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COMMITMENT AND DISCHARGE OF THE MENTALLY ILL IN SOUTH AUSTRALIA

Legal aspects of involuntary hospitalization of the mentally ill receive very little attention in South Australia. Further, litigation by patients claiming to be wrongfully detained is virtually non-existent. This is surprising when one considers the large number of people involved¹, and the often lengthy periods they spend isolated from the rest of the community².

The lack of controversy surrounding this important issue may be attributed, at least in part, to the fact that the compulsory powers conferred on doctors and justices by the South Australian Mental Health Act³ are very rarely abused. In spite of this many unjustified commitments, in my opinion, do occur. This is because the criteria on which commitment is based are exceedingly broad in scope and vague in definition. Moreover, the safeguards provided by the Mental Health Act are patently inadequate.

The purpose of this article is to critically examine the criteria for admission and discharge, and the incidental safeguards in both the criminal and civil spheres in South Australia⁴. Reference will be made to commitment laws in a number of other jurisdictions, and there will be some discussion of general philosophical and policy considerations.

1. Summary of Mental Health Services and Admission and Discharge Procedures in South Australia

The following summary is intended to minimize confusion in my later discussions by outlining the services and institutions available to the mentally ill, and describing the provisions under which patients are hospitalized in and discharged from those institutions⁵. I have included statistics to show which provisions are more commonly used. These are original statistics, compiled from the Register of Patients at each institution, and although I believe them to be basically sound, they do suffer from several defects:

- (i) No distinction is made between patients admitted for the first time, and patients who were readmitted during the period under review.
- (ii) The statistics relating to the duration of hospitalization do not take into account the fact that many patients are released on trial leave before being discharged.

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1. On the 30th June, 1970, there were 995 involuntary mental patients in South Australia.
2. See Chart E, below text accompanying n.22 *infra*.
3. 1935-63. Hereafter called the Mental Health Act.
4. There is no discussion of the civil and property rights of patients once hospitalised.
5. Much of my information concerning the practical effect of the Mental Health Act is a result of interviews I had with people intimately connected with the administration of the Mental Health Services. I am grateful to them, both for the time they gave me and for the frankness of their answers. In particular the Director of Mental Health, Dr. W. A. Dibden, was of great assistance.

- (iii) In a few cases the numbers compiled are so small that the drawing of any valid conclusion is impossible, although they may accurately illustrate a trend.
- (iv) Entries in the Registers of Patients are made in such a way that a complete statistical breakdown of the provisions under which patients are admitted is not always possible⁶.

(A) MENTAL HEALTH SERVICES OF SOUTH AUSTRALIA

This commentary will be concerned with only Glenside, Hillcrest and Enfield Hospitals, for it is only at these institutions that patients are involuntarily hospitalized. However there is a variety of institutions including clinics, day hospitals, hostels, and training centres, all of which are part of the Mental Health Services⁷.

Both Glenside and Hillcrest Hospitals consist of a mental hospital and several receiving houses. Enfield Hospital is only a receiving house. The legal distinction between a receiving house and a mental hospital is important, the former being a type of temporary or observational institution where the authority to detain is severely limited in duration.

A patient admitted to a receiving house under a justice's order (s.32) may be held for 30 days, or if admitted on request (s.35), for two months. These periods may be extended by new proceedings, but only for a total of six months. On the other hand, committal to a mental hospital is for an indefinite period, and a more permanent form of hospitalization is envisaged. Often a patient is transferred from a receiving house to a mental hospital.

Chart A shows the number of admissions, both voluntary and involuntary, to receiving houses and mental hospitals at the three institutions during 1970⁸.

CHART A

	RECEIVING HOUSE			MENTAL HOSPITAL			TOTAL
	Voluntary	Involuntary	Total	Voluntary	Involuntary	Total	
Glenside	593	320	913	237	94	331	1,244
Hillcrest	531	210	741	557	72	629	1,370
Enfield	369	106	475	—	—	—	475
TOTAL	1,493	636	2,129	794	166	960	3,089

Of a total of 3,089 admissions, 802 were involuntary, representing 26% of all admissions.

6. E.g., no distinction is made between patients admitted under s.25, and those admitted under s. 28 of the Mental Health Act.
7. These institutions are the Community Mental Health Services at Parkside and at Woodville; the Day Hospital, East Terrace; Child Guidance Clinics at Wakefield Street and at Prospect; a Diagnostic and Assessment Clinic at Toorak Gardens; the Palm Lodge Hostel, College Park; the Advisory Clinic and Day Hospital for the Elderly at Woodville; and the Strathmont Centre for the intellectually retarded.
8. All statistics in this article relate to the period from January 1, 1970, to December 31, 1970, unless otherwise stated.

(B) PROCEDURES FOR ADMISSION TO A RECEIVING HOUSE*S.137 Mental Health Act*

This section provides for informal admissions of voluntary patients, and requires no formalities. During 1970, 74% of all receiving house admissions were informal. The following provisions apply to involuntary patients.

S.35 Mental Health Act

S.35 requires a request for admission by any person, whether he be the prospective patient or not, supported by the certificate of a medical practitioner who has personally examined the patient within seven days prior to admission. The certificate must state that the patient is "mentally defective" or "apparently mentally defective". A "mentally defective person" is defined in Section 4(I) as

- "(a) A person who is mentally ill, that is to say, a person who, owing to his mental condition requires oversight, care or control for his own good or, in the public interest and who, owing to disorder of the mind or mental infirmity arising from age or decay of his faculties, is incapable of managing himself or his affairs, or
- (b) An intellectually retarded person."

S.35 permits a person to sign a request for his own admission. This has by and large been rendered obsolete by the provision made in 1962 for informal admissions under s.137. However, it does have a limited application where a patient, although voluntarily admitted, recognizes that he might leave hospital before desirable unless the hospital retains a power to hold him¹⁰.

A patient admitted under s.35 may be kept in a receiving house for a period of two months. This may be extended to six months if the Director of Mental Health certifies that this is desirable¹².

S.35 admission represented 19% of all receiving house admissions.

S.32 Mental Health Act

S.32 provides the same criteria for admission as those for admission to a mental hospital under ss.25 and 28. These will be described later¹³. The only difference is that the justice or medical practitioner concerned decides that admission to a receiving house would be more desirable than admission to a mental hospital. The section authorizes hospitalization for 30 days, but this may be extended by a justice's order for further 30 day periods, until a total of six months is reached¹⁴.

S.32 admissions represented 7% of all receiving house admissions.

9. Note that admission to an institution of some patients is recorded twice, once on being admitted to the Receiving House, and once on being admitted to the Mental Hospital.

10. E.g., an alcoholic.

11. Subsequently referred to as the Director.

12. S.37(2).

13. See text accompanying n.15 *infra*.

14. S.33.

(C) PROCEDURES FOR ADMISSION TO A MENTAL HOSPITAL*S.137 Mental Health Act*

S.137 provides for informal admissions of voluntary patients and requires no formalities. In 1970, 83% of all mental hospital admissions were informal.

The following provisions apply to involuntary patients.

S.31 Mental Health Act

This section requires that a request for admission be made, accompanied by the certificates of two medical practitioners who have separately examined the patient within 7 days of reception. The certificates must state that the patient is "mentally defective" within the meaning of the Act. In "special and urgent circumstances preventing examination by two medical practitioners" the certificate of one is sufficient. However, this emergency procedure is only valid for three days unless a second certificate is received¹⁵.

S.31 admissions represented 3% of all mental hospital admissions.

S.25 and S.28 Mental Health Act

Both these sections provide for direct admission to a mental hospital on the order of a justice or, in the case of s.28, two justices. The order follows an examination and inquiry.

S.25 requires that a medical practitioner certify that the person is mentally defective and requires the justice to be satisfied that the person "(a) is without sufficient means of support, or (b) was wandering at large, or (c) was found under circumstances denoting a purpose of committing some offence against the law."

S.28 requires that a medical practitioner certify that the person is mentally defective and, in the opinion of the justice, "(a) is not under proper care and control, or (b) is cruelly treated or neglected by any person having or assuming the care or charge of him."

S.25 and s.28 admission represented about 1% of all mental hospital admissions.

S.37 Mental Health Act

S.37 permits the transfer to a mental hospital of patients admitted to a receiving house on request under s.35. The transfer must be ordered by the superintendent of the hospital. This is easily the most common procedure for involuntary hospitalization, representing 11% of all mental hospital admissions.

S.33 Mental Health Act

This section permits the transfer to a mental hospital of patients admitted to a receiving house on a justice's order under s.32.

The transfer must be ordered by a justice and must be accompanied by a medical certificate.

This type of admission accounts for about 1% of all mental hospital admissions.

15. S.31(2).

(D) CRIMINAL PATIENTS¹⁶

These patients may be hospitalized under the Mental Health Act or the Criminal Law Consolidation Act 1935-71.

S.46 Mental Health Act

This section applies to persons who are in prison

- (a) "under the sentence or order of any superior or inferior court or other tribunal whatsoever or
- (b) under commitment for trial on a charge of any offence, or
- (c) for not finding bail for good behaviour or to keep the peace or to answer a criminal charge, or
- (d) under any other lawful authority".

If one of these persons appears to be mentally defective, and a medical practitioner certifies this, then the Minister¹⁷ may direct that the prisoner be removed to the hospital for criminal mental defectives.

Their number is small, comprising about 1% of all admissions.

Patients admitted under the Criminal Law Consolidation Act, all of whom are detained at the Governor's pleasure, are kept in the hospital for criminal mental defectives, or very occasionally, in a mental hospital. The relevant provisions of the Criminal Law Consolidation Act are:

- (a) s.292: this applies to persons acquitted of an indictable offence on the grounds of insanity.
- (b) s.293: persons under this section have been found by a jury to be unfit to plead at the time of their trial.
- (c) s.77a: this section applies to certain sexual offenders who are certified by two medical practitioners as being either incapable of exercising proper control over their sexual instincts, or, if capable, still require care, supervision and control because of their mental condition.

The number of patients detained at the Governor's pleasure is very small.

(E) TABLES RELATING TO ADMISSIONS

The following tables show the number of patients admitted under the various sections in one year, in the case of civil patients, and ten years, in the case of criminal patients.

While compiling statistics for admission to the hospital for criminal mental defectives, I discovered that some patients had been illegally admitted and detained, usually because their medical certification was not in order. These patients were usually returned to prison. Five patients were admitted in this way between 1961 and 1970, and it is difficult to see why this practice has been tolerated by the hospital authorities. In fact by permitting a person to be

16. Under the heading "Criminal Patients" I include many patients who have never been convicted of any offence, but who nonetheless are housed in the hospital for criminal mental defectives and are treated in practice in the same manner as other criminal patients.

17. In practice, the Chief Secretary orders it.

CHART B

ADMISSIONS TO MENTAL HOSPITALS AND RECEIVING HOUSES
 JAN. 1 TO DEC. 31, 1970

	RECEIVING HOUSE			MENTAL HOSPITAL					
	Request (s.35)	J.P. Order (s.32)	C.L.C.A.	Request Direct (s.31)	J.P. Order Direct (s.25) or (s.28)	R. House on request and trans- ferred	R.H. on J.P. Order and trans- ferred	C.M.D. (s.46)	C.L.C.A.
Glenside	228	92	—	9	4	60	10	10	1
Hillcrest	156	52	2	20	4	43	4	—	1
Enfield	73	33	—	—	—	—	—	—	—
TOTAL	457	177	2	29	8	103	14	10	2

CHART C

ADMISSIONS TO HOSPITAL FOR CRIMINAL MENTAL
 DEFECTIVES — 1960-1969 inclusive

S.46	Invalidly held usually from and returned to prison. S.154	Admitted and discharged under s.91 before an order made.	S.77(a) C.L.C.A.	S.292 C.L.C.A.	S.293 C.L.C.A.	TOTAL
98	5	8	12	6	2	131

detained illegally in the institution, a superintendent is guilty of a misdemeanor under s.154 of the Mental Health Act.

Some patients had been admitted and discharged by order of the Director under s.91 before a valid order authorizing their detention had been made.

CHART D

COMPOSITION OF HOSPITAL FOR C.M.D.s AT 14/7/71

S.46	S.292	S.77(a)	S.293	TOTAL
14 (1 woman)	5	3	—	22

(F) DISCHARGE PROCEDURES

Apart from criminal patients, discharge occurs in practice in only two ways (not including death). If the patient was voluntarily admitted, he is free to leave, and his discharge is recorded under s.137. If the patient was admitted involuntarily, he is discharged by order of the Director under s.91 of the Mental Health Act.

However, other methods of discharge are prescribed by the Act, and although these are never utilized, they are mentioned for the sake of completeness:

- (a) s.89: This permits discharge on the request of the person who signed the original request for reception. However, the Director's consent is required.
- (b) s.90: A patient absent on trial leave may be discharged if the superintendent authorizes it and a medical practitioner certifies that the patient is fit.
- (c) s.92: An official visitor¹⁸ or the superintendent may order the discharge of a patient if the Director consents.
- (d) s.94: The Director may discharge a patient if a relative gives an undertaking that the patient shall be properly taken care of. The relative must also execute a \$100 bond.
- (e) s.95: If, after an examination, a Supreme Court judge believes that a patient is not mentally defective, he may order that patient's release.

Criminal mental defectives are discharged under s.49, which requires certification that the prisoner is not mentally defective¹⁹. The certificate may be signed by the Director alone, or by the superintendent and another medical practitioner. Patients admitted under the Criminal Law Consolidation Act are subject to the Governor's pleasure, the meaning of which will be discussed later²⁰.

(G) DURATION OF HOSPITALIZATION

It is difficult to draw worthwhile conclusions from the figures available concerning the length of time patients spend in hospital. However, it is worth pointing out that although only 26% of all admissions in 1970 were involuntary²¹, a census of patients on 30th June, 1970, showed that nearly 44% of all patients then hospitalized had been admitted involuntarily²². This information suggests that involuntary patients tend to spend much longer periods in hospital than those admitted informally.

Charts E and F, which I compiled from Discharge Books, and which only apply to Glenside Hospital, give a rough indication of how long patients can spend in a mental institution.

CHART E

DURATION OF STAY: INVOLUNTARY PATIENTS DISCHARGED FROM GLENSIDE HOSPITAL JANUARY 1-DECEMBER 31, 1970

Period of Stay	0-14 Days	14-31 Days	1-3 Mths.	3-6 Mths.	6-12 Mths.	1-5 Yrs.	5-10 Yrs.	10,15 Yrs.	15-25 Yrs.	25,35 Yrs.	35 or more Yrs.	TOTAL
No. of Patients	14	9	15	9	8	7	17	5	9	9	4	106

N.B.—Patients for less than 10 days are usually transferred to R. House, or Royal Adelaide Hospital, etc.
(Total hospital discharges were 291 (voluntary and involuntary).)

18. See text accompanying n.86 *infra*.

19. Criminal mental defectives are usually transferred to prison after their discharge from the hospital.

20. See text accompanying n. 125 *infra*.

21. See chart accompanying n.9 *supra*.

22. Of 2,269 patients, 995 had been admitted involuntarily.

CHART F

*DURATION OF STAY: INVOLUNTARY PATIENTS DISCHARGED
FROM RECEIVING HOUSES AT GLENSIDE JANUARY 1-
DECEMBER 31, 1970*

Period of Stay	Discharged on same day	1-5 Days	5-15 Days	15-31 Days	1-2 Mths.	2-3 Mths.	3-6 Mths.	TOTAL
No. of Patients	3	15	43	86	64	18	25	254

(Total receiving house discharges was 935.)

(H) THE INTELLECTUALLY RETARDED

People generally described as "retarded" should not normally be subject to compulsory procedures, and so will receive little special attention, in this article.

However the definition of mentally defective persons includes the intellectually retarded²³, and so they are subject to compulsory commitment procedures.

An intellectually retarded person is defined by the Mental Health Act as one who is "suffering from an arrested or incomplete development of mind including subnormality of intelligence of a nature or degree which requires or is susceptible to medical treatment or other specialized care or training"²⁴.

In recognition of the fact that there is little justification for the commitment of the intellectually retarded to closed institutions, a new legal category of institutions called "training centres" was created in 1964. Admission to a training centre can be voluntary²⁵ or involuntary²⁶, under s.37b. This section requires the request of any one of the patient's nearest of kin, and the certification of a medical practitioner that the person is intellectually retarded and requires specialized training. The patient must be examined as soon as possible after admission by the superintendent or medical officer, and discharged if he would not benefit from treatment.

During 1970 (the year covered by my statistics) the intellectually retarded were housed in Glenside and Hillcrest Hospitals. However, during 1971 they were being moved to the new Strathmont Centre, which ultimately will accommodate approximately 600 patients. This training centre has been designed to permit the patients to live and develop as members of a normal family group.

2. Civil Admission to Mental Institutions

(A) VOLUNTARY ADMISSION

There is little disagreement with the proposition that admission to a mental institution should be made as easy as possible. Co-operation between doctor

23. S.4(1).

24. S.4(1).

25. S.137.

26. In reality, this "involuntary" admission is often merely a non-protested admission.

and patient is likely to be better when the patient actively seeks and recognises the need for help. In addition, help is likely to be sought early in the illness, when cures are usually more rapid, and, by no means unimportant, the stigma which attaches itself to the "certified" or involuntary patient is either non-existent or at least much diminished.

Voluntary or informal admission is provided for in South Australia by s.137 and is by far the most common form of hospitalization²⁷. Surprisingly, voluntary admission was once not encouraged, the theory being that admission is not truly voluntary unless the patient is sufficiently mentally competent to comprehend the full implications of his actions²⁸.

It is a curious argument, for if a person is mentally ill and consents to hospitalization, he is an ideal subject for admission. The United Kingdom Commission on the Law relating to Mental Illness and Mental Deficiency²⁹, criticized the old attitude when it recommended the abandonment of "the assumption that compulsory powers must be used unless the patient can express a positive desire for treatment," and suggested replacing this with "the offer of care, without deprivation of liberty, to all who need it and are not unwilling to receive it. All hospitals providing psychiatric treatment should be free to admit patients for any length of time without any legal formality and without power to detain"³⁰.

Of course, no hospital should be forced to accept persons who would not benefit from treatment. All Australian states except South Australia give the superintendent power to refuse an application if he thinks the person is not mentally disordered³¹. The South Australian statute is not explicit on this point, but the position is probably the same.

The criterion for refusal in New South Wales and Victoria is satisfied if the person is "unlikely to benefit from treatment"³². This seems preferable to the criterion used by the other states which require that the person should not be "suffering from a mental disorder". The purpose of hospitalization is treatment, not provision of a home for people who qualify under the somewhat arbitrary heading of "mentally disordered."

The only significant problem associated with voluntary admissions is the question of what to do with the patient who wishes to leave soon after his arrival, in spite of medical advice to the contrary. This often occurs, for dissatisfaction with hospital life is common. If the patient cannot leave freely then his presence is not truly voluntary, and many otherwise willing patients will be deterred from seeking hospitalization.

27. Voluntary admissions accounted for 74% of all admissions in 1970.

28. Five U.S. States require the patient to be sufficiently competent to comprehend his actions before being admitted voluntarily. See Lindman and McIntyre, *The Mentally Disabled and the Law* (University of Chicago Press, 1961), 110.

29. 1954-1957.

30. U.K. Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957, Report (Her Majesty's Stationery Office), 110.

31. Campbell and Whitmore, *Freedom in Australia* (Sydney University Press, 1966), 87.

32. N.S.W. Mental Health Act s.21(3); Vic. Mental Health Act s.41.

It is common for legislation to require patients to give notice before they leave. The notice required varies from 2 to 30 days³³, and enables the hospital authorities to treat and observe the patient.

Such a power only seems justifiable if patients are made fully aware of their liability for detention before they commit themselves.

The South Australian Mental Health Act does not authorize the detention of voluntary patients. They must be released on request, but commitment procedures can be instigated after release³⁴.

(B) INVOLUNTARY ADMISSION

A patient committed to a mental institution will find that conditions are reasonable and that he is not regarded as a prisoner in the conventional sense. Nevertheless a definite loss of personal liberty is entailed, and it is surprising that commentators interested in civil liberties have been notoriously quiet on the subject of compulsion in this area³⁵. One suspects that the mere classification of commitment procedures as "civil" (as opposed to "criminal") and the acceptance of the purpose of hospitalization as being therapeutic (and not punitive) are the main reasons for this apathy.

This apparent faith in psychiatry is reflected in commitment laws. For the law affords much less protection to a patient hospitalized against his will for life than to the most minor offender in the sphere of criminal law. Whereas the criminal has a huge body of procedural safeguards and evidentiary rules in his favour, the mental patient may depend for his liberty on the opinion of a doctor. Whether "mental health", whatever that means, is such an admirable goal that the taking away of personal liberty in such a sweeping fashion is justifiable, is a highly debatable question. The fundamental issue, then, is what types of illness, and degree of illness, should be regarded as sufficient to justify the use of compulsory powers? As will be seen later³⁶, statutory definitions of mental illness are extremely vague, and by and large leave the determination of whether a person is "mentally ill" to each individual psychiatrist and his personal opinion of where to draw the line between more non-conformity and illness.

Mental illness as such is not often defined in psychiatric textbooks, except in terms of an absence of mental health. Mental health, however, has often been defined. Rennie and Woodward define a mentally healthy person as one who

- "(1) respects and has confidence in himself and because he knows his true worth wastes no time proving it to himself and others;
- (2) accepts, works with, and to a large extent enjoys other people; and

33. Victoria requires 31 days notice, N.S.W. requires 7 days (see Campbell and Whitmore, n.31 *supra*, 88). Illinois requires 30 days notice (see Lindman and McIntyre, n.28 *supra*, 112).

34. In Victoria, reclassification is possible while the patient is still hospitalized. See Victorian Mental Health Act s.41.

35. The question is now receiving much attention in the U.S.A.

36. See text accompanying n.42 *infra*.

- (3) carries on his work, play, and his family and social life with confidence and enthusiasm and with a minimum of conflict, fear and hostility"³⁷.

Ginsburg is more specific than this and lists the following criteria as evidence of mental health:

"The ability to hold a job, have a family, keep out of trouble with the law, and enjoy the usual opportunities for pleasure"³⁸.

From these fairly typical definitions, it is clear that definitions of mental health are not scientifically based but instead express the personal value judgements of their authors.

Professor Kingsley Davis, in an article based on the study of 13 psychiatric textbooks, concluded that the American notion of mental health was strongly tinged with the "Protestant open-class ethic" or the ideals of the American free enterprise society. He says the ethic which the mental hygiene movement seeks to continue can be described in the following terms:

- "(1) democratic, in that it favours opportunity to rise by merit not by birth;
- (2) wordly, in that its goals are the pursuit of a calling, the accumulation of wealth or the attainment of status;
- (3) ascetic, in its emphasis on abstinence, sobriety, thrift, industry and prudence;
- (4) individualistic, in that it holds the individual responsible for his own destiny and stresses personal ambition and self-reliance;
- (5) rationalistic and empirical in its assumption that the world is discoverable by sensory observation; and
- (6) utilitarian, in that it conceives of human welfare in secularized terms, and as attainable by human knowledge and action."³⁹

Kingsley Davis alludes to the dangers of society implicitly trusting the power of the psychiatric cure, and, by implication, he questions the soundness of committing people who do not conform to our ethical standards:

"Mental hygiene can plunge into evaluation; into fields the social sciences would not touch, because it possesses an implicit ethical system which, since it is that of our society, enables it to pass value judgements to get public support and to enjoy an unalloyed optimism. Disguising its valuational system (by means of the psychologistic position) as rational advice based on science, it can conveniently praise and condemn under the aegis of the medico-authoritarian mantle"⁴⁰.

37. Rennie and Woodward, quoted by Eaton "The Assessment of Mental Health" (1951) *American Journal of Psychiatry* (August), 85.

38. Ginsburg, quoted in Kotinsky and Witmer *Community Programs for Mental Health* (Harvard University, Cambridge, Mass., for The Commonwealth Fund, 1955), 7.

39. From Wootton *Social Science and Social Pathology* (George Allen and Unwin, 1959) at 216, discussing Kingsley Davis "Mental Hygiene and Class Structure" (1938) *Psychiatry* (Feb.).

40. Kingsley Davis, n.39 *supra*.

The legitimacy of imposing one's ethical standards on others is a philosophical question of the utmost importance. I must agree with Mill, who wrote that the individual ". . . is the person most interested in his own well-being; the interest which any other person, except in cases of strong personal attachment, can have in it is trifling compared with that which he himself has; the interest which society has in him individually (except as to his conduct to others) is fractional, and altogether indirect; while with respect to his own feelings and circumstances, the most ordinary man or woman has means of knowledge immeasurably surpassing those that can be possessed by anyone else"⁴¹.

If one applies this philosophy to the sphere of mental illness, the implication that commitment could only be justified, if at all, in extraordinary and rare cases is clear. I suspect that Mill would have abhorred the commitment of a person who merely did not match up to society's ethical standards of the day.

Another consequence of psychiatry's inability to define mental health medically and objectively, is that any attempt to assimilate mental and physical disorders and to treat both alike breaks down⁴². This has important implications with respect to commitment, for if mental illness involves broader social issues as well as the medical ones, then placing sole responsibility for commitment on medical practitioners must be misguided.

(C) THE PROBLEM OF STATUTORY DEFINITIONS OF MENTAL ILLNESS

In many jurisdictions a finding of mental illness alone is a sufficient ground for commitment to a mental institution. For example, a person may be hospitalized under s.31 of the Mental Health Act simply if he is certified as being a "mentally defective person". There is no further requirement that the patient be dangerous, or that there be some sort of prediction that treatment will be beneficial. This makes it all the more important that the definition of a "mentally defective person" be tight and restrictive so that only proper subjects for hospitalization can be committed under it. However the definition⁴³ in s.4(1) merely refers to persons who owing to their mental condition require oversight, care or control for their own good in the public interest. This definition obviously does nothing to eliminate the possibility of a doctor imposing his personal ethical standards when committing a patient. Moreover, it is not difficult to see how mental institutions become repositories for such a wide variety of patients. The American Bar Association, in its Report on the Rights of the Mentally Ill⁴⁴, discovered that as well as removing harmful people from society and providing treatment for the mentally ill, hospitalization also served the purpose of relieving the family of the responsibility of an unwanted member, and of providing a refuge for those people in society, the destitute, aged, the mentally deficient, and the maladjusted, who are unwelcome in any social group or institution⁴⁵. A report by Gainfort on the mental health services in Texas went so far as to assert that "seventy per cent of all patients

41. Mill *On Liberty* (Longmans, 1874, 5th ed.).

42. As Wootton points out in *Social Science and Social Pathology*, n.39, *supra*.

43. Set out in text prior to n.10 *supra*.

44. An America-wide survey.

45. Lindman and McIntyre, n.28 *supra*.

do not need to be in a mental hospital . . . They could be treated at home in clinics, or other institutions"⁴⁶.

Attempts by other jurisdictions to define mental illness suffer from the same defects as the South Australian Act. One of the more specific definitions is given by the Western Australian Act which defines mental disorder as any mental illness, arrested or incomplete development of the mind, psychopathic disorder or disability of mind however acquired, and includes alcohol and drug addiction and mental infirmity due to old age and physical disease⁴⁷.

Given the difficulty with defining mental illness, it is submitted that the mere classification of a person as being mentally ill is an inadequate basis for commitment. Moreover, even if a satisfactory definition were produced, a finding of illness alone should not justify the use of compulsory powers. In the sphere of physical illness, it is commonly accepted that consent must be obtained from the patient before he is hospitalized or given treatment.

A more sensible approach to the question of commitment of the mentally ill would be to ascertain what grounds justify the use of compulsory powers, and then ask whether the patient in question is encompassed by one or more of these grounds. The grounds most commonly cited as justifying commitment arise when the person is dangerous or is in need of treatment. These will be investigated as separate grounds for hospitalization.

(D) DANGEROUSNESS AS A JUSTIFICATION FOR COMMITMENT

The threat of danger to others is probably the clearest and most widely accepted justification for commitment. The state has a recognized police power to intervene in order to prevent the infliction of harm by one on another.

The philosophical basis for such a power was recognized by Mill when he wrote . . .

"The only purpose for which power can be rightfully exercised over any member of a civilized community against his will is to prevent harm to others"⁴⁸.

In relation to the dangerous mentally ill, the U.K. Royal Commission considered compulsion justifiable when there is "a strong need to protect others from anti-social behaviour by the patient"⁴⁹.

Given the need for the prevention of dangerous conduct the important question then becomes what type of conduct by the mentally ill is permitted and what type is prevented? As far as existing laws are concerned it seems that the mentally ill are discriminated against, for the standards applied to them are rigorous in comparison with other areas of the law. For example, a person with a history of drunk driving offences is a greater danger to the community

46. Gainfort "How Texas is Reforming its Mental Hospitals" (1956) 19 "The Reporter", 18, 19 (Nov. 29).

47. Campbell and Whitmore, n.31 *supra*.

48. Quoted by Szasz, *Law, Liberty and Psychiatry* (Macmillan, 1963), 223.

49. Royal Commission Report, n.30 *supra*.

than nearly all of the so-called "dangerous" mentally ill who are detained indefinitely in the interests of that community. Yet the drunk driver usually suffers only a fine and a license suspension for a relatively short period.

Civil commitment of the dangerous mentally ill is more rigorous than the standards set by the criminal law in another sense too. The mere threat, not performance, of dangerous conduct is regarded as a justifiable ground for commitment. This is a contrast to the criminal law, which requires either that the offence be actually committed or at least attempted. And the law of attempts "expresses a fundamental distrust of the possibilities of predicting crime from evil intentions alone, much less from past crimes. Some sort of action pointing very clearly towards a crime soon to be committed is regarded as an essential precondition for invoking the harsh sanction of the criminal law"⁵⁰.

The pitfalls inherent in predicting dangerousness have been pointed out by a growing body of U.S. writers, especially Alan Dershowitz, who regard preventive detention as a result of psychiatric predictions as an increasing threat to personal liberty.

The magnitude of the problem is amply illustrated by the fact that in the U.S. alone, more than half a million mentally ill persons are detained in mental institutions on the basis of psychiatric predictions that unless confined they would do violence to themselves or to others⁵¹.

The accuracy of psychiatric predictions is seen by Dershowitz in the following terms:

"It has long been assumed that these psychiatric predictions (of injurious conduct) are reasonably accurate; that patients who are diagnosed as dangerous would have engaged in seriously harmful conduct had they not been confined. The accuracy of these predictions has never been systematically tested, since patients predicted to be dangerous are confined and thus do not have the opportunity to demonstrate that they would not have committed the predicted act if they were at liberty"⁵².

The fact that the errors of underestimating the possibilities of violence are more visible than errors of overestimating inclines the psychiatrist—whether consciously or unconsciously—to err on the side of confining rather than of releasing.

Dershowitz's criticisms received recent support when a decision of the U.S. Supreme Court in 1966, *Baxtrom v. Herald*⁵³, resulted in the release of many mentally ill persons thought to be dangerous. "Grave fear was expressed for the safety of the community. But follow-up studies now indicate that the predictions of violence were grossly exaggerated, and that very few of the

50. Goldstein, *The Insanity Defense* (Yale, 1967), 158.

51. Dershowitz "On Preventive Detention" (1969) *N.Y. Review of Books*, March 13, 22 at 23.

52. Dershowitz, n.51 *supra*, 26.

53. 383 U.S. 107 (1966).

patients have done what the psychiatrists predicted they would do if released"⁵⁴. Why is it then that a person may be civilly committed, often for indefinite duration, on the mere prediction of dangerousness? There are two possible explanations. Firstly, there is an assumption that the person committed, even if not really dangerous, will benefit from treatment. If this is so the hospitalization should be based on the necessity for treatment and not on dangerousness. In addition, the assumption that the person will respond to treatment is often unsound.

Secondly, an important function of criminal imprisonment is deterrence, and deterrence assumes that people can make a choice. A person makes a choice between committing the offence and risking imprisonment, or not. On the other hand, "whether mentally ill persons act dangerously is thought to depend not on their own choice but on the chance effect of their disease. Confining them hinders no respected process"⁵⁵. The fallacy in this is the assumption that all persons who are mentally ill lack the capacity to choose between different courses of conduct.

Although it is conceivable that commitment may be necessary where harmful conduct is only threatened, it is submitted that this situation could arise in only extreme circumstances. At present the prediction of dangerousness is so difficult and so uncertain⁵⁶ that an excessively cautious approach could result in the commitment of a relatively harmless person.

Another aspect of dangerousness is what degree of danger should be tolerated? This problem is discussed later in relation to criminal mental defectives and most of that discussion is relevant here⁵⁷. My only submission at this stage is that threats of property damage and threats of offences against public decency should not justify compulsory commitment.

The author of a Comment in the Harvard Law Review has formulated a test, intending to clarify the circumstances under which a person may be regarded as dangerous. Under this test, there would have to be "clear and convincing evidence" that the person is "highly likely to commit a criminal act"⁵⁸. A similar approach has been attempted in the Draft Act Governing Hospitalization of the Mentally Ill, drawn up by the U.S. National Institute of Mental Health. S.6(a) (2) (A) and (B) provide that a person may be admitted if he is mentally ill and if because of his illness he is likely to injure himself or others if allowed to remain at liberty. However the provision fails to acknowledge the difficulties of prediction and of defining what is meant by "injure"⁵⁹.

The threat of danger by a mentally ill person to himself should be distinguished from the threat of danger to others, although in statutes these criteria are often coupled together. These two headings represent quite

54. Dershowitz, n.51 *supra*, 26.

55. Comment, (1966) 79 Harvard Law Review 1288, at 1290.

56. See generally Morris "The Dangerous Criminal" (1968) 41 S. Calif. L.R. 514, at 534.

57. See text accompanying n.124 *infra*.

58. Comment, *supra* n.55, at 1291.

59. Lindman and McIntyre, n.28 *supra*, 33.

different state interests. The considerations relating to people who are likely to injure themselves are the same as those relating to people thought unable to decide for themselves on the necessity for their hospitalization and treatment. If one accepts as valid laws which prohibit self mutilation, then a power to prevent these acts must be justifiable where there would be a great likelihood of them occurring if preventive measures were not taken. The problem of prediction is as relevant here as it is in determining the likelihood of danger to others. Consequently commitment should only occur in the clearest of cases and where the harm likely to result to the patient is substantial. Assuming this limitation is observed, commitment would, in my opinion, be appropriate where a person posed the threat of injury to himself.

(E) DANGEROUSNESS AS A JUSTIFICATION FOR COMMITMENT IN SOUTH AUSTRALIAN LAW

Despite popular opinion to the contrary, the number of dangerous mental defectives is very small, and nearly all of them are criminal mental defectives.

Dangerousness is not specifically referred to as a ground for hospitalization in South Australia, but there are several broad sections in the Act which would clearly encompass mental defectives who show signs of being dangerous. S.25 deals with the commitment of mental defectives who are found wandering at large, or are found under circumstances denoting a purpose of committing some offence against the law or are without sufficient means of support. This section is broad enough to encompass not only dangerous defectives, but also those who appear to be likely to commit the most trivial and harmless offence. S.24 provides that the defectives described in s.25 may be apprehended by a police officer and taken before a justice if a complaint is made. This section has been strongly criticized by Sharman in the *Australian Journal of Social Issues*. He writes ". . . we find quite extraordinary powers and functions given to the police under mental health acts. For example s.24 of the South Australian Act . . . is a gross infringement of civil liberties . . . not justified by the complexities of modern communities or by the social interference" these defectives cause. The legislation, he says, is "a monument to mid-Victorian ignorance and prejudice"⁶⁰. Fortunately, sections 24 and 25 are rarely invoked.

A dangerous patient could also be certified under s.31 or indeed any other commitment procedure, because the definition of a "mentally defective person" includes a person who "requires oversight, care or control for his own good or in the public interest"⁶¹. Again, this is broad enough to justify the commitment of not only dangerous defectives but also those who are merely a general nuisance. I submit that such a provision is unduly wide in its scope and could result in the commitment (and therefore indeterminate loss of liberty) of a relatively harmless defective. Commitment procedures in the public interest should only be instigated where there is a high degree of risk of bodily violence.

(F) NECESSITY OF TREATMENT AS A JUSTIFICATION FOR COMMITMENT

This second common justification for compulsory hospitalization has its origins in the doctrine of "parens patriae", under which the sovereign has

60. (1969) 4 *Australian Journal of Social Issues* (No. 2).

61. S.4(1).

the right and duty to protect the person and property of those who are unable to care for themselves because of minority or mental illness⁶².

Initially it should be pointed out that clearly there is no justification for committing a person on the basis that he needs treatment if in fact he is given no treatment once hospitalized⁶³. Not only is it a pointless exercise which reduces commitment to virtual imprisonment, but also it causes a loss of services to society and a loss of benefits to the committed individual.

Commitment of those in need of treatment does not command the unanimity of acceptance that commitment of the dangerous mentally ill does. Some writers even suggest that hospitalization should never entail compulsion. For example Szasz, writing under the heading "Involuntary Mental Hospitalization Should be Abolished", states that "... in the scheme I am proposing ... those considered mentally ill by others, who refuse to submit to psychiatric treatment ... could no longer be forced to submit to psychiatric hospitalization"⁶⁴.

On the other hand, many psychiatrists seem ready to commit just as soon as the patient shows signs of mental illness. Davidson writes: "hospitalisation proceedings should involve a maximum reliance on medical judgement. The basic question in deciding whether a person should be hospitalized is his health and his medical needs"⁶⁵.

In so far as it fails to recognize the non-medical aspects of mental illness⁶⁶, and in so far as it ignores the value of personal liberty, this latter view seems difficult to maintain. It is just this sort of approach, typified by Davidson, which has led to the excessive paternalism of some commitment provisions. Legislative approaches to the categorization of mental defectives who need treatment are of two distinct types.

The first is to hospitalize a person if he is unable to make a rational choice about his own treatment. This approach is exemplified by the U.S. Draft Act⁶⁷ which authorizes commitment if two designated examiners are of the opinion that the individual is mentally ill and "is in need of care or treatment in a mental hospital, and because of his illness lacks sufficient insight or capacity to make a responsible application therefor"⁶⁸. This provision has been attacked by Dr. Charles Whitmore, who considers it a radical departure from existing

62. This discussion is of course restricted to the duty to protect the mentally ill person.

63. This point has been made much of by U.S. writers. See generally, Comment "Due Process for Involuntary Civil Commitment and Release" (1966-7) 34 U. Chi. L.R. 633.

64. Szasz, n.48 *supra*.

65. Davidson, *Forensic Psychiatry* (Ronald Press, N.Y., 1952), 182.

66. Mills recognized that commitment was not solely a medical issue. He writes: "However we may wish that treatment in a mental hospital should be accepted as rationally and dispassionately as any other medical services, these illustrations suggest how seldom this is so. The illness itself is only one factor in the confused and often fortuitous circumstances which surround the admission of a mental patient." Mills, *Living with Mental Illness*, 24.

67. See n.28 *supra*.

68. S.6(a)(2) (A) and (C).

law and an unsound policy decision. In his opinion, it would open the door to certain categories which have not been committed in the past, for example the severe psychoneurotic⁶⁹. However this contention has been disputed by Ross⁷⁰.

The second approach is simply to commit people who are categorized as being sufficiently mentally ill to warrant commitment. Typical of this approach is the U.K. Mental Health Act, s.26, which authorizes admission for treatment of a person who is mentally ill if "the said disorder is of a nature and degree which warrants the detention of the patient in a hospital for medical treatment under this section and that it is necessary in the interests of the patient's health or safety"⁷¹. This type of provision gives an unlimited discretion to the doctor, making a successful challenge to a wrongful commitment very difficult. The failure to enunciate grounds for admission signifies an inability to decide why and when compulsion is justified.

The South Australian Mental Health Act utilizes both of the approaches outlined above, but in a vague and formless manner which prima facie authorizes the commitment of an excessively large number of the mentally ill.

A person may be committed to a mental hospital under s.31, or to a receiving house under s.35, if he is a mental defective, that is if "owing to his mental condition (he), requires oversight, care or control for his own good . . . and who owing to disorder of the mind or mental infirmity arising from age or the decay of his faculties is incapable of managing himself or his affairs"⁷².

It is difficult to see the necessity or justification for these compulsory powers insofar as they relate to those patients who are merely incompetent. The emphasis surely should be on treatment and cure, not oversight, care and control.

Perhaps the most paternalistic provision in the Mental Health Act is s.28, which authorizes the commitment of a mental defective who "(a) is not under proper care and control, or (b) is cruelly treated or neglected by any person having or assuming the care or charge of him." It is a curious section. Although it may be laudable to help people who are not under proper care and control, the use of compulsion and the hearing before two justices which the section demands are wholly inappropriate to what essentially is a social welfare function.

I submit that a commitment law should take into account the following factors, all of which should be satisfied before commitment could be authorized:

- (i) The person should be mentally ill.
- (ii) The personnel who commit should believe that treatment will be given and will most likely result in an improvement.

69. Whitmore "Comments on a Draft Act for the Hospitalization of the Mentally Ill" (1957) 19 Geo. Wash. L.R. 512, at 522.

70. Ross "Commitment of the Mentally Ill" (1959) 57 Mich L.R. 945, at 958.

71. S.26 (2) (a) and (b).

72. See definition of a "mentally defective person", s.41.

- (iii) The person's mental condition should be such that he is unable to make a rational decision about his own hospitalization. If his decision conflicts with that of the psychiatrist, but nevertheless was the result of a meaningful choice, he should not be committed.

Such an approach would exclude from commitment defectives unlikely to benefit from treatment, and defectives who, being capable of making rational decisions, do not require the enforced paternalism of the state.

(G) COMMITMENT PROCEDURES AND SAFEGUARDS

Adequate procedural safeguards may not in themselves prevent unjust commitments if the criteria on which commitment is based are unsatisfactory. As Szasz says: "in the most flagrant cases of railroading in the history of American psychiatry no laws were violated. The most "unjustly" hospitalized persons were committed according to proper legal procedure. If we consider their commitment improper, it is because our standard differs from the laws then in effect"⁷³.

However, safeguards still play an important part in any satisfactory commitment scheme. For the system may be abused either intentionally, a very rare occurrence for which penalties are provided,⁷⁴ or unintentionally, due to ignorance, oversight and carelessness. The question is of particular importance where commitment can be authorized by medical practitioners who may be out of touch with the study of mental illness and unfamiliar with the provisions of the Mental Health Act. This problem has been recognised, and to a large extent remedied by the Tasmanian Mental Health Act which requires that at least one of the two medical certificates be made out by a doctor having special experience in the diagnosis or treatment of mental disorders⁷⁵.

The provision of adequate procedural safeguards is a question of balance, for it is quite possible for safeguards to be excessive. They can be not only costly and wasteful, but also positively harmful to the patient. For example, it is sometimes the case that an appearance by a patient at a hearing, during which evidence of a personal nature is being given by his friends and relatives, can be damaging to the patient. Another factor relevant when considering adequate safeguards is that if a hearing has the appearance of a court proceeding, this will tend to encourage the view that the patient has done something wrong and is being punished. It is for this reason that the use of jury trial has been strongly criticized in the thirteen U.S. states which provide for it⁷⁶.

On the other hand, procedural safeguards can be too few, especially if one recognizes the important non-medical aspects which must be taken into account. The position has been well put by the World Health Organization Expert Committee on Mental Health, which said:

"No matter what the composition of the body which authorizes compulsory detention may be, its purpose should always be to decide on

73. Szasz, n.48 *supra*, 57.

74. S.A. Mental Health Act Part VIII, "Offences".

75. Tasmanian Mental Health Act, 1963, s.17.

76. See Lindman and McIntyre, n.28 *supra*, 27, 28.

the legality of the detention of the patient in hospital. It need not be, and should not be, to certify that a patient is insane or mentally sub-normal. The distinction between the authorization of detention and the certification of an individual's state of mind is an important one"⁷⁷.

This view, and the accepted practice in most countries, suggests that a patient has a right to a hearing prior to any lengthy commitment. Unfortunately, this is not the case in South Australia, where indefinite commitment on the certification of two doctors is conclusive⁷⁸, with no appeal possible.

In my opinion the most satisfactory solution recognizes not only the right to a hearing, but also the fact that a hearing is unnecessary or undesirable in many cases. This solution can be achieved by what is called "non-prottested admission", whereby a person is certified and then notified of his right to be heard if he so desires⁷⁹. It is quite common for a patient, while unwilling to hospitalize himself voluntarily, nevertheless to allow himself to be hospitalized without objection. It is debatable as to when the hearing, if it requested, should occur. One's immediate reaction is to say that the hearing obviously should take place after certification and before hospitalization. But there are arguments supporting the proposal that a patient be hospitalized for a short period, for example three days, before the right to a hearing arises. After three days of hospitalization it is possible that the patient will no longer object, either because his fears of hospitalization have not been realized, or because his illness has abated and he now regards his treatment as a good thing. The period also gives the hospital authorities an opportunity to study the patient fully, and so if a hearing eventuates, they are able to give the tribunal more informed advice.

Given the right to a hearing what should be the composition of the body before which the case is brought? The different types of tribunals used in other jurisdictions are staggering in their number, ranging from judicial bodies to administrative tribunals of differing composition. One example of a judicial hearing is N.S.W., where a magisterial inquiry must be held before a person can be detained against his will⁸⁰. However, the hearing, which is very informal, does not incorporate many of the virtues of a normal judicial hearing such as the rights to notice, to cross-examination, to produce witnesses and to be represented by counsel. Moreover, what is being determined is a combination of psychiatric and civil liberty issues, issues which although dealt with by courts from time to time are better dealt with by an administrative tribunal which represents the competing interests. I submit that a satisfactory tribunal could consist of two psychiatrists and one person with legal training, preferably with magisterial or judicial experience. I would include two psychiatrists because the decision to be reached is primarily one of diagnosis and prognosis, both of which are likely to provoke disagreement, even among experts.

77. W.H.O. Technical Report Series 98 (1955-6), 3 at 12.

78. S.31.

79. Non-prottested admission is a feature of much U.S. legislation. See Lindman and McIntyre, n.28 *supra*, 26, 27.

80. N.S.W. Mental Health Act s.12.

(H) THE HEARING ITSELF

To be effective, a hearing should incorporate most of the virtues of a judicial hearing. The hearing should be held in public if the patient so desires, for he may wish to attract widespread attention to his allegedly illegal confinement. The patient too should be offered the services of legal counsel, for "nothing suggests that the subjects of commitment proceedings are more able than criminal defendants to defend themselves"⁸¹. Counsel and the patient should be notified of the hearing, and this should be done early enough to enable a fair case to be presented. At the hearing, the patient should be able to produce his own witnesses, and to cross-examine witnesses for the state.

In some circumstances the disclosure of intimate and personal information by a witness at the hearing is detrimental to the patient's mental condition. This could be guarded against by notifying the witnesses in advance that if they think their evidence is likely to distress the patient they should submit the evidence in writing to the tribunal. The tribunal would then decide whether this evidence should remain confidential, or be disclosed to the patient so that he has an opportunity to refute it.

(I) EMERGENCY PROCEDURES

In emergencies, it is necessary for the normal procedures to be avoided as they may waste valuable time. Typical emergencies occur when a person suddenly becomes dangerous, or requires immediate treatment at a crucial stage of an illness. Emergency admission is authorized in South Australia by s.31(2) which requires the certification of only one medical practitioner. The commitment is valid for only three days unless a second certificate is submitted. The section suffers from the weakness of not stipulating what are valid grounds for emergency admission. All that is required is that there be "special and urgent circumstances preventing examination by two medical practitioners". Apparently this section is never invoked, other provisions being regarded as adequate.

3. Review Procedures and Civil Discharge

It is difficult to see how a compulsory confinement can be justified if a patient receives no treatment or if the conditions on which the confinement were originally based no longer exist. Yet often this is the case, for patients are kept in hospital until total or near-total recovery has been achieved⁸². In order to prevent unnecessarily long confinements, it is necessary for there to be regular review and firmly established procedures to assist the patient in making his plight known. This view was supported by the World Health Organization Expert Committee on Mental Health: "The Committee feels that ready facilities for easy appeal should be open to a patient at any time after his involuntary admission"⁸³.

However, detention in a mental hospital in South Australia is for an indefinite period, and there is no appeal from the original decision. Nor is

81. See Comment, *supra* n.55, at 1292.

82. The appropriate action should be to discharge the patient once the conditions justifying commitment no longer apply, but to encourage him to remain as a voluntary patient if he has not recovered.

83. W.H.O. Technical Report Series No. 98, n.77 *supra*.

there any body to whom a patient may turn if he believes he is no longer ill⁸⁴. In fact the only safeguard provided by the Act, apart from the requirement that there be regular examination of patients⁸⁵, is the system of "official visitors". Official visitors are appointed by the Governor, and there must be at least three per institution, consisting of one male medical practitioner, one female medical practitioner (if practicable), and one special magistrate or practitioner of the Supreme Court⁸⁶. They must visit the institution at least once every three months, and can visit it at any time without notice⁸⁷. Their duties include inquiring "as to the care, treatment, and mental and bodily health of the patients therein"⁸⁸ and inspecting the buildings and facilities of the institution.⁸⁹ When conducting an investigation the visitors have power to summon witnesses and examine them on oath⁹⁰.

As a method of ensuring comprehensive review of individual patients the system is a failure. The direction given by the Act that they "shall, as far as practicable, see every patient detained therein"⁹¹ is patently absurd, given the large number of patients and the time available.

So for all practical purposes, a patient's discharge in South Australia is solely in the hands of his psychiatrist, although strictly speaking the discharge must be authorized by the Director. This is usually a mere formality.

As has been pointed out, involuntarily committed patients tend to stay longer in hospital than voluntary patients⁹². This makes the need for adequate review procedures even more compelling. South Australia is in fact well behind most other jurisdictions, many of which now incorporate two safeguards by providing a time limit on detention, and by providing an opportunity for a patient to submit an application to a review tribunal. Typical of these jurisdictions is Tasmania, where a person may be detained initially for only one year⁹³, and while in hospital, the patient or his relatives may apply directly to a Mental Health Review Tribunal for his discharge⁹⁴. The Tribunal consists of at least one legal practitioner, one medical practitioner, and one layman⁹⁵.

If committal proceedings were conducted by a Tribunal, as suggested earlier⁹⁶, this Tribunal could also be responsible for the discharge of patients. This

84. Appeal may be made to a Supreme Court Judge under s.95, but this procedure is virtually never adopted.

85. Patients must be examined at least six times during the first three years, thereafter annually, see s. 73. Another safeguard is the practice of holding weekly meetings at which grievances may be aired.

86. S.21.

87. S.64(1).

88. S.65.

89. S.64(3).

90. S.66.

91. S.64(4).

92. See text accompanying n.21 *supra*.

93. This is renewable for another year by medical recommendation and, after that, is renewable for periods of two years at a time. See s.32, Tasmanian Mental Health Act.

94. However, applications cannot be made during the first six months, and in subsequent specified periods, only one application per period. See s.21(4) and s.75.

95. 4th Schedule, s.5.

96. See text accompanying n.80 *supra*.

would ensure consistency in the criteria for admission and discharge, and would remove the responsibility from individual doctors, many of whom no doubt have no wish to be regarded as jailors by the people they treat.

The proceedings before the tribunal are best kept flexible and informal, with the tribunal itself assisting the patient by questioning witnesses and examining records. Without such help the patient would be at a disadvantage in comparison to the representatives of the mental institution, who have ready access to records and case histories.

As well as a Review Tribunal, additional methods of discharge are desirable. As the W.H.O. Expert Committee pointed out: "The more widely distributed they (methods of discharge) are, within reason, the better. The next of kin, for instance, should have power to discharge the patient, subject only to a veto by the medical superintendent of the hospital on the specific grounds that the patient is dangerous to himself or others. The next of kin should have a right of appeal against such a veto"⁹⁷. This type of discharge was envisaged by s.89 of the South Australian Act, which allows a patient to be discharged on the request of the person who signed the request for his reception. But, because the Director must give his consent, just like any other discharge, the section confers no additional scope and is in practice virtually a dead letter.

Discharge may also be authorized by the Director under s.94 if a relative or friend of the patient undertakes to care for and control the patient. A bond of at least \$100 must be executed, an archaic requirement that wrongly emphasizes the possibility of bad faith, and not the ability to provide good care. S.94 is never used in practice.

A novel way of obtaining one's discharge from a mental hospital in South Australia is to escape from the hospital and avoid recapture for three months. After this period, the hospitals' authority over the patient ceases⁹⁸, presumably because the patient has demonstrated an ability to cope with outside life! I know of no other explanation.

Two final avenues are open to the restless patient, but to my knowledge neither has been utilized. First, if a Supreme Court judge, after examining the patient and any other witness, decides that the patient is not mentally defective, he may, under s.95 of the Mental Health Act order that patient's discharge. I found no record of any application for discharge under this section and to my knowledge it has never been used⁹⁹.

Secondly, there is the remedy of habeas corpus¹⁰⁰.

There is no doubt that the writ of habeas corpus lies in cases where there is illegal detention in a mental institution¹⁰¹. However, the use of the writ has

97. W.H.O. Technical Report Series No. 98, n.77 *supra*.

98. S.43.

99. It is impossible to state this conclusively, as the investigation of the relevant records proved too laborious. The assessment was mainly based on interviews with the staff of mental institutions and of the Supreme Court.

100. See, generally, Hood-Phillips, *Constitutional and Administrative Law* (Sweet and Maxwell, 1967, 4th ed.), 448-458.

101. See *Harnett v. Fisher* [1927] A.C. 574.

two major restrictions: first, the writ is only available at common law to test the legality of the original detention, and so it cannot be used to protect a patient who was legally committed but has since become sane, and secondly, it is a remedy of last resort, and can only be sought when all other avenues have been exhausted. This means that an application would have to be made under s.95 first, and if that was unsuccessful it is difficult to see how a writ of habeas corpus could be issued. S.95 *prima facie* covers all the issues which would be material in a habeas corpus application.

I know of only one habeas corpus application and that was made by a patient who was detained in the hospital for criminal mental defectives¹⁰².

4. Criminal Patients

A criminal mental patient is regarded far differently from a civil patient. Not only is the criminal patient housed in a more secure institution, but also it is more difficult for him to persuade the hospital authorities that he is fit to be released.

In South Australia, criminal mental defectives are housed in Z Ward, which is situated in the grounds of Glenside Hospital¹⁰³. Z Ward is a maximum security institution, surrounded by a high wall and an internal dry moat. It provides a startling contrast to the civil wards, where in most cases doors are not locked and windows not barred. Built in 1885, it was called the "Refractory and Criminal Ward", but it has not always been the hospital for criminal mental defectives¹⁰⁴.

Since 1940 a small part of Z Ward has been proclaimed the hospital for criminal defectives¹⁰⁵, the remainder being part of the mental hospital for civil patients. The effect of this is that Z Ward houses both criminal patients and several refractory non-criminal patients¹⁰⁶. Although not strictly illegal, the mixing of these two groups can hardly be beneficial especially to the non-criminal patients. This is the spirit of a statement made by the Crown Solicitor in 1934 that "Although the Act nowhere provides in so many words that only criminal mental defectives shall be confined in the place or part declared to be a hospital for criminal mental defectives, I am of the opinion that that is what is intended"¹⁰⁷. It is likely that within the next few years, the hospital for criminal mental defectives will be moved to Yatala Labour Prison. This will effectively stop the mixing of criminal and non-criminal patients, and will remove from Glenside Hospital the last traces of its old prison image. But as

102. See also n.99 *supra*.

103. Occasionally, criminal patients are transferred to secure wards at Hillcrest and Glenside Hospitals. This is permitted by s.51, which requires the transfer order to be signed by the Minister and prohibits the transfer of a person suffering from homicidal propensities.

104. Between 1935 and 1940 they were housed in E ward, a reasonably pleasant environment.

105. This part consists of the room on the ground floor situated south of a steel partition, and encompasses ten cells.

106. In July 1971, 22 of the 32 inmates were criminal patients. One patient was being detained illegally. He had been admitted to the mental hospital informally (under s.137) but was being detained involuntarily in Z Ward.

107. Minutes forming enclosure to H.D. No. 875, 1934.

many of the patients have committed no offence a prison is not the most suitable setting either for such a hospital. Ideally, an institution independent of both the prison and the mental hospital should be established.

Criminal patients¹⁰⁸ may be committed under s.46 of the Mental Health Act or under certain provisions of the Criminal Law Consolidation Act¹⁰⁹. What follows is a detailed examination of each provision.

(A) ACQUITTAL ON THE GROUNDS OF INSANITY

S.292 of the Criminal Law Consolidation Act requires that if a person is acquitted of an indictable offence on the ground of insanity, then the jury must return this special verdict. The person so "acquitted" is then detained in "strict custody" until the Governor's pleasure be known. This raises a presumption that the prisoner is still insane although, ironically, during the trial there would have been a determination, or an acceptance of the fact, that he was competent to stand trial. In South Australia, the special verdict has always been "not guilty on the grounds of insanity". This is usually the verdict required in common law countries, and is the verdict in England, although for many years the form there was "guilty of the act or omission charged against him, but insane at the same time"¹¹⁰. The only practical distinction between the two forms was that the latter provided a technical ground for detaining the accused in an institution, without allowing him to obtain his release upon habeas corpus as he might if held under a non-criminal commitment¹¹¹.

An interesting feature of the insanity verdict is that it is an acquittal, and therefore there can be no appeal, either from the finding of insanity, or from the finding that the actus reus was committed¹¹². This consequence can cause injustice in some very rare cases, for example where the accused disputes the fact that he committed the act, or where the accused is badly advised by defence counsel and is acquitted on the ground of insanity for a relatively minor offence. In this circumstance the accused is usually better off serving time in prison, than suffering indeterminate commitment. For these reasons I submit that a person acquitted on the grounds of insanity should be given the right to an appeal.

The rationale used to justify detention of the prisoner acquitted on the grounds of insanity is not at all clear. If it is that the actor in question did not have the requisite mens rea with respect to a material element of the offence charged, then, no offence having been proved against him, he should be unconditionally discharged¹¹³. He may, of course still be subject to civil

108. I feel "criminal" is an inappropriate label for people who have never been tried. However, these people are designated "criminals" under s.46.

109. For a summary of these provisions see text following n.16 *supra*.

110. Trial of Lunatics Act 1883, s.2, amended by the Criminal Procedure (Insanity) Act, 1964 s.1. For an account of the English changes see Brett and Waller, *Cases and Materials in Criminal Law* (Butterworths, 1965, 2nd ed.), 699.

111. See Weihofen, *Insanity as a Defense in the Criminal Law* (The Commonwealth Fund, 1933), 263.

112. *Appeal of Felstead* (1914) 10 Crim. App. Rep. 129.

113. See Packer, *The Limits of the Criminal Sanction* (Oxford, 1969), 134.

commitment. This clearly is not accepted state practice at present, probably because society is not prepared to exonerate a person who has, in all outward forms, committed an offence. In fact, he suffers what Morris calls the double stigmatization of being both mad and bad. Goldstein offers the following justification for detention of people acquitted on the grounds of insanity:

- (i) Soon after a person has committed a seriously harmful act, some incubation period is necessary to allow time for public outrage to be dissipated.
- (ii) One can predict that the prisoner will be unable to conform in the future.
- (iii) The person requires treatment which could lead to a cure of the misconduct.

Goldstein offers two additional justifications both of dubious validity and limited acceptance:

- (iv) The threat of commitment may deter spurious claims of insanity;
- (v) Some punishment may not be a bad thing.

This last justification has received implied judicial support in the case *Hough v. U.S.*¹¹⁵ where the judge in denying a woman's release, "took into account the shortness of the lapse of time since trial because he felt early release would be in conflict with the function of detention as a means of imposing punishment"¹¹⁶.

Unenlightened as this attitude may be, it is perhaps a reflection of accepted practice in relation to a person acquitted on the grounds of insanity. This is borne out in part by Glanville Williams' assertion, in relation to administrative practice in England in the 1940s, that, "Where a person is found insane and irresponsible by the jury, but subsequent observation gives no ground for believing that he was ever insane, it is the practice to detain him at Broadmoor, for a period equivalent to that which he would have served in prison if he had been sentenced to death and the sentence had been commuted to imprisonment for life"¹¹⁷. Incarceration for an indefinite period in an institution such as Z Ward is unfortunately similar in many respects to imprisonment of the same offender. Statistics show that people acquitted on the grounds of insanity are often incarcerated for a period longer than the term of imprisonment they would have served had they been found guilty. During the period from January, 1941 to June, 1970, 10 people were detained in Z Ward after a s.292 acquittal. Only two were released during this period, after stays of 14 years and of 7 months. The remaining eight were still hospitalized in June, 1970, and had been in Z Ward for periods ranging from two to nineteen years. Such information should be considered by defence counsel when advising his client, for unless the prospects for a complete cure

114. Morris, n.56 *supra*, 523.

115. 271 F. 2d. 458.

116. Goldstein and Katz "Dangerousness and Mental Illness" (1960) 70 Yale L.J. 225.

117. Glanville Williams, *Criminal Law: The General Part* (Stevens and Sons, London, 1953), 299.

are good, the prisoner is likely to find the consequences of an "acquittal" under s.292 worse than a conviction. Naturally the defence of insanity is usually only pleaded on a charge of murder, where the penalty is great¹¹⁸.

The consequences of an acquittal on the grounds of insanity vary from one jurisdiction to another. In South Australia the commitment is at the absolute discretion of the Governor, there being no objective criteria on which the decision can be reached. In England commitment is compulsory and automatic¹¹⁹, a solution which tends to ignore the merits of individual cases. Eleven U.S. States require the trial court to determine the fate of the prisoner. This approach confuses the question of legal insanity at the time of the offence with the separate question of disposition of the prisoner, an issue which the court is hardly likely to be qualified to determine. One stricter proposal comes from Guttmacher and Weifhofen, who, in their book *Psychiatry and The Law* suggest that the prisoner should be automatically committed and be ineligible for release for at least one year. They explain "the community should have the protection afforded by a prolonged period of observation"¹²⁰. This approach again ignores the substantial differences between individual cases and is an unnecessary restriction on the body which is to commit.

I submit that the most satisfactory solution is to establish a body which would include experts from the relevant fields, such as criminology and psychiatry, and fix criteria on which commitment and discharge should be based. A suitable body, the Parole Board, already exists in South Australia and could easily be given jurisdiction over criminal mental defectives¹²¹. The Board consists of at least one criminologist¹²², one doctor experienced in psychology or psychiatry, one sociologist and one nominee of the Chamber of Manufactures^{122a}. (The criterion which the Board would use in committing patients will be discussed below in relation to discharge, since questions relating to the dangerousness of the patient are equally applicable when determining his commitment or his discharge.)

Once a prisoner has been acquitted on the grounds of insanity and detained in a mental hospital, he will experience great difficulty in obtaining his release. A successful invocation of the insanity defence at present provides great scope for preventive detention. This can be limited if the law were changed so that the period of detention as a criminal patient could not exceed the length of the prison sentence (or the punishment) to which the offender might have been subjected had the insanity defence failed. In addition there is little

118. Insanity was once a popular defence for people trying to avoid the death penalty. However the death penalty is virtually a dead letter in South Australia now.

119. Trial of Lunatics Act, 46 and 47 Vict. c.38, s.2.

120. Guttmacher and Weifhofen, *Psychiatry and the Law* (Norton, 1952), 422.

121. The Board already has a limited jurisdiction which it does not exercise. See text accompanying n.131 *infra*.

122. Unfortunately the definition is broad enough to include a person who has no formal training in criminology. The wording of s.42a(2) (a) requires that the person have, "in the opinion of the Governor, extensive knowledge of, and experience in, the science of criminology, penology, or any other related science." The position is at present filled by Chamberlain J., formerly a Justice of the Supreme Court.

122a. Prisons Act s.42(a) (2).

justification for detaining a patient who has been acquitted on the grounds of insanity if he is no longer dangerous. If he is mentally ill, but not dangerous, civil commitment proceedings could be instigated if appropriate.

Dangerousness as such should not be hard to define, for it carries with it the implication of objectively identifiable wrongdoing. However, no real attempt has ever been made at a legislative level to define it. Goldstein and Katz point out that the concept of dangerousness may be referable to any of the following:

- (1) Only the crime for which the insanity defence was successfully raised;
- (2) All crimes;
- (3) Only felonious crimes;
- (4) Only crimes for which a given maximum sentence or more is authorized;
- (5) Only crimes categorized as violent;
- (6) Only crimes categorized as harmful, physical or psychological, reparable or irreparable, to the victim;
- (7) Any conduct, even if not labelled criminal, categorized as violent, harmful or threatening;
- (8) Any conduct which may produce violent, retaliatory acts;
- (9) Any physical violence towards oneself;
- (10) Any combination of these¹²³.

The Victorian Parole Board, when deciding whether to discharge a patient acquitted on the ground of insanity, uses the following test: "is it reasonably certain that he will not commit a further crime of violence"¹²⁴?

No test has been articulated in South Australia where the question depends largely on the personal opinion of the hospital superintendent.

A second problem associated with dangerousness is that of predicting it. At present prediction of this is based purely on clinical insight, there being no available statistical information, and there are indications that this unsureness of how a patient will behave if released often causes the body responsible for discharge to err grossly on the side of caution.

The problem of discharge is further confused by the disparate natures of the people who have some say as to who shall be discharged and when. In South Australia the prisoner is detained "at the Governor's pleasure". This means in practice that a recommendation is made by the Superintendent of Glenside Hospital and his Deputy that the prisoner is fit to be discharged. This recommendation is sent to the Director of Mental Health, and is passed on to the Attorney General before finally reaching the Governor-in-Council. It is sometimes referred to the Crown Prosecutor for his opinion, and his influence

123. Goldstein and Katz, n.116 *supra*, 235.

124. A.L.P. Report on the Law as to Insanity in relation to Criminal Responsibility in Victoria, 1965, 15.

has been known in several cases to cause the rejection of a recommendation. But in the normal course of events the opinion of the Superintendent is upheld and he is the person primarily responsible. This is a burden which is probably excessive, for he is virtually obliged to guarantee to society that the patient will not offend again. Szasz, somewhat idealistically, obviously thinks this burden bearable, for he advocates that release be in the hands of psychiatrists alone: "Acquittal by reason of insanity, followed by automatic commitment, seems to lead by easy steps, to preventive jailing (hospitalization) of persons because of their alleged future dangerousness. . . . While the court has the right to order commitment, once a patient has been committed he comes under the jurisdiction of the hospital authorities. Hospital psychiatrists should be able to release the patient should they wish to do so"¹²⁵.

As Goldstein and Katz point out¹²⁶, this is based on the assumption, probably fallacious, that an acquittal by reason of insanity is equated with all other acquittals in the criminal process. On the contrary, it is a question of when to release a person who has demonstrated an ability not merely a propensity, to commit dangerous acts¹²⁷.

Szasz's position also assumes that the psychiatrist will release the patient in exactly the same manner as he would his civil patients. However the evidence shows that the psychiatrist is acutely aware of the obligation placed on him and is overly cautious when discharging the criminal patient. The problem confronting the psychiatrist is well put by Goldstein, who writes:

"Unfortunately the job of prediction is no easy matter. The disappearance of a symptom . . . the subjective report of happiness, the subjective absence of conflict, are no reliable indices of recovery. The only reliable evidence of "cure" is the absence of observable symptoms over and be able properly to make his defence to the charge; you ought to "play it safe" and to wait out the years, giving greater weight to non-medical considerations than would be the case if a criminal charge had not been involved. It will be easy for them to do so because no calculus lies ready at hand to weigh the competing considerations, to balance the interest of the patient in his liberty against the interest of society in protecting itself against him. And none has been supplied either by legislatures or courts"¹²⁸.

A body far better suited to consider all the aspects of the discharge of a patient would be the Parole Board. Naturally they would give the psychiatrist's opinions due weight, but could exercise independent judgement when balancing the patient's liberty with the risks society can afford to take. The Parole Board in Victoria has just such a jurisdiction¹²⁹, but the final decision rests with the Government¹³⁰. The South Australian Parole Board already has a limited

125. Szasz "Civil Liberties and Mental Illness" (1960) 131 *Journal of Nervous Diseases*, 566 at 60.

126. Goldstein and Katz, n.116 *supra*, 227.

127. Goldstein and Katz, n.116 *supra*, 228.

128. Goldstein, n.50 *supra*, at 152.

129. S.532 Crimes Act 1958 (Vic.).

130. A.L.P. Report, n.124 *supra*, at 15.

jurisdiction over criminal mental defectives. The power conferred derives from s.42(g) (2) of the Prisons Act, which states: "The Board shall, whenever so required by the Minister, and in any case, at least once in every year, furnish the Minister with a written report on every prisoner serving a sentence of life imprisonment or of indeterminate duration." And included in the definition of a "prisoner" is a criminal mental defective detained at the Governor's pleasure¹³¹. For some reason the Board never exercises this jurisdiction.

Whichever authority is ultimately responsible for the release of the prisoners, it seems fairly clear that part of their unwillingness to release a once dangerous patient is due to the fact that their authority over him ceases as soon as he is released. There is no provision in South Australia for conditional release which would permit the discharge of the patient from the hospital, yet ensure that he could be hospitalized again if necessary. Such a device, which would be similar to parole, would enable potential deterioration in the patient to be observed and checked before it was too late.

Conditional release of criminal mental defectives exists in two thirds of the states of the U.S.¹³²

(B) PRISONERS FOUND UNFIT TO STAND TRIAL

A prisoner under commitment for trial may be hospitalized under s.46(b) of the Mental Health Act if he is mentally defective. If he reaches the trial, but is found unfit to plead by a jury, he is similarly hospitalized, this time under s.293 of the Criminal Law Consolidation Act.

Sub-section (i) of s.293 provides that "where a person charged with an indictable offence is insane, so that he cannot be tried on the information and is so found either—

- (a) by a jury lawfully empanelled for that purpose, or
- (b) by the jury empanelled to try the information, the court shall direct him to be kept in strict custody until the Governor's pleasure be known."

Sub-section (2) authorizes a similar procedure and consequence where a person charged with an indictable offence is brought before any court to be discharged for want of prosecution. To my knowledge this sub-section has never been invoked. It is difficult to see any justification for conferring such a power on a court and it should be repealed. Civil commitment proceedings are quite adequate in these circumstances.

Sub-section (i) gives legislative weight to the long-standing common law rule that a person cannot be required to plead to an indictment or be tried for a crime while he is so mentally disordered as to be incapable of making a rational defence¹³³. The rationale is commonly said to be that it is inhuman, and a denial to the right to trial upon the merits, to require a disabled person to defend himself. He may be the only person in possession of information

131. S.5.

132. Goldstein, n.50 *supra*, at 150.

133. 3 Coke Inst. 4.

which would materially influence the trial, and yet be unable to communicate this effectively to his counsel¹³⁴.

The common law rule received close scrutiny from the Court of Criminal Appeal in *R. v. Podola*¹³⁵, where a number of controversial issues were clarified.

(a) The court held that if the trial judge misdirects the jury when the preliminary question of fitness to plead is being determined, then the accused has a right of appeal. They rejected the argument that no appeal could be taken because it was not an appeal against a conviction but simply a preliminary issue¹³⁶.

(b) The court held that the question of fitness to plead could be raised by the prosecution, the defence or the court itself¹³⁷.

(c) On the question of burden of proof, the court implied that the burden differed, depending on who contended that the accused was insane. If this contention is put forward by the defence and contested by the prosecution, then the burden is on the defence to prove it on the balance of probabilities. Conversely, if the prosecution alleges the insanity, and the defence disputes it, then the burden is on the prosecution¹³⁸. The court did not say what the quantum of this burden of proof was, but it is likely that they approved of the trial judge's ruling, on which they did not comment, that the prosecution had to establish the case beyond a reasonable doubt.

(d) The court considered at length what constituted fitness to stand trial, for clearly the legal test of insanity applicable at the time the offence was committed is not appropriate. They concluded that the correct test was that given by Alderson B. to the jury in *R. v. Pritchard*¹³⁹. He instructed the jury to inquire "whether he (the accused) can plead to the indictment", and

"whether he is of sufficient intellect to comprehend the course of proceedings of the trial, so as to make a proper defence—to know that he might challenge any of you to whom he may object—and to comprehend the details of the evidence. Upon this issue, therefore, if you think that there is no certain mode of communicating the details of the crime to the prisoner, so that he can clearly understand them, and be able properly to make his defence to the charge; you ought to find that he is not of sane mind. It is not enough that he may have a general capacity of communicating on ordinary matters"¹⁴⁰.

The instruction given to the jury in South Australia does not differ materially from this¹⁴¹. S.293 is very rarely used, and only twice in the last 30 years has an accused been found unfit to plead.

134. See e.g. *Gutmacher and Weihofen*, n.120, *supra*.

135. [1960] 1 Q.B. 325.

136. n.135 *supra*, 348.

137. n.135 *supra*, 349.

138. n.135 *supra*, 350.

139. 7 C. and P.303.

140. n.139 *supra*, 304.

141. See, e.g. *R. v. Rachwalski*, S.A. Supreme Ct. No. 68, June 1957.

A prisoner detained under s.293 is discharged once he is fit to stand trial, that is, when he is capable of understanding the court proceedings, of challenging the jurors and instructing his counsel. He may still be mentally defective.

The prisoner may never stand trial, for the Crown may enter a nolle prosequi. This is likely where the duration of the hospitalization before trial has been great, and where the crime with which the prisoner has been charged is relatively minor¹⁴².

The second method by which a prisoner may be detained in the hospital for criminal mental defectives before he stands trial is provided by s.46 of the Mental Health Act. It allows for the removal of a person under commitment for trial for any offence if a doctor certifies that he is mentally defective and if the order is signed by the Minister¹⁴³.

The prisoner is kept in the hospital for criminal mental defectives until, under s.49, the Director alone, or the superintendent and another medical practitioner, certify that he is no longer mentally defective. The fact that the prisoner is capable of standing trial is considered irrelevant. I consider this one of the most serious anomalies in the Mental Health Act, for it means that a person who has never been tried is subjected to indeterminate detention irrespective of the gravity of the offence with which he has been charged. One example is Bernard Zabinski who was charged with attempted murder in 1957, was removed to Z Ward before standing trial, and has remained there ever since. I am unable to comment on his mental condition¹⁴⁴, yet after a forty-minute interview with him I left with the impression that he was fit to stand trial. His recollection and comprehension of the events surrounding the alleged crime were good, and I believe his ability to conduct a defence and follow court proceedings was above average. Zabinski challenged the legality of his detention in 1961¹⁴⁵, but he failed because he was still mentally defective and so could not be discharged under s.49. His ability to stand trial was not considered.

I can see no justification for detention of this sort. The rationale for commitment of people found unfit to stand trial is that it would be unfair to convict a man who is unable to present information which might convince the court to decide in his favour¹⁴⁶. Conversely, it is unfair to deny a trial to a prisoner who is both willing to stand trial and is capable of conducting a defence.

I submit that s. 46 (b) should be repealed. Accused prisoners suffering from mental illness should be hospitalized only while they are, in the opinion of the Parole Board, unfit to stand trial.

142. In the South Australian case of *Brennan* in November of 1966, the Crown entered a nolle prosequi on counts of house breaking with intent, and being found by night in the possession of housebreaking implements. Brennan had been hospitalized for two years and eight months.

143. In practice the Chief Secretary signs it.

144. Although I can say he receives no treatment or drugs.

145. He sought a writ of habeas corpus. See 1390 of 1961, S.A. Supreme Court.

146. See text accompanying n.134 *supra*.

(C) INSANITY ARISING AFTER SENTENCE

Insanity arising after a prisoner has been sentenced does not cause any alteration in sentence¹⁴⁷ unless the prisoner was sentenced to death. In these circumstances the execution is stayed until he recovers. As Coke said: "If a man commit treason or felony, and if after judgement he become de non sane memorie, he shall not be executed, for it cannot be an example to others"¹⁴⁸. This attitude reflects on the barbaric nature of the death penalty. If a man were suffering under a happy delusion which made him incapable of comprehending the punishment, then his execution would have to wait until all the horror of it was apparent to him. In recognition of the harshness of this rule, it has been the invariable practice of the executive in England since 1840 to grant a reprieve in these circumstances. The rule has ceased to have any relevance in England since the death penalty was abolished, and it is not likely to arise in the future in South Australia where the death penalty faces imminent abolition.

All cases of insanity arising after sentence are now dealt with under s.46 of the Mental Health Act. Generally this section authorizes the transfer from a prison to the hospital for criminal mental defectives of a prisoner who is mentally defective¹⁴⁹. The period of hospitalization is credited to the prisoner as service, to the extent of the time served, of his term of imprisonment¹⁵⁰.

(D) SEXUAL OFFENDERS — S.77A.CRIMINAL LAW CONSOLIDATION ACT

I do not intend to study this section in any depth, but it does call for some comment insofar as it results in compulsory hospitalization.

It authorizes the detention during Her Majesty's pleasure of certain sexual offenders in an "institution". In practice this institution is nearly always Z Ward. The section can be invoked where an offender is convicted of certain listed offences (ranging from rape and procuration to the relatively innocuous offences of lewdness and indecent exposure)¹⁵¹, or of any other offence where the evidence indicates that the offender may be incapable of exercising proper control over his sexual instincts¹⁵². If at least two medical practitioners report that the offender's mental condition is such that he is incapable of exercising proper control over his sexual instincts then he may be detained during her Majesty's pleasure. And if the offender is capable of exercising proper control over his sexual instincts, he can still be detained if his mental condition is sub-normal, to such a degree that he requires care, supervision and control, either in his own interests or for the protection of others.

With its emphasis on detention the section seems to be based on the assumptions that, first, sexual offenders are dangerous and should be locked away, and secondly, they are best treated in a mental hospital. There is no evidence

147. But a prisoner may be transferred to the hospital for criminal mental defectives under s.41(1) of the Mental Health Act.

148. 3 Coke Institutes 4.

149. For a fuller account see the summary in text accompanying n.16 *supra*.

150. S.50.

151. S.77A(9) (a).

152. S.77A(9) (b).

to support the first assumption in relation to the most common types of sexual offenders, especially exhibitionists. And the second assumption is equally doubtful. In a series of articles in the journal *Federation Probation*, a group of psychiatrists discussed exhibitionists, heterosexual pedophiles and homosexuals, the three largest groupings of sexual offenders. The authors suggest that in most cases supervision by trained probation officers is preferable to hospitalization or even to any form of psychiatric referral. Exhibitionism, for example, "appears to be related to stress situations in the individual's personal and social relations but does not emerge as a result of mental illness or impairment . . . Psychiatric intervention is not necessary for the majority of cases"¹⁵³. Heterosexual pedophilia, similarly, "is not related specifically to psychotic mental illness"¹⁵⁴. The popular image of sexual offenders having a high rate of recidivism is also shattered: "This low recidivist rate of sexual offenders, compared with other types of offenders, is now generally recognized and heterosexual pedophiles have a very low rate. They are a good probation risk"¹⁵⁵.

In view of these findings it seems probable that s.77A is essentially a misguided and unnecessary provision which gives to a court quite extraordinary powers.

Discharge of s.77A offenders has, since 1969, been upon the recommendation of the Parole Board. The Board is authorized to consider their progress at least every year and more often if necessary, and if it is satisfied with the report of two medical practitioners that the offender is fit to be at liberty, the Board can recommend release¹⁵⁷.

5. Conclusions

Present defects in the South Australian Mental Health Act arise basically from a failure to rationalize and justify the aims of commitment. This is especially obvious in the antiquated and nearly obsolete s.28 and s.25. S.28 usurps the function of social welfare authorities in an area where compulsion is quite inappropriate, while s.25 authorizes preventive detention in circumstances where the harm contemplated can only be described as the most trivial. In my opinion both sections should be repealed.

The vagueness of the Act's objectives is further illustrated by the certification procedures set out in s.31 and s.35. They permit certification where a person can be categorized as "mentally defective", that is where a person is mentally ill and requires oversight, care or control for his own good or in the public interest, and is incapable of managing himself or his affairs. An underlying assumption of this seems to be that psychiatric treatment is always beneficial, and should generally be imposed on an unwilling patient despite the indefinite loss of liberty. I feel this assumption is unwarranted, especially where the committing medical practitioners are given such broad scope for personal value judgements.

153. (1968) *Federal Probation*, Sept., 21.

154. (1968) *Federal Probation*, Dec., 19.

155. (1968) *Federal Probation*, Dec., 19.

157. *Prisons Act 1936-1969* s.42p.

I submit there should be a clearer, and a far more restricted, enunciation of when commitment can be justified, namely when there is a substantial risk of the person acting dangerously towards others, or where a person is badly in need of treatment and is unable to make a meaningful choice between the courses of conduct open to him. A person in this latter category should not be detained if he receives no treatment, or if the treatment is better administered at another institution, for example, a clinic.

A satisfactory body of commitment laws is not complete without comprehensive procedural safeguards. The South Australian Act is sadly deficient in this respect and lags well behind most other jurisdictions. The present system of official visitors is totally inadequate as a form of review of individual cases. My proposals for reform include the establishment of an administrative tribunal, which would have the jurisdiction to both review a certification decision when requested, and review the progress of patients at regular intervals. A person appearing before such a tribunal should have all the rights given to criminal defendants, although the hearing itself would be conducted informally.

The evils of preventive detention are particularly obvious in the commitment of the criminally insane. The current procedures for accuseds who have been acquitted on the grounds of insanity are conducive to lengthy and often unnecessary detention. This should be minimized by placing responsibility for discharge on a representative body, such as the Parole Board, and by stipulating that detention could only last for as long as the sentence the accused would have received had he been convicted. In addition, reluctance to release criminal patients could be partially overcome by giving to the Board power to grant conditional release in preference to an absolute discharge.

Prisoners who are hospitalized before standing trial are at a considerable disadvantage by virtue of s.46(b), which authorizes their indefinite detention as criminals, even if they are fit to stand trial. I can see no justification for this section, and suggest that such a patient be either tried (if he is fit to be so), or committed under civil procedures if this is appropriate.

Lastly, there is a need for a reappraisal of the disposition of sexual offenders under s.77A of the Criminal Law Consolidation Act. This section appears to be based on the two assumptions, both of which I consider false, that sexual offenders are generally dangerous and that they will normally respond to psychiatric treatment.

Overall, I may have painted too gloomy a picture of commitment in South Australia. The operation of the Act is vastly better than, for example, in the U.S., where nearly all mental patients are involuntarily committed and many of these receive no treatment. The substance of my allegations concerns the looseness of the present laws and the potential they create for wrongful commitments. The extent of wrongful commitments is difficult to assess, although I did find some criminal cases which I consider do call for urgent review.