EVOLUTION OF FORENSIC PSYCHIATRY WITH REFERENCE TO THE QUEENSLAND MENTAL HEALTH ACT

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Forensic Psychiatry like so many disciplines can trace its origins to a number of different countries as concepts develop in parallel. As with many new concepts, there was opposition to the involvement of psychiatry in legal process and issues.

Foucault, the French Philosopher, talked about the "shadow behind the Judges". He also talked about "the distortion of the use of Psychiatry" and saw Psychiatrists as generally having little basic good. In talking about Psychiatry, he is quoted as saying "we seem to be seeing two different functions – the medical function of Psychiatry on the one hand and the strictly repressive function of the Police on the other, coming together at a given moment in the system we're talking about. But in fact the two functions are only one from outset". This implies that the process of policing and psychiatry are one and the same. He went onto say, "Castel's book on the birth of Psychiatric Order shows very well how Psychiatry as it developed in the early nineteenth century was not only located in the asylum with a medical function, but also became generalised extending to the entire social body right up to the confusion that we see today. Somewhat discrete in France, but much more evident in the Soviet Union".

From the outset, Psychiatry has had as its project to be a function of the "social order".

In fact, the modern definition of law is that "Law is simply one stage in the continuum of disciplinary and normalising discourses, rules of grammar, etiquette and the social, political and moral aspects of collective existence through to the more exclusively coerce of language of Psychiatry, therapy, law and religion".

However the historical origins of Forensic Psychiatry are rooted in the pioneering work of the nineteenth criminologists of the Italian school, the English philosophers, Psychiatrists and Psychologists, various French workers, Isaac Rae in the United States, George Sturup of Denmark and Van der Hoeven and his colleagues in the Netherlands.

Historically the law has long recognised that psychiatry is of some use. This came about, as it became clear that the law did have a merciful function. One of those merciful functions is seen in the case of murder, which is always argued long and hard in the courts when the issue of mental illness in the offender is raised. Thus the insanity defence developed and now the ambit of mental defence covers all crimes.

This evolution was slow and by the end of the 18th Century, only less than 15% of felons were executed and the large scale organised transportation of convicts on a regular basis continued from the second decade of the 18th Century, when most were sent to the Americas. After the War of Independence, they were mainly sent to Australasia.

The book by a French author (Barron D. Montescuieu) published in 1748, pleaded for moderation of penalties and claimed that contemporary punishments were usually too harsh. The Italian, Tesare Beccaria, a well recognised and respected criminologist, published his book in 1764, which was translated into English shortly after and influenced many legal reformers in England. It called for a rationalisation of punishment and stressed that punishment ought to be prompt, certain and moderate. He argued that certainty rather than severity of punishment was the best deterrent to crime. Conviction of a wide range of offences from larceny to murder all officially called for the death penalty regardless of the seriousness of the crime. Beccaria reasoned that punishment should be proportional to the offence and the right proportion was when the misery of the punishment just outweighed the advantages of offending.

It was only in 1825 in the case of Bromage-v-Prosser (1825) that the two forms of malice were distinguished. They were Malice of fact where the offence directly reflected a specific ill will towards the victim, and secondly, "Malice of Law" where the act was intentional but lacks specific will. The 19th Century Legislation progressively emphasised the importance of malice in deciding whether the individual had committed a felony. The distinction was particularly useful for determining compensation and civil actions.

It was really only when the Hatfield case occurred that these issues came to the fore and clarified. Hatfield was patently mad and there could be little doubt his madness was associated with or precipitated by a severe brain damage from a sabre wound to the head sustained in the battle of Incelles in Flanders in 1794 as the Duke of York's bodyguard. This must have excited the deepest sympathy. There was abundant evidence given at his trial, that Hatfield was subject to outbursts of terrifying madness during one of which he had threatened set fire to his own child because he said that he had been commanded by God to do so. He entered the bizarre delusion that, although he must die to save the world, he must not die by his own hand. What better way was there therefore, than to assassinate the King thus guaranteeing his own demise? On May 15, 1800, he attempted to put his plan into effect by firing a pistol at George III as he entered the Royal Box at Drury Lane Theatre. Hatfield missed by 12 inches and was immediately disarmed and arrested. He was charged with High Treason and brought to trial only 6 weeks after the event. They applied "the wild beast test" and his Barrister; Thomas Erskine gave the most eloquent defence. "When a man is labouring under a delusion and if you are satisfied that the delusion existed at the time of the offence and the act was done under it's influence, then he cannot be consider guilty of any crime". During the trial, it was established he knew right from wrong and fully comprehended the nature of his alleged crime. However, Erskine was arguing for less global criteria to determine criminal responsibility than using the wild beast test or the right/wrong test. Dr. Crichton, of Bethlehem Hospital (now Maudsley hospital), gave evidence and the trial was stopped and the jury directed to find Hatfield not guilty.

Hatfield's trial induced John Johnston, the physician at Birmingham General Hospital to write the first separate medical monograph on medical jurisprudence and sanity in English. On January 20, 1843, McNaughton killed the Prime Minister, Robert Peel's Secretary, Drummond after

mistaking him for the Prime Minister. He had a long standing delusional disorder and felt he was constantly being hassled by spies sent by Catholic priests with the aid of Jesuits and the Tories. Queen Victoria was extremely distressed at the finding of the jury that "we find the prisoner not guilty on the grounds of insanity" and McNaughton was sent to Bethlehem Hospital.

Queen Victoria wrote to the Lords and asked that they clarify the issue and what came out from the Law Lords, was the McNaughton rules, which have persisted. I am sure Foucault would turn in his grave if he could see the invasion of the spheres of influence of the law both criminal and civil as well as most tribunals and prisons, police etc. that Forensic Psychiatry as achieved.

Historically, the paragon for Forensic Psychiatry was the issue of insanity and criminal responsibility and the principal psychiatric expert in the criminal trials, was the Medical Superintendent at the local mental hospital who appeared in murder cases where the risk of capital punishment made his task particularly poignant.

(Reference: extracted from Blueglas R,. Bowden, Paul – Principal and Practices of Forensic Psychiatry Churchill and Livingston Publishers (1990) Page VII)

To my way of thinking, modern day Psychiatry was first established in the U.K. starting with Prof. Robert Blueglas, founding the Reaside Clinic in Birmingham and Prof. John Gunn working out of the Maudsley Hospital in London. Both these establishments were close to prisons and involved in care of prisoners. With the widespread establishment in the U.K. of Integrated Community Psychiatry, it became an obvious step for Forensic Psychiatry to become more involved in community treatment and follow up of Mentally ill offenders. Now in the U.K., if you are working as a Forensic Psychiatrist, you are often expected to be closely involved with community psychiatry aspects of the treatment of prisoners. This coverage is not at all complete in the UK however, and many prisoners escaped the net. In Australia I fear we lag considerably behind except possibly in Victoria and Queensland.

The field of operations of Forensic Psychiatry is the overlap, interface and interaction of Psychiatry and the Law in all of its aspects. It covers areas such as criminal behaviour, civil litigation, family law, diagnosis, care and treatment of psychiatric patients suffering disorders associated with abnormalities of behaviour. It also covers numerous other areas, such as, legislative changes and drafting, management of violence and the study of sexual deviance etc.

As in Community Psychiatry, forensic community psychiatry is looking to maintain patients under care for their mental illness after leaving Prison, court or from being under a Mental Health Act following a crime, by using community therapy techniques, and hopefully in that way, achieve some crime prevention.

We now come to the Queensland Mental Health Act. This Act was developed in response to the United Nations paper indicating that the way in which prisoners and anyone associated with the criminal justice system should be cared for if they have a mental illness. This was called " The United Nations Principles on the protection of people with mental illness". The gist of the Queensland Mental health Act is that the

prisoner/patient, if they are suffering a mental illness and have been charged, is taken out of the criminal justice system and placed into the care of the Mental Health Tribunal. I know of no other Mental Health Act, which has such a humane approach. Europe may be the exception to this because after all it was the European influence that underlay the UN paper. They may not need it because they are already involved with an inquisitorial system.

Basically in Queensland these offenders are removed from the adversary system and placed in this far more reasonable inquisitorial system.

The Mental Health Tribunal (or as it is called in the new act The Mental Health Court) carries out an inquiry not a trial and there are a number of clear issues that they deal with. The tribunal determines issues such as criminal responsibility and fitness for trial and by its decision removes the mentally ill and the intellectually disabled offender from the criminal justice system places them firmly into the mental health system. To have jurisdiction to determine the case the tribunal must have an application or a reference. Those that can refer a person are,

- the Director of Mental Health,
- the Crown Law Office,
- person concerned or
- the person's legal advisor or the person's nearest relative or
- The Trial Judge.

The standard of proof is a reasonable cause to believe that the person alleged to have committed an indictable offence is mentally ill or was mentally ill at the time of the alleged offence.

Written reports from the Psychiatrists are mainly used and other medical professionals as well as Police evidence but expert evidence can be given under oath if required.
Normally the hearings are conducted in the Supreme Court in Brisbane but there is talk of beginning a branch of the Supreme Court in Townsville to hear these cases.

The person is normally not required to say anything to the Tribunal but is free to discuss the case with his Solicitor and Barrister. The purpose of the inquiry is to determine:

1) Whether the facts are sufficiently established.
2) Whether at the time of the alleged offence, the person was of unsound mind.
3) To have Defense of unsoundness of mind means to demonstrate the

   Person had a substantial psychiatric disorder or a natural mental infirmity such as to depriving him of the capacity to understand what he is doing or the capacity to control his actions, or of the capacity to know that he ought not to be doing do the Act or make the admission.
4) Where the charge is murder, diminished responsibility is to be dealt with in a psychiatric report and by the Tribunal.
5) If the Tribunal finds the person is not suffering of unsound mind, it will inquire further as to whether the person has enough understanding of a plea and the nature of court proceedings, whether the person is able to instruct counsel, and whether the person is able to endure the trial without serious effect to their mental condition.

One issue that often arises is intoxication and the treating Psychiatrist has to address this issue and consider whether the patient would still have been deprived of his capacities in the absence of the intoxicating substance. However, when an intoxicating substance facilitates a mental illness, this is accepted as being a mental illness such as cannabis precipitating Schizophrenia.

This is all well and good and high minded BUT if the funds are not there we have criminals in district psychiatric units waiting to be heard by the Mental Health Tribunal with poor security and psychiatric staff instead of correctional staff looking after them. It can take some time to get the information together to write a comprehensive forensic report and often the treating psychiatrists are not familiar with such reports. Hold ups occur in rural areas with police evidence being available to the psychiatrists. I think the money saved by corrections should be available to the Mental Health Service to improve the security of District units and make more beds available in the secure High Dependency Units. We should never forget we are usurping the judicial role and it may be that rehabilitation and treatment are not wanted, useful or appropriate and that retribution is more appropriate. It is not our role to make what the court calls the ultimate decision and at some point we should be ready to stand back and let the law take its uninterrupted course.

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