
LAW COMMISSION

Report No 30

Community Safety: Mental Health and Criminal Justice Issues

August 1994
Wellington, New Zealand

The Law Commission is an independent, publicly funded, central advisory body established by statute to undertake the systematic review, reform and development of the law of New Zealand. Its aim is to help achieve coherent and accessible laws that reflect the heritage and aspirations of New Zealand society.

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23 August 1994

Dear Minister

I am pleased to submit to you Report No 30 of the Law Commission, *Community Safety: Mental Health and Criminal Justice Issues*.

The concerns earlier this year which led to your reference on this matter also resulted in the Government's introduction of the Mental Health (Compulsory Assessment and Treatment) Amendment Bill.

Because of time constraints, the Law Commission was not able to follow its usual practices of extensive consultation and fact finding. The process which it did follow confirmed that some changes could usefully be made to the present legislation; other possible changes might also be given further consideration.

The process also confirmed that legislative change is only one part of the answer to the difficult problems in this area. Also critical are resources made available primarily by the state for the application of the law, and better understanding of the law and the powers it confers. In this report, the Commission has brought together information and proposals which should help those three processes of legislative reform, improved resourcing and better understanding and application of the law.

Yours sincerely
K J Keith
President

Hon Douglas Graham MP
Minister of Justice
Parliament House
WELLINGTON

Terms of reference

The Law Commission is asked to consider, with the purpose of protecting members of the public from substantial risk of harm from individuals whose release into the community would pose that risk—

- 1 relevant provisions in the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Criminal Justice Act 1985, including the definition of mental disorder in the 1992 Act, and
- 2 whether the Criminal Justice Act 1985 or any other enactment should be amended to confer a power to continue to detain a person beyond the time the person is, under the present law, entitled to be released.

In each case, the Commission is to consider appropriate powers and procedures including safeguards for the protection of the individuals concerned.

The Commission is to have regard to the situation of children and young persons detained in the custody of the Director-General of Social Welfare under the Children, Young Persons, and Their Families Act 1989 and who pose a substantial risk of harm to other members of the public.

Overview

1 The Law Commission's terms of reference concern two critical values: the right of members of the community to be protected from physical harm inflicted by others, and their rights against the state not to be arbitrarily detained and not to have their personal liberty restricted without good reason.

2 As the terms of reference indicate, it is mainly through criminal justice and mental health legislation that the law strives to protect those critical values. In the writing, interpretation and application of the law, the protection of safety and the protection of liberty may at times conflict, or at least appear to. Ideally, out of that conflict of principles and values should come law consisting of wise restraints that make us free.

3 Any consideration of community safety must recognise that detention is a serious exercise of state power. In assessing a proposed detention power, the New Zealand Bill of Rights Act 1990 is crucial, particularly its affirmation that detention must not be arbitrary. To forestall any question of arbitrariness, powers of detention should be based on principle and be demonstrably necessary. In the present context, any proposal for power to detain dangerous individuals must take into account that, although predicting dangerousness is possible to some extent, and necessary, it is also difficult. Another reason for caution is that broader detention powers may have greater effect on some sectors of the community than on others, as appears for instance from the already disproportionate institutionalisation rates between Maori and non-Maori. Increased rates of detention may have social as well as economic costs. It is important to find solutions providing the least restrictive alternative, which may be less than detention in a secure facility.

4 The Law Commission stresses that only part of the answer to the issues presented by the terms of reference lies in possible changes to the relevant legislation. Legislative change may be necessary. It is not sufficient. Much depends on developing the application, interpretation and understanding of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (“the 1992 Act”), which came into effect only 21 months ago following a lengthy period of preparation and legislative consideration. Also crucial are the resources of people, facilities and money which are needed to support, in the community as well as in institutions, those with mental illnesses, intellectual handicaps and other disabilities.

5 The effects of the 1992 Act should also be seen in the context of major changes in the health sector, including the transfer of patients from mental health institutions to the community. There have also been recent changes in the criminal justice area, especially to the sentence of preventive detention, to give greater protection to the public. The full implications of the recent legislative and administrative changes need to be identified and made known to all who must help to make them work. The focus of this report on aspects of the law which might be changed should not draw attention away from these other essential elements.

BACKGROUND CONCEPTS AND PRINCIPLES (ch 2)

6 In arriving at its recommendations and options, the Law Commission has been guided by factual propositions and certain principles based on the Bill of Rights 1688, the New Zealand Bill of Rights Act 1990, the International Covenant on Civil and Political Rights (1966) and other standards:

- (i) Any power to detain a person must not be arbitrary. The power must be justifiable in a free and democratic society. The justification must rationally relate to the purpose—in this case, the protection of members of the public from physical harm. Any limit on liberty should be the least restrictive needed to achieve its purpose.
- (ii) In addition, whether a power to detain people or to place other restraints on their liberty is arbitrary turns on
 - the independence, qualifications and authority of the person or body exercising the power;

- the statement of the conditions for the exercise of the power of restraint: what are the criteria governing its exercise?
 - the procedures for the exercise of the power: are the individuals affected being given a fair hearing in accordance with natural justice?
 - the rights of appeal against, and review of, decisions taken in exercise of the power.
- (iii) Any proposal for a power of detention based solely on predictions of harmful behaviour must deal with the widely accepted opinion that predictions of dangerousness are likely to have only a 50% rate of accuracy. The person's past offending behaviour provides the best available means of prediction.
- (iv) In principle and in practice, the law providing for detention does not depend solely on judgments of dangerousness. Rather it recognises two principal ways in which individuals considered to be dangerous may be prevented from causing physical harm to members of society:
- by criminal prosecution for an alleged offence, trial, conviction and sentence, including imprisonment for those convicted of offences of violence; and
 - by detention or other restraint on personal liberty under mental health legislation on the basis of findings of a mental disorder which involves a serious danger to the safety of others (or to the person detained).
- (v) A power of detention which essentially depends on a disability has to be justified against the prohibition of discrimination on the ground of disability.
- (vi) A detained person must not be subjected to cruel, degrading or disproportionately severe treatment or punishment. As well, everyone has the right to refuse to undergo medical treatment, although certain compulsory treatment might be able to be justified.
- (vii) Any assessment of management options for dangerous persons should take account of the social and economic costs as well as the benefits of the options, including the implications of any proposals for Maori and other ethnic groups.

PROTECTING THE COMMUNITY: MENTAL HEALTH ISSUES (ch 3)

7 Central to the first term of reference is the definition of “mental disorder” on which the application of mental health legislation depends. The recent controversies and the amendments proposed in the 1994 Mental Health (Compulsory Assessment and Treatment) Amendment Bill emphasise the conditions of “intellectual handicap” and “personality disorder”. We consider the following questions:

- (i) Does the present statutory definition of mental disorder include intellectual handicap and personality disorder?
- (ii) Are intellectual handicap and personality disorder appropriately regarded as mental disorders, and if so should the present statutory definition be amended to explicitly include them?
- (iii) If intellectual handicap and personality disorder cannot be appropriately classified as mental disorders, are there people with these conditions who pose a significant risk to others and who cannot be managed under any existing system? If so, should a new system be established to manage these people?

Intellectual handicap (paras 115–174)

8 Question (i): The definition of mental disorder in the 1992 Act includes some instances of intellectual handicap, but only where the nature or degree of intellectual handicap results in or amounts to mental disorder. The definition will be most applicable to those people who are profoundly disabled and therefore least likely to cause harm to others.

9 Question (ii): The definition of mental disorder should not be widened to cover a broader group of people with intellectual handicap. The definition was settled following a lengthy preparatory and legislative process and has been in operation for only 21 months. Those who have responsibility for its day-to-day application, interpretation and possible review have, as yet, insufficient experience of its operation to propose changes. Differences in the understanding of the legislation should be addressed by those responsible for its application, with the support of relevant information provided by the Ministry of Health. Moreover, much professional opinion opposes any widening of the present definition: intellectually handicapped people are seen as distinct from the mentally disordered; they cannot be treated in the way that mentally disordered people can be; and the symbolism of separate legislation and arrangements is seen as important.

10 Question (iii): As a group, intellectually handicapped people pose no more risk of harm to the community than do people of ordinary intelligence. Of those who do pose a substantial risk, some can be, and are, dealt with under the criminal justice system, by prosecution, trial, conviction and sentence. But some who come to the notice of police or mental health authorities for allegedly criminal and dangerous activities may not be the subject of prosecution. For these people, and for those who are prosecuted but found unfit to stand trial, the mental health system may be an inadequate alternative.

11 Because neither mental health nor criminal justice legislation is appropriate for all intellectually handicapped people who pose a risk of harm, the Law Commission proposes that this legislative gap be addressed by new legislation providing for compulsory status for people found to be intellectually handicapped and to pose a serious danger to the safety of others. That finding might be made following a determination of unfitness to stand trial, an acquittal on account of insanity, or a conviction, or as a result of offending behaviour which does not in fact result in the criminal justice system being invoked. The legislation would differ from the 1992 Act by providing for a compulsory system of supervision, management and education rather than treatment, and having fewer reviews initially (in recognition of the more durable nature of the condition). It would incorporate the principle of the least restrictive alternative and provide for community orders. We also suggest that consideration be given to a comparable legislative scheme for those intellectually handicapped people who are a danger to themselves rather than to others.

Personality disorder (paras 175–228)

12 Questions (i) and (ii): The present definition of mental disorder is capable of including some instances of personality disorder. However, among New Zealand health professionals there is no support for the opinion that personality disorder should in general be included in the definition of mental disorder for the purpose of compulsory treatment. The concept of personality disorder is extremely problematic. There is, for instance, little consensus concerning the fundamental matters of its diagnosis and the role of mental health professionals in its treatment. As well, the concept is circular: a mental condition is inferred from antisocial conduct, yet is used to explain that conduct.

13 Accordingly, the Law Commission considers that the definition of mental disorder should not be amended to explicitly include personality disorder or an equivalent term.

14 Question (iii): The Commission considers that the lack of any explicit reference to personality disorder in mental health legislation does not threaten community safety. Unlike many with intellectual handicap, people with personality disorder who are considered dangerous can be dealt with by the criminal justice system, unless they are mentally disordered as well. Dangerous behaviour will in general trigger the criminal justice procedures; those with a personality disorder can be considered culpable (unless mentally disordered as well), and they can be sentenced in accordance with ordinary criminal justice principles. If further detention powers are considered necessary for personality disordered people who are dangerous in some manifest way, they should be conferred by the criminal justice system (discussed under the second term of reference) and not under mental health legislation.

15 Although there is no need for legislative change with respect to personality disordered people, the Commission supports the development of policy on a number of issues. The Department of Justice and the Ministry of Health should consider the needs for treatment and management of offenders with personality disorder. The Mason Report on psychiatrically disturbed offenders provides a valuable model for such policy development, which should include an examination of the possibly limited use made of the powers in the 1992 Act to transfer prisoners to psychiatric institutions.

General issues in mental health and criminal justice legislation

16 The 1992 Act confers extensive powers that can be exercised over people who are mentally disordered within the statutory definition. These include the power to impose restricted status on a person presenting special difficulties, with consequent restrictions on leave and discharge. Greater use could be made of existing powers. There is no need, from the viewpoint of community safety, for the 1992 Act to be amended to provide further powers in respect of people with mental disorders (paras 230–238).

17 The power under the Criminal Justice Act 1985 to find that a person is not fit to be tried (“under disability”) should not depend on the definition of mental disorder in the 1992 Act. Rather, the issue should be the capacity of the defendant to sufficiently comprehend and participate in the trial. Whether the defendant is dangerous or not is irrelevant to that capacity, as is the cause of the defendant’s unfitness to stand trial—be it mental illness, intellectual handicap, infirmity, or brain injury resulting from an accident (paras 146–148).

18 For a number of reasons, Part VII of the Criminal Justice Act 1985, which regulates much of the relationship between the criminal justice and mental health systems, should be reviewed, particularly with reference to “under disability” issues. One option, relating to the consequences of finding a defendant to be under disability, includes provision for a special hearing to determine the defendant’s innocence of or factual responsibility for the alleged crime, and for the consequences of the latter determination; another option would provide for periodic hearings to determine whether sufficient evidence can be adduced to put the defendant on trial. This aspect of the review should be undertaken in conjunction with the development of the legislation proposed for intellectually handicapped people. The review of Part VII should also examine issues relating to insanity acquittals. It should take into account recommendations made by the Victims Task Force for additional protection for victims: for instance, that victims should be informed when an alleged offender detained in hospital is discharged or escapes, and that the interests of victims should be taken into account in patient status reclassifications (paras 151–157, and 239–241).

19 The Law Commission considers that a commitment to improving community services for those with psychiatric and intellectual disabilities will have indirect positive effects for the community in general. The Commission accordingly supports the Government’s decision to allocate more resources to mental health services (paras 242–244).

Recommendations

20 The Law Commission’s recommendations on the first term of reference may be summarised as follows (see paras 174, 228 and 245 for more detail):

- (1) Those involved in the interpretation and application of the 1992 Act should be encouraged in appropriate ways to address the differences in understanding of that Act and especially of its definition of mental disorder. The Ministry of Health should facilitate this process by gathering and distributing information about the interpretation and application of the 1992 Act, including its provisions about restricted status.
- (2) The definition of mental disorder should not be amended to explicitly include intellectual handicap or personality disorder.
- (3) The needs of community safety do not require powers additional to those already conferred by mental health legislation in respect

of mentally disordered people.

- (4) The law regulating the relationship between the mental health system and the criminal justice system found in Part VII of the Criminal Justice Act 1985 should be reviewed. The review would consider:
 - the test for finding that a defendant is unfit to stand trial;
 - the consequences of that finding;
 - the possibility of holding a special hearing, after a finding of unfitness to stand trial, to establish the defendant's innocence of or factual responsibility for the alleged crime;
 - the related possibility of requiring the prosecutor to show periodically that sufficient evidence could be adduced to put the defendant on trial;
 - the consequences of the above findings;
 - the consequences of acquittal on account of insanity; and
 - the recommendations of the Victims Task Force for increased protection for victims of actions of mentally disordered people.
- (5) New legislation concerning intellectually handicapped people who present a substantial risk of danger to others should be prepared. This would apply to alleged offenders found unfit to stand trial, people whose dangerous behaviour has not resulted in prosecution, and perhaps convicted offenders. The legislation would include criteria for compulsory status and would regulate the management, education and care undertaken in the community and institutions which would apply to this group of people.
- (6) In conjunction with or as part of the consideration of new legislation, there should be a review of the position of intellectually handicapped people who need compulsory care in their own interests. The policy developed under this and the preceding point could result in a single statute applying to intellectually handicapped people who are a danger either to themselves or to others.
- (7) The Department of Justice and the Ministry of Health should, as a prerequisite to the policy development recommended in (8), gather information on the use of the provisions governing the transfer of offenders from prison to hospital, including the reasons for such use, in order to judge whether existing provisions are used sufficiently to maximise the potential for treating personality disordered offenders.

- (8) The Department of Justice and the Ministry of Health should develop policy on the issues posed by personality disordered offenders, their treatment needs and the options for their optimal long-term management and supervision. This would be similar to the policy development for psychiatrically disturbed offenders facilitated by the Mason Report, and would include collecting information on the extent of personality disorders in prisoners and estimates of any potential for treatment.
- (9) Funding implications should be considered in conjunction with policy development and legislative proposals for mental health services, particularly community services.

PROTECTING THE COMMUNITY: CRIMINAL JUSTICE ISSUES (ch 4)

21 The question posed by the second term of reference is whether, in relation to individuals who pose a substantial risk of harm to members of the public, the Criminal Justice Act 1985 or any other Act should be amended to provide for a person to be detained beyond the date on which that person is, under the present law, entitled to be released. Apart from mental health legislation, there are only a few specialised powers of detention outside the criminal justice system; for example, the powers given under the Tuberculosis Act 1948. In such cases, detention is justified either because the people concerned are incapable of looking after themselves due to some physical condition, or because there is a danger arising from that physical condition, which can moreover be the subject of treatment. These civil powers are not an appropriate model for detaining individuals on the sole ground that they present a danger to members of the community.

22 Accordingly, in responding to the second term of reference the Law Commission focuses on imprisonment under the criminal justice system. This focus should not overshadow the fact that imprisonment is not always the only or even the best way of protecting the public from dangerous people.

23 The criminal justice system already contains broad sentencing powers which reflect a need to protect members of the public from dangerous offenders. In recent years, Parliament has increased those powers and the courts have made greater use of them, as the numbers of people imprisoned for sexual and other violent offences show; there may remain scope for even greater use in limited and clearly defined areas. The Commission has identified some options for limited legislative reform.

Sentencing and the protection of the public (paras 255–291)

24 The primary function of the criminal justice system is to protect society from crime. This function is discharged by prescribing offences and by providing for the detection, prosecution, trial and sentencing of offenders, and for the machinery by which sentences are served. While most offences are complete in the sense that there is a victim, the criminal law also includes preliminary offences designed to prevent a complete offence being committed. Examples are threats to kill or to do grievous bodily harm.

25 The criminal justice system is regularly invoked to deal with dangerous people. About 2000 offenders convicted of sexual crimes and other crimes of violence are held in our prisons at any given time.

26 The protection of the public through incapacitation of the offender is well established as a purpose of sentencing. The other purposes are retribution and denunciation, general and specific deterrence, rehabilitation, and reparation. The Criminal Justice Act contains a presumption of imprisonment for certain violent offenders and requires that the protection of the public be taken into account in determining the length of their sentences. Against this is the right of the individual offender, affirmed by the New Zealand Bill of Rights Act 1990, not to be subjected to disproportionately severe punishment.

27 A sentencing judge already has a range of powers in the exercise of which the safety of the public is an important consideration. They include

- imposing longer sentences within the current maximums;
- fixing a minimum period of imprisonment to be served for a serious violent offence where the sentence is more than two years;
- imposing a sentence of indeterminate length (ie, preventive detention or life imprisonment), where that is an available sentence;
- fixing a minimum period of imprisonment to be served of more than the standard 10 years where the sentence is indeterminate.

28 If it is considered that the protection of members of the public has been given insufficient weight in sentencing and that a more severe sentence should have been imposed, the Solicitor-General, with the leave of the Court of Appeal, may appeal against the sentence.

The concept of civil detention (paras 292–310)

29 One response in some overseas jurisdictions to the problem of dangerous persons who cannot or can no longer be detained in the

mental health and criminal justice systems is to provide for an additional system for their detention in a state institution. For instance, in the American state of Washington, a system of civil detention applies to “sexually violent predators”. The Law Commission does not at present recommend such a system of civil detention. Information of the kind which persuaded the Washington legislature to enact the measure is not available to us; predictions of dangerousness are fallible; and a power of civil detention is difficult to reconcile with constitutional principle unless so confined that it essentially replicates the powers already available under New Zealand’s criminal justice and mental health systems. The Commission emphasises that those systems already contain extensive powers to detain dangerous offenders with the purpose of protecting the public, including the power to impose preventive detention. Any proposal for civil detention must take account of those extensive powers, particularly the sentencing powers.

Preventive detention: options (paras 311–319)

30 Preventive detention is available as a sentence for a first conviction for sexual violation and for serious violent and other sexual offending where the offender has had at least one previous conviction for such an offence. The High Court may impose preventive detention if it is expedient for the protection of the public, and, in the case of a first conviction for sexual violation, if it is also satisfied that there is a substantial risk that the offender will commit an offence (specified in the legislation) upon release.

31 Preventive detention is a particularly severe sentence and is not seen as justified if a finite sentence is adequate. Offenders sentenced to preventive detention after 1987 are not eligible for parole until they have served 10 years imprisonment, a period which the sentencing judge can extend. Unless released on parole, an offender subject to preventive detention will be imprisoned indefinitely. There has been a clear increase in the use of preventive detention since 1985. As at February 1994, there were 64 males subject to a sentence of preventive detention. Fifty-four were in prison and 10 were on life parole.

32 The eligibility for preventive detention has been significantly widened on two occasions since 1985, both times in response to public concerns about violent crime. The 1987 amendment lowered the age of eligibility to 21 from 25 and made preventive detention available for a range of serious violent offences in addition to sexual offences. The 1993 amendment made preventive detention available for a first conviction for sexual violation. However, these amendments have so far had a negligible effect on the use of preventive detention. The sentence

might be used more consistently if better information were available about the circumstances in which it might be justified, including that provided by decisions on appeal against sentence, and possibly also if sentencing guidelines were developed.

33 Legislative options that might be considered include widening the eligibility for preventive detention, refining the grounds for its application, and decreasing the non-parole period for offenders sentenced to preventive detention. Another possible amendment is to reverse the presumption that an offender sentenced to preventive detention will be imprisoned until released on parole, to a presumption that an offender sentenced to preventive detention will be released on parole after serving a certain period of imprisonment unless the safety of the public requires the offender's continued imprisonment.

*Options for offenders currently in prison, on parole
or final release (paras 320–338)*

34 There is no power to detain offenders past the date on which their sentences expire. To introduce such a power in respect of those currently imprisoned would breach the constitutional principles prohibiting retrospective penalties and double jeopardy.

35 Although it is not possible to detain an offender currently in prison beyond the date when the sentence expires, there are several limited powers which allow an offender to be detained beyond the usual date of release. The usual date of release, for some offenders, is when released on parole, and for other offenders is the final release date.

36 The existing powers to detain the offender beyond the usual date of release are to refuse parole, to order that the offender serve a longer part of the sentence, and to recall the offender from parole. In addition, the 1992 Act provides for mentally disordered offenders to be transferred to psychiatric hospitals during their prison sentence. Those people can be held under the mental health legislation beyond the period of imprisonment if the mental disorder persists.

37 Most offenders serving sentences of more than 12 months are eligible for parole after serving one-third of their sentence, although offenders convicted of serious violent offences are subject to more stringent rules. Release on parole is discretionary until the final release date, which is generally after two-thirds of a sentence of 12 months or more. In respect of such offenders, the Parole Board and District Prisons Boards are expressly directed to take into account the need to protect the public or any person or class of persons who may be

affected by the release of the offender. The conditions on parole may also be directed at the protection of the public.

38 The Secretary for Justice may apply to the Parole Board for an order that an offender sentenced for certain serious sexual and violent offences serve the full term of the sentence. Such an order may be made if the Parole Board is satisfied that the offender is likely to commit a specified offence if released before the applicable release date.

39 An offender who has been released on parole may be recalled to prison on an application by the Secretary for Justice or a probation officer, if the Parole Board or a District Prisons Board (as the case may be) is satisfied that the offender has breached the conditions of release or has committed an offence, or that further offending is likely because of the offender's conduct or a change in circumstances.

Conclusions on the second term of reference (paras 339–342)

40 In essence, the Law Commission concludes that the criminal justice system already contains wide powers to protect the public from people convicted of sexual and other violent offences who are considered to be dangerous. In some cases greater use might be made of those powers both in imposing the initial sentence of imprisonment and in its administration; as well, greater consistency might be promoted by better information, along with other measures such as appeals and, possibly, sentencing guidelines. Facilities for the rehabilitation of offenders convicted of sexual and other violent offences are also important.

Recommendation (para 343)

41 The Law Commission makes as its sole recommendation that, if the Government wishes to consider changing sentencing powers, any review examine sentencing in a broad context and be supported by appropriate statistical and other research. The review might take up the options for legislative change mentioned in the report.

CHILDREN AND YOUNG PERSONS (ch 5)

42 The Law Commission has confined its examination of the situation of dangerous children and young persons to those posing the most serious management problems for the Department of Social Welfare: compulsive and persistent sex offenders. The Commission makes the following recommendations (para 364):

- (1) The Department of Social Welfare should ensure that relevant agencies are aware that the Mental Health (Compulsory Assessment and Treatment) Act 1992 does not contain an age bar prohibiting its application to children and young persons. However, the statutory definition of mental disorder would not include many of those children and young persons currently presenting the most difficult management problems.
- (2) The Department of Social Welfare should pursue inter-agency discussions with a view to establishing secure residential treatment programmes for young sex offenders.
- (3) The Department of Social Welfare should liaise with relevant agencies, including the Police, the Ministry of Health and Te Puni Kokiri, to consider issues related to the implementation of the Children, Young Persons, and Their Families Act 1989, with particular emphasis on
 - the formulation and effective promulgation of prosecution policies in relation to sexual offences by children and young persons, and the criminal conduct of residents of Children and Young Persons Service (CYPS) institutions, and
 - the question of whether powers to obtain psychiatric and psychological assessments of young offenders are sufficiently used.
- (4) The Department of Social Welfare should consider whether mixing offending and non-offending children and young persons in CYPS residences exposes the most vulnerable to danger and, if so, take appropriate steps to end this practice.

1

Introduction

43 Late in February 1994 the Minister of Justice approved the terms of reference set out at the beginning of this report.

Precipitating event

44 The reference was precipitated by the serious offending of a former psychiatric patient. Soon afterwards another former patient also committed serious offences. Both had previously been special patients, after having been found “under disability” (unfit to stand trial) under the Criminal Justice Act 1985. Appendix A explains the categories of special patients and the procedures for their reclassification and discharge. Their offending focused public attention on the Mental Health (Compulsory Assessment and Treatment) Act 1992 (“the 1992 Act”) and the changes it had made to the previous law.

45 In response to public concern, the Minister of Health made available the information that 37 people who were considered dangerous had been released from detention under the mental health system since the new law took effect, because it was considered that they were no longer able to be detained. That information had, however, been gathered very quickly and unsystematically. In fact, the much-publicised group of 37 included 11 who were able to be detained under the new law and a further two who had never been within the mental health system, having been remanded to hospital for assessment.¹

46 As the Law Commission’s terms of reference were being finalised, the Government announced its intention to introduce legislation amending the 1992 Act. The amendment Bill was introduced in the House of Representatives on 30 March 1994 and referred to the Social

¹ Information supplied by Ministry of Health, letter of 24 March 1994.

Services Select Committee, which called for submissions and in May began considering them. The Law Commission's submission on the Bill is contained in appendix B. An attempt was made by the Ministry of Health to collect information on the possible effects of this Bill. Although it could not arrive at any numerical estimate, the Ministry considers that the people likely to be affected by the Bill are few, but it is possible that the numbers would increase over time.

Process

47 The time-frame for reporting on the terms of reference has not allowed the Law Commission to follow its normal processes, especially of fact-gathering and extensive consultation. Meetings with the Department of Justice, the Ministry of Health, the Department of Social Welfare, the Police, the Crown Law Office, the Human Rights Commission and the New Zealand Society for the Intellectually Handicapped (IHC) were helpful at the outset of our inquiry and facilitated the provision of valuable information. Appendix C briefly describes the process the Law Commission followed.

Previous New Zealand reports

48 Issues relating to mental health and criminal justice have been discussed frequently in New Zealand in the recent past. Appendix D lists some of the relevant reports. Reports relating to mental health and offenders have tackled such questions as the kinds of controls and facilities there should be for offenders with some degree of psychiatric impairment; the rights of people with mental illness; the support for the transfer of psychiatric patients from hospital into the community; the most appropriate level of funding for mental health services; and the most appropriate role for health and justice agencies in relation to psychiatrically disturbed offenders and other offenders with some degree of mental impairment, disturbance or abnormality. Reports relating to criminal justice have considered such issues as the sentencing of sexual and other violent offenders; the role of the prison system; and the aims and justifications of punishment. These issues have also been the subject of inquiries in other countries.

Aims and structure

49 The frequent recurrence of questions relating to dangerous people in New Zealand and elsewhere indicates their complexity and suggests that legislative change alone cannot provide comprehensive solutions.

The evolution of answers appropriate for New Zealand requires coordinated and thorough policy development on the part of all relevant agencies, and clear decisions by the Government. Those processes will involve considering options for service provision, as well as funding implications. As a basis for policy development, the Law Commission in this report

- identifies relevant background concepts and principles,
- provides background information relating to each of the terms of reference,
- identifies the questions and issues inherent in the terms of reference, and
- reaches conclusions, makes recommendations, and presents options for further consideration.

50 We attempt to separate issues relating to the law itself from those relating to its interpretation and the support needed for its adequate implementation.

51 The next chapter of the report, chapter 2, identifies several concepts and principles relevant to the terms of reference. Chapter 3 focuses on the first term of reference and key provisions of the mental health and criminal justice legislation. Chapter 4 discusses issues contained in the second term of reference relating to the Criminal Justice Act 1985 and sentencing, and chapter 5 outlines some related issues concerning children and young persons.

52 Questions common to a consideration of all the relevant legislation—mental health, criminal justice, and children and young persons—are:

- *To whom* should the relevant legislation apply? Could the public be better protected from harm by widening the categories of people who come within its provisions?
- *What means of control* should the relevant statutes contain; who are the appropriate decision-makers; and for how long should the control mechanisms be applied? Could the public be better protected from harm by increasing the means of control available?
- *Can the law be better implemented* by increased understanding between all concerned and by better service support?

2

Background concepts and principles

53 This chapter explores several concepts and considerations relevant to the terms of reference, including dangerousness, human rights principles, the rights of victims, the implications of detention for different ethnic groups, and the role of detention in protecting society. It sets out the principles and propositions which have guided the Law Commission in formulating its recommendations and presenting options.

DANGEROUSNESS

54 The focus of the terms of reference is individuals whose release into the community would pose a substantial risk of harm to the public. For convenience, we refer to these individuals as “dangerous”—a term commonly used in the relevant literature. However, “dangerousness” is not a medical, scientific, psychological or psychiatric concept.

55 Read literally, the terms of reference cover a wide range of people with potential to cause a variety of injuries, including, for example, a promiscuous person who is HIV positive, or males aged between 18 and 25 with access to a car. Given the events that prompted this report (para 44), it is appropriate to regard harm for present purposes as being death, serious personal injury and sexual assault, where the infliction of the harm is unlikely to be accidental. Harm which falls into this category, or a threat of such harm, will probably constitute an offence for which the perpetrator may be prosecuted (although in any particular case may not be).

56 The critical point in relation to dangerousness is that it is not possible to predict it accurately. The reality nonetheless is that those with responsibilities in the criminal justice system must frequently make

predictions of dangerousness, especially in decisions concerning bail, sentencing and parole. Overseas studies (both clinical and statistical) carried out during the 1970s indicate that at least 50% and possibly as many as 66% of judgments that a given person is dangerous will be inaccurate.² More recent consideration of the data from these studies suggests that 50% may be the more appropriate assessment of the accuracy rate.³ The accuracy of prediction varies considerably between different categories of offences.

57 The following is relevant to both terms of reference:

- On the current state of knowledge, the best indicators of future offending are previous offending, age and, to a lesser extent, gender and ethnicity.
- A Department of Justice study indicates that, within five years of their release from prison between 1984 and 1986, 12% of offenders convicted of rape were convicted of a violent sexual offence (ie, rape, unlawful sexual connection, attempted sexual violation and indecent assault) and 37% were convicted of a violent offence (including violent sexual offences). The proportion reoffending was higher than for a comparable group released between 1979 and 1981 (Southey, Braybrook and Spier, *Rape, Recidivism and Sexual Violation* (1994) 31).
- Another (unpublished) study by the Department of Justice (Spier, 17 December 1993) indicates that 19% of offenders convicted of serious violent offences and released in 1987 or 1988 had been reconvicted of a serious violent offence by 1993. (Serious violent offences included homicide, attempted homicide, serious assaults and robbery. No offenders convicted of murder were reconvicted of murder within that period.)
- Predictions of certain sex offences against children are more accurate than those of serious violent offending (Spier, 17 December 1993).

² Floud and Young, *Dangerousness and Criminal Justice* (1981). The select bibliography provides full references to the sources used in the text. The clinical studies involved experts (psychiatric or otherwise) assessing whether particular individuals, who had been released from prison or a psychiatric hospital, were dangerous and determining whether those assessments were accurate on the basis of whether each individual subsequently offended. The statistical studies focused on whether particular demographic characteristics made offending and reoffending more likely in general terms.

³ Ewing, "Preventive Detention and Execution, the Constitutionality of Punishing Future Crimes" (1991) 15 *Law and Human Behaviour* 139.

- People become less likely to offend and reoffend as they get older. In 1992, 72% of violent offenders (including violent sexual offenders) were aged between 20 and 39; only 13% of offenders were 40 or older (Spier and Norris, *Conviction and Sentencing of Offenders in New Zealand: 1983 to 1992* (1993) 37). It appears that the reconviction rate is highest for offenders under 20 years old and thereafter decreases, with the greatest decline for offenders over 30 years (Asher, *Reoffending and Parole: A Study of Recidivism Before and After the Criminal Justice Act 1985* (1988) 42).
- Sexual and other violent offences are overwhelmingly committed by men. In 1992, 92% of such offences which resulted in convictions were committed by men (Spier and Norris, 37).
- Despite comprising only 13% of the population,⁴ almost the same number of Maori were convicted of violent and sexual offences in 1992 as Pakeha; and Maori are more likely to be reconvicted (Spier and Norris, 37; Asher, 42).
- The link between mental illness of any sort and dangerousness is controversial and unclear. Some individual conditions, such as some forms of schizophrenic illness, are associated with an increased risk of violence, particularly when symptoms are acute or the illness is not adequately treated. Antisocial personality disorder is particularly problematic. Although many people considered dangerous are assessed as having an antisocial personality disorder, there is a significant degree of circularity inherent in its definition.
- People who are detained because they have been deemed “dangerous” will have limited opportunity to prove or disprove the correctness of that judgment.

58 However, there appears to be almost universal agreement that there is a small group of individuals who will repeatedly cause serious harm. The public rightly expect the law to protect them so far as possible from that harm. But how is the law to define the circumstances in which there is a need for protection against that harm? How likely should it be that harm will eventuate and what standard of proof is required? Who is to make the decisions, following what procedure and with what rights of appeal and review? In general these questions have been answered through the criminal justice and mental health systems.

⁴ This figure comprises those who identified their ethnic group, or one of their ethnic groups, as Maori. Statistics provided by the Department of Statistics from the 1991 Census.

The answers have been influenced by human rights principles which protect individuals against the exercise of powers by the state and, in so doing, seek to balance competing community interests.

HUMAN RIGHTS PRINCIPLES

59 Legal principles relevant to the terms of reference include common law principles and those contained in the Bill of Rights 1688, the New Zealand Bill of Rights Act 1990, and international human rights instruments (either binding or recommendatory). The principles relate to victims of crime, as well as to people who are suspected or convicted of crimes.

International obligations

60 The International Covenant on Civil and Political Rights (1966) recognises the right of individuals to

- freedom from cruel, inhuman or degrading treatment or punishment (Article 7),
- liberty and security of the person (Article 9), and
- equality before the courts and tribunals, a fair hearing in any criminal case or law suit, and to be presumed innocent until proved guilty if charged with a criminal offence (Article 14).

61 New Zealand has ratified this Covenant and our legislation must conform with its provisions. Also relevant are a number of international instruments which have recommendatory force for New Zealand. The most important are the Declaration of the Rights of Disabled Persons and the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.

62 The Declaration of the Rights of Disabled Persons was adopted by the United Nations General Assembly in 1975. It defines “disabled person” to mean

any person unable to ensure by himself or herself, wholly or partly, the necessities of a normal individual and/or social life, as a result of deficiency, whether congenital or not, in his or her physical or mental capacities.

63 As noted by the Human Rights and Equal Opportunity Commission of Australia in its report, *Human Rights and Mental Illness* (the Burdekin Report), this definition would include many people with a

mental illness (25). It would also include those people with some degree of intellectual handicap, or disability.⁵ Rights recognised by the Declaration include

- the right to any necessary treatment, rehabilitation, education, training and other services to develop skills and capabilities to the maximum (principle 6);
- . . . the right not to be subjected to more restrictive conditions of residence than necessary (principle 9).

64 The United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care were adopted by the United Nations Commission on Human Rights in 1991. They emphasise the concept of the least restrictive alternative in relation to treatment, and state that

- discrimination on the basis of mental illness is not permitted (principle 1.4);
- every person with a mental illness has the right to live and work, as far as possible, in the community (principle 3).

Bill of Rights 1688

65 To the promise in Magna Carta of due process of law in the exercise of royal powers, the Bill of Rights four centuries later added this guarantee:

That excessive baile ought not to be required nor excessive fines imposed nor cruell and unusuall punishments inflicted.

66 Parliament in 1988 confirmed that this provision is part of the law of New Zealand, in the Imperial Laws Application Act 1988 s 3 (see also *Imperial Legislation in Force in New Zealand* (NZLC R1 1987) para 4, 43–49).

New Zealand Bill of Rights Act 1990

67 The importance of the rights enunciated in a number of international human rights instruments has been emphasised by the enactment of the New Zealand Bill of Rights Act 1990. Indeed one of the purposes of the New Zealand Bill of Rights Act, as set out in the

⁵ “Intellectual handicap” and “intellectual disability” are used somewhat interchangeably in the relevant literature, in addition to the older terms of “mental retardation”, “mental subnormality” and “mental handicap”. Although the term “intellectual disability” appears to be the more generally preferred term, “intellectual handicap” is used in this report to avoid potential confusion with disability under s 108 of the Criminal Justice Act 1985.

Act's title, is to affirm New Zealand's commitment to the International Covenant on Civil and Political Rights. The New Zealand Bill of Rights Act affirms that

- everyone has the right not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment (s 9);
- everyone has the right to refuse to undergo any medical treatment (s 11);
- everyone has the right to freedom from discrimination on the grounds of disability (s 19);
- everyone has the right not to be arbitrarily arrested or detained (s 22);
- everyone who is arrested or detained under any enactment has the right to consult and instruct a lawyer without delay and to be informed of that right (s 23(1)(b)); to have the validity of the arrest or detention determined without delay by way of habeas corpus; and to be released if the arrest or detention is not lawful (s 23(1)(c));
- everyone charged with an offence has the right to a fair and public hearing by an independent and impartial court (s 25(a));
- no one may be convicted of an offence that was not an offence at the time the act or omission that is the basis of the offence occurred; and no person who has been finally acquitted of, convicted of, or pardoned for, an offence shall be tried or punished for it again (s 26);
- every person has the right to the observance of the principles of natural justice by any tribunal or other public authority which has the power to make a determination in respect of that person's rights, obligations or interests protected or recognised by law (s 27).

68 The Bill of Rights applies to people detained under mental health or criminal justice legislation. Section 3 states that it applies to acts done

- (a) by the legislative, executive, or judicial branches of the government of New Zealand; or
- (b) by any person or body in the performance of any public function, power, or duty conferred or imposed on that person or body by or pursuant to the law.

69 The Bill of Rights recognises that rights may not be absolute. They are subject, in terms of s 5, to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

70 The High Court has assumed that a person held under a committal order made under the Mental Health Act 1969 is detained in terms of s 22 of the Bill of Rights: *Re M* (1991) 1 NZBORR 217. The High Court has also recognised that the legal controls on a committed patient who is out of hospital on leave constitute detention “to maintain control” although it was termed a limited form of detention (*Re S* (1991) 1 NZBORR 239, 255–257).

71 In New Zealand and elsewhere judicial elaboration of “arbitrary”, in the context of the prohibition on arbitrary detention or arrest, focuses on two matters—substance and process:

Whether an arrest or detention is arbitrary . . . [turns] on the nature and extent of any departure from the substantive and procedural standards involved. An arrest or detention is arbitrary if it is capricious, unreasoned, without reasonable cause: if it is made without reference to an adequate determining principle or without following proper procedures. (Justice Richardson in *R v Goodwin* [1993] 2 NZLR 153, 189)

72 The substantive standards governing the exercise of a power of detention must be rationally related to the purpose of the power. The absence of such standards led the Supreme Court of Canada to strike down a Criminal Code provision requiring the detention in a psychiatric facility of a person acquitted of a criminal offence on the grounds of insanity (*R v Swain* [1991] 1 SCR 933). By contrast, in *R v Lyons* [1987] SCR 309, the Canadian Supreme Court upheld Criminal Code provisions allowing indeterminate sentences for “dangerous offenders”. The provisions did not give rise to an arbitrary detention as they applied criteria for the classification of an offender as dangerous and those criteria were carefully tailored to the legislative purpose (see Hogg, *Constitutional Law of Canada* (3rd ed, 1992), 1070–1072).

73 The requirement of procedural fairness is related to the guarantee of natural justice in s 27(1) of the Bill of Rights. A person who is subject to the possibility of detention must have a proper opportunity to know the allegations being made, to challenge the evidence in support of them, to present evidence and argument and to have an independent decision-maker. Fairness may also require rights of appeal and, given the reasons for detention, periodic review of the grounds for the order (see, eg, Hogg, ch 44 and 1073–1074; on the importance of the independent judicial role, see, eg, *Re M*, para 70).

Compliance with the Bill of Rights and international law

74 Parliament has the general power to enact legislation which is inconsistent with the Bill of Rights, and no provision may be held to be

invalid or ineffective by reason of that inconsistency (s 4). However, the Attorney-General must bring to the attention of the House of Representatives any provision in any Bill on its introduction which “appears to be inconsistent with any of the rights and freedoms contained in this Bill of Rights” (s 7). For instance, the Attorney-General referred to the prohibition on arbitrary detention in certifying that proposed road transport legislation providing for random breath screening of drivers appeared to be inconsistent with the Bill of Rights. He did not issue a certificate in respect of the proposed amendment to the mental health legislation referred to earlier (para 46).

75 New Zealand is required by virtue of its ratification of the International Covenant on Civil and Political Rights to ensure that its legislation conforms with that Covenant. If our legislation appears to be inconsistent, the complaints mechanisms set out in the Covenant and its first Optional Protocol, which New Zealand has accepted separately, might be invoked.

Victims’ rights

76 New Zealand co-sponsored the United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power adopted by the United Nations General Assembly in 1985. The Declaration calls for measures to facilitate the responsiveness of judicial and administrative processes to victims, including

- (a) informing victims of their role and the scope, timing and progress of the proceedings and of the disposition of their cases, especially where serious crimes are involved and where they have requested such information;
- (b) allowing the views and concerns of victims to be presented and considered at appropriate stages of the proceedings where their personal interests are affected, without prejudice to the accused and consistent with the relevant national criminal justice system . . . (Article 6).

77 The New Zealand Victims of Offences Act 1987 was based on the principles in the United Nations Declaration. Among other provisions, it allows for victim impact statements (s 8), for the victim’s views on bail to be conveyed to the judicial officer in certain cases (s 10), and for the victim to be notified of the release or escape of the offender in certain cases (s 11). In *Towards Equality in Criminal Justice* (1993), 70–71, the Victims Task Force makes recommendations concerning “offenders detained in mental health institutions”. These are discussed in paras 239–241 of this report.

78 The Department of Justice has also recently published the results of research and an issues paper relating to victims' needs and the criminal justice system.⁶ The issues paper notes that "[i]nvolvement and participation by victims in their cases . . . is an area of increasing emphasis in victimology" (31). Most survey respondents thought that victims should have some form of input into bail decisions, sentencing decisions and the conditions of release for offenders. Some respondents indicated

that victims should be able to stipulate conditions of release, or participate in the decision making about whether the offender should be released. The suggested methods of input included via Victim Impact Statements, advocates or solicitors, and directly at parole board hearings. (34)

79 These insights into the perspectives of victims are applicable not only to offenders within the criminal justice system but also to those detained in mental health facilities. By analogy, suggestions about input into parole hearings may be useful in comparable processes under mental health legislation, and are taken up in the related recommendations of the Victims Task Force (see paras 239–241).

80 The more general account of what victims themselves want is also important. They are by no means unanimous in a desire for retribution:

More than a third of the respondents indicated that the best outcome for victims is to see justice being done. In addition, a few said that victims want to see the offender being punished. Roughly a fifth of the respondents stated that victims wanted to be believed and receive acknowledgement and validation. Similar numbers mentioned that the best outcome is the restoration of life to normal or the way it was before the offence, and that victims want to receive compensation or reparation. Other best outcomes for victims were said to be safety from further abuse; the regaining of a sense of dignity, mana and control; having a say and being a part of the criminal justice process; and wanting the offender to be rehabilitated. (Lee and Searle, 44–45)

HUMAN RIGHTS IN THE MENTAL HEALTH CONTEXT

81 Incorporating a victims' perspective into measures aimed at protecting society does not necessarily imply conflict with the other human rights principles outlined above. It is helpful to clarify the implications of "human rights" for offenders in general and also

⁶ Lee, Searle and Atkinson, *Victims' Needs: The Results of the Survey* (1993); Lee and Searle, *Victims' Needs: An Issues Paper* (1993).

offenders with some degree of mental disturbance, as the Human Rights Commission did in its Kingseat/Carrington Report, *Mental Health—Patient Rights and the Public Interest* (1991).

82 The Kingseat/Carrington Report recalls that the principles in international instruments require that there be no discrimination on the basis of mental disability—a matter now emphasised by the Bill of Rights and the Human Rights Act 1993. This does not mean that there cannot be legislation for specific groups of people based on real differences. Detention is justifiable, as long as it is not arbitrary. Furthermore, there is a general recognition that

[f]ew human rights are absolute. In any given situation, two or more human rights may be in conflict, requiring a balance of one against the other. Therefore measures may be adopted which restrict the exercise of a right or freedom. But if so there is a corresponding duty on the part of the person or organisation so doing to act reasonably. In New Zealand, this balance is codified in sections 4, 5 & 6 of the Bill of Rights Act, which permits restrictions in certain situations. (Human Rights Commission Kingseat/Carrington Report, 13)

83 The Human Rights Commission goes on to say:

Should it be necessary to restrict patients' rights in the interests of community safety, the restriction of the right must be exercised reasonably. Assuaging unreasonable public fears and condemnation is not sufficient justification for the abrogation of a right. (14)

84 There may be occasions when limiting the rights of one group of patients on the basis of objective characteristics, such as their inherent dangerousness (if this can be established), assists in avoiding unjustified discrimination. The Human Rights Commission considered that the proposed (now enacted) provision for restricted patients in the mental health legislation would

provide an additional option for the disposition of patients who cause concern in this respect and go some way towards limiting the infringement of the liberties of other patients who are not considered dangerous. (56)

DETENTION: IMPLICATIONS FOR DIFFERENT ETHNIC GROUPS

85 Maori are admitted to and detained in penal and mental health institutions in greater proportions than are non-Maori.

86 Maori are over-represented in criminal justice statistics. Although Maori make up only 13% of the population, they comprised 43% of

the people convicted for a violent offence in 1992 and 46% of the prison population as at November 1991. Pacific Islanders are also over-represented in the prison population, although to a lesser extent.⁷

87 These statistics suggest that change to the criminal justice system could have greater implications for Maori and probably also Pacific Island offenders, whether or not they are more likely to be found within the very small group of people of most concern. The statistics also indicate that it is important that the needs of different ethnic groups be taken into account in the allocation of resources. The Law Commission notes that the *Briefing Papers for the Minister of Justice 1993* indicate that the Corrections Operations Group is examining service delivery and management processes that are more appropriate for Maori offenders (Volume One, Key Policy Issues, 36).

88 The discussion document prepared by Te Puni Kokiri, *Nga Ia O Te Oranga Hinengaro Maori—Trends in Maori Mental Health* (1993), reports that while admissions of Pakeha to psychiatric institutions have declined in recent years, Maori admissions have been rising:

Comparing 1981 to 1991, there were close to 1500 fewer Pakeha admissions to psychiatric hospitals and wards. Their place was taken up by an increase in Maori admissions (over 900), mostly with psychotic illnesses On current trends, in 10 years time, [Maori] may eventually make up half the population of psychiatric hospitals.⁸ (30)

89 Information is available both for age-standardised rates of admission and in relation to specific age groups in the population:

Using age-standardised rates the overall difference in admission rates (first admissions and readmissions) between Maori and non-Maori is about 31% higher for women and 43% for men.

. . . the most at risk period of life for Maori men is from 15 to 44 years of age, at which time they have twice the risk compared with non-Maori (if they live in the Northern region) of being admitted to a psychiatric hospital(24)

⁷ Statistics concerning convictions are from Spier and Norris, 37. Statistics concerning the prison population are from Braybrook and Southey, *Census of Prison Inmates 1991* (1992) 38. Note that the same sources indicate gender differences: 52% of women and 43% of men convicted of a violent offence were Maori; and 49% of female inmates and 46% of male inmates were Maori. Statistics demonstrating the relationship between the age and ethnicity of violent offenders were not available.

⁸ *Nga Ia O Te Oranga Hinengaro Maori* provides a picture of Maori mental health trends. However, the information presented may not be totally accurate due to the way in which Maori ethnicity is defined and collected in the health sector. Generally, Maori utilisation of inpatient hospital services is under-reported (“He Kakano Maori Health Handbook 1993”).

- 90 Of particular relevance to the terms of reference is the fact that [m]ore than half of the people placed by the courts in psychiatric hospitals under the Criminal Justice Act 1985 are Maori. (11)
- 91 Reasons suggested in the discussion document for these disturbing trends include the following:
- [A]s community services have got underway in the areas of high Maori population, it is Maori who have been left behind in the psychiatric hospitals. The apparently burgeoning rate of hospital admissions for Maori may be no more than the result of the failure of mental health services to provide culturally appropriate and safe community based services for Maori. (23)
- 92 *Nga Ia O Te Oranga Hinengaro Maori* makes a number of recommendations to address the issues it highlights, including that mental health and criminal justice legislation be reviewed to assess its impact on Maori (31).
- 93 It is not possible to predict exactly what effect, if any, legislative changes will have on Maori and non-Maori rates of admissions to psychiatric institutions. It may be anticipated, however, that increased detention powers could have greater effects on some population groups than on others. At the very least, the possible impact on Maori should be considered in reviewing proposals for change in mental health legislation, as well as the implications of the Treaty of Waitangi for such proposals. As said in *Nga Ia O Te Oranga Hinengaro Maori*, “[t]he Treaty places rights and responsibilities on both Maori and the Crown in the area of health” (8).

DETENTION NOT THE ONLY OPTION IN PROTECTING SOCIETY

- 94 Sometimes it is assumed that the only way of protecting members of the public from substantial risk of harm is by removing from the community people who pose that risk. Incapacitation is a traditional aim of the penal system and provides protection for the community from a dangerous person at least for the length of time that person is detained.
- 95 However, detention does have both social and economic costs, and therefore may not be the most effective means of protecting society in the long term. As discussed, increased detention powers may have greater impact on some ethnic groups than others, particularly on Maori and perhaps also Pacific Islanders. Any increase in present inequities

in detention patterns may have significant disadvantages for society as a whole. Moreover, there is little evidence that rates of imprisonment have any significant effect on rates of offending in general.

96 The heavy financial costs of institutionalisation lead to questions about the best use of scarce resources. Would society be better protected as a result of expenditure on further detention powers or on some other form of protection, such as well-supervised and supported community care?

97 In brief, although incapacitation is one valid way for society to protect itself against dangerous people, it is important to bear in mind that it may not be the only or even the most effective means. Its costs, both social and economic, must be taken into account, as well as its benefits.

GUIDING PRINCIPLES AND PROPOSITIONS

98 A consideration of what is known about dangerousness, of human rights obligations including the rights of victims, and of other issues outlined in this chapter has led the Law Commission to formulate the following principles and propositions which have guided the recommendations and options in this report:

- (i) Any power to detain a person must not be arbitrary. The power must be one justifiable in a free and democratic society. The justification must rationally relate to the purpose—in this case, the protection of members of the public from physical harm. Any limit on liberty should be the least restrictive needed to achieve its purpose.
- (ii) In addition, whether a power to detain people or to place other restraints on their liberty is arbitrary turns on
 - the independence, qualifications and authority of the person or body exercising the power;
 - the statement of the conditions for the exercise of the power of restraint: what are the criteria governing its exercise?
 - the procedures for the exercise of the power: are the individuals affected being given a fair hearing in accordance with natural justice?
 - the rights of appeal against, and review of, decisions taken in exercise of the power.

- (iii) Any proposal for a power of detention based solely on predictions of harmful behaviour must deal with the widely accepted opinion that predictions of dangerousness are likely to have only a 50% rate of accuracy. The person's past offending behaviour provides the best available means of prediction.
- (iv) In principle and in practice, the law providing for detention does not depend solely on judgments of dangerousness. Rather it recognises two principal ways in which individuals considered to be dangerous may be prevented from causing physical harm to members of society:
 - by criminal prosecution for an alleged offence, trial, conviction and sentence, including imprisonment for those convicted of offences of violence; and
 - by detention or other restraint on personal liberty under mental health legislation on the basis of findings of a mental disorder which involves a serious danger to the safety of others (or to the person detained).
- (v) A power of detention which essentially depends on a disability has to be justified against the prohibition of discrimination on the ground of disability.
- (vi) A detained person must not be subjected to cruel, degrading or disproportionately severe treatment or punishment. As well, everyone has the right to refuse to undergo medical treatment, although certain compulsory treatment might be able to be justified.
- (vii) Any assessment of management options for dangerous people should take account of the social and economic costs as well as the benefits of the options, including the implications of any proposals for Maori and other ethnic groups.

3

Protecting the community: mental health issues

INTRODUCTION

99 The first term of reference calls on the Law Commission

to consider, with the purpose of protecting members of the public from substantial risk of harm from individuals whose release into the community would pose that risk—

- 1 relevant provisions in the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Criminal Justice Act 1985, including the definition of mental disorder in the 1992 Act . . .

. . .

[and] to consider appropriate powers and procedures including safeguards for the protection of the individuals concerned.

100 At the heart of this term of reference is the definition of “mental disorder” on which the application of mental health legislation depends. The recent controversies and the amendments proposed in the 1994 amendment Bill show that the conditions of “intellectual handicap” and “personality disorder” are those of most immediate relevance.

101 This chapter

- discusses the concept of mental disorder in the context of mental health legislation (paras 102–114);
- addresses three questions concerning intellectual handicap and personality disorder (paras 115–174 and 175–228):
 - does the present statutory definition of mental disorder include intellectual handicap and personality disorder?
 - are intellectual handicap and personality disorder appropriately regarded as mental disorders, and if so should the present

- statutory definition be amended to explicitly include them?
- if intellectual handicap and personality disorder cannot be appropriately classified as mental disorders, are there people with these conditions who pose a substantial risk to others and who cannot be managed under any existing system? If so, should a new system be established to manage these people?
- considers the powers conferred by mental health legislation over those who come within its scope (paras 229–238);
- considers the rights of victims, issues related to acquittals on account of insanity and aspects of the implementation of the mental health legislation (paras 239–245).

MENTAL DISORDER AND MENTAL HEALTH LEGISLATION

Statutory definitions of mental disorder

102 The definition of “mental disorder” in the Mental Health (Compulsory Assessment and Treatment) Act 1992 differs from that in the former Act, the Mental Health Act 1969. While the definition in the 1969 Act expressly included mental subnormality, the equivalent definition in the 1992 Act does not. That narrowing has major consequences for compulsory admission under the 1992 Act. It is also important in relation to the Criminal Justice Act 1985, because the 1992 definition is the basis for determining that a defendant in criminal proceedings is under disability and for the power of a judge to order that a convicted defendant be detained in a psychiatric hospital, instead of sentenced.

103 The 1992 Act states in s 2:

“Mental disorder”, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it—

- (a) Poses a serious danger to the health or safety of that person or of others; or
- (b) Seriously diminishes the capacity of that person to take care of himself or herself.

104 Section 4 contains general rules relating to liability to assessment or treatment and provides:

The procedures prescribed by Parts I and II of this Act shall not be invoked in respect of any person by reason only of—

- (a) That person's political, religious, or cultural beliefs; or
- (b) That person's sexual preferences; or
- (c) That person's criminal or delinquent behaviour; or
- (d) Substance abuse; or
- (e) *Intellectual handicap*. (emphasis added)

105 The definition in the 1969 Act was as follows:

"Mentally disordered", in relation to any person, means suffering from a psychiatric or other disorder, whether continuous or episodic, that substantially impairs mental health, so that the person belongs to one or more of the following classes, namely:

- (a) Mentally ill—that is, requiring care and treatment for a mental illness:
- (b) Mentally infirm—that is, requiring care and treatment by reason of mental infirmity arising from age or deterioration of or injury to the brain:
- (c) Mentally subnormal—that is, suffering from subnormality of intelligence as a result of arrested or incomplete development of mind. (s 2)

106 Sections 108 and 118 are the principal provisions of the Criminal Justice Act 1985 which depend on the definition of mental disorder. Section 108, dealing with defendants who are not tried because they are under disability, provides:

- (1) For the purposes of this Part of this Act, a person is under disability if, because of the extent to which that person is mentally disordered, that person is unable—
 - (a) To plead; or
 - (b) To understand the nature or purpose of the proceedings; or
 - (c) To communicate adequately with counsel for the purposes of conducting a defence.

107 Section 118 provides that where a person is convicted of an offence, the court, if satisfied on the production of two medical certificates that the person is mentally disordered, and that the person's mental condition requires that he or she should be detained in a hospital either in his or her own interest or for the safety of the public, may order that the person be detained in hospital as a patient, instead of passing sentence.

108 When the Criminal Justice Act 1985 was enacted, s 2 defined "mentally disordered" as having the same meaning as in the Mental Health Act 1969. It is now defined as having the same meaning as it has in the 1992 Act. It has been suggested that when the Criminal Justice Act was amended to apply the new definition, the consequences

of doing so were not clear (*Police v M* [1993] DCR 1119, 1124, Judge Boshier).

109 During this century mental health legislation in New Zealand and elsewhere has evolved away from an emphasis on institutional care towards a greater focus on community treatment. It now recognises that assisting people to remain in their communities is generally preferable to confinement. In addition, modern mental health legislation attempts to differentiate between different groups of mentally impaired people. More so than in the past, it affirms the rights of those with mental disabilities, including their right to treatment. To a large extent changes in mental health services and legislation reflect the optimism arising from new methods of treatment made available in the 1950s, which significantly increased the efficacy of treatment for the mentally ill.⁹

110 The 1992 Act was passed after a decade of policy development and discussion among the relevant agencies and community organisations. As a Bill it received considerable scrutiny at the Select Committee stage during both the Labour and the National administrations. The Bill was considered in a non-partisan way. Key features of the 1992 Act, compared with its 1969 predecessor, are the new definition of mental disorder, the introduction of short periods of assessment and treatment, regular reviews for compulsory status to be continued, compulsory community treatment orders, and increased patients' rights.

Changing concepts of mental disorder

111 The fact that the definition of mental disorder in New Zealand legislation has altered demonstrates that its meaning is not fixed in time. It is difficult to define in any precise way what mental illness or mental disorder is; it is also not very clear how the two concepts relate to each other.¹⁰ Attempts have been made to define mental illness in terms of the absence of health, presence of suffering, or pathological

⁹ For a short account of changes in psychiatric treatment, see Curran and Harding, *The Law and Mental Health: Harmonizing Objectives* (1978) 14–16.

¹⁰ The Parliament of Victoria Social Development Committee interim report on the Inquiry into Mental Disturbance and Community Safety (*Strategies to Deal with Persons with Severe Personality Disorder who Pose a Threat to Public Safety*, 1990) xvi–xvii gives this useful explanation of the meaning of “mental disturbance”: “A general term usually used synonymously with mental malfunction and *mental disorder*; [which are] colloquial terms for which there are no clinical criteria but refer to a wide range of mental illnesses and other disorders or disabilities including intellectual disability, senility, brain damage and personality or other behavioural disorder.” Mental illness is described as “a clinical term used by psychiatrists to refer to a cluster of psychological and physiological symptoms which cause a person suffering and distress and which represent a departure from the person’s usual pattern and level of functioning.”

process, whether physical or psychological.¹¹ *Legal* definitions are not usually identical with *psychiatric* definitions, notwithstanding attempts to achieve consistency. In interpreting statutory definitions, the ordinary meaning of the words may be employed instead of, or in conjunction with, the meanings given by psychiatric experts, (eg, see *R v T* [1993] DCR 600, 610).

112 International consensus and consistency in *psychiatric* definitions and diagnoses are sought by means of international diagnostic systems. The two principal systems in use today are the *International Classification of Diseases*, tenth edition (ICD-10); and the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*, third revised edition (DSM-III-R).¹² In the latest versions of both these classificatory systems, the term “mental disorder” is used instead of “mental illness”. The range of disorders included in the two systems is comprehensive and seems to include all conditions which psychiatrists may have been trained to understand and help or for which people may seek help. In addition to the “psychotic illnesses”, the categories include, for instance, sleep disorders, eating disorders and disorders relating to substance abuse.

113 Both ICD-10 and DSM-III-R include intellectual handicap: under the heading of “developmental disorder” in DSM-III-R, but in a separate category of “mental retardation” in ICD-10. Both systems also cover personality disorders: DSM-III-R has a category employing that term, whereas ICD-10 has the more general category of “disorders of adult personality and behaviour”. In both systems all these conditions are differentiated from such disorders as schizophrenia and mood disorders.

Are people with mental disorders dangerous?

114 The vast majority of the mentally ill are not offenders and are not dangerous to others, although there appears to be an increased level of violence accompanying certain mental disorders, particularly with “established schizophrenics who have drifted out of any ongoing care and supervision” (Mullen, “Violence and Mental Disorder” (1988) 40 *British Journal of Hospital Medicine* 460, 463). However, this increased risk of violence is not high and should be seen in context:

¹¹ For a discussion of the concept of mental illness, see Gelder, Gath and Mayou, *Oxford Textbook of Psychiatry* (wnd ed, 1988) 76 and 77.

¹² DSM-IV was finalised in June 1994 and is being introduced in New Zealand. We understand that it is more similar to ICD-10 than previous DSM editions.

Compared with the magnitude of risk associated with the combination of male gender, young age, and lower socioeconomic status, for example, the risk of violence presented by mental disorder is modest. Compared with the magnitude of risk associated with alcoholism and other drug abuse, the risk associated with major mental disorders such as schizophrenia and affective disorders is modest indeed. Clearly mental health status makes at best a trivial contribution to the overall level of violence in society. (Monaghan, “Mental Disorder and Violent Behaviour: Perceptions and Evidence” (1992) *American Psychologist* 51, 519)

INTELLECTUAL HANDICAP: A MENTAL DISORDER OR NOT?

115 This section addresses the first two questions asked in para 101, in relation to intellectual handicap:

- Does the present statutory definition of mental disorder include intellectual handicap?
- Is intellectual handicap appropriately regarded as a mental disorder, and if so should the present statutory definition be amended to explicitly include it?

116 The answers to these questions are not clear-cut and understanding them requires some appreciation of the development of mental health law and services, and the perspectives of health and disability professionals and of judges.

Background

117 There appears to be reasonable consensus about what constitutes intellectual handicap. The definition generally used in New Zealand is that of the American Association on Mental Deficiency, which defines mental retardation as “significantly sub-average general intellectual functioning resulting in deficits in adaptive behaviour, and manifested during the developmental period.” (Grossman H J (ed) *Classification in Mental Retardation* Washington DC, American Association on Mental Deficiency 1983). Both ICD-10 and DSM-III-R identify four subtypes of retardation: mild (IQ 50–70), moderate (IQ 35–49), severe (IQ 20–34) and profound (IQ below 20) (*Oxford Textbook of Psychiatry*, 827).

118 There may be less agreement about the application of the concept of intellectual handicap in individual cases, particularly in relation to people with mild handicaps (IQs in the 50–70 range) or people on the

borderline between being mildly handicapped and of low intelligence. It is stated in the *Oxford Textbook of Psychiatry* that

People with mild retardation account for about four-fifths of the mentally retarded. Usually their appearance is unremarkable and any sensory or motor deficits are slight. Most people in this group develop more or less normal language abilities and social behaviour during the pre-school years, and their mental retardation may never be formally identified. In adult life most of them can live independently in ordinary surroundings, though they may need help with housing and employment, or when under unusual stress. (829–830)

119 Lack of agreement about whether a particular individual is mildly retarded, borderline, or simply of low intelligence will have implications for which services are regarded as most appropriate for that individual.

120 From a practical viewpoint,

profoundly handicapped people, those whose capacity to understand and control their environment is minimal, are extremely limited in their range of behaviour, so that the notion of their behaving “criminally” need not be considered. (Gunn and Taylor (eds), *Forensic Psychiatry* (1993), 316)

121 However, the people who are the most problematic in definitional terms - the mildly intellectually handicapped and borderline—are as able as people of ordinary intelligence to present a danger to members of the public. They are also, as a group, most likely to benefit from normalisation trends and are the most numerous among the intellectually handicapped: about 85% of the 1% of the population that has an intellectual handicap are mildly handicapped (IHC Position Paper, *Proposed Changes to the Mental Health Act* (1994), 2, relying on information in DSM-III-R).

122 As noted, while the Mental Health Act 1969 explicitly included mental subnormality in its definition of mental disorder, there is no such explicit reference in the 1992 Act. This change reflects the evolution in attitudes towards the intellectually handicapped that has occurred in New Zealand over the last few decades. The change is paralleled in other countries: for example, after the dramatic increase in the number of intellectually handicapped in institutional care in England and Wales (ie, from 6000 in 1916 to 50 000 in 1939),

[i]n the 1960s, the need for reform was recognized, partly because of changes that had already been effected in psychiatric hospitals . . . , partly because of improved psychological research, partly because of campaigning by groups of parents, and partly because of public concern about the generally poor conditions in which the mentally retarded were

housed. . . . The last 20 years have seen the acceptance in all developed countries (especially Scandinavia) of the need for methods of care with a less medical approach. . . . Among the new concepts of care the main principle is “normalization”, an idea developed in Scandinavia in the 1960s. (*Oxford Textbook of Psychiatry*, 846–847)

123 Similarly, information on trends in New Zealand shows the extent to which this country has tried to emphasise methods of care “with a less medical approach”—involving a move away from hospital care. In 1974 there were 4312 people diagnosed as mentally subnormal in psychiatric hospitals (including hospitals for the intellectually handicapped); in 1992 there were 1952 people with the equivalent diagnosis of mental handicap.¹³

124 The change to the definition of mental disorder in the 1992 Act, emphasised by the exclusion of intellectual handicap as a justification in itself for liability to compulsory assessment or treatment (para 104), can be seen as an expression of the view that intellectual handicap is not an illness in the same sense as a psychotic illness and that it is not appropriately treated in mental health institutions or by mental health personnel. The trend towards separating services for people with intellectual handicap from those for people with mental illness has increased, to the extent that services for the intellectually handicapped have, since about 1990, been grouped for health funding purposes with disability services rather than with psychiatric services.

Views of health professionals

125 As noted above, intellectual handicap is included within the international diagnostic systems (ICD-10 and DSM-III-R) and distinguished from mental illnesses such as schizophrenic or mood disorders. There does not appear to be international consensus among health and other professionals about whether it is appropriate to regard intellectual handicap as a “mental disorder”, although a degree of consensus on the issue has emerged in New Zealand. The views of professionals, as well as legislative definitions, are best understood in the context of services in particular countries. In this country, mental health services have tended to shift away from inclusion of services

¹³ The 1974 figure is from Jeffery and Booth, *Survey of Patients in Psychiatric Hospitals* (Department of Health Special Report Series 47) 15. The 1992 figure is from New Zealand Health Information Service, *Mental Health Data 1992* (Ministry of Health, 1993) 4. These figures should be treated with some caution, as diagnostic practices may have differed between the years surveyed. The same sources indicate that the number of people in psychiatric hospitals with diagnoses of mental illness (ie, conditions other than intellectual handicap) also declined sharply over this period: from 4515 in 1974 to 2532 in 1992.

for the intellectually handicapped: as well as the separation of funding, the training of mental health professionals now has less of a focus on people with intellectual handicap. For example, there are no longer specialist health professionals who are qualified as training officers or as psychopaedic nurses (although health workers may have relevant generic qualifications).

126 It appears that New Zealand professionals who work with intellectually handicapped people now de-emphasise those characteristics previously held to be common between intellectually handicapped and mentally ill people, and emphasise the differences between the two groups. It is argued that while mental illness represents a deviation from the ill person's own norm, for the intellectually handicapped person his or her capacities *are* the norm. Also, the amenability of the mentally ill person to treatment and change is contrasted with the underlying developmental disabilities of the intellectually handicapped person which cannot change (although their consequences can be ameliorated by means of specific educational strategies). Thus, in his submission to the Law Commission, Dr A I F Simpson (Consultant Psychiatrist, Regional Forensic Psychiatry Service, Wellington) says:

The nature of the care, containment and support that intellectually disabled people require however is very different from that of the mentally ill. Whilst they require psychological and psychiatric understanding and appropriately structured care, to define such processes as treatment is to miss the difference between the onset of an illness which is largely treatable and reversible in the case of major mental illness [and a condition] which is simply managed by training, allowance of maturation and caring support in the case of an intellectual deficit. This difference rightly requires different legal mechanisms for each group.

127 Similarly the IHC considers that intellectual handicap

is not a medical disorder, although it may sometimes be coded in a medical classification of diseases. Nor is it a mental disorder, although it may sometimes be coded in a classification of psychiatric disorders.

. . . Intellectual handicap is primarily a learning disability. (IHC Position Paper, 2 and 8)

Judicial decisions

128 The courts have considered the question of whether people with intellectual handicap can be “mentally disordered” in the context of both disability hearings under s 108 of the Criminal Justice Act and compulsory treatment order hearings under the 1992 Act. A number of

the judgments consider the meaning and effect of s 4(e) of the 1992 Act, with its provision that the procedures in Parts I and II of the Act cannot be invoked by reason only of a person's intellectual handicap (para 104). Appendix E summarises some of the more important cases.

129 These cases show that the courts consider that “intellectual handicap” can come within the meaning of “mental disorder” for the purposes of disability hearings under the Criminal Justice Act 1985. There is a general acknowledgement that the definition of mental disorder is capable of both broad and narrow meanings, dependent in part on the meaning given to the phrase “abnormal state of mind”. In both *Police v M* [1993] DCR 1119 and *Police v K* (unreported, Porirua District Court, CRN 2091011601, 15 April 1993), there is some discussion about whether this phrase means abnormal in relation to a particular person's normal state, or abnormal when compared with the majority of people in the community. The decisions of the courts suggest that they tend to the latter, and broader, view in the context of disability hearings.

130 The justification given to the use of that broader meaning in disability hearings is that a purposive interpretation is appropriate to enable justice to be done. It was held by Judge McElrea in *R v T* [1993] DCR 600, 10 FRNZ 195 that s 4(e) of the 1992 Act has no application to disability hearings.

131 In May 1994 there were four people with a primary diagnosis of intellectual handicap in psychiatric hospitals who had been found to be under disability and who were special patients. (For a definition of the term “special patient” and other concepts in mental health legislation, see app A.) There were a further two special patients with a primary diagnosis of brain damage who had been found to be under disability. These figures are approximate.¹⁴

132 In the context of the compulsory treatment provisions of the 1992 Act, however, it is clear that s 4(e) does have application. Although a person may not be detained under the 1992 Act if he or she is *solely* intellectually handicapped, the provisions of the 1992 Act may apply if the person also has a mental disorder—either in addition to the intellectual handicap or resulting from it. It may be relevant that in two of the three cases discussed in appendix E which resulted in a decision

¹⁴ Information received from the Ministry of Health. The figure of “four” should be treated with some caution as diagnostic practices can vary. In addition to those four special patients, it is likely that there are other intellectually handicapped patients found unfit to stand trial who have been made ordinary compulsory patients under s 115(2) of the Criminal Justice Act.

to continue the compulsory treatment of intellectually handicapped people, quite significant levels of intellectual handicap seem to have been involved.

133 The High Court and Court of Appeal have yet to consider the question of the inclusion of intellectual handicap in the definition of mental disorder.

134 The conclusions in some recent judgments, to the effect that in some cases people with intellectual handicap do come within the definition of mental disorder in the 1992 Act, are not consistent with the view generally held by New Zealand health and disability professionals that intellectual handicap should be seen as distinct from mental disorder. Because the 1992 Act has been in force for a comparatively short time and there are no higher court rulings on the matter, the judges' findings that certain intellectually handicapped people are mentally disordered may in practice have had little impact on clinical decisions to admit or discharge patients.

Intellectual handicap: generally not a mental disorder

135 All classifications and definitions in this area are to some extent artificial and give rise to difficulties in application. As has been noted, legislative definitions relevant to intellectual handicap vary throughout the world and can best be understood in the context of services in particular countries. Proposals for change should be based on the needs and interests of the parties involved, in this case intellectually handicapped people and society in general.

136 The 1992 definition was in general *intended* to exclude intellectually handicapped people from the scope of the 1992 Act.¹⁵ This was the result of careful decisions about the most appropriate kind of services for intellectually handicapped people, and consequential funding arrangements.

137 In ruling that intellectual handicap can come within the 1992 definition of mental disorder for the purpose of disability hearings, it

¹⁵ Hon David Caygill, Minister of Health, in his 1987 speech on the first reading of the Mental Health Bill (which became the 1992 Act) 485 NZPD 1628–1629, stated: "There is specific exclusion of religious or cultural belief, sexual preference . . . and intellectual handicap as reasons on their own for detention"; see also Hon Katherine O'Regan, Associate Minister of Health, who in 1992 referred to s 4 as an essential limb of the definition of mental disorder (522 NZPD 6862), saying, "This narrower definition of mental disorder for statutory purposes accommodates civil rights concerns and, at the same time, provides reasonable congruence with current psychiatric knowledge and practice."

may be that the courts are stretching the definition to ensure that justice is done. In relation to hearings under the 1992 Act, the definition of mental disorder is most applicable to those with the most severe handicaps and who are least likely to pose any sort of risk of harm to the public. In both contexts, the question whether any particular condition meets the statutory definition of mental disorder is seen to depend to some extent on the meaning given to “*abnormal* state of mind”. It is not clear that the word “abnormal” adds anything significant to the meaning of mental disorder, and consideration might be given to its deletion.

138 The Law Commission considers that the definition of mental disorder should not be widened to include a broader group of people with intellectual handicap. Our reasons are the lack of professional consensus on the issues, the prolonged process which led to the present statutory definition, and the implications for service provision and funding.

139 We consider, however, that not including intellectual handicap specifically in the definition of mental disorder leaves a number of issues unresolved. In addition to the difficulties resulting from the difference in views between the judges and health professionals about whether intellectual handicap is included within the definition of mental disorder, there are issues relevant to community safety. We consider that our proposals addressing community safety questions in the next section will also help resolve some of the more general issues. We also recommend that those involved in interpreting and applying the 1992 Act should be encouraged in appropriate ways to address the differences in the understanding of that Act and especially of the definition of mental disorder. The Ministry of Health should facilitate this process by providing guidance, encouraging dialogue and providing written notes, on when it may be necessary and legally sustainable to regard intellectually handicapped people as being mentally disordered within the definition in the 1992 Act. Not all clinicians may be aware of some case law indicating circumstances in which mental disorder can be interpreted so as to include intellectual handicap.

Resulting problems for community safety?

140 If intellectual handicap cannot be appropriately regarded as a mental disorder, at least in general, and is not explicitly included in the definition of mental disorder in the 1992 Act, will there be intellectually handicapped people posing a substantial risk to the safety of members

of the public who cannot be adequately managed by existing systems?

141 As a group, intellectually handicapped people pose no more risk to the public than people of ordinary intelligence:

There is no evidence of a general causal link between the many conditions subsumed under the clinical label of mental handicap and a propensity to offend. (*Forensic Psychiatry*, 316)

142 Of those with intellectual handicap who pose a substantial risk of harm, some can be, and are, dealt with under the criminal justice system, by prosecution, trial, conviction and sentence. But others who come to the notice of police or mental health authorities for allegedly criminal and dangerous activities may not be the subject of prosecution; both for these people, as well as those who are prosecuted but found unfit to stand trial, the mental health system may be an inadequate alternative. Given that neither mental health nor criminal justice legislation is applicable or appropriate for all intellectually handicapped people who are dangerous, there is a threat to community safety arising from the lack of any appropriate legislative protection.

143 There are a number of statutory and service-related difficulties with the present system's ability to manage adequately some intellectually handicapped people who are thought to be dangerous. They relate to three sets of people who are legally distinct but probably not always distinguishable in behavioural terms. These groups are some intellectually handicapped people who are non-offenders but pose a risk of harm, alleged offenders found to be under disability, and convicted offenders. A particular intellectually handicapped person with difficult behaviour may be in the first category rather than either of the last two because of the influence of such factors as family wishes and prosecutorial discretion. Relevant to that discretion and indeed more broadly is the Law Commission's reference on criminal procedure and in particular its work on prosecution: see eg, *The Prosecution of Offences (issues paper)* (NZLC PP12 1990).

Intellectually handicapped non-offenders who may threaten community safety

144 Not all intellectually handicapped people with a capacity for violent or sexual offending may come to the formal attention of the criminal justice system. Sometimes people whose actions give grounds for prosecution are informally diverted from that system—either because it is assumed that, if prosecuted, the person will be found under disability, or from benevolent motives. It may be thought

inhumane for a person with an intellectual handicap to be subjected to the full rigours of a criminal prosecution or it may be feared that any conviction will result in an inappropriate sentencing decision.

145 In accordance with the goal of normalisation and because of the desirability of triggering society's usual mechanism for responding to dangerous offending behaviour, people with intellectual handicap should so far as possible be charged in accordance with usual prosecution practices if offending is suspected. But we consider that the reluctance to lay a charge in some cases is understandable, given that criminal justice procedures are a serious exercise of state powers and may be inappropriate.

Intellectually handicapped alleged offenders found under disability: definitional problems

146 The power given by s 108 of the Criminal Justice Act to find that a defendant is under disability should not depend on the 1992 Act's definition of mental disorder. The result of that linkage can be contrary to justice. The purpose of a disability hearing is to ensure procedural fairness, which is one element of the right affirmed in s 25(a) of the New Zealand Bill of Rights Act 1990 to "a fair and public hearing by an independent and impartial court". (This right is also important in the Law Commission's reference on criminal procedure.) The focus of s 108 should be the defendant's ability to understand and communicate to a degree which is sufficient to enable participation in a criminal trial. That focus is different from that of the 1992 Act's definition of mental disorder, which gives rise to two difficulties. First, the concept of mental disorder in the 1992 Act incorporates the element of dangerousness or diminished capacity for self-care, although these matters are irrelevant to an individual's capacity to comprehend and participate in a trial. Secondly, the range of mental impairment covered by the 1992 definition of mental disorder is narrow.

147 Although the current definition has not inhibited judges from finding some intellectually handicapped people to be mentally disordered for the purposes of disability hearings, we consider that the implications of the 1992 definition for the related provisions of the Criminal Justice Act do not appear to have been properly thought through. The linking of s 108 to the 1992 definition of mental disorder is inadequate not only for intellectually handicapped people, but also for others who are unfit to stand trial for reasons which are not related to the 1992 definition, for example brain damage acquired in adulthood.

148 The Law Commission agrees therefore that s 108 of the Criminal

Justice Act should be amended. The purpose of the amendment should be to ensure that the focus of a disability hearing is the defendant's ability to communicate and understand. The submission on the 1994 amendment Bill elaborates this point and suggests that the cause of the defendant's incapacity should not be relevant, whether it be psychosis, infirmity, intellectual disability, or brain damage acquired in adulthood (see app B).

*Intellectually handicapped offenders found under disability:
criteria for discharge*

149 Although a special or compulsory patient may have been found to be under disability, it may not be possible to continue to detain the patient following reclassification or upon review (see app A for an outline of reclassification procedures). The test and criteria for discharge are set out in ss 2 and 35 of the 1992 Act. Section 35 states, "if . . . the responsible clinician considers that the patient is fit to be released from compulsory status, that clinician shall direct that the patient be released from that status forthwith." Section 2 defines the phrase "fit to be released from compulsory status" as meaning "no longer mentally disordered and fit to be released from the requirements of assessment or treatment under this Act".¹⁶ The phrase, "fit to be released from the requirements of assessment or treatment under this Act", raises the question of whether the test for release from the mental health system is the same as the test for admission to it.

150 The discharge test gives rise to a number of difficulties in relation to intellectually handicapped people who enter the mental health system after being found to be under disability. First, they may have been found to be mentally disordered and hence under disability because the term mental disorder in s 108 has been interpreted widely, and because, in accordance with Judge McElrea's interpretation (para 130 above), s 4(e) does not apply to under disability hearings under the Criminal Justice Act. But such people may not be considered mentally disordered for the purpose of the 1992 Act. Secondly, people may have entered the mental health system before the 1992 Act came into effect under the previous wider meaning of mental disorder which expressly included mental subnormality. Once their status is reclassified or they are reviewed, the narrower 1992 meaning of mental disorder will apply, requiring their discharge. This appears to have occurred with at least two people among the widely publicised "37" (para 45).

¹⁶ There exists some difficulty and, possibly, confusion about the application of this test: see *Re T* discussed in app E, para E13.

Consequences of disability findings

151 The consequences of finding a defendant to be under disability seem unsatisfactory. A person may be detained for many years without proof that any offence occurred or that the defendant was in fact physically responsible for it. Several possibilities, not mutually exclusive, could be considered to address these difficulties.

152 In some circumstances, alleged offenders with intellectual handicap may be assisted to participate to a greater extent in the trial process. It is clear, however, that whatever help is given, some people will be unable to communicate and comprehend sufficiently to ensure a just trial.

153 A second approach to ensuring justice and appropriate dispositions for alleged offenders who are intellectually handicapped, is to develop procedures enabling a court to attempt to determine a person's innocence or responsibility even though, because of unfitness, he or she cannot stand trial. Models are provided by legislation in New South Wales and the United Kingdom. If a person has been found unfit to stand trial, the Mental Health (Criminal Procedure) Act 1990 (NSW) enables a special hearing to address the issue of "guilt" or innocence. The hearing will be conducted in front of a jury, and take place in a form that is as near as possible to a trial at which the person is presumed to have pleaded not guilty. A person will be acquitted

unless it can be proved to the requisite criminal standard of proof that, on the limited evidence available, the person committed the offence charged, or any other offence available as an alternative to the offence charged. (s 19(1))

154 If a jury finds that the person in fact committed the offence, or some other related offence, the court must then

indicate whether it would have imposed a sentence of imprisonment if the trial had been a normal criminal trial, and if so, it must nominate a so-called "limiting term". This term must be the best estimate of the sentence the Court would have considered appropriate if the special hearing had been a normal trial of criminal proceedings against a person who was fit to be tried for that offence and the person had been found guilty of that offence. (NSW Institute of Psychiatry, *The 1990 Mental Health Act—A Guide Book*, 33)

155 The court will then, after receiving advice from the Mental Health Review Tribunal, make an order concerning the person's custody—either in hospital or some other place as considered appropriate. The jury can also find the person "not guilty on the grounds of mental

illness”, in which case the court has the same options as if the verdict had been returned at an ordinary criminal trial.

156 Similar legislation is found in the United Kingdom: the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991. Under this Act, a court which has determined that a person is unfit to plead must conduct a “trial of the facts” limited to determining whether the defendant committed the physical act involved in the offence. A defendant found unfit to plead but not proved on a trial of the facts to have committed the act will be discharged as acquitted. In other cases, except where the offence has a mandatory sentence, the court has four broad options: to admit to hospital, with or without a restriction order; to discharge the defendant absolutely; to make a guardianship order under the Mental Health Act 1983 (UK); or to make a supervision and treatment order.

157 The Department of Justice has completed some initial work on reviewing Part VII of the Criminal Justice Act, including issues relating to disability findings.¹⁷ It suggests, for example, that a provision similar to one found in Canadian legislation (s 672.33 of the Canadian Criminal Code) relating to defendants found under disability could be considered. The relevant Canadian court is to hold an inquiry every two years to decide whether sufficient evidence can be adduced to put the defendant on trial. If the prosecution does not establish the continued existence of such evidence, the court is to acquit the accused. We consider that the proposed review of Part VII should consider such options and include as well the position of defendants acquitted on account of insanity.

Appropriate facilities

158 What is the most appropriate facility for detaining and managing intellectually handicapped offenders and alleged offenders: hospital, prison, or some other facility? An intellectually handicapped alleged offender found to be under disability is usually detained in a mental health institution following an order for special or compulsory patient status. But this may not be the most appropriate environment for the person’s management needs, given the increased focus of psychiatric hospitals on the treatment of the mentally ill. This problem will also arise in the context of any new provisions relating to the consequences of disability findings (paras 149–157).

¹⁷ Tollefson, “Suggested Reforms to the Mental Disorder Provisions of the Criminal Justice Act 1985” (unpublished, 1992).

Convicted intellectually handicapped offenders

159 The appropriate disposition for intellectually handicapped people who are fit to plead and are convicted has been considered in a number of cases. The recent cases of *R v Arama* (1993) 10 CRNZ 592 and *R v P* (1993) 10 CRNZ 250 highlight the difficulties.

160 Arama appealed to the Court of Appeal on the ground that his sentence of four years imprisonment for convictions of four counts of arson was excessive or inappropriate. Justice Casey acknowledged that “the appellant presented a difficult sentencing problem because he is severely intellectually handicapped”. He had previous convictions for car conversion, theft, assault, malicious damage and burglary. Although psychiatric reports indicated Arama knew the difference between right and wrong, and had a sufficient understanding of court proceedings to be able to plead, he was also described as being “roughly as able to take care of himself as a 5-year-old child”. The He Putea Atawhai Trust residential hostel, a full-time residential home for functionally disabled people, proposed that Arama be placed there, but could not guarantee containment or unconditional supervision; there would be risks to the Trust or the community from his presence (593–594). Justice Casey considered that Arama required

asylum in the true sense of that word—namely a structured environment which will give him the care and protection he needs, coupled with supervision and containment adequate to ensure that he will not reoffend. (593)

161 In the absence of such facilities, the appeal was dismissed: “There are no longer any avenues open to the Court short of imprisonment which could ensure the humane type of custody called for here” (594).

162 In *R v P* (1993) 10 CRNZ 250 the defendant, whose IQ was in the 48–50 range, was found guilty of rape. Justice Williams considered that

imprisonment for this offender with his particular disability would be inappropriate, disproportionate, and unsuitable. Indeed, it would in my view probably amount to cruel or disproportionately severe punishment, which is generally precluded by s 9 Bill of Rights Act 1990. (255)

163 Instead of imprisonment, the court imposed one years supervision involving at least six months residence in the care of an experienced mental health trust organisation and a programme specifically developed for his needs.

164 The Auckland District Law Society states that

[b]ecause of their impulsiveness and slowness in learning from previous experience, intellectually disabled offenders generally do not cope well in a penal setting, where they are often disruptive and vulnerable to exploitation by other inmates. (“Special Patients” (1994) 16)

165 Moreover, as stated by Dr Barbara Disley,

... there is little doubt that prison for this group is not the most desirable alternative. Prison offers little opportunity for those with intellectual or cognitive impairment to learn appropriate behaviours or to modify their disturbed behaviour patterns. (“Editorial” (Autumn 1994) Mental Health News 3)

Options

166 Since some intellectually handicapped people, who are offenders or alleged offenders and who are considered dangerous, cannot be dealt with through the mental health or the criminal justice systems, there is a gap in the law’s protection of the community. Three options for remedying the situation are

- (i) amending mental health legislation to provide it with some ability to cope with intellectually handicapped offenders, in essence the approach of the 1994 amendment Bill; or
- (ii) amending criminal justice legislation to enhance its ability to manage intellectually handicapped offenders; or
- (iii) creating a specific legislative regime for offenders, alleged offenders, and non-offenders who are intellectually handicapped and whose behaviour poses a significant risk for others.

167 The first option is not acceptable for reasons already outlined (paras 135–139). The second option cannot apply to people who are unfit to stand trial and is inappropriate (for reasons set out in paras 151–165) for some intellectually handicapped people with a capacity for dangerous behaviour. We prefer the third option. Its advantages over the option of amending mental health legislation are the following:

- It would emphasise that intellectual handicap is distinct from mental illness.
- Its objectives would be different. The purpose of mental health legislation is to provide, where this is necessary, for the assessment and treatment of the mentally ill. The purpose of a specific

legislative regime for some intellectually handicapped people would be to authorise the compulsory supervision and management of: those found to be under disability and to pose a risk to the public; those found not guilty of an offence on account of insanity and to pose a risk to the public; and those who are otherwise considered to pose a risk to the public. It could also dovetail with any new provisions in criminal justice legislation relating to special trials for people found unfit to stand trial, as suggested above (paras 153–157), and for the consequences of any such procedures. Furthermore, it could be linked with the provisions suggested in para 173 for compulsory status for those intellectually handicapped people who are a danger to themselves.

- The underlying premises and some of the content of such legislation would also differ from mental health legislation which is based on notions of treatability and change. Mental health legislation is structured to provide for short assessment and treatment periods, at the end of which reviews and decisions must occur before any further period of compulsory treatment is permitted. Legislation relating to intellectually handicapped people, on the other hand, would recognise that their underlying disability cannot change, although their behaviour might be amenable to change. The emphasis would therefore be directed to educational strategies to enhance coping abilities and to management strategies so that unnecessary risks are not posed to the public.

168 The criteria for admission, compulsory care and discharge would have to refer to both dangerousness and the existence of some degree of intellectual handicap (or similar term). We consider that the suggested legislation should not be confined to those with developmental disabilities but should include those with organic brain impairment, or brain impairment acquired in adulthood.

169 Because the justification for the suggested legislation is the inability of the criminal justice system to deal with some intellectually handicapped people whose behaviour threatens community safety, it would probably not need to specify that the dangerousness must be *caused* by intellectual handicap. The rationale for proposing new legislation is that some intellectually handicapped people cannot be held fully culpable and cannot adequately comprehend criminal procedures. If a causal relationship were required between the intellectual handicap and dangerous behaviour, some people would not be subject to any relevant law—for there would be some whose potential for harmful behaviour would be unrelated to their disability.

170 If legislation provided, in the manner outlined, for compulsory orders for some intellectually handicapped people whose behaviour threatens community safety, it is our view that it would not constitute arbitrary detention. The extent of the detention powers applicable to intellectually handicapped people would not be significantly greater than those applicable to the general community but they would be authorised by different legislative schemes.

171 To be consistent with the fundamental principles discussed in chapter 2 and those specifically outlined in the United Nations Declaration on the Rights of Disabled Persons, such legislation would need to incorporate the “least restrictive alternative” principle, thereby providing for “compulsory status” in the community as well as institutional care. A possible model for the stand-alone legislation is the Intellectually Disabled Persons’ Services Act 1986 of Victoria.

New institutions?

172 Specific legislation for intellectually handicapped people who are a danger to others does not necessarily require new or specific institutional services. We anticipate flexibility in management to the greatest extent possible, allowing support to be provided in the setting that best meets a person’s needs at the time. Given New Zealand’s small population and the desirability of keeping people near their own communities and families where possible, it is probably inevitable that existing psychiatric hospitals and hospitals for the intellectually handicapped will continue to play a role in supplying the learning, security and other needs of dangerous intellectually handicapped people. Settings could therefore include psychiatric hospitals, hospitals for the intellectually handicapped, community facilities (run by health/disability services or non-government organisations such as the IHC) or, in some situations, a person’s own home.

173 The Ministry of Health has undertaken initial work concerning intellectually handicapped people whose behaviour presents difficult management problems. In particular, an informal Working Party was set up last year to consider whether a legislative mandate is required for the compulsory care of some intellectually handicapped people in their own interests and, if so, what form it should take. We observe that it is often artificial to clearly separate those intellectually handicapped people who present a danger to themselves from those who present a danger to others. It would be sensible for the Working Party’s task to be merged with, or to proceed in conjunction with, the task of considering legislation for intellectually handicapped people who are a danger to

others (paras 166–171). These matters should proceed urgently and with input from all relevant agencies.

Recommendations relating to intellectually handicapped people

174 On the basis of the preceding discussion, the Law Commission makes these recommendations:

- (1) Those involved in the interpretation and application of the 1992 Act should be encouraged in appropriate ways to address differences in understanding concerning how the definition of mental disorder is applied to intellectual handicap. The Ministry of Health should facilitate this process by gathering and distributing information about the interpretation and application of the 1992 Act.
- (2) The definition of mental disorder should not be amended to explicitly include intellectual handicap.
- (3) The law regulating the relationship between the mental health system and the criminal justice system found in Part VII of the Criminal Justice Act 1985 should be reviewed. That review would consider:
 - the test for finding that a defendant is unfit to stand trial;
 - the consequences of that finding;
 - the possibility of holding a special hearing, after a finding of unfitness to stand trial, to establish the defendant's innocence of or factual responsibility for the alleged crime;
 - the related possibility of requiring the prosecutor to show periodically that sufficient evidence could be adduced to put the defendant on trial;
 - the consequences of the above findings.
- (4) New legislation concerning intellectually handicapped people who present a substantial risk of danger to others should be prepared. This could apply to alleged offenders found unfit to stand trial, people whose dangerous behaviour has not been prosecuted, and perhaps convicted offenders. The legislation would include criteria for compulsory status and would regulate the management, education and care undertaken in the community and institutions which would apply to this group of people.

- (5) In conjunction with or as part of the consideration of new legislation, there should be a review of the position of intellectually handicapped people who need compulsory care in their own interests. The policy developed under this and the preceding point could result in a single statute applying to intellectually handicapped people who are a danger either to themselves or to others.

PERSONALITY DISORDER: A MENTAL DISORDER OR NOT?

175 In this section, the Law Commission answers the first two questions asked in para 101 in relation to personality disorder:

- Does the present statutory definition of mental disorder include personality disorder?
- Is personality disorder appropriately regarded as mental disorder, and if so should the present statutory definition be amended to explicitly include it?

Clinical definitions

176 Personality disorders are described in *Forensic Psychiatry* as “an ill defined yet substantial group of diseases . . .” (373). As stated in the Mason Report (*Report of the Committee of Inquiry into Procedures used in Certain Psychiatric Hospitals in Relation to the Admission, Discharge, or Release on Leave of Certain Classes of Patient*, 1988), “[t]his is an extremely wide ranging group of disorders thought to be the result of inadequate or improper formation of the personality in childhood” (214). The definitions in the international diagnostic systems are as follows:

. . . deeply ingrained and enduring behaviour patterns, manifested as inflexible responses to a broad range of personal and social situations. They represent extreme or significant deviations from the way in which the average individual in a given culture perceives, thinks, feels and, particularly, relates to others. Such behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems of social performance. (ICD-10)

Behaviours or traits that are characteristic of the individual’s recent (past year) and long-term functioning (generally since adolescence or early childhood). The constellation of behaviours or traits causes either significant impairment in social or occupational functioning, or subjective distress. (DSM-III-R)

177 Many personality disorders do not result in danger to others; for example, obsessive-compulsive and histrionic personality disorders. We will only consider issues relating to people whose personality disorder is such that they pose a substantial risk of harm to members of the public; that is, those who are dangerous. Such people are within the group variously described as having an “antisocial personality disorder” or a “borderline personality”, or as “psychopaths”. A recent definition of antisocial personality disorder or psychopathic personality, from the Mason Report, suggests that people with this condition have the following characteristics:

[T]hey violate social conventions, are violent, dishonest, irresponsible, devoid of guilt; they fail to learn from punishment, seek stimulation, are intelligent (on average), under achieving, socially deviant, socially unconventional, and abuse drugs and alcohol. Many sex offenders fall into the category of “personality disordered”. (215)

178 People with personality disorder may also be mentally disordered. Their mental illness may or may not be related to any danger they pose to others.

Statutory definitions

179 The Mental Health Act 1969 defined mental disorder, *inter alia*, as mental illness requiring care and treatment (para 105). There was no explicit inclusion of personality disorder or psychopathy. The Mason Report seems to have considered that the 1969 definition did not include personality disorder or psychopathy (216). (It considered also that the definition of mental disorder in the Bill which became the 1992 Act did not include personality disorder.) In *Re M* (1991) 1 NZBORR 217, decided under the 1969 Act, at least some psychiatrists considered that “while M had a personality disorder, this did not amount to mental illness and that he did not require care and treatment by way of detention in the hospital”.¹⁸

180 The 1992 Act states that mental disorder means

an abnormal state of mind . . . characterised by delusions, or by disorders of mood or perception or volition of cognition, of such a degree that it . . . poses a serious danger to the health or safety of that person or of others.

181 On the face of it, the 1992 Act does not seem to be narrower in its potential application to personality disorders than the Mental Health

¹⁸ Other psychiatrists in this case did consider that M was mentally disordered. However, it is unclear whether they considered M to be mentally ill in the usual sense, or whether they regarded personality disorder as a mental illness.

Act 1969 and arguably is wider. The view that the 1969 definition may be more limited depends on whether mental illness, the term used in the earlier Act, is a more limited concept than mental disorder. A narrower meaning of mental illness would be supported by the broad manner in which the term mental disorder is used in the international diagnostic systems.

182 Information is not yet available on whether fewer people with personality disorders are compulsorily admitted now compared with several years ago. Any changes which have taken place may be due to changes in professional practices and attitudes, and resourcing decisions, as much as the new definition of mental disorder.

Other jurisdictions

183 To our knowledge, the United Kingdom is the only country which explicitly includes psychopathic disorder in its definition of mental disorder. Psychopathic disorder is defined as follows:

“Psychopathic disorder” means a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned. (Mental Health Act 1983 (UK) s 1(2))

184 However, people may not be detained in hospital simply because they have a psychopathic disorder. In addition to a danger or safety criterion similar to that in the 1992 Act, s 3(2) of the United Kingdom Act specifies that the psychopathic disorder must be of a nature or degree which makes it appropriate for the person to receive medical treatment in a hospital. Such treatment must also be likely to alleviate or prevent a deterioration of the condition. For a discussion of issues related to treatability and review procedures for those with psychopathic disorders, see *R v Canons Park Mental Health Review Tribunal, ex parte A* [1994] 1 All ER 481 DC, [1994] 2 All ER 659 CA.

185 Those jurisdictions with mental health legislation that depends on the concept of “mental illness” rather than “mental disorder”, may be less likely to consider personality disordered people eligible for compulsory admission, given that the concept of “mental illness” seems associated to a greater extent with symptoms representing a departure from a person’s usual pattern and level of functioning. Also relevant to this point is the use by the international diagnostic systems of “mental disorder” in a broad sense.

Incidence

186 The Mason Report states:

Studies in the incidence and causes of psychopathy suggest that it occurs in less than 1% of the population, and diagnoses are more common in persons from lower socio-economic backgrounds. It is more common in males than females. (215)

187 No recent studies have been completed on the prevalence of personality disorders in the New Zealand prison population, although the Mason Report notes that “[t]he prisons inevitably accumulate a large number of persons with personality disorders” (214).

188 In May 1994 there were two people with a primary diagnosis of personality disorder in psychiatric hospitals who had been acquitted of an offence on account of insanity and made special patients. (This figure is approximate. It should also be noted that the diagnoses made in May 1994 may not be identical to those made at the time of trial.)¹⁹

189 Of the “37” people who, since the 1992 Act came into effect, have been discharged from compulsory status into the community and are considered dangerous, the Ministry of Health states that the best estimate is that 11 had personality disorder as their primary diagnosis.²⁰ The latest information available on diagnoses of people compulsorily admitted to psychiatric hospitals indicates that there were 202 compulsory admissions (including first admissions, readmissions and replacements) in 1992 (that is, under the Mental Health Act 1969) of people whose diagnoses were “other personality disorders”²¹—notwithstanding the lack of certainty about the application of the Mental Health Act 1969 to personality disorders. The number of people involved would presumably be fewer than the number of admissions: some people may have had more than one admission in 1992. Not all would have posed any degree of danger to others.

Issues relating to personality disorder

190 These issues include

- whether personality disorder is a meaningful concept;

¹⁹ Information from the Ministry of Health. Again note that diagnostic practices may vary.

²⁰ Letter to Law Commission, dated 24 March 1994.

²¹ *Mental Health Data*, note 13, 46.

- whether diagnoses of personality disorder are reliable;
- whether personality disorder is treatable;
- whether people with personality disorders should be able to be compulsorily detained and if so where.

191 There is little consensus on any of these issues. It is stated in *Forensic Psychiatry* that

... the diagnosis of psychopathic disorder has no explanatory, descriptive, prognostic or therapeutic function, it is therefore a “pseudo-diagnosis” used just to get patients “through the customs-barrier of the courts . . .”. (402)

The concept and reliability of diagnoses

192 Professor Paul Mullen notes:

The term psychopathic disorder has fallen into disrepute and disuse. . . . Psychopathic disorder has been dismissed as a mythical entity and as a misleading stereotype (Karpman, 1948) Blackburn (1988) points out by defining psychopathic disorder in terms solely of socially deviant behaviour, that what has been produced is a moral judgement masquerading as a clinical diagnosis. (“Psychopathy: A Developmental Disorder of Ethical Action” (1992) 2 *Criminal Behaviour and Mental Health* 234)

193 There is discomfort among health professionals about including as a mental illness “personality disorder” whose only symptom is maladaptive behaviour. In relation to the inclusion of psychopathy in the United Kingdom legislation, it has been said that the definition is “circular in that mental abnormality is inferred from antisocial conduct, yet is used to explain antisocial conduct . . .” (Hill, Murray and Thorley, *Essentials of Postgraduate Psychiatry* (1979) 541).

194 It is also considered that

[t]he problem with any attempt to categorise one group of offenders as psychopathic is that it tends to exaggerate the differences between this group and, on the one side the generality of offenders, and on the other offenders with mental illnesses such as schizophrenia. (Mullen (1992), 236)

195 Mullen (1992) emphasises that psychopathy involves “a developmental disorder distinct from any process or reaction” (236). This is related to difficulties in the concept, given that, in contrast with illness, “the abnormal or accentuated traits of personality disorder are continuous, distributed as traits throughout the normal population . . .” (*Postgraduate Psychiatry*, 184).

196 There is agreement that the reliability of diagnoses of personality disorders is low. Studies of diagnostic practices referred to in *Postgraduate Psychiatry* found that “agreement between psychiatrists failed to reach 50% for both type and severity” (183; see also *Forensic Psychiatry*, 377).

197 But, as Mullen (1992) notes, despite the difficulty in the concept, its use persists:

those working with offender populations find they are forced to resort to the term psychopathy or some equally doubtful circumlocution, or else ignore much of the obvious disturbance and distress which surrounds them. (235)

198 Mullen (1992) goes on to suggest:

There is a group of individuals within the much larger population of offenders who are regarded by the police, lawyers, prison officers and fellow offenders as mad. This same group of individuals, when assessed by mental health professionals, tend to be described as having no formal mental illness. These individuals are seen by the police, judiciary and prison service as suitable cases for treatment: on the other hand, all too many health professionals reject the treatment option and by implication invoke punishment. (235)

Similarly, it is stated in *Postgraduate Psychiatry* that, despite confusions, “the concept of personality disorder remains indispensable to psychiatric practice” (183).

Treatability

199 There is a similar range of views on whether personality disorder can be treated. It is said that “[t]reatment, if that is the right word or concept, of personality disorder is notoriously difficult” (*Postgraduate Psychiatry*, 236). But Mullen (1992) and others certainly consider it possible. The Mason Report says:

There has been a longstanding argument regarding the treatment of those disorders which are not covered by the Mental Health Act in New Zealand. Mental health professionals differ in their views regarding “treatability” of personality disorders. . . . Some state that the antisocial behaviour patterns are so ingrained that treatment is not likely to be effective. Because these persons are not likely to be distressed by their own behaviour, there is little motivation for them to change it. Psychiatric hospitals are not suitable for people who have no identifiable psychiatric illness, and whose presenting complaints are behavioural or personality based. (216–217)

200 The Mason Report concludes that while personality disorder is

not in principle untreatable, in practice it often is:

Personality disordered persons are untreatable by New Zealand's present system. . . . It appears that psychiatric hospitals prefer only those who will respond to treatment in short periods of time, and the remainder, who would require long term treatment programmes, are neglected. . . . It is questionable as to whether any condition is untreatable It is more an unwillingness on the part of hospitals to expend the time and skills required in ameliorating certain disorders which may require extensive behavioural interventions.

Currently the length of stay in psychiatric facilities in New Zealand is, on the average, less than one month. Long stay patients who do not respond quickly to treatment are not as popular in the mental health system. (218)

201 The Mason Report goes on to quote McGeorge:

This policy has aided in the promulgation of myths, such as "people with personality disorders are untreatable", and are therefore not the responsibility of the health system. Some suggest that this is taking the difficulties of treating people with personality disorders to a ridiculous extreme.

Some people with certain kinds of personality disorder are extremely disruptive of hospital routines and may be made worse by undue attention being given to their dysfunctional behaviour. But others may respond very well indeed to a programme which provides an appropriate mixture of limits and support within the context of a long-term therapeutic relationship.

To simply dispense such people to the justice system without this understanding simply condemns them to suffering and the public to huge expense. (218)

Similar views are expressed elsewhere:

For a patient to be deemed "untreatable", he would need to be so resistant to treatment as to be unaffected by nursing, or support, or counselling, so unaffected as to make these techniques completely irrelevant to his management; a rare case. (*Forensic Psychiatry*, 397)

202 There does seem to be general agreement that if treatment is to be possible or successful, it must be long term:

[P]ersonality development based on a long-term complex interaction of nature and nurture, cannot be fundamentally changed by a short therapeutic contact, or by a prescription pad. Enabling a personality to change inevitably demands a consistent therapeutic approach, perhaps over several months or years, a preparedness on the part of both patient

and physician to engage in a long-term high order re-learning process. (*Postgraduate Psychiatry*, 237)

203 A “Statement on Personality Disorders” is set out in the Mason Report. It deserves quoting:

This Inquiry has again demonstrated the need for some direction regarding the care and treatment of those who have personality disorders

We believe that people with personality disorders will respond to psychiatric care.

Under conditions of extreme stress, an individual with personality disorder may demonstrate clear symptoms of mental disorder as defined in Section 2 Mental Health Act 1969. Under these circumstances, committal would be appropriate.

In some cases, a personality disordered individual may not exhibit clear signs of mental disorder but may nonetheless acknowledge behaviour which could be classified as personality disorder. We believe that if, under these circumstances, he/she expresses a wish to change, a willingness to accept psychiatric help and gives an assurance of cooperative participation in treatment programmes, then the care and treatment of the personality disordered individual is unequivocally the responsibility of the psychiatric profession. (109)

Compulsory treatment

204 The Mason Report is not explicit on whether the compulsory treatment of personality disordered people can ever be justified or efficacious. Elsewhere it has been said:

The level of insight in any patient, whatever label is given, should help to determine the type of treatment to be offered and the degree of paternalism with which it is offered It is in these terms that a personality disordered patient may become eligible for compulsory care. (*Forensic Psychiatry*, 398)

205 It is suggested in *Forensic Psychiatry* that the criteria for admitting personality disordered people should be the same as for all other patients. These criteria include

. . . emergency admission to avert a crisis (such as suicidal or homicidal episodes), planned admission to prevent social deterioration, to relieve domestic pressures, to stabilize medication, for fuller observation and assessment, and to begin difficult psychotherapy. (399)

206 But it is also noted that “[c]ompulsory treatment for the personality disordered is a vexed question” (*Forensic Psychiatry*, 399). In the context of the United Kingdom’s psychiatric services, patients

with antisocial personality disorders are often unpopular among health professionals. Difficulties are exacerbated by declining numbers of hospital beds.

Review Tribunal view

207 Only one decision, as far as we are aware, has specifically considered the question of whether personality disorder is a mental disorder in terms of the 1992 Act (*Re J* Mental Health Review Tribunal (Southern Region) 28/93). This contains a very useful discussion of the issues, although strictly speaking it was not essential to the decision of the Tribunal. The patient had been acquitted of murder on account of insanity and was initially diagnosed as suffering from schizophrenia. In hospital he showed no symptoms of this mental illness. The relevant medical reports stated that he showed “no evidence of mental disorder as defined in the Mental Health Act 1992”. It was considered that

. . . he fits the mould of what psychiatry has denoted a psychopath. . . . [T]here is no doubt that he has a severe disorder of personality that could be described as narcissistic in nature or psychopathic. (6)

208 The Tribunal said that it was aware that

a body of psychiatrists in New Zealand have taken the approach that if a person is suffering from a personality disorder, no matter what its nature or type, that person clearly does not fall within the definition of mental disorder. . . . As personality disorder is not specifically covered in the definition, and as a psychopathic disorder has not been specifically defined within the New Zealand legislation, the only appropriate conclusion to draw is that Mr J does not fall within the parameters of the Act. (11–12)

209 But the Tribunal held that a person such as Mr J, with a personality disorder characterised by a disorder of volition, was mentally disordered within the 1992 Act. The Tribunal could not accept the submission that a person suffering from a personality disorder cannot come within the terms of the 1992 Act because Parliament had not specifically included reference to such disorders in the definition. The Tribunal considered that

[b]y introducing the definition of “disorder of volition” the New Zealand Act avoids a descent into abstruse academic debate and argument as to whether or not a person suffering from a personality disorder should or does come within the terms of the Act. Further, by avoiding the use of the term mental illness the Act has not unnecessarily narrowed the issues. (15)

Personality disorder: generally not a mental disorder

210 The preceding discussion allows the following conclusions:

- There is considerable ambivalence and disagreement among health professionals about whether personality disorder is a mental illness or disorder.
- There is not much reliability in the concept's application, and hence any particular diagnosis may convey little real information.
- Some professionals, while recognising the difficulties in the concept of personality disorder, consider that it or a similar concept is useful.
- Some professionals acknowledge that ordinary people recognise a group to which the term "antisocial personality disorder" or "psychopath" can be applied.
- The one known case which considered whether a personality disorder can come within the definition of mental disorder in the 1992 Act has held that it can, as long as the person has a disorder, for example of volition, in terms of the 1992 definition.
- Although professionals differ on the extent to which personality disordered people can be treated, there is agreement that to be successful any treatment must be long term.
- There is little guidance on when personality disordered people can appropriately and effectively be given compulsory treatment.
- There would be resource (and other) implications if more people with personality disorders were compulsorily treated in hospitals or prisons.

211 In the light of those conclusions, we propose answers to the three questions asked in para 101. First, the new definition of mental disorder does not create new difficulties in admitting or detaining people with personality disorder. The present definition, on the *Re J* interpretation, means that sometimes mental disorder can include personality disorder—but not always or even usually. It is, however, quite possible that health professionals interpret mental disorder so that it does not include personality disorder, except where the person also has a mental illness in the usual sense.

212 We consider that clinicians and legal professionals should be made aware, through written guidelines and communications at meetings, of the potential for mental disorder to include personality disorder in some circumstances.

213 Secondly, we consider for a number of reasons that it would not be helpful to explicitly include personality disorder in the definition of mental disorder. Such a measure would enable the compulsory treatment and detention of people who are not mentally ill in the orthodox sense and who have not offended. Although some health professionals recognise personality disorder as a useful concept, there is little consensus that it is a mental disorder. Any amendment to include it would be a major change requiring considerable discussion among the relevant professional groups and would introduce the possibility of a de facto preventive detention through the mental health system, without the safeguards of the criminal justice legislation. There seems no justification for detaining a non-offender where there is little reason to consider that compulsory treatment would be helpful, and where there has been no offending behaviour—such behaviour being, in any case, the most accurate basis for an assessment of dangerousness.

Resulting problems for community safety?

214 With regard to the third question, we do not consider that community safety is threatened by not including personality disorder specifically in the definition of mental disorder. In contrast to what may be the case for some intellectually handicapped people, the criminal justice system can adequately and appropriately consider allegations of dangerous behaviour committed by personality disordered people, and make appropriate dispositional decisions. Unlike some who are intellectually handicapped, personality disordered people can, unless mentally disordered as well, be held responsible for their actions and can cope with the prosecution process. Any sentence of imprisonment in a penal institution would not constitute cruel and unusual punishment as it might for some intellectually handicapped offenders.

215 Dangerous personality disordered people of ordinary intelligence who commit offences should be dealt with by the criminal justice system in the ordinary way (unless mentally disordered as well). The criminal justice system can assess the allegations about such a person's behaviour, and take account of risk to the public in deciding on sentencing options.

216 We see no justification for expanding the scope of mental health legislation to enable it to be applied to non-offenders who are not mentally ill even though they are regarded as possibly dangerous. If existing sentencing options, including preventive detention, are not

considered to provide adequate community protection from dangerous offenders, then any proposal for change should focus on criminal justice rather than mental health legislation. (These issues are discussed further in relation to our second term of reference.)

217 It may be felt that people who have not committed a serious offence, are dangerous because they have, for example, threatened violence. People can be, and are, prosecuted for threats of violence. Those whose actions have precipitated New Zealand and Australian inquiries and reports on how society should respond to “dangerous” people have all been to our knowledge offenders, or people whose acts could have been prosecuted as offences. For instance, Garry David (Webb), who prompted the Victorian inquiry (para 111, fn10), had been charged while in prison under s 20 of the Crimes Act 1958 (Victoria) with threatening to kill a fellow prisoner. He had also allegedly made threats to indiscriminately kill. Although s 20 may have been broad enough to include general threats against safety, the Parliamentary Social Development Committee considering the issue recommended that the question be put beyond doubt: where a person makes a threat to kill or injure, that person should be charged under the Crimes Act 1958 under the ordinary rules, and if necessary the meaning of those rules should be clarified by Parliament to cover generalised or mass threats (interim report, recommendations 5.6.4 and 5.6.5).

218 Although the criminal justice system is the appropriate forum for decision-making about personality disordered offenders, it need not have sole responsibility for their management and supervision, as the following discussion indicates.

Where should personality disordered offenders be detained and treated?

219 Prisons clearly have the major responsibility for detaining personality disordered offenders, and treating them to the extent that that is possible. The Department of Justice provides services to offenders who are psychiatrically ill or psychologically disturbed—some of whom would presumably be personality disordered:

Psychological Services Division has developed specialist programmes for paedophiles (the Kia Marama and Te Piriti residential units), rapists and violent offenders. Programmes in all three areas have resulted in significant reductions in reoffending levels for treated offenders. All three categories of offender are considered amongst the most difficult to

treat internationally and New Zealand's results in these areas compare favourably with those of other countries. (Letter to the Law Commission, 11 March 1994, 8)

220 But given that prisons should take the major role in this area, it may be still asked whether psychiatric hospitals should have a greater role in controlling, managing and treating personality disordered offenders. As a result of the Mason Report, Government decided that the responsibility of caring for psychiatrically disturbed people, whether offenders or not, rested exclusively with the health system. It may have been implicit in the Mason Report that the treatment, if any, of the personality disordered offender remained the primary responsibility of the justice system, but we consider that the relevant agencies should now focus more clearly on the position of this group of offenders. We support, therefore, the development of policy on the treatment needs and management of offenders with personality disorder. There is a need to clarify whether the Ministry of Health or the Department of Justice, or both, ought to be responsible for personality disordered offenders. Such consideration would take into account the disadvantages of placing increased numbers of personality disordered people in hospital—obviously, psychiatric hospitals could not possibly accept all personality disordered offenders, given the numbers involved. Any proposals for the improved management of personality disordered offenders should take into account resource implications for both the justice and the health systems.

221 It is noteworthy that the Mason Report allows for a degree of optimism about treatment of at least some dangerous personality disordered people, even though it is not clear whether compulsory treatment is helpful. Flexibility in the sentencing and management of dangerous offenders is in the interests of both society and the offender. Existing provisions for transferring offenders to and from psychiatric hospitals should be used to maximum advantage.

Sentencing and related options

222 The Criminal Justice Act already provides several options in making decisions about alleged offenders and offenders who have personality disorders (see app A). If they are also mentally disordered, they may be found under disability. They may also be acquitted on account of insanity. In the latter case, the Criminal Justice Act provides for a person to be detained indefinitely as a special patient in a psychiatric hospital (see paras 236–238 for further discussion). If a person is convicted, s 118 provides the sentencing judge with the option of ordering a mentally disordered offender to be detained in a

psychiatric hospital. These options provide reasonable flexibility, and we have no recommendations for change, although a review of Part VII should consider suggestions made by Judge McElrea, “Treatment Instead of Punishment: The Use and Disuse of Section 118 of the Criminal Justice Act 1985” (1992).

Transfer of offenders to hospitals

223 Offenders (some of whom will be personality disordered) who are sentenced to prison may be subsequently transferred to a psychiatric hospital under either s 45 or 46 of the 1992 Act. Section 45 provides that a prisoner may be transferred to hospital, without his or her consent, if mentally disordered.²² Under s 46 a convicted person may be transferred to hospital—whether or not mentally disordered—if the Secretary for Justice considers the person would benefit from psychiatric care and treatment available in a hospital but not in prison, and if the person consents.

224 Section 47 governs the removal of s 45 prisoners from hospital back to prison. Although the test for removal appears at first sight to be the same as for ordinary compulsory patients (ie, “fit to be released”—meaning no longer mentally disordered and fit to be released from the requirement of assessment or treatment under the 1992 Act (s 2)), the language of s 47 is quite different from that of s 35. In s 35 the responsible clinician “shall” release the person from compulsory status if the person is fit to be released; but s 47 states, first, that the Director of Area Mental Health Services “may” release the person and, secondly, the exercise of this discretion necessitates the “consent of the Director of Mental Health”. Therefore, the provisions for prisoners transferred under s 45 differ from those for ordinary compulsory patients (although once their sentence expires, the ordinary test applies).

225 The Department of Justice has informed the Law Commission that, during 1993, 45 sentenced inmates were compulsorily transferred from prison to hospital (comprising eight European, 23 Maori, three “other” and 10 “unknown” males, and one Maori female) and seven sentenced inmates were transferred with their consent (four European and three Maori males).²³ In order to have any basis for assessing whether these figures indicate that full use is being made of existing provisions in relation to personality disordered offenders, it would be

²² A person may not have been mentally disordered when committing the offence, or at the time of trial, but may become so while in prison. Alternatively, the presence of mental disorder may not be diagnosed until the person is in prison.

²³ Letter dated 11 March 1994.

necessary to have up-to-date information on the number of personality disordered people in prison, and on the diagnoses of those offenders who are transferred. This information is not available.

226 However, some indication can be gained of the nature and extent of *mental disorders* in sentenced prisoners. The Department of Justice emphasises that the following information must be treated with caution and may be an underestimate: the assessments were not made by psychiatric specialists; some institutions do not specifically test for intellectual handicap; and it is unclear how “mental health problem” in the context of psychological treatment was interpreted by those carrying out the assessments. Information sought from all penal institutions on sentenced inmates in custody on 1 March 1994 indicates that, of the 3687 sentenced inmates in custody:

- about 20 were mentally disordered as defined by s 2 of the 1992 Act;
- less than five were classified as seriously intellectually handicapped;
- about 140 were receiving psychiatric treatment;
- about 220 were receiving psychological treatment for mental health problems; and
- about 190 inmates were either waiting for psychiatric or psychological treatment or had refused such treatment (no inmate appears in more than one of the above classes).²⁴

227 Conclusions in this area are hampered by a lack of relevant information. We do not know whether all personality disordered sentenced inmates who could benefit from hospital treatment are being transferred. Some anecdotal information would suggest that there is considerable variance in practice throughout the country. Information is not available on the diagnoses of transferred prisoners, nor on how long transferees stay in hospital—particularly whether they stay long enough to reap the benefit of psychiatric treatment. As indicated, existing legislation allows them to stay until the expiry of the sentence, at which point, if mentally disordered, their compulsory detention may continue. If ss 45 and 46 are underused, is this because greater use would provide no treatment benefits, or is it a matter of resources and priorities, or the result of attitudes to having personality disordered offenders in a hospital?

²⁴ Letter dated 11 March 1994.

Recommendations relating to personality disordered people

228 On the basis of the preceding discussion, the Law Commission makes these recommendations:

- (1) Those involved in the interpretation and application of the 1992 Act should be encouraged in appropriate ways to seek a common understanding of situations in which personality disorder may fall within the statutory definition of mental disorder. The Ministry of Health should facilitate this process by gathering and distributing information about the interpretation and application of the 1992 Act.
- (2) The definition of mental disorder should not be amended to explicitly include personality disorder.
- (3) The Department of Justice and the Ministry of Health should, as a prerequisite to the policy development recommended in (4), gather information on the use of the provisions governing the transfer of offenders from prison to hospital, including the reasons for such use, in order to judge whether existing provisions are used sufficiently to maximise the potential for treating personality disordered offenders.
- (4) The Department of Justice and the Ministry of Health should develop policy on the issues posed by their treatment needs and the options for their optional long-term management and supervision. This would be similar to the policy development for psychiatrically disturbed offenders facilitated by the Mason Report, and would include collecting information on the extent of personality disorders in prisoners and estimates of any potential for treatment.

GENERAL ISSUES IN MENTAL HEALTH AND CRIMINAL JUSTICE LEGISLATION

229 The focus in this section is on controls in the 1992 Act and its interface with the Criminal Justice Act. More general provisions of the Criminal Justice Act will be discussed in chapter 4. Most of the issues covered here are directly relevant to community safety, although a number of wider concerns are also mentioned.

Controls on compulsory status patients

230 The 1992 Act applies extensive controls to mentally disordered people. Compulsory patients may be treated against their will, and, if

inpatients, must have permission for leave from hospital. Such leave may have conditions attached and any leave can be revoked. Patients subject to compulsory treatment orders are released from that status only when the responsible clinician or Review Tribunal decides that they meet the relevant standard (ss 35 and 2); patients subject to inpatient orders may be discharged from hospital and transferred to community treatment status only by direction of the responsible clinician (s 30(2)).

231 Should further controls be applicable to compulsory patients? For example, should discharge decisions be made only by Review Tribunals instead of by responsible clinicians? Such a change may have little effect, given that the discharge *test* is more critical than the decision-maker.

232 We consider that further controls are not necessary or justified. Any patient whose potential for dangerousness creates difficulties would be eligible for an order making him or her a “restricted” patient.

Restricted status

233 The 1992 Act already contains provisions for identifying and placing additional controls on any patient considered “dangerous”. These are the provisions for restricted patients in ss 50–56, 78 and 81 of the 1992 Act. The concept of restricted status in the 1992 Act is new, developed as a result of concerns about dangerous mentally disordered people considered in previous inquiries, particularly *The Circumstances of the Release of Ian David Donaldson from a Psychiatric Hospital and of his Subsequent Arrest and Release on Bail—Report of the Commission of Inquiry* (1983). A court may make an order declaring a patient to be a restricted patient if satisfied that the person presents special difficulties because of the danger posed to others and that the order is appropriate (s 55). Consequences of restricted status include limitations on leave (ss 50–52) and specific provisions relating to review and discharge (ss 78 and 81). If a clinician or Review Tribunal considers that a restricted patient is “fit to be discharged”, the Director of Mental Health is responsible for directing release. Only the Minister of Health after consultation with the Attorney-General may make decisions about ending restricted status where the person is not fit to be released from compulsory status, but where it is considered that restricted status is no longer necessary.

234 It was only in early 1994 that the first application under these provisions was made. The Law Commission suggests that where there

are real concerns about the danger presented by individual compulsory patients, the use of these provisions be seriously considered. Any practical difficulties in their use should be identified.

235 A greater use of the restricted category would have procedural consequences for discharge decisions. However, it would not alter the criteria for either eligibility for or discharge from restricted status: a person may become eligible for restricted status only if mentally disordered, and would be discharged when no longer mentally disordered.

People acquitted on account of insanity

236 Section 23(2) of the Crimes Act 1961 provides:

No person shall be convicted of an offence by reason of an act done or omitted by him when labouring under natural imbecility or disease of the mind to such an extent as to render him incapable—

- (a) Of understanding the nature and quality of the act or omission;
or
- (b) Of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong.

237 A defendant who falls within s 23(2) may be acquitted on account of insanity. Because of the differences in the criteria for insanity and the definition of mental disorder in the 1992 Act, a person who is acquitted on account of insanity will not necessarily be mentally disordered within the meaning of the 1992 Act. The Criminal Justice Act 1985 provides for the indefinite detention of people who have been acquitted on account of insanity and who have been made special patients (see app A for further details: people acquitted on account of insanity can also be given compulsory status). Special patients in this category can have their status reclassified, and be made ordinary compulsory patients, only if it is considered “that the person’s mental condition no longer requires, either in the person’s own interest or for the safety of the public, that he or she should be subject to the order” (s 117(2)). Where a medical certificate is given to this effect, it remains at the discretion of the Minister of Health whether or not to reclassify. The continued detention of such patients does not require, therefore, that they be “mentally disordered” within the statutory definition. Indeed, they may not have been mentally disordered from the outset.

238 It is clear that there are already considerable controls on this group of people, and present legislative provisions could not be considered to present a risk to community safety. On the contrary, serious issues arise

about the initial detention of people acquitted on account of insanity and from the fact that they can be indefinitely detained. We recommend that issues relating to people acquitted on account of insanity be reviewed at the same time as other issues in Part VII, as proposed earlier.

Specific victims

239 Although our terms of reference relate to community safety in a general sense, it is relevant to note that the Victims Task Force has a number of recommendations in its final report concerning the protection of specific victims rather than the general public or potential victims. These recommendations are as applicable to mental health legislation as to criminal justice legislation.

240 Some recommendations relate to notifying victims of an offender's release or escape. The Victims Task Force discussed with the Department of Health means for establishing an administrative system for such notifications. In addition, the Task Force made recommendations relating to the expansion of s 11 of the Victims of Offences Act 1987. These legislative changes would make explicit that the Victims of Offences Act 1987 applies to people held in mental health institutions as a result of criminal proceedings. The Task Force also recommended that notification should not be affected by a special patient's reclassification to ordinary compulsory status.

241 In addition, the Victims Task Force proposed that ss 115(2), 117(2) and 118(1) of the Criminal Justice Act 1985, relating to court orders available in respect of people who have been accused or convicted of offences, should be amended to require that the judge take into account the safety of the victim as well as the public. The Task Force considered this to be important since it would mean that information on the defendant's reaction towards the victim should be sought, rather than a general assessment of the defendant's reaction to others. The Law Commission supports action on those recommendations.

Service and funding support for mental health legislation

242 Could the public be further protected by increased service and funding support for mental health legislation? There may be a relationship between the deinstitutionalization trends of the last few years (see para 109) and the increased visibility of people with long-

term mental and intellectual disabilities. Some tentative information indicates that more incidents may have been attended by the Police in recent years where the person primarily involved is suspected to be suffering from a mental illness.²⁵ It is clear that the public are very concerned about community safety, and fearful of violent and sexual offending. It is understandable that people feel powerless in relation to offending and accordingly seek immediate solutions.

243 There seems to be a general view, and it is a theme of many of the relevant reports summarised in appendix D, that funding for community services for those with mental and intellectual disabilities is inadequate. For instance, the Mason Report states that “. . . research shows that community mental health services for psychiatric patients is severely under resourced, despite the fact that deinstitutionalization is well under way” (148). This conclusion still appears valid. The newly released document *Looking Forward—Strategic Directions for the Mental Health Services* (Ministry of Health, 1994) states:

The result is that there are now greater numbers of mental health consumers in the community, and there are insufficient and unsuitable resources available for their care. (6)

244 Well-supported mental health services should have indirect positive effects for the community in general. The Law Commission notes that the Government has identified mental health as a health gain priority area for Regional Health Authorities (*Policy Guidelines for Regional Health Authorities 1994/1995*). A greater commitment to community health services is also emphasised in *Looking Forward*, which identifies increasing specialist mental health services for people in the community, in their homes or in hospital, as a national objective (14). *Looking Forward* also identifies as priority areas the need for services for people with severe psychiatric disabilities (21) and the continued development of forensic services (23). A true commitment to community services for those with mental health and intellectual disabilities might not only be essential in the interests of those with disabilities, and a recognition of their rights, but also go some way to allaying public concern about community safety. The Commission accordingly supports Government’s decision to allocate more resources to mental health services.

²⁵ Letter dated 6 April 1994 to the Law Commission from W A R Galbraith, Assistant Commissioner of Police: Crime and Operations.

Recommendations relating to general issues

245 On the basis of the foregoing discussion, the Law Commission makes these recommendations:

- (1) Consideration should be given to using the “restricted patient” provisions when appropriate to provide for greater control over those inpatients thought to be dangerous.
- (2) Consequences of an acquittal on account of insanity should be reviewed in conjunction with the review of the provisions in Part VII of the Criminal Justice Act 1985.
- (3) The review of Part VII should also consider the recommendations of the Victims Task Force for increased protection for victims of the actions of mentally disordered people.
- (4) Because adequate funding support is necessary to ensure the implementation of any legislation, funding implications should be considered in conjunction with policy development and legislative proposals for mental health services, particularly community services.

4

Protecting the community: criminal justice issues

INTRODUCTION

246 The second term of reference calls on the Law Commission

to consider, with the purpose of protecting members of the public from substantial risk of harm from individuals whose release into the community would pose that risk—

...

2 whether the Criminal Justice Act 1985 or any other enactment should be amended to confer a power to continue to detain a person beyond the time the person is, under the present law, entitled to be released

[and to] consider appropriate powers and procedures including safeguards for the protection of the individuals concerned.

247 This chapter of the report, in addition to stating the Commission's conclusions, suggests options for further consideration rather than making recommendations. That course was adopted due to the limitations of time, fact-finding and consultation mentioned in chapter 1. Another reason is that the inquiry so far indicates that the options are probably better considered in the context of a broader review of sentencing policy.

248 The second term of reference emphasises imprisonment under the criminal justice system. A major purpose of the system and the penalty of imprisonment in particular is the protection of the public from dangerous offenders. As this report has already indicated, mental health legislation also, in some circumstances, protects members of the public from danger. In addition, a small number of specific civil powers of detention provide for protection through the confinement of individuals likely to spread an infectious disease (Health Act 1956),

tuberculosis sufferers (Tuberculosis Act 1948), and alcoholics and drug addicts (Alcoholism and Drug Addiction Act 1966). The powers are analogous to those under the mental health legislation in that

- there is a personal condition defined with some precision,
- the condition may give rise to danger to the person affected or others, and
- the condition can be the subject of treatment—indeed, the person should have a right to treatment if detained under such legislation.

249 Protecting society from crime, as the primary function of the criminal justice system, includes protecting individuals from sexual and other violent attacks. This function is discharged by prescribing offences, by providing for the detection, prosecution, trial and sentencing of offenders, and providing the machinery by which sentences are served.

250 The most important statute prescribing offences is the Crimes Act 1961, and the category of crimes most significant to this report comprises crimes against the person. That Act is principally concerned with the prosecution of alleged offenders after the substantive offence has been committed and there is already a victim. However, the law also covers preliminary offences, designed to forestall the committing of the substantive offence and the evil associated with it. Among those preliminary offences are various actions endangering and threatening other people, including threats to kill and to do grievous bodily harm. Offences related to the possession of firearms, offensive weapons and disabling substances also have that preliminary character. Arrest and prosecution for offensive and disorderly behaviour might similarly be used in a preemptive way. As well, one of the purposes of the Domestic Protection Act 1982 (which is being reviewed at the moment) is to protect family members from future violence.

251 The criminal justice system is regularly, indeed routinely, invoked to deal with people charged with sexual and other violent offences. At any given time about 2000 people convicted of such offences are held in our prisons. The system is triggered by a prosecution. While the Police have a discretion not to prosecute, it is not likely that they will use it in the case of violent offending except where there is an issue about fitness to stand trial (refer to the prosecution guidelines prepared by the Crown Law Office (9 March 1992)). Another prosecutorial discretion, however, may be of major significance. The offence for which an alleged offender is prosecuted will affect the severity of the sentences available upon conviction. We have already mentioned related

Law Commission work on criminal procedure, including prosecution (NZLC PP12). A further relevant discretion, to grant or refuse bail, was recently amended to give greater weight to the protection of the public.

252 The emphasis in the following discussion is on imprisonment under the criminal justice system. That emphasis should not overshadow the fact that imprisonment, along with detention under the mental health legislation, is not always the only, or even the best, way of protecting the public from dangerous people. In a particular case, the protection of the public, along with the other purposes of the criminal law including the rehabilitation of the offender, might be better served by non-custodial sentences or by releasing the offender on parole or final release with appropriate conditions.

253 This chapter of the report, in turn,

- considers the present law of sentencing so far as it is concerned with the protection of members of the community from danger;
- considers the possibility of powers of civil detention based solely on dangerousness and established separately from the criminal justice system;
- states options for changes to the sentence of preventive detention;
- considers the law relating to the position of people currently in prison, or on parole, or final release.

254 Under the first and last headings, the Commission calls attention to existing powers which might be used more extensively to protect community safety.

SENTENCING AND THE PROTECTION OF THE PUBLIC

255 The terms of reference emphasise the protection of the public. What is its role in sentencing at present? What further role, if any, might it play?

256 The purposes of sentencing include denunciation and retribution, incapacitation, general and specific deterrence, reparation and rehabilitation. The protection of the public is sometimes identified as a distinct and comprehensive purpose of sentencing. The Criminal Justice Act indeed begins its statement of general sentencing policy with a presumption of imprisonment for certain offenders convicted of offences involving violence. In addition, it expressly requires the court, in

determining the length of the sentence of imprisonment for such offenders, to have regard to the need to protect the public (ss 5 and 5A). That presumption may also reflect the purposes of denunciation and deterrence.

257 But the protection of the public is not the only relevant value. Balancing it are the rights of the individual offender not to be subjected to cruel, degrading or disproportionately severe treatment or punishment. Our legal and constitutional system has long placed limits on the exercise of state power against the offender, as shown in the Bill of Rights 1688 and in s 9 of the New Zealand Bill of Rights Act 1990 (paras 65–67).

258 Similarly, the Criminal Justice Act requires a court to take into account the desirability of not imprisoning offenders so far as that is consonant with promoting the safety of the community (s 7).

259 Of the more particular purposes of sentencing, that which is the most relevant to the terms of reference is incapacitation; also relevant are deterrence and rehabilitation.

260 Incapacitation is specifically directed at the protection of the public, and applies particularly to imprisonment. Its method is simple. By physically detaining the offender, the public is protected, for the period of the imprisonment under the sentence, from the possibility of further offences being committed by that offender. The incapacitation may be selective, being determined by reference to the individual offender, or it may be collective, being directed at the offence—in either case because of the threat to the public. The purpose implies some prediction about future offending on an individual or collective basis.

261 There is, however, a limit to the extent to which the protection of the public can be used to justify a longer sentence. The sentence must bear some relation to the intrinsic nature of the offence and the gravity of the crime, but, because the calculation is not a matter of formulas, the length of a sentence often will take into account the protection of the public (*R v Ward* [1976] 1 NZLR 588 CA). As well, if in a particular case the defendant is liable to preventive detention, a longer determinate sentence than the usual can be justified (eg, *R v Brown*, unreported, Court of Appeal, CA 181/82, 16 December 1982; *R v Bidwell*, unreported, Court of Appeal, CA 249/85, 20 December 1985). As noted below (para 265), Parliament has emphasised the protective element in provisions about violent offending.

262 Deterrence can be either general or specific; aimed at deterring people in general from committing that offence or, in the case of specific

deterrence, a particular offender. In both cases the protection of the public can be seen as a desired purpose. Although this purpose can be achieved in the community where there is close supervision, it is often regarded as requiring a custodial sentence.

263 Rehabilitation is directed at reforming the offender. The Ministerial Committee of Inquiry into the Prisons System, *Prison Review Te Ara Hou: The New Way* (1989), comments that “[r]ehabilitation has been [an] ongoing hope . . . but there is scant evidence that rehabilitative programmes existing inside traditional prisons are effective” (para 2.3). More recent reports prepared by the Department of Justice,²⁶ the development of the regional Forensic Psychiatric Services since the Mason Report, and the consequent improvement in the quality of forensic psychiatric services²⁷ provide cause for optimism.

264 Next this report discusses the presumption of imprisonment for people convicted of violent offences and considers major powers already available to the sentencing court to protect the safety of members of the community:

- imposing longer sentences within the current maximums;
- fixing a minimum period of imprisonment which is actually to be served;
- imposing cumulative sentences when more than one offence has been committed; and
- imposing indeterminate sentences.

The presumption of imprisonment for violent offenders

265 The presumption of imprisonment applies (except in special circumstances relating to the offence or the offender) to those offenders who are convicted of offences punishable by imprisonment for two years or more, and who,

- in the course of committing the offence, used serious violence against or caused serious danger to the safety of another person, or
- have been convicted of at least one such offence within the preceding two years and who, in the course of committing the current offence,

²⁶ Report of the Department of Justice Habilitation Centre Development Group, *Habilitation Centres* (1990) ch 2; Bakker and Riley, *Reconviction Study 1990/91* (1994); and McLaren, *Reducing Reoffending: What Works Now* (1992).

²⁷ Regional Forensic Psychiatric Service—Annual Report 1992/1993.

used violence against or caused danger to the safety of another person, or,

- at the time of committing the offence, were on bail or remanded at large in respect of an offence involving violence against or danger to the safety of a person and who in the course of committing the current offence used violence against or caused danger to the safety of any person (Criminal Justice Act ss 5 and 5A).

266 The 1987 amendments added the last of these provisions and widened the application of the first and second provisions by reducing the prerequisite liability to imprisonment from five to two years. Insofar as the underlying purpose of the provisions is the protection of the public, assumptions are made, which may or may not be accurate, about the predictive value of earlier offending. The provisions may also have a denunciatory purpose.

267 In determining the length of imprisonment for such offenders, the court must have regard, among other matters, to the need to protect the public (ss 5(3) and 5A(3)). As the protection of the public is well established as one of the purposes of sentencing, that direction indicates that the matter is to be given greater weight than might otherwise be the case. In 1985 Parliament gave a similar direction in respect of sexual violation (Crimes Act 1961 s 128B(2)).

Imposing longer sentences within the current maximums

268 One possible response to the concerns reflected in the terms of reference is for the courts to impose longer sentences. The courts in general are left with broad discretions. Parliament can give important directions to the courts about how they are to exercise those discretions—as has occurred with the introduction of s 5, the later amendments which strengthened and broadened it, the wider availability of preventive detention, and, particularly, the increases in maximum penalties. A recent example of the last-mentioned direction relates to the increase in the maximum penalty for sexual violation from 14 years to 20 years imprisonment. In *R v A* [1994] 2 NZLR 129, the Court of Appeal responded to that increase by raising the starting point for sentencing in a contested rape case from five to eight years. As mentioned, such legislation reinforces the indications already given by these cases that the protection of the public may justify a penalty beyond that which would ordinarily be imposed (*R v Ward* [1976] 1 NZLR 588 CA).

269 Such changes in legislation and the public opinion they reflect, together with an increase in the seriousness of offending, appear to

explain the substantial increase over the last decade of the average length of custodial sentences for violent and sexual offences (Spier and Norris, 62). Many have noted that New Zealand's imprisonment figures are proportionately higher than those of most comparable countries.

Fixing minimum periods of imprisonment

270 A court which imposes a sentence of more than two years for a serious violent offence may order the offender to serve a minimum period of imprisonment which is longer than the statutory minimum periods fixed by the Criminal Justice Act. A court may impose a minimum period of imprisonment only if the circumstances are so exceptional that that is justified. The same power is available in respect of preventive detention, where the usual time for initial consideration of parole is after the offender has served 10 years (s 80).

Cumulative sentences

271 Where an offender has been convicted of multiple offences, imposition of cumulative sentences may result in a lengthy sentence. A determinate sentence of imprisonment may be cumulative on any other determinate sentence or sentences of imprisonment, whether then imposed or to which the offender is already subject (s 73). For the purpose of determining parole, final release and sentence expiry dates, cumulative sentences are treated as one term (s 92(2)).

272 On the choice between cumulative and concurrent sentences, Hall describes the general principle as follows:

[W]here two offences arise out of a single set of facts (the one transaction) and the nature of the offending is similar, concurrent sentences will be imposed. Where offences are committed virtually simultaneously but comprise different types of criminality, they are not normally to be regarded as part of the one transaction, and thus cumulative sentences are appropriate.

In determining whether there is one course of criminal conduct, . . . it is necessary to examine if the offences are so related either by *time*, *subject matter*, or *pattern* as to constitute a single invasion of the same legally protected interest . . . (Hall, *Sentencing*, S73.11)

273 Cumulative sentences will, of course, also be appropriate where the offences are unconnected in time. Where the court imposes a series of cumulative sentences or a combination of concurrent and cumulative sentences, it must determine an effective total that reflects the totality of the offending involved (*R v Strickland* [1989] 3 NZLR 47 CA).

The overall sentence for multiple offences (whether cumulative or concurrent) should not, however, give the impression that once a particular offence is committed, the offender can commit others with impunity (see *Hiroki v Police*, unreported, High Court, Wellington, AP31/92, 13 May 1992; and *Moroney v Police*, unreported, High Court, Auckland, AP143/91, 25 July 1991, as cited in Hall, *Sentencing*, S73.10(d)).

Indeterminate sentences

274 Sentencing, in the vast majority of cases, involves the imposition of a finite sentence: paying a certain fine, doing a certain number of hours of community work, or serving a certain period of imprisonment. The problem that the terms of reference reflect is that a finite period of detention may be considered inadequate to protect the public, as a particular detainee might be considered dangerous at the time of release. Moreover, it will not be possible to supervise that person indefinitely after release, either under the mental health or the criminal justice system. The only provision for the supervision of offenders who are released is the parole regime, which may last only as long as the original sentence.

275 The most obvious solution to this is to provide for indeterminate sentences. The concept of indeterminate sentences has been subject to much criticism in terms of both its practical protective effect and its impact on the rights and interests of the offender.²⁸ Parliament has responded to this criticism by supporting the proposition that the harm threatened by certain dangerous offenders to particular members of the public may be so serious that indeterminate sentences are justified for such offenders. In turn, the critics challenge the ability to predict reoffending. One problem with the predictive approach in individual cases is that by the time previous convictions have accumulated to the point of justifying a sentence of preventive detention, the offender may have passed the peak age of offending. Moreover, such offenders could in any event be sentenced to lengthy finite terms of imprisonment. Therefore the protection available from the extra years of imprisonment may be negligible. As well, the provisions must be tested against relevant constitutional principles (paras 59–84 and 98).

276 The criminal justice system currently includes two indeterminate

²⁸ See, eg, The Law Reform Commission, *Sentencing* (1988, ALRC 44, para 230). Although every Australian state except Victoria and the Australian Capital Territory has a form of preventive detention, those provisions, without exception, are used infrequently and are disliked by the courts (Parliament of Victoria, Social Development Committee, Interim Report, 39).

sentences: life imprisonment and preventive detention. Life imprisonment is the mandatory sentence for murder and is a discretionary sentence for a small number of other particularly serious offences. Where life imprisonment is a discretionary sentence, the protection of the public may be the factor that tips the scales in favour of sentencing an offender to life. In *R v Wickliffe* [1987] 1 NZLR 55, the Court of Appeal imposed a sentence of life imprisonment, saying it could not neglect considerations of public safety. The statutory provisions applying to release during a life sentence were the only ones enabling the Court to ensure some reasonable degree of continuing protection. The Court commented that the release should be at as early a date as reasonably practicable—but under the control which the law and the Parole Board could provide.

277 Section 75 of the Criminal Justice Act provides that a person who is 21 years of age or older is eligible for preventive detention if the person is convicted of sexual violation, or is convicted of a specified offence after earlier being convicted of such an offence since that person was 17 years of age. Specified offences are (a) certain offences against children, (b) certain sexual offences and (c) certain offences of violence:

- (a) incest, unlawful sexual intercourse and indecency with girls, indecency between males and sodomy, or attempted sodomy, in all cases with a child under 16;
- (b) sexual violation, attempted sexual violation, compelling indecent act with animal or attempting to do so;
- (c) attempted murder, wounding with intent or attempting to do so, injuring with intent to cause grievous bodily harm, aggravated wounding or injury, or acid throwing.

278 The High Court may impose preventive detention on an eligible offender if “it is satisfied that it is expedient for the protection of the public that [the] offender . . . be detained in custody for a substantial period . . .” (s 75). The protection of the public is the paramount consideration. This has been reinforced by the Court of Appeal on numerous occasions. It has also stated that “satisfied” in s 75 does not mean that the High Court must be satisfied beyond reasonable doubt that preventive detention is the appropriate sentence. It simply means that the Court has made up its mind and is indicative of a state where the Court on the evidence comes to a judicial decision (*R v White* [1988] 1 NZLR 264).

279 The High Court may not impose a sentence of preventive detention on a person for a first conviction for sexual violation unless the Court has first obtained a psychiatric report and, having regard to that

and any other reports, is satisfied that there is a substantial risk that the offender will commit a specified offence upon release (s 75(3A)).

280 Preventive detention first appeared in the Criminal Justice Act 1954 but had its antecedents in the habitual offenders legislation introduced in 1906. Since the Criminal Justice Act was passed in 1985, the scope of preventive detention has been twice widened, on each occasion in response to public concerns about violent crime. Before 1987, preventive detention could be imposed only on offenders over 25 years of age who were convicted of a serious sexual offence where they had at least one previous conviction for a serious sexual offence. In 1987, the eligibility was widened, in response to the *Report of Ministerial Committee of Inquiry into Violence* (1987), to include violent offences and to reduce the minimum age to 21. The Criminal Justice Amendment Act 1993 widened the scope further by making preventive detention available for a first conviction for sexual violation—tempered by the requirements of a psychiatric report and a finding of a substantial risk that the offender will commit a specified offence on release.

281 Preventive detention is an indeterminate sentence—the offender is detained in prison until released by the Parole Board. It is therefore a particularly severe sentence. Unlike offenders subject to a finite sentence, those subject to preventive detention can never point to a date when they can no longer be detained; even when they have been released they continue to be subject to recall (unless discharged from liability to recall).

282 An offender sentenced to preventive detention is first eligible for parole after 10 years if the sentence was imposed after 1 August 1987, and after seven years if sentenced earlier. However the High Court, when imposing the sentence, can order that a minimum period of more than 10 years be served if it is satisfied that the circumstances of the offence were so exceptional that that is justified (s 80). According to Department of Justice statistics, only five offenders subject to preventive detention have been released by the Parole Board since 1985, and, of that number, one has been convicted of further serious offences and recalled to prison (letter dated 4 March 1994).

Judicial approach to preventive detention

283 The Court of Appeal has emphasised on a number of occasions that sentencing an offender to preventive detention is a serious step and should be avoided where possible in favour of a finite sentence (eg, *R v K* (1990) 6 CRNZ 210).

284 In determining whether “it is expedient for the protection of the public” to impose preventive detention, the High Court will look to the likelihood of the person reoffending. While each case will depend on a consideration of its particular circumstances, the Court of Appeal has identified a number of factors relevant to that likelihood:

- the medical evidence;
- the repetitive nature of the offending;
- the offender’s predilection or proclivity for offending;
- the nature or class of person who is the victim of the offending, eg, young children;
- the serious nature of the offending;
- the absence of efforts by the offender to take positive steps to avoid reoffending;
- a failure to heed a warning about the likely consequences of offending;
- a failure to recognise the enormity of the offending or the plight of one’s victims (see Hall, *Sentencing*, S75.8).

285 It is not yet clear how the above factors will apply to an offender who qualifies under the amendment made in 1993 by being convicted for sexual violation and having no prior convictions for specified offences. It can be anticipated that a sentence of preventive detention for a first conviction of sexual violation will be imposed only in the most extreme cases; for instance, where there is strong evidence of relevant past conduct which would have constituted an offence if the person had been prosecuted and convicted. After all, the High Court is expressly required to find that there is a substantial risk that the offender will commit a specified offence upon release. The power has recently been used for the first time in a case in which, according to the sentencing judge, the defendant (one of the “37”: para 45) had a history of offending against children on a number of occasions in the very gravest circumstances but had never been tried because of his mental condition (*R v Miller*, unreported, High Court, Auckland, 20 April 1994, S37/94, Justice Speight). Another possible instance is where the offender is convicted on multiple charges of sexual violation. In such a case the court has the alternative of imposing cumulative sentences. Also relevant is the recent increase of the maximum sentence for rape to 20 years.

286 In the five years after preventive detention appeared in its modern form in the Criminal Justice Act 1954, an average of 19 offenders a year received the sentence. Its use then declined steadily. Preventive detention was substantially restricted in 1967 by narrowing the qualifying range of offences. In the years from 1968–1985 the sentence was imposed in only 23 cases, and in five of those cases the Court of Appeal replaced preventive detention with a finite sentence. In April 1981 only 15 offenders, all male, were subject to a sentence of preventive detention.

287 Within the last decade, there has been a clear trend towards the increased use of preventive detention. Earlier, preventive detention was generally regarded as being a sentence to which an offender graduated, after having already served a substantial term of imprisonment. Since 1987, an increasing number of offenders receiving preventive detention have not previously served a sentence of more than three years, and for the first time preventive detention has been imposed on offenders who have not previously served any sentence of imprisonment (five offenders from 1987–1993). The Solicitor-General, with the leave of the Court of Appeal, may appeal against a determinate sentence and seek preventive detention. Moreover, the Court of Appeal has for the first time replaced a finite sentence with preventive detention (*R v Priske*, CA 266/87, 2 June 1988; see also *R v Mataira*, CA 347/91, 30 April 1992). From 1986–1993 preventive detention was imposed in 52 cases. As at February 1994 there were 64 males subject to a sentence of preventive detention; 54 in prison and 10 on life parole.

288 In contrast to those general trends, the 1987 amendments have had a negligible effect on the use of preventative detention: no offender convicted of the violent offences added in 1987, has been sentenced to preventive detention, and only three offenders aged between 21 and 24 have been so sentenced since 1989.

289 Even with the recent increases in its availability and allowing for recent trends, preventive detention is rarely used. It is imposed in only a small proportion of the cases in which it is available. In the year 18 November 1992–1993, nine of the 86 offenders convicted of a specified violent offence and imprisoned were eligible for preventive detention but all received finite sentences, and of the 408 offenders convicted of specified sexual offences, 56 were eligible for preventive detention but only six were sentenced to preventive detention.²⁹ The 1993

²⁹ Statistics from letters from the Department of Justice dated 4 March 1994 and 31 March 1994.

amendment will, on the basis of 1992 statistics, make about another 250 offenders eligible each year.

290 There are suggestions that preventive detention is being imposed inconsistently. Although inconsistency is, to some extent, an unavoidable by-product of sentencing discretion, the severity of preventive detention means that it is particularly desirable that it is imposed as consistently as possible. Of course, consistency would be assisted by better information about sentencing judgments and by appeals. Another step, which is also relevant to sentencing more generally, is the development of sentencing guidelines and the availability of well-based statistical information which should be used in conjunction with predictions about individuals.

291 The already very extensive powers in the criminal justice system were the subject of major reconsideration in the process leading to the Criminal Justice Act 1985 and have been amended and added to on a number of occasions since. It is against this background that the Law Commission turns to consider possible changes to the powers of the state to detain those who may inflict certain types of harm on members of the public.

THE CONCEPT OF CIVIL DETENTION

292 The criminal justice system provides for the detention of offenders convicted of crimes of violence following a court process in which the defendant has been charged with a specific offence. The defendant has rights of defence, the benefit of the presumption of innocence and the requirement that the prosecutor prove the charge beyond reasonable doubt, as well as rights of appeal. The detention involved in imprisonment and its length are likely to be justified in part by the protection of the public. Later decisions about the release of dangerous offenders may also be governed or affected by considerations of community safety. Furthermore, the mental health legislation provides for the protection of members of the public from physical harm from people with mental disorders, who because of their disorders present a serious threat to the safety of others.

293 Should the law make further provision for the detention of people for reasons of community safety? Constitutional principle (paras 59–84 and 98) would require such legislation to contain the following elements:

- the nature and scope of the power must be justified by the need to protect the public from serious physical harm;

- in determining the nature of the protection required, less restrictive alternatives should be considered;
- the person's predisposing condition must be stated or defined with some precision, as must the resulting danger to others;
- the person or body making the detention decision must be independent and qualified to make the decision;
- the decision-maker is obliged to follow fair procedures which give those affected a full opportunity to know the issues in dispute, to rebut and challenge the evidence and arguments in favour of detention, and to put forward their own evidence and arguments in defence;
- those detained should have appropriate rights of appeal and of periodic review.

294 Some see a parallel between the quarantine of people carrying life-threatening diseases and the civil detention of dangerous people. Some jurisdictions have schemes of civil detention standing apart from their mental health and criminal justice systems.

295 One such scheme, recently enacted and the subject of discussions and court test, is found in the state of Washington in the United States. Is this a way of handling a small number of people who pose a serious danger which could be applied to New Zealand?³⁰ The Washington legislation begins with extensive findings including the following:

The legislature finds that a small but extremely dangerous group of sexually violent predators exist who do not have a mental disease or defect that renders them appropriate for the existing involuntary treatment act [T]he prognosis for curing sexually violent offenders is poor, the treatment needs of this population are very long term, and the treatment modalities for this population are very different than the traditional treatment modalities for people appropriate for commitment under the involuntary treatment act. (Part X of the Community Protection Act 1990 RCW 71.09.010)

296 In brief, the legislation authorises a judge or jury to determine that an offender who is about to be released or has been released is a "sexually violent predator". If a judge or jury, after the offender

³⁰ For further discussion of some of the issues relating to civil detention, see, eg, C Williams, "Psychopathy, Mental Illness and Preventive Detention: Issues arising from the David Case" (1990) 16 Monash ULR 161; Glanville Williams, "Controlling the Repetitive Dangerous Offender" (1993) 1 Medical Law Review 1; and Wood, "Dangerous Offenders and Civil Detention" [1989] Crim L J 324.

has been evaluated by a professional, determines that the offender is a sexually violent predator, the offender is committed to a secure facility of the department of social and health services.

297 “Sexually violent predator” is someone “who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence”. A crime of sexual violence is defined as rape, indecent liberties, child molestation, various violent offences where sexually motivated, and attempts and conspiracy to commit such offences. “Mental abnormality” means “a congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to the commission of criminal sexual acts in a degree constituting such person a menace to the health and safety of others”. Personality disorder is not defined. “Predatory” means acts directed towards strangers or individuals with whom a relationship has been established or promoted for the purpose of victimisation (RCW 71.09.020).

298 The provisions regarding sexually violent predators apply to a person who has been convicted and sentenced either as an adult or a juvenile, a person who has been found incompetent to stand trial, and a person who has been found not guilty by reason of insanity. Any person who appears to be a sexually violent predator must be referred to the prosecuting attorney of the county in which they were charged, three months before release (RCW 71.09.025). As well, a petition may be filed when the confinement is about to expire or after it has expired (RCW 71.09.030).

299 Once a petition is filed, the judge determines whether there is probable cause to believe that the person is a sexually violent predator (RCW 71.09.040). If probable cause is found, the person is taken into custody and transferred to an appropriate facility for evaluation by an appropriate professional under rules developed by the department of social and health services. Within 45 days of the petition being filed, a trial must be held (RCW 71.09.050). The person has a right to counsel at all stages and may retain experts. Either of the parties or the court may demand a jury trial. The state must prove beyond a reasonable doubt to the judge or jury (which must be unanimous) that the person is a sexually violent predator (RCW 71.09.060). If it is so proved, the person is committed to a secure facility of the department of social and health services for control, care and treatment until his or her mental abnormality or personality disorder has so changed that the person is safe to be at large.

300 If the person who is the subject of the petition was earlier found incompetent to stand trial, then the court must determine whether the person did commit the acts charged before the court considers the petition. The procedure for this “trial on the facts” is strict. The normal evidential rules and constitutional rights apply, and the court must make specific findings concerning whether the person did the acts charged and the extent to which their disability affected the outcome of the current hearing.

301 Every person who is found to be a sexually violent predator must be re-examined at least once each year (RCW 71.09.070) and may at any time file a petition for discharge (RCW 71.09.100).

302 The provisions were considered by Washington’s highest court—the Washington Supreme Court—in *In Re Young* 857 P.2d 989 (1993). The issues raised in the case are now being pursued through the federal courts. Although the two petitioners in that case were successful and partly successful in obtaining their release, the Court, by a vote of six to three, rejected the challenge to the constitutionality of the provisions. The most important aspects of the decision to this report were that the detention was civil and therefore did not violate the ex post facto clause nor the prohibition against double jeopardy; the statute was not void for vagueness, in part because, where the person who is the subject of the petition has been released before the petition was filed, there must be evidence of recent overt acts; and a person can be confined under the statute only after less restrictive alternatives have been considered.

303 It was necessary to determine whether the statute was civil or criminal, as the constitutional prohibitions against double jeopardy and ex post facto (retrospective) laws generally apply only to criminal statutes. The test is whether the legislature intends that a statute be civil or criminal and, if it is intended to be civil, whether the effect of the statute is so punitive as to negate that intention. It was noted that the United States Supreme Court had held that an Illinois statute which provided for the committal of sexually dangerous people was civil, with the consequence in that case that the privilege against self-incrimination did not apply (*Allen v Illinois* 478 US 364 (1986)). The Washington Supreme Court held that the clear intent of the Washington statute was civil, and that it was not punitive because its goals were incapacitation and treatment, unlike criminal confinement which is directed to retribution and deterrence. The prohibitions on double jeopardy and ex post facto laws therefore did not apply.

304 The Court then considered substantive due process. The United States Supreme Court had upheld those civil committal schemes which

are based on findings that a person is both mentally ill and dangerous (*Addington v Texas* 441 US 418 (1979); cf *Foucha v Louisiana* 118 L Ed 2d 437 (1992)). It was held that the Washington statute satisfied this requirement—it was sufficiently narrowly drawn and the definition of mental abnormality was not so vague that it denied due process. (The “personality disorder” element was not relevant to the two offenders in question.)

305 The committal of the appellant who had been released before the petition was filed was reversed because the requirement, which the majority read into the statute, that there be a recent overt act to prove dangerousness, was not satisfied. The other appellant’s case was remanded for consideration of less restrictive alternatives. It was held that equal protection requires the state to consider less restrictive alternatives to confinement.

306 The dissenting judges held that the statute was “masquerading” as civil when its purpose was penal, and that it violated the *ex post facto* and the double jeopardy prohibitions. They also held that the definition of mental abnormality was circular: “abnormality” was derived from the person’s past sexual behaviour which was then used to establish the person’s predisposition to future dangerous sexual behaviour. The reading into the statute of a requirement of a recent overt act was regarded as “judicial rewriting of the Statute [which] is unprincipled decision-making at its worst”. The Court was upholding the statute which “in effect sets up an Orwellian ‘dangerousness court’, a technique of social control fundamentally incompatible with our system of ordered liberty guaranteed by the Constitution . . .”.

307 The office of the Attorney-General in Washington has provided the Law Commission with some very helpful information about the legislation. Over the last four years, between 1200 and 1500 sex offenders have been released from prison. (The population of Washington is about 4 500 000.) The prosecutors have referred 27 of them to the courts under the new legislation, and a jury or judge has found 18 to be sexually violent predators. The 18 include the two who were successful in whole or in part in *In Re Young*. Washington does not have any equivalent to the New Zealand sentence of preventive detention: all convicted offenders are sentenced under the Sentencing Reform Act to a determinate sentence based on the seriousness of the offence and the offender’s record. We understand that such a sentence could be very long and might involve cumulative sentences.

308 While the purpose of civil detention legislation equivalent to the Washington statute is valid, the Law Commission does not at present

recommend such legislation for New Zealand. Our reasons relate in part to differences between the New Zealand and Washington situations and in part to matters of principle:

- (i) A court sentencing a sex offender in New Zealand can in many situations impose a sentence of preventive detention if there is a real likelihood of future offending. That option is not available in Washington.
- (ii) Other features of the Washington legislation bring it closer to the New Zealand criminal justice system and raise the question of its likely effect in practice:
 - the requirement (according to the majority) for a person at large to have committed a recent overt act which is sufficient to show probable cause for believing the person is dangerous;
 - the requirement that a judge or unanimous jury make the findings of mental abnormality and dangerousness beyond reasonable doubt;
 - the requirement that the least restrictive alternative be applied.
- (iii) Unlike the New Zealand Bill of Rights Act, the United States Constitution does not contain an express guarantee against arbitrary detention. A related point is that the International Covenant on Civil and Political Rights (which does contain such a guarantee) has only recently been ratified by the United States and is yet to have a real impact in the United States legal system.
- (iv) The information available to the Law Commission and the limited process it has followed do not enable it to form a view like the finding made by the Washington legislature about the need for the legislation (para 295); that finding was based on the report of the Governor's Task Force on Community Protection (1989).
- (v) Any such finding would have to deal with the acknowledged extensive uncertainty in predicting dangerous behaviour in particular cases.
- (vi) The wide, circular definitions of critical elements of the Washington legislation also appear to breach the prohibition on arbitrary detention and to undermine the value of fair procedures; in particular the evidence of "a personality disorder which makes the person likely to engage in predatory acts of sexual violence" is likely to be the acts themselves.

309 The broad point is that the criminal justice system with the associated powers of sentencing has been developed to protect members

of the community from physical harm caused by dangerous people, but to do that in a way which also protects the liberties and freedoms of individual New Zealanders. The relevant powers should in essence be found in that system and to a lesser degree in mental health law (supplemented in the ways which we indicated in ch 3).

310 We now return to one of the extensive powers of the court to sentence dangerous offenders under the criminal justice system.

PREVENTIVE DETENTION: OPTIONS

312 The sentence of preventive detention is one means of protecting the public so far as possible against those dangerous offenders who will continue to inflict serious harm on its members if they have the opportunity. The Law Commission recalls, however, that most serious offenders are sentenced to determinate periods of imprisonment: only about 50 of 2000 offenders in prison for sexual and other violent offences are serving sentences of preventive detention. The Commission now presents options which might be further considered. They concern

- the availability of the penalty of preventive detention,
- the test for its imposition, and
- the alternative of an indeterminate sentence which consists of a specified term of imprisonment liable to extension.

Availability

312 The limits on the availability of preventive detention relate to the offender's age, the character of the offence and, sometimes, earlier offences. Although the limits have been considerably relaxed in recent years, this has not had a significant impact on the use of the penalty (paras 288–289). Presumably this is because the High Court is not frequently asked to impose it in those wider circumstances or, if it is, is not persuaded that the protection of the public requires indefinite detention in custody. The Commission notes, too, that preventive detention may be imposed for attempts to commit certain offences (para 277). That is, the very serious penalty might be available even though the offender has not done physical harm.

313 Some would doubt whether any further extension of the scope of this most substantial power can be justified. Questions can be raised about the availability of the power for first convictions as a result of

the 1993 amendment: how is that to be aligned with the purpose of protecting the public, the relevant constitutional principles, and the lack of compelling evidence (at least in general) of a substantial risk to the safety of the public in such cases?

314 The eligibility for preventive detention should not be altered unless there is clear and cogent evidence that there are offenders who should be given preventive detention but who are not eligible, and until the issue of whether preventive detention is being imposed consistently is addressed in appropriate ways and any problems rectified. The likely protective effect of the penalty as it has operated in recent years should also be assessed, so far as that is possible.

315 Resourcing is another important issue. The scope of preventive detention should not be widened unless Parliament is satisfied that those offenders who are sentenced to preventive detention will have the benefit of an adequate level of psychiatric and psychological services, and other relevant training and rehabilitation programmes. Because offenders sentenced to preventive detention will be imprisoned until it is determined that they no longer represent a danger to society, the emphasis on rehabilitation should be even stronger than with other sentences of imprisonment. Appropriate services and programmes will also be required for parolees who are subject to conditions designed to enhance community safety.

The test for imposing the penalty

316 Under current law, the High Court has to be satisfied in the general case that it is expedient for the protection of the public that the offender be detained in custody for a substantial period. In the particular case (introduced by the 1993 amendment) of a first conviction for sexual violation, the test is a more rigorous one: the Court also has to be satisfied that there is a substantial risk that the offender will commit a specified offence upon release.

317 It might be thought that the additional condition in the latter test provides a better focus in all cases, consistent with principle and as the essential reason for applying this most serious power. As well, it might be useful to clarify the phrase “upon release”: it is presumably to be taken to mean upon release from what would otherwise be the appropriate determinate penalty. There is, in addition, the anomaly that the possible future offences do not include murder and other serious offences.

318 It is worth recalling the point made in para 290 that there are

suggestions that preventive detention is not being imposed consistently, yet the severity of the sentence means that it is particularly desirable that its imposition be as consistent as possible.

A specified term of imprisonment liable to indeterminate extension

319 Preventive detention as currently applied in New Zealand is indeterminate (and could be lifelong), with the Parole Board having powers to release the offender. A possible alternative is the reverse: the offender would be eligible for release on parole, after a specified period of imprisonment fixed by the sentencing judge, unless the Parole Board is satisfied that the protection of the public requires continued detention. One justification—which much research challenges—for this course would be that decisions about the probability of further acts of serious violence, if made nearer the time of possible release, would be more likely to be reliable. The offender would be on notice from the outset of the sentence that it could be extended. The incentives for the offender might be better ones. Sentencing judges might have an additional valuable sentence available to them. There is much experience elsewhere of such different methods of sentencing.

OPTIONS FOR OFFENDERS CURRENTLY IN PRISON, ON PAROLE OR FINAL RELEASE

320 The question asked by the second term of reference is whether it is possible to detain offenders beyond the time they are, under the present law, entitled to be released. For offenders currently in prison, the answer is straightforward.

321 To introduce a new power of detention for offenders currently in prison and serving a finite sentence would be to breach the constitutional principle which prohibits, in the clearest terms, punishing an offender for an offence for which that offender has already been punished. That right is reflected in s 10(4) of the Crimes Act 1961, Article 14(7) of the International Covenant on Civil and Political Rights 1966, and s 26 of the New Zealand Bill of Rights Act 1990. Those principles apply to *criminal* process.

322 We have considered civil detention separately (paras 292–309); but we do not think that introduction of this problematic option would be justified simply as a means of continuing to detain a handful of potentially dangerous people who were not sentenced to preventive detention. The problem such people present upon release may be

transitional. We have suggested that the amendments already made to the preventive detention system, along with its consistent application, provide a mechanism for detaining indefinitely those who can reasonably be predicted to be likely to commit serious sexual or other violent offences if they were released.

323 An offender in prison who is mentally disordered can, of course, be detained within the mental health system. Such detention may continue beyond the date on which the sentence would have expired, but only where the mental disorder continues—that diagnosis of course depending on the scope of the definition of mental disorder and the different views covered in chapter 3. We recall the recommendations that those involved in the interpretation and application of the 1992 Act be encouraged to address their different understandings of that Act (paras 174 and 228); and also recall one of the recommendations of the Gallen Report (*Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters*, 1983) which is relevant in this context:

No person should be detained at a hospital such as Oakley Hospital on social grounds alone and in no sense should prison sentences be extended by decisions made which are not subject to control of the Courts. (19.6.11)

324 It is not possible to introduce a new power applying to offenders currently in prison to detain them beyond their sentence expiry date. There are, however, existing powers to detain such offenders until closer to the end of their sentences than might otherwise be the case, or to release them on parole on appropriately stringent conditions.

Requiring offender to serve full term of imprisonment

325 Section 105 of the Criminal Justice Act provides that the Secretary for Justice may apply to the Parole Board for an order that an offender serve the full term of imprisonment. An application may be made only in respect of an offender sentenced to imprisonment for any of those offences that are specified for the purposes of preventive detention (para 277).

326 The Parole Board may make the extension order only if it is satisfied that the offender, if released, is likely to commit a specified offence between the date of release and the applicable release date (which is generally three months before full term, to allow release conditions to be imposed). Such an order must be reviewed once every six months.

327 Section 105 was introduced in 1987 (and amended in 1993) in

response to public concerns about violent crime. It came into force in July 1987, and no applications were made until 1990. Since then, eight s 105 orders have been made and three are still in force (there is also one application pending). Of the five offenders who have been released, two are now serving sentences of preventive detention and one is remanded in custody charged with several serious offences. The numbers are too few to support a general conclusion that is statistically strong, but this small group does help highlight the problem of sexual and other violent offending by a core of truly dangerous people.

328 The Department of Justice suggests that s 105 could not deal with all cases of potentially violent inmates due for release. It gives the example of an obsessive domestic violent offender as one who would not be covered by s 105. Further, the length of time for which a s 105 order will be in force will always be limited by the length of the sentence. On the other hand, the protection of the public might be better safeguarded by the release of an offender on parole, so that the offender's reintegration into the community can be better facilitated over a period of time: if the offender serves the full term of imprisonment, that opportunity is diminished.

Parole

329 In 1993 Parliament significantly altered the rules for the parole and release of offenders from a prison sentence: Criminal Justice Act Part VI (see, eg, Young, "Sentencing Principles" in *Adams on Criminal Law* (Robertson), vol 2, ch 3). In most cases, offenders are eligible for parole after they have served a specified proportion of a sentence of imprisonment, and must be released on what is described as the final release date, after serving a greater proportion (also specified). Decisions in relation to parole are made by the Parole Board if the offender is serving a sentence of seven years or more, and a District Prisons Board if the offender is serving a sentence of more than 12 months and less than seven years. Offenders serving 12 months or less are not eligible for parole although the final release date for such offenders is after one-half of the sentence.

330 Eligibility for parole is determined as follows:

- an offender who is sentenced to more than 12 months imprisonment for other than a serious violent offence is eligible to be released on parole after serving one-third of the sentence;
- an offender who is sentenced to less than 15 years imprisonment for a serious violent offence is not eligible to be released on parole;

- an offender who is sentenced to 15 or more years imprisonment for a serious violent offence is eligible to be released on parole after serving 10 years imprisonment;
- an offender subject to an indeterminate sentence—life imprisonment or preventive detention—is eligible for parole after serving 10 years imprisonment;
- the sentencing court can fix a longer minimum period for those sentenced to more than two years imprisonment for a serious violent offence or to an indeterminate sentence;
- the Parole Board or a District Prisons Board as appropriate may direct that an offender be released on parole at an earlier stage.

331 The final release date is determined as follows:

- for an offender sentenced to 12 months imprisonment or less, after serving half the sentence;
- for an offender sentenced to more than 12 months, after serving two-thirds of the sentence.

332 These two sets of rules are subject, as noted, to a minimum period of imprisonment being specified under s 80 or any extension order made under s 105 (see paras 270 and 325–328). These powers are limited in their scope and rarely invoked. In a recent 10-year period, only 1.8% of offenders served more than two-thirds of their sentence (Spier and Norris, 111).

333 Section 104 sets out the matters that must be taken into account by the Parole Board and District Prisons Boards in determining whether to release an offender on parole. The first matter is the need to protect the public or any person or class of persons who may be affected by the release of the offender. There is then a more specific list of matters. The first is the likelihood of the offender reoffending upon release. Where the offender is subject to an indeterminate sentence, the Parole Board must also have regard to Government policy and any written directions of the Minister of Justice, although the Minister cannot usurp the Parole Board's discretion in any particular case (s 98). To date, no such directions have been issued. Apart from s 98, the regime for release on parole is basically the same whether the offender is subject to a finite or an indeterminate sentence.

334 The conditions that automatically attach, or that may attach, to release on parole or final release are provided for in ss 107A–107F. However, an offender sentenced to 12 months imprisonment or less is

not subject to any of these conditions on final release. Section 107B contains the standard conditions for release, most of which revolve around reporting to a probation officer. Section 107C provides for such special conditions as the Parole Board thinks necessary to protect the public or any person or class of persons who may be affected by the release of the offender, or for the rehabilitation or welfare of the offender. These conditions are specifically required to be designed to reduce the risk of reoffending (s 107C(3)).

335 It follows that it would be possible to provide for a power to detain offenders for a limited period beyond their expected release date. This is because for virtually all offenders sentenced to imprisonment, their final release date is earlier than the date on which their sentence expires. On the other hand, holding a person until a finite sentence has expired would deprive the community of the protection which may be afforded by release subject to conditions designed to protect the public.

Recall

336 An offender who has been released on parole or at the final release date may be recalled to a penal institution to continue serving his or her sentence (s 107L). Application is made to the Parole Board by the Secretary for Justice where the offender is subject to an indeterminate sentence, and to the Parole Board or a District Prisons Board by a probation officer where the offender is subject to a finite sentence (s 107I). The main grounds on which the Parole Board and District Prisons Boards have discretion to recall a parolee are, where they are satisfied on the balance of probabilities, that

- the offender has breached the conditions of release, or
- the offender has committed an offence, or
- because of the offender's conduct or a change in his or her circumstances, further offending is likely (s 107L(2)).

337 If the offender has committed an offence, clearly an alternative or additional option (which is not limited by the length of the current sentence) is to prosecute for that offence.

338 In considering an application for recall, the need to protect the public or any person or class of persons must be taken into account (s 107L(3)). A parolee who is subject to an indeterminate sentence will be liable to recall for life, unless discharged from liability to recall under s 107N. Section 107N only applies to an offender who is detained

in or on leave from a hospital. Its purpose is not entirely clear but is possibly that those people to whom it applies should be dealt with under the mental health system.

CONCLUSIONS ON THE SECOND TERM OF REFERENCE

339 The criminal justice system already provides broad powers, especially through imprisonment, which are designed to protect the public from dangerous offenders. Parliament has increased those powers in recent years. The courts have made greater use of those powers: more people convicted of sexual and other violent offences are sent to prison and serve longer periods of imprisonment. At present about 2000 such offenders are held in the nation's prisons.

340 The period of imprisonment can, in a significant range of cases, be indeterminate, with the consequence that an offender who is considered dangerous can be held in or returned to prison at any time. For those offenders who are not sentenced to that most heavy—and controversial—penalty, there are significant powers in the criminal justice system which can be used to protect the community, both when the penalty is imposed and in the course of its implementation. Further, there is the power to transfer an offender who is serving a sentence of imprisonment to a psychiatric institution. That power is not to be used to impose an extra sentence on an offender who has already been sentenced.

341 The Law Commission does not at present recommend the enactment of a power of civil detention similar to legislation enacted in the state of Washington. Information of a kind which persuaded the Washington legislature is not available to us; predictions of dangerousness are fallible; and such a power is difficult to square with constitutional principle unless it is so confined that it essentially replicates the powers already available under criminal justice and mental health legislation.

342 The report sets out options for legislative reform which might be considered. Any new powers could apply only to people convicted of offences committed after the new powers were introduced. The Commission repeats that the existing powers are broad. They are already being used extensively, although in some situations greater use might be considered. Those powers include imposing parole conditions designed to enhance community safety; such conditions may require the support of appropriate rehabilitative services and programmes.

RECOMMENDATION

343 If the Government wishes to consider changing sentencing powers, the Law Commission makes the sole recommendation that any review examine sentencing in a broad context and be supported by appropriate statistical and other research. The review might take up options for legislative change mentioned in this report.

5

Children and young persons

INTRODUCTION

344 The terms of reference require the Law Commission, in the context of the mental health and criminal justice systems,

to have regard to the situation of children and young persons detained in the custody of the Director-General of Social Welfare under the Children, Young Persons, and Their Families Act 1989 and who pose a substantial risk of harm to other members of the public.

345 Under the Children, Young Persons, and their Families Act 1989 (“the 1989 Act”), a child is a boy or girl under 14 years of age. A young person is a boy or girl of or over 14 and under 17 years of age who has never married (s 2).

346 It became clear early in discussions with relevant agencies that this aspect was included in the terms of reference because of concern with possible inadequacies in the law’s treatment of children and young persons who are compulsive and persistent sex offenders. While other children and young persons may also be dangerous, for example those who commit other serious violent offences, we have focused our attention on compulsive and persistent young sex offenders. However, we believe that the information we have collected and summarised below may be instructive for any more general consideration of the situation of dangerous children and young persons.

347 After outlining the most relevant situations in which children and young persons are detained in the custody of the Director-General of Social Welfare, this chapter examines

- the application of mental health legislation (and mental health services) to children and young persons,

- the availability of treatment facilities for young sex offenders, and
- aspects of the care and protection and youth justice provisions of the 1989 Act.

DETENTION IN DIRECTOR-GENERAL'S CUSTODY

348 There are various interim situations provided for in the 1989 Act in which a dangerous child or young person may be placed in the custody of the Director-General of Social Welfare. Of more relevance, however, is the situation where the seriously antisocial behaviour of a child or young person (s 14(1)(d)) or the criminal behaviour of a child (s 14(1)(e)) results in a Family Court declaration that the child or young person is in need of care and protection (s 67) and an order placing the child or young person in the custody of the Director-General (s 101). Dangerous children and young people in this category will generally be placed in one of the five New Zealand Children and Young Persons Service (CYPS) residences. There is room for argument whether all residents of these institutions are, to use the words of our terms of reference, “*detained* in the custody of the Director-General”, but we do not consider it profitable to pursue that point here. We have assumed that all compulsive and persistent young sex offenders who reside in CYPS residences are “detained” there, whether or not they are in secure care.

349 The other most relevant situation in which a young person will be detained in the Director-General's custody under the 1989 Act is upon the making of a Youth Court order for supervision with residence (s 311). Made upon proof of a criminal charge against a young person, this order is the most restrictive available to the Youth Court. It places the young person in the custody of the Director-General (and therefore in a CYPS residence) for a period of three months, reducible to two months if he or she does not abscond or commit further offences during that time (s 314).

MENTAL HEALTH SERVICES

350 The Mental Health (Compulsory Assessment and Treatment) Act 1992 applies to people under the age of 17 years subject only to Part VIII of the Act (ss 85–90). The most significant limiting provision is s 88, which prohibits the performance of brain surgery for mental disorder on anyone under the age of 17 years. We believe there may have been some misunderstanding about the scope of s 87, which

provides that a parent or a guardian of a patient over 16 years cannot consent to the patient's assessment and treatment. However, because the 1992 Act establishes a compulsory assessment and treatment regime, consent of a patient, or parent or guardian, is rarely essential, making the scope of s 87 very limited.

351 Although the 1992 Act contains few age-related restrictions, the ability of our mental health services to respond to the needs of children and young persons is limited by the lack of inpatient psychiatric facilities suitable for juveniles. This matter was frequently mentioned to the Commission by those who deal with disturbed children and young people. We are aware that the Ministry of Health is well advanced in its development of a youth mental health policy, and that the Minister has identified both child health and mental health as matters of priority for Regional Health Authorities. It would seem, therefore, that the limitations in the provision of specialised psychiatric facilities for children and young people, both inpatient and outpatient, are receiving appropriate attention.

352 Nevertheless, the role of mental health services in relation to young sex offenders is not at all clear cut. For example, the very fact of youthfulness hinders, and sometimes precludes, the diagnosis of certain mental conditions. Antisocial personality disorder, for example, is a condition identified only in adults. Compulsive and persistent young sex offenders are likely to be described by relevant professionals as "conduct disordered". That disorder, as with antisocial personality disorder, is not clearly a "mental disorder" for which compulsory psychiatric treatment is appropriate.

TREATMENT PROGRAMMES AND FACILITIES

353 There is a dearth of alternative treatment programmes available in New Zealand for young sex offenders. This lack of services was consistently identified by those with whom we spoke as the greatest obstacle to the rehabilitation of young sex offenders and to the safety of the community from their criminal acts. The only programmes presently available for young sex offenders are non-residential and cater only for those who are willing participants. Amongst the relevant agencies and professionals with whom we spoke, there was a unanimous call for residential programmes to be provided in a secure setting. It was made clear that the young offenders most in need of such programmes require secure care in the interests of public safety.

354 There was also a strongly held view that treatment programmes for young sex offenders can usefully be provided on a compulsory, rather than voluntary, basis. One psychiatrist practising in the field of child psychiatry explained that while the unwillingness of young sex offenders to cooperate in their rehabilitation certainly makes the task harder, it is still worth attempting. Referring to overseas experience, the same psychiatrist explained that often young sex offenders do not disclose the true extent of their offending, and so do not admit their need for treatment, until they have entered a treatment programme and been confronted with their behaviour. Once disclosure has occurred, there is a far greater likelihood that a young offender will willingly continue with the programme. This “chicken and egg” situation is only possible in a system which incorporates some element of coercion in obtaining the young person’s initial participation in an appropriate programme.

355 We are aware that various official initiatives have been or are being pursued, involving either or both of the Ministry of Health and the Children and Young Persons Service of the Department of Social Welfare, towards the development of residential treatment programmes for young sex offenders. At least one lobby group of concerned professionals has been formed with the aim of informing and hastening that process. While efforts to date may have been hampered by a lack of coordination and a lack of clarity as to the respective agencies’ responsibilities, we understand that the implementation of recommendation 21 in the recent Weeks Report on the Children and Young Persons Service (*A Study of Financial Management Practices in the Children and Young Persons Service in Fiscal 1994*) bodes well for better cooperative effort between relevant agencies in the future. The substance of that recommendation is that inter-agency boundary issues that impact upon Vote: Social Welfare should be identified and referred to The Treasury for resolution and funding reallocation as appropriate.

356 If, as was unanimously proposed to us as being necessary, residential treatment programmes for young sex offenders are to be established, including secure facilities, it will need to be decided whether treatment should always be voluntarily undertaken or whether it should be able to be imposed on a young sex offender. The answer to this question will affect the ability of the Director-General of Social Welfare to place in such programmes young sex offenders detained in the Director-General’s custody who are unwilling to participate. If compulsory attendance at treatment programmes is favoured, it will

be necessary to consider whether the sentencing options for young sex offenders require modification to allow a court to order attendance at a programme as a condition of, or instead of, existing options. The length of time which treatment may take will be a highly relevant factor in any such consideration. It is agreed amongst relevant professionals that treatment will take a minimum of several months and possibly up to three or four years. Consequently, it may be that eligibility for court-ordered treatment should be limited to those young sex offenders whose offending warrants the imposition of a comparable period of imprisonment. We have not pursued these matters, but urge that they be carefully considered in the process of developing residential treatment programmes for young sex offenders.

CARE AND PROTECTION AND YOUTH JUSTICE ISSUES

357 In the course of our discussions with relevant agencies and professionals, a number of criticisms were made about the operation of the 1989 Act with regard to dangerous children and young persons, including those detained in the custody of the Director-General of Social Welfare. It is noteworthy that no one with whom we spoke identified as a concern issues relating to the Act's application to Maori. Most of the criticisms that were made did not relate to the 1989 Act itself but to its implementation. We consider that some of these criticisms highlight areas in which the Act's operation in regard to dangerous children and young persons could be modified to the advantage of public safety.

358 It was suggested that failures to report to the police the criminal conduct of residents of CYPS institutions, for example assaults on staff, can later, when the young person is charged with another offence, mislead the court in its assessment of the offender, with the result that he or she is dealt with too leniently. Another criticism was that police decisions to lay charges for lesser offences than might be proven or, where an offence is not purely indictable, to prosecute summarily rather than by indictment, can again result in the lenient disposition of a young offender. The operation of the adult criminal justice system is similarly affected by victims' decisions not to complain and by prosecutorial discretion.

359 One matter that seems to warrant further attention by the Department of Social Welfare and the Police is the formulation and effective promulgation of policy, consistent with the principles of the 1989 Act

and with expert opinion, with regard to the prosecution of children and young persons who are sex offenders. A united view was expressed to us that children and young persons who commit “more serious” sex offences should be dealt with under the youth justice provisions of the 1989 Act—which are designed to confront young offenders with the impact of their conduct and have been shown to be effective in inhibiting future sexual offending. While there was a difference in views about the level of sexual offending which is properly described as “more serious”, it was alleged that the 1989 Act is being incorrectly applied on occasion, to the detriment of young sex offenders and community safety. In particular, the “youth justice object” of the 1989 Act, contained in s 4(f), and the specific provision in s 18(3) for child offenders to be referred to a Youth Justice Co-ordinator, were said to be circumvented by inappropriate decisions, made by the Police or social workers, to invoke care and protection procedures in respect of some young sex offenders.

360 It was also suggested that both the care and protection and youth justice systems fail to make sufficient use of psychiatric and psychological assessments of young offenders, with the result that the needs of some will not be adequately identified and catered for. While the Family Court and Youth Court can order that medical, psychiatric and psychological reports be made available (ss 178 and 333), it was suggested that those powers may be under-used. Moreover, where the courts do not become involved because of diversion through the Family Group Conference procedures, it was alleged that lack of resources, or lack of knowledge as to how to obtain a psychiatric or psychological report or when one might be justified, were obstacles to the acquisition of that potentially important information.

361 Another criticism frequently made, and specific to CYPS residences, was that mixing offending and non-offending children and young persons in residences exposes the most vulnerable to danger. It was further suggested that because those working under the 1989 Act know of this fact, it can influence decision-making so that, for example, a particular child or young person might not be placed in a residence when that would be the best option in the circumstances. Our terms of reference focus on the risk of harm posed by dangerous detainees upon their release into the community and, in the body of this report, we have not discussed the issue of the risk posed by dangerous detainees to other detainees. But if the above criticisms of the management of CYPS residences have any substance, it is important that the Act which recognises society’s obligation to advance the wellbeing of

children, young persons and their families should not be implemented in a manner which exposes some children and young persons to fresh danger.

362 Criticisms made to us of the 1989 Act's inherent limitations were few and centred largely on what may be described as its marginal areas. Thus, there was some concern that certain children (10–13 years of age) display such a level of criminality that the Act's more stringent provisions for offending by young persons might appropriately be applied to them. Similarly, there was concern that the Youth Court's lack of power to transfer young persons under 15 years of age to the District Court for sentencing, coupled with the limited range of dispositions available to the Youth Court, thwarts its ability to respond appropriately to some young offenders who must be or can be dealt with there. In particular, the maximum term of the s 311 supervision with residence order was singled out as being too short to ensure that certain young persons who were offenders benefited from any programme designed to modify their offending behaviour.

363 For each of these alleged weaknesses in the 1989 Act, there was an opposing view and, in sum, we gained the impression that the 1989 Act works well, or at least is capable of working well, for the vast majority of children and young persons with whom it deals. We stress, however, that our own inquiry into this area has been limited to dangerous young sex offenders.

RECOMMENDATIONS

364 On the basis of the foregoing discussion, the Law Commission recommends:

- (1) The Department of Social Welfare should ensure that relevant agencies are aware that the Mental Health (Compulsory Assessment and Treatment) Act 1992 does not contain an age bar prohibiting its application to children and young persons. However, the statutory definition of mental disorder would not apply to many of those children and young persons currently presenting the most difficult management problems.
- (2) The Department of Social Welfare should pursue inter-agency discussions with a view to establishing secure residential treatment programmes for young sex offenders.

- (3) The Department of Social Welfare should liaise with relevant agencies, including the Police, the Ministry of Health and Te Puni Kokiri, to consider issues related to the implementation of the Children, Young Persons, and Their Families Act 1989, with particular emphasis on
- the formulation and effective promulgation of prosecution policies in relation to sexual offences by children and young persons, and the criminal conduct of residents of CYPS institutions, and
 - the question of whether powers to obtain psychiatric and psychological assessments of young offenders are sufficiently used.
- (4) The Department of Social Welfare should consider whether mixing offending and non-offending children and young persons in CYPS residences exposes the most vulnerable to danger and, if so, take appropriate steps to end this practice.

APPENDIX A

MHA/CJA interface: entry and exit procedures for special patients and others; important terms

A1 The diagram at the conclusion of this Appendix sets out, in very simplified form, the steps by which alleged offenders who enter the criminal justice system and are either found to be under disability, acquitted on account of insanity, or found guilty are detained in hospital as special patients or patients under compulsory treatment orders. The procedures for reclassification from special patient status, and eventual discharge, are also illustrated.

A2 The diagram is not comprehensive and does not refer, for example, to persons on remand or provisions for review other than those that apply to special patients. For the sake of brevity, “MHA” is used in the diagram to refer to the Mental Health (Compulsory Assessment and Treatment) Act 1992, and “CJA” is used to refer to the Criminal Justice Act 1985.

A3 The following are some key terms that are relevant to the interface between the mental health and criminal justice systems:

Mental disorder: This term is defined in s 2 of the 1992 Act. For a discussion, see paras 102–114 of the report. Briefly, mental disorder means any abnormal state of mind characterised by delusions, or disorders of mood, perception, volition or cognition, of such a degree that a serious danger is posed to the health or safety of that person or of others, or the capacity of the person for self-care is seriously diminished.

Compulsory treatment orders: People admitted under the ordinary procedures of the 1992 Act—ie, not through the criminal justice system—are subject to several short periods of assessment. A District Court must then determine whether the patient is mentally disordered and whether a compulsory treatment order is

necessary (s 27). Such an order may be either an inpatient order or a community treatment order. Compulsory status, whether as an inpatient or community based, is equivalent to “committal” under the Mental Health Act 1969. As the diagram illustrates, a court may order that an alleged offender who has been found to be unfit to stand trial, an insanity acquittee, or a convicted offender, be detained in hospital as a “patient” rather than a “special patient” (the latter is discussed below). Such an order is equivalent to a compulsory treatment order; the legal status of a patient who enters hospital in this way is identical to that of a patient who enters hospital under the ordinary compulsory assessment and treatment procedures.

Restricted status: Under s 55 of the 1992 Act, a District Court may make an order declaring a patient to be a restricted patient if satisfied that person presents special difficulties because of the danger he or she poses to others and, for that reason, it is appropriate the order be made. Only inpatients can be made restricted patients. Restricted patients are subject to restrictions relating to leave and discharge. It is perhaps unlikely that an application for restricted status would be made in respect of an inpatient who is an offender or an alleged offender: offenders or alleged offenders are likely to be special patients and the effect of restricted status is equivalent to the effect of being a special patient. However, a former special patient who is detained under a deemed compulsory treatment order may be able to be declared a restricted patient. As noted in para 234 of the report, no patient has ever been made a restricted patient.

Special patient: This term is defined in s 2 of the 1992 Act. It is a legal, not a psychiatric, term. Under the 1992 Act, a special patient is defined as:

... a person who is—

- (a) Subject to an order made under section 115 or section 121 of the Criminal Justice Act 1985, or to an order for the detention of that person in a hospital made under the proviso to section 171(3) of the Summary Proceedings Act 1957; or
- (b) Is detained in a hospital pursuant to section 45(4)(d) or section 46 of this Act and has not ceased, by virtue of section 48 of this Act, to be a special patient.

For practical purposes, there are three main categories: alleged offenders who have been found to be unfit to stand trial, insanity acquittees, and prisoners transferred to hospital under s 45 or 46

of the 1992 Act. Section 115 of the Criminal Justice Act 1985 sets out the possible orders that a court may make in respect of a person found to be unfit to stand trial or acquitted on account of insanity:

- an order that the person be detained in a psychiatric hospital as a special patient (s 115(1)); or
- if, having regard to all the circumstances of the case and after hearing medical evidence, the court is satisfied that it would be safe in the interests of the public, it may
 - make an order that the person be detained in hospital as a patient (ie, the person is deemed to be under a compulsory treatment order),
 - make an order for the person's immediate release (which very rarely happens in practice), or,
 - if the person is liable to be detained under any full-time custodial sentence, decide not to make any order (s 115(2)).

Special patients are subject to restrictions on leave (ss 50–53). Their status must be regularly reviewed (s 77).

In May 1994 there were approximately 65 special patients resident in psychiatric hospitals who were subject to orders under s 115(1) of the Criminal Justice Act 1985. Four of these patients had been found to be under disability on a primary diagnosis of intellectual handicap, and another two found to be under disability on a primary diagnosis of brain damage. Two of these patients were insanity acquittees with a primary diagnosis of personality disorder; one other insanity acquittee was brain damaged. It seems that the other special patients had all been diagnosed with conditions that fell clearly within the definition of mental disorder. (This information was supplied by the Ministry of Health; it should be treated with some caution, as diagnostic practices vary.) Information from the Department of Justice indicates that 25 orders under s 115(1) were made in 1993, all applying to males. The ethnicity of those subject to the orders was as follows: 12 Caucasians, nine Maori, two Pacific Islanders, one Asian and one of unknown ethnic origin. (No statistics are available from the Department of Justice that compare the nature of orders made following findings of disability with orders made following insanity acquittals.)

Responsible clinician: This is defined in s 2 of the 1992 Act as meaning, in relation to a patient, the clinician in charge of the treatment of that patient. In relation to special patients, the responsible clinician is likely to be a medical practitioner.

Review Tribunal: The Mental Health Act 1969 did not provide for review tribunals. The 1992 Act provides that there shall be such number of Review Tribunals as the Minister of Health determines (s 101). Each Tribunal must comprise three persons appointed by the Minister, of whom one is a barrister or solicitor and one a psychiatrist. Review Tribunals have functions relating to compulsory, special and restricted patients.

Under disability (unfit to stand trial): The term “under disability” is defined in s 108 of the Criminal Justice Act, and is discussed in paras 146–157 of the report. A finding of disability can only be made in respect of a person who is mentally disordered within the meaning of the 1992 Act.

Insanity: This is not defined in either the 1992 Act or the Criminal Justice Act. Section 23(1) of the Crimes Act 1961 contains a presumption of sanity but s 23(2) states that

[n]o person shall be convicted of an offence by reason of an act done or omitted by him when labouring under natural imbecility or disease of the mind to such an extent as to render him incapable—

- (a) Of understanding the nature and quality of the act or omission;
or
- (b) Of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong.

This definition follows the traditional M’Naghten Rules. It will cover some persons with an intellectual handicap. It differs from the definition of mental disorder, although a person who is acquitted on account of insanity may also have been mentally disordered at the time of the offence. Conversely, a person may be acquitted on account of insanity yet not be mentally disordered. Such an insanity acquittee may be detained in a psychiatric hospital as a special patient even though that person is not mentally disordered.

See the published version of this report for
the two flowcharts:

**Entry and exit procedures for
special patients and others**

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APPENDIX B

Submission of the Law Commission to the Social Services Select Committee on the Mental Health (Compulsory Assessment and Treatment) Amendment Bill

BACKGROUND

B1 The Mental Health (Compulsory Assessment and Treatment) Amendment Bill (“the Bill”) was introduced into Parliament on 30 March 1994. The Law Commission prepared a submission on the Bill which it discussed with the Social Services Select Committee on 25 May 1994.

B2 Part I of the submission summarised the Law Commission’s report which, at that stage, had yet to be completed. The conclusions in that summary are substantially the same as the conclusions and recommendations contained in this report. The Commission provided a summary of the report for three reasons:

- the position on the Bill is based on the material and reasoning in the report;
- while many of the comments on the Bill are critical, the suggestions in the report offer constructive ideas for future development;
- our inquiry confirmed very clearly that the issues which arise in connection with the compulsory detention of citizens cannot be considered in isolation from one another. With regard to the Bill, this means that although its focus is on increasing the detention powers that are authorised by the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the 1992 Act), its justification or effect cannot be comprehended without understanding the rationale and effect of other New Zealand laws which also authorise the compulsory detention of citizens. The major compulsory detention powers in this country are sentencing powers, including those in the Criminal Justice Act 1985.

B3 Part II of the submission set out the implications of those conclusions for the Bill. In particular, Part II discussed:

- the Bill’s reform of “under disability” and its consequential effects;
- an alternative to the Bill’s reform of “under disability” and its consequential effects;
- the Bill’s amendment to “serious danger”;
- the Bill’s compulsory care regime—“specified condition” and “specified offence”;
- the nature of compulsory care;
- people liable to compulsory care;
- the Bill’s application to insanity acquittees;
- s 115(2) patients;
- restricted patient status;
- safeguards on decisions based on dangerousness;
- retrospective effect on former patients.

B4 The remainder of this appendix is a copy of Part II of the submission. Only paragraph numbers have been altered.

PART II OF THE SUBMISSION

Introduction

B5 The summary of the Report’s findings and recommendations makes it plain that we support the Amendment Bill’s objective of reforming the definition of “under disability” in s 108 of the Criminal Justice Act and making necessary consequential amendments. We discuss these matters in paras B7–B34, before considering the Bill’s proposed amendment to the phrase “serious danger” in the definition of mental disorder (paras B35–B38).

B6 It will also be plain that we do not support the Bill’s more general aim of creating, for certain people considered dangerous, a new detention regime separate from the criminal justice and mental health systems but dependent on mental health facilities and services. Nevertheless, we discuss (in paras B39–B74) some specific matters of concern arising from the scope and effect of the proposed compulsory care regime.

The Bill's reform of "under disability" and its consequential effects

B7 The Amendment Bill proposes a new definition of "under disability" (see Second Schedule amending ss 2(1) and 108(1) of the Criminal Justice Act) which will not be dependent on a finding of "mental disorder". Instead, a person will be under disability if "mentally impaired" to such an extent as to be unable to plead, understand the nature or purpose of the proceedings or communicate adequately with counsel for the purposes of conducting a defence. "Mental impairment" does not require any element of dangerousness and expressly includes severe intellectual handicap:

- 'Mentally impaired', in relation to any person, means suffering from—
- (a) An abnormal state of mind (whether of a continuous or intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition; or
 - (b) A state of arrested or incomplete development of mind involving severe impairment of intelligence and social functioning.

B8 Once a defendant has been found unfit to stand trial and the prosecution suspended, there may then be the question whether that person should be the subject of orders under the mental health legislation. The Criminal Justice Act provides for an automatic link. The court is to decide whether the person will be held as a special patient (s 115(1)) or whether, having regard to all the circumstances of the case and being satisfied, after hearing medical evidence, that it would be safe in the interests of the public, the person be

- (a) held as a patient under a compulsory treatment order
- (b) immediately released or
- (c) detained under any full time custodial sentence to which the person is liable (s 115(2)).

B9 The present powers may be justified by reference to the dangerousness element in the definition of mental disorder. But that element will disappear in the new provisions. There is no reason for a finding of danger.

B10 Further, the Amendment Bill would add to the list of powers (a)–(c) noted above, a new power (s 115(2)(aa)) to order that the person be detained as a patient in a secure place that is a service within the meaning of Part II of the Bill—that is, under the compulsory care regime.

B11 The Bill also proposes amendments to ss 116 and 117 of the Criminal Justice Act so that when a special patient who has been found

under disability (or acquitted on the grounds of insanity) is reclassified, the Attorney-General (or Minister of Health) may direct that the former special patient be held subject either to a compulsory treatment order or a compulsory care order.

Comment

B12 The definition of “under disability” should be broadened to remove the requirement of dangerousness and to clearly include intellectually handicapped people and any others who, by reason of their mental state, are unfit to stand trial. This will allow under disability hearings to serve their purpose of ensuring procedural fairness, which is a fundamental element of the right, guaranteed by s 25(a) of the Bill of Rights Act 1990, to “a fair and public hearing by an independent and impartial court.” Naturally, reforming the definition of under disability will have flow-on effects. Specifically, it will create a category of people who are unfit to stand trial but who are not mentally disordered within the meaning of the mental health law and so who may or may not suffer from a mental illness and may *or may not* be dangerous to themselves or others. It is necessary, therefore, to consider when any of these people may lawfully be detained, where they should be detained, under what conditions, and for how long.

B13 It is significant that intellectually handicapped people will comprise by far the majority of people in the expanded “under disability” category. Also, because their handicap will have caused their unfitness to stand trial, it is not likely that they will subsequently become fit to be tried.

B14 The Bill’s answer to the vital questions posed about the extended class of persons found to be under disability (who may be lawfully detained, where, under what conditions and for how long) is to add another option to the range of court orders presently available for that extended group. The added court order of compulsory care appears designed to apply to dangerous people found to be under disability: the compulsory care regime is analogous to the special patient regime in that it involves inpatient care and limited entitlement to leave; and the compulsory care is to be provided in a secure place. (There is the oddity that the compulsory care power would appear in subs (2) of s 115 along with the power to order an immediate release, with the same criterion.)

B15 But the Bill does not require—indeed it does not authorise—the court to find that the person is dangerous because of the mental condition. The finding will be of unfitness to stand trial solely

because of that condition. Principle opposes detention simply for that reason. The present law of course generally involves a finding of dangerousness.

B16 If our recommendation for a review of Part VII of the Criminal Justice Act is acted on and it is amended to dovetail with new legislation designed to address the specific gaps in the law's treatment of *dangerous* intellectually handicapped people, there will be a short term need to provide for the placement of those people. We consider that a less complex and more acceptable short-term alternative can be found than the compulsory care regime of the Bill. Also, we believe that the Bill's proposed new definition of "under disability" can be improved upon. We now turn to those two matters.

An alternative to the Bill's reform of "under disability" and its consequential effects

B17 The Bill's proposed reform of the definition of "under disability" gives rise to two problems. The first is that its definition of "mental impairment" incorporates the concept of an "abnormal" state of mind. This concept has posed difficulties for the courts when faced with intellectually handicapped defendants who seem unfit to stand trial. There has been doubt expressed whether "abnormal" imports an objective or subjective standard: should it be judged in terms of what is "normal" for the majority of the population or in terms of what is "normal" for the particular defendant?

B18 If the Bill's definition of "mental impairment" is enacted, this problem will not be a major one in the context of under disability hearings. This is because the second limb of the "mental impairment" definition (dealing with arrested development) is plainly aimed at intellectual handicap, making it unnecessary to assess intellectually handicapped defendants under the first limb which requires the presence of an "abnormal" state of mind. However, the condition of defendants who are not covered by the second limb can be expected to test the meaning of "abnormal" state of mind, perhaps compounding the difficulties already posed by that expression.

B19 The second and more significant difficulty posed by the Bill's definition of "mental impairment" is that it appears too narrow to cover all defendants who are unfit to stand trial as a result of their mental condition. By requiring that a defendant's inability to stand trial must derive from an abnormal state of mind or a state of *arrested or incomplete development* of mind, the definition will not apply to

people whose mental impairment derives from some event occurring or condition acquired in adulthood. One such category of people comprises those who suffer brain damage as the result of motor accidents or other traumas. We understand that some people in this situation do not suffer from delusions nor from what may readily be termed disorders of mood, perception, volition or cognition. As a result, they would be excluded by the Bill's definition despite lacking the mental capacity to participate sufficiently in a trial.

B20 Any attempt to exhaustively define the types of mental conditions which might cause a defendant to be unfit to be tried runs the risk of excluding some people who warrant being found under disability. Therefore, we consider the most satisfactory solution is for the phrase "mentally disordered" in s 108 of the Criminal Justice Act (and other provisions which use the phrase in the context of under disability findings) to be replaced by another, for example "mentally impaired", but to leave that new phrase undefined. This would leave the matter of its precise meaning to be determined by the courts, which would be free to interpret it consistently with the overriding purpose of ensuring procedural fairness.

B21 Recent Canadian legislation provides a helpful model. It was enacted as a consequence of the Supreme Court of Canada striking down related legislation as contrary to the guarantees of fair procedure in the Charter of Rights. "Unfitness to stand trial" means unable on account of mental [impairment] to conduct a defence or to instruct counsel to do so and in particular unable to

- (a) understand the nature or object of the proceedings
- (b) understand the possible consequences of the proceedings or
- (c) communicate with counsel.

B22 Although we commend this alternative method of reforming the definition of under disability in s 108 of the Criminal Justice Act, we do so in the expectation that the recommendation in our Report for a thorough review of Part VII of that Act, including s 108, will be adopted. We are aware that our own proposal for reforming s 108, being dependant on a defendant's *mental* impairment, may itself prove too limited to deal appropriately with all people who should properly be found unfit to stand trial. We note, for example, that physically frail defendants are excluded from the reform of s 108 that we have proposed. At present, people who are unable to stand trial as a result of such frailty are dealt with by the courts' powers to adjourn or dismiss proceedings. We consider that a review of Part VII of the Criminal

Justice Act should include an examination of the appropriateness of the law's response to the unfitness of those people.

B23 As indicated, we consider that the Bill's compulsory care regime should not be adopted. This will require the necessary flow-on effects of the reformed s 108 to be met by an alternative proposal. Again, in light of our Report's recommendations for a thorough review of Part VII of the Criminal Justice Act and for policy development, with a view to separate legislation, in relation to certain intellectually handicapped people, the need to provide immediately for the flow-on effects of the reformed s 108 is a need for an interim solution. Because the most appropriate solution will be discovered only as a result of the process we have recommended, it is inevitable that any interim solution will contain elements which are inconsistent with existing understandings and practices. However, we believe that the interim solution we recommend here poses far less of a challenge to those matters, as well as to the fundamental principles which underlie our criminal justice and mental health systems, than does the Bill's compulsory care regime.

B24 In brief, we consider that the existing legislative provisions for the disposition of persons found to be under disability can be utilised, with some amendments, to deal with the expanded group of people who will be found under disability as a result of the reformed definition of that term. The central provisions involved are ss 115 and 116 of the Criminal Justice Act and ss 76 and 77 of the Mental Health (Compulsory Assessment and Treatment) Act. The Criminal Justice Act provisions establish the range of orders a court may make upon finding a defendant to be under disability and set the maximum duration of special patient status for any such defendant who is made a special patient. The mental health provisions establish the review procedures for, and the tests to be applied to compulsory and special patients in determining whether they are fit to be released or reclassified.

B25 As has been noted, the reformed definition of "under disability" will create a new group of people found unfit to stand trial: they will not suffer from any mental illness and they may or may not be dangerous. It is only this group which needs to be considered for any who are "mentally disordered" are already provided for by the two Acts. They may be made special patients or, if safe to do so, compulsory patients, and their rights of review and the tests for their reclassification and release are clearly provided for.

B26 Of the new group, those who are neither mentally disordered nor dangerous will not be of concern: the court can and should order their immediate release under s 115(2)(b) of the Criminal Justice Act.

Therefore, the only group of future under disability defendants who require attention comprises those who are not mentally ill but who are considered to be dangerous.

B27 Under the reformed provision about unfitness to stand trial, the court will reach that finding without any regard for the defendant's dangerousness. It will also be able to reach that finding without categorising the defendant's mental condition as a mental illness. In light of this, it would be inappropriate for s 115 of the Criminal Justice Act, as presently worded, to come into play immediately upon a finding of under disability. That section is premised on the assumption (justified by the present definition of "under disability") that the defendant's unfitness to stand trial is the result of a "mental disorder", which not only incorporates the requirement of a particular type of mental condition but also the element of dangerousness to self or others or diminished capacity for self-care. As a result, s 115(1) proceeds from the basis that a defendant found under disability will often need to be made a special patient. Section 115(2) then provides that where the court is satisfied, having regard to all the circumstances of the case and after hearing medical evidence, that it would be safe in the interests of the public to do so, it may make less restrictive orders: an order that the defendant be made a compulsory patient or immediately released. It may also make no order, where the defendant is already liable to be detained under any full-time custodial sentence.

B28 To make these criminal justice provisions consistent with the expanded definition of "under disability" will require the insertion of an extra step - between a court finding a defendant to be under disability and making an order which might restrict that person's liberty. It will be necessary to provide that, upon a finding of under disability, the court must then determine whether the defendant is "mentally disordered" and, if not, whether the defendant is, to use a shorthand term for now, "dangerous". (The exact definition of the requisite level of "dangerousness" will require attention and the solution will be related to the outcome of the Bill's proposal to omit the word "serious" from the "serious danger" formula in the definition of mental disorder. We discuss this matter in paras B35-B38.)

B29 The essential point for present purposes, however, is that it is only once mental disorder or "dangerousness" has been established or negated that it will be appropriate for the scheme of s 115 to come into play. At that stage, a mentally disordered defendant will be able to be dealt with under the existing s 115 (and s 116) of the Criminal Justice Act. And a defendant who is not mentally disordered, but "dangerous"

(however that is to be exactly defined) will also, we believe, be able to be dealt with under those provisions, provided that due regard is also had to the provisions of the Protection of Personal and Property Rights Act 1988 which may be able to be used in some cases to supplement the range of dispositional options for a defendant found under disability. (That Act authorises a Family Court, on application, to make a variety of residential and other orders which might be appropriate to the circumstances of particular under disability defendants who are not mentally disordered.) The Criminal Justice Act might usefully make it explicit that the Court might defer to the processes available under the 1988 Act if they are more appropriate.

B30 The basic nature of the above proposal is then that future defendants found unfit to stand trial who are “dangerous” can be included in the existing criminal justice/mental health scheme for mentally disordered under disability defendants. We recognise that this may not be an ideal solution and stress again that we propose it as an interim measure only, until a thorough review of the relevant law is conducted and a more principled solution found.

B31 Naturally, if the law is amended to add a new group of under disability defendants to the existing criminal justice/mental health scheme, it will be necessary to provide an appropriate standard or test to govern the reviews which will be conducted of the condition of the new group of special and compulsory patients. The review standard in s 77 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 for special patients who have been found under disability, is worded in such a way as to be readily applicable to any future under disability patients who were never mentally disordered. It requires the responsible clinician to review the patient’s condition and determine if he or she remains under disability and, if still under disability, whether the patient should continue to be detained as a special patient. The consequences of any of the responsible clinician’s findings seem apt to apply to any of the new group of special and compulsory patients created as a result of the changes in respect of fitness to stand trial. When reviewing such patients, responsible clinicians (and the Review Tribunal when its powers are invoked) will need to have regard to the new tests of unfitness to stand trial and dangerousness. Those are of course the tests which apply to the initial detention decisions.

B32 We acknowledge that refinements will be needed to this basic scheme. For instance, it may well be necessary to specify the criteria upon which a responsible clinician is to base a finding, under s 77, that

a special patient should no longer be detained as such and, similarly, to specify the criteria upon which to base a finding that a compulsory patient be released. Also, as signalled above, the important matter of the “dangerousness” of a defendant found under disability but not mentally disordered, which will act as the criterion for the initial and continued detention as a compulsory or special patient, needs to be resolved. Our later comments on the Bill’s proposal to omit the word “serious” from the “serious danger” phrase in the definition of mental disorder are relevant to this matter.

B33 Finally, we note that our later comments in paras B67–B70 about the use of restricted patient status are of general relevance to the proposal we have made for modifying the existing criminal justice/mental health scheme to deal with the extended group of defendants found under disability as a result of reforming the definition of that term.

B34 We summarise here the main points of our recommendation for an alternative to the Bill’s reform of the test “under disability” and its necessary consequential effects:

- the new term “mental impairment”, to be substituted for “mental disorder” in s 108 of the Criminal Justice Act 1985, should be left undefined;
- with some amendments, ss 115 and 116 of the 1985 Act and s 77 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 can be used, together with the provisions of the Protection of Personal and Property Rights Act 1988, to provide for the consequential effects of the reform relating to unfitness to stand trial;
- section 115 of the 1985 Act will require amendment so that after a finding of unfitness the court must determine whether the defendant, in addition to being mentally impaired, is mentally disordered or dangerous;
- in conducting reviews of unfit [to plead] special and compulsory patients, responsible clinicians and the Review Tribunal will need to apply the same test as governed the initial detention;
- the immediate reform of s 108 and its consequences should be reviewed when Part VII of the 1985 Act is reviewed in conjunction with policy development for dangerous intellectually handicapped people.

The Bill's amendment to “serious danger”

B35 The Bill proposes to omit the word “serious” from the phrase “serious danger” in the definition of mental disorder (cl 2 amending s 2(1) Mental Health (Compulsory Assessment and Treatment) Act). Plainly, the effect will be to lower the threshold for entry to the mental health system and raise the threshold for release from it. We understand that the intention of the proposed amendment is to preclude judicial rulings to the effect that, to be mentally disordered, a person must possess an abnormal state of mind of such a degree that it poses an imminent danger to the health or safety of that person or of others.

Comment

B36 We are concerned that this intention is sought to be implemented in the proposed manner. Quite apart from the arguments, which we support, that it is appropriate to set a high threshold for compulsory entry to the mental health system (and a correspondingly low threshold for release), it is arguable that the proposed amendment does not tackle the issue of the imminence of the required danger at all. At best it does that indirectly.

B37 The direct way of achieving the intended result would be to amend the definition to require the person's abnormal state of mind to be such as to pose a “serious danger (whether or not imminent) to the health or safety of that person or of others”.

B38 We believe the present definition is appropriate and that authoritative court rulings may be expected in future which will require the gravity of the danger to be weighed with its imminence. However, if an amendment is desired to preclude the possibility that “serious danger” may be interpreted meantime solely in terms of imminence, we recommend that this will be best achieved, not by the Bill's proposed amendment, but by retaining the words “serious danger” in the definition of mental disorder and inserting the qualifying words that we have suggested.

The Bill's compulsory care regime—“specified condition” and “specified offence”

B39 The most significant amendment proposed to the Mental Health (Compulsory Assessment and Treatment) Act 1992 is that there be created a compulsory care regime for certain people who have a

“specified condition” and are considered likely to commit a “specified offence” if not subject to compulsory care.

B40 “Specified condition” in relation to any person is defined to mean:

- (a) A state of arrested or incomplete development of mind involving severe impairment of intelligence and social functioning and associated with abnormally aggressive or seriously irresponsible conduct on the part of the person; or
- (b) A persistent disorder or disability of mind (whether or not involving significant impairment of intelligence) associated with abnormally aggressive or seriously irresponsible conduct on the part of the person (cl 2(3), amending s 2(1) of the 1992 Act).

B41 “Specified offence” is defined (as it is in the Criminal Justice Act for the purposes of defining eligibility for a sentence of preventive detention) to include the most serious offences against the person.

Comment

B42 It seems that the two limbs of the definition of “specified condition” are intended to cover those persons ordinarily referred to as intellectually handicapped or disabled and who are considered dangerous, and those with personality disorders of an anti-social or aggressive kind.

B43 To fall within the first limb, which is closely modelled on the definition of “severe mental impairment” in the Mental Health Act 1983 (UK), a person needs to be intellectually and socially impaired to a “severe” degree. As already stated, experience indicates that people with the greatest degree of intellectual disability rarely pose danger to the community.

B44 As noted, some people with personality disorders in terms of the second limb of the definition are covered by the current definition of mental disorder. We have already stated our view that those with personality disorders who are dangerous and who are not mentally disordered should be dealt with as appropriate through the criminal justice system (para 214 of the report). We note as well that the second limb of the definition is so broadly worded as to be capable of including a range of mental illnesses which are already clearly included within the definition of mental disorder. Is that result intended? It is certainly not justified granted the existing capacity of the mental health system to detain people with mental disorders.

B45 The Commission has two other objections to the provisions, based on principle and on a comparison with the United Kingdom Act. First, the Bill does not require a causal nexus between the targeted mental conditions (intellectual handicap and personality disorder) and the “abnormally aggressive or seriously irresponsible conduct”. In both limbs of the definition, it is sufficient that a person’s arrested mental development or persistent disorder of mind (etc.) is *associated with* abnormally aggressive or seriously irresponsible conduct on their part. This looser form of wording is used in the United Kingdom Mental Health Act’s definition of “severe mental impairment” (corresponding to the first limb of the definition of “specified condition”) but it is not used in that Act’s definition of “psychopathic disorder”—which requires the disability of mind to *result in* abnormally aggressive or seriously irresponsible conduct. The second limb of the “specified condition” definition therefore departs from its United Kingdom model in a significant way.

B46 There is a second important difference. The Mental Health Act 1983 (UK) does not simply prescribe that the presence of “severe mental impairment” or “psychopathic disorder”, without more, is grounds for invoking the Act’s compulsory treatment regime. Section 3 of that Act establishes what may be referred to as the appropriateness, necessity and treatability criteria. It authorises an application for the compulsory admission for treatment of a person only on the grounds that the person’s mental condition (including severe mental impairment and psychopathic disorder) is of a nature or degree which makes it appropriate for the person to receive medical treatment in a hospital (s 3(2)(a)) and that it is necessary for the health or safety of the person or for the protection of others that the person receive such treatment and it cannot be provided unless the person is detained (s 3(2)(c)). In addition, where the person has a psychopathic disorder or a “mental impairment” (which is defined differently from the “severe mental impairment” used as a model in the Bill) the application for treatment must be based on the ground that medical treatment in a hospital is likely to alleviate or prevent a deterioration in the person’s condition (s 3(2)(b)).

B47 The effect of s 3 is to circumscribe the number and nature of “severely mentally impaired” and “psychopathically disordered” people who may be compulsorily treated in the United Kingdom mental health system. By contrast, the Amendment Bill seeks to adopt that Act’s terminology (with modifications) for a different purpose. In doing this, the Bill is open to the criticism of targeting for detention and compulsory treatment an arbitrarily chosen group of people who are,

as well, dangerous. The group's selection is arbitrary in the sense that it is defined by reference to a disability (in apparent breach of the principle underlying s 19 of the Bill of Rights Act) which is not causally connected to the danger. As indicated later there are other apparently arbitrary elements in the identification of the groups.

The nature of compulsory care

B48 The most salient features of the compulsory care regime established by the Bill may be summarised as follows:

- the care must be provided in a hospital or in a secure place which is a “service” as defined in the Bill;
- every compulsory care order is to be an inpatient order, and leave for compulsory care patients is limited as it is for special patients;
- treatment may be provided compulsorily to compulsory care patients as it can to those subject to compulsory treatment except that their consent must be obtained not only to brain surgery but also to electro-convulsive treatment;
- only those former patients to whom the Bill applies will be assessed for compulsory care by means of the staged procedures contained in Part II of the Bill (cls 12–16). All other patients will have their eligibility for compulsory care determined by a criminal court, the Review Tribunal or a civil court (acting on review, appeal or by way of judicial inquiry);
- reviews of and appeals from decisions making a person subject to compulsory care are equivalent to those provided in respect of compulsory treatment orders.

Comment

B49 From this brief outline, it is plain that the “care” to be provided to compulsory care patients amounts to detention with liability to compulsory treatment. The Bill of Rights Act provides a guarantee, in the absence of good reason to the contrary, against medical treatment without consent (s 11). The very fact that there is no provision for the equivalent of community treatment—so that compulsory care cannot be provided elsewhere than in a hospital or secure place—also raises the serious question whether the least restrictive alternative has been provided for the proposed compulsory care patients.

B50 Further, since only those with “specified conditions” will receive

compulsory care, the relevance and legitimacy of providing for their compulsory treatment in a manner virtually identical to the treatment of compulsory treatment patients, must be questioned. The Report records a widely expressed professional opinion that intellectual handicap should not be approached and dealt with in the same manner as mental disorder. By contrast, but leading to the same result, there is very little consensus about issues relating to personality disorder, including its diagnosis and the role of mental health professionals in its treatment.

B51 In light of these facts, the compulsory care regime of the Mental Health (Compulsory Assessment and Treatment) Amendment Bill is open to the criticism of being a euphemism for incarceration under questionable conditions. Given that mental health professionals will be central figures in the implementation of the Bill's provisions, it must be of concern that their support for the proposal cannot be guaranteed and moreover that, even if they willingly participate in the Bill's regime, there is such scope for inconsistency in its application.

People liable to compulsory care

B52 The people who will or may be assessed for compulsory care under the Bill fall into three major groups:

- some patients presently in hospital
- some future patients
- some former patients.

B53 While the liability of some former patients to compulsory care has been the focus of public attention, the application of the Bill to the far more numerous groups of present and future patients may not be well understood, especially given the complexity of the provisions which create this situation. We outline below the categories of patient who may be made subject to compulsory care as a result of the Bill.

B54 There are four sub-groups of *patients presently in hospital* eligible for assessment as to whether they have a "specified condition" and are likely to commit a "specified offence". For all but one of these sub-groups, the Review Tribunal is required to conduct a review before a patient is released from compulsory status. The purpose of the review is to consider whether the patient is (a) mentally disordered *or* (b) has a specified condition and is likely to commit a specified offence. If the Review Tribunal makes the latter finding, the patient then becomes liable to compulsory care. The four sub-groups comprise:

- (a) Patients presently subject to compulsory treatment after reclassification from special patient status (cl 6 inserting s 81A(1)(a)(i) and (ii)):

These are patients who, upon being found unfit to stand trial (under disability) or upon acquittal of an offence on the grounds of insanity, were made special patients by order of the court and who have subsequently been reclassified to compulsory status under ss 116 or 117 of the Criminal Justice Act 1985.

The proposed s 81A of the principal Act requires these patients to have their condition reviewed by the Review Tribunal before they are released from compulsory status. As noted, any who are found to have a “specified condition” and likely to commit a “specified offence” will then become subject to compulsory care.

- (b) Patients presently subject to compulsory treatment as a result of a court order under s 115(2) or s 118 of the Criminal Justice Act 1985 (cl 6 inserting s 81B):

These are patients who entered hospital, not as special patients, but subject to a compulsory treatment order upon being found under disability, acquitted on the grounds of insanity (s 115(2)) or convicted of an offence (s 118).

A review of these patients’ condition by the Review Tribunal is not automatic. The proposed s 81B of the principal Act requires the Review Tribunal to review the condition of any patient in this category only where an application for review is made by a responsible clinician or certain mental health officers.

- (c) Patients who are presently subject to compulsory treatment as a result of the expiry of their special patient status, which status derived from their compulsory transfer to hospital from prison or from a certified institution under the Alcoholism and Drug Addiction Act 1966 (cl 6 inserting s 81A (1)(a)(iii)):

As with the patients in (a) above, it will be necessary for the Review Tribunal to review these patients before their release from compulsory status.

- (d) Patients presently subject to compulsory treatment who were formerly “restricted patients” (cl 6 inserting s 81A(1)(b)):

To date no patients have been declared to be restricted patients

under s 55 of the 1992 Act. However, the condition of any such patients, as with those in (a) and (c) above, will be required to be reviewed by the Review Tribunal before their release from compulsory status.

B55 Six sub-groups of *future patients* will be eligible for compulsory care under the Bill's provisions. Three of these correspond to categories (b), (c) and (d) of the patients presently in hospital and liable to assessment for compulsory care: any future patient who enters hospital as a result of an order under ss 115(2) or 118 of the Criminal Justice Act, any future patient who is transferred from prison or a certified institution and later reclassified, and any future restricted patient who is later reclassified.

B56 The other three sub-groups all comprise people who will be found in the future to be under disability or acquitted on the grounds of insanity. One of these sub-groups comprises those who are found to be under disability as a result of the reformed definition of that term and then immediately ordered by the court to be subject to compulsory care (Second Schedule adding s 115(2)(aa) Criminal Justice Act).

B57 The fifth sub-group comprises those people who are in future found under disability or acquitted on the grounds of insanity, ordered to be special patients and later reclassified and detained subject to compulsory *treatment*.

B58 The sixth sub-group is created by the proposed amendments to ss 116 and 117 of the Criminal Justice Act. These would authorise the Attorney-General and Minister of Health (respectively) to direct, at the time of reclassification from special patient status of a person found under disability or acquitted on the grounds of insanity, that the person be held subject to a compulsory care order.

B59 *The group of former patients* who are subject to the Bill's compulsory care regime comprises those who satisfy three criteria:

- they are not now patients but were on 1 November 1992 subject to compulsory treatment as a result of having earlier been special patients; and
- they have since been discharged from hospital; and
- they have a "specified condition" and are likely to commit a "specified offence" if not subject to compulsory care (cl 12).

B60 The procedure by which these people may become subject to compulsory care essentially parallels the compulsory assessment and treatment procedure of the Mental Health (Compulsory Assessment

and Treatment) Act, culminating in a court order for compulsory care (Part II of the Bill).

Comment

B61 In addition to the elements of the specified condition and likelihood of offending, the Bill establishes liability to assessment for compulsory care largely on the basis of the manner in which patients entered, or will enter, the mental health system. In so doing, it focuses attention on the fact that most of those to whom it applies have a background of offending - sometimes proven, sometimes merely alleged (in the case of persons found under disability and not later brought to trial) or, in the case of insanity acquittees, not proven because of the person's mental condition. This emphasis, we believe, may tend to encourage a perception that the Bill is an appropriate response to the well-publicised situation of recent offenders who have psychiatric histories. As summarised earlier and elaborated in our Report, this view is not endorsed by our own analysis of the problems which exist in the present mental health and criminal justice systems and our understanding of the legal and factual constraints upon solutions to those problems.

B62 Apart from our general criticisms of the compulsory care regime, there are several specific features of it which are questionable. In particular, we draw attention to:

- the Bill's application to insanity acquittees
- the Bill's application to s 115(2) patients
- the fact that the Bill overlooks the untapped potential in the "restricted patient" provisions of the Mental Health (Compulsory Assessment and Treatment) Act with respect to dangerous compulsory patients
- the need for strict safeguards upon a decision based on a prediction of dangerousness
- the Bill's retrospective effect for former patients.

The Bill's application to insanity acquittees

B63 Presently, a special patient who has been acquitted of an offence on the grounds of insanity can only be reclassified by the Minister of Health, under s 117 of the Criminal Justice Act, after the responsible clinician or the Review Tribunal has certified that the person's mental condition *no longer requires, either in the person's own interest or for*

the safety of the public that the patient be subject to the order making them a special patient. Moreover, even where the responsible clinician or Review Tribunal has given such a certificate, the Minister has a discretion not to act upon it and so may require the patient to continue to be detained as a special patient.

B64 Granted then that an insanity acquittee who has been a special patient and then reclassified must have been judged to be no longer a risk to public safety, and in circumstances where the Minister is authorised to be especially cautious about the matter, it is highly questionable that the Review Tribunal should have the power, prior to the patient's discharge from compulsory status, to assess that patient for eligibility for compulsory care. To find the patient eligible would require findings both that the patient has a "specified condition" and, significantly, that the patient is likely to commit a specified offence if released. If it made the latter finding, the Review Tribunal would be directly contradicting the Minister's decision that the patient is no longer a risk to public safety. The Bill therefore exposes insanity acquittees to a form of double jeopardy in respect of dangerousness and the likelihood of committing a specified offence.

Section 115(2) patients

B65 Similar criticism can be levelled against the Bill's application to patients who were ordered to be compulsory patients under s 115(2) of the Criminal Justice Act. Before making an order under that subsection, the court must be satisfied, after hearing medical evidence, *that it would be safe in the interests of the public* for the person to be made a compulsory patient rather than a special patient. It may be argued from the way s 115 is worded that it creates a presumption in favour of ordering a person to be detained as a special patient. For a court to invoke s 115(2) then, it will have considered the matter of public safety very carefully.

B66 The Bill proposes that the Review Tribunal may, on application, review the condition of s 115(2) patients prior to their release from compulsory status. Yet if, in any such review, the Review Tribunal found a s 115(2) patient to be in need of compulsory care, that would be inconsistent with the court's earlier decision that it was safe in the interests of the public to make the person a compulsory rather than a special patient. We question the need for this "double-check" when, as explained next, there is protection already provided in the Mental Health (Compulsory Assessment and Treatment) Act for the one situation in

which it will be necessary: where a person made a compulsory patient under s 115(2) later becomes dangerous.

Restricted patient status

B67 It is possible that a s 115(2) patient may become dangerous while subject to compulsory treatment but the Mental Health (Compulsory Assessment and Treatment) Act expressly caters for such a situation by making provision for restricted patients (ss 54–56, 78 and 81). A court can, upon the application of the Director of Mental Health, make a patient a restricted patient where he or she “presents special difficulties because of the danger that he or she poses to others”. Restricted patients are subject to the same limited leave provisions as special patients, their reclassification to compulsory status requires action by the Minister of Health, and their release requires action by the Director of Mental Health.

B68 Restricted patient status may also be applied for and ordered with respect to the remaining compulsory patients presently in hospital to whom the Bill applies: those ordered to hospital under s 118 of the Criminal Justice Act, those who were previously special patients upon transfer from prison or a certified institution, and former restricted patients.

B69 The Commission is aware that no applications to make a compulsory patient a restricted patient have been made since the 1992 Act came into effect. We are also aware that a court recommendation that an application be made in respect of a particular patient was not acted upon. Further, we have heard comments from health professionals which suggest that the intended purpose and effect of restricted patient status is not clearly understood. Health officials should urgently focus attention on ss 54–56, 78 and 81 of the 1992 Act and develop clear guidelines about the meaning, purpose and use of restricted patient status.

B70 We emphasise this untapped potential of the 1992 Act to draw attention to the full extent of the detention powers it authorises with respect to mentally disordered people, regardless of the manner in which they entered hospital. In particular, we draw attention to the possible use of an application for restricted patient status in any case in which there may be room for professional disagreement as to whether a patient continues to be mentally disordered, although there is agreement upon his or her dangerousness. In such a situation an application made by the Director of Mental Health that the patient be made restricted

would allow the matter to be aired and determined in court. This existing method of resolving some at least of the difficulties faced by psychiatrists in assessing dangerous patients for continuing mental disorder seems to have been overlooked to date. If it is explored, we believe it could render unnecessary the proposal, incorporated in the Bill, that the Review Tribunal review the condition of every present and future patient in the categories outlined earlier.

Safeguards on decisions based on dangerousness

B71 That last effect would be especially desirable in our view if the compulsory care regime of the Bill were to be enacted. Under the Bill, the ways and means by which a person may become subject to compulsory care are very varied. It is of particular concern, however, that the Review Tribunal is vested with the power to make numerous people subject to compulsory care. To do that, the Review Tribunal must not only find that a person has a specified condition but also, and importantly for present purposes, that the person is likely to commit a specified offence if released. We stress in our Report the difficulty in predicting the dangerousness of particular individuals. While reliance upon dangerousness is inevitable in certain circumstances within the criminal justice and mental health systems, decisions based on that factor must be set about with appropriate safeguards. The most important safeguard consists in requiring a court or a suitably qualified tribunal following procedures required by the principles of natural justice to make any decisions which depend upon the prediction of dangerousness.

B72 By authorising the Review Tribunal to make findings that people are likely to commit specified offences, we consider the Bill departs from the safeguards that must accompany a decision based on such a difficult concept as dangerousness, and especially when the potential consequences of that decision so gravely affect citizens' liberty. In our view, only a court or a body composed of the most highly qualified relevant professionals should be entrusted with such powers.

Retrospective effect on former patients

B73 With respect to this category of people, there is in addition an apparently arbitrary element of retrospectivity in the Bill's application to former patients which requires strong justification. The publicity given to the situation of former patients who are within the ambit of the Bill has suggested that they were discharged because of a "loophole"

in the 1992 Act. The implication has been that, had the Mental Health Act 1969 not been repealed and replaced by the 1992 Act, the former patients identified by the Bill would not have been discharged whereas, with the passage of the 1992 Act, they obtained the benefit of changed rules and became entitled to be discharged.

B74 In fact that is not an accurate summary of the situation of any personality disordered former patients who would be liable to compulsory care under the Bill's provisions. Just as the 1992 Act does not explicitly include personality disorder within its definition of mental disorder, neither did the 1969 Act. Indeed, it is arguable that the 1992 definition has wider coverage of some personality disorders than the 1969 definition. Therefore, the Bill is not turning the clock back in making provision for the detention of those former patients: it is creating a new detention regime the application of which is dependent as well on the apparently arbitrary element of the date of detention.

APPENDIX C

The process followed by the Law Commission in preparing the report

Initial phase

C1 During the period February–March 1994 the Law Commission met with a number of agencies with responsibilities relevant to the terms of reference, including the Department of Justice, the Ministry of Health, the Department of Social Welfare, the Police, the Crown Law Office, the Human Rights Commission and the IHC. Officials from these agencies supplied statistical and other factual material to the Law Commission over the following months.

C2 The Law Commission also discussed the issues and sought assistance from several clinical practitioners and lawyers with relevant experience in New Zealand. We had some contact with Australian academics: Leanne Craze from the Australian Institute of Criminology, who was particularly helpful, and Professor C R Williams, Dean of Law, Monash University, Victoria.

C3 Warren Brookbanks (Senior Lecturer, University of Auckland) completed a paper for the Law Commission, “The Disposition of Special Patients and Related Matters” (18 March 1994). He subsequently clarified issues relating to the concept of psychiatric parole, the Intellectually Disabled Persons’ Services Act 1986 (Victoria), and the Mental Health (Criminal Procedure) Act 1990 (New South Wales) in a letter dated 30 March 1994 to the Law Commission.

C4 John Dawson (Senior Lecturer in Law, University of Otago) provided valuable references, suggestions for reading and copies of papers he had prepared on related topics.

C5 Dr Thakshan Fernando (Consultant Psychiatrist; former Director of Mental Health at the Ministry of Health) provided some back-

ground information and made copies of relevant reports available. Dr A I F Simpson (Consultant Psychiatrist, Regional Forensic Psychiatry Service, Wellington) made helpful oral and written submissions. Dr John Crawshaw (General Manager, Porirua Hospital, Capital Coast Health) gave a useful practical perspective, including a tour of a ward at Porirua Hospital.

C6 Pauline Hinds (Aotearoa Network of Psychiatric Survivors) met with us. Helpful letters were received from Judge McElrea, and other professionals and caregivers.

C7 Issues related to the terms of reference were discussed by the Law Commission with its Maori Committee. Given the short time-frame, the Maori Committee was not able to exercise its function of advising on appropriate strategies for consultation. The Commission forwarded an early draft of the report's overview to the Maori Committee, in addition to an excerpt from the draft text relating to rates of institutionalisation among Maori.

Research phase

C8 Law Commission staff collected and studied judgments, articles, textbooks, overseas legislation and existing reports covering issues related to the terms of reference. Key questions were clarified and the information necessary to respond to them sought from relevant agencies.

C9 The Minister of Justice and the Minister of Health were kept informed of progress.

Mental Health (Compulsory Assessment and Treatment) Amendment Bill

C10 This Bill was introduced on 30 March 1994 and referred to the Social Services Select Committee. The Commission then focused its attention on preparing a submission which summarised the conclusions it had reached on its terms of reference at that point and identified the implications for the Bill. Those conclusions are substantially the same as the conclusions and recommendations contained in this report. The substance of the submission is contained in appendix B.

C11 The Law Commission discussed its submission with the Social Services Select Committee on 25 May 1994. At that meeting the Committee expressed interest in seeing the final report as soon as possible.

Final phase

C12 Copies of drafts of the report were circulated for review to

The Hon Justice Thorp (High Court, Auckland and Chairperson of the Parole Board)

Professor Warren Young (Victoria University of Wellington)

Warren Brookbanks

John Dawson

Department of Justice

Ministry of Health

Department of Social Welfare: Social Policy Agency, and New Zealand Children and Young Persons Service

Te Puni Kokiri.

C13 Comments were received very promptly on matters of substance and style. Full account was taken of comments in preparing new versions of the draft.

C14 On 29 June 1994 a draft of the report was forwarded to the Minister of Justice, the Minister of Health and the Social Services Select Committee. At that stage, the report had not been externally edited nor had final formatting been completed. On 19 July 1994 the content of the draft report was discussed with the Select Committee.

APPENDIX D

Recent reports relevant to the terms of reference

This list, which is not exhaustive, is intended to give an indication of the level of attention that has been focused on issues relevant to the terms of reference since the early 1980s.

D1 *Report of the Penal Policy Review Committee 1981*

The Penal Policy Review Committee was established because of the “growing disquiet” over the amount of crime occurring in the community and the apparent ineffectiveness of the remedies (9). The Committee’s terms of reference were extremely broad and, in essence, covered the entire field of penal policy as it related to the treatment of offenders on and after sentencing. Many of the recommendations made by the Committee were reflected in the Criminal Justice Act 1985.

D2 *Report of the Working Party on Psychiatrically Disturbed Prisoners and Remandees* (Department of Justice, Wellington, 1981)

The terms of reference of the Working Party required an examination of where and how psychiatric services were used, and the extent to which the psychiatric needs of prison inmates and remandees were met. The foreword noted that the problems identified were not new, and quoted from the *Report of New Zealand Inspector of Prisons* (1882):

The questions respecting lunatics and inebriates being placed in prisons or hospitals ought to be settled once and for all It has been, for ten years, a case of each institution refusing to take them in. (7)

The report identified three types of inmate who were particularly problematic:

- those with a personality disorder, who are labelled psychopaths, sociopaths, explosive personalities, etc;
- those whose intelligence is in the borderline area—ranging from the

lower end of the normal range to mild subnormality—and/or who are socially inadequate;

- those whose fragile mental condition fractures in the stress-inducing prison environment (47–50).

The report noted that inmates in the first group did not fit comfortably within the accepted diagnostic criteria of mental illness, and that offenders with personality disorders will be a control problem in hospitals as well as in prisons (48).

D3 Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters (January 1983): the Gallen Report

This report was precipitated by the death of a patient in Oakley Hospital. Its recommendations were primarily oriented towards the need for the better organisation and increased quality of forensic psychiatry in the Auckland Hospital Board area. Tensions between security and the treatment of the mentally ill were an important aspect of the inquiry, as was the need to safeguard the rights of the mentally ill. It became clear in the course of the inquiry that patients who had been transferred to Oakley Hospital from prison were sometimes detained in the hospital after expiry of their sentence because of their perceived danger to the community (10.16). The report recommended that

[n]o person should be detained at a hospital such as Oakley Hospital on social grounds alone and in no sense should prison sentences be extended by decisions made which are not subject to control by the Courts. (19.6)

D4 The Circumstances of the Release of Ian David Donaldson from a Psychiatric Hospital and of his Subsequent Arrest and Release on Bail: Report of the Commission of Inquiry (August 1983)

This inquiry was precipitated by the actions of Ian Donaldson who had a long history of offending and a severe personality disorder. The report said:

[a] group of individuals exist of whom Donaldson was an example, who, though they have a disorder of personality which results in episodes of abnormally aggressive and seriously irresponsible conduct, are not currently provided for under the provisions of the Mental Health legislation. There are at present no adequate means for dealing with this group, either in the prisons or the mental health services. (83)

The report also noted difficulties relating to potentially dangerous persons who were neither patients nor former patients of a psychiatric hospital.

D5 Psychiatric Treatment and Security in Auckland: Report of Working Party (November 1984)

The Working Party comprised persons from the Auckland Hospital Board, the Department of Justice, and the Department of Health. Its terms of reference were to report on the need for secure facilities for psychiatric patients, including prisoners and other offenders, in Auckland. The report considered previous reports and said:

We are very well aware of the problems associated with the distinctions between “madness” and “badness”, and the dilemma, not peculiar to Auckland or New Zealand, in determining whether psychiatrically disturbed prisoners should be the responsibility of the criminal justice or the health systems. (2)

Recommendations made by the Working Party concerned improving mental health services in penal institutions, establishing a special prison in Auckland (in Oakley Hospital), and establishing and improving services in psychiatric institutions.

D6 Review of Psychiatric Hospitals and Hospitals for the Intellectually Handicapped (Report to the Minister of Health, March 1986)

This report noted a number of inadequacies in patient care relating to the fact that

[m]ajor and important changes have occurred in the philosophy and techniques of treatment and care of the psychiatrically disabled and intellectually handicapped; and an increased awareness has developed, worldwide, of the need for new standards to be applied to the care of such patients. (3)

D7 Community Mental Health Services: Issues and Implications (New Zealand Board of Health, Mental Health Committee, October 1986)

The purpose of the report was to direct attention to the need to further develop mental health services in the community. Added impetus was given by the increasing trend towards deinstitutionalisation:

This means quite simply that there are greatly increased numbers of mentally/emotionally impaired people in our community—both people who have been discharged from hospital, and people who previously would have been admitted but no longer fulfil admission criteria. (1)

D8 Report of Ministerial Committee of Inquiry into Violence (March 1987): the Roper Report on violence

The terms of reference required the Committee to report on practical steps which could be taken to reduce the incidence of violence and

violent crime in the community. The Committee considered and reported on a number of matters including alcoholism, drugs and solvent abuse, education, firearms, home and family, and prison and community services. Of particular relevance is the chapter on sentencing. The Committee made a number of recommendations as to the way in which sentencing could form part of a response to the problem of violent crime. Some of those recommendations were subsequently reflected in amendments to the Criminal Justice Act 1985. Examples are that there be no parole for short sentences (cf s 89 of the Criminal Justice Act), that there be a presumption of imprisonment for offenders convicted of any offence of violence while on bail for any offence (cf s 5A), and that s 5, which provides for a presumption of imprisonment for violent offenders, be amended by substituting two years for five years (cf s 5, as amended).

D9 *Report of the Committee of Inquiry into Procedures used in Certain Psychiatric Hospitals in Relation to the Admission, Discharge or Release on Leave of Certain Classes of Patients* (August 1988): the Mason Report

This report was precipitated by several homicides committed by a person with a long psychiatric history. Concerns were raised about the inadequate follow-up of psychiatric patients who had been discharged from hospital into the community. A large number of recommendations were made relating to establishing regional forensic services, medium secure units, services in prisons and community care. Forensic psychiatric services developed rapidly after the report, and the Regional Forensic Psychiatric Service was established.

D10 *National Mental Health Consortium* (Department of Health, Department of Social Welfare, June 1989)

The National Mental Health Consortium was set up in late 1988 to address major issues concerning the development of a coordinated community care system. It recognised the implications of the Mental Health Bill (now the Mental Health (Compulsory Assessment and Treatment) Act 1992) for community services. National objectives and principles for community care were developed, a system of service development outlined, and responsibilities and funding mechanisms identified. The report discussed the perspectives of Maori and consumers.

D11 Ministerial Committee of Inquiry into the Prisons System, *Prison Review Te Ara Hou: The New Way* (1989): the Roper Report on prisons

The focus of this review was very broad. It inquired into the policies, establishment, organisation and management of the prison system, its place in the criminal justice system, and its present and future role. The core of the report's recommendations was a "two-pronged" approach to prison reform: humane containment of repetitive offenders whose detention is required for the protection of society; and a system of habilitation centres to confront offenders with the reality of their offending and the need to alter their behaviour.

D12 *Crimes Bill 1989: Report of the Crimes Consultative Committee* (April 1991)

The purpose of the Committee was to examine the Crimes Bill 1989 which was intended to reform and rewrite the Crimes Act 1961. The report contains a clause by clause consideration of the Bill. The parts of that report with the most relevance to the present report were those concerning preliminary offences (attempts and threats) and offences against the person, particularly sexual and other serious violent offences.

D13 *Mental Health—Patient Rights and the Public Interest*, A Report to the Prime Minister by the Human Rights Commission on certain incidents at Kingseat and Carrington Hospitals in May 1991

Immediately following a series of incidents, the most critical of which involved a patient who left Kingseat Psychiatric Hospital without permission and allegedly raped a woman, the Auckland Area Health Board ordered the locking of some wards at both Carrington and Kingseat Hospitals, resulting in the mass detention of patients. The Human Rights Commission, after an inquiry, concluded that the locking of the wards was a breach of human rights. The report also discussed general issues relating to "balancing the potential danger to the public against the rights of patients . . ." (5).

D14 *Report of the Working Party for Improving the Management of High Risk Mentally Ill Patients* (Department of Health, October 1991)

The stimulus for this report was the series of incidents mentioned in para D13. The principal aim of the Working Party was to consider ways of enhancing the systems and procedures required for the effective management of high risk mentally ill patients. Issues considered included the definition of "high risk patients", the balancing of patients' rights and public safety, and the difficulties of making accurate predictions of dangerousness. Recommendations were made relating to high risk patients and their identification, security issues, the design

of secure facilities, the clinical care of high risk patients, the Maori approach to care, the need for review panels, managerial issues and audit, and quality assurance and training.

D15 Report of the Committee of Inquiry into the Death at Carrington Hospital of a Patient Manihera Mansel Watene and Other Related Matters (July 1991)

Manihera Watene, who had a history of antisocial behaviour and psychiatric problems, died in Carrington Hospital soon after being restrained and placed in seclusion. He was detained in hospital pursuant to an order under s 118 of the Criminal Justice Act. The report summarised the history of difficulties, inquiries and organisational changes associated with the Oakley and Carrington Hospitals. It noted that the Auckland Area Health Board faced great problems in relation to the level of demand for its services and insufficient funding. Recommendations were made relating to procedures associated with s 118 orders, the need for quality assurance programmes for restraint and seclusion, the adequacy of training, equipment and protocols on a number of matters, and the need for clear lines of management authority.

D16 Report of the Controller and Auditor-General on Community Care for People with Mental Illness (December 1993)

The aim of this report was to examine how effectively the organisation and management of community care services were dealing with the greater demands being placed on them following the closure of some psychiatric hospitals and the scaling down of others. The report reviewed services in two areas: central Auckland and Dunedin. It summarised the main elements it considered necessary for the provision of effective and efficient community care services, including the need for services and facilities to be established in the community before a hospital's closure (43).

APPENDIX E

Summary of selected cases relevant to whether the statutory definition of mental disorder includes intellectual handicap

Disability hearings

E1 The following cases illustrate the circumstances in which intellectual handicap has been held to fall within the definition of mental disorder and so justify a finding, under s 108 of the Criminal Justice Act 1985, that a defendant is under disability.

E2 In *R v T* [1993] DCR 600, 10 FRNZ 195, Judge McElrea considered whether T, who was mentally retarded but not mentally ill, was fit to stand trial for assault with intent to commit sexual violation. Evidence was given that T's ability to communicate was highly defective, and that, although he had a primitive notion of how a court functioned, he was not able to discuss his plea to the charge.

E3 Judge McElrea considered that a mentally retarded person was capable of being "mentally disordered" within the meaning of s 2 of the 1992 Act. He held that on the ordinary meaning of the words—the starting point for statutory interpretation—mental retardation was an "abnormal state of mind . . . characterised by . . . disorders of . . . cognition" (610). He said that in ordinary parlance "abnormal" included an unusual condition of mind, and there was no requirement that it be temporary, or amenable to treatment.

E4 Judge McElrea then considered s 4(e), which provides that the procedures in Parts I and II of the 1992 Act shall not be invoked by reason only of intellectual handicap. He held that s 4(e) did not limit the scope of the definition of mental disorder; rather it limited the procedures of the 1992 Act. He accepted that Parliament intended that mentally retarded persons should not normally be in psychiatric hospitals and that this was achieved by s 4(e). The result of the section was held to be that a mentally retarded person could not be the subject

of an ordinary application for assessment and treatment, but could be found to be mentally disordered for the purposes of a disability hearing and those parts of the 1992 Act applying to special patients. Judge McElrea also stressed the purpose of a disability hearing: that it is fundamentally unfair to require a person, such as T, to undergo a trial where mental incapacity prevents that person from conducting a proper defence.

E5 Having held that T was under disability, Judge McElrea was not satisfied that special patient status for T was necessary in the interests of public safety. Instead he made an order, under s 115(2) of the Criminal Justice Act, that T be detained in a hospital as an inpatient under a compulsory treatment order. However, Judge McElrea did direct that the case be referred to the Director of Area Mental Health Services for consideration as to whether T should be declared to be a restricted patient.

E6 In *Police v K* (unreported, Porirua District Court, CRN 2091011601, 15 April 1993, Judge Lee), K faced one charge of indecent assault on a girl aged 14 and two charges of assaulting a female. His IQ had been assessed as between 58–60, and there was medical evidence that he was unable to understand the nature of legal proceedings. There was also medical evidence that K was mentally disordered; that is, he suffered from an abnormal state of mind of a continuous nature characterised by disorders of cognition to such a degree that his capacity to take care of himself was seriously diminished. However, both the doctors who gave the medical evidence and Judge Lee, had difficulty with the concept of “abnormal”, particularly whether it should be interpreted subjectively (ie, in relation to the person concerned) or objectively (ie, by comparison with the majority of people in the community). Judge Lee held that K clearly suffered from a disability, and that therefore a wider objective definition of mental disorder should be preferred to avert the grave injustice that would otherwise result. For the purposes of the finding that K was under disability, she accepted that the disability arose as a result of a mental disorder.

E7 Judge Lee made an order for K’s release under s 115(2)(b), holding that an order that K be detained in hospital would contravene s 4(e) of the 1992 Act, which prevents the application of Parts I and II of the 1992 Act to a person with intellectual handicap.

E8 In *Police v M* [1993] DCR 1119 Judge Boshier largely agreed with Judge McElrea’s approach in *R v T* (para E2). In this case, M faced

charges of assault on his sister and attempted arson. Medical evidence indicated that M was very difficult to communicate with and unlikely to be able to follow court proceedings. Judge Boshier considered that M did have an abnormal state of mind characterised by a disorder of cognition which caused serious diminution in his capacity to care for himself. Judge Boshier believed that there was merit in taking a purposive approach to the interpretation of mental disorder, the present purpose being the application of s 108 of the Criminal Justice Act. He noted, however, that the purpose might not be the same if the court was considering an application for a compulsory treatment order.

E9 Judge Boshier then considered the disposition of M. He held that s 4 of the 1992 Act did not affect the application of Parts I and II in the way that Judge Lee, suggested in *Police v K* (para E7). As Judge Boshier was not satisfied that public safety required an order that M be detained as a special patient, he made an order that M be detained under a compulsory treatment order pursuant to s 115(2)(a), with the suggestion that outpatient supervision would be appropriate.

Compulsory assessment and treatment hearings

E10 The subject of *Re H* [1993] 10 FRNZ 422 was intellectually handicapped to a relatively severe degree and also mentally disordered. The issue was whether, because H's mental disorder resulted from or was a manifestation of his intellectual handicap, it precluded an application for an extension of a compulsory treatment order under the 1992 Act. Judge Inglis QC said that the true purpose of s 4(e) was to prevent it being too readily assumed from the existence of intellectual disability that there must also be a state of "mental disorder" within the meaning of the 1992 Act. He held that s 4(e) provided no bar to the continuation of a compulsory treatment order.

E11 *Re T* (unreported, Papakura District Court, CA&T No 213/93, 27 October 1993) also concerned an application for an extension of a compulsory treatment order. T had been found to be under disability and was a compulsory patient pursuant to an order under s 115(2)(a) of the Criminal Justice Act. T had an intellectual disability and was considered to have a level of functioning akin to that of a five- or six-year old child.

E12 Judge Boshier held that the purposes of the 1992 Act as set out in the long title indicated that intellectual disability was not enough, by itself, to justify the operation of the assessment and treatment procedures. However, Judge Boshier held that the 1992 Act could apply to T because he also had a disorder of mood to such an extent that

he had an abnormal state of mind within the meaning of s 2. It did not matter whether the disorder of mood resulted from the intellectual disability.

E13 *Re T* (unreported, Mental Health Review Tribunal, Northern Region, No 191, 28 July 1993) was a review, under s 79 of the 1992 Act, of T's fitness for discharge from compulsory status. T had been the subject of *R v T* (Judge McElrea, para E2) where he was found to be under disability and made a compulsory patient. The main issues in the later case were the effect of s 4(e) and the meaning of the discharge provisions in the 1992 Act. The Review Tribunal held that s 4(e) meant that T could not be treated for behaviour associated with his intellectual handicap. It held that T was therefore "fit to be released" because s 2 defined "fit to be released" as meaning ". . . no longer mentally disordered and fit to be released from the requirement of assessment and treatment under this Act", even though the Tribunal tended to the view that he was mentally disordered. The Tribunal considered that the statutory references to "mental disorder" and "fit to be released" (in the definition of "fit to be released") should not be read conjunctively. Section 4(e) meant that an intellectually handicapped person would be fit to be released if the only treatment capable of being provided related to the handicap. If a patient could not be treated, he or she would have to be released:

The Act does not contemplate that a person be compulsorily detained for any appreciable period as a "patient" for the purpose of controlling that person's behaviours and improving their adaptive functioning but not otherwise treating them where the sole underlying problem is intellectual retardation. (10)

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