Persons detained at The Governor's Pleasure January 1977
Research and Statistics Division
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A REPORT ON PLEA: An overview of New South Wales reference to trial, imprisonment and release

Due Date

GOVERNOR'S
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This report was prepared by E.C. Seyssener (B.S.W. (Hons) U.N.S.W.) under the direction of the Senior Research Officer, M.S. Dewdney (M.A. (Hons) U.N.S.W.; Dip. Soc. Stud; Dip. Crim. Melb.)
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SECTION 1. INTRODUCTION

1.1 The focus of this report is on those criminally disordered offenders who have been tried and found to be "not guilty on the grounds of mental illness". The aim of the report is to outline the relevant legislation and to describe the processes and procedures adopted in the detention, treatment, and release of this category of offender. This leaves aside those other categories of mentally-disordered offenders who come within the criminal-justice system: persons found not fit to plead and prisoners who become mentally ill while serving a determinate sentence. Reference is made to these categories of offenders when it is considered to have bearing on the processes that affect persons detained at the Governor's Pleasure*.

1.2 A description of what happens to G.P.s in the Corrections-Health system leads to consideration of the problems involved in implementing present legislation and an examination of possible alternative systems of disposition, treatment and review. A brief description of legislation and practice in other Commonwealth countries is introduced to illustrate alternatives in philosophy and management of this category of offender.

1.3 The central issue hinges on where the responsibility for management of G.P.s should lie. The dual system approach involving both the Department of Corrective Services and the Health Commission, leads to a reluctance to classify such individuals as either criminal or mentally ill. The offender is not treated like an ordinary criminal, but neither is he treated like an ordinary mentally-ill person.

1.4 Some of the trends in attitudes that highlight the need for re-examination of this group of offender can be summarized as follows:

* The abbreviated notation, G.P.s, is used in this report to refer to persons detained at the Governor's Pleasure.
(i) The growing community orientation of psychiatric care and the concurrently shorter hospitalization periods for the mentally ill.

(ii) A growing emphasis on treatment facilities and concern about the possible detrimental effects of certain legal procedures.

(iii) Growing concern about transgression of civil liberties.

(iv) A re-examination of the assumptions used in predicting dangerousness.
SECTION 2. LEGISLATION

A. "Special Verdict"

(a) The Legislation: N.S.W. Mental Health Act 1958

2.1 Section 23 of the Mental Health Act 1958 provides for a special verdict to be brought in where it can be shown that the offender was mentally ill at the time of the offence: a verdict leading to acquittal on the grounds of mental illness. In the case of such a verdict the judge shall order that

... such person be kept in strict custody, in such place and in such manner as to such judge seems fit until the Governor's Pleasure is known, and thereupon the Governor may give such order for the safe custody of such person during the Governor's Pleasure in a prison as the Governor seems fit.

(b) Transfer of Governor's Pleasure prisoners to Psychiatric Hospitals

2.2 Section 23(4) of the Mental Health Act provides for the transfer of G.P.s from prison to a psychiatric hospital in the form of a Schedule Three completed by two medical practitioners. A Schedule Three requires evidence of observable mental illness which suggests that persons treated with drugs and being kept in remission by those drugs are not eligible for scheduling. The problems that this provision in the legislation creates for appropriate placement of G.P.s are discussed in paragraphs 6.19-6.20.

(c) N.S.W. Legislation - An Historical Perspective

2.3 Under the first legislation enacted in N.S.W. in 1878, which contained provision for disposition of G.P.s, the Governor was not required to make an order until Schedules were completed for transfer of the G.P. to a hospital for the criminally insane. From this it must be concluded that the person was detained in prison after trial and only entered a mental hospital on completion of Schedules.
2.4 The Lunacy Act 1898 introduces the provision for the Governor to make an order in respect of all G.P.s if he so wishes and the order was for safe custody in "such gaol or other place of confinement as to the Governor seems fit." The provision for Scheduling was retained. Although the Governor could exercise his discretion as to place of custody, it seems that in practice prison became established as the first place of detention after trial.

2.5 The Mental Health Act 1958 confirms this procedure in statute as it states that "... the Governor may give such order for the safe custody of such person ... in a prison as the Governor seems fit."

(d) The English Legislation

2.6 Under the first legislation introduced in England in 1800, which provided for the special verdict and for custody until the pleasure of His Majesty was known, His Majesty's order was to "such place and in such manner as to His Majesty seems fit." Persons were often directly admitted to county mental asylums or in the case of the dangerously mentally ill to Bedlam Hospital. No provision was made for schedules as direct disposition in psychiatric hospitals was possible. The English legislation has remained largely unchanged since 1800. The most recent changes in 1964, provide for the executive order, now made by the Home Secretary, to specify only a hospital as the place of safe custody.

(e) A Comparison of the Trends in N.S.W. and England

2.7 The legislative trends in England and in N.S.W. appear to run in opposite directions. In England the trend moved from the use of discretion as to place of detention to specifying a hospital as the only place of detention. In N.S.W., the Governor's discretion was narrowed in the Mental Health Act 1958 to specifying prison as the place of detention to be nominated in the order.
(f) **Canadian Legislation**

2.8 Similar provisions in Canada are covered by a Federal Act: The Criminal Code of Canada 1953-54. Section 542(2), providing for the court to order custody after the finding of not guilty by reason of insanity, is very similar to the N.S.W. legislation: "... the judge ... shall order strict custody in the place and in the manner that the .... judge directs until the pleasure of the lieutenant governor of the province is known."

2.9 Provisions for transfer to a psychiatric hospital are however different from N.S.W. legislation. The Lieutenant-Governor may order transfer to a psychiatric hospital on satisfactory evidence. Completion of schedules is not necessary for transfer to a psychiatric hospital in the Canadian legislation.

B. **Variations in the Governor's Order - N.S.W. Mental Health Act 1958**

2.10 Section 29 of this Act is concerned with effecting variations in the Governor's Order. If a G.P. is detained in a psychiatric hospital and the medical officer wishes the patient to go outside the grounds of the hospital as a further step towards rehabilitation he may apply, through the Principal Adviser, Mental Health, for a variation in the Governor's order. This may be for employment, weekend leave or extended leave. Similarly an application for conditional release directly from the psychiatric hospital can be made to the Governor.

C. **Statutory Review Provisions**

(a) **N.S.W. Legislation - Health Commission**

2.11 There are two sections of the Mental Health Act which provide for review of G.P.'s detained in psychiatric hospitals: these apply equally to all categories of prisoners who are mentally ill. Firstly, section 29B requires the G.P. to be brought before the Mental Health
If it is determined that the patient should not be detained for further observation and treatment and he is subject to remain in custody, as are G.P.s, the person shall be returned to prison. These provisions are discussed further in paragraphs 3.28.

2.12 Secondly, the superintendent of the psychiatric hospital is required to medically examine or "cause to be medically examined" offender detainees to determine whether or not they are still mentally ill and whether continued detention in a mental hospital is necessary.

(b) Department of Corrective Services

2.13 Section 7 of the Parole of Prisoners Act 1966 provides for the Parole Board to review and report to the Minister as to whether a G.P. should continue to be detained in prison. The policies adopted to implement this provision are discussed in paragraph 3.21 and the associated difficulties in paragraphs 6.23-6.29.

(c) English Legislation

2.14 There are two bodies concerned with review of "Her Majesty's Pleasure" detainees. One of these bodies is a statutory Mental Health Tribunal and the other is a non-statutory advisory board to the Home Secretary.

2.15 The Tribunal is a safeguard for psychiatric patients generally and offender patients may apply to the Tribunal for a review of their case once within the six months from the date of order and every six months thereafter. The patient's nearest relative has the right to apply to the Tribunal once in the first twelve months and once a year thereafter. The Tribunal only acts in an advisory function to the Home Office in the case of "Her Majesty's Pleasure" detainees.

* The Mental Health Tribunals are statutory bodies for the safeguard of psychiatric patients generally. The Tribunal consists of a psychiatrist, a medical practitioner and a barrister/solicitor. The decisions of the Tribunal override any decision made by the medical superintendent of the hospital.
2.16 The recommendation by the Arvold Committee(1) that the Home Secretary should be assisted in decisions about restricted hospital order patients and "Her Majesty's Pleasure" patients has been put into effect. The committee comprises a legal chairman, a forensic psychiatrist and a representative of the social work profession.

(a) **Canadian Legislation - Boards of Review**

2.17 The Criminal Code (Section 547) authorized the creation of Boards of Review at the option of the provincial governments. The legislation stipulates that the board shall consist of three to five members. Further, at least two members shall be qualified psychiatrists and one member shall be a member of the bar.

2.18 The board must review every person not later than six months after the making of the order and at least once every 6 months thereafter that the offender is detained. After each review the board is to report to the Governor setting out the results and stating whether the person has recovered and, if so, whether it is the board's opinion that it is in the interest of the public and of that person for him to be released on either conditional or absolute discharge.

2.19 Review and report can also be requested by the Governor at any time.

D. "**Diminished Responsibility**"

(a) **The Legislation - N.S.W. Crimes Act 1900, Amendment 23A, 1974**

2.20 This new section of the Crimes Act introduces "diminished responsibility" into N.S.W. law. This provision in the legislation allows for the reduction of a murder charge to manslaughter if there is a mental abnormality and if, in the opinion of the jury, this led to a diminution of responsibility.
2.21 The provisions in English legislation in the Homicide Act 1957 are very similar to the N.S.W. Legislation.

2.22 There is no provision for a defence of diminished responsibility in Canadian law.

(c) Use of Diminished Responsibility in England

2.23 Reference to this new form of defence becomes relevant to G.P.s when seen in the context of developments in England. In England, successful use of the defence of diminished responsibility works in conjunction with provisions under the Mental Health Act 1959, which allows the court to order detention in a psychiatric hospital instead of prison. The mental health legislation covers the whole range of offences from vagrancy to manslaughter. Conjointly, these two pieces of legislation ("hospital orders" and "diminished responsibility") give the court adequate power to deal appropriately with cases involving a wide range of mental disorder where the McNaughton rules may not apply. The development and improvement of these procedures is becoming of far greater practical importance than the application of the McNaughton insanity defence. (2)

(d) Use in N.S.W.

2.24 N.S.W. legislation allows for no other order of confinement to be made, if a conviction is proven, except for sentence. Penalties for manslaughter range from nominal punishment to penal servitude for life. The use of the defence of "diminished responsibility" is relatively new in N.S.W. and sentencing under this section has already raised important issues.

2.25 In R. v. Veen (Aug. 1975) this defence was successfully used and a sentence of penal servitude for life was handed down. The trial judge stated in his judgement that the ordinary sentencing principle of punishment did not apply and life imprisonment was seen as necessary for the protection of the community. The judge conceded that there
were grounds for considering Veen as mentally disordered but there was no institution, other than prison, to which he could be sent. This problem has implications for the use of this defence, especially when long sentences are passed on the principle of protection.
SECTION 3. IMPLEMENTATION OF THE LEGISLATION

A. INTRODUCTION

3.1 Current institutional arrangements for the apprehension, detention and treatment of G.P.s involve two major systems - the Criminal-Justice and Mental Health systems. Figures 3.1-3.3 represent the interface of the criminal justice and mental health systems. The arrows indicate the usual directions of patient-inmate movements with a note along the arrow indicating the procedural mechanism involved.

B. COURT PROCEDURE & DISPOSITION

(a) The Defence of Mental Illness

3.2 Although this report is not directly concerned with the defence of mental illness, reference as to how it is interpreted by the judge has bearing on the extent of mental illness of an offender at the time of detention.

3.3 The defence of mental illness is based on application of the McNaughton rules, which relate to the mental condition of the offender at the time of the offence; i.e., a person's intellectual ability to appreciate firstly, the physical act that he was doing and secondly, whether that act was wrong.

3.4 Australian judges have been able to use the McNaughton rules with some degree of flexibility. Mr. Justice Dixon in R. v. Porter instructed the jury that they should acquit the prisoner if, at the time of the crime, he could not reason about rightness or wrongness "with a moderate degree of composure". (3) This instruction has subsequently been used in cases where the judge considers it appropriate and for all practical purposes establishes irresistible impulse as a part of criminal law in Australia. (4)
Figure 3.1 Usual Routes for G.P.'s in N.S.W.
Figure 3.2 Route for Her Majesty's Pleasure Cases in England

COMMUNITY
   Charge
   ↓
   COURT
   Special verdict
   ↓
   CIVIL HOSPITAL ← SPECIAL HOSPITAL
   ↓
   Tribunal or Advisory Council recommendation licence
   ↓
   COMMUNITY

Figure 3.3 Route for G.P.'s in Ontario, Canada

COMMUNITY
   Charge
   ↓
   COURT
   Special verdict
   ↓
   HOLDING PRISON 7–10 days
   ↓
   Governor's Order
   ↓
   MENTAL HOSPITAL
   ↓
   Board of Review recommendation
   ↓
   COMMUNITY
(b) **Disposition of C.P.s in N.S.W.**

3.5 When an offender is acquitted on the grounds of mental illness the established procedure is for the judge to order his detention in a prison, as a place of safe custody, till the Governor's Pleasure is known. An order from the Governor is obtained confirming detention in a prison during the Governor's Pleasure.

3.6 The implication of the broad use of the defence of mental illness discussed above, is that persons suffering from a temporary mental disorder, who commit an offence, can be detained indeterminately. They may be sane at the time of the trial and, in some instances, considered not likely to commit a further offence, yet detention in strict custody is mandatory. The dilemma that the judge may find himself in is illustrated in R. v. Cynthia Butterworth. Mrs. Butterworth spent 10 months in the community on bail before trial and then had to be ordered to be kept in strict custody. The judge expressed the wish that she be psychiatrically assessed immediately and that the result be brought to the notice of the Governor as soon as possible. The N.S.W. legislation did not permit court release of the offender to either conditional or unconditional liberty. However, the statutory provisions do not appear to restrict confinement to prison as the place of safe custody to be ordered by the court. Further discussion of this interpretation of the legislation is in paragraphs 6.13 - 6.14. Over the years it seems to have become a matter of procedural tradition rather than legislative restraint that has led to prison being the only place of confinement directly after the trial.

(c) **Disposition in England**

3.7 As noted in paragraph 2.6 disposition of "Her Majesty's Pleasure" cases in mental hospitals has been part of the English procedure since the enactment of the
legislation in 1800*. There were considerable management and security problems but the policy regarding management of these offenders has always been that they are basically the responsibility of the Mental Health System. This was confirmed in statute in 1964 when it was enacted that the Home Secretary could only specify a hospital as the place of custody.

(d) Disposition in Canada

3.8 The Mental Health Association study(6) of mentally disordered offenders indicates that detention, review and release of G.P.s varies from province to province. Whilst most are held in mental institutions, some are housed in prison and a small number in nursing homes.

3.9 Offenders in Ontario found not guilty on the grounds of mental illness go from the trial to Don's Jail in Toronto which acts as a holding centre until the Lieutenant-Governor signs the warrant which allows admission into a psychiatric hospital. The average length of stay at Don's Jail is 7 - 10 days.**

C. DETENTION OF GOVERNOR'S PLEASURE PRISONERS

(a) Department of Corrective Services

3.10 A G.P. is received into prison in much the same way as other prisoners. He is medically examined on reception and the examiner may refer the prisoner directly to the prison psychiatrist; such referral may also be effected by the Reception Committee. Prisoners who show overt mental illness are detained in the Observation Section at Long Bay.

* The practice in the 19th century was for the Home Office, before making out the order, to ask the visiting justices of the gaol, where the person was detained at Her Majesty's Pleasure, whether there was a county asylum to which they could send the person. Bedlam, the first hospital designated for the criminally insane was requested to take only the most dangerous. A National Survey in 1837 showed that of the 178 persons detained at Her Majesty's Pleasure only 40 were in local gaols. The others were either in Bedlam or scattered among the county asylums. By 1856 of the 596 criminal lunatics only 22 were in gaol.(5)

** Verbal communication Dr. P. Houston, Prison Medical Service.
3.11 G.P.s may be transferred from prison to a psychiatric hospital on the completion of certificates by two doctors, in the form of a Schedule Three. However, for those who respond well to medication or who are mentally disturbed rather than mentally ill, transfer to psychiatric hospitals can become problematic. In some cases the prisoner may be certified by one doctor but may show insufficient observable signs of mental illness at the time of the second medical interview. The doctor is then unable to complete the second schedule and thus the requirements for transfer to psychiatric hospital are not fulfilled.

3.12 There are indications* that some G.P.s would be more suitably placed in psychiatric hospitals, yet they are either not transferred or long delays are experienced before the transfer. These administrative problems may well result from unclear criteria relating to the transfer of prisoners.

3.13 Prisoners who are not mentally disturbed on reception or who respond well to medication move into the general prison population and subsequently come before the Classification Committee.

3.14 The Life Sentence Review Committee includes G.P.s in its area of responsibility. The committee's role in the review process is discussed in paragraphs 3.21. The Committee's main focus is on investigating and recommending suitable educational and therapeutic programmes, which also includes recommendations for movement between institutions.**

(b) Health Commission of N.S.W.

3.15 There are three psychiatric institutions in N.S.W. which are involved in the care and treatment of G.P.s. These are Rozelle Hospital (formerly Callan Park), Morisset Psychiatric Hospital and Parramatta Psychiatric Hospital which accepts female G.P.s. These hospitals

* Verbal communication with Probation and Parole staff.
** The Committee comprises senior management personnel, a psychiatrist, a psychologist and a social worker (senior probation and parole officer
provide a range of security conditions including a maximum security ward at Morisset. Security conditions for G.P.'s are determined by the Principal Adviser, Mental Health, who can authorise transfer of G.P.'s anywhere within the hospital grounds or to any other psychiatric hospital. The Director refers recommendations for any activity outside the hospital grounds to the Minister of Health as these require a variation in the Governor's order.

3.16 The Principal Adviser relies on submissions from the medical officer concerned with G.P.'s and from the medical superintendent. At Morisset the superintendent fills both functions and, for a second opinion, he relies on a psychiatrist from the Prison Medical Service who visits regularly every three months.

3.17 The approach to the management of G.P.'s in the psychiatric setting is similar to the management of other mentally ill patients except for the closer supervision by the Principal Adviser, Mental Health. This approach is one of continual assessment resulting in a gradual movement towards reduced security conditions and placement in situations where their social skills and individual coping skills can be developed and tested. This system of hurdles may include transfer to mixed open wards and more demanding work situations as well as movement into the community for employment, social and family contacts.

3.18 The daily observation by psychiatrist and staff allows a profile of the particular stresses which cause breakdown or regression to be worked out for each individual. Since each hospital contains facilities for varying levels of development a patient can be called back when new stresses are seen to cause adverse effects.
(c) Detention in England

3.19 The hospital to be specified in the Home Secretary’s warrant can either be a "special hospital"* or a local mental hospital. The Mental Health Act 1959 placed the three special hospitals under the direct management of the Ministry of Health so that there is no sharing of management of mentally ill offenders.** The general principle adopted in specifying a special hospital as the place of detention is a "last resort" policy "after all other possibilities have been considered unsuitable". (7)

3.20 It is considered desirable for a patient in a special hospital to go to a local psychiatric hospital before being discharged into the community and in the majority of cases this practice is adopted. (8) The Butler Report commented on some difficulties in effecting these transfers; one of the reasons given was lack of secure facilities in the local hospitals. (9) On the whole, the 1959 Mental Health Act is considered to be successful in relation to the treatment of mentally ill offenders. (10).

D. REVIEW AND RELEASE

(a) Department of Corrective Services, N.S.W.

3.21 Under legislative provisions, review for G.P. prisoners is a matter for the Parole Board which can report to the Minister, on the continued detention of a G.P., whenever it considers it is appropriate. In February 1969 a policy was introduced that reviews be initiated by a referral from the Minister of Justice on the advice of the departmental Life Sentence Review Committee. The Life Sentence Review Committee then ensures that up to date psychiatric reports are submitted for consideration by the Board.

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* Special hospitals are for mentally ill patients who, because of dangerous or criminal propensity are not suitable for placement in local psychiatric hospitals. Broadmoor specialises in mentally ill or psychopathic patients whose intelligence is average or higher and the other two hospitals take patients with some degree of subnormality or brain damage.

**Prior to 1959 the special hospitals were the responsibility of the Prison Service.
3.22 The general policy is to review at twelve monthly intervals. However, the Life Sentence Review Committee has proposed that generally, prisoners should be reviewed as soon as possible after trial, that is within six months, and the case should be resubmitted at three or six monthly intervals. Periods between review should not be longer than twelve months. In practice each case needs to be individually considered in terms of the mental health of the G.P. and the risk to society if he were to be released.

3.23 The flow of communications between the government agencies involved in the review process is represented below.

3.24 The Parole Board may review a G.P. without a request from the Minister and in isolated cases the Board uses this prerogative. Similarly, in cases where the new review dates set by the Board and the Life Sentence Review Committee coincide, a request for new review from the Minister is not necessary.

3.25 G.P.s who are released from custody are released on conditions in the form of a licence. The licence contains a number of universal conditions but additional conditions may be added if it is seen as necessary. The duration of a licence is usually five years for those who have committed serious offences and three years for lesser offences. A person on licence can be returned to custody for breaking any conditions of the licence, in the event of psychiatric breakdown or for committing another offence. Return to custody means return to prison, in the first instance, even if the reason for revocation is based on psychiatric grounds.
Figure 3.4 Communication Flow in Review Process

Dept. of Corrective Services
Life Sentence Review Committee
recommendation for review

Commissioner of Corrective Services

Minister of Justice and Services
request for advice

Parole Board

recommendation against release addressed to Commissioner

Life Sentence Review Committee
Board's recommendation against release & new review date;
Committee's recommendation & review date if in disagreement with Board

Minister

recommendation for release

Board's recommendation & new review date
Commissioner's comments, if any, and new review date if in disagreement

Governor

order for release on licence

Commissioner

endorsed recommendation

new review date
sent to Departments
Correspondence
Section. Forwarded to Board at a later date.

licence

community
(b) Health Commission of N.S.W.

3.26 A patient within the mental health system is under continual review. The programme for a patient is based on the "multiple hurdle" approach discussed in paragraphs 3.17 - 3.18. This approach necessitates constant review and assessment by the medical officer to determine when the patient is ready for the next step.

3.27 The Mental Health Act 1958 only provides for the detention of persons, subject to be held in custody, in psychiatric institutions while they are mentally ill. Should the Mental Health Tribunal or the Principal Adviser, Mental Health declare the patient no longer mentally ill, within the terms of the Act, the patient is returned to prison.

3.28 The Act requires that persons under detention be brought before the Tribunal at the expiration of a six month period. Although the Tribunal takes into account medical reports it does not always follow the medical officer's recommendations. If a G.P. is declared to be no longer mentally ill, the decision may result in return to prison and consequently an interruption of a graduated programme aimed at re-introduction into the community. The Mental Health Tribunal is primarily concerned with the issue of mental illness and not with the issue of potential dangerousness and the desirability, or otherwise, of release of offenders into the community (see Section 5 (h)).

3.29 However, if it is in the interest of the patient the Tribunal has, in some cases, agreed to allow a patient to remain in the mental institution beyond the period of overt mental illness.* A number of patients have, in fact, been released directly into the community from Morisset Psychiatric Hospital. Another two patients are currently under consideration for release from Rozelle Hospital.**

* Verbal Communication, medical officer, Rozelle Hospital.
** Out of 55 released G.P.s, 9 have been released from psychiatric hospital. (see table 4.2)
3.30 If G.P.s remain in hospital following the Mental Health Tribunal assessment the superintendent is responsible for subsequent review. A medical report is submitted by the medical officer and if there is a difference of opinion between the superintendent and the medical officer, other psychiatric opinions are requested. A final recommendation is sent to the Principal Adviser, Mental Health. In the case of release or variation in the Governor's Order he sends the recommendation to the Minister of Health and subsequently to the Governor.

3.31 Persons released from psychiatric institutions are released on licence as described in paragraph 3.38. In 3 cases patients were released on "leave of absence" effected by a variation in the Governor's warrant.

(c) Review and Release in England

3.32 Since all Her Majesty's Pleasure cases in England are detained in mental hospitals the review is entirely within the mental health system.

3.33 It is not compulsory for cases to be brought before the Mental Health Tribunal but as already stated in paragraph 2.15 patients, including patients in special hospitals, may apply to the Tribunal for review within the six months from the date of order and every six months thereafter. The patient's nearest relative has the right to apply to the Tribunal once in the first twelve months and once a year thereafter. The Tribunal acts in an advisory capacity to the Home Office.

3.34 For special hospital cases, that have been classified as needing special care in assessment, the Home Secretary is assisted by an Advisory Board. The Board comprises a legal chairman, a forensic psychiatrist and a representative of the social work profession. The Butler Report recommended certain modifications and extensions to this Advisory Board. Firstly, all restricted patients in the special hospitals should be referred to an appropriately constituted advisory board and the advisory board should be available to the Home Secretary and to the responsible medical officer in cases in local psychiatric hospitals.
Secondly, the advisory board should be involved in proposals to the Home Secretary to transfer restricted hospital patients to local psychiatric hospitals, to grant patients leave or to discharge them into the community. The board would continue to be concerned with restricted patients throughout the period of supervision and should be involved in the recall of any such patient.

(d) Review in Canada

3.35 In the past five years the provinces have moved towards establishing formal boards of review and seven provinces have established boards under the Federal Criminal Code. Two other provinces have created boards under provincial acts, which fulfil virtually the same functions, but one province has no board.

3.36 In Ontario, the Review Board is created under the provincial Mental Health Act and review is only once a year instead of the six monthly review required in federal legislation.

3.37 The review procedure adopted in Ontario is briefly as follows*. A case conference is held in the hospital where the offender is detained, which is attended by medical staff involved in the case and the Clinical Director. The advice of independent psychiatrists is sought when it is considered necessary. A legal officer writes a submission containing the determination of the case conference for the Board of Review. The hearing before the Board is held in the office of the Chief Justice at which the patient may appear or be represented. Witnesses may be called. The Board's recommendation, which requires a four-fifths majority, is sent to the Lieutenant-Governor through the Minister of Health.

E. Supervision on Release, N.S.W.

3.38 G.P.s in prison are released to the community on licence under the supervision of the Probation and Parole Service. The licence contains general conditions as to place of residence, reporting to the supervising officer.

* Verbal communication Dr. P. Houston.
and notifying changes in employment and residence. The licence may also contain additional clauses for particular individuals. These could be clauses pertaining to abstinence from alcohol or requiring the licensee to attend for psychiatric treatment, usually at a community clinic. Some prisoners are released on licence with the condition that they admit themselves as voluntary patients into a psychiatric institution. This is usually for a period of resocialization and gradual reintroduction into the community.

3.39 G.P.s have also been released on licence from Morisset Psychiatric Hospital under the same conditions as outlined above. Some cases have also been released from Morisset on "leave of absence", remaining under the jurisdiction of the Health Commission for supervision purposes. Leave of absence has been for a period of two years after which application has been made to the Governor, through the Minister of Health, for termination of the Governor's warrant.
4.1 The following tables are presented to describe the G.P. population received in custody since 1946. The major source of information is departmental records which in some instances are incomplete. All basic data has been checked with police records.

4.2 The files of 121 G.P.s known to have been received since 1946 were examined. There is no way to verify whether this is the exact number of G.P.s received into custody.

Table 4.1 Location of G.P.s in Custody at 16.12.76

G.P.s in Prison

<table>
<thead>
<tr>
<th>Location</th>
<th>G.P.s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bermima</td>
<td>2</td>
</tr>
<tr>
<td>Goulburn</td>
<td>2</td>
</tr>
<tr>
<td>Long Bay</td>
<td>12</td>
</tr>
<tr>
<td>Maitland</td>
<td>1</td>
</tr>
<tr>
<td>Nulawa (females)</td>
<td>5</td>
</tr>
<tr>
<td>Total G.P.s in prison</td>
<td>22</td>
</tr>
</tbody>
</table>

G.P.s in psychiatric hospitals

<table>
<thead>
<tr>
<th>Location</th>
<th>G.P.s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morisset</td>
<td></td>
</tr>
<tr>
<td>Ward 21 (max. security)</td>
<td>5</td>
</tr>
<tr>
<td>Ward 19 (med. security)</td>
<td>5</td>
</tr>
<tr>
<td>Ward 17 (min. security)</td>
<td>4</td>
</tr>
<tr>
<td>Rozelle Hospital</td>
<td></td>
</tr>
<tr>
<td>Ward 2 (med. security)</td>
<td>8</td>
</tr>
<tr>
<td>Ward 20 (min. security)</td>
<td>5</td>
</tr>
<tr>
<td>Repatriation Ward</td>
<td></td>
</tr>
<tr>
<td>Parramatta Hospital (females)</td>
<td>1</td>
</tr>
<tr>
<td>Total G.P.s in psychiatric hospital</td>
<td>29</td>
</tr>
</tbody>
</table>

Total G.P.s in custody | 51 |
Table 4.2  Status of Released G.P.s at 16.12.76

**Released from prison**

- Current first licence 15
- Licence expired 23
- Total released from prison 38

**Released from psychiatric hospital**

- Under Mental Defectives Act 1
- On licence 4
- To inter-state psychiatric hospital 1
- Leave of absence 3
- Total released from psychiatric hospital 9

**Released on licence and revoked**

- Currently in prison 4
- Died in prison 1
- Currently in psychiatric hospital 2
- Released to psychiatric hospital 1
- Total released and revoked 8

Total released G.P.s. 55

4.3 Of the twenty-three whose licences have expired nine are known to have completed successfully. Records of the other fourteen licensees are at Sheas Creek Government Repository. It is most likely that all of these completed licence without further incident.

Table 4.3. Classification of Outcomes for Remaining G.P.s

- Died in psychiatric hospital 11
- Deported 4
- Committed suicide in prison 2
- Sentence changed to life by appeal 1
- Trial leave, discharged from court 3

Total 21
Table 4.4. Summary

<table>
<thead>
<tr>
<th>Total in prison</th>
<th>22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total in psychiatric hospital</td>
<td>29</td>
</tr>
<tr>
<td>Total released</td>
<td>49</td>
</tr>
<tr>
<td>Total of other outcomes</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>121</td>
</tr>
</tbody>
</table>

4.4 The total of released G.P.s (49) excludes six G.P.s released and revoked and who are counted in the present population of G.P.s in custody.

Table 4.5. Reasons for Revocation

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offence committed while on licence</td>
<td>1</td>
</tr>
<tr>
<td>Recommended by psychiatrist</td>
<td>2</td>
</tr>
<tr>
<td>Breach of conditions of licence:</td>
<td></td>
</tr>
<tr>
<td>- not reporting to Parole Service</td>
<td>2</td>
</tr>
<tr>
<td>- not attending psychiatric clinic</td>
<td></td>
</tr>
<tr>
<td>- unable to be located by Parole Service</td>
<td>1</td>
</tr>
<tr>
<td>- did not abstain from alcohol</td>
<td></td>
</tr>
<tr>
<td>- suicide attempt, failure to co-operate with Parole Service</td>
<td>1</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>8</td>
</tr>
</tbody>
</table>

4.5 The offence committed by the G.P. on licence was murder and the two G.P.s who were revoked on the recommendation of a Psychiatrist had made threats to kill.
Table 4.6. Offences of G.P.S (coded by most serious offence)

<table>
<thead>
<tr>
<th>Offence</th>
<th>Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Homicides, assaults and like offences</strong></td>
<td></td>
</tr>
<tr>
<td>Murder</td>
<td>77</td>
</tr>
<tr>
<td>Murder -</td>
<td></td>
</tr>
<tr>
<td>attempts</td>
<td>13</td>
</tr>
<tr>
<td>threats</td>
<td>1</td>
</tr>
<tr>
<td>Manslaughter</td>
<td>1</td>
</tr>
<tr>
<td>Assaults -</td>
<td></td>
</tr>
<tr>
<td>major</td>
<td>11</td>
</tr>
<tr>
<td>minor</td>
<td>2</td>
</tr>
<tr>
<td>Acts endangering life -</td>
<td></td>
</tr>
<tr>
<td>arson (person therein)</td>
<td>2</td>
</tr>
<tr>
<td>other*</td>
<td>1</td>
</tr>
<tr>
<td>Total homicides, assaults and like offences</td>
<td>108</td>
</tr>
<tr>
<td><strong>Sexual Offences</strong></td>
<td></td>
</tr>
<tr>
<td>Attempted rape</td>
<td>1</td>
</tr>
<tr>
<td>Indecent assault on female -</td>
<td></td>
</tr>
<tr>
<td>under 10 years</td>
<td>1</td>
</tr>
<tr>
<td>under 16 years</td>
<td>2</td>
</tr>
<tr>
<td>Total sexual offences</td>
<td>4</td>
</tr>
<tr>
<td><strong>Robbery and Extortion Offences</strong></td>
<td></td>
</tr>
<tr>
<td>Robbery -</td>
<td></td>
</tr>
<tr>
<td>with assault</td>
<td>2</td>
</tr>
<tr>
<td>Total robbery and extortion offences</td>
<td>2</td>
</tr>
<tr>
<td><strong>Property Offences</strong></td>
<td></td>
</tr>
<tr>
<td>Break, enter and steal</td>
<td>1</td>
</tr>
<tr>
<td>Larceny</td>
<td>1</td>
</tr>
<tr>
<td>Injury to property -</td>
<td></td>
</tr>
<tr>
<td>arson (person not therein)</td>
<td>4</td>
</tr>
<tr>
<td>property over $10</td>
<td>1</td>
</tr>
<tr>
<td>Total property offences</td>
<td>7</td>
</tr>
<tr>
<td>Total all offences</td>
<td>121</td>
</tr>
</tbody>
</table>

* Discharge a loaded firearm with intent to prevent apprehension.
4.6. The G.P. who was convicted of break, enter and steal, among other offences, was not committed to a G.P. term on the grounds of mental illness. After sentence had been passed he was declared an habitual criminal and ordered to be held at the Governor-General's pleasure. This decision was made in the Australian Capital Territory.

Table 4.7. Length of Time in Custody before Release from Prison

<table>
<thead>
<tr>
<th>Time</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1y</td>
<td>4</td>
</tr>
<tr>
<td>1y &lt; 2y</td>
<td>7</td>
</tr>
<tr>
<td>2y &lt; 3y</td>
<td>8</td>
</tr>
<tr>
<td>3y &lt; 5y</td>
<td>9</td>
</tr>
<tr>
<td>5y &lt; 8y</td>
<td>7</td>
</tr>
<tr>
<td>8y &lt; 10y</td>
<td>6</td>
</tr>
<tr>
<td>10y and over</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>46</td>
</tr>
</tbody>
</table>

Average length of time in custody - 5 years 1 month
Shortest term - 3 months
Longest term - 17 years

4.7. The total of G.P.s released includes released and revoked G.P.s but excludes G.P.s released from psychiatric hospital as the dates of release are not known. (9 cases out of a total 55 released shown in Table 4.2)

Table 4.8. Length of Time in Custody for G.P.s Currently in Custody

<table>
<thead>
<tr>
<th>Time</th>
<th>Currently in psych. hosp.</th>
<th>Currently in prison</th>
<th>Total persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>under 1y</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>1y &lt; 2y</td>
<td>2</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>2y &lt; 5y</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>5y &lt; 10y</td>
<td>7</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>10y &lt; 14y</td>
<td>9</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>14y and over</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
<td>18</td>
<td>45</td>
</tr>
</tbody>
</table>

4.8 The total of forty-five G.P.s excludes the six G.P.s in custody who have been released and revoked.
SECTION 5. SELECTED CASE ILLUSTRATIONS

(a) Introduction

5.1 These case summaries have been drawn from the prison population current at the time that this study was undertaken and are not necessarily representative of the C.P.s that have passed through the prison system. Not all C.P.s have constituted problems for the Department of Corrective Services. However, the cases summarized below illustrate some of the difficulties that can be experienced in implementing the Governor's order in a penal setting. The summaries are based on the departmental files of the prisoners.

(b) Mr. B. (murder, Dec. 1965)

5.2 Mr. B. was held at Norisset as unfit to plead for eight years until his trial in 1973. Since his trial he has remained in prison, spending most of the time atoulburn Training Centre.

5.3 Mr. B. is said to suffer from a chronic paranoid psychosis which fluctuates although psychiatric reports since 1975 indicate that he has shown considerable improvement and stability. It is recognized, however, that should medication be removed that he would again become psychotic. Psychiatric intervention in this case demonstrates different psychiatric opinions in the treatment of psychosis. It was recommended by a psychiatrist, outside the Prison Medical Service, in 1973 that Mr. B. be transferred to a psychiatric institution for "more active treatment." The opinion of the prison psychiatrist was that there was no cure for Mr. B.'s condition and could see no advantage in transfer. Recommendations for transfer to a psychiatric hospital have more recently been made by the Life Sentence Review Committee and supported by the Parole Officer. The prison psychiatrist maintains his original view.

(c) Mr. J. (murder, Nov. 1974)

5.4 Mr. J. was admitted to the observation section at Long Bay following his arrest and has remained there as a sweeper.

* Date of conviction
although no longer for medical or custodial reasons.
Mr. J. responded quickly to medication for his paranoid
psychosis and no longer shows overt psychotic symptoms
although he needs to remain on medication.

5.5 Although reports indicate that he is reasonably
content, statements made by Mr. J. indicate that he
thinks he will only need to serve a short time in prison.
Mr. J. states that he was told by his solicitor that he
would be transferred to Morisset Psychiatric Hospital
within a month of the trial and at the expiration of this
time he enquired of the prison psychiatrist when he would
be transferred. Mr. J. states that the reply was that he
would not be transferred to a psychiatric hospital as he
was no longer mentally ill. Mr. J. concludes that since he
is no longer considered mentally ill and since he was found
not guilty by the court he should be considered for early
release. Evidence* indicates that this line of thinking is
becoming more prevalent among G.P.s detained in prison and
perhaps this reflects the growing concern for individual
rights throughout the community generally.

(d) Mr. F. (murder, June 1973)

5.6 Mr. F. made several suicide attempts in prison after
his arrest and he spent 16 months at Morisset Psychiatric
Hospital before coming to trial. He was originally given
a life sentence but this was changed to a Governor's
Pleasure term by the Court of Criminal Appeal in May 1975.
Mr. F. was returned to Long Bay after the trial and
transferred to the O.B.S. Section** because of his refusal
to take medication.

5.7 Mr. F. was diagnosed as a chronic schizophrenic and
remained psychotic for a considerable amount of time even
though he was receiving medication. A Parole Report of
June 1976 states that Mr. F. displayed a general lack of

* Verbal communication, Probation and Parole Officer
** Observation Section, Long Bay Complex.
appropriate affect in his reactions and adds that custodial officers considered him unsuitable for placement in the general prison population and may well be a suicide risk. The Parole Officer recommended transfer to a maximum security psychiatric hospital. Mr. F. improved sufficiently in the ensuing months to be transferred out of the C.B.S. section and although he is said to no longer show any overt psychotic symptoms he remains slow and retarded.

5.8 Mr. F. is a New Zealander and the matter of his deportation is at present under consideration by the Immigration Department. Mr. F. is not liable for deportation under Section 12 of the Immigration Act as he is not convicted of a criminal offence and he has not been admitted to a psychiatric hospital. The only section under which he can be deported, while he remains in prison, is Section 14 of the Act which allows for "undesirable persons" to be deported. The case has been referred to the Minister of Immigration for formal direction and such a decision may take several months. The psychiatric reports from the prison indicate a support for deportation on the condition that he is admitted to a psychiatric hospital on arrival in New Zealand.

5.9 It is difficult to ascertain why Mr. F., has not been transferred to a psychiatric hospital since his trial. Both management and deportation would seem to be more appropriately handled in such a setting.

(e) Mr. S. (discharging a loaded firearm with intent to prevent lawful apprehension - April 1975)

5.10 Mr. S. quickly remitted from his paranoid schizophrenic condition with medication. In Sept. 1976 Mr. S. was examined by a consultant psychiatrist with a view to completing a Schedule Three for transfer to a psychiatric hospital. Although the doctor was convinced that Mr. S. was still schizophrenic he was unable to complete a Schedule Three as he was not actively psychotic at the time of examination. He was therefore not able to be transferred to a psychiatric hospital.
5.11 Mr. S. was recommended for deportation back to his family in West Germany but deportation was not possible as he was not convicted of a criminal offence, nor was he admitted to a psychiatric hospital. Mr. S. subsequently provided the money for his passage as this was the only means of securing release. He was released into the custody of a family friend who escorted him on the flight back to West Germany.

(f) Mr. K. (murder, March 1966)

5.12 Mr. K. is classified as a borderline mental defective and although he has not presented as a management problem in prison his retardation has led to constant taunting by other prisoners. He was quite easily led into situations where he found it difficult to control his impulses to retaliate.

5.13 Mr. K. is at present located at Berrima which seems to be the most appropriate of the prisons in which he has been placed, although he is still subject to a considerable amount of taunting.

5.14 Psychiatric reports state Mr. K.'s problem as primarily a social one and assessment in regard to increased self-control is a matter of day-to-day observation in the context of his living and working arrangements. A later report (March, 1976) by the same psychiatrist suggests an examination of what can be done to find more suitable placement within the conditions of the Governor's Pleasure warrant.

5.15 There seems to be few places where a person such as Mr. K. can be suitably placed. His family are not interested in his welfare and he requires the care and supervision that would be offered by a concerned family environment. It may be noted, however, that patients with varying degrees of retardation constitute the majority of the long term population at Norisset Psychiatric Hospital and this setting may offer an alternative for mentally defective G.P.s.
(g) Mr. T. (damage to property in excess of £10, Aug. 1971)

5.16 Mr. T. is diagnosed as a chronic paranoid-schizophrenic. Since his offence he has been released on licence which was revoked for not reporting to his Probation and Parole Officer and not taking medication. Subsequent to revocation he spent 12 months in Roselle Hospital and was returned to prison after a determination by the Mental Health Tribunal that he no longer be detained in a mental hospital.

5.17 In June 1976 Mr. T. was recommended for re-release by the psychiatrist but it became known to the parole officer that he was delusional and severe breakdown was near the surface. The comment made by the psychiatrist in his subsequent report was that this case illustrated most forcibly the advantage of a multi-dimensional approach to a prisoner to avoid his being able to "pull the wool over the eyes". The psychiatrist became well aware of the advantage of not depending solely on his interviews with the patient.

(h) Mr. L. (attempted murder, July 1975)

5.18 Mr. L. was transferred to a psychiatric hospital within a week of conviction and spent eight months there before being returned to prison as a result of a decision made by the Mental Health Tribunal. During this time at Roselle Hospital Mr. L. made considerable improvement and at the time of the Tribunal's decision the mental health authorities were considering an application to have Mr. L. transferred to an open ward with a view to gradual re-introduction into the community.

5.19 The Mental Health Tribunal is only concerned with the issue of mental illness and not with the issue of suitability for release into the community in terms of the "dangerousness" issue. In this case the intervention of the Tribunal's decision may be seen as interrupting a programme of rehabilitation and may prolong the time before eventual release.
(i) Mr. R. (murder, June 1959)

5.20 Mr. R. committed a particularly bizarre murder under the effect of excessive drinking of alcohol. The major issue in considering release of Mr. R. is not one of mental illness but of risk to the community. Mr. R. has been under review for release since 1967 and during the subsequent years numerous psychiatric reports have been presented containing varying opinions as to whether Mr. R. is likely to offend again. Mr. R. has presented well in prison and there are no questions raised about his sanity. The reservations expressed by psychiatrists are based on his behaviour relating to the offence and any further testing out as to how he would react under the influence of alcohol or in the company of females was not possible. The reservations therefore remain and the result of review remains the same.

5.21 The Life Sentence Review Committee considers transfer to a Psychiatric Hospital the most appropriate move so that Mr. R. can be tested in varying social situations and so that some resocialisation can take place. Since he cannot be transferred by means of a Schedule the view is that he should be released with the condition that he admits himself as a voluntary patient.

5.22 This case illustrates the problem of the long term G.P. where insanity is no longer the issue but where conservatism may enter the review process partly because of the length of time already served in prison. Secondly, the problem of suitable means of testing behaviour and resocialisation to provide a more realistic basis for review is highlighted.

(j) Mr. N. (murder 1969)

5.23 Mr. N. became a G.P. as a result of the murder of his mistress after she terminated the relationship. After the murder Mr. N. attempted suicide by shooting himself in the head. At the time psychiatrists were concerned that the shooting may affect his ability to control emotions but this fear was later considered to be unfounded and that, in fact, the injury seemed to have the effect of making him more placid.
5.24 Mr. N. was first recommended for release in psychiatric and parole reports in early 1970 but in 1973 a report was received from an inspector of police containing allegations of aggressive behaviour towards members of the opposing faction in the Yugoslav community. Parole Reports indicate that Mr. N. was not interested in politics and his connection with the clubs of this group of the Yugoslav community was to pursue his interest in chess. In view of the political context of these allegations the difficulty in substantiating the facts was recognised from the outset and subsequently the allegations were largely rejected as either unfounded or contrary to Mr. N.'s present behaviour, which may have been effected by the suicide attempt.

5.25 Mr. N. was eventually released in Nov. 1976. In the light of the decision that had to be made, the concern of the decision makers over the allegations made is understandable. However, this case illustrates long delays between recommendations in reports and subsequent action which were aggravated by the involvement of the Attorney General in Canberra. The long delays led to the need for further up-to-date psychiatric reports which take time as the prisoner has to be transferred to Long Bay for psychiatric examination.

5.26 Detention in prison is considered as a serious matter and delays involved in release especially where it does not involve questions of change in the prisoner's behaviour or change in release plans, need to be considered as requiring urgent attention. A re-examination of the communication channels, especially where an outside body is concerned, may be needed.
SECTION 6. DISCUSSION OF PROCEDURES AND THE EMERGING ISSUES

A. Introduction

6.1 Before discussing the procedures and practices adopted in the disposal, treatment and discharge of G.P.s, described in the first sections of this report, some discussion, in broad terms, of the two recurring issues that are central to the decision-making process for this group of offender is presented. They are the concept of dangerousness and the difficulties in its assessment and secondly, the issue of civil rights: the right of the public to protection versus the rights of the individual.

B. The Concept of Dangerousness and its Prediction

(a) General

6.2 Dangerousness tends to be a vague concept when related to the mentally ill offender. Whilst there might be some consensus in the broad definition of the term, in practice it provides little or no assistance in applying the term to specific behaviour areas. This broad definition refers to the potential for inflicting serious bodily harm on another (and sometimes oneself).\(^{12}\) The Butler Report extends the definition to include lasting psychological harm.\(^{13}\)

6.3 The label of dangerousness can be applied to two groups. Firstly, that very small group of individuals who feel an ongoing compulsion or need to inflict injury or pain and secondly, the much larger group of individuals with the potential to act dangerously under certain conditions or stressful situations. The first group is most frequently associated with serious mental illness or psychopathic disorder: such patients are found in our psychiatric hospitals. Some of these people may never be dealt with in the criminal justice system. Dangerousness, therefore, "is not usually a more or less constantly exhibited disposition".\(^{14}\)

6.4 The available research on the prediction of future dangerousness tends to concentrate on identifying "probability groups," which have a higher or lower risk.
Research findings seem to indicate that it is not possible to accurately predict future dangerous behaviour for an individual. (15)

6.5 There has been a tendency towards overprediction and conservatism resulting in the detention of many to prevent the actions of a few. Norval Morris (16) poses the problem as a moral dilemma: how many false positive predictions of dangerousness can be justified for the sake of preventing crimes by the true positives?

Morris goes on to say about overprediction:

"... we possess an extremely convenient mechanism by which to conceal from ourselves our critical incapacity as predictors: the mask of over-prediction. If in doubt, put him in or keep him in." (17)

(b) Sociological Research - "Operation Baxstrom"

6.6 Over-prediction also makes it difficult to validate the predictive capacity. A recent opportunity to test the issue came as a result of a judicial decision. In February 1966 the United States Supreme Court ruled that the detention of Johnnie Baxstrom in a special security hospital, beyond the expiration of his prison sentence, without receiving the usual due process protections of the ordinary civil commitment, was unconstitutional. The immediate effect of this decision was that 967 "Baxstrom" patients were transferred from special security hospitals to civil hospitals within the year. These patients were all convicted criminals who were not only considered too dangerous to be released but too dangerous to be transferred to civil hospitals.

6.7 The progress of the "Baxstrom" patients in the civil hospitals was monitored and generated a number of follow-up studies. The broad conclusion of the follow-up studies was one of gross over-prediction of dangerousness. Research (18) in the first year indicates that the Baxstrom patients became indistinguishable from the general patient population. After four years only 2.6% of the initial group were sent back to special security hospitals. (19) In the follow-up study on a 20% random sample of males and all the females, 56% of the males and 43% of females were released. Of the 98 males released, 11 were convicted of committing a crime
in the subsequent 4½ years and of the two cases involving felonies, only one included violence. Steadman concludes that the "cumulative effect of this information can lead to but one interpretation: the Baxstrom patients were not very dangerous." Similar conclusions can be drawn from other research findings.

(c) Clinical Research

6.8 Kozal et al. employ a more clinical approach to the measurement and prediction of dangerousness. Their conclusions are that dangerousness is a result of multiple forces and is not detectable through routine psychiatric examination. Diagnostic considerations are based on a meticulous inquiry into multiple aspects of the personality, and individualisation is the essence of treatment. In the Kozal study the frequency of assaultive behaviour was more than four times greater for those released against advice. Morris, however, points out the cost. Of the 49 who were released against the advice of the Kozal team, 32 did not subsequently commit any serious assaultive crimes during five years of freedom.

0. Individual Rights

(a) The Right to Appeal under British Law

6.9 Present law permits the compulsory detention, for an indefinite period, of an offender who is acquitted on the grounds of mental illness. The offender has no right of appeal in a court of law against his continued detention. The offender is detained at the Governor's Pleasure and British law does not allow legal action to be taken against the Crown. The only avenue left open to a G.P. is direct petition to the Crown.

(b) Right to Appeal in the United States

6.10 United States law, on the other hand, is underpinned by a Bill of Rights and individuals can appeal to a court that these rights be upheld. In relation to persons "found not guilty by reason of insanity" (N.G.R.I.), court cases have been successful on issues of "right to treatment" and
"equal protection". The latter upholds the right of N.C.R.I. offenders to be subject to procedures of involuntary commitment similar to those in civil commitment proceedings.

(c) **Prison as a Place of Detention in N.S.W.**

6.11 A prison sentence is primarily considered as a form of sanction. A G.P. is acquitted of any criminal responsibility yet he is detained in a prison. The warrant is ostensibly for the psychiatric benefit of the individual, yet the legislation is silent on treatment or therapy.

6.12 Continued detention of a G.P. is usually justified by two reasons: he is still mentally disordered and/or still considered to be potentially dangerous. In both instances the institution used implies the existence of adequate treatment and assessment facilities. In the first instance, detention in a psychiatric institution seems to be the only appropriate facility. In the second instance the ultimate objective is to modify the offender's dangerous potential, (in cases where this is possible), to a point where it can be reasonably predicted that he will not be a danger to the community. Whether the treatment facilities should be provided in a prison setting is, and will probably continue to be, a contentious issue.

D. **Court Procedures and Disposition**

(a) **Present Disposition Procedures**

6.13 An offender acquitted on the grounds of mental illness requires the trial judge to order the offender to be "kept in strict custody ... until the Governor's pleasure is known". In N.S.W. this is interpreted by the court as meaning detention in prison. On one occasion at least, however, a Judge has ordered detention of a G.P. in a private psychiatric institution. Subsequent to this order being made advice was sought from the Crown Solicitor as to the validity of the Order. The Crown Solicitor concluded that there was nothing in the provisions in s.23(3) which necessarily restricts the powers of the Judge in relation to place of detention of a G.P. However, in relation to any discretion being with the Governor as to place of safe custody, the conclusion was
that he had to order prison as the place of safe custody. The Crown Solicitor expressed doubts as to the possibility of the case simply being reported to the Governor, and that the Governor should make no order pending a further report.

6.14 In most organizational settings procedures become established and institutionalized and the longer the procedure has been established the more difficult it is to effect change. This tendency is even more pronounced in the courtroom setting since the judges rely not only on legislation but on precedent and tradition.

(b) Judicial Attitudes

6.15 A factor which may be contributing to the continuance of the existing procedures without seemingly questioning its appropriateness, is the view of the court officials themselves as to what happens to the offender after the trial. No generalised statement can be made but several judgements and statements by court officials indicate some misconceptions as to the future of these offenders.

6.16 In the case of R. v. Fuller (1974) defence counsel made application to the judge (while the jury was absent) that the jury be informed of the consequences of the verdict of "not guilty on the grounds of mental illness".

"... the accused is detained usually in the maximum security section of a mental hospital ... the verdict of manslaughter by reason of diminished responsibility leaves the accused liable to the ordinary penalty of penal servitude."

Similarly in the judgement handed down in the Court of Criminal Appeal in the case of R. v. Veen (Aug. 1976) Justice O'Brien states that,

"... where the ... verdict is an acquittal by reason of mental illness ... his disposal is to a mental hospital in New South Wales by direction of the executive by virtue of S.23 (2) and (3)* of the Mental Health Act 1958."

In terms of established procedure this interpretation is questionable as the executive order is made for detention in a prison. A G.P.'s route to psychiatric hospital is determined by the same procedures as apply to other prisoners suffering from mental illness - by completion of two certificates in

* The transcript of the judgement reads "S24(2) and (3)". This appears to be a typographical error.
the form of Schedule Three.

6.17 Other examples indicate that at least some court officials have similar views. A letter from a methodist minister in relation to a G.P. stated that detention in prison "was out of harmony with the spirit that permeated the investigation and the attitude of the police, the Public Solicitor who represented him, and the Prosecutor in his address to the jury." Similarly, a prisoner stated that his solicitor told him that he would be going to Morisset Psychiatric Hospital within a month. (See Section 5(c) ) Since he has been told that he is no longer regarded as mentally ill he feels he should be considered for release. The implication in the verdict is that he is considered as mentally ill and not as a felon. The comment of Hallock is appropriate, at least in terms of the prisoner's perspective. 

"To 'sentence' offenders into an indeterminate programme on the basis of a promise of help and then not to supply that help is deceptive. Then indeterminacy means only prolonged custody without help, the offender perceives himself as the victim of a sadistic hoax." (25)

B. Detention of Governor's Pleasure Offenders in Prison

6.18 The question of the appropriateness of prison as the place of detention for G.P.s has already been raised in a number of different contexts in this report. Inappropriateness is most evident in terms of the individual rights issue and the treatment issues: custody and punishment remain the primary reasons for giving a prison sentence.

6.19 Although many G.P.s are appropriately transferred to psychiatric institutions there are a number of covertly and overtly psychotic G.P.s in prison. (See Section 5 (b)(d) (e)(g) ). It is difficult to distinguish any uniform criteria governing transfer to psychiatric hospitals. In instances where offenders have gone into reasonably good remission as a result of medication and the psychiatrists wish to transfer a G.P. to a psychiatric hospital, difficulties are sometimes encountered in completing the required Schedules. In the case of Mr. S. (paragraph 5.10) the consequent non-transfer led to a rejection of a request
for deportation by the Department of Immigration, Mr. S. did not fulfill the requirements of Section 12 of the Immigration Act as he was not a convicted criminal and not in a psychiatric institution. A similar situation has occurred in the case of Mr. F. (paragraph 5.8). He has remained in prison even though reports indicate that he is psychotic, despite medication.

6.20 For many of the prisoners who are in remission from psychosis it is recognized that the underlying psychotic state remains. Even though medication usually frees the emotionalism associated with a delusional state, if not the delusion itself, certain stress situations can reactivate a psychotic condition. Such stress situations can occur in the prison setting and could lead to breakdown; for example during an industrial dispute when, for security reasons, prisoners are kept in their cell for extended periods of time. It may be unrealistic to expect prison officers to possess the necessary skills to recognize deterioration and handle the consequent breakdown.

6.21 The G.P. group is comparatively small and categorization into neat problem areas is difficult. In some instances one prisoner may highlight a problem that may not be expected to occur regularly. Such is the case of Mr. K. (Section 5(j)) which demonstrates the difficulty of detaining retarded or persons of very low intelligence in the prison setting. They are a minority group and cannot be expected to receive a great deal of sympathy from other inmates and few prison officers would be experienced in managing the behaviour problems of such an offender.

6.22 It becomes apparent to those prisoners who are either sane at the time of trial or who regain sanity while in prison that they are serving a sentence even though they are found not guilty. A growing number of G.P.s are raising questions about the reasons for their continued detention and some develop a deep resentment against the authorities which have the power to hold them indeterminately. Furthermore, long-term detention can result in increasing institutionalization. This may be seen as counter-productive in terms of rehabilitation for life in the community.
F. Review in Department of Corrective Services

(a) The Parole Board

6.23 The Parole Board has as a secondary function the review of G.P.'s, its major role being to decide whether to relieve prisoners of penal sanctions imposed by courts. In relation to mentally ill offenders the Parole Board is basically required to consider whether to refuse a doctor's recommendation that a patient should be released. The conclusions reached by the Parole Board and the subsequent recommendations made to the Minister are largely based on reports completed by psychiatrists, generally on the staff of the Prison Medical Service. These decisions largely reflect the reservations expressed in psychiatric reports. There is no medical officer on the Parole Board who can assist in weighing up the evidence: to assist in decision-making about how much weight is to be placed on the reservations expressed.

6.24 When the Butler Commission in England was considering whether the Parole Board should take on the role of reviewing patients on restriction orders it concluded that the two types of review required roles that were opposite in principle and that it was important that any review for such offenders should not be associated with the penal system. (26)

(b) Psychiatric Assessment

6.25 The assessment by the psychiatrist is a longitudinal one, based on a collection of reports made over a period of time. Although the offender is interviewed by the psychiatrist before each report is submitted he has to rely heavily on preceding reports, most often written by himself and perhaps another psychiatrist. The psychiatrist is not in a position to observe the prisoner's behaviour across the range of everyday situations and relies on general conduct reports from prison officer, based on a rating scale, for this information. The inclusion of probation and parole officers' reports gives an assessment of the social situations and sometimes adds information about the psychiatric condition of the offender, as in the case of Mr. T. (see paragraph 5.17), which completely altered the psychiatric assessment. Then this longitudinal approach to assessment is adopted the tendency is towards recapitulating previous reports and recommendations.
In view of the lack of opportunities for observation and 
assessment it is understandable that in cases involving 
serious offences the task of the psychiatrist becomes 
difficult once the offender regains sanity or the overt 
symptoms of mental illness have been brought into good 
remission.

6.26 Case histories of long term G.P.'s indicate that 
recommendations against release are often based on 
reservations about how the offender will react to and 
function in particular situations outside the prison. The 
psychiatrist has no opportunity to test out the validity of 
his reservations and so they are reiterated. The 
difficulties in predicting dangerousness have been discussed 
previously. These difficulties can only be exacerbated when 
review and assessment are carried out on this basis.

6.27 There is general agreement among the professionals that 
the psychiatric setting offers a more flexible environment 
in which to undertake the tasks of testing out behaviours 
and re-socialisation, giving a more realistic base to 
decision-making about release. The difficulty is that a 
prisoner, at this stage, cannot be transferred to a psychiatric 
institution unless he is released on licence with the 
condition that he admit himself as a voluntary patient. 
Something of a cyclical decision-making pattern can arise: 
there is a reluctance to release on licence because of the 
doubts about the dangerous potential of the offender and the 
opportunities cannot be made available to test out their 
basis. One such case is outlined in Section 5 (i).

(c) Delays in the Review Process

6.28 The chart of communication flow in the review process 
(figure 3.4) shows the number of different levels which must 
be negotiated before review takes place and in the case of a 
recommendation for release, before the licence is issued. 
This can take considerable time and in matters of 
consideration for release from prison it would seem that 
delays should be avoided as much as possible. Another 
possible effect of such a number of communication levels is 
that periods between review may become longer than is
considered necessary. There are some options open to streamline this process. Under present policy requests for review are received by the Parole Board from the Minister. The Parole Board, however, is empowered to review G.P.s without their being referred by the Minister. In view of this, an alternative procedure would be for the Life Sentence Review Committee, via the Commissioner, to make requests to the Parole Board to make a review, especially in the case of an initial consideration. Such a procedure may also assist the Parole Board in completing agendas to include G.P.s. The Board receives schedules of detained G.P.s from the Department and in view of the involvement of the Ministerial level in forwarding requests for review it may be difficult to anticipate when a request will be received and thus take it into account when completing Parole Board agendas.

6.29 Up until recently the recommendation of the Parole Board went back to the Life Sentence Review Committee before being submitted to the Minister. If a case is considered just after a meeting of the Committee there was a delay of four weeks before the committee met again and before a submission could be forwarded to the Minister, incorporating the Parole Board's recommendation. The new procedure is that in cases where the recommendation of the Parole Board coincides with that of the Life Sentence Review Committee, the Board's recommendation is sent directly to the Minister. The Committee is involved only when their views are at variance with the Parole Board's recommendation.

G. Interface of the Two Systems - Corrections and Health

(a) Roles

6.30 Tradition and practice has established the Department of Corrective Services as having the major responsibility for the custody and release of G.P.s. This is reflected in the relevant sections of the legislation. Although provisions are included in mental health legislation, which implies that the Governor's warrant is ostensibly for the psychiatric benefit of the individual, the legislation is silent on the aspects of treatment or therapy. The only authority given is to keep "in strict custody" and this is
seen as primarily the role of the Department of Corrective Services.

6.31 Many G.P.s are transferred to psychiatric institutions for treatment but the majority of cases are returned to prison once this treatment is seen as completed or the person is said to be no longer mentally ill.

6.32 The Mental Health Tribunal has no official role in considering suitability for release of G.P.s, being only concerned with determination of the mental health of the patient. The Tribunal, however, does take into account the recommendations of the medical officer and a number of G.P.s have remained at the hospital beyond the term of actual mental illness and have been released into the community. In most cases, where mental illness ceases to be overt, the mental health system undertakes treatment to the point at which it feels that no further progress can be made. Some of the reasons put forward for returning a G.P. to prison include concern about potential risk to society, adverse social conditions preventing release, intervention of a Mental Health Tribunal decision, or the patients expressing a desire to return to prison, sometimes in the belief that they will be released sooner from prison than from a psychiatric institution.

6.33 Some comments by a doctor who works in a psychiatric service in New York, which finds itself placed between these two systems, may add some theoretical perspectives to the dual system approach. (27) Dr. Werschau observes that staff of institutions as well as inmates can become institutionalized and build up "territorial kingdoms". This is evident between institutions as well as within institutions.

"... particularly in those Ping-Pong games in which an individual is bounced back and forth between one system and another ... What we see is differential labelling: the guard calling him sick, and the doctor calling him criminal. These are the verbal messages, but behind them are rather different messages which are transmitted non verbally in the actual transfer... These messages are saying bilaterally, 'we don't want him, you take him'." (28)

The process of institutionalization is reflected in the need "both systems feel to keep one's own place in his own way and conservatively to resist any change". (29)
(b) **Proposals for Changing Roles and Responsibilities**

6.34 In 1975 a Study Group for the Cabinet Sub-Committee on Machinery of Government was established to investigate whether Corrective Services should take over the responsibility for offenders detained under Part VII of the Mental Health Act 1959. The Committee concluded that custody of mentally ill prisoners should be the responsibility of the Commissioner of Corrective Services but that the treatment of mentally ill persons should be carried out by members of the Health Commission in an atmosphere primarily therapeutically orientated. This conclusion was put forward as a recommendation. This would mean that the Health Commission would continue to provide a therapeutic programme within the maximum security unit but the Department of Corrective Services would be responsible for security. The Committee also recommended that a psychiatric unit be established within the metropolitan area and a new committee was established to consider possible sites. A member of that new Committee later revealed that practical consideration of site and finance may be overriding factors in the viability of such a project, at least in the short term. He recommended, in the interim, to utilise the maximum security section of Hornsby Psychiatric Hospital for the custody and treatment of mentally ill offenders.

6.35 These proposals envisage the employment of prison officers for security purposes. This raises the question of the effect of the dual roles of security and treatment being performed in the same setting by different officers employed by different departments. Is it possible to so distinguish these two roles so that they can be efficiently performed by distinct groups, which are often influenced by competing values and objectives? If these roles are performed by the same person, as they have been in psychiatric hospitals in the past, a judgement is made in each individual case as to how much weight is to be placed on the varying aspects. If these roles are performed by officers of different departments conflict may arise and the battle for the staff of each department to preserve their "territorial kingdoms", as described by Dr. Hersereau (paragraph 6.32), may be fought
6.36 In terms of custody and treatment of prisoners serving
determinate sentences, the proposal of proclaiming part of a
psychiatric hospital as a prison has certain advantages as it
obviates the necessity of invoking Schedule Three action.
Completion of schedule, however, would continue to be
necessary for transfer to any other part of Morisset
Hospital or to any other psychiatric institution and this
would become even more difficult than it is at present. A
maximum security unit, such as the one at Morisset Hospital,
is only the first step in a graduated system aimed at
release into the community. G.P.s and prisoners under
determinate sentence would be transferred back to prison
when they were considered to be no longer mentally ill or if
it was considered desirable to place them in less secure
conditions.

6.37 A security hospital needs to be a specialized system
with recreational and industrial facilities as well as a
support system which allows for re-introduction into the
community. Practical considerations of finance are, at
present the major argument against establishing such a
hospital.

6.38 The major issue is whether the emphasis, in the
detention of G.P.s, is on custody or treatment. The problems
associated with detention of G.P.s in prison, discussed in
part 4 of this section, and the issue of individual rights of
offenders, found not guilty because of mental illness, would
remain largely unresolved in the absence of legislation
giving the right of appeal against continued detention. A
review of policy and legislation affecting G.P.s is
indicated.

"The criminal mental patient is the neglected off-spring
of society, labelled as psychotic, felonious,
dangerous, anti-social or violent. Relegated to penal
institutions or to maximum security state institutions,
the neglect of the essentially unique features of
these patients, coupled with restraint ... perpetuates
dependency, deterioration and despair. The currently
evolving philosophies liberalizing mental hospital
procedures and practices is an attempt to emulate
those aspects of the community that strengthen ego
boundaries; that is family contact, work, recreation,
self determination etc. The mentally disordered
offender has (often) been excluded as not amenable or
too dangerous ... His acting out in a violent and
dangerous manner is the call for help that outrages
society and demands retaliatory measures ... This
disorganized personality must not be excluded from full utilization of all services featuring multidimensional approaches in a therapeutic community aimed at his rehabilitation. *(30)*

Some possible alternatives for dealing with G.P.s are presented in Section 7.

**F. Supervision on Release**

6.39 Conditional liberty recognizes the importance of continued assessment of persons who have a history of violent reactions in particular situations. The supervising officer is sometimes in a position to recognize that the released G.P. may be moving into a similar situation to that which originally precipitated an offence of violence, or to perceive other signs indicating the likelihood of a repetition of dangerous behaviour. Where this is so he can warn the licensee and if necessary arrange for him to be recalled to custody. The Butler Report stresses that the supervising officer must have discretion as to the degree of possible risk which may be acceptable. *(31)* The main purpose of supervision after release is to assist the licensee to settle down in the community and to this end to help him to cope with his problems by providing him with professional guidance, support and control while he does so. The Butler Report goes on to point out the negative effects of premature recall to an institution. "Not only is the person not helped to deal with the situation but he suffers a positive set-back and a fresh interruption of his life, while his attitude to his supervising officer is likely to be seriously undermined." *(32)*

6.40 In cases where ongoing psychiatric assessment and treatment is seen as necessary, the services of the local community mental health clinic is usually enlisted. Since the G.P. is usually released from prison, the hospital which may have been involved in treatment is not necessarily included in supervision. In some cases this non-involvement of the hospital may have serious repercussions*. A case was reported where the Probation and

* Verbal communication, Medical Officer, Roselle Hospital.
Parole Officer was concerned that breakdown was imminent and that there was a risk involved. The licensee was taken to the psychiatric institution serving the area in which he lived but they were not convinced of the necessity to admit him. The licensee was subsequently admitted to Rozelle Hospital where he had been during his G.P. term. They were familiar with the case and the consequences of a failure to recall in a deteriorating situation were appreciated. This may indicate that a close working relationship is needed between the responsible medical officer at the hospital, who was previously involved in the case, the supervising officer, and the local mental health clinic so that progress or changes in the patient's social circumstances and mental condition may be made known and their implications fully appreciated. Furthermore, it would seem desirable that a G.P. licensee be admitted to the hospital where he may have spent some time during his G.P. term if hospitalisation is necessary.
SECTIOJL. ALTERNATIVES IN PROCEDURE AND LEGISLATION

A. Alternative Forms of Disposition

(a) General Comments on Current Procedure

7.1 It has been suggested in paragraph 6.13 that the judge may have discretion in the disposition of G.P.s. The judge is only required to order "strict custody" and if this implies discretionary power as to place of custody then a unit offering such security is available within Morisset Psychiatric Hospital. Should such a disposition be ordered and a G.P. is detained at Morisset, then an assessment could be made as to the most suitable placement of that offender. The Principal Adviser, Mental Health has the power to direct what security conditions are necessary for each individual.

7.2 This alternative procedure transfers the responsibility for custody and care to the Health Commission thus avoiding the historical problem of detaining unconvicted mentally ill persons in a prison, without side-stepping the issue of dangerousness. The legislation, however, is unclear and is subject to a number of interpretations. For this reason it would seem desirable to review the legislation and consider changes that would make more explicit the most appropriate forms of disposition.

(b) N.S.W. Proposed Mental Health Act

7.3 The draft of the proposed Mental Health Act makes no changes in the sections referring to the disposition of G.P.s. Transfer: Section 25, which refers to the transfer of prisoners, other than G.P.s, to psychiatric hospital, has, however, been considerably broadened. The condition of "mental illness" is broadened to persons "suffering from a mental condition which could be more appropriately treated in a mental hospital". The condition for transfer back to custody in prison is broadened from "no longer mentally ill" to "no longer require treatment in a mental hospital". By implication these same definitions would operate in relation to transfer of G.P.s. Section 23(4), which relates to the transfer of G.P.s, contains no specific criteria for transfer of G.P.s to psychiatric hospital.
7.4 **Direct Discharge:** The proposed Mental Health Act contains a new Section 23A which relates specifically to offenders who are unfit to be tried. Section 23A(10(2)) is included to allow direct discharge from the court, for those offenders who remain unfit to be tried and who are convicted by a "special trial". These provisions, however, do not apply to G.P.s. This apparent anomaly needs to be closely examined.

7.5 The proposed Mental Health Act does not appear to significantly change the current situation in relation to the disposition of G.P.s and the dual responsibility of Health Commission and Department of Corrective Services.

(c) **The Canadian Proposal**

7.6 In March 1976 the Law Reform Commission of Canada submitted a report to Parliament on mentally disordered offenders which refers to offenders held on a Lieutenant Governor’s Warrant. The report concludes that the use of a Governor's warrant as a means of disposition is incompatible with overall sentencing policy and suggests "... that dispositions should be made openly, according to known criteria, be reviewable and of determinate length". The Commission, therefore recommends that this form of disposition be abolished and that the verdict of "not guilty by reason of insanity" be made a real acquittal, subject only to a post-acquittal hearing to determine whether the individual should be civilly detained on the basis of his psychiatric dangerousness or psychiatric illness.

7.7 In order to make the verdict of "not guilty because of mental illness" a real acquittal in N.S., Sections 23 and 29 would need to be repealed as redundant. A new section would be required to allow the court to conduct a post-acquittal hearing to determine whether the offender needs to be admitted to a psychiatric hospital as an involuntary patient. The administrative implications are that such offenders would be handled as civil patients and the Department of Corrective Services would only be involved in providing pre-sentence reports for the trial and for the hearing.
7.8 The court, having full power for disposition, would, in the first instance, be involved in assessing the issue of dangerousness. The judge or magistrate has at his disposal the full facts of the offence and the reports of medical personnel and probation officers whose pre-sentence report would contain an assessment of the offender's social situation and support systems. Both the medical and social aspects are important in determining disposition. In some cases more time may be needed to complete assessment so that the court can make the most appropriate disposition. The legislation could impose a time limit beyond which a person cannot be detained for assessment purposes.

(d) The English System - Hospital Orders

7.9 Reference has already been made in paragraphs 2.6 and 2.21 to the English system of Hospital Orders which apply to some convicted offenders and to all offenders detained at Her Majesty's Pleasure. This system, however, does not allow direct release into the community from the court. The English circumvent this by more extensive use of the defence of diminished responsibility which allows the court to issue a probation order or guardianship order.

7.10 Introduction of this system of disposition would require some changes to the existing legislation. Section 23(3) would need to specify a hospital as the place of detention and section 23(4) would be repealed as it would no longer be necessary to complete certificates to effect a transfer from prison to mental hospital. Administratively, the care and custody of G.P.s would be transferred entirely to the Health Commission.

B. Alternative Forms of Review

(a) N.S.W. Proposed Mental Health Act

7.11 The proposed legislation does not substantially change review provisions for G.P.s. A proposed new subsection to section 23 provides for a yearly review by the Mental Health Tribunal instead of the one review presently done at the expiration of the first six months. The review, however, is still confined to recommendations "as to the necessity for
the continued detention of such person in a mental hospital." This implies that the Tribunal does not have to consider suitability for release into the community and the C.P. could be returned to prison, as is the present general practice. The present situation remains largely unaltered.

(b) The Canadian System—Boards of Review

7.12 Boards of Review in Canada are established under legislative provisions in much the same way as the N.S.W. Parole Board is established. These Boards of Review are described in paragraphs 3.35 - 3.37. The major features of the Board in Ontario, are as follows: the review is conducted as a hearing, with the Chief Justice acting as chairman; the patient may appear with representation; and witnesses may be called. Other members of the Board include at least two qualified psychiatrists and a member of the bar.

7.13 The administrative implication of such a proposal is that the Parole Board would no longer be involved in the review of G.Ts. Section 7 of the Parole of Prisoners Act 1956 would need to be repealed and a new section introduced into the Mental Health Act to provide for the establishment of such a board, its composition, and frequency of review.

7.14 If, however the Governor's warrant is abolished (paragraph 7.6 - 7.7) then it may be unnecessary to establish such a board. The already existing Mental Health Tribunals may be considered the appropriate body to review persons acquitted on the grounds of mental illness and admitted to a psychiatric hospital as involuntary patients.

(c) The English System—Advisory Board to the Home Secretary

7.15 There is no statutory board of review in England which deals exclusively with offenders detained through a hospital order, although the Mental Health Tribunal reviews such patients if they apply, and forwards their recommendations to the Home Secretary. The Advisory Board to the Home Secretary, a non-statutory body (described in paragraph 3.34), reviews particular restricted patients. At present the Advisory
Board constitutes a legal chairman, a forensic psychiatrist and a social worker. The Butler Report recommends an extension of this membership so that the Board can undertake the review of all restricted patients.

7.16 In New South Wales, since the actual authority to release G.P.s lies with the Governor on advice from his Minister, review bodies do not necessarily need legislation in order to be established. However, this may be seen as desirable, in order to safeguard the right of the offender to systematic review.

7.17 The core issue focuses on whether the sole responsibility for the care and custody of G.P.s should be vested in one department. This needs to be resolved before the full implications of the establishment of such a review board can be assessed. At present both the Minister of Justice and the Minister of Health can be involved in forwarding recommendations to the Governor.

C. In Conclusion

7.18 The present legislation, in relation to G.P.s, has remained largely unchanged since 1878. However, many changes have since occurred in the management and treatment of the mentally ill, with far more emphasis on community programmes.

7.19 This report is an attempt to present a factual description of the current management of G.P.s from the court process to release. Any attempts to streamline the legislation and administrative procedures relating to Governor's Pleasure detainees needs to take into account the following ethical and administrative issues.

Ethical issues:
- detention in prison of an offender who is acquitted of any criminal responsibility;
- the rights of the individual to adequate treatment and to systematic review;
- the limitations of the assessment of dangerousness and its prediction.
**Administrative issues:**

- the difficulties in the dual responsibility of the Department of Corrective Services and the Health Commission in the care and custody of G.P.s.

- the difficulties of assessment in a prison setting;

- the role of the Parole Board as the reviewing body.
References


3. Ibid., p. 69.

4. Ibid., p. 70.


8. N. Walker, op. cit., p. 11.


10. Ibid., p. 63.

11. Ibid., p. 63.


15. Ibid., p. 60.


17. Ibid., p. 72.

18. The study is quoted in H.J. Steadman, op. cit.

20. Ibíd., p. 139

21. Ibíd., p. 140


28. Ibíd., p. 122

29. Ibíd., p. 123


32. Ibíd.


34. Ibíd., p. 38.

35. Ibíd., p. 22.
MENTAL HEALTH ACT, 1959.

Mentally Ill Persons Under Detention for Various Offences

23. (1) If any person indicted for any offence is mentally ill and, upon arraignment, is found to be so by a jury lawfully empaneled for that purpose, so that such person cannot be tried upon such indictment, or if upon the trial of any person so indicted such person is found by the jury, before whom he is tried, to be mentally ill, the judge before whom any such person is brought to be arraigned or tried as aforesaid may direct such finding to be recorded, and thereupon may order such person to be kept in strict custody in such place and in such manner as to such judge may seem fit until he is dealt with as provided by section twenty-four of this Act.

(2) In all cases where it is given in evidence upon the trial of any person charged with any treason, felony or misdemeanour that such person was, at the time the act or omission the subject of the charge was done or omitted to be done, mentally ill, and such person is acquitted, the jury shall be required to find specially whether such person was at such time mentally ill and to declare whether such person was acquitted by them on the ground that he was at such time mentally ill.

In this subsection "mentally ill" means in relation to any person charged as aforesaid, so insane as not to be responsible, according to law, for the act or omission the subject of the charge.

(3) If the jury find that such person was at the time the act or omission the subject of the charge was done or omitted to be done mentally ill as aforesaid, the judge before whom such trial is had shall order such person to be kept in strict custody, in such place and in such manner as to such judge seems fit until the Governor's pleasure is known, and thereupon the Governor may give such order for the safe custody of such person during the Governor's pleasure in a prison as the Governor deems fit.

(4) Upon the receipt of certificates by two medical practitioners in or to the effect of the form of Schedule Three, the Governor, by warrant under his hand, may direct that such person be conveyed to and detained in a mental hospital during the Governor's pleasure.
29. When any person is ordered to be kept in custody during the Governor's pleasure, any order made by the Governor in relation to the custody of such person may be renewed and varied from time to time or revoked; and the Governor may permit any such person or any person conveyed to and detained in a mental hospital pursuant to a direction by the Governor, not being a person under conviction and sentence, to be liberated from custody or such mental hospital, upon such terms and conditions as the Governor may think fit; and if any such term or condition is broken, such person may be retaken and dealt with as provided in section thirty of this Act.

29A. (1) This section shall notwithstanding anything in this Act, apply to all persons detained in a mental hospital pursuant to the provisions of this Part of this Act.

(2) Special leave of absence may in an emergency be granted, upon such terms and conditions as hereinafter approved, by the superintendent to any person to whom this section applies.

No such leave shall be granted unless the Minister has approved of a recommendation of the superintendent for this purpose and of the terms and conditions upon which such leave shall be granted.

No such recommendation shall be made by the superintendent unless the superintendent is of the opinion that no danger to the community or any member thereof would result if the person in respect of whom the recommendation is made were granted such leave.

If any term or condition upon which special leave of absence is granted to any person pursuant to this section is broken such person may be retaken and dealt with as provided in section thirty of this Act.

(3) In this section -
"emergency" means visit to a sick or dying near relative, attendance at the funeral of a near relative or such other circumstance as may be deemed by the superintendent and approved by the Minister as an emergency;
"near relative" has the meaning ascribed thereto in subsection seven of section twelve of this Act.
298 (1) If at the expiration of six months from the date of his conveyance, removal or being sent to a mental hospital pursuant to the provisions of this Part of this Act, such person is still a person detained in a mental hospital pursuant to the provisions of this Part of this Act, the superintendent shall, as soon as practicable, cause such person to be brought before a Tribunal as constituted under section thirteen of this Act for examination.

The Tribunal shall determine whether or not such person should be detained in a mental hospital for further observation and treatment.

If the Tribunal determines that such person should be so detained such person shall be detained in accordance with such determination.

If the Tribunal determines that such person should not be so detained, such person shall, if he remains subject to be continued in custody, be removed to the prison or other place from where he was taken or to some other prison or place of confinement or if such person does not remain subject to be continued in custody he shall be discharged.