Mental disorder and the Crimes Bill

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At first sight it seems that the Crimes Bill offers little change directly affecting the issue of mental disorder. There are no additional concepts such as diminished responsibility and there is no new process by which psychiatric evidence may be obtained or heard, and by which the mental state of an accused may be adduced. Provocation, a quite sophisticated defence psychiatrically speaking, has disappeared. The definition of insanity (clause 28) is not hugely different to the present; infanticide remains in clause 124 (Culpable Homicide by Mother of Child).

However, other changes may have quite profound indirect effect on the significance of mental disorder for the criminal law.

I SETTING THE SCENE

In assessing the impact of the changes - or lack of them - the wider contexts against which the Bill should be viewed may be no less important than the law itself.

The relevant contexts are:

1 the moral/social/ethical context;

2 the legislative context - especially the Criminal Justice Act 1985 and the Mental Health Act 1969;

3 the context of psychiatric facilities and services - both in the penal and health systems.

A Moral/social/ethical context

The most commonly cited reason for introducing the notion of mental disorder into the criminal law is that of humanitarianism. The basic principle is that people who are ill in such a way, and to such a degree, that their criminal behaviour may be attributable in part or whole to the illness may be excused from the usual penalties of law; and further, their illness is seen as requiring treatment rather than punishment.

It is not unusual, however, for the two competing threads of community morality to conflict and become confused. Persons acquitted on the grounds of insanity, or in some other way finding their way to hospital, may be seen as "getting away with it". Some crimes are seen as so horrific that the perpetrator has little chance of being acquitted no matter how mad he is shown to be. The most well known recent example is that of

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Peter Sutcliffe, the Yorkshire Ripper, where the psychiatric evidence seems not to have influenced the jury. His later transfer to hospital from prison suffered prolonged delay so that when he was eventually transferred, the official statement had to describe him as "gravely ill".

Similar confusion is shown in relation to the subsequent fate of those persons whom the court does transfer to hospital, having been acquitted on account of insanity. The humanitarian intent of the court and the verdict is soon forgotten. An implicit and sometimes explicit assumption seems to be that such patients should "serve" as long in a hospital as they would have done had they been sentenced to prison. In the wake of the 1982 Oakley Inquiry,[1] initiated by allegations that repressive and custodial philosophies and methods were being employed in the hospital, an outraged press conducted a campaign concerning a man, legitimately in hospital and under treatment, who had been - by that very same allegedly repressive and custodial regime - allowed as part of his therapy out of hospital for a couple of hours; all this even though, given the circumstances of the crime with which he was charged, there was general agreement that repetition was extremely unlikely.

By no means are all patients who are in hospital rather that in prison discharged sooner that would have been the case had they been convicted. At the present time a small number of patients have resided for 25 years or more in hospital. Paradoxically, as the briefer stays in hospital are condemned by the conservative end of the philosophical spectrum, so are the longer stays viewed with concern by the liberal end as "indefinite detention", or "preventative detention".

Both ends of the spectrum, I believe, have failed to grasp fully the significance, and the consequences, of acquitting persons on the grounds of insanity. Logically, if a person's propensity for offending arises as a result of his/her psychiatric illness, it is the prognosis of that illness, and its response to treatment, which should determine the duration of the stay, rather than the passage of an arbitrary period of time. For the very few persons whose illnesses have not responded to treatment, to discharge them would be, for their own sake as well as that of others, irresponsible.

The length of any custodial sentence prescribed by the criminal law is determined by factors such as the gravity of the crime, the person's past offending, etc; it can be predetermined by reference to such factors, and its justness or otherwise can be assessed. It is intended as punishment - for deterrence, as retribution, for denunciation, etc. But in the case of illness, the decision to detain in hospital is based on the needs of the person (though the needs of the community are not forgotten), and its purpose is treatment. The duration, short or long, can be predetermined only within the limits of existing medical knowledge; it ultimately depends on the outcome of the illness. Prevailing social values affect alike both psychiatric attitudes and the thinking of lay persons.

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1 *Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters* (1983).

B The legislative context

Both the law and psychiatry are concerned with categories - the law with categories such as guilty/not guilty, psychiatry with diagnostic categories, or with the broader categories of ill/not ill, disordered or not. Although such categorisations are to some extent fiction, it is generally seen as convenient and useful. This approach does, however, obscure the reciprocal relationships between the categories.

The reciprocal, dimensional approach to the relationship between criminal responsibility and psychiatric disorder, is of course an over-simplification but it represents the situation more realistically than do categories, notwithstanding their apparent pragmatic convenience. The fact that an individual's place on the continuum between "responsibility" and "disorder" may vary significantly over time suggests that flexibility in the connections between the justice and health systems is of the essence. It may seem therefore, that that reticulum by which a person might pass from the justice system to the health system should be so rich that changes in the Crimes Act 1961 are almost irrelevant. There are many reasons, however, why this is not so.

First, the fact that at present the mandatory sentence for murder is life imprisonment may account in part for the relative frequency of the insanity defence, and hence the firm allocation of an individual to the disorder end of the scale. At present there are 44 patients in hospital acquitted on the grounds of insanity. The possible effects of discontinuation of mandatory sentencing on the frequency of the insanity defence are discussed below.

Secondly, movement from justice to health may not prove easy, and accordingly the initial disposition of the court is often vital. For example, a person hospitalised by a court order, who has an antisocial, psychopathic personality, can very seriously disrupt a treatment programme and the hospital's general therapeutic climate; such a person may be seriously divisive to group dynamics to the detriment of other patients; may be exploitive and destructive, sexually and in other ways, again to the detriment of other patients; and may infringe, and incite others to infringe, rules and laws relating to such matters as the consumption of alcohol, the importation to the hospital of illegal drugs, etc.

Such a person tends not to be susceptible to the treatment regimes most psychiatric hospitals can offer, and the hospital is forced reluctantly into the simple custodial model from which psychiatry has extricated itself with so much difficulty over the last few decades.

Lastly, discharge of such a person from hospital is fraught with danger in the sense that should things go awry after discharge, and the patient in some way reoffend, then the hospital is held responsible. Reoffending is not unexpected in former prisoners and the prison suffers no undue opprobrium. Ex-hospital patients, however, are seen as in a very different category, and it is the hospital rather than the person who frequently attracts the criticism. The double shooting in the High Street in Gore of Kevin and

Donna Fox in 1985, and the much publicised homicide and suicidal death of Ian Donaldson, both gave rise to public inquiries, and are vivid examples of this point.[2]

Such events can lead to the practice, in one form of another, of what has been called "defensive psychiatry", manifest in clinical decisions or opinions relevant to the application of legal provisions.

C The pragmatic context - services and facilities

One of the most serious impediments at the interface between psychiatry and the law lies in this third contextual setting, which deals with the availability of facilities and services to implement the intentions of the law or its judicial officers.

In New Zealand over the last 8 years, of the many inquiries into the various facets of forensic psychiatry, two stand out above the others - the so called Oakley Inquiry in 1982,[3] and the Mason Inquiry in 1988.[4] It is important to provide some historical backdrop.

Until the early 1970s, Carrington and Oakley Hospitals comprised one large hospital, known as Oakley. In the early 1970s, following mounting criticism of the administrative and therapeutic styles, the hospital was divided into the larger Carrington, destined to pursue an open door policy, (and for the next decade, if Carrington was not trendy, then at least it was seen as representing many of the ideals of modern psychiatric hospitals) and the smaller two-ward part of the original Oakley, which retained that name, and developed a forensic function.

The new Oakley Hospital had a policy of ready acceptance of persons both from the courts and from the prisons, and was highly regarded for this reason by those agencies. It is probably fair to say that its role was seen, at least to a significant extent, as an extension of the justice system.

The dynamics of Oakley Hospital and its relationship with Carrington and the rest of the Auckland psychiatric service during the decade 1973-83 offer important lessons.

Administrative communication between Oakley and other facets of the psychiatric services shriveled; its closed wards, often violent inmates, heavy use of medication, etc, began to be seen as a relic of what was bad, historically, in the mental hospital system. Paradoxically, however, it continued to be used by the rest of the mental health services in Auckland, as well as by the justice system; and patients who could not be reasonably

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2 *Report of the Commission of Inquiry into the circumstances of the release of Ian David Donaldson from a psychiatric hospital and of his subsequent arrest and release on bail* (1983).

3 Above n 1.

4 *Report of the Committee of Inquiry into procedures used in certain psychiatric hospitals* (1988).

contained in the more open setting of Carrington for instance were sent to Oakley. The staff at Oakley began to feel beleaguered; doing work that they (and given the referral from other sources, other people too) thought necessary, yet attracting criticism in the process. In my view it was an illustration of group projection, a process by which unwanted, disliked and feared parts of the self are relocated elsewhere, enabling one to function oneself in a comfortable and "enlightened" way, which virtue at the same time legitimises one's criticism and derogation of the other who is, so to speak, carrying the "bad bits". I think it has to be said that, without Oakley Hospital during that decade, the rest of the psychiatric services in Auckland could not have functioned as they did.

Notwithstanding those interesting dynamics, the volume of criticism mounted, and then finally following the death of a patient, Percy Watene, came the Oakley Inquiry. There seems little doubt from the Inquiry's Report that the increasing isolation of the hospital had been the result of an implicit collusion between itself and the outside world; and that in the sequestrated institution, strange and idiosyncratic practices had developed.

Following that inquiry, Oakley Hospital came under the management of the Auckland Hospital Board Executive Officers, still bruised and wounded by the inquiry, and determined, it would seem, not to allow the hospital to be used again as what they saw as a dumping ground. This was however achieved by a massive denial that there were any problems; a denial that offending patients had anything to do with psychiatry; and an implication that agencies other than the Auckland Hospital Board should assume any necessary responsibility.

Most of the consequent burdens fell on the prison system, and on Lake Alice Hospital, but the community was not spared. Several very serious crimes were committed by patients who should, there is no doubt, have been in hospital, and ultimately in mid-1987 there was a double homicide which gave rise to the Mason Committee of Inquiry.

It is not my intention to deal in any detail with the Mason Report. Its relevance really, like most reports of its kind, is less in the detail than in the fact that it represents a water-shed event, hopefully terminating a chaotic and anarchic period, and laying the ground for more rational development of forensic psychiatry.

Identification of the spectrum of problems, and the corresponding spectrum of resources necessary to cope with them should precede consideration of the necessary processes, and indeed may suggest the kind of provisions which are required in the criminal law.

What these inquiries show is the need for a range of institutions and facilities. The proper spectrum from prison to ordinary hospital can be described as follows: prisons, as long as they are deemed necessary, are for villains. Prisoners who have relatively mild forms of psychiatric illness, or have psychiatric illness which is relatively easily treated, may be cared for by the prison psychiatric service within the justice system.

The special prison comes next and needs particular mention. This is seen as a specially designed and separately administered prison within the justice system, with its own carefully selected and specially trained superintendent and prison staff, supplemented as necessary by health professionals, and run as a therapeutic community rather than a punitive institution. The inmates, by and large, will be sentenced prisoners with vulnerable personalities, who would have decompensated in the environment of an ordinary prison and become psychiatrically ill; but who do not otherwise have psychiatric illness per se. In other words, it is to prevent the more noxious consequences of ordinary prisons for vulnerable people; to provide an appropriate prison management environment; to attempt as far as possible to reduce recidivism; and to conduct research. It is not a prison hospital, nor is it for psychiatrically ill people who suffer from disorders such as schizophrenia, manic depressive illness, etc. It is, in my view, one of the shortcomings of the Mason Inquiry that it misunderstood this concept. The report, for instance, uses the terms "special prison" and "prison hospital" apparently inter-changeably ("we have been informed that the Justice Department intends proceeding with a construction of a prison hospital on a site at Paremoremo"), and declares that the "the establishment of a therapeutic milieu would (be) virtually impossible". No reference is made to several excellent examples of such special prisons elsewhere (eg Barlinie, Grendon Underwood).

The Roper Report[5] earlier this year echoes the sentiments of the Mason Committee, and seems to have been misled by it.

Yet without such a facility the most problematic group of persons (the personality-disordered offender) will again not be catered for, and the outcome of other initiatives is likely to be seriously jeopardised. The proposed inmates fall mid-way between the psychiatrically ill and the psychiatrically normal; as indicated, the regimes of prison are intolerable to them, yet the required therapeutic regime is not ordinarily part of any psychiatric hospital. It is one which has to be specially designed in a secure setting.

Further along the spectrum into the area of health responsibility, the National Maximum Security Unit at Lake Alice has maximum capacity for 40 persons, and usually runs at approximately 35. This, roughly one place per 100,000 population, in the present situation seems to be adequate in terms of *maximum* security places; and it may well be with the current development of regional facilities that its size could be reduced. The maximum security unit is intended to house those psychiatrically ill persons who cannot be managed adequately in other psychiatric hospitals, who are determined escapers or potentially so, and whose absence without leave would pose an instant and serious threat to the community.

Further along still the concept of "regional secure units" is currently being developed, as a result of the recommendation of the Mason Committee that such units be established in Auckland, Hamilton, Wellington, Christchurch and perhaps Dunedin.[6] To that list has been added the mid-North Island, on the Lake Alice Hospital site.

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5 *Prison Review: Te Ara Hou: The New Way* (1989).

6 Above n 4, 184.

Such medium secure units would be in the order of size which would accommodate 15 persons, and would form part of a forensic psychiatric service which, in addition to supervising the psychiatric care of the patients within them, would also offer a consultative service to the rest of the hospital, and by negotiation, to the Justice Department facilities. It would also be responsible for follow-up and other community services.

Finally, at the far end of the spectrum, is the ordinary hospital which is largely open, and takes predominantly informal patients. It must be emphasised, however, that if the spectrum is incomplete, experience has shown that this more idealised part of the mental health service cannot function.

II THE CRIMES BILL

The Crimes Bill can now be examined against these various contexts.

Section 28 of the Bill essentially re-iterates the M'Naghten Rules. They are now a set of criteria which are almost universally criticised; indeed it has been said that they provide such limited protection, that Daniel M'Naghten himself would have flunked the test that bears his name. The British Royal Commission on Capital Punishment[7] described the M'Naghten Rules as this "ancient and humane principle that has long formed part of our common law" and concluded that

> the gap between the natural meaning of the law and the sense in which it is commonly applied having for so long been so wide, it is impossible to escape the conclusion that an amendment of the law, to bring it into closer conformity with the current practice, is long overdue.

The explanatory note to the Crimes Bill, referring to the clause on insanity, states:

> [T]he clause does not attempt to deal with the vexed question of volition. It seems that there are people who know what they are doing, know that it is wrong, but are unable, because of psychiatric disorder, to stop doing it. How the law can provide for these cases without opening the floodgates to those who simply give in to temptation is a question that has so far defied a practical answer.

Part of the problem may lie in the continued commitment to categorical as opposed to dimensional approaches. "Insanity" is a nosological category; "life" is a sentencing category. The Bill attempts to deal with the second, but not the first. The intention behind abolishing the mandatory life sentence for murder may be similar to that described by the Butler Committee with respect to diminished responsibility, viz "a special device for untying the hands of the judge in murder cases".[8] In other words, the abolition of the mandatory penalty should enable judges to respond more flexibly to offenders with unusual psychiatric states - even those who "lack volition".

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7 Great Britain Royal Commission on Capital Punishment *Report* (1953: Cmd 8932).

8 *Report of the Committee on Mentally Abnormal Offenders* (1975: Cmnd 6244).

Experience of the diminished responsibility defence[9] in the United Kingdom may therefore offer some clues to what may be expected with regard in particular to the insanity defence.

The consequences may be summarised as follows:[10]

First, the number of cases of murder in which a plea of insanity was offered fell dramatically, and at least for the first couple of decades, pleas of insanity in the United Kingdom dropped to about 1 or 2 per year.

Secondly, there was a steady rise in the number of men convicted of manslaughter by reason of diminished responsibility. As a proportion of the increasing number of homicides, the number remained relatively steady at about 20%.

Thirdly, three years after the Homicide Act 1957 (UK) was first introduced, it was decided that pleas of guilty of manslaughter could be accepted at the discretion of the judge in cases charged as murder where the medical evidence was not challenged. In these circumstances, over a ten year period, 87% of cases were dealt with by pleas of guilty.

Fourthly, a change in apparent sentencing policy is to be noted. In 1964, more than half the persons convicted of manslaughter became the subject of hospital orders; this proportion rose to 70% at the end of the 60s, only to fall progressively through to 1979, to a quarter of such cases. Correspondingly, the use of imprisonment increased.

Dell's research[11] showed that the main reason for the change in sentencing was the reduction in the proportion of cases in which the reporting doctors recommended a hospital order. This trend, she wrote, deprived the judges of the opportunity of making such orders. Thus judges, faced with a person with a psychopathic personality disorder who was guilty of homicide, chose to send the convicted person to the one institution which did not have the power to refuse admission - ie prison.

Some of the consequences of this trend bear consideration. In 1963, the author examined the first 26 "diminished responsibility" prisoners sentenced under the Homicide Act 1957 (UK). The findings suggested that, although not always overly psychotic, many had an underlying psychosis, and were periodically vulnerable to serious psychotic decompensation. At the end of their finite sentence, the problem was envisaged of discharging such persons, not only untreated but also psychiatrically unmonitored, into the community. Similar problems may arise in New Zealand if the only significant change is the abolition of mandatory life imprisonment.

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9 Under section 2 Homicide Act 1957 (UK), the defence of diminished responsibility provides for an accused to be convicted of manslaughter instead of murder where, at the time of the killing, "he was suffering from such abnormality of mind ... as substantially impaired his mental responsibility for his acts ..."

10 S Dell, *Murder into Manslaughter* (1984).

11 Above, 14ff.

III THE DISPOSITIONAL DECISION

Currently there is a range of options open to a judge when the verdict is one of acquittal on the grounds of insanity. The accused may be made a special patient, a committed patient or ordered to be released immediately. Such decisions involve consideration of the adversarially adduced medical evidence given during the trial; such evidence, having been led by counsel or elicited under cross-examination, can tend to be selective and important questions relating to issues such as prognosis are frequently not addressed. Section 115(4) of the Criminal Justice Act 1985 provides for the court to remand the person to a hospital for a period of up to seven days in order to make enquiries to determine the most suitable method of dealing with the case. However, there is no further formulation of the means whereby such guidance may be provided. Consequently, many problems may arise. For example, the concerns of the hospital referred to earlier may conflict with those of the court; in particular, vicissitudes of philosophy or management style as described above may occur, and the quality of local opinion may be variable, not to say idiosyncratic.

In several European jurisdictions courts are advised by selected psychiatric counsel. More recently, through the Mental Health Services Act 1985, a Mental Health Tribunal, consisting of a Supreme Court Judge assisted by two psychiatrists, was created in Queensland. The main function of the Tribunal is the determination of criminal responsibility. Where there is reasonable suspicion that a person charged with an indictable offence is mentally ill, or was so at the time of the offence, they may refer themselves to the Tribunal, or may be referred by their nearest relative, their legal representative, a crown law officer or, if the patient is in hospital, by the Director of Psychiatric Services.

The proceedings of the Tribunal are deemed judicial, but the Tribunal is also invested with the powers of a commission of inquiry. The Tribunal first meets informally to inspect the available evidence and may order further examinations and reports. Defence counsel may also arrange further reports on his or her own initiative. Hearings are held in one of Brisbane's Supreme Courts. Evidence is taken on oath, but there is no strict adversarial system. The accused, the prosecutor, and defence counsel are present, and most hearings are open to the public. The psychiatrists assisting are able to question expert witnesses. Appeals, with some limitations, by the accused or by the Crown, against Tribunal findings may be made to the Court of Criminal Appeal. Appeals are in fact few. No advantage has been taken of the further option to go to trial subsequent to a Tribunal finding. Some comparable advisory system in New Zealand would seem to have advantages either in the determination of insanity (or fitness to plead), as in Queensland, or to advise the court at the time of disposition. Important information hitherto unknown may then be available to the court including issues related to the nature and quality of specific psychiatric services. Advice, similarly, may be of value in deciding on disposition in cases where the defence of insanity has not been raised, but psychiatric factors are clearly relevant.

Thought should also be given to the possible consequences of a court order which leads to hospitalisation without special patient status. The seriousness of a particular crime does not always correlate with the seriousness of an illness, and particularly given

the very high standards of insanity required by the M'Naghten Rules, it seems quite possible that many persons, particularly in the future, will enter hospital from the courts as ordinary committed patients.

The designation "special" ensures certain safeguards and diminishes the possibility of the intensity of concern amongst treating health professionals attenuating over time. Such dilution of concern may occur when, through staff changes or a change of ward, succeeding health care teams may have little or no contact with the original circumstances of the case, and "ordinary" committed patients may be discharged by their treating doctor. Further, the Mental Health Bill 1989 provides for mental health tribunals with similar power to discharge.

Thus consideration may be given to a provision whereby the court could designate a particular person "special" (in the way that patients are designated "restricted" in the UK), so that the same safeguards may be put in place which currently apply to special patients under section 115 of the Criminal Justice Act.

Lastly, let me comment on clause 124 of the Crimes Bill - culpable homicide by mother of child. There is now no evidence to suggest that the illnesses which occur post partum are significantly different from similar illness occurring at other times; they seem simply to be precipitated by the experience of child birth. However, on the other hand, (and here I speak as a mere male!) it does seem to me that the period of 10 years is a peculiarly long time to specify for recovery from childbirth.

There seems to be no reason why, since a life sentence is no longer to be mandatory for homicide, the mitigating circumstances involved in such events may also not be taken into account in the case of murder of a child.

IV SUMMARY

1 The success or otherwise of criminal law as it relates to psychiatric disorder is determined by a variety of contextual factors. These include the effect of prevailing social values, the provisions of related legislation and the adequacy and organisation of psychiatric services.

2 The retention in the Crimes Bill of what are essentially the M'Naghten Rules is very questionable. The criteria set are much too high to be of more than very limited use.

3 The abandonment of the mandatory sentence for murder is likely to lead to fewer pleas of insanity. Psychiatric factors are more likely to be used in mitigation, and either more psychiatrically ill persons are going to be sent to prison for finite sentences, or more mentally disordered people are going to be sent as ordinary committed patients rather than special patients to psychiatric hospitals. Both these options require careful thought. A psychiatrically ill person in prison may or may not get the full range of treatment that he or she needs; if such people are sent to hospital, they become ordinary committed patients at the termination of the period of their sentence if they are still in hospital (and therefore lose the safeguards of

special patient status); or, as sometimes happens, they are transferred back from the hospital to the prison shortly before the termination of their sentence, so that the hospital does not have the anxiety of discharging a person who may reoffend.

4 There would be great value in closer collaboration between the judicial and health systems, perhaps with the creation of a panel of expert psychiatrists available to advise the court, possibly as part of a tribunal on the Queensland model, especially with regard to disposition. The opportunity for informal as well as formal discussions between nominated psychiatrists and a judge - a kind of case conference - would ensure the more appropriate tailoring of dispositions to the individual case, to prevailing organisational circumstances, etc.

5 The justification for the retention of the infanticide equivalent is questionable so long as the abolition of the mandatory sentence remains, and there is introduced some more effective system of providing psychiatric advice to the court.