such as those who have demonstrated violence in the past), and determining individual risk (Nielssen 2003; Mullen 2002). Whilst actuarial risk assessment may be helpful in anticipating risk amongst populations, they argue, clinical risk assessment based on intimate knowledge of the patient's history is a more thorough method of anticipating individual risk and devising a program to manage that risk.

The reality of political decision-making in the NSW forensic system leaves little room for debate about the appropriateness of actuarial risk assessment, nor for a nuanced approach to the interpretation of risk assessments. For all the contention about what these tools actually reveal, they do facilitate the production of a number or percentage relevant to a person's risk. Thus the political priority on protection of the public has led to the widespread practice of risk assessment based on actuarial tools. However an assessment of risk is only as helpful as the management plan it underpins. In practice, and as we will discuss below, limited resources and inadequate staffing mean that risk management becomes something that is done according to the means of the service, rather than according to the needs of the patient.

It is both legally required and appropriate that risk of dangerousness be considered prior to a patient's release. However this ought to be assessed on the basis of the patient's current mental health and rehabilitation, as much as on prior behaviour. To determine release based on the index offence rather than a person's current mental state contradicts the principle of least restrictive care cited above. It also indicates an exercise of preventative detention on the grounds of protection of the public. Whilst it is certainly the case that mental health legislation allows for preventative detention, the need to protect the community should be based primarily on a patient's current mental state and rehabilitation. It ought not to be determined solely on the basis of an offence for which a person has been found not guilty by reason of mental illness.

The Provision of Services

The consideration of risk to the community takes place in a context where inadequate and under-resourced forensic mental health services undermine the ability of treating teams to manage forensic patients adequately. In most jurisdictions in Australia forensic patients are managed in a clinically therapeutic setting. Whilst there are obviously requirements for security in many cases, these needs are not usually met by detention in prison or management by prison or custodial staff. However in NSW, as we will show, a substantial proportion of the forensic population are detained in Long Bay Prison Hospital. This is under the overall management of the Department of Corrective Services, even though Justice Health,[6] who runs the hospital, is a health agency. What this means in practice is that forensic patients are detained in a hospital on prison grounds, under the overall management of the Department of Corrective Services in NSW, and with security provided by custodial staff. Custodial staff are not necessarily trained to work with people with a mental illness. Their primary concern is to ensure the general safety of staff and other patients, which may be at odds with a therapeutic approach to the management of challenging behaviour by people with a mental illness. Working under these constraints poses a considerable challenge to mental health professionals attempting to provide a therapeutic environment for their patients. Moreover for patients at Long Bay Prison Hospital, their access to therapeutic programs and to allied health professionals is severely limited.

The lack of a dedicated secure forensic hospital in NSW is one key obstacle to the delivery of quality mental health services for forensic patients. A hospital is currently being built, and is expected to be operating by 2007–08. In the meantime Long Bay Prison Hospital is the only setting available for high security detention of forensic patients. Even here, lack of beds in this facility means that some forensic patients are actually detained in Long Bay Prison. This includes people acquitted on the grounds of their mental illness, as well as those found unfit to be tried, and those serving a limiting term.

The treatment available for female forensic patients who are acutely ill is even more dire. Until 2003 there was no high-security facility available for the treatment of female transferees; that is women in prison requiring treatment in hospital for their mental illness. Additionally, there has been little provision for the care, treatment and detention of female forensic patients found NGMI, or undergoing fitness proceedings, if they are acutely mentally ill or manifesting aggressive behaviour. Since July 2003 there has been capacity at Long Bay Prison Hospital for up to 9 women. However this requires the frequent movement of women in and out of the hospital to ensure the availability of beds for more acute patients. This is not a facility for long-term treatment in a therapeutic environment. This also requires that these women be treated in a men's hospital in a men's prison.

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6 Formerly the Corrections Health Service.

The poor provision of services to female forensic patients is not unique to the forensic system in NSW. As women make up a small proportion of the forensic system, so this is frequently reflected in the allocation of resources to address their needs. This phenomenon has been addressed by criminologists in relation to women in prison more generally (Carlen 2002; Alder 1998). However in the forensic mental health system the effect is that women with acute mental illness who present management difficulties are distinctly disadvantaged in accessing adequate (including long-term) treatment in a therapeutic setting (for a case study in point see *R v Adams* [2003] NSWSC 142 (14 March 2003)).

Forensic patients with an intellectual disability are another group generally managed within the prison system. Not having a mental illness, they cannot be detained in a hospital under the MHA. However they are detained under the MHA if they are found unfit to stand trial or are set a limiting term. Patients with an intellectual disability are at a distinct disadvantage within the forensic system, being both isolated from treatment opportunities in a clinical context, and often unable to access programs and activities in the prison system. Moreover, whilst the MHRT is able to recommend early release of people serving a limiting term, the lack of community services for people with an intellectual disability and a forensic history means that in practice the Tribunal is rarely able to make such recommendations.

A third group particularly disadvantaged within the forensic system is that of people with a 'dual diagnosis', whereby mental illness affects a person concurrently with either an intellectual disability or a drug or alcohol dependency. In offender populations, the presence of any one of these factors increases the risk of re-offending (Butler & Allnutt 2003). In the forensic population, these factors work to increase the risk both of re-offending and of relapsing a mental illness. However the under-resourcing of the mental health system in NSW prevents adequate, cross-discipline services to meet the dual or multiple needs of these patients.

Climate for Research

There is an established body of literature that has addressed the growing problem of mental illness amongst prisoner populations (Janus 2000; Prins 1995; Monahan & Steadman 1983; Wexler 1976). There is also a significant volume of literature, for instance in the United Kingdom, which looks at forensic patients (mentally disordered offenders) from both clinical and sociological perspectives (see for example Buchanan 2002; Harris 1999; Watson & Grounds 1993). Additional work has considered the role of executive discretion in relation to the human rights of forensic patients (Padfield 2002; Richardson 1993) and has questioned the purpose and effect of constructing forensic patients as a separate legal category to either offenders in the criminal justice system or civil patients in the mental health system (Peay 2002). There have also been several UK studies measuring the success of forensic care and treatment, including as measured by reoffending rates (Padfield 2002; Harris 1999; Dell & Grounds 1995: Watson & Grounds 1993).

Certainly criminal justice agencies in Australia are aware of the treatment and rehabilitative needs of offenders with a mental illness. However there has been very little attention paid specifically to forensic patient populations in Australia, outside of the clinical contexts of psychiatric and psychological study. There is very little information publicly available about how many forensic patients there are; how long they spend in detention; how successful their treatment and rehabilitation is; and to what extent (if at all) they re-offend. Filling this gap in the literature is an ambitious task, and not one that we can undertake in this publication. Our aim in this article is to take an initial step in publishing some basic demographic data about the forensic patient population in NSW. This is intended to build a picture of the forensic patient population, as a starting point for a broader project of criminological inquiry into the management of forensic patients in Australia.

Inaugural Census of Mental Health Review Tribunal (MHRT) Files

Sources of data in this paper

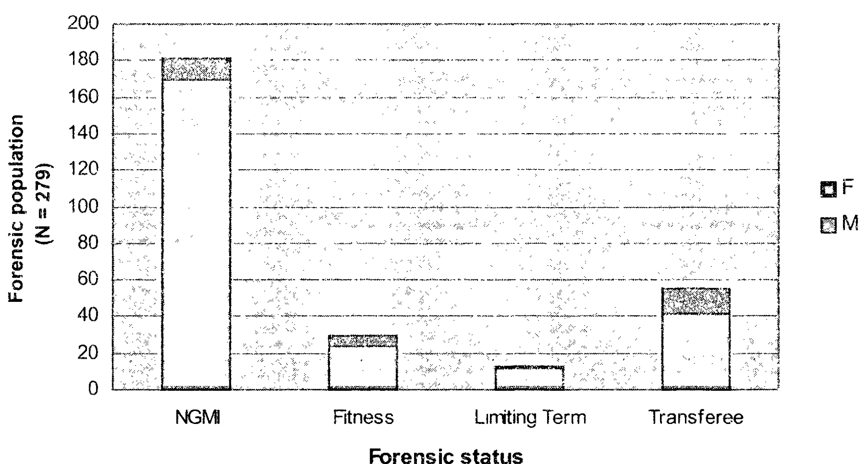
The data presented in this paper comes from a number of MHRT sources. The key source is the inaugural census of MHRT files. The census was conducted on 30 June 2003 by the Forensic Unit of the MHRT. We acknowledge the limitations of census data, particularly in its inability to examine the flow of people through the forensic mental health system. However as this article aims to explain and analyse the forensic mental health system as well as present an overview of the patient population, detailed flow data is beyond the scope of this paper. Trend data from previous years are taken from two public sources: MHRT annual reports from 1991–2003; and the MHRT Submission to the Select Committee Inquiry into Mental Health Services in NSW, 2002. Additional data is taken from the Tribunal's Client Management System.

From the Census data we took a sub-section of the forensic patient population, those associated with an index offence of homicide, and looked at particular trends in that group. The first section of data in this paper addresses the basic demographics of the forensic population in NSW. The second section examines in greater detail forensic patients whose forensic incident was homicide.

Demographics of the forensic population

The forensic population has steadily increased over the 13 years since the proclamation of the MHA in 1990, from approximately 80 in 1991, to approximately 250 in 2002. As the forensic population is relatively fluid, given the movement of people in and out of the categories of fitness and transferee, population data is most reliable taken as a snapshot from a tool such as a census count. The current forensic population as at the census date of 30 June 2003 was 279.

Graph 1: Current forensic population by legal category



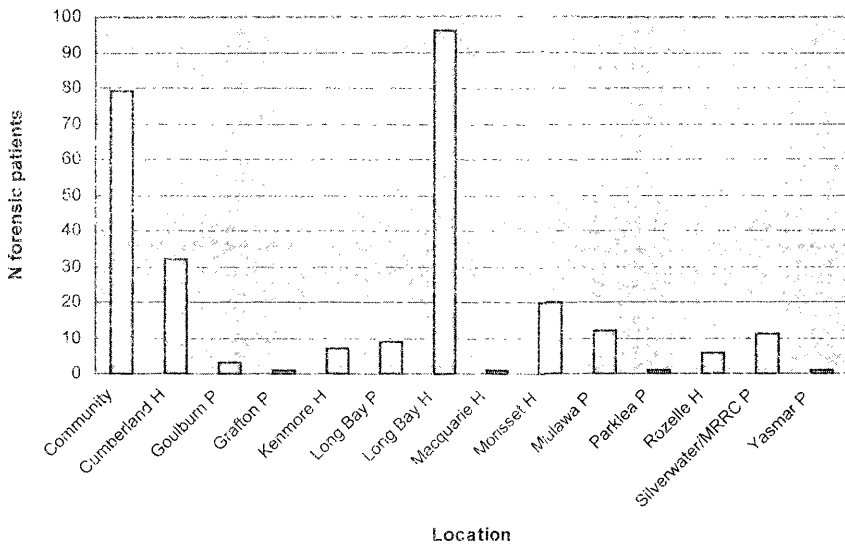
Source: MHRT Census 2003.

This data shows the breakdown of the forensic population by legal category. NGMI's made up the vast majority of forensic patients, at almost 65%. The second-highest category was that of transferees, who represented almost 20% of the forensic population at the time of the census. Whilst we would expect the transferee population to maintain this position as second-highest proportion of forensic patients, the actual number of patients in this category should be treated with caution. Transferees are the most variable element of the forensic patient population, as they only become forensic patients for a finite period of treatment for their mental illness (compared with the indefinite detention of people found NGMI). Unlike other forensic patients, once a transferee is certified as fit to return to prison, they can be returned by the Chief Health Officer and do not require an order from the executive to cease their forensic status.

The fitness population was a much smaller group, representing just over 10% of the total forensic population. As with transferees, the movement of the fitness population is highly fluid. People undergoing fitness proceedings generally only remain in the system for one year, sometimes up to two, whilst the necessary determinations in relation to their fitness are finalised, and their criminal matter is dispensed with. The Tribunal generally sees a large number of fitness forensic patients return with either a finding of NGMI or a limiting term. Finally, people serving limiting terms make up the smallest part of the forensic population, at just less than 5%. Women made up approximately 12% of the total forensic population. This compares with a national average of 6% of the prison population (AIC 2002).

Graph 2: Current forensic population by location

This graph shows the spread of forensic patients at the locations in which they are detained, or in the community if they are on conditional release. Each venue in which a person is detained is marked with a P for prison if it is a correctional facility, including Yasmar Juvenile Justice Centre; and H if it is a hospital.



Source: MHRT Census 2003.

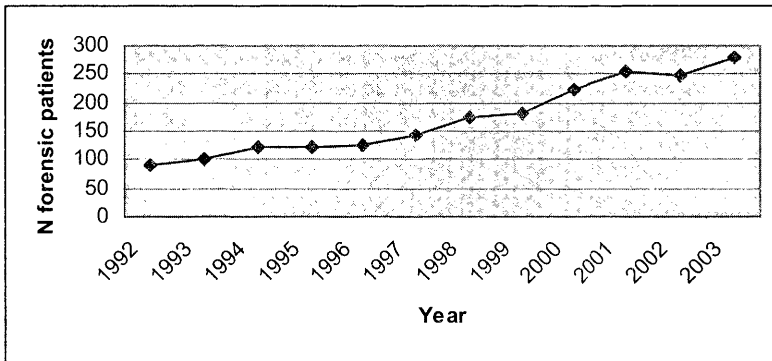
The data on location of forensic patients show the high concentration of most of the population at three locations, and the significant spread of the rest of the population throughout various locations in the State. Almost 35% of the forensic population are detained at Long Bay Prison Hospital, the highest security forensic hospital in NSW. At the time of the census, this population included men only, although women are now detained at this hospital also. The next highest proportion of forensic patients by the category of location are those in the community on conditional release orders. This represents 28% of the forensic population. The Bunya Unit is a locked ward, high-security forensic facility at Cumberland Hospital, which also has provision for extensive leave privileges and transitional release to the community. Just over 11% of the forensic population are detained here. Morisset Hospital has similar facilities ranging from high security to transitional release, and holds 7% of forensic patients. Roughly 20% of the forensic population are detained in the remaining 12 locations throughout the state. These locations include secure psychiatric facilities in civilian hospitals, and prisons.

Generally, forensic patients are detained in hospital or the community, as opposed to a prison. Importantly, forensic patients residing in the community have almost always served significant periods of time in detention, prior to being released on conditions. They have generally progressed through a process of less and less restrictive conditions of detention in a hospital, before attaining release.

However, at the Census almost 10% of forensic patients were being detained in prisons. These facilities included Long Bay Prison, the Metropolitan Reception and Remand Centre, Silverwater Prison, and Yasmar Juvenile Justice Centre. Forensic patients detained in prisons are usually on remand and are undergoing fitness proceedings, or have had schedules signed for involuntary treatment under the MHA and are waiting to be transferred. There are also a number of mental illness acquitees who are detained in prisons. In some cases, these people are no longer presenting symptoms of mental illness but continue to be detained as a result of their forensic incident. In other cases, patients who have breached their conditions of release and have been returned to detention by order of the Minister for Health have been detained in a prison rather than a hospital.

It is Tribunal policy that all forensic patients who have been found not guilty by reason of mental illness should be detained in hospital (MHRT 2004:Item 4.2). This principle is widely held throughout the system and it is the subject of recommendations from the Tribunal in any cases where NGMI's are detained in prison. However the reality is that, like in the civil mental health system, there simply are not enough secure (forensic) mental health beds to meet the demand in the system. There are waiting lists to get into every forensic unit in the state, even when these placements have been approved by the Executive Council. Whilst these constraints have traditionally affected forensic transferee patients and persons serving a limiting term, increasingly they are effecting the placement of mental illness acquitees also. In numerous cases the lack of available and appropriate beds in hospital means that forensic patents are detained in prison against the recommendations of the Tribunal; the wishes of the person's treating psychiatrist; and in contravention of orders made by the courts and the Minister for Health.

Graph 3: Forensic patient population, 1992–2003



Source: MHRT Annual Reports, 1992 –2003.[7]

The trend data in Graph 3 indicates the growth in the forensic patient population from 1992 to the census date. This data represents the total (cumulative) number of forensic patients in the system each year. This data shows that there has been a notable growth in the forensic patient population since the introduction of the MHA, from 90 patients in 1992, to 144 in 1997. By 2003 the forensic patient population had risen to 279.

Whilst there are a number of possible explanations, there simply is no research to explain the growth in the forensic population over this time. General mental health morbidity rates have also increased exponentially over this time, which may be one factor (NSW Health 2002). Another explanation may be a shift in perceptions about the mental health legislation of 1990, as compared with its predecessor. Whilst executive discretion continued, there was nonetheless a perception that the new legislation was more just in terms of the rights of the individual patient. Consequently, more defendants may have chosen to plead the defence of mental illness and take a chance with the indefinite detention that a successful plea would result in. From our own perceptions, the increase is at least in part due to the significant increase in offenders being transferred from prison into the mental health system for compulsory treatment. As Graph 1 shows, the forensic transferee population makes up the second highest proportion of forensic patients, and there has been an increase over time amongst this group. This may well reflect the increased attention paid to the problem of mental illness in prisons; and hence increased use of scheduling under the MHA to transfer inmates into the mental health system for treatment.

The current data point to one other explanation as to the increase in the overall forensic population. There has been a significant burgeoning of the population, based on the fact that as new forensic patients enter the system, existing forensic patients have not been released. The next graphs represent this trend.

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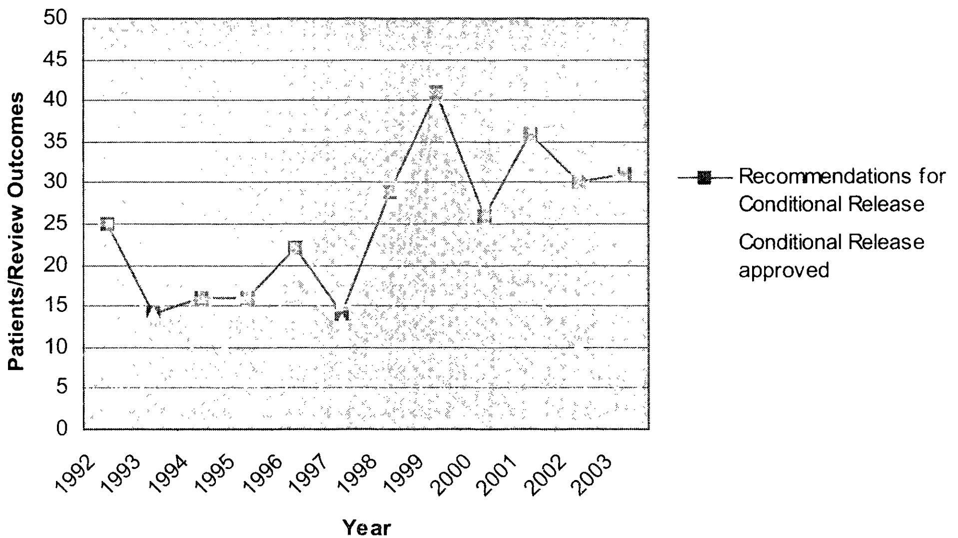
7 Discrepancies in published Annual Report data may occur, due to the fact that data on determinations may not have been complete at the publication date.

Decision-making in the forensic process

Graph 4: Recommendations and determinations for conditional release, 1992–2003



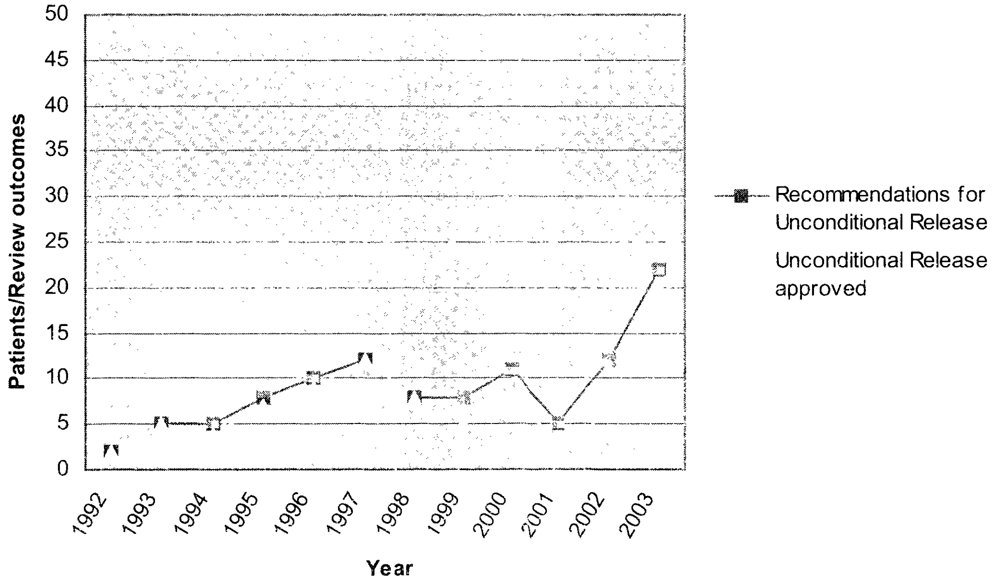
Source: MHRT Annual Reports, 1992 –2003.

In Graph 4, the top line shows recommendations for conditional release made by the Tribunal from 1992 to 2003. The bottom line shows the success of those recommendations as determined by executive approval.

Over this period, the number of people being recommended for release increased marginally. Recommendations for release were fairly static from 1992–1996, and then increased gradually from 1997. There were between 14 and 30 recommendations for conditional release each year during this period. In 1999 there is a notable spike with 41 recommendations for release made. This figure declined in following years, but recommendations for release remained higher than in the first part of the decade. Recommendations for conditional release numbered 26 in 2000; 36 in 2001; 30 in 2002; and 31 in 2003.

The bottom line indicates the approvals by the executive of recommendations for conditional release over the same period. These data indicate that there is a notable gap between the Tribunal's recommendations and their approval by the executive. Determinations for release were fairly static from 1992, even throughout the increase in recommendations for release from 1997–1998. In 1999 there were 39 forensic patients granted conditional release. This accorded with the spike in recommendations for release from that year. However in subsequent years the number of determinations for release dropped significantly, with 18 in 2000, 17 in 2001; 10 in 2002; and 4 in 2003. From 1992–1994, the proportion of forensic patients granted conditional release each year was just over 13% of the forensic population at that time. By contrast, from 2000–2003 forensic patients granted conditional release represented roughly only 6% of the total forensic population at that time.

Graph 5: Recommendations and determinations for unconditional release, 1992–2003



Source: MHRT Annual Reports, 1992 -2003.

Graph 5 shows data on unconditional release by recommendations from the Tribunal (top line) and determinations from the executive (bottom line). Here the gap between recommendations and determinations is notably narrower than for conditional release. The highest number of recommendations for unconditional release occurred in 2003 with 22 patients recommended for unconditional release. However the smallest discrepancy between recommendations and approvals came in 1997 and 1998, with 12 patients recommended for and granted unconditional release. In 1999, 8 people were recommended for unconditional release, and only 5 approved. In subsequent years the figures were as follows: 2000 had 11 recommendations and 8 approvals; 2001 had 5 recommendations and 3 approvals; 2002 had 12 recommendations and 7 approvals; and 2003 had 22 recommendations from which 4 were approved.[8] From 1992–1994 the proportion of forensic patients released entirely from their forensic orders was just over 3% of the forensic population at that time. From 2000–2003 the number of forensic patients unconditionally released represented just under 2% of the forensic population at that time.

It is important to exercise caution in drawing conclusions from these data. For sentenced offenders, courts have guidelines to ensure consistency in sentence relative to offence and extenuating circumstances. By contrast, in the forensic jurisdiction, the progress of each forensic patient is entirely unique. Progress can vary significantly across patients, and is dependent upon accuracy of initial diagnosis, responsiveness to treatment and availability of appropriate therapy. Progress is not necessarily consistent even amongst patients with the same diagnosis, let alone those that differ.

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8 Of these four patients, two were unconditionally released in order to be immediately deported by the Department of Immigration, Multicultural and Indigenous Affairs.

We want to focus on two key points evidenced from these data: the numbers of recommendations for release made by the Tribunal; and the discrepancy between Tribunal recommendations and executive determinations. In relation to the first point, these data indicate that the Tribunal has been relatively conservative in its recommendations for release. As Graph 3 above shows, the forensic patient population has increased dramatically since 1992. Graphs 4 and 5 show that, although the number of recommendations for both conditional and unconditional release have increased slightly over this time, they have not increased in proportion to the increase in the overall patient population. Moreover some years have shown significant spikes and drops in terms of Tribunal recommendations, particularly for conditional release. We conclude from this that although the forensic patient population has experienced a burgeoning from 1992–2003, the Tribunal has continued to recommend release only in those cases where it was considered clinically appropriate for the individual patient's progress. Anecdotally and from our own experience, the Tribunal has been aware of the increasing drain on resources, and the crisis in available beds and care for forensic patients over this time. However the Tribunal has not sought to relieve this crisis by moving patients through the system prematurely.

In relation to the second point, it is clear from these data that there is a discrepancy between the recommendations for release made by the Tribunal, and those that are approved by the executive. Executive determinations for release have almost always been under-representative of recommendations for release, both conditional and unconditional. Additionally, the proportion of forensic patients being granted conditional release has declined markedly, particularly following the spike in releases in 1999. In the early 1990's approximately 13% of the forensic population was granted conditional release each year. In recent years, that figure has more than halved, with only 6% of the population being granted conditional release. At the same time, the number of people being unconditionally released has remained relatively stable, at a rate of between 2%–4% of the population each year.

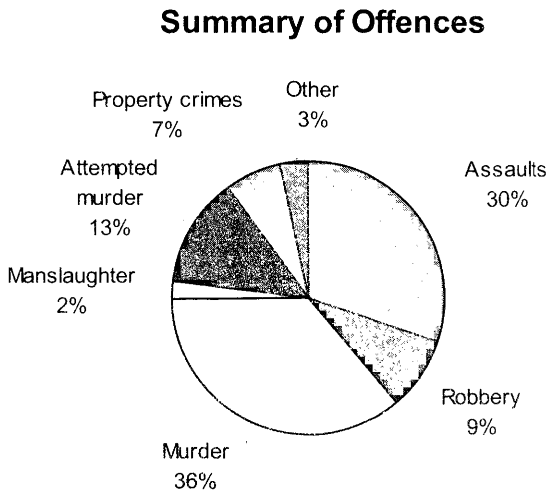
These data clearly indicate that executive approval for release is by no means guaranteed following a Tribunal decision to recommend conditional or unconditional release. The question this raises is why? One possible explanation for this is that the preoccupation with concern about risk posed by patients, as discussed above, is leading to preventative detention of forensic patients beyond the point at which they require detention for compulsory treatment. As we discussed above, the clinical appropriateness of release must be considered in the context of the question of risk the patient poses to themselves or the community. This is a condition on the Tribunal's decision-making, and one which the Tribunal readily adheres to prior to any recommendation for less restrictive detention including release. Despite the Tribunal's assessment on the evidence that certain patients are ready for release, these assessments have not satisfied the concerns of the political decision-makers. This is a question we will explore in greater detail below. We turn now to look at a sub-section of the forensic population, those who committed a homicide-related index offence.

Homicide Study

Offences

Chart 1 indicates the spread of index offences throughout the forensic population at the census date of 30 June 2003.

Chart 1: Summary of offences



This chart represents the breakdown of index offence (as charged) for all current forensic patients where that information is available. As the defence of mental illness is only available in the higher courts, there is an inevitable process of self-selection towards serious and violent index incidents amongst the forensic population. Notably, homicide or attempted homicide comprises just over half of the index offences amongst the current forensic population. In keeping with the accepted definition of homicide in criminological literature, the homicide data presented here includes murder, manslaughter and attempted murder.

In order to examine trends in the length and nature of detention for forensic patients in NSW, we conducted a study of the subset of forensic patients whose index offence was homicide-related. We selected this subset because their index offences are of the most serious type, and because they account for such a large proportion of the forensic population. This subset includes transferees but not fitness patients, as they may subsequently be completely acquitted of the offence. At the census date, patients with a homicide-related index offence numbered 114, or 51% of the forensic population at the time.

The following table shows the breakdown of homicide-related offences amongst the forensic categories of NGMI, transferee and limiting term.

Table 1: Forensic categories of the homicide subset as percentages (number)

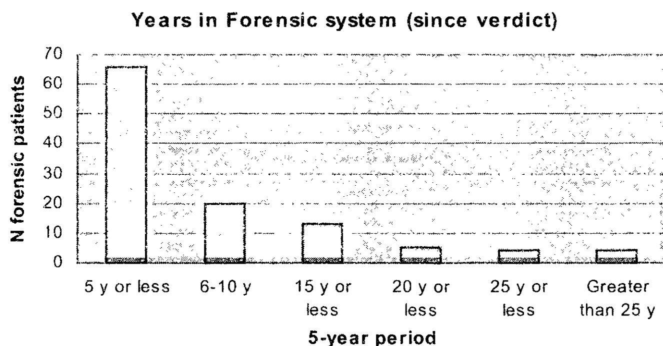
Forensic category	Murder	Manslaughter	Attempted Murder	Total
NGMI	63.16% (72)	0.88% (1)	26.32% (30)	90.35% (103)
Transferee	4.39% (5)	2.63% (3)	0	7.02% (8)
Limiting Term	1.75% (2)	0.88% (1)	0	2.63% (3)
TOTAL	69.30% (79)	4.39% (5)	26.32% (30)	114

From this table we can see that forensic patients with a homicide-related index offence are concentrated in the category of NGMI, at just over 90% of the subset. This is a much higher proportion than for the forensic population in general, where NGMI's represented almost 65% of the forensic categories. Amongst the homicide subset, almost 70% were charged with murder. Only 4% were charged with manslaughter. Attempted murder was the second highest category of charges, at 26%.[9]

Time spent in the forensic system

Any aggregate data representing time spent in the forensic system is of limited value. Given that the system is one of indefinite detention, length of detention is supposed to be determined by individual patient factors such as diagnosis, responsiveness to treatment, and success of rehabilitation. As individual recovery from any illness varies between patients, so too the time required for compulsory treatment of mental illness varies between individuals. Hence averages of time spent across the forensic population are of questionable benefit in understanding the forensic process. Nevertheless if we are concerned about the propensity for, or use of preventative detention with forensic patients, it may be enlightening to compare the amounts of time forensic patients spend in detention as compared with offenders convicted of the same charges. The next data explore the periods of time spent by patients under a forensic order where their index offence was homicide.

Graph 6: Years in the forensic system

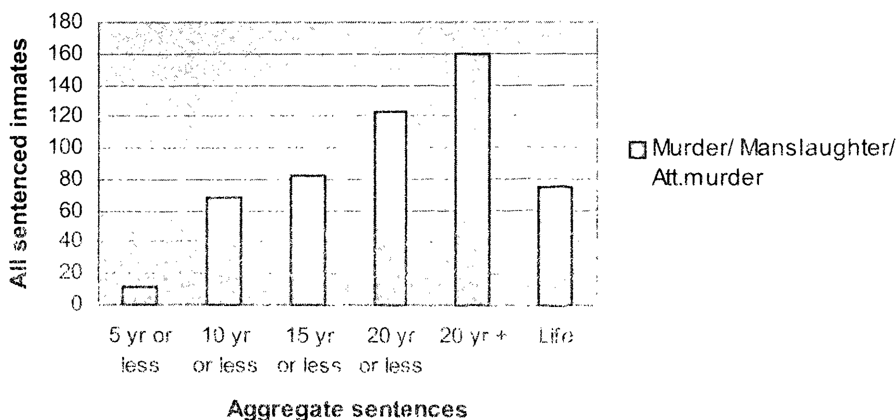


9 Generally these were incidents that did not result in death of the victim.

This graph shows the length of time spent under a forensic order (either in a secure facility or in the community) for the homicide subset, by five-year periods. The periods are calculated from date of verdict to the census date (30 June 2003). The graph excludes remanded transferees and fitness patients (because of their high degree of movement in and out of the forensic system). This data covers the remaining population subset, from those who entered the forensic system under the current legislation to those whose forensic status pre-dates the MHA 1990.

There are 66 patients or 58% of the subset population whose verdict came down in the last five years. For matters in the system longer than that there is a significant spread of patients over the next two periods. Over 17% of the subset population have been on a forensic order for 6–10 years, and more than 11% have been in the system for 11–15 years. Finally, whilst there are only 5 and 4 patients respectively on the last three periods, these are notably lengthy periods of time on forensic orders. Importantly, all of these patients are still on forensic orders. Thus these data represent only the amount of time spent up to the time of the census. They cannot be regarded as total periods of time spent on a forensic order. It is likely that most of these patients have a considerable number of years ahead of them on forensic orders. We now compare the forensic patient data with sentenced offender data.

Graph 7: Aggregate sentences for murder, manslaughter and attempted murder for sentenced offenders in NSW, 2003



Source: NSW Department of Corrective Services 2003 Inmate Census.

From a basic comparison of sentences for homicide-related convictions and time spent on forensic orders for the same index offence, we can draw two simple conclusions. Firstly, some forensic patients are serving a length of time on a forensic order comparable to that of sentenced offenders convicted of the same charge. Secondly, as the MHRT census data reveals length of time served to the census date only, and is not reflective of total amounts of time in detention, it is likely that greater numbers of forensic patients spend periods of time on forensic orders comparable to those of convicted offenders serving a sentence, than is reflected by the census data.

Progress of detention

The next table presents a breakdown of the Tribunal's recommendations from forensic patient reviews for the homicide subset. At the time of the census the decision-making process was taking 6–12 months after the Tribunal's recommendations had been sent to the Minister. Most matters were determined within six months of the recommendation from the Tribunal and were generally cases where the Tribunal had recommended no change. Those recommending change, and particularly recommending increased leave privileges or release, could take up to twelve months for determination. Therefore a sample from the homicide subset has been selected to allow adequate time for the process of executive determinations in each case. The sample size is 73. The sample excludes adjournments; fitness and other determinations that do not require Ministerial authority (eg S024 *Mental Health (Criminal Procedure) Act* 1990 (NSW) referrals); transferees returned to prison; and recommendations not acted upon (for instance if the Minister has already made an order to the effect of the recommendation).

The recommendations are grouped into categories that describe the nature of the recommendation in terms of restrictiveness of the forensic order.

Table 2: Executive decisions following receipt of Tribunal recommendations for release, 2002

Recommendation	2002	Approved	Rejected	Partially approved	Determination outstanding
Less restrictive detention Tribunal recommends that the patient remain detained but in less restrictive conditions, such as via transfer to a less secure hospital; or leave privileges.	9	2	1	2	4
No change — detention Tribunal recommends maintaining the status quo in the patient's order for detention.	33	32	-	-	1
Conditional release Tribunal recommends release from detention to the community, subject to conditions.	2	1	-	-	1
Less restrictive release Patient is already on conditional release. Tribunal recommends reduction in the conditions imposed in the community eg permission to travel outside jurisdiction, or to consume alcohol.	1	1	-	-	-
No change — release Tribunal recommends maintaining the status quo in the patient s order for release.	22	20	-	-	2
Unconditional release Tribunal recommends complete discharge of the forensic order.	6	-	5	-	1
TOTAL	73	56	6	2	9

From Table 2 we can see that the most common Tribunal recommendations were for no change. These recommendations were the most successful recommendations in terms of executive approval. Notably, only two people with a homicide-related index offence were recommended for conditional release, and only one had been successful by the Census date. By contrast, six people were recommended for unconditional release. No determination had been received in any of these matters.

With such small numbers in the sample it is difficult to generalise to the entire forensic population, or even to the homicide subset. However this data might be used to argue that, at the point of decision-making about release, index offence plays a significant role in the progress of the patient. We have already established in relation to the forensic population as a whole that there is a discrepancy between the Tribunal's recommendations for release, and the success of those recommendations by executive approval. The data from the homicide subset indicate that there is a particularly high degree of unsuccessful recommendations for release in relation to patients whose index offence was homicide-related. In our conclusion we will discuss the implications of these findings.

Conclusion

The data presented here are intended to provide a snapshot of the forensic patient population in NSW. As there is no current data available, we have presented basic demographics and trends to build a picture of the population in question. These data raise a number of questions about the management of forensic patients and the decision-making process of the forensic mental health system in NSW. Are forensic patients spending amounts of time detained on forensic orders comparable to those of sentenced offenders? Are forensic patients being 'punished' for their index offence, by being detained longer than necessary under mental health legislation? Is the forensic mental health system one of preventative detention? In the following discussion we will address these questions and make some concluding remarks on the data presented in this paper, and on the forensic mental health system more generally.

Firstly, it is clear that some patients are spending periods under forensic orders comparable to those of sentenced offenders. However, as the forensic system is designed to allow for individual patient needs to be addressed, small numbers of patients spending long periods of time under forensic orders might simply be a reflection of the severity of their mental illness or poor responsiveness to treatment. A thorough analysis of this question would require detailed data on flow through the system, and trends over time. We hope to pursue this in future work.

Secondly, progress through the system does seem to have become steadily more restricted since 1992. This is relative both to the likelihood of being recommended for release by the MHRT and the success of that recommendation in terms of executive approval. Consequently, as the intake of forensic patients has increased without a proportionate release of patients at the other end of the spectrum, there has been a burgeoning of the total population.

The question of whether forensic patients are being punished as a result of their index offences cannot be answered definitely. The fact that almost 65% of the forensic patient population have been acquitted of the offence charged means that they ought not to be punished. However as we discussed above, the preoccupation with risk, and the insistence that assessments of risk be conducted in relatively narrow and constrained ways may well mean that there is a disproportionate regard for the nature of a patient's index offence at the consideration of release, compared with the patient's current mental state or readiness for release into the community.

Another question raised by the data presented here is the high representation of homicide amongst the forensic population, particularly those acquitted on the grounds of mental illness. It is important to acknowledge that there is a process of self-selection of serious and violent offences amongst the forensic mental health system in NSW, by virtue of the legislative provisions of the *Mental Health (Criminal Procedure) Act* 1990 (NSW). The legislation only makes the defence of mental illness available to defendants going through the higher courts, that is the District and Supreme Courts. This automatically discounts minor offences from the ambit of the forensic system.

However there is another possible explanation for the high representation of homicide-related index offences amongst the forensic patient population, and that is the decision-making process by defendants at trial. It may be that there is a process of selection by defendants in weighing up the likely sentence for a conviction, as compared with the indefinite term of a forensic order if a person is found NGMI. For a property crime or similar type of offence, a defendant may be unwilling to risk the indefinite term of a forensic order. Whereas for a possible murder conviction, and given the lengths of sentences as shown above, it may be that defendants are more likely to risk a finding of NGMI on this charge, and the consequent indefinite detention of a forensic order. Furthermore, the *Crimes (Sentencing Procedure) Amendment Standard Minimum Sentencing Act* 2002 (NSW) may have an effect on the use of the NGMI defence in the future. It has been suggested that as a result of this legislation, sentences for serious offences are likely to increase significantly. If this is the case, it may be that more defendants plead mental illness as a defence and risk the indeterminate period of detention that comes with a forensic order, rather than risk the sorts of sentences that would result from conviction under this new legislation. These sentencing amendments may also have a flow on effect to the length of detention experienced by the forensic population generally. For instance there may be longer periods of detention or time spent on a forensic order in the community, as a result of the longer sentences imposed on sentenced offenders for the same index offence. It also seems likely that limiting terms would be affected by sentencing amendments, modelled as they are on the sentence the person would have received, had they been found guilty in a full trial.

To return to our original question, is the NSW forensic mental health system one of preventative detention? In one very obvious way, the answer to this question is yes. Sections 83 and 84 of the MHA require that the DPP and the Attorney-General be notified immediately if the Tribunal has recommended release of a forensic patient, to allow them to object if they believe the patient has not served enough time. Thus the legislation requires consideration of the index offence at the point of release for a forensic patient.[10] This is despite the fact that, as we have shown, 70% of forensic patients have been acquitted of the offence charged.

The question about preventative detention also facilitates a broader consideration of the way in which forensic orders function to control forensic patients. The data on location of forensic patients showed that over 70% of the forensic population are detained, either in hospital or in a prison. Amongst the detained forensic population, there is a wide range of variables that may be attached to forensic orders, as necessitated by the individual patient's condition. A key variable for forensic patients is the extent to which they have leave privileges. These are critical to the patients' ability to progress through the forensic system towards release. In the first instance, leave privileges provide an opportunity for patients to

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10 The Attorney-General's stated policy on this issue is not to object to recommendations for release of forensic patients who have been found not guilty by reason of mental illness.

be tested in terms of responsibility, trust, insight into their illness, and the general progress of their rehabilitation. Leave privileges are also gradual steps towards greater liberty and access to family, friends and the broader community.

However leave privileges are difficult to obtain. As we have discussed above, the Tribunal considers risk of dangerousness at any request for leave privileges. Nevertheless the executive frequently cites inadequacy of the amount of time already spent in detention as a reason for rejecting the leave. The ability to exercise leave privileges adequately is also a particular challenge within the climate of understaffing and under-resourcing that we have described above. A key obstacle to the exercise of leave privileges is the availability of suitable staff to supervise leave. This usually requires nursing or other specialist staff to vacate their posts and attend to patients individually. Patients often complain to the Tribunal of limited opportunity to exercise their leave privileges between the forensic review cycle, which is then grounds for a rejection of recommendations for additional leave privileges by the executive. The executive frequently raise inadequate utilisation of existing leave privileges as a reason for rejecting additional privileges, expressing concern that a patient has not yet demonstrated their ability to be trusted at the next level of leave available.

The data on location also indicated that almost 30% of the forensic patient population are on conditional release in the community. Whilst this means that forensic patients are ostensibly at liberty, their conditions of release are highly controlled. Conditional release requires patients to accept the direction of their psychiatrist or doctor and their case manager. This includes taking prescribed medication that often has serious side effects for patients. Whilst it is essential that community forensic patients abide by these conditions, the consequences if they do not can be extremely harsh. For instance, a relapse of mental illness, or behaviour by a forensic patient that is considered risky or inappropriate may result in a breach of the conditional release order. In a number of cases, breaches of orders have resulted in the patient's return to prison, from whence the person must start again the process of obtaining less restrictive conditions of detention towards the goal of release.

In some cases re-detaining a released forensic patient under the MHA is warranted, particularly if a person has become mentally unwell and poses a risk to themselves or others. In other cases the outcome may be seen as punitive and disproportionately harsh given general standards in the community. For example a forensic patient on conditional release in the community who produces a positive drug screen for marijuana may be breached for failing to comply with the conditions of their release (which include abstinence from illicit substances). Following their breach the patient may be detained for a process of monitoring and rehabilitation before they can be considered for conditional release again. In numerous cases, this period of detention is initially, if not wholly served in a prison. If the breach results in a return to prison, a patient may spend many months there before being returned to the community. Even in hospital, the forensic process requires the person to go through the time-intensive steps of Tribunal review and executive determination. However, were the person to be prosecuted and convicted for possession or personal use of a prohibited substance, a prison sentence would be a relatively severe court outcome, and the period of any order would usually not exceed a few months. Thus breach procedures have the potential to be punitive and out of step with community standards, rather than therapeutic.

There are other features of the forensic mental health system in NSW that may equally lead to a system of preventative detention, despite the best efforts of service providers and administrators to the contrary. The lack of a coordinated, state-wide forensic mental health service in NSW has meant that care and management of forensic patients in the community

has been provided by existing community mental health services. Existing services are already poorly resourced, and frequently lack expertise in forensic mental health. Thus concerns about the quality of the management of forensic patients in the community are legitimate. However, these concerns also prevent patients being released even when it is clinically warranted and legally appropriate that they no longer be detained. The Statewide Forensic Mental Health Directorate, established in 2004, is intended to address this issue.

Additionally, the forensic decision-making system is not subject to public scrutiny, in the way that other legal processes are. For instance in court, judges are under both public and political scrutiny in relation to their verdicts and sentences. Additionally, most criminal jurisdictions have some form of guidelines by which to determine sentencing, and to ensure consistency, natural justice and procedural fairness in the disposition of criminal matters. The Parole Board is a structure analogous to the Tribunal, whose processes are not necessarily open or transparent either. However the Parole Board operates in relation to convicted offenders who have been given a definite sentence. Thus there is not the same complete discretion over the length of time a person serves on the order, as occurs in the forensic system.

In the forensic system, there simply is no scrutiny of the process. Tribunal recommendations are not published when they are sent to the Minister for Health. The MHA provides for no shaping or constraining of executive decision-making, which is entirely discretionary. Moreover, there is no right of appeal of decisions by the executive in this context. Consequently, there is poor transparency and little to regulate practices of procedural fairness in the decision-making process for forensic patients in NSW.

We do not contend that indefinite detention itself is the flaw in the forensic decision-making process in NSW.[11] On the contrary, and as we have noted above, the purpose of indefinite detention is to be able to respond to the individual needs of each patient on a forensic order. Definite orders would not necessarily be capable of responding to the complexities of diagnoses, responsiveness to treatment, and access to leave privileges that are critical to the care, treatment and rehabilitation of forensic patients.

However we do suggest that the system of indefinite detention is susceptible to facilitating preventative detention. This is of particular concern when decisions are made without transparency or right of appeal, and without any guarantee of procedural fairness in the decision-making process. As we have shown, in many cases the Tribunal has been satisfied of the appropriateness to order less restrictive conditions of detention or release, having had regard to risk of dangerousness as well as clinical appropriateness. Whilst the ultimate decision-makers are not required to accept these recommendations, and whilst there is no finite term to guide the progress of patients through the system, the fact remains that detention in the forensic system is susceptible to a privileging of preventative aims over therapeutic or rehabilitative ones.

11 We are grateful to a reviewer for highlighting this distinction.

Table of Abbreviatons

Title	Abbreviation
New South Wales	NSW
Mental Health Review Tribunal	MHRT
Mental Health (Criminal Procedure) Act 1990 (NSW)	MHCPA
Mental Health Act 1990 (NSW)	MHA
Not Guilty by Reason of Mental Illness	NGMI
Director of Public Prosecutions	DPP

Legislation

Crimes (Sentencing Procedure) Amendment Standard Minimum Sentencing Act 2002 (NSW).

Mental Health Act 1990 (NSW).

Mental Health Act 1986 (Vic).

Mental Health (Criminal Procedure) Act 1990 (NSW).

Mental Health Act 2000 (Qld).

Crimes (Mental Impairment and Unfitness to be tried) Act 1997 (Vic).

Criminal Code (R.S. 1985, c. C-46) (Canada).

Mental Health (Compulsory Assessment and Treatment) Act 1992 (New Zealand).

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