"OUT OF MIND, OUT OF SIGHT": THE DISPOSITION OF MENTALLY DISORDERED PERSONS INVOLVED IN CRIMINAL PROCEEDINGS

ARIE FREIBERG*

In recent years, the rights of those classified as mentally ill have been the subject of a great deal of legislation, litigation, official concern and public debate. In England the Report of the Committee on Mentally Abnormal Offenders chaired by Lord Butler[1] has recently been published after three years of gathering evidence, while previously the Aarvold Committee[2] had reported on the supervision and discharge of hospital patients subject to special restrictions under the *Mental Health Act* 1958 (Eng.). In the United States, there has been trenchant criticism of the concept of mental illness itself[3] and the courts have been active in attempting to define the rights of the mentally ill.[4] Underlying the examination of the treatment of this group has been an increasing recognition of the dangers inherent in liberal welfare legislation, especially the danger of abuse of the discretion vested in courts and administrators made possible by the sacrifice of procedural and other safeguards for the postulated need for "protection".[5]

In Australia similarly an increasing concern has been evident. In 1974 Queensland enacted a sweeping new *Mental Health Act*, and the Mental Health Act Review Committee of New South Wales in 1975 released its

* LL.B. (Hons.), Dip. Crim. (Melb.), Barrister and Solicitor of the Supreme Court of Victoria. Tutor in Law, Monash University.
Research for this article was carried out under the auspices of the Australian Institute of Criminology. The author is indebted to Miss Mary Daunton—Fear for her advice and encouragement, and to Mr Richard Fox for his comments and criticisms of the manuscript.

1 London, H.M.S.O. Cmnd. 6244 (1975) hereinafter cited as the Butler report.

2 *Report on the Review of Procedures for the Discharge and Supervision of Psychiatric Patients Subject to Special Restrictions*, London, H.M.S.O. Cmnd. 8932 (1973).

3 See e.g. T. Szasz, *The Myth of Mental Illness* (Harper & Row, New York, 1961) and *Ideology and Insanity* (London, Calder & Bayars, 1973). Critical writings have not, of course, been confined to the United States. In Great Britain writers such as R. D. Laing have been prominent in questioning orthodox psychiatry. See e.g. R. D. Laing and A. Esterson, *Sanity Madness and the Family* (England, Pelican, 1970).

4 See e.g. F. N. Flaschner, "Constitutional Requirements in the Commitment of the Mentally Ill in the U.S.A.: Rights to Liberty and Therapy" (1974) 18, 3 *International Journal of Offender Therapy and Comparative Criminology* 283. L. B. Kassirer, "The Right to Treatment and the Right to Refuse Treatment—Recent Case Law" (1974) 2, 4 *Journal of Psychiatry and Law* 455. Practising Law Institute, *Legal Rights of the Mentally Handicapped* (1974).

5 C. Foote, "A Comment on Pre-trial Commitment of Criminal Defendants" (1960) 108 *University of Pennsylvania Law Review* 832.

report on the *Mental Health Act* 1958. Also in that year the Criminal Law and Penal Methods Reform Committee of South Australia[6] produced its third report on *Court Procedure and Evidence* which included recommendations with respect to fitness to stand trial, while in Victoria the Law Reform Commissioner in his second report[7] examined, though not in great detail, this and related problems. The Australian government has presently before it a draft criminal code for the Australian Capital Territory in which some of the dispositional problems of dealing with the mentally disordered are analyzed and some novel solutions proposed.

Concern with inadequate or unjust legislation has not been confined to official bodies or organs of government and public anxiety has been manifest at a number of seminars in Victoria,[8] New South Wales[9] and the Australian Capital Territory.[10] It is the purpose of this article to examine some aspects of the law in Australia relating to the disposition of mentally disordered persons who become involved in the criminal process and to discuss the existing provisions in the light of the numerous suggestions for reform which have recently been published.

MENTAL DISORDER

No discussion of procedures dealing with the mentally disordered can commence without a prefatory caveat relating to the dangers implicit in the terminology adopted and it is necessary at the outset to briefly explain the basic inadequacy of the term "mental disorder". The phrases "mental disorder", "mental illness", "mental abnormality" or "insanity" are probably as ill-defined as any in the English language. Little assistance is available from existing mental health legislation which either fails to define mental disorder or illness or does so in a tautological manner which is unsatisfactory. In the *Mental Health Act* of New South Wales for example, the term "mental illness" is not defined, but a "mentally ill person" means a person who owing to mental illness requires care, treatment or control for his own good or in the public interest, and is for the time being incapable of managing himself or his affairs.[11] The Queensland *Mental Health*

[6] Hereinafter cited as the "Mitchell Committee".
[7] Victorian Law Reform Commissioner, Report No. 2, *Criminal Procedure Miscellaneous Reforms* (1974). The Courts have also grappled with the problem of the mentally ill offender. In *R.* v. *His Honour Judge Rapke Ex Parte Curtis* [1975] V.R. 641 the Full Court of the Supreme Court had to deal with the relationship between an order made under s. 51(1) of the *Mental Health Act* (1959) enabling institutionalization of a person before a court and a sentence of imprisonment later imposed after revocation of the order.
[8] Organized by the Mental Health Action Group, 23 August, 1975. See Reports in "The Age" Melbourne, 25 and 26 August, 1975.
[9] Organized by University of Sydney, Institute of Criminology 13 February, 1975.
[10] Organized by Department of Health (A.C.T.) and Australian Institute of Criminology, 26-27 September, 1975. In March 1976 the Council of Social Services of the A.C.T. also held a seminar on mental health policy.
[11] S. 4.

Act 1974 states simply that a "patient means a person suffering or appearing to be suffering from mental illness" while in Victoria under the *Mental Health Act* 1959 to be "mentally ill" means "to be suffering from a psychiatric or other illness which substantially impairs mental health". Tasmania in its revision of mental health legislation in 1963 adopted the definition found in Section 4(1) of the *Mental Health Act* 1959 (Eng.) where "mental disorder" is defined as meaning "mental illness, arrested or incomplete development of mind, psychopathic disorder or any other disorder or disability of mind".[12]

The Butler Committee in its examination of the treatment of mentally abnormal offenders was well aware of "the current controversies about the concept of mental disorder",[13] but refused to become involved in them to any significant degree. Its view was that resolution of this psychiatric dialectic could not be brought about by the Committee, but would come about by the gradual formulation of professional and public opinion over a long period of time. The Committee did however eschew the use of the term "mental abnormality" as a comprehensive term in its report, preferring instead the term "mental disorder", for as it said, abnormality, in the sense of a statistical divergence from the norm does not necessarily imply a "disorder", i.e. a condition which should be remedied.[14] In its review of s. 4 it also addressed itself to the expression "psychopathic disorder" at which much criticism had been directed, and gave some consideration to excluding the term "psychopathy" from the Act and replacing it with the term "personality disorder".[15] It felt however that there would be even greater problems in defining that phrase and that in any case this was outside its term of reference. Recognizing that the "treatment" of psychopaths was difficult, if not impossible, the Committee instead chose a

[12] The full text of s. 4 is as follows:

"4(1) In this Act 'Mental disorder' means mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of mind; and 'mentally disordered' shall be construed accordingly.

(2) In this Act 'severe subnormality' means a state of arrested or incomplete development of mind which includes subnormality of intelligence and is of such a nature or degree that the patient is incapable of living an independent life or of guarding himself against serious exploitation, or will be so incapable when of an age to do so.

(3) In this Act 'subnormality' means a state of arrested or incomplete development of mind (not amounting to severe subnormality) which includes subnormality of intelligence and is of a nature or degree which requires or is susceptible to medical treatment or other special care or training of the patient.

(4) In this Act 'psychopathic disorder' means a persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to medical treatment.

(5) Nothing in this section shall be construed as implying that a person may be dealt with under this Act as suffering from mental disorder, or from any form of mental disorder describing in this section, by reason only of promiscuity or other immoral conduct."

[13] Op. cit. para. 1.18.

[14] Ibid. para. 1.12.

[15] Ibid. para. 5.24.

pragmatic course, recommending that a long term programme of training, research and evaluation be commenced in a series of special units within the penal system (not the hospitals) to establish what conditions and regime produce the most encouraging results.[16] Apart from these, and a number of other relatively minor comments, the Committee was content to accept the established framework of the existing legal, penal and other systems.

Comparatively little work has been carried out in Australia on the definitional problems of mental illness, which is probably symptomatic of the lack of interest in this area generally. There is however one informative study done in New South Wales by Dr Briscoe.[17] Analyzing 100 consecutive admissions to the Rozelle Admission Centre, Callan Park Hospital in New South Wales he found that over one half of those admitted were not suffering from mental illness in the strict interpretation of the term. Most of these persons were suffering personality disorders or drunkenness, were vagrants needing social attention or were individuals publicly displaying instability. He writes that

> "The impression given was really that almost anyone whose acute behaviour could not be controlled within the accepted norms of society either at home or in hospital might be admitted as 'mentally ill', particularly if there was known to be some medical condition as well. . . . The average stay was eight days."[18]

Some medical officers at a recent Melbourne seminar claimed that many people in urgent need of medical attention through accident or serious illness were inappropriately certified and that one in every five patients (some claimed one in three) certified could be sent home immediately. The Deputy Chairman of the Mental Health Authority is reported to have agreed with this claim.[19]

The problem of definition has particular relevance to forensic patients, for its seems to change, chameleon like, with each stage of the criminal process. At the very earliest stage, a person displaying aberrant or anti-social behaviour "presents a choice between treating the offending act as

[16] Ibid. chapter 5. Cf. the view of the Mitchell Committee which concluded
"that in the light of the general uncertainty of the subject, and particularly of the lack of reasonably specific medical definition of the condition, no specific measures can be safely recommended. There is a school of thought that for forensic purposes such terms as 'psychopathic personality' or 'psychopath', or equivalents are too vague to be determinative of any particular course of action and ought to be discarded. For our purposes we agree. We recommend accordingly that an offender who is, or may be, a psychopath in any medical sense should be tried and sentenced in the usual way, the sentencing judge taking into account such personality characteristics as may appear from the evidence before him to the extent which seems to him appropriate, as he would with any other offender."
op. cit. p. 98.

[17] O. V. Briscoe, "The Meaning of 'Mentally Ill Person' in the *Mental Heath Act* 1958-1965 of New South Wales" (1968) 42 *A.L.J.* 207.

[18] Ibid. 212.

[19] See "The Age" 26 August, 1975.

a crime or a symptom of mental illness"[20] and in many cases it is a policeman who is faced with such anti-social behaviour and who must make the decision. Goldstein notes that such a choice at the outset may pre-determine questions of guilt or responsibility which are usually the province of a court of law, and that whatever choice is made a process of labelling is commenced which may have important consequences. The two streams, the mental health power and the police power are not mutually exclusive[21] and while a broad mental health policy may result in fewer people being stigmatized as criminal, it may also mean a corresponding decrease in the legal safeguards afforded for their protection.

The vague definitions of mental illness for the purposes of civil commitment have already been outlined, but should a person be proceeded against, he may become, or be found to be mentally disordered at various stages of the criminal justice process. For the purposes of this article this process can be divided into three basic areas

(a) Persons found mentally disordered or incompetent at or before trial;

(b) Persons acquitted of a criminal charge by reason of insanity;

(c) Persons who become or are found mentally disordered after sentence.

At the first stage, for the person found to be insane on arraignment or at trial the test of incompetence is generally whether that person is able to understand the nature of the charge, understand the course of proceedings, understand the probable consequences of a finding of guilt, challenge a jury and properly conduct a defence or coherently instruct a legal adviser.[22] A deaf mute may be incompetent if he satisfies the requirements above.

Assuming that the person is fit to stand trial he may yet be found not guilty on the ground of insanity, the criteria here being the notorious M'Naughten Rules.[23] If however, the person is fit to stand trial and found to be legally sane he may, while in prison, be found to be sufficiently mentally disordered to be transferred to a mental hospital. The definition

[20] A. Goldstein, *The Insanity Defense* (New Haven, Yale University Press, 1967) p. 171. See also Butler report op. cit. para. 9.1.

[21] For a detailed study of the operation of police powers in Ontario, Canada see R. G. Fox and P. G. Erickson, *Apparently Suffering from Mental Disorder* (Centre of Criminology, University of Toronto, 1972). The authors found that approximately 14-19% of total admissions to hospital were by the police, and that other than arrest the police had the alternatives of
(1) getting other persons to make application for admission;
(2) taking care of the problem themselves in the field; and
(3) continuing care, i.e. getting to know the people on their beat who behave strangely and learning to tolerate their behaviour.

[22] *R.* v. *Presser* [1958] V.R. 45.

[23] These state that if the accused, at the time of the committing of the act "was labouring under such a defect of reason, from disease of mind, as not to know the nature and quality of the act he was doing or, if he did know it, that he did not know he was doing what was wrong", there must be a special verdict against him.

in this case would probably be similar to that for civil commitment rather than that for unfitness to plead or the M'Naughten Rules.

THE GENERAL APPROACH

The myth of a value free social science has probably been laid to rest, and it may be appropriate at this point to outline the basis upon which the procedures to be detailed are viewed. It is perhaps best summed up by the oft-quoted remark of Mr Justice Brandeis of the United States Supreme Court when he said

> "Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficient. . . . The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding."[24]

In fact for legislators and law reformers generally the American experience has much to offer, despite the fact that it is based on legislation which has no exact counterpart in this country. It is the rationale underlying the legal provisions which deserves some attention and which has a more universal value.[25]

From the evolving case law[26] two themes emerge which at first seem contradictory, but which perhaps are not. The first is what has been called "the right to treatment" and the second "the right to refuse treatment". The right to treatment has been developed under the general head of "due process" found in the Fifth Amendment. The argument is that because a person committed has not been guilty of a criminal offence, treatment is the only constitutionally permissible purpose of confinement, regardless of procedural protections under the governing commitment statute.[27] Under this head the courts have developed the useful analytical tool of asking

[24] *Olmstead* v. *United States* 277 U.S. 438, 479 (1928) (dissenting) quoted in Flaschner, op. cit. p. 301. Szasz states that the well-meaning men of zeal disguise what they are really doing by "language games" and do not recognize the patient's perceptions. "The defenders of psychiatric imprisonment call their institutions 'hospitals', the inmates 'patients', and the keepers 'doctors'; they refer to the sentence as 'treatment', and to the deprivation of liberty as 'protection of the patient's best interest'." *Ideology and Insanity*, op. cit. pp. 133-134.

[25] It is recognized that even where similar laws do exist Australian and American courts adopt widely divergent methods of construction. An excellent illustration appears in *McKinlay* v. *The Commonwealth* (1975) 7 A.L.R. 593, which concerned the principle of numerical equality of electorates. Contrast the view of some of the majority who distinguished leading United States authorities on the basis of the vastly different socio-political histories of the two nations, *per* Barwick C.J., Gibbs and Mason JJ. with that of Murphy J. who thought that what were important were the great underlying principles in the U.S. Constitution which could be relevant as aids to understanding the law, being part of Australia's cultural heritage.

[26] See generally supra footnote 4.

[27] Compare, however, a recent judgment by Chief Justice Burger which does not support a constitutional "right to treatment". *O'Connor* v. *Donaldson*. Decided 26 June, 1975. Unofficially reported in (1975) 3, 3 *Journal of Psychiatry and Law* 263.

generally whether there is a "logical and fair connection between the stated purpose of the law and the measures employed for their attainment".[28] In fact the law in this area is developing in such a manner that there must be due process, i.e., the right of hearing, representation and so on before suffering any "grievous loss", for example, transfer to an institution with a stricter regime, loss of privileges, punishment and so on.

Under the Eighth Amendment prohibiting cruel and unusual punishment the courts have questioned whether it is possible to make distinctions between "punishment" and "treatment", between "control" and "management", between "discipline" and "punishment". This developed because the horrific conditions in some of the mental institutions shook the belief of some judges that there was a difference between punishment and treatment. The conditions were uncivilized, inhuman and degrading to the dignity of man.[29]

Under the "equal protection" provisions of the Fourteenth Amendment courts have insisted that there must be good reasons why certain classes and persons should be treated differently from others. These cases have held that a person cannot be detained in a mental hospital after the expiration of his sentence without a full civil commitment procedure,[30] and similarly apply to a defendant's commitment by way of transfer from a penal institution[31] and after being found not guilty by reason of insanity.[32]

Under the freedom of speech of the First Amendment and the Fourth Amendment's provision giving the right to be free from arbitrary search and seizure the courts have developed a right of privacy, a right to be left alone. It has been seen as the right of an individual to control his body and to protect his own mental processes. The Thirteenth Amendment prohibiting involuntary labour, originally enacted to abolish slavery, has been resurrected to combat the use of free labour by patients under the guise of "therapy". Also developed has been the right to "the least restrictive alternative", which regarding civilly committed patients must be the least restrictive to achieve the purposes of confinement. It is possible this may be extended to forensic patients.

Thus on the one hand it seems that the right to treatment has developed, especially where there are indeterminate civil commitments, to force the State to justify detention, and the right to refuse treatment has developed to ensure that if the State can justify detention, the incursion of the detainee's rights is minimal. There may be a tension between the value of mental

[28] N. Kittrie, *The Right to be Different: Deviance and Enforced Therapy* (Baltimore, John Hopkins Press, 1971) p. 317.
[29] For excerpts of testimony of a psychiatrist regarding the less than adequate conditions in an Alabama mental institution in the case of *Wyatt* v. *Stickney* see *Legal Rights of the Mentally Handicapped* op. cit. Vol. 2, pp. 455 ff.
[30] *Baxstrom* v. *Herold* 383 U.S. 107 (1966).
[31] *Schuster* v. *Herold* 410 F. 2d. 1071 (1969).
[32] *Bolton* v. *Harris* 395 F. 2d. 642 (1968).

health and the value of liberty, but they are not necessarily antithetical. The courts in the United States may have opened a Pandora's Box but this probably is a better situation than one where many thousands of people were simply warehoused for years in atrocious conditions, out of mind, out of sight.

A number of general observations may be made on this experience. The first is that some courts have undertaken an analysis of the law on the basis of the purpose of the legislation and have proceeded to an evaluation of the methods used to implement the law. Particularly they have been concerned to determine whether the methods used are congruent with the purposes of the legislation.

The second is that the courts have shown themselves ready to go into the institutions, acknowledging that justice need not stop at the gates. Contrast the approach of the lower court in one case with that of the appeal court in 1961. The lower court refused to enquire into the propriety of a transfer from a prison to a hospital for the criminally insane on the basis that "[o]nce a valid commitment [disposition] is made, the place of detention is an administrative matter not subject to court intervention". The appeal court disagreed, saying that it could enquire and that "[the prisoner] is not to be divested of all rights and unalterably abandoned and forgotten by the remainder of society".[33]

The third observation is that while it is recognized that principles as outlined above are significant, of equal importance are the facilities which must be provided to implement them. While "community treatment" or "de-institutionalization" may be desirable for therapeutic ends it would be unwise and likely to invite a backlash from the community suddenly to return patients to a community which is unready and unable to cope.[34] The "open door" policy should not become a "revolving door"[35] practice.

[33] *People* v. *Johnston* 9 N.Y. 2d. 482, 482 (1961) quoted in S. Brakel and R. Rock, *The Mentally Disabled and the Law* (Chicago, University of Chicago Press, 1971) p. 407. The Australian courts seem to adhere to the first approach and perhaps some of the problems evident in many Australian prison systems stem from the fact that prisoners do feel divested of all rights and feel abandoned by the rest of society. A recent example of the strictly legalistic approach can be found in *R.* v. *Visiting Justice at Her Majesty's Prison Pentridge; Ex Parte Walker* [1975] V.R. 883 where it was held that a prisoner had no right to be represented by a legal practitioner before a visiting justice. Part of the "Catch 22" reasoning involved was that while a legal practitioner had a right of audience before a court, that right was contingent upon him being present in court. Because the visiting justice sat in a closed court in prison and there being no right of access to that court, there was therefore no opportunity to exercise the right of audience. The right to be heard, it was held, does not imply a right in the prisoner to be represented.

[34] This may be happening already in certain parts of the United States. See C. W. Offir, "Field Report: Mental Patients" *Psychology Today* (October 1974) 61. See also R. Slovenko and E. D. Luby, "On the Emancipation of Mental Patients" (1975) 3, 2 *Journal of Psychiatry and Law* 191.

[35] See generally H. R. Rollin, *The Mentally Abnormal Offender and the Law* (London, Pergamon Press, 1969); also "The *Mental Health Act*, 1959" (1974) *British Journal of Hospital Medicine* 272.

Finally attention must be drawn to the warning sounded by Halleck[36] that with stringent scrutiny of psychiatric decision-making psychiatrists may find that they are spending more time in the courts and less time with their patients. He suggests that because of this some psychiatrists may be tempted to avoid any involvement with involuntary patients.

PERSONS FOUND MENTALLY DISORDERED OR INCOMPETENT AT OR BEFORE TRIAL

The Present Position

New South Wales

Where a person is found mentally ill upon arraignment or upon trial he must be kept in strict custody until dealt with by the Minister.[37] Such a person, as well as any person committed to take his trial who is certified to be mentally ill may be transferred by direction of the Minister and detained in a mental hospital until certified not to be mentally ill.[38] Review of such cases by the Mental Health Tribunal is mandatory at the expiry of six months following admission.[39]

Victoria

A person found unfit to stand trial must be kept in strict custody until the Governor's pleasure is known.[40] The Governor may then direct that the person be kept in safe custody during the Governor's pleasure in such place as a person or authority designated may from time to time determine. The Adult Parole Board is under a duty to furnish to the Minister a report and recommendation on every person held in strict or safe custody during the Governor's pleasure under s. 393, once in every year and whenever so required by the Minister.[41]

Queensland

A person incapable of understanding the proceedings because of unsoundness of mind or unfitness for some other reason may either be discharged or be ordered to be kept in custody until dealt with under the law relating to insane persons.[42] The situation is similar where a person is found not to be of sound mind during the trial.[43] The Minister may order the removal of such a person to a security patients' hospital.[44]

[36] S. Halleck, "A Troubled View of Current Trends in Forensic Psychiatry" (1974) 2, 2 *Journal of Psychiatry and Law* 135.
[37] S. 23(1) *Mental Health Act* 1958 (N.S.W.).
[38] S. 24(1) *Mental Health Act* 1958 (N.S.W.).
[39] S. 29B *Mental Health Act* 1958 (N.S.W.).
[40] S. 393 *Crimes Act* 1958 (Vic.).
[41] S. 188(3)(a) *Social Welfare Act* 1971 (Vic.).
[42] S. 613 *Criminal Code* (Qld.).
[43] S. 645 *Criminal Code* (Qld.).
[44] S. 36(1)(a) and (b) *Mental Health Act* 1974 (Qld.). See also ss. 33 and 35 for procedures where there is mental illness prior to the actual trial.

The patient must be examined by a psychiatrist who must have regard to the mental condition of the patient, any relationship between the mental illness and the alleged offence, the likely duration of the mental illness and the likely outcome of treatment and any other matter likely to assist the Governor-in-Council in making a determination.[45] The psychiatrist's report must be sent to the Director, who must make a report to the Minister for Justice who must, together with presenting the other two reports, present his recommendation to the Governor-in-Council as to the continuation or otherwise of proceedings against the patient. All this must be done within three months of admission to hospital of the patient.

The Governor-in-Council may

(1) order that the patient not be further proceeded against, in which case a further review by a psychiatrist is necessary to determine the nature of further detention;

(2) order that proceedings be continued;

(3) defer determination for a period not exceeding 12 months—deferments may occur for further periods of 12 months.[46]

South Australia

The law is similar to that in Victoria, with provision for strict and safe custody during the Governor's pleasure.[47] There do not seem to be any provisions for the regular review of such cases.

Western Australia

Mentally ill persons at or before trial[48] may be transferred to approved hospitals and there classified as "security patients". They can be detained there until certified as fit to be discharged.[49] It appears that the Parole Board is required to make a written report and recommendation to the Minister once in every year or whenever so required.[50]

Tasmania

The legislation in this State is modelled on the English *Mental Health Act* 1959. Incompetent persons are dealt with as mentally disordered persons who have become subject to the criminal process. They are then admitted to a hospital as if in pursuance of a hospital order together with a restriction order.[51] A patient unfit to stand trial may stand trial again when the Attorney-General, after consultation with the appropriate medical officer, is satisfied that the person can properly be tried on the indictment in consequence of which the order was made.[52]

[45] S. 36(4) *Mental Health Act* 1974 (Qld.).
[46] For a proper understanding of this complex legislation, the original provisions should be referred to.
[47] S. 293 *Criminal Law Consolidation Act* 1935-1975 (S.A.).
[48] S. 652 *Criminal Code* (W.A.).
[49] S. 47 *Mental Health Act* 1962-1974 (W.A.).
[50] S. 34(2)(a) *Offenders Probation and Parole Act* 1963-1971 (W.A.).
[51] S. 380 *Criminal Code Act* (Tas.).

Commonwealth

Persons found unfit to stand trial are held during the Governor-General's pleasure. Detention continues until the Governor-General is satisfied by the certificate in writing of not less than two duly qualified medical practitioners that the person has become of sound mind and fit to be tried.[53]

Australian Capital Territory

Under the *Lunacy Act* of 1898 (N.S.W.) a person found insane on arraignment or during trial, or a person who has been committed for trial and who is certified insane by two medical practitioners may be directed by the Attorney-General to be removed to a hospital for the criminal insane. Such person is detained until certified to be of sound mind.[54]

Northern Territory

Persons found unfit to stand trial are held during the Governor-General's pleasure. As in the Australian Capital Territory there are some questions as to the operation of the *Interpretation Ordinance* and the applicability of Commonwealth law.[55]

Problems

The original aim of the common law was to ensure fairness of procedure to an accused who could not defend himself. It was said that

> "It is a cardinal principle of our law that no man can be tried for a crime unless he is in a mental condition to defend himself."[56]

The courts have operated under the assumption that an incompetency commitment is for the defendant's welfare but the reality is that this assumption is sometimes not justified.[57] The problem arises thus. The disposition of a person unfit to stand trial is predicated on the assumption that a presently incompetent person will eventually become of "sound mind" when he will be able to stand trial on the offence charged. However the danger is that a person who is unfit to stand trial under the present law may have no hope of recovery and may therefore never be brought to trial. Although the offence with which the person is charged may not be serious, he may, in effect, be serving a life sentence for it.

A celebrated case recently in the United States Supreme Court[58] highlights this problem. The accused was a deaf-mute of low intelligence who

52 S. 382 *Criminal Code Act* (Tas.).
53 S. 20B *Crimes Act* 1914-1973 (Cth).
54 Ss. 65(1), 66(1) and (2) *Lunacy Act* 1898 (N.S.W.). The situation in the Australian Capital Territory is somewhat complicated by s. 7(1) of the *Interpretation Ordinance* 1971 (A.C.T.), the effect of which is unclear. This section makes applicable s. 20B of the *Crimes Act* 1914-1973 (Cth) to the Territory, which prescribes a different procedure for dealing with forensic patients.
55 S. 382 *Criminal Law Consolidation Act and Ordinance* 1876-1974 (N.T.); s. 4A *Interpretation Ordinance*.
56 *R.* v. *Dashwood* (1943) 1 K.B. 1.
57 See N. R. Janis, "Incompetency Commitment: The Need for Procedural Safeguards and a Proposed Statutory Scheme" (1974) 23, 4 *Catholic University of America Law Review* 720.
58 *Jackson* v. *Indiana* 406 U.S. 715 (1972).

had been charged with two robberies, the total proceeds of which were $9.00. It appeared from the medical evidence that his condition precluded his comprehension of the nature of the charges against him nor would it be likely that he would be able to develop the necessary skills to enable him to be "sane", i.e., fit to stand trial. Burt and Morris point to the injustice of this, asking why if the criminal charge alone or the mental disability alone would not have justified indeterminate commitment, these two factors combined should do so.[59]

Using the due process clause, and relating the purpose of the disposition to its practice, the court questioned the purpose of incompetency legislation and found that it was only to allow the State to hold a person for no more than the reasonable period of time necessary to determine whether there was a substantial probability that the accused would become competent in the forseeable future.[60] Again, it is submitted that although the law may be inapplicable in Australia, the analysis is not.

In a recently published report on life sentences in Australia[61] it was found that merely looking at lengths of detention of convicted persons or those found not guilty on the ground of insanity did not give the full picture for there were also those who were not tried and those whose trials were delayed. The figures quoted are by no means comprehensive, covering as they do only those charged with offences for which a life sentence may have been imposed, but such is the paucity of statistics in this area that they are included as perhaps indicative of what may be happening generally.

In England, the Royal Commission on Capital Punishment found that from 1900-1949 of 3,130 persons committed for trial on a charge of murder, 428 or 13.6% were found insane on arraignment and 49 or 1.57% were certified insane before trial.[62]

In Canada between 1961 and 1970 of 476 persons charged with murder who were not sent to trial, 73 or 15.3% were not sent because of insanity. In the same period, of 1,649 persons sent to trial, 92 or 5.6% could not stand trial or were so found during trial because of insanity.[63]

In Victoria between 1962-1971 Martin[64] found that six out of 345 or

[59] R. A. Burt and N. Morris, "A Proposal for the Abolition of the Incompetency Plea" (1972) 40, 1 *University of Chicago Law Review* 66, 69.

[60] The Supreme Court found that this was not the case here, and that as well the procedure in Indiana violated the equal protection clause as the procedure for indeterminate commitment was less stringent than that for civil commitment. The Court held that if the accused was not to be put on trial the State must either institute civil commitment proceedings or release the defendant. It went even further and said that, if it were determined that the defendant would soon be able to stand trial, his continued commitment must be justified by progress toward that goal.

[61] A. Freiberg and D. Biles, *The Meaning of 'Life': A Study of Life Sentences in Australia* (Canberra, Australian Institute of Criminology, 1975).

[62] *Royal Commission on Capital Punishment 1949-1953: Report*, London H.M.S.O. Cmnd. 8932 (1953) p. 77 and Appendix 3, table 8, p. 311.

[63] See B. Schloss and N. A. Giesbrecht, *Murder in Canada* (Centre of Criminology, University of Toronto, 1972) pp. 58, 61.

[64] J. Martin, *People Imprisoned in Victoria for Murder and Manslaughter 1962-1971* (Victoria, Social Welfare Department, 1974) table 4, p. 14.

1.7% suspected homicide offenders were unfit to plead. As at 31 December 1974 there were five persons in custody who had been found unfit to plead, one for seven years, two for four years and one each for three and two years. Rinaldi[65] cites one case in Victoria of a person being released on parole in 1961 after 15 years in custody after being found unfit to plead.

In South Australia three males had been detained for 22 years, 18 years and 11 years respectively and one female for 10 years without having been brought to trial. George[66] quotes a case of a man charged with attempted murder in 1957 who was certified insane while in custody before coming to trial. He spent over 13 years without being tried and his incarceration was ended only by his suicide. One person who is shown in the statistics as serving four years 11 months of a life sentence was in fact convicted some five years after the offence itself, the intervening period being spent in a mental hospital.

In Western Australia a similar picture emerged. At 31 December 1974, three persons had been held for 20 years, 19 years and two years respectively. One was considered by the authorities as unlikely to recover. The records show another case, transferred to the Mental Health Service, who was transferred from one authority to another for eight years without standing trial. Another died in custody after 18 years detention.

There are a number of further problems attendant on the present disposition. In many cases the lapse of time between the alleged offence and the trial make a trial almost impossible either because of the death or movement of witnesses or simply because of fading memories. The prosecution may then be discontinued without the accused ever having the issue determined.

Although the situation in each jurisdiction varies it would seem that persons found incompetent may not be held with general mental patients but may be held with the restricted patients, those, for example, found not guilty on the ground of insanity or persons transferred from prisons. This may lead to a stigmatisation in the public and administrative mind which may in turn mean less likelihood of release. It is also thought that the knowledge of pending criminal proceedings may have a deleterious effect on a patient.

The problem of the "least restrictive alternative" was raised in an interesting case[67] in Victoria recently. The accused, on a charge of conspiracy to defraud in the County Court, had been found unfit to plead by a jury empanelled to determine this issue. The trial judge ordered the accused to be remanded for trial and the recognizances of the accused and his surety to be respited. At the trial Dr Bartholomew, Psychiatric Superintendent at Pentridge Prison, gave evidence that

[65] *Parole in Australia* (Canberra, Australian National University, Faculty of Law, 1974) 224.
[66] T. George, "Commitment and Discharge of the Mentally Ill in South Australia" (1972) 4, 2 *Adelaide Law Review* 330, 334.
[67] *R.* v. *Judge Martin; Ex parte Attorney-General* [1973] V.R. 339.

"if the accused man went to Pentridge he would immediately be certified and this would put him into a mental hospital; that he was the nearest thing to a cabbage[68] and that to put him into a chronic ward would let him go straight downhill; that he had a wife and daughter who could look after him in home surroundings; and that this added up to keeping him going."[69]

The Full Supreme Court held by majority (Smith A.C.J. dissenting) that on the wording of the particular statute[70] the judge had no discretion but had to order that the accused be held in "strict custody" until the Governor's pleasure was known and then in safe custody during the Governor's pleasure. As a matter of statutory construction that decision may be correct, but on the evidence presented by the doctor one wonders whether that was the psychiatrically correct choice. It certainly would not seem to be "the least restrictive alternative".

In most jurisdictions there are no provisions for periodic reviews of persons so held and it is not impossible for a person to become metaphorically "lost" in the system. Because of understaffing in mental health institutions the "unfit" patients may, if their disorder is chronic, rather than acute, receive less than a thorough examination, merely because of the pressure of work on medical personnel. Finally there is the question of whether the test of recovery is legal or psychiatric, and the confusing nature of the meaning of 'insanity' for unfitness to plead has already been discussed.

If one of the criteria is being able coherently or sufficiently to instruct a legal advisor, the paradoxical situation may arise where the test of the accused's sanity may depend on the personality or training of his legal adviser. As had been said

"Different lawyers will have different standards and different tolerance levels for evaluating the ability of their client to consult with them. . . . [S]ome lawyers deal particularly well with emotionally disturbed clients and feel comfortable about representing them. Other lawyers expect very little collaboration from their clients. . . ."[71]

This raises further questions as to the desirability of giving psychological training to legal practitioners or of the development of a "mental health

[68] And the evidence seemed to be that his condition would never get better and would probably get worse. Ibid. 340.

[69] Ibid.

[70] S. 393 *Crimes Act* 1958 (Vic.). The phrase in issue was "it *shall be lawful* for the court to order such person [i.e. the person found insane] to be kept in strict custody in such place and in such manner as to such court seems fit until the Governor's pleasure is known" (emphasis added). Smith A. C. J. in view of the history and context of s. 393 construed this as conferring a discretion upon the judge while the majority held it be mandatory for the judge to make such an order.

[71] Group for the Advancement of Psychiatry, Committee on Psychiatry and Law, *Misuse of Psychiatry in the Criminal Courts: Competency to Stand Trial* Vol. V111, Report No. 89, 1974, p. 884.

bar", specializing in this area,[72] but the point to be made here is that there are difficulties in determining what is recovery and who is to determine it.

Alternatives

The problems outlined above, causing as they do injustice in some cases, have led to a search in many jurisdictions for alternative modes of resolution. The common law rule as now embodied in the statutes evolved at a time when legal aid was not as widely available as it is presently and when concern for the civil rights of accused persons was not as important an issue as at the moment.

The alternatives proposed for replacing the present scheme or improving it fall into two main categories

(1) legislative controls on the length of time a person can be held without trial and thereafter requiring release or commencement of civil commitment proceedings and prescription for regular reviews both psychiatrically and by the prosecuting authorities;

(2) making fitness to plead a ground only for adjournment of proceedings and the provision of a "special trial" which takes into account the accused's disability. A slightly different procedure exists where there may be a postponement during a trial of the issue of incompetency until a time to be determined.

With regard to (1) above, the main reforms would be basically that

(a) there must be periodic review of the progress of the accused;

(b) there must be treatment directed towards regaining the accused's fitness to stand trial;

(c) there must be a decision within a reasonable time whether or not proceedings will be continued;

(d) there must be a decision, if proceedings are not to be continued whether to order release or further detention. In the latter case the procedure for detention, it is submitted, should be on the same basis and criteria as if criminal proceedings had not been commenced.

With regard to (2) above, there have been numerous schemes, some of which will be outlined below. The aims of certain of such schemes have been put by the English Criminal Law Revision Committee[73] as

(a) to test the case for the prosecution;

(b) to put the case for the defence to the extent of the disability;[74]

(c) not to complicate the trial;

(d) not to prejudice the defendant if he recovers later.

[72] See e.g. discussion in the Report of the New South Wales Mental Health Act Review Committee.

[73] Third Report, *Criminal Procedure (Insanity)* 1963, p. 8.

[74] For example, the prosecution may be barred as a matter of law, or there may be a defence based on a statute of limitations. The prosecution case may depend on inadmissible evidence or there may be an alibi defence based on evidence other than that of the defendant. See Foote, op. cit. p. 841.

The requirements for changing the present position have been put at length. The following is a summary of some of the arguments put against changing the law[75]

(a) to try an insane person is absurd and cruel and would only disrupt proceedings;

(b) there is little difficulty in practice because there is seldom any real doubt that the accused did the act; if there is any doubt the judge should be allowed to consider the depositions;

(c) the consequences of being found unfit to stand trial are not necessarily as serious as supposed;

(d) pleas of unfitness to be tried occur very infrequently;

(e) an accused would have a worse grievance if found guilty on a "special trial" because of the implication of guilt where a vital defence which could have led to acquittal was not put;

(f) it is difficult to decide when the issue of incompetency should be put to the jury.

England

The provisions of this procedure are found in the *Criminal Procedure (Insanity) Act* 1964, passed following the Third Report of the Criminal Law Revision Committee.

This procedure provides for the court to have complete discretion to decide whether fitness to be tried should be determined on arraignment, or as soon as it arises, or whether to postpone it to any time up to the opening of the case for the defence. If, before the issue were determined, the jury acquitted the accused, he would be discharged. If the issue were determined on arraignment and the accused found fit, he would be tried by a different jury to avoid the danger of prejudice to the accused. If the issue were postponed, the trial would continue, and if the accused were not acquitted, but found fit to plead (by either a separate jury or the trial jury, at the judge's discretion) the trial would proceed. If found unfit, the trial would not proceed but the accused would be made the subject of a hospital order with a restriction order. If the accused later recovered, he could again stand trial.[76]

New South Wales

The Mental Health Act Review Committee accepted the basic scheme outlined above but felt that because there are cases where the weakness of a prosecution case would be shown if the defence could introduce evidence, that a complete trial should be held, what it calls a "special trial". The following is a brief summary of the proposals.

[75] Criminal Law Revision Committee, op. cit. pp. 8, 9.
[76] For a discussion of other alternatives which were considered, see Criminal Law Revision Committee, op. cit. pp. 10, 11.

If a person indicted on any offence is unfit to be tried and on arraignment is so found by a jury so that he cannot be tried or is so found upon trial by the jury before whom he is tried, the judge may direct such finding to be recorded and then may order that that person be held in strict custody until dealt with as further provided, below. Information as to unfitness may be derived from any source and the issue of fitness must be determined on the balance of probabilities. Where the judge presiding at trial of an indicted person decides that it is necessary to make an enquiry into the issue of fitness, he may, if in his opinion it is in the interests of the accused, or shall if requested by the defence, postpone such enquiry until any time up to the opening of the case for the defence, and if before determination of the question of fitness the jury acquits, then the issue shall not be determined. Where the accused is found fit on arraignment, he shall be tried on the indictment by a jury other than that which determined the question of fitness. Where the issue of fitness arises at any later time, it may be determined by a separate jury or the jury by whom the accused is being tried as the judge directs, provided that

(a) no person can be tried by the same jury which found him fit to be tried;

(b) no person can be tried by way of special trial by the same jury which found him unfit to be tried, but to be put on special trial.

Where it appears to a judge that an accused charged with an indictable offence may not be fit, he may order the accused be remanded in a mental hospital for a maximum of 28 days for psychiatric assessment but only with the consent of the Superintendent of the hospital. There must be an examination by two doctors separately regarding

(a) the general mental and physical condition of the accused at the time of examination,

(b) whether his mental or physical condition could derogate from his
  (i) ability to understand the nature of a criminal charge or the possible consequences of guilt;
  (ii) ability to conduct his defence;
  (iii) ability to comprehend the significance of the course of criminal proceedings up to and including sentence;

(c) the likelihood of future improvement or change in condition. The doctors should consider whether the condition is more likely than not to improve significantly.

If then the judge can infer from either report that there is unfitness to stand trial and that such unfitness is likely to be permanent, then the judge may order the jury, empanelled to determine the question of fitness, to consider as an alternative verdict whether the person is unfit but should be put on a special trial.

The aim of the special trial is to confer on the permanently unfit accused the right to confront the charges against him. The procedure is basically that of a normal trial but the accused must be legally represented, a plea of not guilty must be entered, a plea of not guilty by reason of insanity is not to be raised, and the judge must bear in mind and instruct the jury with regard to the accused's disability. If the accused is acquitted, it is treated as an acquittal following a normal trial but, if the accused is convicted, it is treated as a finding of unfitness to stand trial. Conviction is a bar to future prosecution. There is a right of appeal as from a normal trial. The person may then be detained in a mental hospital when the Minister directs. If the person improves he must be sent for trial.

However, if, at the end of 12 months from the date of the Minister's order the person is still in hospital, he must be brought before a Mental Health Tribunal, which must decide whether he is fit to be tried (in this case upon the certificate of two medical practitioners that he is not mentally ill). If he is not fit to be tried, the Tribunal must enquire whether, if the person were to recover, he would be brought to trial. If he would not be proceeded against, he must no longer be held as unfit to stand trial, but he could still be held under the normal provisions of the *Act*. Such reviews must be annual.

Finally no person so held can be detained for longer than the maximum period, less one-third, which he could have been imprisoned had he been found guilty and sentenced by 'ordinary' trial, but in no case more than 10 years. Again, this does not preclude the possibility of steps being taken to secure that person's involuntary detention by civil commitment procedures.

South Australia

The Mitchell Committee recommended the abolition of the plea of unfitness to stand trial as it now is.[77] It recommended that the plea of unfitness should be a ground only for an adjournment of trial, but for not more than six months and only if there is likelihood of improvement. The question of fitness is one to be decided by a judge in the absence of agreement between the Crown and the accused. The use of a jury to try the issue of fitness would be discontinued.

If the accused does not recover at the end of six months, the trial would proceed, with the jury being able to take into account the defendant's unfitness in deciding on the guilt of the accused. If found guilty, the judge would take into consideration when sentencing, the accused's mental capacity. If imprisonment is the sentence, it would be for the administrative authorities to decide whether all or part of that sentence would be served in hospital. At the expiration of sentence the prisoner would be treated as

[77] Op. cit. pp. 32-38.

an ordinary person of his capacity. A right of appeal is recommended from any granting or refusal of an adjournment of the trial.

Discussion

It is difficult to come to any firm conclusions on such a complex topic, for in each jurisdiction account must be taken of the legislative context. However, regarding the majority of legislation in Australia two comments need to be made. First, there must be a clarification of the term "insanity" in the context of unfitness to plead. Secondly, there ought to be provision for a right of appeal against a finding of unfitness. This has been done in the English legislation and has been recommended by the Victorian Law Reform Commissioner in his second report. As he states

> "the issue of fitness to be tried may have been raised by the prosecution, or even by the trial judge, and there may be good grounds for setting aside the finding of unfitness as not being supported by the evidence, or as being vitiated by a misdirection or by a wrongful reception of evidence or by some other irregularity at the trial."[78]

As to the alternative schemes outlined above, a number of observations are warranted. The English scheme, though limited in that it only enables the courts to postpone the question of fitness to plead until the conclusion of the case for the prosecution, has at least gone part of the way in removing innocent people from the criminal justice system. It has, however, recently been criticized by the Butler Committee on a number of grounds, and new procedures have been recommended which aim to obviate these problems. The term "unfitness to plead" would be replaced by the term "under a disability" which the Committee thought would more aptly describe the position of a mentally disordered offender.[79] The Committee felt strongly that the facts should be established before accepting that a defendant should be indefinitely detained under a hospital order. That this detention could be for a very long period, perhaps even for life, merely at the discretion of the Home Secretary was thought to be a serious shortcoming of the *Criminal Procedure (Insanity) Act* 1964 (England) and required remedying. The Committee recommended that the "question of disability should be decided at the outset of the trial or as soon as it is raised. Where disability has been found and where there is (on medical evidence) a prospect of early recovery, the judge may adjourn the trial for up

[78] Op. cit. p. 2. This recommendation has now been acted upon in Victoria. S. 570C and S. 570(1) of the *Crimes Act* (1958) inserted by s. 8 of the *Crimes Act* (1976) (not yet proclaimed) provides that where a question of unfitness has arisen in the Supreme or County Court, at the instance of the defence or otherwise, the accused may appeal to the Full Court upon (a) any ground which involves a question of law alone and (b) upon the certificate of the trial judge that it is a fit case for appeal, on any ground which involves a question of fact alone or a question of mixed law and fact, (c) or with leave of the Full Court, on any other ground. A successful appeal results in the accused being tried for the offence.

[79] Op. cit. para. 10.2.

to three months in the first place with renewal for a month at a time for up to a maximum of six months. If the defendant recovers within the six-month period, the normal trial should proceed immediately".[80] Should the defendant recover, or should there be no prospect of recovery, a trial should be held immediately. The object of the trial would be to enable a jury to return a verdict of not guilty where the evidence is not sufficient for conviction. The opposite verdict would not be one of "guilty" but a finding that "the defendant should be dealt with as a person under a disability".[81] In this event the Committee proposed that the court be given a wide discretion as to disposal, a diametrically opposite view to that of the Criminal Law Revision Committee which vested the discretion in the Home Office. It suggested that an overtly penal disposal would be both wrong in principle and unsuitable for such a defendant, and instead the court should have a power to order in-patient or out-patient treatment at a hospital with or without a restriction order, a guardianship order, forfeiture or disqualification, or simply discharge without any order. In the event of recovery from the disability after the return of a disability verdict, it would be open to a defendant to apply to the Court of Appeal for a normal trial.

The Butler Committee also found that there were serious shortcomings in the available procedures in magistrates' court. It found, inter alia, that there was not statutory authority enabling magistrates to hear evidence on the issue of fitness to stand trial and that the powers to seek medical reports or to remand were inadequate.[82]

In Australia similarly it seems that the powers of the magistrates may be inadequate and what occurs in practice seems to depend partly on the law and partly on expedience. In New South Wales, where a person is in an unfit state of mind to make his plea, but is not strictly mentally ill and unfit to plead, the court has power under ss. 68 and 69 of the *Justices Act* to adjourn the case and remand the accused into custody for examination by a consultant psychiatrist at the prison.

If the accused is mentally ill, the psychiatrist will usually write a certificate initiating involuntary admission and detention (Schedule 2, *Mental Health Act*) and the police, with the court's approval, will take the person to an admission centre. If, however, in the opinion of the authorities at the admission centre, he is not mentally ill, he will be returned to the court, where he may be tried, but if the court is of the opinion that he is not fit to plead, it has no option but to release him, for the magistrate cannot try the issue of fitness to plead.

If he is detained at the admission centre, the non-appearance is entered in the court's record, which usually terminates the matter, though there is

[80] Ibid. p. 158.
[81] Ibid. para. 10.24.
[82] See also B.T.H., "The Mentally Abnormal Offender in the Magistrates' Court" (1975) 139 *Justice of the Peace* 631; [1975] *Criminal Law Review* 673 ff.

nothing to prevent the trial continuing upon recovery. There is also a procedure under section 12(2) of the *Mental Health Act* whereby the prosecutor, or some other person, can give evidence on oath as to the defendant's mental condition, and the magistrate can, on that basis, order that the defendant be taken to an admission centre.[83]

In Queensland the *Mental Health Act* provides essentially the same procedure in the magistrates courts as in the superior courts. Thus, where the justices are satisfied, on the evidence of two medical practitioners, that the defendant is mentally ill, they may make an order authorizing his admission to a hospital, and he is deemed to have been admitted for a period of 12 months, but not as a restricted patient. The hearing must be adjourned to a date to be fixed. A psychiatric examination must follow and reports must be sent to the Governor in Council who may order that the hearing of the complaint not be proceeded with, and if no order is made by the Governor in Council within three months, the complaint will be deemed to be dismissed. Alternatively, the Governor in Council may order, where the patient is no longer detained or no longer need be detained, that the hearing of the complaint proceed. However, the complainant is under no obligation to proceed with the complaint, but where it is heard again, it must be heard de novo.[84]

Under the *Mental Health Act* of Western Australia, magistrates are empowered to remand mentally disordered offenders for observation[85] while in Tasmania a similar situation exists as in England whereby hospital or guardianship orders may only be made if it is thought a person ought to be convicted, though it need not record a conviction.[86] In Victoria it would seem that the powers of adjournment and remand as well as the involuntary commitment powers are used for there appears to be no specific power to determine the question of fitness.[87]

The Butler Committee's solution to the problem of fitness in the magistrates' courts was to propose that these courts be given the same powers as the Crown Courts, though where a magistrate decides that a defendant is fit to stand trial, this trial should take place before a different bench. The magistrate's powers of disposition would be similar to the Crown Court except it would have no power to make a restriction order.[88] The Mitchell Committee similarly suggested that a court of summary jurisdiction should

[83] See W. J. Lewer, "Legal and Other Problems Relating to Fitness to Plead in Magistrates' Courts" in *Proceedings of the Institute of Criminology*, Faculty of Law, Sydney University, 1967, 103. New South Wales Mental Health Act Review Committee, op. cit. p. 95 ff.

[84] S. 32 *Mental Health Act* 1974 (Qld.).

[85] S. 36 *Mental Health Act* 1962-1974 (W.A.).

[86] S. 49 *Mental Health Act* 1963 (Tas.).

[87] S. 51(1) of the *Mental Health Act* 1959 allows a court, instead of passing sentence, to direct that a mentally ill or intellectually defective person be admitted to an appropriate State institution, but this is of no assistance as it requires a conviction prior to disposition.

[88] Op. cit. paras. 10.33-10.40.

have the same right of adjournment as courts dealing with indictable offences.[89] The New South Wales Committee was critical of the s. 12(2) procedure and recommended its abolition.[90] It also recommended that magistrates not be restricted to a remand to a prison or lock-up but that provision be made allowing the magistrate a choice of remanding a defendant either to the prison or to a mental hospital for psychiatric examination.[91] The basic scheme suggested is that the present schedule 2 procedure should be the pattern to be followed, but where the defendant is unfit to be tried, though not because of mental illness, and the magistrate considers that he presents a grave threat of harm to others, he may be able to deem the offence to be indictable and commit the person for trial on indictment, so that thereafter the rules applicable to indictable offences should be invoked.

It is obvious that the schemes outlined above for new procedures for indictable offences, and to some extent, for the magistrates' courts have much in common for all are involved in an attempt to balance the dangers of indefinite detention of the mentally disordered offender on the one hand with the cruelty and unfairness of trying him on the other. The Queensland scheme now operating does not attempt to try such a person but commendably provides for strict time limits with a requirement that decisions to be made at the highest level whether or not to continue proceedings. The main danger with this scheme seems to be that the 12 month deferments may stretch indefinitely. The New South Wales proposal has much to commend it, even though there may be problems in the conduct of a special trial. There is the risk of adverse stigma following a "conviction" and also the risk of prejudice at a later trial where there has been a conviction at a special trial. The Butler Committee sought strenuously to find an alternative to a finding of "guilt" and emerged with a verdict of "a person under a disability". The Mitchell Committee adopted the course that there could be a finding of guilt despite the disability, with questions of mental capacity being relevant to sentence, and discretion as to placement of such a person being left to the "authorities". It is submitted that the approach adopted by the Butler Committee regarding the vesting of discretion is to be preferred. The exercise of discretion in an open court is subject to public scrutiny and there can be representation and appeal. Generally when the distribution of sentencing or dispositional authority is being considered, it should be that body which has the greater safeguards for the rights of the individual which should be preferred. The Butler Committee's express disavowal of overtly penal measures upon a finding of disability seems also to be preferable to the Mitchell Committee's approach which would certainly allow a penal disposition.

[89] Op. cit. p. 37.
[90] Primarily because it is not aimed at the problem of fitness to plead, and also because it recommends other procedures for the initiation of involuntary admission.
[91] Op. cit. p. 99.

The retention or otherwise of the jury is another issue upon which the various committees have differed. Both the New South Wales Committee and the Criminal Law Revision Committee felt that the jury was so much a part of the present criminal justice system that a public outcry may ensue if it were abandoned. The Mitchell Committee argued that while a jury trial may be a necessary safeguard where the consequence of a finding of unfitness to stand trial is indefinite detention, where such a finding is merely a ground for adjournment, it is not essential. The Butler Committee took a middle path on this issue, proposing that where the medical evidence was unanimous the judge alone should decide the question, as he should if the evidence was disputed, unless the defence requests a jury. This right would remain to allay any grounds of suspicion that the judges and psychiatrists are committing people to hospital in an arbitrary fashion.[92]

Finally, both the New South Wales Committee and the Butler Committee insist on legal representation as of right, and the latter recommends that even if counsel is repudiated by the defendant, the court should appoint an *amicus curiae* in any case.[93]

PERSONS ACQUITTED BY REASON OF INSANITY[94]

The Present Position

The general scheme in most jurisdictions[95] is that following the return of a special verdict of not guilty on the ground of insanity the person so acquitted is held in "strict" and then "safe custody" during the Governor, or Governor-General's pleasure.

92 Op. cit. paras. 10.20-10.23.

93 For a lengthy rationale of legal representation in all mental health hearings, see New South Wales Mental Health Act Review Committee, *Report*, "Appendix J.".

94 The present discussion will deal only with the procedural and dispositional aspects of the insanity defence. It is beyond the scope of this article to enter into a debate as to the substance of the insanity verdict, and it would be a daunting task even to summarize the immense literature on this topic. It should be noted, however, that the Butler Committee has recommended a revision of the present insanity verdict. It proposes that a new verdict of "not guilty on evidence of mental disorder" if the jury (1) acquit the defendant solely because he is not proved to have had the state of mind necessary for the offence and they are satisfied on the balance of probability that at the time of the act or omission he was mentally disordered; or (2) they are satisfied on the balance of probability that at the time he was suffering from severe mental illness or severe subnormality (para. 18.37). It seems that in England the insanity defence has dwindled into insignificance, in 1974 there being only three persons found not guilty by reason of insanity. A. J. Ashworth "The Butler Committee and Criminal Responsibility" [1975] *Criminal Law Review* 687, 688. For the most recent Australian contribution to this debate, see K. L. Milte, A. A. Bartholomew and F. Galbally, "Abolition of the Crime of Murder and the Mental Condition Defences" (1975) 49 *A.L.J.* 160.

95 New South Wales s. 439 *Crimes Act* 1900-1974, s. 23 *Mental Health Act* 1958, s. 7 *Parole of Prisoners Act* 1966-1970; Victoria s. 420 *Crimes Act* 1958 as amended; South Australia s. 292 *Criminal Law Consolidation Act* 1935-1975; Commonwealth s. 20B *Crimes Act* 1914-1973; Australian Capital Territory ss. 65, 72 and 72A *Lunacy Act* 1898 (N.S.W.) as amended in its application to the Territory; Northern Territory s. 381 *Criminal Law Consolidation Act and Ordinance* 1876-1974.

In Western Australia detainees are also held during the Governor's pleasure. The Governor can make an order transferring such persons to approved hospitals. Once the Governor makes such an order, the obligation of the Parole Board to make an annual review and report on such cases lapses.[96] In Tasmania detainees are dealt with under the *Mental Health Act*.[97]

In Queensland, following the usual strict and safe custody procedures during the Governor's pleasure, the Minister is empowered to order admission of the person to a security patients' hospital to be held there until the Minister "after making such enquiry as he thinks fit" is satisfied that such person may be released "with safety to himself and others". The Governor-in-Council has the power to release on conditions after being satisfied of the above. The *Mental Health Act* provides for mandatory review of the patient by the psychiatrist in charge at least once in every 12 months, and this must be considered by the Governor-in-Council.[98]

Problems

These procedures highlight the nature of the classificatory limbo of neither being 'mad' or 'bad'. Theoretically a verdict of not guilty on the ground of insanity is an acquittal and an accused should be expected to be discharged. Having stood trial, under the present law it may be assumed that the accused was at least superficially sane, however, that may be defined, and therefore should be released. In some cases the event in question may have occurred some time previously and recovery may have occurred in the meantime. There is the possibility of course that the accused may only have had a "lucid" interval at the time of trial.

However, in no jurisdiction in Australia is release automatic, and the question is therefore raised of the purpose of post-acquittal detention. The Victorian Parole Board has stated that

> "A verdict of not guilty on the ground of insanity is a verdict of acquittal . . . and the purpose of detention in safe custody during the Governor's pleasure . . . is not to punish the defendant for his act, but to protect members of the community from harm at his hands."[99]

This seems to raise more problems than it solves. It assumes that the special verdict signifies that the person is still dangerous but it is not clear on what it is based, whether on the alleged offence or present insanity.

In most jurisdictions automatic detention either in prison or mental hospital follows this verdict, and it would seem that this special verdict allows for conviction and punishment anyway, albeit clothed in more

[96] S. 653 *Criminal Code*, ss. 48 and 49 *Mental Health Act* 1962-1974, s. 34, 34A, 34C *Offenders Probation and Parole Act* 1963-1971.
[97] Ss. 381 and 382 *Criminal Code*.
[98] See ss. 647, 668 *Criminal Code*, s. 37 *Mental Health Act* 1974.
[99] *Annual Report* 1962, p. 15.

TABLE 1:

AVERAGE LENGTH OF DETENTION OF PERSONS FOUND NOT GUILTY ON THE GROUND OF INSANITY

	MALE							FEMALE						
Jurisdiction	*N*	*Average Length of Detention*		*Maximum*		*Minimum*		*N*	*Average Length of Detention*		*Maximum*		*Minimum*	
		Years	*Months*	*Years*	*Months*	*Years*	*Months*		*Years*	*Months*	*Years*	*Months*	*Years*	*Months*
New South Wales (1932-1974)	23	6	2	12	4	2	2	11	2	3	5	1	0	7
Victoria (1928-1974)	30	7	5	13	4	0	4	11	4	7	17	11	0	5
Queensland (1900-1974)	Not Available			—	—	—	—	—	—	—	—	—	—	—
South Australia[a] (1918-1974)	2	See maximum/ minimum		29	4	14	4	0	—	—	—	—	—	—
Western Australia (1918-1974)	12	6	7	21	3	2	0	2	See maximum/ minimum		5	1	1	3
Tasmania	Not Available			—	—	—	—	—	—	—	—	—	—	—

[a] The information presented here does not fully accord with that given by George, *op. cit.*, 355 who states that, 'During the period from January, 1941 to June, 1970 10 people were detained . . . after a s. 292 acquittal [insanity verdict]. Only 2 were released during this period, after stays of 14 years and of 7 months. The remaining 8 were still hospitalised in June, 1970, and have been in . . . for periods ranging from two to nineteen years'.

benign terms. The individual is still blamed, stigmatized and exposed to severe sanctions.[100] In Victoria most insanity verdict cases are held in prison. In New South Wales of the 33 males acquitted on the ground of insanity after charges of murder or equivalent seriousness almost one-third were held in prison.

It should be remembered that M'Naughten, after whom the 'insanity rules' are named, was acquitted, but spent the rest of his life in hospital—22 years. In Australia the situation is summarised in Tables 1 and 2.[101]

TABLE 2:[a]

ANALYSIS OF MALE PERSONS FOUND NOT GUILTY ON GROUND OF INSANITY IN CUSTODY 31 DECEMBER 1974

Length of Time	*N.S.W.*		*Vic.*[b]		*Qld*		*S.A.*		*W.A.*		*Tas.*	
Years	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*
5	10	30.3	29	72.5	8	61.5	3	33.3	6	60.0		
6–10	10	30.3	8	20.0	3	23.1	5	55.6	2	20.0	Not	
11–15	8	24.2	3	7.5	—	—	—	—	1	10.0	Available	
16–20	2	6.1	0	0	2	15.4	—	—	—	—		
20+	3	9.1	0	0	—	—	1	11.1	1	10.0		
Total	33	100.0	40	100.0	13	100.0	9	100.0	10	100.0		

[a] This table may not give a true picture of the length of detention, not only because of omissions but because in a number of cases persons were held for some period prior to trial as being unfit to plead and this time should be included in their length of detention. The same applies to Table 1.

[b] Taken from date of Governor's order rather than date of verdict as more complete information was available. The difference is usually about 1 to 2 months, but can be up to 4 months in some cases.

From Table 1 it can be seen that for the two States where any meaningful data were obtained, Victoria and New South Wales, the average length of detention is considerable, seven years five months and six years two months respectively, but this is considerably less than the average time served by life sentence prisoners, the difference being about six years in Victoria and 11 years in New South Wales. It is also clear from Table 1 that females are released far earlier than males from custody during the Governor's pleasure.

The interesting feature in Table 2 is the greater number of persons held for an extended period of time (10 years or more) in New South Wales, compared with other jurisdictions. In fact 92.5 per cent of male insanity verdict cases in Victoria have been detained less than 10 years, 72 per cent

[100] I. N. Perr, "Is the Insanity Defense 'Unconscionable'?" (1975) 20, 1 *Journal of Forensic Sciences* 169, 171.

[101] From Freiberg and Biles, op. cit. pp. 106, 107.

less than five years, compared with 60.6 per cent less than 10 years in New South Wales, 84.5 per cent in Queensland, 88.9 per cent in South Australia and 80 per cent in Western Australia, though very small numbers are involved in the last three cases.[102] These figures may not reflect the true situation as there were other persons who died in custody, committed suicide or were repatriated.

The question also remains of how valid a "diagnostic tool" the insanity verdict is, i.e., whether it purports to screen out for special treatment insane defendants. It would seem, however, that this is not the case, a more important "indicator" of mental illness being whether capital punishment exists or not in that jurisdiction. Table 3[103] aimed to test the hypothesis that there will be a greater number of acquittals on the ground of insanity in States where capital punishment exists (or existed until recently) than in abolitionist States.[104]

TABLE 3:

LIFE SENTENCES, COMMUTED DEATH SENTENCES AND PERSONS FOUND NOT GUILTY ON THE GROUND OF INSANITY IN CUSTODY AT 31 DECEMBER 1974

State	*Life Sentence and Commuted Death Sentence*	*Not Guilty on Ground of Insanity*	*Total*	*(B) as Percentage of (C)*
	A	*B*	*C*	*D*
New South Wales	180	33	213	15.5
Victoria	63	40	103	38.8
Queensland	90	13	103	12.6
South Australia	32	9	41	21.9
Western Australia	22	10	32	31.2
Tasmania	No Data	—	—	—

Although these data must be treated with some reserve, it can be seen from Table 3 that there are considerable differences between the former and the latter. In the latter category, the percentage of "insanity verdict" cases in custody compared to the total number undergoing life sentences,

[102] In New South Wales the three cases over 20 years detention comprise one of 28 years, one of 26 years and one of 23 years; in South Australia the one person has been detained for 23 years and in Western Australia 21 years (all at 31 December 1974).

[103] Freiberg and Biles, op. cit. p. 42.

[104] S. W. Johnston, "Criminal Homicide Rates in Australia" in D. Chappell and P. R. Wilson, *The Australian Criminal Justice System* (Sydney, Butterworths, 1972) had found that rates of conviction and acquittal for murder, manslaughter and insanity verdicts varied in accordance with the political persuasion of the government in power in those states where capital punishment exists. Where the governments had a policy of not commuting sentences of death, juries were less likely to convict persons of murder and consequently acquittals and convictions for manslaughter rose.

commuted death sentences and insanity verdicts is only 12.6 per cent in Queensland and 15.5 per cent in New South Wales. In the former category, Victoria has 38.8 per cent, Western Australia 31.2 per cent and South Australia 21.9 per cent. There may of course be many other factors influencing these data, but it would be a remarkable coincidence if the existence of capital punishment were of no relevance. It will be interesting to see whether the percentage of "insanity verdict" cases in Victoria decreases following the abolition of capital punishment.

Where an "insanity verdict" case is detained in prison, what are the implications? Does it imply that he is untreatable, and if so, what is the purpose of detention? Does it imply that a mental hospital is unwilling to accept him or does it imply that it is simply punishment? Prison, of course, may be more convenient for the respective authorities, the convenience perhaps arising from the geographical location, the overcrowding of mental hospitals or the lack of security staff in mental hospitals. It is submitted that the term "Governor's pleasure" is anachronistic and anomalous in the context of modern penal and mental health legislation, giving little idea of what the criteria for release are or should be, and must be replaced.

The present law does not allow a right of appeal against an acquittal on the ground of insanity. In England this right exists, and in some jurisdictions in Australia a right of appeal exists where the issue was not raised by the defence.[105] The Victorian Law Reform Commissioner has said in this regard

> "The absence of any right of appeal against a verdict of not guilty on the ground of insanity may cause serious injustice. For example, the accused may have put forward at his trial a defence other than insanity. He may have made a case that he did not do the act charged against him, or that it was done by him accidentally, or without malice aforethought, or in self defence, or under duress, or while he was sleep-walking, or while he was in a state of non-insane automatism. The verdict of not guilty on the ground of insanity will ordinarily involve that the jury rejected any defence so raised. But there may be good grounds for contending that the rejection was unreasonable or was due to a misdirection on the part of the trial judge or to a wrongful admission of evidence or to some other irregularity at the trial. Or it may sufficiently appear (either from the form of the charge or otherwise) that the jury wrongly failed to consider the accused's other defences. Or again there may be good grounds for attacking the verdict of insanity itself as being unsupported by the evidence or as being based upon evidence wrongly admitted despite objection or as being vitiated by some other irregularity.
>
> It seems altogether unjust that in cases such as these the person found insane should not be entitled to appeal and ask to have the verdict and

[105] S. 5(2) *Criminal Appeal Act* (N.S.W.), s. 668 *Criminal Code* (Qld.).

the order for detention set aside and either an appropriate order substituted or a new trial directed."[106]

There are three further problems. The first is that in most jurisdictions there are no legislative provisions for the regular review of persons held during the Governor's pleasure, this being undesirable for reasons outlined earlier with reference to those unfit to stand trial. The second is that also adverted to earlier, i.e. that orders for strict custody and then safe custody in a prison are not necessarily the "least restrictive alternatives" available, and in an age when the courts are being vested with a wide number of dispositions in dealing with offenders, this would seem to be an unnecessary exception.

The third problem is that at the magistrates' court level there seems to be no power to return a special verdict, for the power to do so in superior courts is expressly bestowed by statute. It appears that if, in a summary trial, it is found that a defendant was insane at the time of the commission of the offence, there must be a verdict of acquittal. As the present Chief Magistrate of New South Wales has written of the situation there

"Summary trials do not ordinarily involve contention by the defence that the defendant is insane. The punishments likely to be inflicted are not usually such as to make it worthwhile avoiding them by assuming the stigma of insanity. If the question be raised, it is most likely to be so by the police or by the court itself, after the evidence is in, because the nature of the facts disclosed points to it. . . . There can be little doubt that if in a summary trial a court decides that the defendant did the act charged, but was mentally ill . . . then the information must be dismissed. . . . From many viewpoints this situation can hardly be thought satisfactory. A person may be more dangerous to his fellows, though he

[106] Op. cit. 1. This recommendation has now been acted upon in Victoria. S. 570A and S. 570B of the *Crimes Act* (1958) inserted by S. 8 of the *Crimes Act* (1976) (yet to be proclaimed) provides for appeal on a number of grounds (see fn. 78 supra) to the Full Court. The Full Court shall allow an appeal if it thinks the verdict is unreasonable, insupportable on the evidence, or the order of the court was wrong on a question of law or where there was a miscarriage of justice. An appeal may be dismissed if there is no miscarriage of justice, although the point on appeal might be decided in favour of the applicant. Where an appeal would be allowed on a ground which does not relate to the insanity of the accused, the Full Court may dismiss the appeal if of the opinion that but for the insanity of the accused the proper verdict would have been that he was guilty of an offence other than the offence charged. Where an appeal is successful, but the Full Court thinks that the proper verdict would have been guilty of an offence, the Court shall substitute a verdict of guilty of that offence and shall have the same powers of sentence as the Court before which he was tried. The Full Court may also set aside the jury verdict and enter an acquittal or direct a new trial to be held. The Mitchell Committee has recommended that, if the accused has raised the plea of insanity, and no other defence, he should have no appeal from a finding that he is not guilty on the ground of insanity. If, however, the accused has relied upon any defence which, if found in his favour, would have resulted in a finding of not guilty, he would be entitled to appeal, even if he has raised the plea of insanity as an alternative defence. Where the issue has been raised by the Crown, the Committee recommends that the accused should be entitled to appeal. Op. cit. 131-132.

have, so far, committed only a summary offence, than say a person who has killed a relative while in a state of depression."[107]

The course taken by the New South Wales courts in cases where they would be loathe to completely discharge such a person appears to be the use of the involuntary admission procedure, but this of course presupposes that the defendant is still mentally disordered at the time of the trial, whereas the event in question may have occurred some time previously. This procedure is probably also adopted in most other jurisdictions.

In England the Butler Committee reported that use was made of s. 60(2) of the *Mental Health Act* 1959 whereby magistrates' courts in certain cases, having heard psychiatric evidence, may make a hospital or guardianship order without convicting, a provision sometimes also used in unfitness to stand trial cases. Tasmania has a similar provision[108] but the Butler Committee found that the use of this provision was "inappropriate for this purpose since it requires the court to be satisfied that the defendant did the act charged".[109]

Alternatives

The American experience once again provides valuable guidelines for a more suitable scheme. This would entail a justification for detention executed through the least restrictive alternative. The detention would be continued for the shortest period necessary and the progress of the detainee would be constantly monitored. The criteria for release should be clear and understandable and, it is submitted, the onus of justifying detention should be on those detaining. As two American authors have written

"Any model procedure concerning disposition following acquittal on the grounds of insanity should discountenance commitment to a penal facility and should preclude mandatory commitment procedures which fail to consider the defendant's present mental condition."[110]

The New South Wales Committee suggested no alteration to the M'Naughten Rules and the only change recommended in this respect was the annual review of all forensic patients. It did not advert to the question of whether detention in a prison, in the first instance, is even necessary or desirable.

In the proposed criminal code for the Australian Capital Territory, the basic scheme proposed is that a person acquitted on the ground that he was insane or suffering from insane automatism at the time of commiting such offence may be dealt with either by the manner provided by the *Lunacy Act*, or, in the discretion of the court, made subject to a protection order, except in cases involving killing or infliction of grievous bodily

107 Lewer, op. cit. 109.
108 S. 49 *Mental Health Act* 1963.
109 Op. cit. para. 18.19.
110 Brakel and Rock, op. cit. 404.

harm.[111] A protection order can be made for those acquitted also by reason of sane automatism or intoxication.[112] The court may by order direct that the person be discharged on recognizance or otherwise on condition that he will undergo some treatment reasonably related to the crime or control of the condition experienced at the time of the offence. The minimum period is one year, and the maximum being two years or, where the maximum term of imprisonment exceeds two years, the maximum period would be equal to the maximum period of imprisonment. Other conditions may also be imposed. In cases of sane automatism or intoxication the court may order that the person be discharged unconditionally. There are a number of provisions for dealing with breach of conditions, basically giving the later court the same powers as the original court or to impose a fine or order that any recognizance or security be enforced. This procedure is welcome in that it takes into account the individual's mental condition at the time of disposition and employs the least restrictive alternative philosophy, extending even to unconditional discharge. The only reservations one may have are first that in some cases the maximum term of imprisonment may be very lengthy, up to life, for many crimes, at least under the present law, and second that the notion of compulsory treatment, especially for extended terms has been questioned by many as being contradictory, unethical and unworkable.[113] If one accepts that compulsory treatment is undesirable, it is not clear what the alternative disposition would be if the acquitted person were to refuse to be treated.

The Butler Committee was critical of existing English provisions which provide that a special verdict must be followed by a committal of the defendant to a hospital selected by the Home Secretary, there to remain until the Home Secretary authorizes discharge. The Committee proposed instead that the powers of disposal of the court in this case be the same discretionary powers as those recommended in the event of a disability finding.[114] Discretion would be vested in the courts and in appropriate cases the courts could order an absolute discharge. In other cases courts could make rules for placing the offender in the community under supervision.[115] Both the A.C.T. scheme and the Butler proposals contain the very important innovation of placing discretion with the courts and giving them a wide choice of disposition and should be given serious consideration.

111 It would seem that the working party which drafted this code inserted this provision in recognition of the fact that the community would be unlikely to tolerate the release of a person involved in a killing or serious violent offence immediately following the trial, even under the supervision of a court.

112 This proposal breaks new grounds in that it provides a court with authority to make an order in respect of an acquitted person. At present this power only exists in relation to persons who have been acquitted on the ground of insanity.

113 There are contrary arguments to the effect that compulsory treatment does not necessarily affect the success of treatment and that an insane person is incapable of giving informed consent.

114 See supra p. 153.

115 Op. cit. paras. 18.42-18.45.

Another possible scheme, it is submitted, is one which takes the notion of acquittal at face value and then leaves the question of the disposition of that person to the existing civil procedures, provided of course that those procedures have sufficient safeguards. This is the trend in certain American jurisdictions where the courts have held that persons found not guilty on the ground of insanity must be given a hearing substantially similar to those in civil commitment hearings.

Yet another alternative may be a blending of the criminal and civil procedures. A scheme could be devised whereby the trial judge presides over the commitment hearing, for relevant facts may emerge during the trial which need to be known to the adjudicating body. He could have the power to remand the person in custody for some short period in order to obtain reports as to his present mental condition. The dispositions available should be reasonably wide, perhaps ranging from complete release to supervised liberty to commitment to care as a civil patient under normal or stringent supervision.

It is recognized that some of the schemes mooted above may involve too fundamental a change to be readily acceptable and, should the present schemes remain, at the very least it is necessary to provide, for those who are automatically detained, regular and thorough review procedures, definite criteria against which decisions to release or discharge can be made, and as previously discussed, the right to appeal against a verdit of acquittal. It seems also necessary that consideration be given to providing the magistrates' courts with a similar range of powers and disposition as are suggested for the superior courts.

INSANITY FOLLOWING CONVICTION

The Present Position

The problems in this area fall into three main categories. These are the need for transfer to a mental hospital, the right not to be transferred, and the question of disposition at the expiration of the sentence.

In most Australia jurisdictions[116] the legal situation is essentially that transfer between prisons and mental hospitals is possible upon certification by medical officers, with release being possible, regardless of whether the sentence has expired, only when the detainee is certified as no longer being mentally ill.

In Queensland[117] a more complex procedure is provided for transfer in

[116] See s. 28 *Prisons Act* 1952-1972 (N.S.W.), s. 27 *Mental Health Act* 1958 (N.S.W.); ss. 52 and 54 *Mental Health Act* 1959 (Vic.) as amended; s. 31 *Prisons Act* 1933-1972 (S.A.), ss. 46, 49, 50, 54 *Mental Health Act* 1935-1974 (S.A.); s. 54 *Prisons Act* 1903-1975 (W.A.); ss. 68, 70, 71 and 76 *Lunacy Act* 1898 (N.S.W.) as amended in its application to the Australian Capital Territory; s. 21 *Prisons Ordinance* (N.T.).

[117] S. 31 *Mental Health Act* 1974.

this jurisdiction. A prisoner can only be admitted to a mental hospital on the written recommendation of a government medical officer. However, within three days of admission to the hospital he must be examined by a psychiatrist who must certify whether in his opinion the person is mentally ill and needs to be detained in hospital on account of mental illness. That person may be held in hospital for the remainder of his sentence less remission. His case must be reviewed by the psychiatrist at least once every 12 months. At the expiration of the prison term he is deemed to be a compulsory patient for a period of 12 months and is also deemed to be a restricted patient. At this time the case must be reviewed to decide whether the patient should continue to be a restricted patient, be transferred to another hospital or be discharged. In Tasmania[118] the Attorney-General has power to order the transfer of prisoners but only on the reports of two medical practitioners who must certify the nature of the illness and the fact that it warrants treatment in a hospital. A transfer direction must be coupled with a restriction direction, which ceases to have effect on the expiration of that sentence.

Problems

In most jurisdictions the use of the words "insane" or "mentally ill" may be too narrow in that there may be some persons on the borderline of insanity who may not qualify for removal to hospital. The New South Wales Committee has recommended substitution of the words "suffering from a mental condition which could be more appropriately treated in a mental hospital". The Committee also recommended that it may be desirable for the view of the superintendent of a hospital as to the appropriateness of the transfer to be obtained prior to such transfer.

It is usually assumed that the problem of transfer is that of the prisoner trying to assert his disability to obtain transfer to a less strict place of confinement. But there may be situations where the reverse may be true. In certain circumstances a person may be detained in hospital at the expiration of the sentence for some time, and this entails a substantial loss of liberty. The New South Wales Committee has recommended a limited right of appeal by a prisoner against transfer and a declaration that transfers can only be effected for medical and not disciplinary or management purposes.

The Butler Committee was of the opinion that although there was no evidence of the transfer procedures being abused, every mentally disordered offender transferred should have the right of application to a Mental Health Review Tribunal for an early hearing when what would have been his earliest date of release is reached, not, as at present, when the right exists only when the full sentence has expired.

[118] See Division III of Part IV of the *Mental Health Act* 1964. For a discussion of the operation of the similar English legislation see the Butler Report op. cit. para. 3.37 ff.

In the United States Court of Appeals for the Second Circuit it has been held that

> "before a prisoner may be transferred to a state institution for insane criminals, he must be afforded substantially the same procedural safeguards as are provided in civil commitment proceedings. . . ."[119]

Perhaps in the light of the conditions in some United States hospitals, this may be reasonable, but it may not be acceptable in Australia, mainly because, as was stated earlier, the courts have refused to question administrative matters behind the walls of prisons.

Perhaps the major problem pertaining to the movement of prisoners to and from mental hospitals is that of the fate of the prisoner in a hospital at the expiration of his sentence. This problem of indeterminacy in sentencing has been well analysed by the New South Wales Committee in its report. It points to the discrepancy where a sane person who may be considered extremely dangerous must be released upon expiration of sentence whereas an insane person, even if not dangerous, may be detained indefinitely. It argues that unless indeterminate sentences are introduced generally, a course which carries with it many dangers, the principle of determinacy should be applied in all cases.

It is not known how many prisoners are detained under this type of provision in Australia nor for how long. This shuttling of responsibility may work to the disadvantage of prisoners who are serving an indeterminate sentence, like a life sentence. Some research[120] has found that many of the prisoners who have served extremely long periods have been the ones moved back and forward between the penal and mental health services, neither of which wishes to take responsibility, or in some cases, know who has the responsibility, for release. The danger of becoming lost in the system is not a remote one.

In New South Wales at the end of 1974, of the two longest serving prisoners, one has been in a psychiatric hospital since 1934 and is now 70 years of age. The other, imprisoned for 28 years, spent 23 years in a mental hospital. In Queensland of 11 prisoners who at that time had served 20 years or more, five were in a security patients' hospital and two spent considerable time in mental hospitals. The two longest serving prisoners, 46 years and 35 years respectively, were in a security patients' hospital. One wonders how dangerous to the community their release would be.[121]

[119] *United States ex rel. Schuster* v. *Herold* 410 F. 2d 1071, 1073 (2d Cir. 1969). See Brakel and Rock, op. cit. 408.

[120] Freiberg and Biles, op. cit.

[121] A study has shown that the older chronically ill offender can be released from a maximum security prison environment and successfully managed in other ways. It showed that the release of such men to alternative placements resulted in the fairly rapid return of a percentage of them to the community without threatening the security of the community. The important finding was that 'for a segment of the prisoner population, continued incarceration may be inhumane as well as unnecessary to the safety of society at large'. See T. B. Brelje, W. H. Craine and J. Hayes, "The Chronically Mentally Ill Prisoner—An Alternative" (1972) 5, 3 *Correctional Psychologist* 167.

In the United States the Supreme Court held in *Baxstrom* v. *Herold*[122] that a convicted criminal cannot be shifted into indeterminate mental hospitalization at the end of his sentence without benefit of the same standards and procedural protections that apply to civil commitments. This led to an emptying of New York's hospital for the criminally insane of such prisoners and presented a natural experiment in the overprediction of dangerousness.[123]

Nine hundred and sixty-seven "Baxstrom patients" had to be either released into the community or committed to civil mental hospitals pursuant to ordinary civil procedures, and there have been several studies of these patients. It is worth quoting the report of results of one study at length.

> "In following the 967 Baxtrom patients, we found that on average they had been continuously institutionalized for 14 years. These retentions on the average exceeded the actual or possible sentences they could have received by 8 years. . . . While in the civil hospitals about 15 per cent of our sample of these 967 patients exhibited assaultive behaviour and about 25 per cent were discharged to the community during their first year in state civil facilities. . . .
>
> When released to the community, the Baxstrom patients fared well on indicators such as re-arrest and conviction, although almost half were rehospitalized. Between 1966 and 1970, 20 per cent of the released Baxstrom patients were re-arrested. Practically all arrests were for nuisance crimes such as vagrancy and intoxication. Conviction for a felony occurred in less than 5 per cent of the cases. Similarly, of the 967 patients, only 27 . . . were returned to hospitals for the criminally insane at any time during our four-year follow-up. . . .
>
> In sum, the experiences of the Baxstrom patients as shown in our data certainly indicate that society through institutions for the criminally insane exercised considerably more social control than was warranted by their subsequent behaviors."[124]

As Morris has stated, when predictions of violence are tested, massive over-predictions are revealed

> "To regard practice in New York and the institutions of Dannemore and Matteawan as lying outside the mainstream of practice in institutions for the criminally insane would be erroneous. The story of the Baxstrom patients could be told for many of the people we currently hold in

[122] 983 U.S. 107 (1966).

[123] See N. Morris, "The Future of Imprisonment: Toward a Punitive Philosophy" (1974) 72, 6 *Michigan Law Review* 1161, 1169. New York had been holding, after the expiration of sentence, those who had been certified as mentally ill and dangerous to themselves or others.

[124] H. J. Steadman and J. J. Cocozza, *Careers of the Criminally Insane* (Massachussets, Lexington Books, 1974) pp. 186-187. It must be remembered, however, that many of the Baxstrom patients were quite old when released, over 50 years on average, and it was found that the younger patients fared less well on release.

prisons and mental hospitals in many parts of the world because we deem them likely to be involved in future violence."[125]

The Butler Committee was aware of the Baxstrom experiment and of the problems inherent in the concept of dangerousness.[126] It noted the difficulties in assessing dangerousness and the inadequacies of the predictive techniques presently available, be they actuarial or subjective, but it thought that a balance had to be struck between the right of the public to reasonable protection and the right of mentally afflicted individuals in psychiatric hospitals or prisons to be returned into the community when their detention is no longer justified.[127] The Committee's solution to the offender considered dangerous was the "reviewable sentence". This sentence would be imposed at the time of sentencing by the sentencing court and would be appropriate for dangerous offenders who present a history of mental disorder which could not be dealt with under the *Mental Health Act* and for whom a life sentence would not be appropriate, because of the different criteria for release. The essential feature of this sentence is an obligatory review at two-yearly intervals. Criteria for release would centre on the prisoner's dangerousness, and account would be taken of such factors as his susceptibility to treatment, change in circumstances which precipitated the offence, and an increased maturity with the simple passage of time.[128] The sentence would be restricted to those offences which cause or might have caused grave harm to others, and most would be offences which presently in England carry a maximum, but not mandatory, life sentence.

Although the imposition of this sentence is hedged by a number of safeguards,[129] it is submitted that these recommendations should be approached with some caution. The indeterminate sentence has had an unfortunate history. Theoretically based on a medical model which viewed crime as a disease, it completely ignored the socio-political nature of crime and its relationship to society. The rehabilitative ideal was based on the notion of cure, but in practice it became obvious that there were few adequate criteria for release. The measurement of "recovery" or "reform" was found to be extremely difficult and, erring on the side of caution, releasing authorities tended to retain prisoners in custody, with detention occurring for periods far out of proportion to the gravity of the offence.

125 Morris, op. cit. 1171.
126 Op. cit. Chapter 4.
127 Ibid. para. 4.16.
128 Ibid. para. 4.40.
129 E.g. that the defendant not be a juvenile, that the court be satisfied on the evidence of two psychiatrists that the defendant shows or has shown evidence of mental disorder but cannot be satisfactorily dealt with under the *Mental Health Act*, that the psychiatric reports, social inquiry report, police antecedents report, previous conviction or finding of guilt all indicate that there is a substantial probability of his committing a further offence involving grave harm to another person, and that prior notice is given to the defendant that he appears eligible for such a sentence (para. 4.42).

Despite the fact that the Committee states that the "new sentence would not be punitive in intent but designed to enable the offender to be detained only until his progress under treatment, and other factors . . . allow him to be released under supervision without serious risk to the public",[130] it is probable that such a sentence would be perceived as punitive by the recipient. As Allen has written

> "Measures which subject individuals to the substantial and involuntary deprivation of their liberty are essentially punitive in character, and this reality is not altered by the facts that the motivations that prompt incarceration are to provide therapy or otherwise contribute to the person's well being or reform."[131]

The Committee's criteria for release, despite its awareness of the pitfalls, still appear amorphous and unsatisfactory. The definition of dangerousness as a "propensity to cause serious physical injury or lasting physiological harm"[132] while having the advantage of restricting the concept somewhat, still leaves a number of questions unresolved. Must the substantial probability of a further offence be of an imminent offence or a remote one? How are "substantial" probability and "serious" injury to be defined? Would a high probability of violence in a rarely occurring situation be sufficient to justify prolonged detention?[133] If the aim of the reviewable sentence is to prevent dangerous offenders from being released at the end of a determinate sentence, why should the sentence be confined to those who have shown evidence of mental disorder and not extended to those who show a propensity to cause grave harm generally, for example, terrorists?[134] Could there be an undue reliance on the psychiatric and social enquiry reports which may be too hurriedly compiled as the demand for them increases? Finally, upon whom will the onus lie to justify detention? Will the prisoner need to prove he is "cured" or will the detaining authorities have to demonstrate every two years that he is still unsafe or dangerous? Would the prisoner have a right to be heard before the Parole Board, the right to have reasons given for refusal of a licence for release or the right of representation?

Even accepting that this definition of dangerousness is workable, the question of prediction of this behaviour remains at the crux of this sentence. After reviewing the difficulties of predicting behaviour by either

130 Ibid. para. 4.39.

131 F. A. Allen, "Criminal Justice, Legal Values and the Rehabilitative Ideal" (1959-1960) *Journal of Criminal Law, Criminology and Police Science* 226, 230.

132 Ibid. para. 4.10.

133 On the problem of defining dangerousness, see N. Morris and G. Hawkins, *The Honest Politician's Guide to Crime Control* (Chicago, University of Chicago Press, 1970); R. G. Laves, "The Prediction of 'Dangerousness' as a Criterion for Involuntary Civil Commitment: Constitutional Considerations" (1975) 3, 3 *Journal of Psychiatry and Law* 291; H. J. Steadman and J. J. Cocozza, "We Can't Predict Who is Dangerous", *Psychology Today* January 1975, 32.

134 It is recognized that the Committee's terms of reference were restricted to the mentally abnormal offender, but if such a sentence were introduced, this question would eventually have to be confronted.

clinical or statistical techniques and concluding that certainty is impossible in prediction, the Committee nonetheless considered that the present state of knowledge is sufficient upon which to base a potentially indefinite, indeterminate, preventative sentence. It is submitted that, having regard to the dangers of indeterminate sentences and in the light of conflicts among psychiatrists and social scientists with regard to predictive techniques, and together with the paucity of reliable research data, a new sentence such as this ought not to be introduced. "Susceptibility to treatment" is too amorphous a term and places too much power in the hands of the treaters to be acceptable at this stage of our knowledge. Until it is far more clear exactly what it is which is supposedly being treated, Morris and Howard's statement that "power over a criminal's life should not be taken in excess of that which would be taken were his reform not considered one of our purposes" should be heeded.[135]

There remains the problem of the prisoner who may not have received a reviewable sentence but who is thought to be dangerous at the expiration of his sentence. It would seem that he would still have to be released at the end of his sentence.

The Committee, in settling on a form of indeterminate sentence for the dangerous offender decided against the use of the life sentence for a number of reasons. First, it was felt that the existing life sentence was ambiguous in its aims, being sometimes imposed as the heaviest penalty available and sometimes because its flexibility allows release earlier than if a determinate sentence were imposed. Secondly, the punishment aspects of the sentence were felt not to be congruent with a sentence in which release would be determined solely on the issue of dangerousness. Thirdly, the present life sentence in England is not subject to mandatory review and, in practice, review occurs at long intervals by the Home Office and the Parole Board. The Committee has performed a valuable service in pointing to some of the deficiencies of the determinate sentence, and it is clear that there needs to be far more discussion of the relationship between the determinate sentence and the indeterminate sentence, especially the life sentence which in many Australian jurisdictions is available for a wide range of offences, though rarely, if ever, imposed where it is not mandatory. It is true, as the Committee notes, that it is precisely those offenders who are the greatest risk to the community who are the ones usually ineligible for the "socialization" schemes, such as work release or weekend leave. It is probably also true that some form of indeterminate sentence will always be needed in the dispositional armoury, either as the heaviest penalty or as the ultimate form of "sanitization", i.e. complete removal from the community of an offender for its protection. However, it is submitted that rather than introduce a new sentence, with the concomitant confusion that always seems to follow, the Committee would have been better advised to

[135] N. Morris and C. Howard, *Studies in Criminal Law* (Oxford, Clarendon Press, 1964) p. 175.

modify the existing life sentence by ensuring that all indeterminately held prisoners, not only those deemed dangerous, be subject to mandatory and regular reviews at short intervals. The indeterminate sentence, whatever it is called, needs careful monitoring, and rather than confine these worthwhile reforms to the reviewable sentence, it is the life sentence itself which should become a reviewable sentence.

A preferable course for Australia to follow, it is submitted, would be to follow the guidelines set down by the New South Wales Committee. These state that no person be detained as a forensic patient after the expiration of his sentence or 10 years, whichever is the shorter. At the expiration of such period, the normal involuntary commitment proceedings must be commenced and the ex-forensic patient could then become an ordinary civilian patient, though he could, of course, continue to be detained under secure conditions. This scheme has much in common with the philosophy of the United States Supreme Court decisions. It has the advantage that the person does not continue indefinitely to be detained but puts the onus on the authorities at a certain stage (and logically this should be the expiration of sentence or a date which takes into account parole or remission entitlements) and periodically thereafter to justify detention.

Conclusion

Momentum is gathering throughout England, America and Australia for reform of the laws relating to mentally ill people. The adequacy and value of present civil commitment procedures are being increasingly questioned and more attention is being paid to those caught in the limbo between the mental health and criminal justice systems. Attention has also been focused on the nature and function of review bodies, and although not discussed in any detail in this paper, there is a great need to study the operation of Mental Health Tribunals or any other review machinery in this field.

It is clear that there is a necessity to review the role of the State, to delineate whether it is acting in a penal/coercive role or in a paternal role and to ensure that paternalism does not become a blind for more subtle and pervasive coercion. Finally, there is a need for the physical and human facilities to support legal reform so that the latter is not undermined unintentionally. This includes the desirability of building up a core of legal counsel experienced in this field of law. Such counsel would be persons who are aware of what dispositions are or may be used, who are adept at cross-examining psychiatrists, who can become familiar with medical and social welfare jargon, and who can learn to relate to their clients. The provision of representation is desirable, but the advice given must be competent advice. If there can be specialists in family law or conveyancing, there can also be in mental health law, and if that occurs there may be more progress in this nascent but vital area of the law.