A Study of Presentence Psychiatric Reports in Tasmania

by

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PREFACE

Psychiatric involvement in the criminal justice system in Australia is an area from which little empirical research has emanated. Concluding a brief examination of the numbers of psychiatric presentence reports requested by Victorian Judges, Bartholomew and Milte (1977)* concluded,

> "... it is necessary at this time to find out which offences the 983 psychiatric pre-sentence reports referred to in this article were concerned. How many were concerned with violence? How many reports made recommendations to the court of a specific type? If a specific recommendation was made in the report was it adopted by the court? Did courts not requesting pre-sentence psychiatric reports sentence in any significantly different manner to those who did request such reports?
>
> It is with this type of question in mind that we publish this small piece of research in the hope that it will lead to a larger undertaking which may answer some of the questions posed here."

Not only was my research designed to answer this sort of question, but it also provided the opportunity to examine other aspects of the criminal process such as the judicial behaviour of judges and magistrates, the changing role of females in the criminal process and the after conduct of offenders receiving psychiatric treatment.

Tasmania is a very suitable place for criminological research. It is comparatively isolated, small and the records are accessible and relatively manageable. I hope that my findings will provide some ideas and impetus for further research as well as implications for present action.

I must acknowledge the help of all those who have allowed me access to the records necessary to compile the data for this study. I

* Bartholomew, A.A. and Milte, K.L. "Victorian Judges and the Psychiatric Pre-Sentence Report". The Australian & New Zealand Journal of Criminology, 1977, 10, 121.

wish to thank the Attorney-General, the Commissioner of Police, the Mental Health Services Commission, all the officers from the Court of Petty Sessions, the Supreme Court, the Police Department, Mental Health and the Royal Derwent Hospital who have patiently helped me extract the necessary information from their records.

I must also thank all members of the judiciary and magistracy who co-operated and completed my questionnaire and in particular the Chief Justice who made valuable suggestions as to its content.

I would very much like to thank my supervisor Professor Derek Roebuck who has provided me with such persistent encouragement throughout, and Dr. Sornarajah, also of the Faculty of Law, for his constructive criticisms and help.

For their financial assistance which played a large part in making the research possible in the middle stages of my work I must thank the Australian Institute of Criminology, and in particular I would like to express my sincere gratitude to Dr. E. Cunningham-Dax who has devoted many hours helping me to design the study initially, to carry it out and to interpret the findings. I must also thank my family and friends for their tolerance and help, and add that despite such eminent assistance, any errors are of course mine alone.

The subject matter of thesis, the large number of journal articles and monographs and the small number of cases seemed to me to demand some method of citation other than the standard legal method of citing journal articles and monographs. Perhaps arbitrarily, I chose to adopt the style recommended by the Publication Manual of the American Psychological Association which has been accepted in Australia for psychological publications. This seemed to have the advantages of avoiding a vast number of footnotes and providing an easier method of discovering further details of the work referred to.

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CHAPTER ONE

INTRODUCTION

The role of the psychiatrist in the criminal process is a topic which arouses much controversy among lawyers, psychiatrists and the general public. If an offender escapes from a mental hospital there is a public outcry.[1] If an offender referred for psychiatric treatment does not receive the treatment the court expected there is an outcry.[2] And if an offender assessed as dangerous and in need of treatment is released by the court without treatment and subsequently commits a murder, the psychiatric service feels disgruntled.[3]

The question of criminal responsibility and the M'Naghten Rules has traditionally pre-occupied lawyers and psychiatrists, but in practice it is after conviction but before sentence that a psychiatrist is most often involved in the criminal process. There are fundamental differences between contemporary specialists in law and psychiatry as to whether or not psychiatric knowledge and treatment should be used by the courts in the disposition of offenders. Treatment oriented jurists and commentators support and justify the involvement of psychiatrists in the sentencing process as the most humane and effective way of dealing with offenders, many of whom are seen as mentally disturbed or ill. (E.g., Alexander & Staub, 1956; Bazelon, 1974; Weihofen, 1956). They constantly urge the better use of modern psychiatric knowledge in the administration of criminal law and see treatment in hospital as inherently good and therapeutic. Some commentators, who believe in a deterrent penal policy, see psychiatric involvement and psychiatric treatment of offenders as

(1) The Mercury, August 12 1976, p.3 (see Appendix C for complete text).
(2) The Mercury, March 5 1976, p.8 (see post p.109).
(3) R. v. Reed (unreported, December, 1974). In this case the accused, who was charged with murder was found unfit to plead. He had previously been convicted of a minor offence and a presentence report disclosed that he was dangerous and in need of treatment. No action was taken.

a threat to law abiding behaviour and respect for the law. Some, who give weight to a retributive aim of penal policy, view the treatment of offenders who are minimally responsible, as denying the community its right to expect that criminals be punished.(4) Others, including Hall (1960), Szasz (1963), and Anttila (1971) criticize psychiatric involvement in sentencing on entirely different premises, and they warn of the grave danger an emphasis on treatment has for the freedom of the individual. This group of commentators is concerned that under the guise of treatment or therapy, we may engage in practices which we would not undertake under the name of punishment. Their arguments include denying that psychiatric treatment is more effective with regard to preventing recidivism than conventional sentencing alternatives and a rejection of the hypothesis that all offenders are psychologically disturbed or mentally ill.

As well as such fundamental philosophical differences, many other questions have been raised. Doubts are frequently expressed about the value and reliability of psychiatric reports. Magistrates and judges are thought to vary in the number of psychiatric reports they request, and the amount of notice they take of them. Sometimes sentencers are criticized for relying too heavily upon reports and for being insufficiently sceptical of the recommendations and assessments in them. This it is said is an improper delegation of judicial functions and disregards evidence of the unreliability of psychiatric diagnosis and prognosis. Conversely, sentencers are sometimes criticized for not following expert advice, or for making insufficient use of psychiatric reports and the available treatment options.

(4) The power to impose a sentence of imprisonment in addition to a hospital or guardianship order was inserted into the Mental Health Act at the suggestion of the Chief Justice. He argued that the element of retribution cannot be overlooked. The community still requires criminals to be punished if they are suffering from a mental disorder which is not enough to absolve them from responsibility for the crime.

Despite these questions, there is in Australia very little reported research or even statistical data on the way in which courts deal with "mentally abnormal" offenders. Nothing of an empirical nature is known about the following matters:

(i) The proportion and type of offenders remanded for presentence psychiatric reports.

(ii) the proportion of offenders diagnosed as having a mental disorder.

(iii) the proportion of cases in which psychiatrists are able to recommend treatment.

(iv) the proportion of cases in which their recommendations appear to be followed.

(v) the degree of disparity which exists between sentencers in the proportion and type of cases they remand for reports, and the reliance they place upon the recommendations in them.

(vi) the response of offenders to treatment and their reconviction rates compared with other offenders.

(vii) the reliability of diagnosis and psychiatric predictions.

In an attempt to discover the ways in which the Tasmanian courts make use of psychiatric reports and facilities in sentencing, and to answer some of the questions posed above, the records were examined of 354 offenders convicted by a court of petty sessions, and 100 offenders convicted by the Supreme Court.[5] These offenders were all those referred for psychiatric examination by the Hobart court of petty sessions and the Supreme Court of Tasmania in the years 1969, 1970, 1974 and 1975.

(5) Generally the Supreme Court has jurisdiction in respect of all indictable offences and justices or stipendiary magistrates of the courts of petty sessions hear summary offences. There are some exceptions to this which provide certain less serious indictable offences shall or can be deemed to be simple offences and can be dealt with summarily (Justices Act 1959, section 71).

Referrals under the Alcohol and Drug Dependency Act were not included. The earlier years of 1969 and 1970 were chosen to allow for a four year follow-up, and the years of 1974 and 1975 were chosen for a comparison.

A questionnaire was designed to elicit information about the reasons for referring offenders for reports, the impact of recommendations on the sentencing decision of the court and matters as to form and content of psychiatric reports. All judges and half of the magistrates approached answered the questionnaire. The questionnaire is reproduced in Appendix A.

The views of various writers on technique in report writing, and the conduct of psychiatric examinations were reviewed and are included in Appendix B together with a summary of the questionnaire responses in relation to the content of reports. It was felt that these matters, although important, are subsidiary to the main argument of the thesis and would be more appropriately dealt with in an appendix.

This study does not attempt to challenge the use of psychiatric reports in sentencing, but it is an attempt to understand more about this practice. It is not assumed that the practice of requiring offenders to submit to psychiatric examination and treatment is justified because psychiatric measures are more effective and humane than penal measures. Unfortunately it was not possible to test these premises conclusively but some trends were observed from the available data.

It is assumed that the courts should try to make the most effective use of available presentence information, and that the administration of justice requires a measure of consistency in the way judges approach sentencing tasks.

CHAPTER TWO

RELEVANT LEGISLATION, PROCEDURE AND FORENSIC PSYCHIATRIC FACILITIES

1. The Remand

There is a paucity of legislation in the area of remands of offenders for presentence psychiatric reports. Magistrates and judges have the power, under the Mental Health Act 1963[6] to make hospital and guardianship orders in certain cases. It is a prerequisite of such an order that the court be satisfied on the evidence of two doctors that the offender is suffering from a mental illness, psychopathic disorder or subnormality. This and the Alcohol and Drug Dependency Act 1968 are the only legislative provisions concerning presentence psychiatric evidence, but it is obvious from the types of offenders remanded and the reasons for doing so, that courts ask for psychiatric reports and offenders are required to submit to psychiatric examinations in cases where there is no possibility of orders being made under the Mental Health Act or the Alcohol and Drug Dependency Act. The court may want an expert opinion on the best method of dealing with the offender, or perhaps it may wish to know if the psychiatrist has anything to offer for the rehabilitation of the offender other than the conventional methods. So, although psychiatric examinations are often referred to as "Mental Health Act examinations", this is really a misnomer.

Magistrates and judges have of course a general power to obtain presentence information. Magistrates have the power under Rule 42(4) of the Justices Rules 1961, to receive such evidence or statements as they think fit in order to inform themselves of the circumstances of the case or the proper penalty to be imposed. Judges have a similar power,[7]

(6) Section 48(1) and section 49(1).

(7) Criminal Code Act 1924, section 386(7).

but it is also provided that it is the duty of the judge to ensure that the convicted person has knowledge of, and the opportunity to challenge the information received, unless that information was supplied by a medical practitioner and the judge considers it should not, in the interests of the convicted person, be disclosed to him. If the truth of any of the information is challenged, the judge may require it to be proved.[8] This provision as to proof provides little protection to the convicted person in respect of statements of opinion in psychiatric reports which are not susceptible to proof, assuming the report is made available, which it may well not be. The right to call evidence in rebuttal would provide a more effective protection.

In the absence of a specific legislative power to withhold a psychiatric report from a defendant in summary proceedings, strictly it would not be permissible to do so. The general rule is that a convicted person has the right to be informed of presentence information regarding him, and if not admitted or proved, such information must be disregarded.[9]

There are statutory exceptions to this. Section 5(2) of the Probation of Offenders Act 1973 (Tas.) gives the courts power to order that the whole or part of a presentence report prepared by a probation officer be not shown, or be shown only to the offender's attorney. The effect of section 51(3) of the Mental Health Act 1963 is to provide that where a medical report recommending a hospital or guardianship order is tendered in evidence and the person on whom it is made is not represented, the substance of the report shall be disclosed to him but he has no right to a copy of that report.

(8) Criminal Code Act 1924, section 386(8)(9) and (10).
(9) R. v. Brooks (1913) 8 Cr. App. Rep. 156 (C.C.A.).

There does not seem to be any reason why the general rule should not apply to the disclosure of other psychiatric reports, although it must be conceded that the contents of such reports may cause social or psychological damage if revealed, or may make the offender feel he has been sentenced by the psychiatrist, who may be subsequently responsible for treating the offender.(10) That psychiatric reports should always be made available to the convicted person is not without judicial support in Australia. In the course of a judgment concerning an appeal against sentence which alleged the judge had placed undue weight on an inaccurate presentence report, Bray C.J. said,

> Reports by probation officers, and psychiatric and other reports are becoming increasingly prominent in the deliberations of sentencing courts ... it is of crucial importance that nothing should be taken into account against a convicted defendant except what he admits or what is proved against him by sworn evidence which he has had a chance to test by cross-examination. Any report of the kind mentioned should always be shown to him and he should be asked whether he admits its contents in so far as it relates to matters of fact and what comment he has to make on it. If he disputes any matter of fact alleged in the report, then either that matter must be disregarded by the court or the question must be resolved by the calling of evidence ... Even opinion evidence from experts should not be used against a convicted person if he objects to it without the expert being called: and opinion evidence based on hearsay information obtained in his absence is not evidence against him except by consent. *(11)*

The responses to the questionnaire(12) indicate that in Tasmania the practice of judges and magistrates is to always make a psychiatric report available to counsel if the accused is represented. If unrepresented, practices differ. Some always make reports available but some magistrates as well as judges sometimes read an edited version, hide part or occasionally withhold it completely. One judge made the

(10) In the Canadian Case, R. v. Benson & Stevenson, (1951) 100 Can. C.C. 247, the court was of the opinion that psychiatric data provide an exception to the rule because such information would not warrant a heavier sentence. But psychiatric reports frequently contain matters which would warrant more severe penalties, for example a gloomy prognosis or assessment of dangerousness.

(11) R. v. Lucky (1974) 12 S.A.S.R. 136, 139. Supreme Court (In Banco).

(12) Question 23 asked "Do you make the psychiatric report available to the defendant or his counsel?"

comment that he would not act on the contents of a report so as to impose any penalty or treatment more onerous than he would have imposed in the absence of a report, unless the defendant or his counsel knew of its contents.

When a decision is made to order a psychiatric report, the offender is remanded in custody, or on bail on the condition that he submits to a psychiatric examination. A request by a magistrate for a report is communicated to the Mental Health Services Commission by the Clerk of Petty Sessions on a roneoed form. The form merely specifies the name of the offender, the offence, the name of the magistrate and the date by which the report is required. Judicial requests for reports with similar information are communicated to the Commission by the Crown Advocate's Office.

There is no mandatory procedure requiring the court to supply either the reasons for referral or any other information to the examining psychiatrist. In practice, the Police Department invariably supplies a police file or the Office of the Crown Advocate supplies papers, and if a probation officer is involved, he or she will provide a presentence report. Personal communication between the Bench and the examining psychiatrist is forbidden on the principle that anything said about an offender must be said or tendered in writing in open court in the offender's presence. Rarely is any information from magistrates and judges conveyed to the examining psychiatrist, presumably because the principle forbids private communications and there is no local precedent or administrative procedure enabling matters stated in court to be communicated.

Reports ordered by the court are prepared in most cases by a psychiatrist from the Mental Health Services Commission. Occasionally, the defendant's counsel will arrange for a psychiatrist to prepare a report and this may be in addition to the report from the Commission. The offender is interviewed at the gaol if he is in custody or at Clare House, the headquarters of the Forensic Psychiatric Services, if he is on bail. Examination by the psychiatrist lasts approximately one hour, and in selected cases the offender may be sent to the forensic psychologist for psychometric testing, or a psychiatric social worker will obtain background information. Occasionally a further examination is arranged, or the offender is referred to another psychiatrist for a second opinion. Sometimes the court specifically asks for two psychiatrists to report, and sometimes a psychologist's report is specified.

Occasionally[13] it is made a condition of bail that the defendant admit himself as a voluntary patient pending the preparation of a report. Despite the apparent lack of any legal basis for attaching conditions to a grant of bail, it has been a recognized practice of many courts for a considerable time. Now, by virtue of an amendment in 1974,[14] magistrates

> may make orders related to bail, its commencement or termination, and the conduct of the defendant during the currency of bail, ... including orders controlling the conduct of the defendant, requiring him to report at specified times, and limiting his movements and social intercourse.

Failure to comply with such an order, in addition to entailing forfeiture of bail, is made the subject of a separate offence with a penalty of three months imprisonment or $500.

(13) In the court of petty sessions group, I discovered four cases in which this was done, and in another two the psychiatrist requested a period of in-patient observation before presenting his final recommendations.

(14) Justices Act 1959, section 35.

The only conditions which receive statutory mention in relation to the power of judges to grant bail are those requiring appearance at every time and place to which during the course of the proceedings the hearing may be from time to time adjourned, and a condition requiring sureties.[15] Whether it is strictly within the express or inherent powers of magistrates or judges to impose a condition as to hospital admission is not entirely clear.

Specific power to remand an offender to hospital for a short period before deciding upon his ultimate disposal, may be useful in cases where the offender is known to be suffering from a mental disorder and needs immediate treatment, or where a period of observation in hospital is necessary to prepare an adequate report. In the majority of cases an out-patient attendance is sufficient for the preparation of an adequate report, and when the forensic psychiatric unit at the gaol is completed there will be adequate facilities for examining those offenders remanded in custody. But there still may be cases where the use of prison facilities for a psychiatric examination is undesirable, for example when the offence is unlikely to attract a prison sentence, or it is not punishable by imprisonment.

The report of the Committee on Mentally Abnormal Offenders (1975)[16] recommended giving the courts power to make an order remanding the offender to hospital for compulsory treatment for a maximum of three months whenever immediate care or psychiatric observation as an in-patient was necessary for the preparation of a report. Such a power was also recommended by Walker and McCabe (1973) on the ground that it is desirable that an offender, who is eventually to be committed to hospital, be admitted at the earliest possible stage in the process which leads to

(15) Criminal Code Act 1924, sections 304, 305 and 306.
(16) Cmnd. 6244, 1975, London H.M.S.O.

conviction and sentence. In Scotland there is such a power.[17]

When the court has sentenced the offender, the Mental Health Services Commission is notified of the decision, and at this stage communication between sentencer and psychiatrist ends. If treatment is ordered there is no provision for the magistrate or judge to be advised of the patient's progress on termination of treatment, except in so far as a probation officer may include this in a terminal probation report.

2. Sentencing Powers in Relation to Mentally Disordered Offenders

Apart from the Alcohol and Drug Dependency Act provisions, hospital and guardianship orders are the only methods of dealing with mentally disordered offenders which receive legislative recognition and yet they will be shown to account for a decreasing proportion of the sentences imposed by the courts. A far greater number of offenders are required to submit to in-patient and out-patient treatment as a condition of probation.

(i) Hospital and Guardianship Orders

Sections 48(1) and 49(1) of the Mental Health Act 1963 give the Supreme Court and a court of petty sessions power to make hospital and guardianship orders in cases where a person is convicted of an offence punishable with imprisonment.

Section 51 provides that before making such an order the court must be satisfied on the oral or written evidence of two practitioners, (one of wnom must be approved for the purposes of the Act), that the person is suffering from mental illness,

(17) Section 54 Mental Health (Scotland) Act, 1960.

psychopathic disorder, severe subnormality or subnormality,[18] and that the disorder is of a nature or degree that warrants his detention in a hospital for medical treatment, or reception into guardianship as the case may be. The court must also be of the opinion that having regard to all the circumstances, including the character and antecedents of the person concerned and the nature of the offence and to the methods available for dealing with him, that it is expedient that a hospital or guardianship order should be made in respect of him.

A hospital order is not to be made unless the court is satisfied that arrangements have been made for the offender's admission to the hospital to which the order authorizes him to be admitted within a period of 28 days beginning with the date of the making of the order, nor is a guardianship order to be made unless the Guardianship Board or person named as guardian is willing to receive him into guardianship.[19]

The hospital or guardianship order must specify whether the offender is suffering from a mental illness, psychopathic disorder, severe subnormality or subnormality, and no order shall be made unless the offender is described by each medical practitioner as suffering from

(18) Section 4 defines "subnormality" as "a state of arrested or incomplete development of mind (not amounting to severe subnormality) that includes subnormality of intelligence and is of such a nature or degree that requires or is susceptible to medical treatment or other special care or training of the patient"; "Severe subnormality" as a state of arrested or incomplete development of mind that includes subnormality of intelligence and is of such a nature or degree that the patient is incapable of living an independent life or of guarding himself against serious exploitation, or will be so incapable when of an age to do so. "Psychopathic disorder" is defined as "persistent disorder or disability of mind (whether or not including subnormality of intelligence) that results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to medical treatment." "Mental illness" is not defined.

(19) Section 51(3) and (4).

the same one of those forms of mental disorder, whether or not he is also described by either of them as suffering from another of those forms.(20)

The necessary medical evidence may be received in the form of a report without the need for proof of signature or qualifications of the medical practitioner, but the court may in any case require him to be called to give oral evidence. Provisions exist requiring that the offender's legal representative be given a copy of the report, or if he is unrepresented that the substance of the report be disclosed to him. The offender or his legal representative may require the medical practitioner to give oral evidence and may call any rebutting evidence.(21)

The Supreme Court, but not a court of petty sessions, has the power to make a "restriction order" in addition to a hospital order, where it appears to the court, having regard to the nature of the offence, the antecedents of the offender, and the risk of his committing further offences if he is set at large at any time during the continuance of the hospital order, that it is necessary for the protection of the public to do so.(22)

The Supreme Court also has the power to make a hospital or guardianship order in addition to a custodial sentence, a probation order or fine, and any other powers exercisable by it,(23) but it cannot make a guardianship order and a sentence of imprisonment unless the sentence is suspended.(24) This power has no parallel in the English Mental Health Act 1959, upon which the Tasmanian Act was modelled. It was designed to give effect to the then Chief Justice's view that the

(20) Section 51(5).
(21) Section 52(3).
(22) Section 48(2).
(23) Section 48(1).
(24) Section 55(5) In practice this is not seen as preventing the imposition of a term of imprisonment with a recommendation that the convicted person be placed under guardianship at the conclusion of this sentence. The certificate of the two doctors is sent to the Controller of Prisons at the time of sentence.

court should have concurrent power to punish convicted persons as well as to make hospital or guardianship orders. The Chief Justice felt that a mentally disturbed offender who would satisfy the requirements for a hospital order was nevertheless criminally responsible and the element of retribution should not be overlooked. Without such a power there would be a great incentive to get a hospital order as a "soft cop".

The Act provides that before making a hospital order and a restriction order, or a hospital order and sentence of imprisonment, the court must hear and take into account the oral rather than written evidence of two medical practitioners.[25]

A court of petty sessions has one power which is not available to the Supreme Court. It may make a hospital or guardianship order in respect of a person suffering from mental illness or severe subnormality without recording a conviction. This power appears to be used very infrequently in Tasmania, as in the U.K., where in 1970 only 8.3% of hospital and guardianship orders were made without conviction. It has been suggested that the triviality of the case, the severity of the offender's mental state or the fact that the magistrate felt it impossible to communicate with the offender, are reasons why magistrates have used this power (Walker & McCabe, 1973, pp.104-107).

The courts of petty sessions also have the power to refer cases to the Supreme Court if it appears that the case should be dealt with by that court.[26]

(25) Section 51(2).

(26) Section 49(4).

A hospital or guardianship order expires after one year if not renewed,[27] but the patient may be discharged at any time by the responsible medical officer or by the hospital authority.[28] A patient who is the subject of a hospital order with restriction can only be discharged by order of the Governor on the recommendation of the Mental Health Tribunal.[29] A patient who is the subject of a hospital order and a sentence of imprisonment, may be returned to the gaol on his discharge from hospital.[30]

(ii) The Alcohol and Drug Dependency Act, 1968.

This Act commenced on 26 November 1969, almost half way through the first period of the sample studied. It gave the courts certain powers to deal with persons convicted of an offence punishable with imprisonment who committed the offence while drunk or under the influence of alcohol or drugs, or as a consequence of suffering from alcohol or drug dependency. If the court is satisfied on the evidence of a medical practitioner that an offender is suffering from alcohol or drug dependency, it may make a treatment order, specifying the period for which the offender is liable to be detained in a treatment centre, or suspend the sentence on condition that the offender is admitted to a treatment centre in pursuance of a personal application.

(iii) Recognizances, Suspended Sentences or Probation with a Condition to Submit to Psychiatric Treatment

There is no specific power comparable with section 4 of the English Criminal Justice Act 1948, to make psychiatric treatment a condition of probation. Psychiatric probation orders were omitted from

(27) Section 32.
(28) Section 36.
(29) Section 70.
(30) Section 70 and 47(1).

the English Mental Health Act 1959 on the ground that results of Grünhut's investigation of them were being awaited. Consequently, either intentionally or unintentionally they were not included in the Tasmanian Act of 1963 which closely follows the English Act. The results of Grünhut's research were published in 1963 supporting the continued use of psychiatric probation orders, but nothing has been done to embody them into a consistent scheme in the Tasmanian Mental Health Act or to give them other legislative recognition. As a consequence, the power to impose psychiatric treatment as a condition of sentence depends upon general powers.

Under section 7(3) of the Probation of Offenders Act 1973, courts of summary jurisdiction and the Supreme Court may make a probation order against the offender whether or not they impose a fine, a term of imprisonment or a work order.(31)

Section 6 provides that a probation order may contain such conditions for securing the supervision, conduct or welfare of the person against whom it is made as the court may consider desirable, and may contain such provisions with respect to residence, abstention from intoxicating liquor or drugs and any other matters as the court may consider necessary for preventing a repetition of the same offence or the commission of other offences.

The attaching of conditions to probation orders is the most frequently used way of ordering psychiatric treatment for offenders other than orders under the Alcohol and Drug Dependency Act. Such

(31) Section 11 of the Probation of Offenders Act 1973 provides Supreme Courts and courts of summary jurisdiction may sentence an offender to Saturday work for up to 25 Saturdays. This scheme has been described and evaluated by Rook (1975) and Varne (1975).

conditions may, for example, require the offender "to submit to such psychiatric treatment as the probation officer sees fit", or "to such treatment including in-patient treatment as the Mental Health Services Commissioner orders".

Occasionally judges and magistrates make psychiatric treatment a condition of a suspended sentence, or they mingle a suspended sentence and a recognizance with or without a probation order and make psychiatric treatment a condition. Both section 386(1)(d) of the Criminal Code Act 1924 and section 74C of the Justices Act 1959 confer a very wide discretion on magistrates and judges to impose such conditions of suspension "as they think fit".

If offenders are admitted to hospital as in-patients pursuant to a condition of sentence, they are informal or voluntary patients. This means they are not ordinarily liable to be detained, but can be detained for three days if the medical practitioner in charge of treatment believes they should remain in hospital and reports to that effect.(32)

If offenders refuse to co-operate, or leave hospital against medical advice, they may be brought before the court in breach of bond proceedings which may attract a penalty, or in proceedings to have the suspended sentence put into execution.

Several comments can be made about the use of psychiatric probation orders. First, they may be made without any legislative safeguards such as psychiatric evidence which is a prerequisite for

(32) Section 15(2) Mental Health Act.

orders under the Mental Health and Alcohol and Drug Dependency Acts. It is true that a psychiatric report is almost invariably sought before such an order is made, but sometimes treatment is ordered despite a recommendation to the contrary.(33) In some cases no report to the court is requested, but the offender is required to submit to such examination and treatment as the probation officer deems necessary.(34) This is a delegation of the sentencing function of the judge or magistrate and it is seriously arguable whether such wide powers should be given to the probation officer and psychiatrist.(35)

Secondly, and unlike the position in England, these conditions may be attached without the consent of the offender. This is inconsistent with the Mental Health Act which makes treatment of uncertified patients voluntary. A probationer's consent to the imposition of a condition as to psychiatric treatment may not be a voluntary and informed consent, for it may be vitiated by the fear of imprisonment and the hope of advantage. Nevertheless with other limitations on the exercise of the power to make psychiatric probation orders it would afford some protection. The present situation is too open to the possibility of abuse. It is not difficult, although perhaps melodramatic to imagine a probationer being coerced by fear of the consequences of imprisonment, to seek admission to hospital as a "voluntary" patient and to undergo lobotomy or electric shock therapy. Such opportunities for abuse should not be available.

(33) Evidence will be presented to support this, post. at p.77.

(34) Evidence of this was unintentionally exposed during the course of the case studies.

(35) The use of psychiatric probation orders couched in a discretionary way has been criticized even where there was a report recommending treatment. In an Edinburgh study a high proportion of such orders were found to fail in their purpose, for many of the offenders never attended hospital at all. (Woodside, 1971).

(iv) Recommendations for Transfer Directions

By virtue of sections 59 and 60 of the Mental Health Act, the Attorney-General has the power to direct that a person serving a sentence of imprisonment be transferred to hospital with or without a restriction direction. In practice a restriction direction is automatically made unless the date of release is imminent. The legal status of patients transferred without restrictions on their discharge is that of hospital order cases, so they can be discharged at any time or detained for twelve months. If the Attorney-General makes a restriction direction, the effect is that, if the patient recovers before his sentence expires, the Attorney-General may insist upon his return to prison.(36)

Sometimes magistrates and judges impose a sentence of imprisonment with a recommendation that the Attorney-General make a transfer and a restriction direction under the Mental Health Act. Woolley v. Devine(37) is typical of such cases. Devine, a youth of 17, had a very long record including 29 convictions for illegal use of a motor vehicle. In imposing an 18 month sentence of imprisonment for two more charges of illegal use and one of dangerous driving, Magistrate Wood made the following comments:-

> The course that I intend to take with you is this: I am going to impose a sentence on you, and I am going to send the papers to the Attorney-General with the request that he consider making a transfer direction under the provisions of the Mental Health Act, so that you can spend all or some part of the sentence in a mental hospital. I am not prepared to accept counsel's submission that I should simply make a hospital order at this stage. If I did that, it means that you would be received into the Royal Derwent Hospital and would be discharged. Now that might be a comparatively short period of time. In fact, experience tends to show that it is, and I have absolutely no confidence at all that upon discharge you would not immediately start to take other people's cars and behave as you have in the past. Consequently, while I am prepared to go along with the idea that you should have treatment if you want treatment, that is to be in the situation where you are

(36) Section 69(1) Mental Health Act, 1963.
(37) Unreported reasons for sentence, 8th July 1974.

in custody, and you will be transferred from the gaol for treatment and returned to the gaol afterwards. So it may be, for example, that you will spend three or four months of this sentence in the Royal Derwent Hospital. It is a matter for the doctors to determine. A long sentence will not only protect the public, but it will enable you to learn a trade in prison and hopefully increase your prospects of having stable employment upon release.

3. Psychiatric Facilities

(i) The Royal Derwent Hospital

This is the largest psychiatric hospital in Tasmania, with an average of almost 900 patients at any one time throughout the year. Offenders who are the recipients of hospital orders are invariably sent there. They are not necessarily confined in closed wards even if subject to a restriction order, although this is usually the case initially. There are three "closed wards", Ward A, Ward C, and Ward 10. Ward A is a women's ward which mainly houses court orders and failed girls from Weerona and Mt. St. Canice. Ward C, the maximum security ward, is exclusively forensic. It has facilities for up to 20 patients, but is rarely filled to capacity. Its patients have either been found unfit to plead, not guilty on the ground of insanity, insane on arraignment or are offenders on hospital orders or transfer orders from the gaol. In addition to the usual staff, two or three of the 13 security officers attached to the hospital are always on duty. Ward 10, a male ward, is a mixed ward not exclusively forensic, and includes those who cannot be managed in open wards, for example the severely psychotic, absconders, dangerous patients and those with social behavioural disorders irrespective of intelligence.

In each of these closed wards patients receive minimal treatment. For example, a psychiatrist visits Ward 10 half a day each week. There are no facilities for psychotherapy.

As there is no compulsion for hospital authorities to contain in closed wards those subject to hospital orders, even if the hospital order is coupled with a restriction direction, placement is a matter for the hospital, which puts the patients in categories. Forensic patients may be in category A, B or C. Category A patients cannot leave the ward except with an attendant, category B patients cannot leave the hospital grounds, and have freedom of the grounds on a five minute warning. Category C patients have all privileges except that they cannot leave the hospital grounds.

(ii) The John Edis Hospital

The main role of this hospital is as a day centre with associated in-patient and out-patient facilities. As well as the traditional range of psychiatric treatment methods, the use of group therapy and behaviour modification techniques is developing. The average daily bed occupancy rate is about 15.4.

(iii) The Professorial Psychiatric Clinic, Royal Hobart Hospital

This clinic is primarily a place for initial psychiatric contact for the metropolitan area of Hobart. Patients are thoroughly assessed to determine where they can best be treated. A small number of carefully selected patients remain for a longer stay to undergo special treatment programmes. The clinic also provides an out-patient service. Some hospital order patients are referred here after discharge from the Royal Derwent Hospital.

(iv) Regional Clinics

The Linday Miller Clinic in Launceston provides in-patient, out-patient and day-patient facilities. There are in-patient facilities at the Spencer and Mersey hospitals, and out-patient facilities at Burnie, Smithton, Devonport and Ulverstone.

CHAPTER THREE

RESEARCH STUDY

1. Previous Studies

Apart from two rather small surveys there appears to be no published Australian empirical research in this area.

The first, a study by Guile (1965), was a study of the reports prepared in respect of 141 males remanded in custody by courts of petty sessions, general sessions and Supreme Courts in 1961. The reports were analysed in terms of diagnosis and recommended treatment. For the purposes of providing a comparison with Guile's selected court of petty sessions group, this was followed by a diagnostic review by Bartholomew and others (1967), of 70 men remanded in custody without a request for a psychiatric report.

From the United Kingdom several informative studies have emanated. Prior to the introduction of the Mental Health Act 1959, De Berker (1960) looked at the type and diagnostic category of offenders remanded to Brixton Prison for psychiatric reports, but the study by Sparks (1966) into remanding policies at two London magistrates courts in 1961 is regarded as the pioneer inquiry.[38] This was followed by Dell and Gibbens' (1977) study of women remanded to Holloway prison. From Scotland there have been several hospital based surveys, two by Binns and others (1969) and more recently Woodside (1976) reviewed 138 offenders examined for the courts by consultants from the Royal Edinburgh Hospital in 1972. The most comprehensive British research is a recently published study by Gibbens Soothill and Pope (1977). This study was in two parts. The first was a retrospective study of all

(38) The results and implications of this study were discussed by Walker and McCabe (1973), pp.54-56.

cases referred for medical reports in 1969 by 18 Inner London magistrates courts and 38 Wessex courts and the appropriate High Court in the two areas. The second, a prospective study reviewed psychiatric and probation reports and completed questionnaires about all offenders remanded for a medical report in Wessex only for 8 months in 1970-1971.

Of the research from the U.S.A., two studies in particular contain some interesting comparative data. The earlier is a study of all convicted felons referred to the Kansas State Reception and Diagnostic Centre in 1963, 1966 and 1969 for reports by a psychiatric team (Davis, Hedden, Miller, and Witten 1971). The second is Bohmer's study (1976) of all males convicted of a sexual offence in Philadelphia over a 5 year period and the presentence psychiatric reports which were obtained in respect of about half of them.

There are many other studies which are not based upon samples of offenders selected for presentence psychiatric reports, but which have some peripheral relevance or interest. For example the following studies will be referred to: the studies of probationers with orders for psychiatric treatment by Grünhut (1963) and Woodside (1971); the important Oxford survey of hospital and guardianship orders reported by Walker and McCabe (1973); Rollins' study (1969) of prosecuted and unprosecuted mentally abnormal offenders; and the research of Boehringer and McCabe (1973) of discharged hospital order patients who subsequently reoffended.

2. Research Design

The subjects for this study were all males and females remanded by the Hobart court of petty sessions and the Supreme Court of Tasmania for a presentence psychiatric report in the years 1969, 1970, 1974 and 1975.

For most purposes the subjects were divided into groups, separating the courts, the periods of 1969 and 1970 from 1974 and 1975, and males from females.

Each of the periods combined two years to provide a sample which would be manageable in terms of data collection and sufficiently large for analysis. Two different periods were selected to determine if any significant changes occurred. It was expected that the size of the sample would be large enough to examine such variables as type of offence, age, prior convictions and mental disorders. This was in fact not possible because the numbers in the tabulations were too small. Studies conducted elsewhere indicate that no significant correlations exist, apart from a relationship between some vagrancy offences and schizophrenia (Lackzo, James, and Alltop, 1970; Sparks, 1966). This is not a surprising finding, for there is convincing evidence that apart from psychopathy, alcoholism and drug abuse, the incidence of mental disorder among offenders is no more prevalent than in the general population (Guze, Goodwin, and Crane, 1969). It was also planned to obtain a medical prognosis at the conclusion of the treatment of those offenders who were ordered by the courts to receive treatment in 1969 and 1970, but this was not available.

Data was collected from four separate sources: the courts; the records of the Mental Health Services Commission; the records of the Royal Derwent Hospital; and records of convictions at the Police Department.

In addition to the court files containing complaint or indictment, probation officer's report, psychiatric report and judge's comments on passing sentence, the daily court records of the Hobart court of petty

sessions, and the completed Criminal Calendars of the Supreme Court were examined to calculate the number and type of offences heard by each magistrate or judge. Each offender was counted once for each appearance in court in respect of which convictions were recorded, regardless of the number of charges against him. For example if a man was convicted in January 1969 of three counts of illegal use and again in April 1970 of two counts of stealing, and he was remanded in each case for a psychiatric report, he would be included twice in the 1969-1970 remand group, and in different diagnostic categories if the psychiatric reports differed. This offender would also be included twice in the total number of offences for 1969 and 1970, once for illegal use and once for stealing. Offenders charged and convicted of more than one type of crime are classified under the offence which attracted the heaviest penalty, and attempts are classified with completed crimes of the same type.

The data were used to look at the following:-

(1) a comparison of the use made of psychiatric reports by the courts of petty sessions and the Supreme Court.

(2) the place of remand, i.e. bail or custody.

(3) the type of offender.

(4) female offenders.

(5) factors influencing the decision to remand.

(6) the content of reports.

(7) the impact of the report on the court.

(8) the variation in use of psychiatric reports by judges and magistrates.

(9) a comparison between the after conduct of those receiving treatment and those not.

It cannot be categorically stated that all offenders remanded by the courts for psychiatric reports are included. The offenders remanded were traced from the Mental Health Services Commission, through which all courts' requests should be directed, but it is possible that others were remanded for psychiatric reports, particularly by the Supreme Court when sitting outside Hobart.

In addition to the objective data, the questionnaire circulated to judges and magistrates elicited subjective data about attitudes to psychiatric reports.

(1) COMPARATIVE USE OF PSYCHIATRIC REPORTS BY COURTS OF PETTY SESSIONS AND SUPREME COURTS

TABLE 1:

PROPORTION OF MALE & FEMALE OFFENDERS
REMANDED FOR PSYCHIATRIC REPORTS

	MALES			FEMALES		
COURT OF PETTY SESSIONS	TOTAL CONVICTED	*REMANDED	%REMANDED	TOTAL CONVICTED	REMANDED	%REMANDED
1969-70	2001	153	7.6	170	30	17.6
1974-75	2790	145	5.1	382	26	6.8
SUPREME COURT						
1969-70	552	40	7.2	14	2	14.3
1974-75	635	57	9.0	34	2	5.9

* for the court of petty sessions, parking, licensing and income tax offences were excluded from the total.

The similarity in the proportion of male offenders remanded in 1969 and 1970 is striking. One would perhaps expect that magistrates, because of the greater volume of cases dealt with and the less serious nature of the charges, would remand a smaller proportion of cases. That

this is not the case, or at least was not for the years 1969 and 1970 may indicate that the gravity of the offence has little bearing on the decision to remand for psychiatric report, or that some obviously disturbed offenders disappear from the system before being convicted by the Supreme Court.

It is also interesting to note that the proportion of offenders remanded by the court of petty sessions has shown a downward trend, but the proportion remanded by the Supreme Court has shown an upward one. Changes in types of offences and the judges and magistrates making up these courts may be shown to have some bearing on this.

How do the Tasmanian figures compare with the proportion of offenders remanded in other jurisdictions? Official statistics on this question do not appear to be kept, and comparisons with other studies are defective in that it is not always clear what types of offence are included.[39] In his study of two London magistrates courts, Sparks (1966) found 2.7% of all cases heard were remanded for psychiatric reports. Gibbins Soothill and Pope (1977) found the proportion remanded medically in 1969 was smaller in Wessex than London. In London magistrates courts between 2 and 3 per cent of the court turnover were remanded for psychiatric reports (one in ten for indictable offences and one in a hundred for non-indictable offences), but in Wessex less than one per cent were so remanded. They also produced some evidence indicating that the demand for reports in Britain began to fall after 1970 (pp.16, 22).

(39) If all offenders appearing before magistrates had been included in the data base for this study, e.g. parking, licensing and income tax offenders, the rate of remand for psychiatrric reports would then only be 1.5% of offenders in 1969-1970.

(2) PLACE OF REMAND

TABLE 2

OFFENDERS REMANDED ON BAIL AND IN CUSTODY

	BAIL		CUSTODY		NO INFORMATION	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
COURT OF PETTY SESSIONS						
1969-70	89(58%)	24(80%)	64(42%)	6(20%)	-	-
1974-75	77(53%)	22(85%)	68(47%)	4(15%)	-	-
SUPREME COURT						
1969-70	4	-	36	2	-	-
1974-75	11	2	44	-	2	-

The majority of offenders remanded for psychiatric reports by the Hobart magistrates courts are remanded on bail, and only the Supreme Court remands most such offenders in custody. It would appear that a decision to remand an offender for a psychiatric report does not in any way affect the question of bail or custody. This is as it should be, and it is to be hoped that the position will not alter when the forensic unit at Risdon Gaol is completed. The adverse effects of remands in custody, including loss of accommodation, job, reputation and motivation for rehabilitation, contamination by other criminals and family break-up have been frequently stressed. Forensic psychiatrists and others seem adamant that remands on bail for psychiatric reports are preferable and custody should only be used as a last resort (Bartholomew 1973; Gunn 1971; and Lucas 1972). On bail the patient is seen in his own social context, and if the sentence is not one of imprisonment as little damage as possible will have been done to the patient's social situation.

In England different criteria for bail or custody apply to those remanded for psychiatric reports and those remanded without. Remands on bail for psychiatric reports are infrequent and this has provoked adverse comment. Indeed it is known that convicted persons are sometimes remanded in custody for a psychiatric report to give them a taste of prison. Sparks (1966) found that in two magistrates courts in London in 1961 only one of 494 male offenders remanded for psychiatric reports was remanded on bail. Boehringer and McCabe (1973), and Dell & Gibbens (1971) also found very few offenders were remanded on bail for psychiatric reports. The difficulty in the way of remands on bail seemed to be the administrative one of making arrangements and seeing that the offender appeared for examination. Results of the examinations in prison were received more quickly, with less effort and a higher degree of regularity and certainty. Gibbens, Soothill and Pope (1977) strenuously argue that the evidence from their study supports the view that there are no reasons for differentiating medical remands from others. They deny that it provides a period of informative observation, for in most cases in their experience the time is spent in cells, and the effects of contamination by more experienced and cynical delinquents outweigh any positive value. They too found that greater proportions of medical remands were in custody (London, 90%) although, according to certain specified criteria, they seemed suitable for examination on bail.

(3) THE TYPE OF OFFENDER REMANDED

Information about each offender was obtained to determine the type of offender remanded for psychiatric reports. The following factors were considered, the age of the offender at the date of remand; the type of offence; the police record; prior psychiatric treatment and the sex of the offender.

(i) Age

TABLE 3

AGE OF COURT OF PETTY SESSIONS OFFENDERS REMANDED

AGE	MALES		FEMALES	
	1969-70	1974-75	1969-70	1974-75
17-26	98(64.0)	97(66.8)	10(33.3)	14(56.0)
27-36	25(16.3)	22(15.1)	7(23.3)	5(20)
37-46	15(9.8)	15(10.3)	4(13.3)	0 (-)
47-56	10(6.5)	8 (5.5)	7(23.3)	1 (4.0)
57-66	4(2.6)	3 (2.0)	2 (6.6)	4(16.0)
66	1 (.6)	-	-	1 (4.0)
	153	145	30	25*

* no information was available for one offender in this group.

TABLE 4

AGE OF SUPREME COURT OFFENDERS REMANDED

AGE	MALES		FEMALES	
	1969-70	1974-75	1969-70	1974-75
17-26	22 (55.0)	33 (58.9)	2	1
27-36	9 (22.5)	15 (26.8)	-	1
37-46	3 (7.5)	5 (8.9)	-	-
47-56	5 (12.5)	3 (5.4)	-	-
57-66	1 (2.5)	- -	-	-
66 and over	- (.6)	- -	-	-
	40	56*	2	2

* no information was available for one offender in this group.

Tables 3 and 4 show the ages of the offenders remanded. As would be expected a high proportion of males were aged between 17 and 26. The proportion within the next four decades declined progressively, but there was a slight increase in the 1969-70 sample in the proportion of males remanded by the Supreme Court aged between 47 and 56. Interestingly,

if the court of petty sessions offenders are broken down into five year age groups, there was an increase for the 1969-70 period in the proportion of offenders in the group aged between 47 and 52.

The average age of male offenders was 28.2 (1969-70) and 26.7 (1974-1975) for the court of petty sessions remand groups, and 29.2 (1969-70) and 26.1 (1974-75) for the Supreme Court remand groups.

The average age of the female offenders was higher.

There are no statistics of the age distribution of the male and female offender population in Tasmania but the annual prison figures consistently show that 59-62% of convicted male prisoners are under 25, with emphasis on 18 and 19 year olds.(40)

A comparison of the courts shows little difference. In contrast Gibbens, Soothill and Pope (1977) found that while magistrates concentrated their medical inquiries mainly on the younger age group, judges concentrated on the 30 and over age group, particularly in the case of females.

(ii) Type of offence

(40) Reports of Controller of Prisons. A Tasmanian study has shown that 45% of a 1968 sample of male indictable and quasi-indictable offenders were under 25 years (Varne, 1975).

TABLE 5

TYPE OF OFFENCE, COURT OF PETTY SESSIONS

TYPE OF OFFENCE	MALES						FEMALES					
	1969-70			1974-75			1969-70			1974-75		
	TOTAL	REM.	%	TOTAL	REM.	%	TOTAL	REM.	%	TOTAL	REM.	%
PROPERTY	738	63	8.5	840	63	7.5	123	22	17.8	260	22	8.5
SEX	52	33	63.4	72	38	52.7	1	1	100	-	-	-
PERSON	241	28	11.6	324	21	6.5	9	2	22.2	15	2	13.3
OTHER	970	29	3.0	1554	23	1.5	37	5	13.5	107	2	1.9
TOTAL	2001	153	7.6	2790	145	5.2	170	30	17.6	382	26	6.8

TABLE 6

TYPE OF OFFENCE - SUPREME COURT

TYPE OF OFFENCE	MALES						FEMALES			
	1969-70			1974-75			1969-70		1974-75	
	TOTAL	REM.[a]	%[b]	TOTAL	REM.[a]	%[b]	TOTAL	REM.	TOTAL	REM.
PROPERTY	365	16	4.4	361	21	5.8	12	1	28	1
SEX	101	17	16.8	105	22	21.9	-	-	1	1
PERSON	71	5	7.0	123	14	11.3	2	1	3	-
OTHER	15	2	13.3	46	-	-	-	-	2	-
TOTAL	552	40	7.2	635	57	9.0	14	2	34	2
							14.3		5.9	

a REM. = remanded.

b The percentages in this column represent the proportion of the total court turnover of each type of offender remanded for psychiatric reports.

Tables 5 and 6 show that offenders against property predominated in the court of petty sessions remand groups as they accounted for 41% of males in 1969-70, and 42% in 1974-75. However, in the Supreme Court sample there were marginally more sexual offenders than property offenders remanded, 43% sex, 38% property in 1969-70, and 38% sex and 36.2% property in 1974-75.

The high proportion of property offenders remanded is predictable in view of the comparative prevalence of these offenders. Studies conducted in the U.K. have shown similar proportions of property offenders in groups remanded for psychiatric reports. Sparks (1966) reported figures of 49.2% and 42.5%, Bearcroft (1965) 53% and de Berker, (1960) nearly half.

In relation to the total court turnover before each court and in each period, a larger proportion of sex offenders than any other type of male offender was remanded. This is particularly apparent in the court of petty sessions, where more than 50% of sexual offenders were remanded. The Supreme Court remanded rather smaller proportions of such offenders, but for both courts the proportion of sex offenders remanded was significantly greater than any other category of offender.[41]. Such a finding is to be expected because it is likely that judges and magistrates are more likely to view a sex offender as an abnormal individual whose behaviour needs to be understood before he is sentenced. However it is surprising that the level of significance differed between the

(41) Court of petty sessions - differences between sex offenders and offenders against the person. $\chi^2=71.17$, *d.f = 1, p > .001 (1969-1970);* $\chi^2 = 99.55$, *d.f = 1, p > .001 (1974-1975). Supreme Court - differences between sex offenders and offenders against the person;* $\chi^2 = 4.6$, *d.f = 1, .05 > p > .02 (1969-1970);* $\chi^2 = 4.08$, *d.f = 1, .05 > p > .02 (1974-1975).*

court of petty sessions and the Supreme Court and in both periods highly to very highly significantly less sexual offenders were remanded by the Supreme Court than the court of petty sessions.[42]

It is instructive to compare these figures with the results of studies in other jurisdictions. De Berker (1960) stated that in his remand group there were 2-3 times as many sexual offenders as one would expect from general prison figures. Sparks (1966) found 8.6% of the remand group of offenders at Court A were sexual offenders and 7.4% of the control group, and at Court B 21.7% of the remand group and 15.1% of the controls were sexual offenders. In New Zealand Blignault (1962) has reported that 10% of the charges preferred in respect of remand patients at Oakley hospital were sexual offences. Gilbert and Maradie (1961) found that in Miami 21% of offenders remanded for mental status examination were charged with offences considered to reflect sexual aberration. In Philadelphia, a study of all males convicted of a sexual offence over a 5 year period (1966-1970) (Bohmer, 1976) showed 51.7% were sentenced after receipt of a psychiatric report.

The percentage of persons found guilty of assault by the court of petty sessions and remanded for a psychiatric report is higher than expected. Inexplicably, significantly less were remanded in 1974-1975,[43] unless more were referred under the Alcohol and Drug Dependency Act 1968. The trend in the Supreme Court is in the reverse direction with a larger proportion of offenders against the person being remanded in 1974-1975, but this was not statistically significant.

(42) $\chi^2 = 7.01$, $d.f = 1$, $.01 > p > .001$ *(1969-1970);* $\chi^2 = 20.92$, $d.f = 1$, $.01 > p > .001$ *(1974-1975).*

(43) $\chi^2 = 4.35$, $d.f = 1$, $.02\ p < .05$.

The proportion of offenders in the court of petty sessions group remanded for minor social crimes and driving offences was rather less than reported in other jurisdictions. Sparks (1966) found 25% of the remand group of offenders at Court A and 30% at Court B were convicted of vagrancy, nuisance and other crimes; de Berker (1960) found nearly one third of the offences recorded against his prison remand group were public offences, loitering, vagrancy and similar offences. The fewer number of offenders in this category may well be because more of these offenders than any other category are referred to psychiatrists under the Alcohol and Drug Dependency Act.

Table 5 shows that almost all female offenders remanded, 77% in 1969-1970 and 85% in 1974-1975, were property offenders; in 1974-1975 more than half of these were shoplifters.

(iii) Police Record

TABLE 7

POLICE RECORDS OF OFFENDERS

	MALES				FEMALES			
	NO PRIOR CONVICTIONS	1 - 4 CONS.	5+ CONS.	TOTAL OFFENDS.	NO PRIOR CONVICTIONS	1 - 4 CONS.	5+ CONS.	TOTAL OFFENDS.
COURT OF PETTY SESSIONS								
1969-70	39(26%)	64(41%)	50(33%)	153	16(53.3)	10(33.3)	4(13.3)	30
1974-75	25(17%)	53(36.5)	67(46%)	145	9(34.6)	13(50.0)	4(15.4)	26
SUPREME COURT								
1969-70	8(20%)	22(55%)	10(25%)	40	1	1	-	2
1974-75	9(16%)	26(45.6)	22(38.6)	57	1	1	-	2

Table 7 shows the prior record of convictions of the male offenders at the date of remand.

There are no official statistics available of the proportion of first offenders convicted annually in courts of petty sessions or the Supreme Court in Tasmania with which to compare the remand groups. One research study reported that "only 39%" of offenders in 1968 convicted of indictable and quasi-indictable offences were first offenders, and 25% had at least 6 prior convictions, (Varne, 1975). Official statistics show that the percentage of male prisoners with no prior convictions dropped from 26% in 1969 to 13% in 1974, and the percentage of prisoners with three or more convictions had increased from 56% in 1969 to 78% in 1974.(44)

Of the female offenders remanded by the court of petty sessions 50% of the first period and 35% of the second period were first offenders and 13% and 15% had more than 5 convictions. The prison figures show 50% of female prisoners were first offenders in 1969 and 35% were in 1974.

The similarity between the proportions of first offenders in the remand groups and in the prison figures is quite striking, and it would be reasonable to assume that a randomly sampled group of offenders would have a much higher percentage of first offenders. This is supported by Varne's study (1975), and by Victorian statistics which show between 40 and 43% of adult offenders and between 79% and 83% of adult female offenders for the relevant years had no previous convictions (Victoria Police, Statistical Review of Crime, 1974).

(44) The introduction of the Saturday Work Order Scheme is a possible explanation for this change.

It would appear then that in the remand groups the picture is one of primarily a recidivistic group of offenders, with a trend towards a decreasing number of first offenders being remanded. Perhaps courts are more likely to refer offenders with prior convictions and with whom the traditional methods of disposal have failed.

Most other studies show a higher proportion of first offenders in the remand groups. De Berker (1960) reported that 35% had no record, Bearcroft 27.4% (1965) and in a study of offenders referred to the Kansas State Reception and Diagnostic Centre two thirds had no record, while in a control group less than half were first offenders (Davis et al, 1971). This was said by the authors to indicate that the courts were more likely to refer offenders who are less experienced and who have committed less serious crimes. Bohmer (1976) found no significant relationship between the previous record of offenders and the ordering of psychiatric reports. Gibbens, Soothill and Pope (1977) showed that medical remands tended to have many more criminal convictions than the general run of offender; only 28% of males and 31% of females had no prior adult convictions; and more details of the criminal records of the sample gave further indications of chronicity.

TABLE 8

PRIOR TREATMENT OF OFFENDERS

	MALES				FEMALES			
	IN-PATIENT	OUT-PATIENT	TOTAL PRIOR TREATMENT	% OF TOTAL REMANDED	IN-PATIENT	OUT-PATIENT	TOTAL PRIOR TREATMENT	% OF TOTAL REMANDED
COURT OF OF PETTY SESSIONS								
1969-70	45	16	61	39.8	5	5	10	33.3
1974-75	29	39	68	46.9	5	8	13	50.0
SUPREME COURT								
1969-70	9	6	15	37.5	1	1	2	100.0
1974-75	24	8	32	56.1	-	1	1	50.0

(iv) Prior Treatment

Table 8 shows the number and proportion of offenders who had received psychiatric treatment at the date of remand. These figures may be conservative estimates. They were obtained from the Mental Health Services Commission's records and the court files, and it could have happened that some offenders had received treatment privately or interstate and this was communicated to the court but not recorded.

The proportion of offenders with a previous psychiatric history is rather high and would appear to be increasing. Similarly high proportions of offenders remanded for psychiatric reports with records of previous treatment have been reported elsewhere. Bearcroft (1965), reported a figure of 55% in a group referred from courts and prisons, and Dell and Gibbens (1971) found 36% of females remanded had previously had mental hospital treatment. Gibbens, Soothill and Pope (1977) found

45% of the males and 68% of the females in their prospective Wessex study had had contact with psychiatric hospitals.

(4) FEMALE OFFENDERS

In 1969 and 1970 women accounted for 30 of the 170 (or 17.6%) of the psychiatric reports requested by the court of petty sessions. In 1974-1975 26 of the 382 (or 6.8%) related to women offenders. This is considerably more than one might expect considering the total number of women offenders convicted by the courts in the relevant periods. In fact in 1969 and 1970 a very highly significantly greater number of female offenders than males were remanded for psychiatric reports [45] and in 1974-1975 a larger percentage of females than males were remanded but the difference was not enough to be statistically significant. However the drop in the number of females remanded was very highly significant[46].

Female offenders in the Supreme Court are in an even smaller minority than in the court of petty sessions, and the numbers are too small to ascertain with any accuracy whether judges show or have shown a bias towards female offenders.

That magistrates and judges do have such a bias has been demonstrated elsewhere. Wastell, (1976) showed, in a matched pair sample of 20 males and 20 females, that the female offenders had significantly more psychiatric reports requested on them than the male offenders. This she said showed that sentencers presumed that because so few women get into trouble, those that do must be sick. Wastell commented

(45) $\chi^2 = 20.18$, $d.f = 1$, $p > .001$.
(46) $\chi^2 = 13.62$, $d.f = 1$, $p > .001$.

pungently - "That some women need psychiatric treatment is not arguable, but to assume that a man with an identical background and history does not, is psychological lunacy". In one section of Gibbens, Soothill and Pope's (1977) comprehensive study of the remand for psychiatric report procedure in England, a significantly greater proportion of females than males were remanded. In 1969 London judges remanded 4.1% of males but 18.87% of females convicted by magistrates and committed for sentence to a higher court. This was attributed by the authors to the opportunity to be more flexible with the smaller number of women offenders and to a greater willingness to be lenient with women offenders "who offer little threat to public safety and are less likely to know or be influenced by what happens to other women offenders." (p.88).

In their responses to the questionnaire for this study, all judges and magistrates denied that they were more likely to remand female offenders than males.[47] The differential treatment shown to women offenders in 1969-1970 must either be unconscious or no longer exist as a result of a change in attitudes.

A tendency to refer a greater proportion of female offenders for psychiatric reports is not inexplicable. First, what has euphemistically been called "the chivalry factor", which is generally acknowledged to operate to give women offenders preferential treatment in the criminal justice system, may result in sentencers requesting more reports in respect of women offenders than males in the hope of uncovering any possible mitigation for the offence, or "help" for her. It must be pointed out that a greater willingness to use psychiatric remands and

(47) See Appendix A, question 24.

disposals for women offenders does not necessarily mean they are treated more leniently than their male counterparts. On the contrary in some cases it could lead to fairly trivial behaviour being sanctioned by a hospital order.(48)

Secondly, it could result from the assumption that female offenders are more often psychologically abnormal than the male offenders. The comparative rarity of female offenders in the courts, and the widespread conception of the female as basically gentle, moral and law-abiding, which make a delinquent woman look more unnatural than a delinquent male, could contribute to such an attitude. Is there any evidence that female offenders are more often mentally disordered than males?

In England there has been some suggestion that the ratio for disturbed to non-disturbed offenders is higher for women than men. (Walker & McCabe, 1973, p.33). For this reason the Butler Committee recommended that in the case of a woman defendant the court should be especially vigilant throughout the proceedings for any sign of mental disorder (p.163). The Committee agreed in principle with the suggestion of the Governor and staff of Holloway Prison that in the case of women defendants the court should invariably request a social inquiry report, to provide amongst other things information of any possible mental disorder (1975, Cmnd. 6244). Walker (1968) refers to statistics which show that in practice women offenders have a significantly greater chance of being dealt with as mentally abnormal, and that in cases dealt with under the Mental Health Act women have a higher proportion of diagnoses of mental illness than males. This does not necessarily

(48) Paternalism to females may result in adverse treatment in other areas of the criminal justice system. There is some evidence that the childrens court system in Tasmania applies the provisions of the Child Welfare Act in relation to uncontrolled and neglected children in accordance with a double standard of morality. For although girls form only a small proportion of the children appearing before childrens' courts (about 20%), they account for the majority of complaints proven under the Child Welfare Act. (Australian Bureau of Statistics, Tasmania, Public Justice Bulletin, 1974 - 1975).

prove that in England and Wales there is more mental disorder among women offenders than males. For, as Walker points out, the statistics depend upon the psychiatrists' diagnoses, and the possibility cannot be excluded that they are influenced by the presumption he is trying to test, namely that there is something abnormal about a woman delinquent. He adds -

> This would not necessarily mean that psychiatrists were deceiving themselves for it might be that by their standards too few male offenders were being referred to psychiatrists, or even that a male offender who is referred to a psychiatrist is less likely to seem abnormal, either because the psychiatrist is of the same sex or because he has seen so many male offenders. (p.313)

A higher rate of remand of female offenders can really only be justified if it can be proved that more women offenders than men are mentally disordered or in need of psychiatric treatment, but as Walker (1968) has stated this is difficult to establish. In the absence of such proof, an even-handed and non-discriminatory attitude should be adopted. The trend noted above, to remand a more equal proportion of both sexes for psychiatric reports may well continue. It is plausible to assume that a change in attitude to women offenders has occurred in response to the demands of women to be treated equally in the law-abiding areas of society, and that such attitudes will continue to change as the status of women improves.

Table 1 shows that there was a dramatic increase in the number of female offenders in 1974 and 1975, more than doubling the 1969-1970 total. Statistics collected for this research provided some material for a brief examination of female crime in Tasmania. Women offenders and the rising female crime rate is a topic which has aroused some considerable discussion with resultant literature in recent years (Adler, 1975, 1977; Dalesman, Scarpitti, & Stephenson, 1973 ; Price, 1977 ;

Simon, 1975 ; Singer, 1973). Reasons for the disparity in the amount of male and female crime have been suggested. These include the lack of opportunity and motivation for crime which the traditional female role provides; differences in strength and skill; The bias of the criminal law against men; and the paternalistic or chivalrous attitude of male victims, police, juries and sentencers to women, which distorts the amount of female involvement in crime. A less popular view is that women have stricter moral attitudes to crime than men and a stronger tendency to conform to the perceived values of society. Pollak (1950) adopts a contrary view denying that females are engaged in less criminal behaviour than men, but asserts they are less likely to be detected because their traditional roles provide excellent cover.

There is convincing evidence which shows that in the United Kingdom and America lack of opportunity and paternalism are at least part of the explanation for the disparity in the amount of male and female crime. In the United Kingdom a woman is more likely to be let off by the police with a caution than is a male offender, and has slightly less chance of being found guilty than a male (Walker 1965, pp.299-300). There is also some evidence which supports the widespread belief that women receive lighter sentences than men (Walker 1965, pp.300-302; Davidson et. al., 1964; Hogarth, 1974). In Tasmania too, there is evidence of biased court attitudes to females. Simon (1975) has argued that the increase in the proportion of female arrests for serious crime in America, which is owing almost wholly to the fact that women seem to be committing more property offences (mainly theft, embezzlement, fraud and forgery), indicates that women's participation in crime has and will increase as their employment opportunities expand and their role changes from a more traditional to a more liberated one. She predicts that female criminal behaviour will increase as her participation in the work force and her

opportunities increase and gradually the types of crime women commit will resemble much more closely those committed by men. This prediction is endorsed by Freda Adler (1977) who relies upon statistics from developing countries as well as Western Europe, North America, Australasia and juvenile court records to support the relationship between increase in female criminality and the decrease in social and economic disparity between the sexes.

In Tasmania and apparently in all societies, women constitute a small percentage of the total offender population and this is so particularly for more serious offences, offences of violence and sexual offences. But the numbers are converging gradually. The Criminal Justice statistics from 1969 to 1975 show steady increases in the number of female petty offences, so that from 1969 to 1975 there was an 88% increase in the number of female convictions as against a 28% increase for males. Female offences which show the greatest increase are offences against property; for males, offences against good order show the largest increase. Rather different trends emerged from the offender based statistics extracted for this research study.[49] The combined total number of female offenders convicted in 1969 and 1970 of certain selected offences compared with the combined totals for 1974 and 1975 showed a 112% increase. These increases were due very largely to an increase in the number of females convicted of drug offences and shop-lifting, both of which are not specifically referred to in the official statistics.

Both the official statistics and those compiled for this research show substantial increases in the numbers of female offenders appearing before the Supreme Court. These increases are almost entirely due to an increase in the number of property offenders.

(49) Ante., 32.

The criminal statistics generally show that in Tasmania as well as in Britain and America the proportion of females involved in prosecutions for violent crime has hardly changed (Simon, 1975). This would seem to be quite contrary to popular impressions, although it must be conceded that the proportion of women convicted for minor assaults has increased.

(5) THE DECISION TO REMAND

There is, in Tasmania, no procedure compelling magistrates or judges to state their reasons for requesting a psychiatric report, so there can be no accurate quantitative assessment of the reasons for referral. Although such a procedure does exist in England, in a survey of mentally disordered recidivist offenders Boehringer and McCabe (1973) found the reasons prompting a request for a psychiatric report difficult to isolate. The most frequently expressed reason for a report was a known history of mental disorder, and they found some other evidence that this and the offender's behaviour in court influenced the decision to remand. The type of offence with which the offender was charged, for example, a sexual offence, or persistence in offending, was said by magistrates to influence their decision to remand, but no recorded evidence of this was found in the cases falling within their survey.

If a control group of offenders sentenced without remand for a psychiatric report had been used in this study, some factors significantly related to the decision to order a report may have been isolated. Nevertheless the data obtained gives some information about the circumstances in which courts are most likely to refer offenders for psychiatric reports.

Many writers and commentators have listed instances where courts should call for psychiatric reports before sentencing an offender. Such suggestions have usually included all or some of the following:-

1. Mature first offenders, who after years of steady respectable living, commit an out of character offence.
2. Offenders with a history of persistent anti-social behaviour which fails to respond to ordinary measures.
3. Offences of a bizarre, motiveless or irrational nature, particularly if repetitive.
4. Violent behaviour, especially if against his or her own family.
5. Most sexual offenders.
6. Prior history of mental disorder.
7. Offenders with social problems, with wife or parents, social deterioration, or alcohol and drugs.
8. Certain other offences such as stealing milk from a doorstep or arson.
9. Unusual behaviour or appearance on arrest or in court.

Questions 1-5 of the questionnaire were designed to discover material about the decision to remand an offender for a psychiatric report. Table 9 was compiled from the responses to Question 1, which asked magistrates and judges to state factors they considered in deciding who to remand, and Table 10 from the responses to Questions 2-5.[50]

(50) See Appendix A for the text of the questions.

TABLE 9

REASONS FOR OBTAINING A REPORT

REASONS	Number of responses
Request of counsel, accused or probation officer	4
Likelihood of some mental abnormality	2
Known history of mental disorder	3
Nature of offence	3
Circumstances of offence	2
Age or youth of offender	3
Demeanour of prisoner	1
Lack of obvious motive	1
Possibility that defendant may modify behaviour through psychiatric treatment	1
For opinion as to recidivism	1
Total	21 (a)

(a) The high n of 21 is because all respondents gave more than one reason.

TABLE 10

REQUESTS FOR REPORTS IN CERTAIN CIRCUMSTANCES

CIRCUMSTANCES (a)	ALWAYS	USUALLY	SOMETIMES	RARELY	TOTAL RESPONSES
Prior psychiatric treatment	1	7	1	-	9
Sexual offence	-	3	5		8
Counsel's request	-	5	4		9
Probation officer's request	1	4	4		9

(a) Magistrates and Judges were asked whether they ordered reports in these circumstances.

These tables show that in particular an offender's previous psychiatric history, the requests of probation officers and counsel are stated by judges and magistrates to have considerable influence upon the decision to remand.

The value of presentence reports in the selection of candidates for psychiatric reports was recognized by the Butler Committee. In its report the committee suggested that social inquiry reports should be used as a screening process for mental disorder, alerting magistrates to the need to call for a report. It was proposed that social inquiry reports should be mandatory in all cases of grave non-sexual offences against the person, all sexual offences involving children below the age of 13 or involving violence to persons of any age, and property offences which involve risk to life. In other cases magistrates should continue to have a discretion to call for a social inquiry report and a medical report where they think it right to do so. As previously stated, in the light of evidence that the ratio of disturbed to non-disturbed offenders is much higher for women than men, the Committee expressed the need for special vigilance throughout the proceedings for signs of mental disorder in the case of women. (1975, cmnd. 6244, pp.161-163).

Just how many psychiatric reports in this study were ordered as a result of a probation officer's report is difficult to ascertain precisely, but the following facts are instructive. An oral or written presentence report preceded the request for a psychiatric report in 44 cases in the court of petty sessions 1969-1970 sample of male offenders and in 47 cases in the 1974-1975 sample. Of these, 17 in 1969-1970 and 27 in 1974-1975 specifically recommended a psychiatric report. Many others were known to have given information pointing to the wisdom of

obtaining a psychiatric report.[51] It cannot be categorically said in these cases that the probation officer's recommendation was the reason for reference, but it could well have been at least a contributing factor.

In the Supreme Court sample it was not feasible to attempt to discover the proportion of cases in which receipt of a probation officer's report preceded the request for a psychiatric report.

TABLE 11

REPRESENTATION OF OFFENDERS

GROUP		REPRESENTED	UNREPRESENTED	NO INFORMATION	TOTAL
COURT OF PETTY SESSIONS					
MALES:	1969-70	52(34.0%)	99	2	153
	1974-75	71(49.0)	74	-	145
FEMALES:	1969-70	10(33.3)	20	-	30
	1974-75	11(42.3)	13	2	26
SUPREME COURT					
MALES:	1969-70	26(65.0)	11	3	40
	1974-75	45(78.9)	8	4	57
FEMALES:	1969-70	2(100.0)	-	-	2
	1974-75	1(50.0)	-	1	2

Table 11 shows the number and proportion of cases in which the offender was represented on the occasion of the request for a psychiatric report. It was not possible to ascertain the cases in which a psychiatric report was requested by counsel, but it is known that if a report is requested the court will usually or sometimes accede to the request to

(51) Evidence of this was obtained from notes on probation files.

protect the sentence against appeal even though the likelihood of any mental disturbance is remote.[52] Although no systematic search of the number of cases in which counsel requested a psychiatric report was possible, in the case of the 1969-1970 Supreme Court population of male offenders it was discovered that in 10 cases defence counsel asked for a psychiatric report, and the judge noted the request or commented upon it in his comments on passing sentence.

It is recognized that the court may request a report even though none of the factors mentioned so far are present, if the judge or magistrate is at a loss to determine an appropriate sentence without expert help.

Both the objective data from the remand sample, and the subjective data from the questionnaire suggest certain factors are related to the decision to remand. The responses to the questionnaire showed that an offender's previous psychiatric history and the requests of probation officers and counsel are stated by judges and magistrates to be the most influential factors in the decision to request a psychiatric report. Other less influential factors include nature of the offence, the circumstances of the offence and the age of the offender.

A study of all the cases in the remand sample revealed that a very high proportion of offenders (44% of the total sample) had a history of psychiatric treatment, that a significantly greater proportion of sexual offencers than any other type of offender were remanded for reports, and that a higher than expected number of offenders with prior

(52) See Table 10. This was publicly given as a reason prompting a request for a psychiatric report by one of the magistrates represented in this study at a seminar on 15th December, 1973. (Mental Health Services Commission, Tasmania, 1973, p.9).

convictions were remanded. This suggests that these factors are related to the decision to remand. There is also some evidence from the remand sample that the requests of probation officers or counsel have a bearing upon the decision to remand.

A comparison of the reasons given by the magistrates and judges with the objective data, shows that in relation to the factors of prior psychiatric treatment and the requests of counsel and probation officers, the expressed behaviour of the judiciary is to some extent borne out by the data from the research sample.

Comparative findings from other studies show that prior history of mental disorder, prior convictions and the requests of probation officers influence the decisions of some English and Scottish courts to refer offenders for psychiatric reports.[53]

Gibbens, Soothill and Pope's (1977) more detailed analysis throws more light upon why magistrates ask for psychiatric reports. Their data showed certain characteristics were systematically related by magistrates to the need for a medical remand, particularly older offenders, those with more prior convictions than average, sexual offenders, the socially isolated, and offenders with previous contact with psychiatric hospitals. In addition to the collection of objective data, the researchers also asked the doctors who had had offenders referred to them why in their view the medical remand was required by the court. The commonest

(53) G. Boehringer and S. McCabe (1973) and M. Woodside (1976) found the most frequently expressed reason for ordering a psychiatric report was a prior history of mental disorder. R.F. Sparks (1966), found some evidence that the type of offence, a prior criminal record, prior psychiatric treatment, demeanour in court and the requests or recommendations of probation officers, may have influenced the decision to remand. Compare C. Bohmer's (1976) finding that reports on sexual offenders were requested primarily for criminal justice reasons.

reasons given were nature of the present offence (25 per cent men, 25 per cent women) and knowledge or suspicion of previous mental illness (34 per cent men, 63 per cent women). Occasionally a medical report was thought to be requested for "good measure" in addition to other reports.

(6) THE CONTENT OF PSYCHIATRIC REPORTS

TABLE 12

DIAGNOSIS OF COURT OF PETTY SESSIONS & SUPREME COURT SAMPLES - MALES

DIAGNOSIS	COURT OF PETTY SESSIONS				SUPREME COURT			
	1969-70	%	1974-75	%	1969-70	%	1974-75	%
NORMAL	42	27.4	13	8.9	7	17.5	12	21.0
PSYCHOSIS	8	5.2	5	3.4	1	2.5	3	5.3
NEUROSIS	4		4		2		1	
ORGANIC BRAIN SYNDROME	8		7		2		2	
OTHER AND UNSPECIFIED MENTAL DISORDER	24		19		6		6	
ALCOHOLISM	6		20		-		3	
SUBNORMALITY	7		10		3		6	
TOTAL ABNORMAL	57	37.3	65	44.8	14	35.0	21	36.8
PSYCHOPATHY	13		14		5		17	
INADEQUATE etc.*	37		52		12		7	
TOTAL PERSONALITY	50	32.7	66	45.5	17	40.0	24	42.1
NO REPORT OBTAINED	4	2.6	1	.7	2	7.5	-	
TOTAL	153	100	145	100	40	100	57	100

* this includes inadequate and other personality disorders.

TABLE 13

DIAGNOSIS OF COURT OF PETTY SESSIONS SAMPLE - FEMALES

DIAGNOSIS	1969-70	%	1974-75	%
NORMAL	12	40.0	3	11.5
PSYCHOSIS	2		-	
NEUROSIS	-		2	
ORGANIC BRAIN SYNDROME	-		2	
OTHER & UNSPECIFIED MENTAL DISORDER	4		4	
ALCOHOLISM	-		1	
SUBNORMALITY	1		1	
TOTAL ABNORMAL	7	23.3	10	38.4
PSYCHOPATHY	4		4	
INADEQUATE ETC.	6		6	
TOTAL PERSONALITY	10	33.3	10	38.4
NO REPORT OBTAINED	1	3.4	3	22.7
TOTAL	30	100	26	100

(i) Diagnoses and the Incidence of Mental Disorder

A comparison of the courts of petty sessions data in tables 12 and 13 shows that the combined abnormal and personality groups accounted for 70% of males and 56% of females in the 1969-70 period and 90% of males and 76% of females in the 1974-75 period.

The larger proportion of females who were apparently normal is rather striking, and this can be related to the fact that a higher percentage of female offenders than male offenders were remanded for psychiatric reports.

A comparison of the court of petty sessions diagnostic groups in 1969-1970 and 1974-1975 reveals the number of normal offenders decreased very highly significantly between 1969-1970 and 1974-1975.(54) At least two explanations for this can be suggested.

First, as the majority of reports in 1969-1970 were prepared by a different psychiatrist from the one responsible for the majority of reports in 1974-1975, it may well be that different methods of diagnosis were used. For example, three times as many alcoholics were diagnosed in 1974-1975 despite the fact that several hundred other offenders had been referred for reports specifically to determine whether they were alcohol dependent. Furthermore it is appreciated that the boundary between personality disorders and no psychiatric diagnosis is a nebulous one, and psychiatrist A may have included some offenders in the latter category whom psychiatrist B would have classified in the former.

Secondly, magistrates may have been more discriminating in their selection of candidates for reports in 1974-1975, which is supported by the smaller proportion of offenders remanded in 1974-1975, or they may have been more proficient at recognizing mental disorder than previously.

The data in relation to the proportions of mentally disordered offenders from the Supreme Court group of offenders does not follow the same pattern as the court of petty sessions data. The increase in the proportion of normal offenders remanded in 1974-1975 can be explained by the existence of five cases of borderline subnormal offenders in the normal category for this year, none having been so diagnosed in 1969-1970.

(54) Males - $\chi^2 = 11.51$, *d.f.* $= 1$, $p > .001$.
Females - $\chi^2 = 21.22$, *d.f.* $= 1$, $p > .001$.

Clear and precise comparisons of the incidence of mental disorder reported in other studies are difficult to make because of the lack of definition of the diagnostic categories used. Despite their shortcomings such comparisons are of interest.

In the United States, in a study based on several state-wide surveys, Smith (1971) has found the prevalence of mental disorder among offenders to be about 20%. In selected groups it is much higher than this. For example in Hartford, Connecticut, Gold (1969) found that of 100 court appointed psychiatric examinations, 50% showed some type of mental illness requiring hospitalization. Guze et al.(1969) have determined that 79% of convicted felons in Missouri penitentiaries have "definite antisocial personality disorder" and 43% have alcoholism; 1% or less suffer from schizophrenia and other mental illnesses and mental deficiency.

In Britain, Sparks (1966) found that of his total of remanded offenders, just over one third were said by medical officers to be suffering from some form of mental disorder and one fifth were described as having a personality disorder. This compares with an almost equal proportion of male offenders suffering from mental disorder and personality disorder in this study (nearly 40%). Dell and Gibbens (1971) found that 38% of all women offenders had a mental disorder and 32% had personality disorders. Gibbens, Soothill and Pope (1977) reported that the questionnaire responses in relation to the mental state of offenders in their prospective study showed 30% of the men and 28% of the women to have minor or no problems, but only 6% of the men and none of the women had no problems (pp.56, 95). The researchers in the Glasgow studies found about 95 per cent of their offenders were mentally disordered, (Binns, Carlisle, Nimmo, Park and Todd, 1969, 1969a).

In Australia, Bartholomew and others (1967) found that in a random sample of convicted male offenders in Pentridge Gaol from courts of petty sessions in Victoria, 45% were diagnosed as suffering from some mental or personality disorder, personality disorders excluding alcoholics accounting for 14.3%. In a group remanded to Pentridge from courts of petty sessions for psychiatric reports, Guile (1965) found 51.5% were suffering from mental disorders (including borderline mental deficiency) and 30.3% were suffering from personality disorders. A group remanded from general sessions and Supreme Courts consisted of 26.6% mental disorder and 42.8% personality disorder. In the petty sessions group, psychosis was diagnosed in over one-third (34.8%) compared with 4.0% of the general sessions group.

The incidence of psychosis in the present study, 4.4% for all male offenders, was smaller than reported in other groups of convicted offenders and, as would be expected, considerably smaller in comparison with groups of unprosecuted offenders admitted to mental hospitals.[55] As there is no evidence that the incidence of psychosis is any less in Tasmania than elsewhere, and because the issue of fitness to plead is raised extremely rarely, it seems that some psychotic offenders are diverted from the criminal justice system before charges are heard. If the police are assisting to arrange for informal treatment of these people, this is desirable. The obvious contrast in Guile's (1965) study between the proportion of mentally disordered and particularly psychotic offenders remanded by the court of petty sessions and by the general sessions did not appear in this study. There appeared to be no significant differences between the two courts in any of the data in Table 12.

(55) H.R. Rollin (1965) found schizophrenia was diagnosed in 78% of a group of male unprosecuted offenders admitted to Horton Hospital, Epsom.

The high incidence of personality disorder in the remanded population reinforces the need, expressed elsewhere, for preventive and treatment programmes to be directed at this group.

The proportion of normal offenders overall is small. Does this suggest a high incidence of psychiatric disorder in the offender population generally, the proficiency of the courts at recognizing those with mental disorder, or psychiatric opinion that most offenders are "sick"?

The available empirical evidence provides convincing support that it is not the case that all offenders are psychologically disturbed or mentally ill. In America, Guze et al. (1969) has shown that with the exception of sociopathy and drug abuse mental illness is no more prevalent in the offender population than in the population at large. The studies of hidden criminality, (Christie, Andenaes, and Skirbeck, 1965; Erickson & Empey 1966), which show in relation to juveniles at least that it is statistically normal to break the law but that few offenders are discovered, suggest as a consequence that it is questionable whether the average criminal should without exception be considered sick. It is interesting but predictable that the researchers in the Glasgow study, a group of psychiatrists, attributed the high incidence of mental disorder in their two samples to pre-selection by police and prosecuting authorities, denying that they, the reporting psychiatrists, equated crime with mental disorder (Binns et al. 1969, 1969a). Similarly the study by the psychiatrists Bartholomew et al. (1967) said the disparity in the proportion of mentally disordered offenders in a group of prisoners remanded for reports and a group not remanded demonstrated the proficiency of the courts and prosecutors at recognizing those with mental disorder.

Their findings could also be used to demonstrate that they at least were not of the opinion that all offenders are mentally disordered. But in the present study, a comparison of the proportion of normal petty offenders in 1969-1970 and 1974-1975 suggests that the psychiatrist responsible for the majority of the reports in the later period may be of this opinion, although from the courts' point of view the purpose of the remand was not always to isolate the mentally disordered.(56)

The assertion that at least some psychiatrists see a high proportion of offenders as sick or suffering from mental or personality disorder deserves some elaboration. Although they may consciously deny that crime can be equated with mental disorder, it is suggested that there are various factors which contribute to a high proportion of offenders remanded for psychiatric reports being diagnosed as mentally disordered. First, it may be that some psychiatrists have difficulty in defining what is "normal", and will try to place a patient within some diagnostic category which falls within the psychiatric model.(57) Secondly, the classification of mental disorder seems to consist of an increasing number of categories which could be used to encompass much of any population. This applies particularly to criminal groups, for the commission of an offence may be used as evidence upon which a diagnosis of psychopathic personality disturbance is based. In fact it is widely conceded that the psychopath makes nonsense of attempts to distinguish between sick and healthy delinquents. Thirdly, some psychiatrists with very optimistic ideas of the therapeutic potential of psychiatry, may wish to extend the influence of psychiatry and "treat" more and more offenders. A diagnosis of mental or personality disorder tends to have

(56) Ante., 47.
(57) Bohmer (1976) claimed this difficulty was demonstrated by psychiatrists of the Philadelphia Court Clinic who said in respect of a mere 3 offenders out of approximately 150 that there was nothing psychiatrically wrong with them.

the effect of making the possibility of psychiatric treatment, rather than traditional methods, both feasible and proper.

The large proportion of mentally disordered offenders and the differences in this respect in the two periods selected, lend some support to those critics who challenge the efficacy and accuracy of diagnosis. The value of diagnostic labels should not be overestimated by judges and magistrates and the dangers of labelling should be realized.

The object of diagnosis, to convey information about the patient's past, present and future, is considered by many to have failed. Diagnosis is recognized as an uncertain guide from which to predict a person's future course or from which to infer a type of treatment, and in particular the diagnosis of psychopathy, performs no explanatory, prognostic, therapeutic or descriptive function. Diagnosis is notoriously unreliable, due to the confusion about the basis for assignment to particular categories of the diagnostic system, and to the breadth of the diagnostic categories.

As well as being unreliable and non-functional, there are those who argue that diagnosis has a detrimental effect, that it is dehumanizing and incompatible with treatment. A diagnosis, it is said, acts as a barrier between patient and therapist, making interaction almost impossible. Some go further and see the diagnostician as moulding the behaviour of the patient to fit the diagnosis so that it becomes not an objective guide to predicting behaviour but a self-fulfilling prophecy. Supporters of labelling theory argue that diagnosis and patient status may stabilize behaviour that would otherwise be transitory. The evidence in support of labelling theory is considerable and

persuasive.[58] No discussion of the merits of diagnosis would be complete without mentioning the views of Szasz (1963). Szasz's theory asserts that mental illness is a harmful myth, and psychiatric labels are pejorative statements with aversive consequences to the person diagnosed including segregation, confinement, loss of civil rights, status and prestige. His errors must be admitted. Szasz fails to support his views with appropriate evidence. He ignores crucial evidence to the contrary and he makes egregious mistakes of logic by assuming that physical signs and symptoms are necessary for mental illness and by assuming there are no such signs or symptoms and that therefore there is no such thing as mental illness (Schoenfeld, 1976). Nevertheless his views, articulately and dramatically expressed, have an invaluable contribution to make. They create an acute awareness of the possible abuses of psychiatry and the social, legal and ethical issues in relation to human rights which the concept of mental illness and psychiatric treatment obscures.

(ii) Treatment Recommendations

The high proportion of offenders who were found to have a mental or personality disorder would appear to indicate, in theory, and at least for those with a mental disorder, that some form of treatment was potentially available. Table 14 shows that diagnosis of mental or personality disorder and suitability for treatment do not necessarily coincide and even for a few offenders with no mental or personality disorder treatment was recommended.

(58) Some of the evidence is discussed by Scheff (1974). One particularly startling study is that reported by Rosehan (1973). For this study eight sane persons gained secret admittance to twelve different mental hospitals. In his initial interview each pseudo-patient simulated psychotic symptoms. Immediately upon admission to a ward each stopped simulating the symptoms. In all cases they had enormous difficulty establishing they were sane and the length of their stay in hospital ranged from 7 - 52 days.

In the 1969-1970 court of petty sessions group, treatment was offered in only 23.5% of the remanded population of males but in 62.7% of the 1974-1975 group. The figures for females were remarkably similar.(59) In the Supreme Court sample there was an increase, but the trend was not as definite with 25% remanded in 1969-1970 and 38.6% in 1974-1975. The increases in treatment recommendations were particularly apparent in the personality group.

TABLE 14

NUMBER AND PROPORTION OF DIAGNOSTIC CATEGORY RECOMMENDED FOR TREATMENT

DIAGNOSIS	COURT OF PETTY SESSIONS								SUPREME COURT			
	MALES				FEMALES				MALES			
	1969-70		1974-75		1969-70		1974-75		1969-70		1974-75	
	T.R.[a]	%[b]	T.R.	%	T.R.	%	T.R.	%	T.R.	%	T.R.	%
NORMAL	2	4.9	1	7.7	-	-	1	33.3	-	-	2	16.7
MENTAL DISORDER	26	45.6	57	86.4	6	85.7	7	70.0	9	64.3	16	76.2
PERSONALITY DISORDER	8	15.7	33	50.0	2	20.0	8	80.0	1	5.9	4	16.7
TOTAL	36	-	91	-	8	-	16	-	10	-	22	-
% OF REMAND GROUP RECOMMENDED FOR TREATMENT	23.5		62.7		26.7		61.5		25.0		38.6	

[a] T.R. = treatment recommendations

[b] % = percentage of total diagnostic category (see tables 12 and 13) recommended for treatment.

(59) The increase in treatment recommendations was highly significantly greater in 1974-1975. $\chi^2 = 23.32$, *d.f.* = 1, $p > .001$.

Clearly, the increase in treatment recommendations cannot be attributed only to a smaller proportion of normal offenders remanded, for two reasons. First, the decrease in normal offenders remanded in the court of petty sessions group of males and females was not paralleled by a decrease in the number of normal offenders remanded by the Supreme Court. Secondly, the increase in treatment recommendations exceeds the increase in the number of offenders with mental or personality disorders remanded.

There was in the court of petty sessions population a considerable change in the treatment recommendations themselves. More than one third of the recommendations for treatment for males and females in 1969-1970 were for hospital orders, but in 1974-1975 hospital orders accounted for less than one tenth. However, in this period, in 14 cases (all males) the psychiatrist specifically recommended in-patient treatment or assessment, and in an additional eight cases admission to hospital for treatment for alcoholism under the Alcohol and Drug Dependency Act. In some of these cases at least, grounds for a hospital order would have existed.

The Supreme Court population in contrast to the court of petty sessions population showed no significant changes in the type of treatment recommendations made.

A cohort of offenders from the Wessex magistrates courts provides some interesting comparative data. Psychiatric treatment was recommended for 26% of the men, and a table of the relationship between mental health assessment and court sentence shows that some of those with mild or no problems nevertheless received medical sentences (Gibbens et al. 1977, p.67 and Appendix A).

TABLE 15

DIAGNOSIS, NON-PSYCHIATRIC RECOMMENDATIONS AND NO ADVICE

DIAGNOSIS	COURT OF PETTY SESSIONS																SUPREME COURT							
	MALES								FEMALES								MALES							
	1969-70				1964-75				1969-70				1974-75				1969-70				1974-75			
	R[a]	%[b]	NA[c]	%[d]	R	%	NA	%	R	%	NA	%	R	%	NA	%	R	%	NA	%	R	%	NA	%
NORMAL	16	38.1	23	54.8	9	69.2	3	23.1	2	16.7	10	83.3	1	33.3	1	33.3	-		7	100.0	3	25.0	7	58.3
MENTAL DISORDER	14	24.6	17	29.8	6	9.2	3	4.6	-		1	14.3	3	30.0	-		3	21.4	2	14.2	3	14.3	2	9.5
PERSONALITY DISORDER	15	29.4	28	54.9	11	18.2	20		3	30.0	5	50.0	1	10.0	1	10.0	5	29.4	11	64.7	7	29.1	13	54.1
TOTALS	45	-	68	-	26	-	26	-	5	-	16	-	5	-	2	-	8	-	20	-	13	-	22	-
% OF REMAND GROUP	29.4		44.4		18.6		18.6		16.6		53.3		19.2		7.7		20.0		50.0		22.8		38.5	

[a] R = non-psychiatric recommendations.

[b] % = percentage of diagnostic category receiving recommendations.

[c] NA= no advice.

[d] % = percentage of diagnostic category receiving no advice.

Table 15 shows the number and proportion of cases in which recommendations were made as to matters other than treatment.

TABLE 16

TYPES OF NON-PSYCHIATRIC RECOMMENDATIONS

RECOMMENDATION	COURT OF PETTY SESSIONS				SUPREME COURT	
	MALES		FEMALES		MALES	
	1969-70	1974-75	1969-70	1974-75	1969-70	1974-75
PRISON	3	11	1	1	3	7
PROBATION	19	4	2	1	1	1
OTHER SENTENCE	11	5	1	1	-	1
MISCELLANEOUS	12	6	1	2	4	4
NO ADVICE	68	26	16	2	20	22

Table 16 shows most of these recommendations related to sentence, and that psychiatrists did not shrink from unambiguous recommendations for gaol sentences in certain cases. The miscellaneous recommendations concerned such things as repatriation to country of origin, employment in gaol or non-psychiatric medical treatment.

The evidence that psychiatrists do in fact make recommendations as to what sentence should be imposed is interesting, for it is a matter upon which opinion is divided. The responses to the questionnaire indicate that 70 per cent of the judges and magistrates who completed the questionnaire do not object to sentencing recommendations,[60] but one of the most frequently cited writers on technique in writing psychiatric reports, Scott (1953) has asserted that psychiatrists should not make

(60) See Appendix A, question 10.

recommendations for punishment. This was rejected by Bartholomew (1962), who argued that penal recommendations concern modification of behaviour which is within the province of a psychiatrist's expertise, as penal measures can be therapeutic and rehabilitative. He also argued that by making such recommendations a psychiatrist is not arrogating to himself the functions of the court but merely voicing an opinion, a request for which is implicit in the initial demand for a psychiatric report. Both of these views have been recently commented upon by Schiffer (1976) who concluded that a psychiatrist's expertise in matters of psychic rehabilitation does not justify all recommendations he makes with regard to sentence, for he may do so on the basis of matters outside his expertise, and the result in effect makes him a sentencing judge. Schiffer points out this may create problems if the psychiatrist is ultimately responsible for treatment. He suggested that judges should not seek such recommendations, citing Szasz's opinion that to do so is an attempt to escape responsibility and alleviate their own feelings of guilt.

It is clear that in Tasmania psychiatrists freely make recommendations for punishment or sentence, and the majority of sentencers tolerate and even appreciate such advice.[61] Provided psychiatrists are not unrealistically viewed by judges and magistrates, and their opinions are critically evaluated along with all the other evidence, psychiatric opinion on sentencing matters, for example the negative or positive effects of imprisonment on a particular offender, can assist the court in the lonely and difficult task of sentencing.

Table 15 shows the number and proportion of cases in which no specific advice was offered other than such statements as "the law

(61) The responses to question 11(b) (See Appendix A) indicated that most respondents found recommendations helpful in determining an appropriate sentence.

should take its course". All groups in the 1974-1975 period show a smaller proportion of cases in which no advice was offered.

Although the absence of any recommendations could be relied upon as indicating that the report was of little value, this may not have invariably been the case. A negative report, with no indication that psychiatric treatment nor any other sentencing alternative was deemed appropriate to rehabilitate the offender, may nevertheless have been of some value to the court.

It was rather surprising to find that in four cases of female shoplifters the psychiatrist made no recommendation other than to suggest that no criminal intent was involved, although in fact the complaint had been found proved or the offender had pleaded guilty.[62]

(iv) Intelligence

TABLE 17

INTELLIGENCE

INTELLIGENCE	COURT OF PETTY SESSIONS				SUPREME COURT	
	MALES		FEMALES		MALES	
	1969-70	1974-75	1969-70	1974-75	1969-70	1974-75
SUBNORMALITY	10	15	2	1	4	6
BORDERLINE FEEBLE MINDED	10	10	1	2	-	7
DULL NORMAL	33	22	3	4	7	11
AVERAGE	42	29	12	5	12	11
ABOVE AVERAGE	7	4	-	-	2	-
TOTAL	102	80	18	12	25	35
NO INFORMATION	51	65	12	14	15	22
TOTAL	153	145	30	26	40	57

(62) De Berker (1960) found that in roughly half of his total sample, no special recommendation was made; and Dell & Gibbens (1971) found that in 38% doctors did not feel able to advise about disposal, in 5% custodial sentences were recommended, and in 18% probation.

Table 17 shows the intelligence range of the remanded offenders in respect of whom information was available from various sources. Only about half of the reports contained any intelligence assessment. Psychometric tests were stated to have been performed in some of these cases, and occasionally the exact I.Q. specified, but more often only estimates were given, and the terminology was often vague, ambiguous and difficult to classify.

A substantial proportion of offenders whose reports contained an intelligence assessment were of below average intelligence and between 10 to 20% were diagnosed as subnormal. These figures would probably not relate to the remand group as a whole, for psychiatrists may omit to mention intelligence where it is thought to be average.

Responses to the questionnaire indicate that judges and magistrates value the inclusion of a statement of the offender's intelligence in a report. Most are satisfied with an estimate rather than a psychometrically analysed assessment.[63] Sentencers should be careful not to place too much reliance upon intelligence tests, for there is convincing evidence that I.Q. tests are not scientifically valid, and that they are socially and racially discriminatory (Sussman, 1974).

(63) See Appendix A. Eight affirmative responses to the questionnaire, question no.15, with no negative responses indicated a preference for a prognosis in terms of recidivism, treatment and dangerousness.

TABLE 18

PROGNOSIS IN TERMS OF RECIDIVISM

GROUP	PROGNOSES	
	1969-1970	1974-1975
COURT OF PETTY SESSIONS		
MALES	20	52
FEMALES	1	8
SUPREME COURT		
MALES	7	24

Table 18 shows that there was a dramatic increase in the 1974-1975 group in the number of reports in which a prediction of the offender's criminal behaviour was given.(64) The accuracy of the prognoses in the 1969-1970 group will be discussed later.(65)

Assessments of dangerousness were sometimes made, and in the court of petty sessions group these were invariably in respect of male sexual offenders.

(64) This was very highly significant for the court of petty sessions $\chi^2 = 21.24$, *d.f.* $= 1$, $p > .001$.

(65) Post., p.98.

TABLE 19: PSYCHIATRIC DISPOSITION OF OFFENDERS REMANDED FOR PSYCHIATRIC REPORTS

GROUP		HOSPITAL ORDERS	PROBATION & PSYCH. T.[a]	TRANSFER DIRECTION	GUARDIAN-SHIP	PRISON THEN GUARDIAN.[b]	A.D.D.A.[c]	SUSP. SENT. & IN-PAT.[d]	RETURN TO RDH[e] & OTHER	TOTAL	% OF REMAND GROUP IN WHICH TREATMENT ORDERED
COURT OF PETTY SESSIONS											
MALES:	1969-70	8	28	3	-	-	-	-	3	42	27.4
	1974-75	1	60	5	-	-	10	-	2	78	53.8
FEMALES:	1969-70	6	1	-	-	-	-	-	-	7	23.3
	1974-75	1	11	-	-	-	-	-	-	12	46.1
SUPREME COURT											
MALES:	1969-70	4	3	2	-	-	-	-	1	10	25.0
	1974-75	5	5	2	1	1	2	1	-	17	29.8
FEMALES:	1969-70	1	-	-	-	-	-	-	-	1	50.0
	1974-75	-	2	-	-	-	-	-	-	2	100.0

Probation & psych. T.[a] = probation and psychiatric treatment;
guardian.[b] = guardianship; A.D.D.A.[c] = order under the Alcohol and Drug Dependency Act;
Susp. sent. & in-pat.[d] = suspended sentence with a condition as to in-patient psychiatric treatment.
RDH[e] = Royal Derwent Hospital.

TABLE 20

COURTS' RESPONSE TO TREATMENT RECOMMENDATIONS

GROUP		HOSPITAL ORDER		PROBATION & TREATMENT		OTHER TREATMENT		TOTAL		%
		R[a]	F[b]	R	F	R	F	R	F	
COURT OF PETTY SESSIONS										
MALES:	1969-70	11	8	9	4	16	12	36	24	66.6
	1974-75	8	1	13	11	70	57	91	69	75.8
FEMALES:	1969-70	6	6	2	1	-	-	8	7	87.5
	1974-75	1	1	5	4	10	7	16	12	75.0
SUPREME COURT										
MALES:	1969-70	4	4	1	1	5	5	10	10	100.0
	1974-75	6	5	1	1	15	10	22	16	72.7

[a]R = recommendation; [b]F = followed.

In assessing the influence of recommendations on the decision of the courts some difficulties were encountered.

The first was the problem inherent in this type of study: that it is not possible to say categorically, when the decision of the court corresponds with the recommendation made, that the recommendation was followed. Where the court's decision was the same as the psychiatrist's recommendation, the psychiatrist may have anticipated the court's decision by making a recommendation thought to be the one desired. Alternatively the recommendation may have had no bearing on the court's decision. The limitations of the data in Tables 19 and 20 are realized, and it is conceded that it can only be said that in a certain proportion of cases the recommendations appeared to be followed or were not followed. To obtain a more accurate result a more sophisticated research design would be necessary.[66]

(66) See Hogarth (1971) at p.249.

A second difficulty was encountered in consistently representing in tabular form the cases in which recommendations appeared to be followed. Frequently the recommendations involved more than one factor, for example Saturday work and psychiatric treatment, and only part of the recommendation appeared to be followed. The following rules were adopted. If a hospital order was recommended and the court imposed a sentence of imprisonment with a recommendation for a transfer direction, this was counted as not followed. If probation was recommended and probation and psychiatric treatment ordered this was counted as a sentencing recommendation which was not followed. If probation and psychiatric treatment was recommended but probation only imposed, this was counted as a treatment recommendation which was not followed. If Saturday work, probation and treatment was recommended but probation and treatment imposed, this was counted as a treatment recommendation which was followed.

Table 19 shows the courts' treatment decisions, and Table 20 the treatment recommendations and the cases in which they appear to have been followed.

The decline in the number of hospital orders made by the court of petty sessions in respect of males and females in 1974-1975 was significant.[67] Although there were less recommendations this was not statistically significant. This shows a change in attitude over the relevant years to a reluctance to make hospital orders and a preference for sentences of imprisonment with recommendations for transfer directions or psychiatric treatment as conditions of probation. Of the cases in 1969-1970 where the magistrates declined to make hospital orders, one offender was sentenced to imprisonment with a recommendation

(67) $\chi^2 = 5.24$, *d.f.* $= 1$, $.02 > p > .05$.

for transfer, and one was released on probation with a condition as to psychiatric treatment. In the 1974-1975 period, of the sentences where magistrates declined to make hospital orders, five were sentenced to imprisonment with recommendations for transfer and one was released on probation on the condition he seek admission to the Royal Derwent Hospital and remain there for one year unless released before.

The figures for 1974 and 1975 would seem to indicate that for magistrates courts the hospital order is virtually redundant. The comments of magistrate R.C. Wood previously quoted demonstrate the dissatisfaction felt with hospital orders. Other magistrates share similar sentiments.(68)

The position with regard to hospital orders is not the same in England. There magistrates and judges almost invariably make a hospital order where there is medical evidence in support of one. This general readiness to make hospital orders was testified to the Butler Committee by members of the Bar Council, the Law Society and by medical witnesses. Examples of the sort of case where hospital orders might not be made were where the judge or magistrate was not satisfied that the hospital in question was secure enough for a particularly dangerous offender, or where the doctor offering treatment held out no solid hope of treatment succeeding or of retaining the offender if it did, or where the offender challenged the medical evidence and asked for a prison sentence. Nevertheless the Committee was also informed of the dissatisfaction felt by some courts at the almost immediate discharge of some offenders who

(68) In response to question 25 of the questionnaire, 3 magistrates replied "No" to the question 'Do you think hospital orders are a satisfactory means of dealing with mentally disordered offenders'. Only one judge and one magistrate replied with an unqualified "Yes". One judge replied in the affirmative adding 'until something better can be devised'; another judge said the results are far from satisfactory and a third said he had no opinion because he did not know the results of them.

would have received a punitive custodial sentence had the court not accepted medical recommendations in favour of a hospital order (1975. Cmnd. 6244, para. 13.10). Further support of the readiness of magistrates to accept recommendations for hospital orders emerged from Gibbens' study (1977), which reported that in Wessex in the relevant period all but one of the 17 recommendations for hospital orders were accepted.

The decline in the use of hospital orders by magistrates by no means reflected a decline in the ordering of in-patient psychiatric care. In 1974 and 1975, in addition to 10 orders under the Alcohol and Drug Dependency Act, and recommending that the Attorney-General make a transfer direction in five cases, the court specifically ordered in-patient treatment as a condition of probation in seven cases, four of which were diagnosed as suffering from mental illness, two from personality disorders, and one from alcoholism. In another case a subnormal offender was remanded on bail on condition he enter the Royal Derwent Hospital as a voluntary patient. He was subsequently discharged from bail and no further action was taken. Another offender, who had already entered a plea of guilty, was said by the psychiatrist to be unfit to plead and to require treatment. The matter was adjourned sine die.

The highly significant increase in the number of cases in which the court of petty sessions ordered treatment in 1974 and 1975 was paralleled by the increase in treatment recommendations previously mentioned.

In contrast to the court of petty sessions, the Supreme Court figures show the number of hospital orders over the two periods remained constant, and a greater tendency than the court of petty sessions to

follow recommendations for them.[70] At least part of the explanation for this is the wider powers judges have in relation to hospital orders.[71] Nevertheless judges recommended transfer directions in some four cases, as Table 19 shows, but in only one of these had the psychiatrist recommended a hospital order. In two cases the psychiatrist had recommended gaolwith a recommendation for transfer, and in the other case treatment was recommended without specifying what form it should take.

The reason why judges impose gaol sentences with recommendations for transfer seems difficult to explain. Transfer directions and hospital orders have the same prerequisites, except that the Attorney-General is expressly required to take "the public interest" into account as well as "all the circumstances" in formulating his opinion as to the expediency of the order. If there are cases in which the court feels there is a risk of the offender committing further violent offences after being discharged prematurely from hospital by an optimistic or careless psychiatrist, then control over discharge can be retained by a hospital order and a restriction order. If there are cases where the necessity for retribution requires a custodial sentence this can be achieved by a hospital order coupled with a sentence of imprisonment. The position is rather different in England where the higher courts have no power to impose a sentence of imprisonment and a hospital order, and a gaol term with a recommendation for transfer is seen as a real alternative. In R. v. Morris[72] Lord Chief Justice Parker said,

> Of course there may be cases where, although there is a substantial impairment of responsibility, the prisoner is shown on the particular facts of the case nevertheless to have some responsibility

(70) Testing by Fisher's Exact Test for both 1969-1970 and 1974-1975 there was no significant difference between the responses of the Supreme Court and the court of petty sessions.
(71) Ante., p.13.
(72) (1961) 45 Cr. App. Rep. 185.

for the act he has done, for which he must be punished, and in such a case, although, as the court reads the sentence imposed by the learned judge, this was not such a case, it would be proper to give imprisonment, allowing the Secretary of State to exercise his powers under Section 72 in order that any necessary mental treatment should be given.

TABLE 21

COURTS' RESPONSE TO SENTENCING RECOMMENDATIONS

GROUP		GAOL		SATURDAY WORK		PROBATION		OTHER		TOTAL		% FOLLOWED
		R[a]	F[b]	R	F	R	F	R	F	R	F	
COURT OF PETTY SESSIONS												
MALES:	1969-70	3	2	1	-	19	13	10	2	33	17	51.5
	1974-75	11	9	5	3	4	3	-	-	20	15	75.0
FEMALES:	1969-70	1	-	-	-	2	2	1	1	4	3	75.0
	1974-75	1	-	-	-	1	1	1	1	3	2	66.6
SUPREME COURT												
MALES:	1969-70	3	3	-	-	1	-	-	-	4	3	75.0
	1974-75	7	7	1	-	1	1	-	-	9	8	88.9

[a]R = recommendation; [b]F = followed

Tables 20 and 21 show the relationship between psychiatric treatment and sentencing recommendations and the decision of the court. Subject to the reservations mentioned it would seem that the courts appear to follow recommendations in the majority of cases, and to follow treatment recommendations rather more than sentencing recommendations. The substantial proportion of cases in which the decisions did not correspond with the recommendations tends to refute the allegation that is sometimes made that courts are not sufficiently sceptical of psychiatrists and improperly delegate their sentencing responsibilities to them (Hakeem, 1958; and Suarez, 1967).

Questions 11 and 12 of the questionnaire were designed to throw more light upon the impact of psychiatric reports. The answers to question 12 are reproduced below in tabular form.

TABLE 22

THE NUMBER OF MAGISTRATES AND JUDGES WHO REACH A DIFFERENT DECISION BECAUSE OF PSYCHIATRISTS' RECOMMENDATIONS

	Always	Usually	Sometimes	Rarely	Never
Treatment Recommendations	1	4	1	1	1
Sentencing Recommendations	-	3	2	2	1

This table shows that most of the judges and magistrates responding to the questionnaire reach a different decision because of a recommendation for treatment in a psychiatric report. Their responses indicate they assess the influence of sentencing recommendations as of smaller impact, which is borne out by the objective data.

The value of psychiatric reports is very difficult to assess objectively. If one assumes, in the proportion of cases in which recommendations were made and appeared to be followed, that the reports were useful, this omits from consideration other reports which were nevertheless perhaps useful. Such cases can be readily imagined. For example, a negative report (without recommendations) may enable a court to sentence without feeling guilt; or a report may be helpful and even illuminating quite apart from the recommendations.

One rather disturbing matter emerged from the analysis of the relationship between psychiatric recommendations for treatment and the decision of the courts. This was the fact that in some cases psychiatric

treatment was made a condition of probation although the psychiatric report contained no recommendation for treatment. This was done only in cases of male offenders.

TABLE 23

PROBATION ORDERS AND PSYCHIATRIC TREATMENT WITHOUT RECOMMENDATIONS

GROUP	NUMBER OF OFFENDERS
COURT OF PETTY SESSIONS	
1969-1970	12
1974-1975	7
SUPREME COURT	
1969-1970	1
1974-1975	3

The court's response to psychiatric recommendations can be compared with figures from other jurisdictions. In most of the reported British studies read, the courts appear to decline to follow psychiatric recommendations in only about 10% of cases. De Berker (1960) reported that in 92% of the cases where "special action" was suggested, the courts appeared to follow that recommendation. Sparks (1966) found the courts followed definite recommendations for mental treatment in 90% of the cases in which recommendations were made, and in just under half of the remainder the offender was known to have had treatment arranged informally for him. Gibbens and Dell (1971) found that in all but 9% magistrates acted upon the advice offered, and in this minority it was normally clear that something had prevented the advice being followed; for example, the offender had refused to be put on probation with medical treatment. Bearcroft (1965) found recommendations for admission to hospital and

treatment were accepted in 92% and Binns et al. (1969) found recommendations for psychiatric treatment were accepted in 28/42 cases. More recently Woodside (1976) has reported that treatment recommendations were accepted 48/66 cases in Edinburgh, and Gibbens et al. (1977) found that recommendations for probation with a condition of psychiatric treatment were accepted by Wessex magistrates in 69% of cases, but hospital orders were acted upon in 16/17 cases (pp.67-68).

In the U.S. the following figures have been reported. In North Carolina the courts adopted recommendations of the diagnostic study group in 75% of 600 cases studied over 3 years (Smith, 1971). Judicial disposition agreed with the psychiatric recommendations of the Philadelphia State Maximum Security Forensic Diagnostic Hospital in 97.7%; when they differed they favoured stricter security rather than leniency (Jablon et al., 1970).

(8) COMPARATIVE USE OF PSYCHIATRIC REPORTS BY INDIVIDUAL JUDGES AND MAGISTRATES

(i) The Problem of Sentencing Disparity

"A universal criticism of sentencing is the apparent disparity of sentences imposed by different judges for cases which do not appear to be substantially different from one another." (Hogarth, 1971, p.6).

There is considerable value placed upon consistency in the way different judges and magistrates approach sentencing tasks. Unwarranted inconsistencies of sentencing arouse disrespect for the law by the public at large and are likely to prejudice the chances of an individual offender benefiting from a sentence. If an offender believes he is the victim of an unusually harsh sentence, a sense of hostility and disrespect for the law is likely to impede attempts of the law to rehabilitate him.

Complete uniformity is unrealizable and problems of uniformity seem more apparent where great importance is attached to considering the interests of individual offenders. Perhaps the ideal should be, as Hood (1962) suggests, "equality of consideration".[73] In roughly similar situations the courts ought to consider similar factors and have similar reasons for selecting particular forms of sentence. In the use of psychiatric reports as in other aspects of the sentencing process, the same equality of consideration is desirable. Moreover, if there is a lack of uniformity in the type and amount of presentence information judges use, this will contribute to disparities in the ultimate sentencing decision. Such an ideal is difficult to achieve not only because of disagreement about what factors are relevant for the same aims of the penal process, but because of the lack of consensus about the aims of the penal process which means that different factors are relevant to different aims.

That disparity does exist in sentencing practice has been demonstrated overwhelmingly in many countries.[74] That magistrates also differ in the extent they make use of psychiatric reports and the way they deal with mentally abnormal offenders has also been demonstrated (Sparks, 1966). As a result of a survey of recidivist mentally abnormal offenders, Boehringer and McCabe (1973) concluded that the system of criminal justice in London magistrates' courts operates like a conveyor belt with little flexibility or individuality. This they said applies to the sentencing process, the decision to remand for psychiatric reports, and the adequacy of reports when they are made.

(73) The use of this term may avoid facing the implications of the belief that justice means like cases should be dealt with alike. See Bottomley (1973) pp.130-133.

(74) For example, Hood (1962) found differences in imprisonment rates of English magistrates could not be explained by the different offenders appearing at each court, and E. Green (1961) found sentencing disparities between individual judges in the Philadelphia Court of Quarter Sessions. In Tasmania, Daunton-Fear (1967) reported sentencing disparities between judges of the Supreme Court.

Lack of uniformity in sentencing has been shown to be unexplained by differences in the kinds of cases dealt with (i.e. in the type of offenders and offences). By empirical research, Hogarth (1971) has created a "phenomenological model" of sentencing behaviour which explains the decision process in sentencing and which could explain over 50 per cent of the variation in sentencing. He showed that there are various elements in sentencing behaviour unrelated to the offender or the offence which make an independent contribution to it. These elements include the magistrates' penal philosophy and judicial attitudes, the way in which they define the operative legal and social constraints in their environment, and the subtlety of their thought processes in handling information. Variations in these elements were shown to be associated with variations in judicial behaviour. In contrast, variations in objectively defined facts, relating to the offender and offence, were shown to account for only 9% of the total variation in sentencing practice. Other sentencing studies, comprehensively reviewed by Bottomley (1973) collectively show that three elements, (i) social background of individual magistrates and judges, (ii) the characteristics of the communities in which the courts are situated and (iii) the extent and type of information available contribute to sentencing disparity (pp.143-170).

Hogarth's data also showed that magistrates interpret cases, the law, cause of crime and the expectation of others in ways which minimize inconsistency. Enormous variation was found to exist in penal philosophies of magistrates, but it appeared that most individual magistrates had a fairly consistent and coherent set of beliefs supporting their personal penal philosophy. For example a positive relationship was found to exist between belief in reformation and the proportion of offenders perceived as mentally ill, and a negative

association between amount of mental illness perceived and belief in general deterrence and retribution (Hogarth, 1971, p.85). A magistrate who believes in reformation is more likely to believe that offenders are mentally ill and need treatment than one whose philosophy is oriented towards punishment.

Certain relationships were found to exist between social characteristics and attitudes and beliefs. Magistrates with professional family backgrounds attached less weight to 'justice' and deterrence and more weight to reformation. They believe that a large proportion of offenders are mentally ill and they have a more positive attitude towards parole and other correctional methods. In contrast, magistrates from working class backgrounds appear to be rather more punitive in their attitudes and beliefs (p.212). Previous association with the prosecution side of the administration of justice was shown to be associated with the belief that fewer offenders are mentally ill, and length of experience on the bench tends to be associated with a greater likelihood to attach some value to psychiatry and psychology. Magistrates with heavy workloads are likely to restrict the use of psychiatric reports and to have negative attitudes towards psychiatrists (chap.13).

Hogarth also produced data which showed that differences in information used in the process of coming to decisions are closely associated with penal philosophy and attitudes. He found 62/71 magistrates would use psychiatric reports when fitness to stand trial was in issue; 49/71 would request reports when there was evidence of emotional disturbance that might require psychiatric treatment, and 24/71 would request reports when the offence was committed in a bizarre or unusual way or there were other circumstances requiring an explanation. The data showed that those magistrates who made more frequent use of

psychiatric reports had a penal philosophy and attitudes showing more concern for the treatment of offenders than those who restricted the use of reports to cases where fitness to plead was in issue (chap.14).

This present study does not attempt to explain any disparity in the use of psychiatric reports by judges and magistrates. The complexity of the questions involved in understanding and comparing judicial decisions is realized, and the unsophisticated nature of the present study is conceded. It merely attempts to ascertain if there is any apparent disparity in the proportion of offenders remanded by judges and magistrates, in the mental health of those remanded, their suitability for treatment, and in the proportion of cases in which recommendations for treatment are followed. The optimum number of offenders for remands for psychiatric reports cannot be accurately ascertained, but if some judges or magistrates remand too few or too many offenders this could be revealed, and if some magistrates or judges invariably follow or disregard recommendations this too will be revealed.

This study has concentrated on a comparison of the courts' decisions, and no attempt was made to examine in detail variability in the recommendations made by psychiatrists. It is recognized that disparity in this area is one of the contributing factors to judicial variability.[75] In this study it was found that one psychiatrist in each of the two periods was responsible for a great majority of the reports prepared, but because of the time lapse their reports could not be validly compared in this context, nor did the data collected provide sufficient information to make a comparison possible within each period.

(75) Empirical research in California has showed variability in the recommendations made by psychiatrists and psychologists which could not be related to offenders' characteristics. It was attributed to differences among decision makers in attitudes towards sentencing (Holland & Holt, 1976).

TABLE 24: REMAND RATES OF MAGISTRATES AND IMPACT OF TREATMENT RECOMMENDATIONS. MALE OFFENDERS 1969-1970.

MAGISTRATE	TOTAL CASES HEARD	NO. REMANDED[a]	NORMAL	MENTAL DISORDER	PSYCHOPATHY	OTHER PERSONALITY	NO DIAGNOSIS	TREATMENT RECOMMENDATIONS FOLLOWED
A	PPTY 245 SEX 13 ASSAULT 70 OTHER 271 TOTAL 599	20 (8%) 8 (62%) 6 (9%) 6 (2%) 40 (6.7%)	8 (20%)	14 (35%)	2 (5%)	14 (35%)	2	5/9 (55.5%)
B	PPTY 170 SEX 14 ASSAULT 36 OTHER 237 TOTAL 457	12 (7%) 14 (100%) 6 (17%) 10 (4%) 42 (9%)	16 (38%)	16 (38%)	3 (7%)	7 (17%)	-	6/10 (60%)
C	PPTY 130 SEX 11 ASSAULT 68 OTHER 200 TOTAL 409	11 (8%) 4 (36%) 7 (10%) 4 (2%) 26 (6%)	8 (31%)	9 (34.6%)	3 (11.5%)	6 (23%)	-	4/5 (80%)
D	PPTY 136 SEX 9 ASSAULT 47 OTHER 194 TOTAL 386	16 (12%) 6 (66%) 9 (19%) 8 (4%) 39 (10%)	9 (23%)	17 (43.6%)	5 (12.8%)	6 (15%)	2	8/11 (81.8%)
E (miscellaneous group)	PPTY 57 SEX 5 ASSAULT 20 OTHER 68 TOTAL 150	3 (5%) 1 (20%) 1 (5%) 1 (4%) 6 (4%)	1 (17%)	1 (17%)	-	4 (66%)	-	1/1 (100%)
TOTALS	2001	153 (7.6%)	42	57	13	37	4	24/36

[a] The percent in parenthesis relates to the proportion of offenders remanded by each magistrate for each type of offence.

TABLE 25: REMAND RATES OF MAGISTRATES AND IMPACT OF TREATMENT RECOMMENDATIONS. MALE OFFENDERS 1974-1975.

MAGISTRATE	TOTAL CASES HEARD	NO. REMANDED[a]	NORMAL	MENTAL DISORDER	PSYCHOPATHY	OTHER PERSONALITY	NO DIAGNOSIS	TREATMENT RECOMMENDATIONS FOLLOWED
A	PPTY 214 SEX 11 ASSAULT 58 OTHER 345 TOTAL 628	9 (4.2%) 5 (45%) 7 12%) 8 (2.3%) 29 (4.6%)	2	16	1	10	-	17/22 (77.3%)
B	PPTY 135 SEX 14 ASSAULT 41 OTHER 312 TOTAL 502	10 (7.4%) 6 (42.8) 1 (2.4%) 1 (.3%) 18 (3.5%)	3	8	-	7	-	7/11 (63.6%)
C	PPTY 84 SEX 6 ASSAULT 32 OTHER 170 TOTAL 292	8 (9.5%) 6 (100%) 2 (6.2%) 5 (2.9%) 21 (7.1%)	2	9	3	7	-	7/11 (63.6%)
D	PPTY 109 SEX 12 ASSAULT 60 OTHER 229 TOTAL 410	19 (17.4%) 6 (50%) 6 (10%) 5 (2.2%) 36 (8.8%)	3	17	5	11	-	19/22 (86.3%)
E	PPTY 118 SEX 11 ASSAULT 60 OTHER 182 TOTAL 371	9 (7.6%) 6 (54.5%) 1 (1.6%) 1 (.5%) 17 (4.6%)	3	6	2	6	-	7/11 (63.6%)
F	PPTY 113 SEX 9 ASSAULT 52 OTHER 179 TOTAL 353	6 (5.3%) 7 (77.7%) 3 (5.7%) 2 (1.1%) 18 (5.0%)	-	7	1	9	1	11/12 (91.7%)
G (miscellaneous group)	PPTY 67 SEX 9 ASSAULT 21 OTHER 137 TOTAL 234	2 (2.9%) 2 (22.2%) 1 (4.7%) 2 (1.4%) 6 (2.5%)	-	2	2	2	-	1/2 (50%)
TOTALS	2790	145 (5.1%)	13	65	14	52	1	69/91 (75.8%)

[a]The percent in parenthesis relates to the proportion of offenders remanded by each magistrate for each type of offence.

(ii) Magistrates

The data from tables 24 and 25 show that there were no significant differences in the remand rates of the magistrates in the Hobart courts of petty sessions in 1969 and 1970 or 1974 and 1975. All magistrates remanded between 6.4 per cent and 10.1 per cent in 1969-1970 and between 3.5 per cent and 8.8 per cent in the later period. Magistrate D remanded the greatest proportion in each period. Magistrate B was the only magistrate to remand a significantly different number of offenders over the two periods.(76).

An analysis of the type of offence committed by the offenders remanded by each magistrate showed a pattern of uniformity rather than disparity. In 1969-1970 each magistrate remanded sexual offenders, offenders against the person and offenders against property in descending proportions. In 1974 and 1975 the pattern was not quite so consistent, some magistrates remanding a higher proportion of property offenders than offenders convicted of assault.

The numbers of offenders remanded by each magistrate in the four diagnostic groups are too small to ascertain if there are any significant differences. But it is interesting to note that magistrate D, who remanded a higher proportion of offenders than the others, remanded a smaller proportion of normal offenders in both periods than most, nor did he remand the smallest proportion of offenders who were considered by the reporting psychiatrist to be in need of treatment. It cannot be said then, that he should have adopted a more discriminating policy in his selection of candidates for psychiatric reports.

(76) $\chi^2 = 12.92$, $d.f. = 1$, $p < .001$.

Magistrates' response to treatment recommendations did not differ to any substantial degree, and all but one magistrate ordered treatment as a condition of probation although it was not recommended. Of the five magistrates who received recommendations for hospital orders, four decided not to make the order in at least one case, two of whom were known to have pointed out the drawbacks of hospital orders in certain cases in their comments on passing sentence. Three of the four magistrates responding to the questionnaire answered question 25: "Do you think hospital orders are a satisfactory means of dealing with mentally disordered offenders?", in the negative.

Thus dissatisfaction with the hospital order is shared by almost all magistrates.

TABLE 26: REMAND RATES OF MAGISTRATES AND IMPACT OF TREATMENT RECOMMENDATIONS. FEMALE OFFENDERS 1969-1970

MAGISTRATE	TOTAL CASES HEARD		NO. REMANDED[a]	NORMAL	MENTAL DISORDER	PSYCHOPATHY	OTHER PERSONALITY	NO DIAGNOSIS	TREATMENT RECOMMENDATIONS FOLLOWED
A	SHOPLIFTING	24	2	2	1	2	5	5	2/2
	OTHER PPTY	29	7						
	ASSAULT	1	-						
	OTHER	11	2						
	TOTAL	65	11 (16.9%)						
B	SHOPLIFTING	20	5	6	4	1	1	1	4/5
	OTHER PPTY	11	5						
	ASSAULT	2	-						
	OTHER	11	2						
	TOTAL	44	12 (27.2%)						
C	SHOPLIFTING	9	-	1	1	1	-	-	1/1
	OTHER PPTY	4	1						
	ASSAULT	4	1						
	OTHER	8	1						
	TOTAL	25	3 (12%)						
D	SHOPLIFTING	14	2	3	1	-	-	-	No treatment recommended
	OTHER PPTY	12	1						
	ASSAULT	2	1						
	OTHER	8	-						
	TOTAL	36	4 (11.1%)						
TOTALS		170	30 (17.6%)	12	7	4	6	6	7/8 (87.5%)

TABLE 27: REMAND RATES OF MAGISTRATES AND IMPACT OF TREATMENT RECOMMENDATIONS. FEMALE OFFENDERS 1974-1975.

MAGISTRATE	TOTAL CASES HEARD	NO. REMANDED[a]	NORMAL	MENTAL DISORDER	PSYCHOPATHY	OTHER PERSONALITY	NO DIAGNOSIS	TREATMENT RECOMMENDATIONS FOLLOWED
A	SHOPLIFTING 64 OTHER PPTY 19 ASSAULT 4 OTHER 28 TOTAL 115	1 3 1 5 (4.3%)	1	-	2	1	1	1/2
B	SHOPLIFTING 30 OTHER PPTY 4 ASSAULT - OTHER 15 TOTAL 49	4 2 6 (12.2%)	-	5	-	-	1	1/3
C	SHOPLIFTING 25 OTHER PPTY 8 ASSAULT 2 OTHER 24 TOTAL 59	4 1 5 (8.5%)	-	1	-	3	1	3/3
D	SHOPLIFTING 21 OTHER PPTY 6 ASSAULT 3 OTHER 12 TOTAL 42	1 1 1 3 (7.1%)	-	1	1	1	-	3/3
E	SHOPLIFTING 27 OTHER PPTY 10 ASSAULT 1 OTHER 15 TOTAL 53	1 1 2 (3.8%)	-	2	-	-	-	1/1
F	SHOPLIFTING 21 OTHER PPTY 5 ASSAULT 5 OTHER 6 TOTAL 37	2 2 (5.4%)	1	1	-	-	-	2/2
G	SHOPLIFTING 17 OTHER PPTY 3 ASSAULT - OTHER 7 TOTAL 27	1 1 1 3 (11.1%)	1	-	1	1	-	1/2
TOTALS	382	26 (6.8%)	3	10	4	6	3	12/16 (75%)

a - The percentage in parenthesis indicates the proportion of offenders remanded by each magistrate.

The fact that magistrates remanded significantly more females than males in the earlier period has already been discussed.[77] Tables 26 and 27 show that magistrate B in particular remanded high proportions of females, and although he remanded only half as many in 1974-1975 as he did in the first period, it was a considerably larger proportion than his male remanded offenders. Interestingly all other magistrates remanded fairly equal proportions of males and females in 1974-1975. Magistrate D, who remanded the highest proportion of males in both periods, alone remanded very similar proportions of males and females in both periods.

(77) Ante., p.39.

TABLE 28: REMAND RATES OF JUDGES AND IMPACT OF TREATMENT RECOMMENDATIONS. MALE OFFENDERS 1969-1970.

JUDGES	TOTAL CASES HEARD	NO. REMANDED[a]	NORMAL	MENTAL DISORDER	PSYCHOPATHY	OTHER PERSONALITY	NO DIAGNOSIS	TREATMENT RECOMMENDATIONS FOLLOWED
A	PROPERTY 65 SEX 29 VIOLENCE 14 OTHER 4 TOTAL 112	2 (3.1%) 5 (17.2%) 2 (14.3%) 1 (25.0%) 10 (8.9%)	2	1	2	4	1	1/1
B	PROPERTY 59 SEX 15 VIOLENCE 18 OTHER 2 TOTAL 94	6 (10.2%) 1 (6.7%) 1 (5.5%) - 8 (8.5%)	1	5	-	2	-	3/3
C	PROPERTY 88 SEX 21 VIOLENCE 12 OTHER 6 TOTAL 127	1 (1.1%) 2 (9.5%) 2 (16.7%) 5 (3.9%)	-	2	1	2	-	1/1
D	PROPERTY 58 SEX 10 VIOLENCE 15 OTHER 3 TOTAL 86	3 (5.2%) 1 (10.0%) - 1 (33.3%) 5 (5.8%)	2	1	1	1	-	2/2
E	PROPERTY 95 SEX 26 VIOLENCE 12 OTHER - TOTAL 133	4 (4.2%) 8 (30.7%) - - 12 (8.3%)	2	4	1	3	1	3/3
TOTALS	552	40 (7.2%)	7	13	5	12	2	10/10

a - The percentage in parenthesis indicates the proportion of offenders remanded by each judge for each type of offence.

TABLE 29: REMAND RATES OF JUDGES AND IMPACT OF TREATMENT RECOMMENDATIONS. MALE OFFENDERS 1974-1975.

JUDGES	TOTAL CASES HEARD	NO. REMANDED[a]	NORMAL	MENTAL DISORDER	PSYCHOPATHY	OTHER PERSONALITY	TREATMENT RECOMMENDATIONS FOLLOWED
A	PROPERTY 54 SEX 21 VIOLENCE 12 OTHER 6 TOTAL 93	1 (1.9%) 4 (19.9%) - - 5 (5.4%)	1	1	2	1	1/1
B	PROPERTY 79 SEX 24 VIOLENCE 24 OTHER 7 TOTAL 134	2 (2.6%) - 3 (12.8%) - 5 (3.7%)	2	1	1	1	-
C	PROPERTY 70 SEX 19 VIOLENCE 16 OTHER 10 TOTAL 115	4 (5.8%) 5 (26.8%) 2 (12.8%) - 11 (9.6%)	5	3	2	1	3/4
D	PROPERTY 71 SEX 22 VIOLENCE 32 OTHER 14 TOTAL 139	9 (12.9%) 6 (27.8%) 7 (21.9%) - 22 (15.8%)	4	7	8	3	5/8
E	PROPERTY 87 SEX 19 VIOLENCE 39 OTHER 9 TOTAL 154	5 (5.8%) 7 (36.8%) 2 (5.2%) - 14 (9.0%)	-	9	4	1	7/9
TOTALS	635	57 (9.0%)	12	21	17	7	16/22

a - The percentage in parenthesis indicates the proportion of offenders remanded by each judge for each type of offence.

(iii) Judges

The numbers of offenders in Tables 28 and 29 are too small to enable clear comparison between the judges. Nevertheless some obvious facts emerge from the data. First, as is true of the magistrates, all judges remand some offenders for psychiatric reports. Of the three Judges A, B and C who are represented in both Tables 28 and 29, Judges A and C remanded a marginally greater proportion of offenders in 1974-1975, but Judge B remanded a smaller proportion. Judge D, a new appointment, remanded significantly more than Judge B,[(78)] and it is his presence which accounts for the overall increase in proportion of offenders remanded in 1974-1975.

Although the numbers are small, an analysis of the type of offence committed by the offenders remanded by each judge tends to reinforce the view that the type of offence is significantly related to the decision to remand. Most judges remanded a greater proportion of sexual offenders than other offenders, and fewer property offenders than any other category. Judge E, who retired before 1974, remanded a high proportion of property offenders in 1969-1970, which indicates some difference in his attitudes in relation to the remand of offenders for psychiatric reports.

Tables 28 and 29 show nothing noteworthy in the numbers of offenders in diagnostic groups, nor in the reaction of individual judges to psychiatric reports. Judge D, who remanded 15.8% of offenders in 1974-1975, did not remand the highest proportion of normal offenders, nor the smallest proportion of offenders who received treatment recommendations.

(78) $\chi^2 = 8.2$, *d.f.* $= 1$, $.01 > p > .001$.

The decision to remand an offender for a psychiatric report is a matter of judicial discretion uninstructed by guidelines or the results of empirical research. A personal element is inevitable. Whether a recommendation in a report is followed is again and necessarily a matter for the presiding judge or magistrate. Both decisions are likely to be affected by differences in penal philosophy, attitudes and the magistrate's or judge's perception of the legal and social constraints upon his behaviour, as well as his cognitive complexity. In particular the degree to which magistrates and judges are influenced by presentence information depends upon the amount of confidence in the communicator of it. Some differences between remand rates and an individual judge or magistrate's reaction to reports are bound to exist, and are to some extent unavoidable in the present circumstances. It is pleasing that this research study indicates that the differences in Hobart magistrates' courts and in the Supreme Court are not enormous. All magistrates and judges rely upon the expert help a psychiatrist can offer. The results of this study indicate that no judge or magistrate makes too much use of reports nor follows recommendations blindly.

Hogarth's (1971) findings that length of experience on the bench tends to be associated with a greater likelihood to attach some value to psychiatry, and that heavy workloads are likely to restrict the use of psychiatric reports and to create negative attitudes towards psychiatrists, are not supported by this study.

(9) FOLLOW-UP. PSYCHIATRIC HISTORY AND AFTER-CONDUCT OF OFFENDERS

(i) Psychiatric Treatment of Hospital Order and Transfer Direction Offenders and Probationers Subject to Psychiatric Treatment

TABLE 30: HOSPITAL ORDERS: DAYS IN HOSPITAL AND DURATION OF LIABILITY TO BE COMPULSORILY DETAINED.

DURATION OF HOSPTIAL ORDER	COURT OF PETTY SESSIONS				SUPREME COURT		
	MALES		FEMALES		MALES		FEMALES
	1969-70*	1974-75	1969-70	1974-75	1969-70	1974-75	1969
DAYS IN HOSPITAL	277	47	99	365	318	2 yrs.	393
LIABLE TO BE DETAINED	18 months	3 months	Died in hosp.	365	365	Still in hosp.	19 months
DAYS IN HOSPITAL	232		365		346	393	
LIABLE TO BE DETAINED	365		365		18 mths.	19 months	
DAYS IN HOSPITAL	291		347		629	273	
LIABLE TO BE DETAINED	365		347		Died in hospital	273	
DAYS IN HOSPITAL	41		57		365	2 yrs.	
LIABLE TO BE DETAINED	5 months, died on leave		9 months		365	Still in hosp.	
DAYS IN HOSPITAL	16		207			2 yrs. 62 days	
LIABLE TO BE DETAINED	6 months		365			2 yrs.246 days	
DAYS IN HOSPITAL	56		51				
LIABLE TO BE DETAINED	8 months		233				
DAYS IN HOSPITAL	1095						
LIABLE TO BE DETAINED	3 yrs. 4 mths.						

* Information for one male in this period was unavailable.

Table 30 shows the time actually spent in hospital by those offenders who were made subject to a hospital order. It also shows the time they were in hospital and on leave but liable to be detained pursuant to a hospital order or a renewal of such an order under Section 32 of the Mental Health Act.

The average stay for the 1969-1970 group of males and females was 241 days. Of the nineteen hospital order patients thirteen remained liable to be detained for the full 12 months, which is the natural duration of a hospital order.(79) Some patients remained in hospital for longer, but as informal patients who were free to leave at any time, so such periods were not taken into account. Authority to detain a patient was extended under section 32 of the Act in the case of five patients in the 1969-1970 group.

Conceding that entirely different considerations apply to determine the length of gaol sentences and hospital orders, it is nevertheless interesting that the average length of sentence for those in the 1969-1970 Supreme Court group of males who received a prison sentence was 22.9 months and 6.9 months for the court of petty sessions group for the same period.(80)

TABLE 31

TRANSFER DIRECTIONS: DAYS IN HOSPITAL AND LENGTH OF SENTENCE (MALES ONLY)

	COURT OF PETTY SESSIONS		SUPREME COURT	
	1969-70[a]	1974-75	1969-70[b]	1974-75
DAYS IN HOSPITAL	203	201	378	172
LENGTH OF SENTENCE	11 months	$2\frac{1}{2}$ years	18 months	6 years
DAYS IN HOSPITAL	763	156		117
LENGTH OF SENTENCE	18 months	18 months		9 months
DAYS IN HOSPITAL		333		
LENGTH OF SENTENCE		9 months		
DAYS IN HOSPITAL		203		
LENGTH OF SENTENCE		11 months		
DAYS IN HOSPITAL		50		
LENGTH OF SENTENCE		3 months		

a in this period one offender was not transferred to hospital despite the magistrate's recommendation.
b the information for one male in this period was unavailable.

(79) Mental Health Act, 1963 section 32.
(80) The average length of sentence dropped in the 1974-1975 period to 18.1 months for the Supreme Court group, but rose to 7.4 months for the court of petty sessions group.

Table 31 shows the time spent in hospital and the length of gaol sentence of those offenders who were transferred from gaol to hospital pursuant to a transfer direction. The average time spent in hospital for these patients for both periods was 258 days. Table 31 also shows that in two cases the time spent compulsorily detained in hospital was longer than the prison sentence.

Unfortunately the psychiatrist's prognosis on discharge of a patient was not recorded on the hospital files of the 1969-1970 group of patients who received treatment at the Royal Derwent Hospital.

In many of the cases in which psychiatric treatment was made a condition of probation, the court gave the probation officer or psychiatrist a discretion as to whether or not the offender should be required to submit to treatment. The Mental Health Service's psychiatric records of each probationer subject to a psychiatric treatment condition in 1969-1970 were examined to determine if in fact they were required to have treatment. In the case of the sample from the magistrates' courts only 11 or 39% were recorded as actually having received treatment. The treatment received varied between one and a dozen out-patient attendances, and five offenders received in-patient treatment during the period of probation.

Only three Supreme Court offenders in the 1969-1970 sample were required to submit to psychiatric treatment as a condition of probation and no record could be discovered of these conditions having been enforced.

(ii) Subsequent Psychiatric Treatment

TABLE 32

SUBSEQUENT TREATMENT OF TREATED AND NON-TREATED OFFENDERS 1969-1970

	SUBSEQUENT TREATMENT	NONE	TOTAL
MALES:			
TREATED OFFENDERS			
COURT OF PETTY SESSIONS	10	13	23
SUPREME COURT	3	3	6
TOTAL:	13 (44.8%)	16 (55.2%)	29
NON-TREATED OFFENDERS			
COURT OF PETTY SESSIONS	25	105	130
SUPREME COURT	3	31	34
TOTAL:	28 (17.1%)	136 (82.9%)	164
FEMALES:			
TREATED OFFENDERS			
COURT OF PETTY SESSIONS	2 (33%)	4 (66%)	6
NON-TREATED OFFENDERS			
COURT OF PETTY SESSIONS	2 (8.3%)	22 (91.7%)	24
TOTAL:	4 (13.3%)	26 (86.7%)	30

Table 32 shows those offenders who received psychiatric treatment in the five years following the report requested in 1969-1970, or in the case of those offenders who were required to submit to treatment (treated offenders) in the five years following the termination of that treatment. The large proportion of treated offenders who subsequently received treatment reflects the well known fact that many former psychiatric patients subsequently require readmission to hospital, or further treatment. The proportion of non-treated offenders who subsequently received treatment is higher than one would expect in an unselected group of offenders.

(iii) Reconvictions

TABLE 33

RECONVICTIONS OF TREATED AND NON-TREATED OFFENDERS, 1969-1970

	NO RECONVICTIONS	RECONVICTIONS	TOTAL
MALES:			
TREATED OFFENDERS			
COURT OF PETTY SESSIONS	11 (47.8%)	12 (52.1%)	23
SUPREME COURT	-	4 (100%)	4
TOTAL:	11 (40.7%)	16 (59.2%)	27
NON-TREATED OFFENDERS			
COURT OF PETTY SESSIONS	51 (64.5%)	79 (60.8%)	130
SUPREME COURT	11 (40.7%)	16 (59.2%)	27
TOTAL:	62 (39.4%)	95 (60.5%)	157
TOTAL TREATED AND NON-TREATED	73	111	184

TABLE 34

RECONVICTIONS OF TREATED AND NON-TREATED OFFENDERS
(COURT OF PETTY SESSIONS ONLY)

	NO RECONVICTIONS	RECONVICTIONS	TOTAL
FEMALES:			
TREATED OFFENDERS	1 (16.6%)	5 (83.3%)	6
NON-TREATED OFFENDERS	15 (62.5%)	9 (37.5%)	24
TOTAL:	16 (53.3%)	14 (46.6%)	30

The police records of those offenders who received treatment, and those who did not are compared in tables 33 and 34.

The shortcomings of reliance upon reconviction rates as an indicator of the success of sentencing options are conceded. They are obvious and well known. The offender may have benefited from his treatment and become more responsible, mature and socially adjusted and yet commit a further offence. Conversely the offender may avoid further court convictions and yet deteriorate in other respects. This difficulty is even more apparent in assessing the success of psychiatric treatment by looking at reconviction rates. An offender may respond well to psychiatric treatment and yet re-offend. This could frequently occur in cases where there is no relationship between the mental disorder and the criminal behaviour.

For this study no other means of evaluation was feasible. A four year follow up period was used, that is four years from the end of the prison sentence, period of in-patient hospital treatment, or probationary period. It was necessary to omit nine offenders from the Supreme Court group because they were not at risk for the requisite four year period, either because they were in hospital or gaol for a long time.

Tables 33 and 34 show those treated and non treated offenders who were convicted of further offences and those who were not. The proportion of males in each group who were reconvicted is strikingly similar, and for female offenders the reconviction rate of the treated offenders was far worse than the non-treated offenders.

(iv) Prognoses

As mentioned earlier[82] a prognosis in terms of recidivism was made in only a very few cases, about 13% of the 1969-1970 remanded offender

(82) Ante., p. 68.

sample. In 19 of 28, or 68% of cases, the prognosis was correct over the four year follow-up period. That psychiatrists are unreliable in their predictions of future behaviour has considerable empirical support. In particular, the evidence that in predicting dangerous behaviour they are more often wrong than right is overwhelming; it seems they always err by overpredicting (Diamond, 1974; Ennis, 1972; Morris, 1968; and Price, 1970).

(v) Other Follow-up Studies

Although the number of treated offenders followed up was small, the implications of my findings provide support for the assertion of Rollin (1969), that there is a 'revolving door' phenomenon between psychiatric hospitals and prisons and that psychiatric treatment and particularly in-patient treatment does not prevent criminality. Rollin found that within a short two year follow-up of convicted mentally abnormal offenders who received treatment, 61% were re-admitted to hospital, were discovered to have committed further offences or both. He relied upon this result and other similar findings as indices of the failure of psychiatric treatment of abnormal offenders. He said, "It is my opinion that the tools of psychiatry are blunt and primitive and in fact are largely ineffectual when used upon the general body of abnormal offenders we are called upon to treat" (p.121).

The follow-up of the Oxford survey of offender patients showed similarly discouraging results. Of those offenders who were discharged within the first year of the making of the hospital order 40% re-offended, 46% were known to have been admitted to hospitals and only 39% avoided both reconviction and rehospitalization (Walker & McCabe, 1973).

Unsatisfactory results have also emerged from follow-up studies of psychiatric probation order patients in Britain. Grünhut (1963) reported

the outcome of treatment in a sample of 636 cases from England and Wales in 1953. Although 70 % were described on termination of treatment as "condition improved" or "some benefit", 28.4% of all offenders were re-convicted within one year of the termination of the probation order, and almost 20% of those who received benefit or improved re-offended within one year. Grünhut deduced that the outcome of probation for section 4 offenders does not differ much from the after effects of probation in general.

In a later hospital based survey, Woodside (1971) followed up 52 psychiatric probation order patients one year from the date of their probation order.[83] Only 16 of the 52 patients satisfactorily completed probation, and 33 were unsatisfactory, 17 of whom had again appeared in court. The author suggested that the "unsatisfactory and disquieting situation" revealed that the psychiatric service was not geared to the needs of the offenders treated. She suggested that better facilities for observation would improve selection of offenders for psychiatric probation orders, and closer liaison between medical staff and Probation Department would improve the results.

Despite a paucity of data comparing the outcome of psychiatric treatment with the outcome of penal measures, it is implicit from the results of this survey and the reported English studies, that the treatment of mentally disordered offenders cannot be justified on the basis of comparative effectiveness. Such gloomy results suggest the need for constructive changes in the management and treatment of offender patients. In this context some of the recommendations of Walker and McCabe (1973) arising from their experience with the Oxford survey cohort, are relevant.

(83) All offenders in the study were recommended for treatment at the Royal Edinburgh Hospital during the three years from 1966 to 1968.

In particular, the need in some cases for a procedure for in-patient assessment prior to recommending treatment, the power to refer hospital order patients back to court if found to be unco-operative or unsuitable subjects for treatment, and the importance of after-care of discharged patients, particularly for those in the high risk groups.[84]

(10) SUMMARY AND RECOMMENDATIONS

The major findings which emerged from an analysis of the data for this survey can be quite briefly summarized.

Contrary to the results anticipated no increase was found in the number or proportion of offenders remanded for psychiatric reports by courts of petty sessions in 1974-1975 compared with 1969-1970, and for female offenders the number remanded declined significantly. In the earlier period a significantly greater proportion of females than males were remanded. In the Supreme Court there was an increase in the proportion of offenders remanded, attributable to the existence of a new judge who remanded significantly more offenders than the others. Most petty offenders were seen by the examining psychiatrists on bail, and most Supreme Court offenders were seen in custody.

Both courts remanded significantly more sexual offenders than any other category of male offender, and the data suggested that the courts were more likely to remand offenders with prior convictions than first offenders. Both the objective data from the remand samples and the inverview responses of the judges and magistrates indicated that previous psychiatric history, the requests of probation officers and counsel for psychiatric reports also influenced the decision to remand.

(84) From the data obtained for the survey, Walker and McCabe (1973) devised a simple method of predicting reconvictions and selecting high risk groups of patients for especially intensive efforts (pp.189-193).

The number of offenders with no psychiatric diagnosis was small, and significantly less in the 1974-1975 group of petty offenders. A substantial number of reports in the earlier period made no positive recommendations, but in the 1974-1975 period there were more treatment recommendations and there was a decrease for the petty sessions group in the number of cases in which no recommendations were made. It was found that psychiatrists frequently made explicit recommendations as to punishment contrary to the opinion of some of the experts in forensic psychiatry, who deem it improper.

The courts' decisions showed that for petty offenders at least, treatment was ordered for a substantial proportion of the remand group in 1974-1975, significantly more than in 1969-1970. There was a significant decline in the number of hospital orders made by the courts of petty sessions, but the numbers for the Supreme Court remained the same.

The results of the objective data and interview responses suggested that psychiatric reports have considerable impact upon the courts' decisions, particularly in relation to treatment. The courts appear to follow treatment recommendations in about 75% of cases and sentencing recommendations in about 64% of cases. The evidence from the questionnaire responses and the recommendations made and acted upon shows that the role of the psychiatrist is not merely to detect and treat mentally ill offenders, but extends to the assessment and explanation of selected offenders' behaviour and to advising the court of the best way to deal with them.

Comparisons between individual magistrates and judges revealed a picture of uniformity rather than disparity. There were no significant differences in the remand rates of magistrates within each of the relevant periods, nor in the current offence of the offenders remanded, their mental

health, nor in the response to treatment recommendations. In the Supreme Court only one judge remanded significantly more offenders than the others, and the data suggests that the fact that the current offence was sexual did not influence the decision to remand of another judge.

Of those offenders who were required to submit to treatment in 1969-1970, a large proportion subsequently required further treatment, and the majority re-offended. Prognoses in relation to recidivism were often inaccurate. For petty offenders, hospital orders or transfer directions probably resulted in periods of involuntary incarceration for much longer than they would have been obliged to endure if gaoled. Probationers with a condition as to psychiatric treatment received treatment in only a minority of cases.

It happened that the data collected provided some interesting information about women petty offenders. In the earlier period a high proportion of female offenders were remanded for psychiatric reports but in the second period the number of women petty offenders had increased dramatically and the proportion remanded for psychiatric reports declined significantly.

These findings and their implications are of importance to those who wish to study all aspects of the sentencing process and particularly those who seek to justify psychiatric intervention in the criminal process on the basis of effectiveness and humanity and those who would oust psychiatry from the criminal process on the grounds that it is fraught with insuperable difficulties and terrible dangers to the liberty of the individual.

There are findings from this study which support both the zealots and the sceptics. The sceptics could argue that there is evidence that

diagnostic criteria and the perception of mental health of offenders generally differed between psychiatrists so that persons remanded for psychiatric examinations by some psychiatrists stand little chance of being found completely normal. The data also suggest that psychiatrists were not very reliable in their predictions of criminal behaviour and that despite often lengthy periods of hospitalization, psychiatric treatment was not very effective in reducing recidivism. On the other hand, the zealots could argue, with some empirical support, that the decision to remand an offender for a psychiatric report in the courts studied was not a purely haphazard decision and there is substantial uniformity between judges and magistrates in their use of psychiatric reports. The principle that like cases should be treated alike is in this context more than just an empty platitude.(85) Moreover there is evidence that the courts did not rely too much upon recommendations contained in reports, and the general supposition that the use of psychiatric reports is increasing rapidly is not supported by the evidence, although a greater proportion of offenders are receiving treatment.

It is respectfully suggested that to dispense with psychiatric reports and treatment of offenders is too radical, melodramatic and inadvisable. Nevertheless the warnings of the sceptics and critics of psychiatric involvement in the criminal process should be heeded. Psychiatric power should be limited to prevent abuses and to protect offenders from excessive rehabilitation. The issues in relation to the treatment of offenders, its justification and the rights of the offender and the community are difficult to resolve, and this study does not attempt to evaluate either psychiatric reports or treatment. Unfortunately it was not possible to isolate the factors which make a report useful, nor to determine the type of report which would be best in the interests of

(85) This would appear to differ from the situation in Canada as revealed by a survey of recent Canadian decisions (Schiffer, 1976).

criminal justice. Even so, the empirical evidence collected and analysed and the observation and study of the legal and administrative provisions which regulate the use of psychiatric reports have revealed certain deficiencies. The following recommendations, some of which require implementation by legislation and others by changes in administrative practice, are measures which could help to alleviate these deficiencies.

(i) There should be a specific statutory power in Tasmania to remand an offender for a psychiatric examination for the purposes of a presentence report. The matter of disclosure of the report to the offender or his counsel and the right to call evidence in rebuttal should be embodied in a uniform provision applicable to both the courts of petty sessions and the Supreme Court, replacing the existing provisions in the Criminal Code and the Mental Health Act.

(ii) The power to order in-patient or out-patient psychiatric treatment as a condition of probation should be embodied in a specific statutory provision. That this is necessary is indicated by the evidence that courts impose such conditions without recommendations and even, it appears, without requesting reports. Whether or not to refer an offender under such an order should not be left to the discretion of the probation officer. Such a power should be contingent upon the following matters:-

(a) a request to a psychiatrist for a report based upon an examination of the offender, with reasons for the request and copies or a summary of relevant material relating to the offender and the offence.

(b) a report recommending treatment.

(c) the offender's consent to treatment.

Hospital orders are clearly inappropriate for many of the cases where in-patient treatment could fulfil a rehabilitative function. They were designed to deal with the acutely disturbed offender who lacks insight and often denies he needs treatment. Many disorders require co-operation rather than compulsion, and can be treated by techniques and drugs which were not freely available when the hospital order was devised. In many cases offenders requiring psychiatric treatment can be adequately treated as out-patients or day-patients.

(iii) Enlarging upon (a) above, whenever a psychiatric report is ordered, the psychiatrist should be made aware of the reasons for requesting it and the issues he is required to discuss. He should also be supplied with as much of the relevant information about the offender and the offence as is possible.

There is precedent in other jurisdictions for such practices. In the United Kingdom, courts are required by statutory rules to make available all the relevant reasons prompting a request for a presentence psychiatric report.[86] Courts are also required to supply certain information to the examining doctor, including previously known medical history, prior convictions, circumstances of the offence and home circumstances.[87]

An alternative way of ensuring dialogue between the reporting psychiatrist and the judge has been developed in the juvenile courts in South Australia. Extempore remarks are made by the judge in court concerning the reasons for referral and directing the psychiatrist's attention to the relevant issues. These are recorded, typed and sent to the psychiatrist. Upon receipt of the report there may be a further

(86) Magistrates Courts Rules 1968, rule 23.
(87) See the form produced in Appendix D.

request for a supplementary report to elucidate certain matters and comment upon others. There is some judicial support in favour of extending this system to the adult courts in South Australia.[88]

The need to inform the examining psychiatrist of the reasons for requesting a psychiatric report, and to set out any specific questions to be answered, has been expressed by two eminent forensic psychiatrists Bartholomew (1962) and Lucas (1972). However, despite the apparent advantages of allowing the psychiatrist to direct his examination and report to the issues defined by the court, it has little judicial support. Only one each of the judges and magistrates responding to the questionnaire were in favour of communicating their reasons to the psychiatrist concerned.[89]

(iv) There are no general guidelines as to the scope of psychiatric examinations, or as to the contents of reports. Vagueness as to what is an adequate examination could contribute to some of the scepticism which surrounds psychiatric opinion in legal cases. An agreed outline should be prepared and circulated among psychiatrists covering observational and historical aspects of routine evaluations for psychiatric reports. Similarly, if agreement could be reached as to what matters a report should contain, reports would be easier to prepare and be more satisfactory for the bench. The responses to the questionnaire relating to content of reports show that most judges and magistrates are in agreement about the issues they like to see covered by presentence psychiatric reports.[90]

(v) The Courts should keep records of psychiatric reports requested. Quite apart from facilitating research, this would certainly

(88) This system was described by Wilson J. in an unpublished paper delivered in 1974, 'The Courts and Mental Health Services'.
(89) Questionnaire, question 7.
(90) See Appendix B.

expedite matters in those cases where the magistrate or judge would be satisfied with an existing and recent report.

(vi) There should be a legislative power, subject to adequate safeguards, enabling judges and magistrates to remand certain offenders to a psychiatric hospital for observation. In some cases at least, extensive interviewing and investigations, as well as in-patient observation would be useful. Some experts say that four to six hours of intensive psychiatric interviewing are necessary before the dynamics of an individual offender can begin to be understood (Smith, 1971). At least it can be said with certainty that the opportunities that are available for a comprehensive diagnostic study of an offender while on bail or on remand in prison are inadequate in some cases. This problem, and others associated with keeping offenders in mental hospitals will be overcome to some degree when the new forensic psychiatric unit at Risdon gaol is completed. Even so, there may be cases in which the use of prison facilities would be undesirable.

(vii) Magistrates and Judges should be informed of treatment details. Information about the length and type of treatment and its results would increase their understanding of the psychiatric treatment available, and be invaluable as giving indicators of the type of offenders who respond to specific rehabilitation programmes. An example of the type of misunderstanding which can arise is illustrated by the following comments of a magistrate reported in a daily newspaper.

> "What is the good of sending people to the John Edis Hospital when all they do is sit in a group and say I have been a naughty boy?" asks the Magistrate Mr. D.A. Burton, in the Hobart Court.
>
> He had just been told a man ordered to undergo treatment at the hospital had received only group therapy.
>
> The man was before him charged with exceeding .08 and driving while disqualified for a similar offence.

> William Harvey Evans (33), of Deloraine, pleaded guilty to three charges involving driving an unregistered car with a blood alcohol reading of .19 on November 11 last year while disqualified.
>
> The Court was told Evans had been responding to treatment he was receiving at the John Edis Hospital following the previous offence.
>
> However, when told the treatment had taken the form of group therapy, Mr. Burton said he was very surprised.
>
> Questioning an officer from the hospital about Evans, Mr. Burton was told he had not received any form of aversion therapy.
>
> "I am surprised alcoholics are not being given drug treatment", he said. "No wonder we are not getting results". (Mercury, March 5, 1976).

(viii) Close co-operation between probation officer and the psychiatric services should improve the management of psychiatric probation order patients. The Mental Health Services forensic psychiatry section should be informed by the court of offenders with psychiatric probation orders and liaison with the probation service should be established immediately. The follow up of such patients in this study, although on a very small scale, would seem to reinforce findings reached elsewhere of psychiatric probation order patients receiving no treatment at all or not persisting with treatment and fading away unnoticed from out-patient treatment or being discharged without the responsible probation officer receiving any notification. If breaches of probation have been committed by non-attendance or absconding, it is important that the probation officer be advised.

(ix) The hospital or psychiatrist in charge of the treatment of hospital order patients should be able to refer patients back to court if unco-operative or unsuitable for treatment. This recommendation is one made by Walker and McCabe (1973). The present study indicates that magistrates are dissatisfied with hospital orders in their present form, and this recommendation may remove some of their fears of premature discharge particularly in the case of offenders whose response to treatment is not certain.

APPENDIX A

QUESTIONNAIRE

THE USE OF PRE-SENTENCE PSYCHIATRIC REPORTS

1.	In deciding who to remand for a psychiatric report prior to sentencing what factors do you consider in order of importance?	1. (i) (ii) (iii) (iv) (v)
2.	If the defendant has previously received psychiatric treatment do you order a report?	2. Always ..... Usually ..... Sometimes ..... Rarely.....
3.	If the offence is of a sexual nature do you order a report?	3. Always ..... Usually ..... Sometimes ..... Rarely .....
4.	If defendant's counsel requests a psychiatric report, do you order a report?	4. Always ..... Usually..... Sometimes ..... Rarely .....
5.	If the probation officer suggests a report is necessary do you order a report?	5. Always ..... Usually ..... Sometimes ..... Rarely .....
6.	Do you communicate your reasons for referral to the examining psychiatrist?	6. Always ..... Usually ..... Sometimes ..... Rarely .....
7.	Do you think your reasons for referral should be communicated to the examining psychiatrist?	7. Yes ..... No .....
8.	Do you find the quality and form of psychiatric reports, as between psychiatrists, varies?	8. Frequently ..... Sometimes ..... Rarely .....
9.	Do you find the quality of the reports prepared by an individual psychiatrist varies?	9. Frequently ..... Sometimes ..... Rarely .....
10.	Do you object to psychiatrists making recommendations as to sentencing matters other than psychiatric treatment?	10. Yes ..... No .....

11. Do you find the recommendations in psychiatric reports helpful -

(a) in determining whether treatment should be ordered? — 11a
Always .....
Usually .....
Sometimes .....
Rarely .....

(b) in determining an appropriate sentence (other than psychiatric treatment)? — 11b
Always .....
Usually .....
Sometimes .....
Rarely .....

12. Do psychiatrists' recommendations influence your decisions (i.e. cause you to reach a different decision than was first contemplated):

(a) recommendations as to treatment? — 12a
Always .....
Usually .....
Sometimes .....
Rarely .....

(b) recommendations as to sentence? — 12b
Always .....
Usually .....
Sometimes .....
Rarely .....

13. Do you rely on the psychiatrist's assessment of the possibility of recidivism? — 13.
Always .....
Usually .....
Sometimes .....
Rarely .....

14. Do you like the psychiatrist to make a classical diagnosis if possible -

(a) with explanation? — 14a
Yes .....
No .....

(b) without explanation? — 14b
Yes .....
No .....

15. Do you like the report to contain an intelligence assessment? — 15.
Psychometric .....
Estimate .....
Unnecessary .....

16. Do you like the report to contain a social history of the defendant/accused? — 16.
Full .....
Brief .....
Minimal .....

17. Do you like the psychiatrist to state whether he believes there to be a direct relationship between the mental condition of the offender and the offence? — 17.
Yes .....
No .....

18. If treatment is recommended, do you like details as to -

(a) type of treatment? — 18a
Yes .....
No .....

18.	(b) estimated length?	18b	Yes ..... No .....
19.	Do you expect the psychiatrist to make, if possible, a prognosis -		
	(a) in terms of recidivism?	19a	Yes ..... No .....
	(b) in terms of success of treatment?	19b	Yes ..... No .....
	(c) in terms of dangerousness?	19c	Yes ..... No .....
20.	Do you like a report to specify any of the following sources of information, which may have been used in the preparation of the report -		
	(a) length and number of interviews?	20a	Yes ..... No .....
	(b) psychometric testing?	20b	Yes ..... No .....
	(c) mental health visitor's report?	20c	Yes ..... No .....
	(d) prior psychiatric reports and records?	20d	Yes ..... No .....
	(e) pre-sentence report?	20e	Yes ..... No .....
	(f) police file?	20f	Yes ..... No .....
	(g) other?	20g	Yes ..... No .....
21.	What form of report do you favour -		
	(a) structured report?	21a	Yes..... No .....
	(b) narrative report?	21b	Yes ..... No .....
22.	Do reports contain terminology which is outside your knowledge?	22.	Frequently ..... Sometimes ..... Rarely .....
23.	Do you make the report available to the defendant/accused or his counsel?	23.	Always ..... Usually ..... Sometimes ..... Rarely .....

24.	Are you more likely to request a psychiatric report on a female that a male?	24. Yes ..... No .....
25.	Do you think hospital orders are a satisfactory means of dealing with mentally disordered offenders?	25. Yes ..... No .....

APPENDIX B

1. TECHNIQUE IN REPORT WRITING

In one of the most comprehensive discussions of the technique which should be used in writing psychiatric reports for courts, Peter D. Scott (1953) made the following suggestions and comments. Language, he said, should be simple and technicalities avoided. Indefinite words such as 'unstable' or 'immature' which mean little or nothing should be avoided. Some highly charged words and intimate details should be avoided especially if the report is to be read in open court.

The source of information, the names of the people interviewed, and the length of the interview with the offender should be stated in the report.

Facts should be separated from opinion and inferences. There is a tendency for laymen to overemphasize the importance of the intelligence quotient which sometimes does not reflect real ability because of mood, hostile negativism or lack of confidence. In cases of any doubt, I.Q. is better omitted or qualified with a brief assessment of its reliability. The type of intelligence test used should be mentioned, so that an alternative test can be used later if necessary.

Scott was firmly of the opinion that diagnosis is an unimportant part of the court report.

Unless the diagnosis has also a legal definition (e.g. mental deficiency) it is usually better to omit it. For instance, the diagnosis of epilepsy does not of itself imply anything definite as to responsibility or disposal, and more or less publicly affixes a

label which it may be difficult to detach. It may be in this sense that Mullins (1944d) quotes the advice said to have been given to a newly appointed judge by a colleague of much experience: 'Never give your reasons. Your decisions will probably be right. Your reasons will probably be wrong.' In general the diagnosis should be reserved for the case notes and for the letter which accompanies a patient to hospital or clinic. A further point is that if the diagnosis becomes familiar to the offender, it may be a source of anxiety to him or may provide him with an attractive and useful shibboleth. Lastly, even in those cases selected for psychiatric report a classical diagnosis cannot be made in more than 20 per cent. In the other 80 per cent it is impossible to attach a label any more accurate than 'personality disorder' or 'social mal-adjustment'. Such omnibus terms would not stand up well to cross-examination. Yet this 80 per cent is likely to respond to treatment as well as, or better than, those with a classical psychiatric diagnosis. There is the risk, especially where a given court does not often use psychiatric services, that the magistrate may begin to base his decisions on the diagnosis rather than on the recommendation; further, certain diagnoses may come to be regarded as demanding admission to hospital, which might be undesirable. The cut and dried diagnosis is very popular, and lay people look for it and value it altogether more than they should, just as they tend to do with the I.Q. There is too great a tendency, having heard the diagnosis,to pigeon-hole a case in accordance with the classical treatment of the disease rather than in accordance with the needs of the individual. Conversely there is the danger that those to whom a simple or classical diagnosis cannot be attached may be presumed beyond the need or reach of help (p.93).

Scott said reports should include a prognosis because courts want to know if the disorder or abnormal behaviour can be cured, and if so, how long this will take. As to recommendations he said -

> The recommendation should appear to follow logically upon the preceding part of the report. In framing it one should consider first and foremost the best interests of the offender but also try to visualize what particular problems this case offers to the bench. Why did the magistrate decide to refer it for psychiatric opinion? What probable alternative disposals might already have been in his mind? Did the offender's looks or demeanour at his original court appearance suggest that he was perhaps mentally unbalanced or defective? Should he be in hospital rather than in prison? Is there any good reason why he should not be 'sent down' for six months? Will punishment make him better or worse?

Scott thought it inadvisable to recommend psychiatric treatment unless there is a reasonable chance of it being successful. This is certainly sensible; a contrary approach would soon lead to a disinclination by sentencers to follow treatment recommendations. But as to the form recommendations should take Scott appeared to favour subtle suggestion rather than firm recommendation. He felt it is sometimes better to say that certain treatment may be helpful, rather than it is recommended or advised, because some magistrates and judges are opposed to explicit recommendations. Positive recommendations for punishment should not be made, for this is a matter for the magistrate. But he thought the probable effects of punishment can properly be mentioned. He said ideal recommendations, if realistic and well founded, could and should be included and can be qualified by a more practical recommendation.

As to the actual plan of the report, Scott approved of Sir Norwood East's advice given in 1927 -

> Each medical man will draw up such report in his own way, but it should be as precise, concise and accurate as possible. My own practice was to subdivide it under five heads. A short preamble gave the general steps adopted to arrive at an opinion, stated when the accused first came under observation, the number of interviews held with him, and from whom information concerning him had been received. Then followed the family history relevant to mental disease, also stating from whom the information had been obtained. The personal history came next, and any corroboration of material points was noted. Then an account was given of the physical and mental condition of the accused, the progress of the case, and the indications of insanity or mental deficiency, if present.

'And', added Scott, 'finally the opinion'. (pp.96-97). In summary he concluded

> The psychiatrist's report to the court should be clearly understandable, accurate, logical, modest, and appearing to be made by a physician and therefore by one who is impartial and genuinely concerned with the welfare of the offender. (p.97).

An eminent forensic psychiatrist in Australia, Bartholomew (1962) has also contributed his opinions on what psychiatric reports should contain.

He suggests that reports should be prepared in the "multifactorial manner" with a dynamic or multifactorial diagnosis. Diagnostic labels can be included, but do not constitute an end in themselves. Bartholomew clearly indicates a preference for the multiple factor theory approach to crime which recognizes that no one 'cause' is sufficient to explain behaviour but that it arises from a multiplicity or variety of usually interacting influences. He accepts that this approach replaced the typological or biotypological school which accepted one casual factor that was responsible for all or the majority of criminal conduct. So reports should not contain phrases such as 'This man is an epileptic' or, 'This man is a psychopathic personality' set out as representing an analysis and understanding of the particular piece of behaviour that is the subject of the conviction. But this approach, Bartholomew said, with its simplicity of presenteation has the support of many courts. He cites medical and legal authorities in support of dynamic diagnosis, including the American case of Carter v. U.S. 252 F.2d 608, where the court stated:

> Unexplained medical labels - schizophrenia, paranoia, psychosis, neurosis, psychopathy - are not enough. Description and explanation of the origin, development, and manifestations of the alleged disease are the chief functions of the expert witness. The chief value of an expert's testimony in this field, as in all other fields, rests upon the material from which his opinion is

> fashioned and the reasoning by which he progresses from his material to his conclusions; in the explanation of the disease and its dynamics, that is how it occurred, developed, and affected the mental and emotional processes of the defendant; it does not lie in his mere expression of conclusion. The ultimate inference vel non of relationship, of cause and effect, are for the triers of the facts.

Bartholomew is of the opinion that clear recommendations as to the disposal of the prisoner should be made in all possible cases. He questions Scott's statement that the psychiatrist should not make recommendations for punishment in the following words -

> This is a statement that is a little difficult to interpret as it is not clear what is meant by the word 'punishment' but it would seem that it should be construed as being synonymous with imprisonment, or, at any rate, with measures that are penal rather than rehabilitative. The personnel connected with the penal aspects of criminology are all concerned with the modification of behaviour and it would seem that behaviour and its study is [sic] within the province of the psychiatrist. An order under section 4, Criminal Justice Act 1948, a conditional discharge or a period of imprisonment are all sanctions imposed by the court aimed at influencing future behaviour. Thus there would seem to be no good reason for the psychiatrist feeling permitted to recommend probation with, maybe, various conditions, but not permitted to recommend a period of imprisonment, perhaps with the opportunity of receiving psychiatric treatment. It is sometimes stated that for the psychiatrist to recommend imprisonment is to arrogate the functions of the court to himself.

> This is not so as at any time he is voicing an opinion - often one of many for the information of the Bench. Again, it is said that it is not a suitable task for a doctor to be involved in recommending 'punishment'. This is equally foolish; many psychiatrists, and other doctors, advise parents in bringing up children and recommend in certain cases a punitive regime at appropriate times. Finally, it must be realised that imprisonment is not simply what is left over when all other sanctions have been tried and found to fail or have been rejected in the first place. Imprisonment can be therapeutic and rehabilitative in a number of cases, particularly when the cases are carefully selected and properly classified. (pp.24-25).

All recommendations, Bartholomew said, should be explicit despite suggestions which have been made to the contrary. Implicit recommendations can be confusing and may be misinterpreted by the court.

An American forensic psychiatrist, Danto (1973) in an article entitled 'Writing Psychiatric Reports for the Court', gives concrete examples of how to write reports in a manner helpful to attorneys and the court. He gives two illustrations of effective reporting of psychiatric evaluations -

> The following is section of a report on a drug addicted 19 year old man who robbed a cleaning establishment by walking in with his hand in his coat pocket, simulating that he had a gun.
> 'Diagnostically, he is a sociopathic personality. He is both antisocial as well as drug-addicted. Although his condition is moderately severe, his prognosis is better than his history might

indicate. I feel that he is a candidate for out-patient therapy, both individual and group. He needs to relate to a male therapist to achieve a reasonable male image with whom to identify. The therapist must assist him in dealing with his depression and self-doubts. Group therapy would offer him peer support to control his addiction as well as a 'collective conscience' to control his antisocial acting out and his general impulsiveness. A methadone programme for withdrawal from heroin as well as comfortable maintenance, will provide physical relief and make it unnecessary for him to commit crimes in order to satisfy his heroin habit. Placement at a Synanon House programme would provide contact with other controlled persons who have and are trying to 'make it', giving him appropriate social contacts. I do not feel that he poses a danger to the community but he does constitute a suicidal risk and he needs intensive psychiatric and social rehabilitative assistance, and therefore he should be placed into a highly supervised and structured probation setting such as I have outlined.'

The psychiatrist can point out to the court constructive and beneficial alternatives to imprisonment and so make it aware of the therapeutic possibilities open to courts in making a disposition, outlining specific goals and concrete plans by means of which these goals might be realised.

The responsible psychiatrist, however, must also honestly appraise those defendants whose histories and behavior show them to be dangerous to the community. The following is from a report on a 16 year old boy who tied a girl to a tree, raped her and left her to die in the woods.

'I would consider his condition to be severe; hence he is dangerous. He weakly indicates how much he feels he committed a wrong deed. Yet he shows no genuine emotion about what he has done. Accompanying poor insight, there is also a significant degree of impaired judgement. For example, he rationalized killing the girl in order to avoid prosecution for rape. Tragically, he presents the profile of a person looking for an accident. There appears to be no organic brain syndrome such as temporal lobe epilepsy. His moves have been calculated and he was aware of each step along the way toward rape and murder. He knew the difference between right and wrong and was not impelled by any overwhelming massive impulse. Prior to the murder he carried a knife, which he had used on a boy in a gang fight. He is possessed of a great fear of women and displays much doubt about his own potency, self-concept and masculinity. To him, being powerful toward women is to force them into submission. Such a perspective is dangerous. His wish to be placed in a Training Unit is unrealistic. He is not motivated for school, but thinks what he tries to say will impress others. There is little indication of self-discipline, nor of being able to work in a responsible manner; he has been consistently rebellious towards authority.

It would appear to me from a psychiatric standpoint, that he should be placed in a well structured setting like a minor security prison, a mental hospital, or a rehabilitation setting. I would feel he needs such outside sources of control before any psychotherapy is attempted. Group therapy would be better than individual psychotherapy since his peers may be able to penetrate more effectively his defensive armour. Prognosis is guarded. I feel that he could kill again. Therefore he should not be placed on probation or for out-patient therapy. He will require an institutional setting for many

years and should be granted freedom only as his ability to accept responsibility for his actions increases.'

The above segment of a report makes clear the possibilities for disposition and the court is made aware of the limits of psychiatric treatment as well as of the poor rehabilitation potential of the defendant.

These reports discuss clearly the prognosis, the rehabilitation Potential of the offender and the therapeutic alternatives. They give reasons for the recommended course of action, with details of the type of treatment which would be offered. This makes it far easier for the courts to evaluate the sentencing alternatives than would a bald statement recommending in-patient or out-patient treatment without reasons or details.

Danto also warns against the inclusion of mystical words and concepts, which instead of impressing the reader may be rejected as 'a bunch of garbage.'

A South Australian judge, His Honour Judge A.B.C. Wilson, at a seminar in April 1974, also used Dr. Danto's illustrations of effective and ineffective reporting and strongly criticised psychiatrists for attempting to be impressive by using incomprehensible psychiatric jargon.

You use words like 'autistic', 'psychotic', 'schizophrenic', 'psychopathic' and 'sociopathic'. No educated man likes to admit that he does not understand words addressed to him by another educated man. I suggest that the judge and jury do not understand many words used in the courtroom by psychiatrists but hesitate to

question you about them lest they seem naive or ignorant (or, as is sometimes the case, lest they receive an equally incomprehensible answer).

You psychiatrists and other behavioural scientists talk in public as if you all agreed about basic principles and about the meaning of your jargon. Of course you don't! I think you ought to discard all of your "obscurantist, pejorative designations".

Another forensic psychiatrist, Gittleson (1972) has reiterated Scott's warning that reports which view the situation entirely from the accused's strivings and wishes are unlikely to be helpful to the court in deciding an appropriate disposal of the problem. The prime duty of the court is to protect society by trying to ensure the offence will not be repeated.

Brancale, the director of the New Jersey State Diagnostic Centre, wrote in 1958,

... clinicians can provide the court with relevant data which may include any or all of the following points:

1. A clinical evaluation of the seriousness of the offense.
2. The psychological matrix from which this offense arose and the underlying psychological significance of the act.
3. The diagnostic category into which the defendant falls.
4. The chronicity of the process, with evidence of repetitive, compulsive element if any.
5. The insight the defendant has obtained into the true nature of his crime, if any, including the amount of guilt, sense of remorse, etc.

6. The motivations and responsiveness he has for a treatment plan, should one be necessary i.e., how plastic is an individual to remedial efforts, both general and specific?
7. The degree of hazard he poses for others in the community; the prospects of a dangerous episode repeating itself.
8. The overall prognosis.
9. Recommendation: a. quarantine (institutionalization);
   b. probation; or
   c. any special ancillary measures which may specifically lessen or remove causal factors toward crime or contribute to reducing stresses which lead to crime, such as referral to Alcoholics Anonymous, medical treatment, or psychotherapy, either individual or group.

Such a rough framework of data should be useful to the court. It may also have some value to the agencies which may be called upon to supervise the defendant, either in the institution or on probation. In preparing such reports for the court, it is quite essential that the psychiatric data be expressed in a simple language and this need not invalidate the scientific findings. Dogmatism should be avoided, and speculation should be clearly described as such. One must guard against the danger of becoming overly exonerative in attitude. It is important for the clinician to avoid injecting his own personal philosophy into his reports. A psychiatrist who happens personally to feel that prisons do harm to a defendant may be reluctant to recommend incarceration. The judge may, consequently, classify this 'expert' as one who would exonerate all offenders. Another psychiatrist, impressed with the psychopathology of a given crime, may too enthusiastically prescribe ambulatory care, without

sufficiently weighing the seriousness of the offense or the threat of recurrence. In short, an adequate clinical report to the court should have the virtues of simplicity, validity, and adaptiveness.

Another American psychiatrist, Roberts (1965), says the psychiatrist should, in addition to a clinical diagnosis in accordance with standard psychiatric nomenclature, formulate a psychodynamic diagnosis. This 'includes a description of the personality factors in the individual which operate in daily living including thoughts and impulses and their attached emotions.' In conclusion the psychiatrist should state his medico-legal opinion. This must be lucid, concise, and contain minimal technical language. Such technical terms as may be used should be fully defined.

Lucas (1972), a consultant forensic psychiatrist working in New South Wales, says a psychiatric report must detail the psychiatrist's contact with the prisoner, his sources of information, and then, in a descriptive section, consider his background, health and so on and relate this where possible to the offence. The psychiatrist should include diagnosis, prognosis and personality assessment and he should make clear recommendations to the court 'in appropriate language'. Dr. Lucas says that this in no way means he is trying to usurp the sentencing functions of the court as at times has been suggested. Clear recommendations indicate what conclusions the psychiatrist has drawn from his examination and suggest what weight he places on psychiatric and therapeutic considerations in the particular case. The court is free to draw on the descriptive section of the report and the general findings and reject the recommendations without implying the whole exercise was a waste of time.

In his influential text, Sentencing as a Human Process John Hogarth (1971) makes some pertinent comments about the quality of presentence information.

> to be of practical value to a court, presentence information should pass four tests: namely, reliability, validity, relevance, and efficiency. Information ought to be reliable in the sense of being reproducible by different people over different periods of time, valid in the sense of representing what it purports to represent, relevant to the objectives of the court and the alternatives available in law, and efficient in the sense of not duplicating the contribution of other information already received. The thought was expressed that if research was conducted as to the quality of information commonly presented to the courts through the medium of pre-sentence and psychiatric reports, a number of profound and terrible truths would be revealed, but the point was not pressed (p.303).

A lot of what has been said in this review of some of the relevant literature is eminently sensible. In particular the reasons for the following points seem convincing.

1. The report should refer to the sources of information used and to the length of interviews so that the court is in a better position to assess the accuracy of the report and the offender can challenge any matter if necessary.

2. Diagnosis, if it is to be included, should not be overemphasized nor stated as if it is an explanation of the criminal behaviour. The origin development and manifestations of the disease should be briefly explained.

3. Prognosis in terms of treatment should be included.

4. Any social history which is relevant to the offence or motivation for treatment should be included.

5. Technical language should be explained.

6. Treatment recommendations should be made only if there is a reasonable chance of success.

7. Recommendations should be clearly and unambiguously stated, including recommendations for imprisonment or other penal measures. This should not be regarded by magistrates and judges as usurping the functions of the court, but as an expert opinion which the court should consider with all the other relevant material. Provided this approach is adopted, and courts do not have unrealistic expectations of psychiatry and retain a healthy scepticism and carefully scrutinize psychiatric opinions, fears of invasion of the judicial province by psychiatry and of the growth of it as a social power should be allayed.

8. An intelligence assessment should be included in the report. If the offender has been recently tested, I.Q. should be stated and it should be further explained by stating whether the offender is mentally defective, of dull normal, average or about average intelligence. If there is any doubt about the accuracy of the test or estimated intelligence, it should be omitted or the doubts mentioned.

Although there is much subjective opinion about desirable techniques in report writing, little is known about what reports should contain. What type of report would help the courts reach the best decision? If we knew the answer to this question psychiatrists could be trained to write such reports and perhaps even judges to use them.

Some things do have empirical support and should be carefully considered in this context. It seems that courts should <u>not</u> know all about the offender. There is considerable research evidence suggesting

that in decision making the capacity of individuals to use information effectively is limited to the use of not more than five or six items of information. Reports which are too long result in an 'information overload' and hinder the effective use of relevant information (Hogarth, 1971, pp.302-303). With regard to diagnosis and prognosis, there is evidence which suggests that a diagnosis is an inaccurate and even a dangerous label, and that psychiatrists' prognoses are frequently inaccurate. As to the helpfulness of psychiatric reports, there is a research study which indicates that those parts of the report said by judges in the study to be most useful did not appear to influence the sentence significantly. (Bohmer, 1976)

2. QUESTIONNAIRE RESPONSE TO QUESTIONS RELATING TO THE CONTENT OF REPORTS

Questionnaire responses relating to the contents of psychiatric reports were obtained to help find out what type of report the courts found most helpful. Of course the subjective responses do not necessarily reflect the actual helpfulness of the report in the sentencing decisions nor do they help determine the type of report which would assist the court to reach the best decision.

A majority of judges and magistrates responding to the questionnaire said they liked the report to specify the number and length of the interviews with the offender (5 Yes, 2 No), and the following sources of information if the psychiatrist had access to them:-

(i) mental health visitor's report (5 Yes, 2 No).

(ii) prior psychiatric reports and records (5 Yes, 2 No).

(iii) presentence report (6 Yes, 1 No).

(iv) police file (5 Yes, 1 No).

(v) other (3 Yes, 2 No).

One judge answered this question by stating that it was ordinarily a matter for the psychiatrist's judgement.

None of those answering the questionnaire wished to see diagnosis omitted from the report, and with one exception they preferred that it be explained. A majority indicated that they like reports to contain an intelligence assessment (6), one third of which specified psychometric testing and the remaining two thirds indicated an estimated assessment was sufficient.

Five respondents stated a brief social history was all that was required; one judge said it was not required because usually he obtains it from the presentence report. Another judge stated that it depended on what counsel and perhaps a probation officer tell him. This is an understandable comment, for an unnecessary repetition of information is to be avoided. It underlines the importance of supplying the psychiatrist with a copy of the probation officer's report in good time, but one wonders how the psychiatrist is to know what counsel will say in mitigation of sentence. The most that could be done is to advise the psychiatrist whether the offender is to be represented or not.

All nine respondents stated that they like the report to contain an opinion, if the psychiatrist is able to form one, as to the relationship between the offence and the mental condition of the offender. Current psychiatric thinking on the causes of criminal behaviour makes this often very difficult.

Eight affirmative responses (with no negative responses) indicated a preference for a prognosis in terms of recidivism, treatment and dangerousness; one judge said he did not expect it but it might be

useful. As to how much they rely upon the psychiatrist's assessment of the possibility of recidivism, one said he always did, three said usually, and four said sometimes. One judge merely said he certainly gave it weight.

If treatment is recommended, it was said with only one exception that reports should specify the type and length of treatment. In reply to question 21, 'Do you object to psychiatrists making recommendations as to sentencing matters other than treatment?', seven answered a simple 'No'; one judge indicated he would object if the recommendation was a firm and direct recommendation; another judge indicated he would also take exception to a clear recommendation, for example, of a gaol sentence. He said,

> The answer to this has to be qualified. It depends on the meaning of "sentencing matters". For example, the psychiatrist may say that he can see no psychiatric reason why the defendant should not be subject to the normal sentencing processes of the law, or he may say that if the defendant is to be imprisoned a period of probation or psychiatric treatment or guidance or the like may be useful after the end of the imprisonment. I imagine such matters are sentencing matters, and I value these indications. They do not trespass on the judicial function and I have not known of a case where a psychiatrist has made any recommendation which I thought did. They are sensible enough to know where to draw the line.

As to the form of the report, of the six who answered question 21, 4 favoured a narrative style report, one a structured report and one judge said it was a matter for the psychiatrist's judgment.

Finally question 22 asked, 'Do reports contain terminology which is outside your knowledge?' The answers were Frequently 1; Sometimes 5; and Rarely 3.

On the evidence of the questionnaire answers, the courts like a rather detailed but precise report. They appear to want diagnostic labels and arithmetic prognostication. Generally they want clear recommendations even as to sentence.

3. THE PSYCHIATRIC EXAMINATION

It is not proposed to examine this subject in detail, for much depends upon the facilities and personnel available for pre-sentence psychiatric evaluation. For example, where there are forensic psychiatric clinics on the scale of Herstedvester in Denmark, a psychiatric investigation is done in an in-patient setting and takes a minimum of 6 to 8 weeks.

In Australia, Bartholomew (1962) envisages an adequate investigation encompassing individual examination of the prisoner, contact with relatives for further information and corroboration of the history obtained from the prisoner, visits by psychiatric social workers and, more rarely, special medical investigations such as x-rays and electroencephalography.

The American psychiatrist, Roberts (1965) describes the framework for a psychiatric evaluation of a client referred by a lawyer. His first point is that there must be sufficient time. The examination may in certain cases consist of a single interview, though in most cases a more intensive evaluation is desirable. In complex cases the evaluation time may extend to several days or weeks in an in-patient institutional setting. A

detailed history must be obtained from the client. This should be supplemented by information from outside sources to broaden the scope of his inquiry during interviews with the client and to corroborate statements made by the client.

The evaluation should also include a mental status examination. This includes

> assessment of intelligence, competence of organic brain functioning, symptoms of mental disorder, patterns of coping with stressful situations and levels of anxiety and depression. The determination of ability to respond to treatment required detailed knowledge of the specific person, his mental disorder, motivation for therapy, responsivity of the particular disorder to known treatment techniques and available treatment resources. With alleged sex offenders, the detailed history of prior sexual activity, relationship of sexual problems to the alleged offense and assessment of danger to past victims are all important. (p.252)

Roberts suggested a physical examination should be made whenever organic brain functioning is in question. Psychological testing, he said, provides useful data to corroborate the findings of the psychiatrist and to extend the scope of his inquiry with the client. The examination should be conducted in private, and the offender should not be restrained by handcuffs. The psychiatrist should at the outset of the examination state the reasons for the interview and reveal the absence of confidentiality in the relationship.

APPENDIX C

"ESCAPE SPARKS CRITICISM

Circumstances connected with the escape of three prisoners from the Royal Derwent Hospital at New Norfolk on Monday were strongly criticised yesterday by Mr. Pitt, M.H.A.

Speaking at Launceston, Mr. Pitt said the escape should never have taken place.

"If a prisoner could be just transferred by a stroke of a pen, then escape and put the public at risk, the position needs reviewing", he said.

Dangerous criminals should not be transferred to the Royal Derwent Hospital.

"The trial judge had stated emphatically in the case of Peter Apted that the crime called for a prison sentence and not committal to an institution, but his recommendations had obviously been ignored", Mr. Pitt said.

"Over the past week or so, three senior detectives involved in the Apted case became so concerned that they had individually and at different times, both at Launceston police headquarters and at other places, personally expressed the fear that certain prisoners, especially Apted, could escape from the Royal Derwent Hospital.

"Their judgment, and that of the judge, has now been vindicated.

"It seems to me that too little notice is taken of police opinion.

"A thorough and proper explanation as to how this escape occurred must come from the Government immediately", he said.

In Hobart yesterday, the Attorney-General, Mr. Miller, said the three escapees had been sent to the Royal Derwent Hospital from Risdon Jail "to get proper medical help".

The transfer had been made "in strict accordance with the law", he said, responding to criticism that three men described by police as "extremely dangerous" had been held at Royal Derwent.

Mr. Miller said it was a "fundamental principle of the Mental Health Act that a prisoner who needed treatment for a mental disorder should be treated by experts, and that treatment should be under acceptable conditions and surroundings".

The three prisoners concerned had been examined by two psychiatrists, who certified that each man was suffering from a mental disorder warranting his transfer to a mental hospital for treatment.

Mr. Miller said that because of this he was obliged to have them transfered to the Royal Derwent Hospital.

Ultimately, a psychiatric unit would be built near Risdon Jail to accommodate prisoners suffering from mental disorders.

The Opposition spokesman on law, Mr. Baker, M.H.A., said yesterday the "latest serious breach of security" again pointed up the need for a formal and open inquiry into the State prison system.

The Warden of New Norfolk, Mr. C. Fitzgerald, last night expressed concern that dangerous criminals were being held in the Royal Derwent Hospital.

Mr. Fitzgerald, an endorsed Liberal candidate for Wilmot, said many people had contacted him yesterday to lodge protests over the matter.

He said it was part of the Liberal Party's policy that "Court-referred offenders" - those people convicted but recommended for treatment by the judiciary - should be held in a proper psychiatric wing inside Risdon Jail.

"Nobody would deny treatment that is recommended for convicted offenders, but I do not agree with that treatment being given in a hospital such as Royal Derwent", Mr. Fitzgerald said.

He said wives of shift workers in the New Norfolk area had suffered considerably over the years when escapes were made from the hospital.

"No family should be subjected to this type of tension", he said.

Mr. Fitzgerald said it was unreasonable that a hospital should have the onerous job of running a jail within its grounds.

"Escapes such as the one this week unfairly bring discredit to the hospital, which is doing a good job caring for the mentally ill"."

'The Mercury', August 12, 1976, p.3.

APPENDIX D

Magistrates' Court Rules, 1968

Appendix I - Precedents

Precedent 200. Statement of reasons for medical enquiry
(M.C. Rules 1968, r.23; H.O. circular 113/73)

REMAND FOR MEDICAL REPORT

Remands in custody under s.14(3) or s.26, Magistrates' Courts Act 1952

Statement of reasons for medical enquiry (Rule 23)

Name of defendant .....

Court ..... Date .....

Offence .....

Section under which remand is ordered .....

.....

Dear Sir,

This defendant has been remanded for a medical report. To assist the Medical Officer I give below the information available.

1. Type of report (e.g. on physical or mental condition or suitability for particular treatment).

2. Reasons which led the Court to request the report.

3. Previous medical history of offender and family history, so far as known.*

4. Particulars of circumstances of offence (including, if the offender is of no fixed abode, the place where it was committed, if known).*

5. Previous conduct, including previous convictions if known.*

6. Address and home circumstances of offender.*

7. Name and station of police officer concerned with case.

8. Name and telephone number of any probation officer appointed to or having knowledge of the case.

Yours faithfully,

The Governor,
H.M. Prison,

.....

Clerk to the Justices

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*Where the required information can best be conveyed by attaching a copy of a report or statement in the court's possession, all that need be entered here is "See attached ....."

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