



MENTAL IMPAIRMENT DECISION-MAKING AND THE INSANITY DEFENCE





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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 purpose is to help achieve law that is just, principled, and accessible, and that reflects the heritage and aspirations of the peoples of New Zealand.

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The Hon Simon Power
Minister Responsible for the Law Commission
Parliament Buildings
WELLINGTON

16 December 2010

Dear Minister

NZLC R120 – MENTAL IMPAIRMENT DECISION-MAKING AND THE INSANITY DEFENCE

I am pleased to submit to you Law Commission Report 120, *Mental Impairment Decision-Making and the Insanity Defence*, which we submit under section 16 of the Law Commission Act 1985.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Geoffrey Palmer', with a horizontal line underneath.

Geoffrey Palmer
President

FOREWORD

The Law Commission's report on the insanity defence and some other issues relating to mental impairment has been a long time coming. That is because it is a very difficult topic. Some will be disappointed in our recommendation that, despite problems with the insanity defence in section 23 of the Crimes Act 1961, we do not find any of the reform options more attractive than the existing law. We do not wish to minimise the issues, but we cannot suggest anything better, so we have not recommended reform.

We do think that the current Ministerial responsibility for mental health and intellectual disability decision-making, under sections 31 and 33 of the Criminal Procedure (Mentally Impaired Persons) Act 2003, should be removed. We make a number of detailed recommendations in this area. We recommend a new Special Patients' Review Tribunal as the appropriate body for decision-making. The Tribunal would deal with reclassification, discharge and long leave decision-making, for special patients, special care recipients, and restricted patients.

There are occasions in the law where significant change cannot be undertaken because a demonstrably better set of rules cannot be designed. This is one of those occasions. Dr Warren Young was the lead Commissioner on this review, and the policy and research adviser was Claire Browning. Students Miriam Wiek and Sam McMullan contributed to the research.



Geoffrey Palmer
President

Mental impairment decision-making and the insanity defence

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Summary

PART 1 –
THE INSANITY
DEFENCE:
SECTION 23
OF THE CRIMES
ACT 1961

The insanity defence

Section 23 of the Crimes Act 1961, which statutorily defines the insanity defence, provides (in relevant part):

23 Insanity

- (1) Every one shall be presumed to be sane at the time of doing or omitting any act until the contrary is proved.
- (2) 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.

...

This drafting closely follows the language of the common law *M’Naghten* rules, developed in 1843, by a panel convened to answer questions about the case of Daniel M’Naghten and settle the common law scope of the insanity defence.

There is a further case law gloss on some elements of section 23, in particular, the question of what constitutes a “disease of the mind”.

Expressed in more modern language, “disease of the mind” would be “mental disorder”, and “natural imbecility” would be “intellectual disability”. In practice, the “natural imbecility” aspect of the defence is rarely relied upon.

With minor semantic variations, and sometimes the addition of a third so-called ‘volitional’ limb, every comparable jurisdiction with an insanity defence takes approximately the same approach.

Problems with the defence

The insanity defence serves two purposes. Section 23(2)(b) has the effect of partly protecting some defendants, by shielding them from a criminal conviction. Section 23(2)(a) protects the community, by ensuring that the defendant who would otherwise be entitled under normal principles of criminal liability to an acquittal can be detained.

The defence therefore tends to mix up the defendant-focused question of criminal responsibility with a second and different question: who needs to be detained for the protection of the public (because of the likelihood that their disorder, which in turn produces criminal behaviour, will recur).

This has been regarded as unprincipled and, in practice, the defence does not serve either of its purposes particularly well.

It has archaic and inappropriate terminology: “insanity”, “natural imbecility”, “disease of the mind”. There is also a gulf between the section 23 language and case law on the one hand, and on the other, psychiatric concepts and practices. This makes psychiatrists’ jobs difficult in practice, and may be a ground on which the New Zealand defence could be held to breach international human rights obligations.

Finally, it has produced anomalous results in some cases, for example, classification of hyperglycaemia as a disease of the mind, and hypoglycaemia as not; and somnambulism being viewed as a disease of the mind in England and not a disease of the mind in Canada.

However, the overall size of these problems needs to be assessed against the options for reform.

Reform options

Abolition

The first option for reform of the insanity defence is its total abolition.

If the defence was abolished, defendants who lacked mens rea would be acquitted. There would be other methods of dealing with them, in the interests of public safety: they might instead be civilly committed, under the Mental Health (Compulsory Assessment and Treatment) Act 1992 or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. Defendants who did have criminal intent would be convicted. However, imprisonment or other penal sanction would not be inevitable: the Criminal Procedure (Mentally Impaired Persons) Act 2003 is sufficiently flexible to allow disposition to a mental health facility in lieu of a penal sanction, or transfer to such a facility after a prison sentence has been imposed.

Arguably, this approach would achieve similar social policy objectives to the insanity defence, with less confusion of objectives. However, we think that it would diverge too far from community norms. In other jurisdictions where the defence has been abolished, defendants who would formerly have been acquitted on account of insanity have tended to be diverted from the criminal justice system in other ways, for example, by finding them unfit to stand trial.

We do not recommend this option.

Update the language of the qualifying mental conditions

There is widespread agreement that the current legislative language – “insanity”, “natural imbecility”, and “disease of the mind” – used to describe the qualifying mental conditions for the defence is outdated, inappropriate, and inconsistent with expert usage.

“Disease of the mind”, in particular, is also an open-ended, flexible concept, further defined in case law. Perhaps inevitably, it is open to a degree of interpretation on a case by case basis, and has produced some anomalous outcomes.

However, changes to the defence’s scope were not supported, by either those whom we consulted, or the much more extensive exercise undertaken by the Crimes Consultative Committee on the Crimes Bill 1989. After ourselves considering a range of options, we did not find that any of them promised significant advantages over the status quo.

The argument for simply updating the language of the defence, to something more contemporary, was somewhat stronger. This has been common in overseas jurisdictions, particularly a number of Australian jurisdictions. In Australia, the preferred language appears to be “mental impairment”, and that would also sit well with New Zealand’s statutory scheme. Most Australian definitions also refer, non-exhaustively, to intellectual disability and mental illness (instead of “natural imbecility” and “disease of the mind”).

However, while this seems to have been a popular and, apparently, workable approach in Australia, we concluded that there would be some tricky aspects to it, given that the same language is already used in New Zealand elsewhere on the statute book, for civil commitment purposes.

The rationale for doing so would be simply a desire to make the defence look and feel more modern. We did not consider this sufficient, to justify an exercise with some difficulty and some risk, in circumstances where the defence is in fact working in practice.

Revise the cognitive impairment part of the defence

We reviewed five approaches that might be taken to reform of the second part of the defence, that describes the connection between the mental impairment and its effects on cognition. They were:

- Treating mental impairment as a status defence – providing, for example, that at the time of the unlawful act or omission, the defendant was suffering from severe mental impairment.
- A general causation test – providing, for example, that the unlawful act or omission was the product of mental impairment.
- An open-ended community standards test – for example, that mental impairment affected the defendant’s behaviour to such a substantial degree that the jury considers that he or she ought not to be found criminally responsible.
- Reform of the language around the concept of ‘incapacity’.
- Inclusion of a new volitional element of the defence.

Overall, we did not consider any of the approaches to be good ones.

In our view, the status defence approach could not be justified. Its premise is that those with a qualifying mental impairment are “globally incompetent”, regardless of the actual nature and degree of incapacity experienced, which will vary from case to case.

The general causation and open-ended community standard approaches would give psychiatrists and juries, respectively, too much discretion and flexibility, leading to a likelihood of inconsistency in application. Furthermore, both of these approaches are, essentially, a delegation of what ought to be the legislative function.

Different formulations of the incapacity concept that can be found overseas are really only semantically different to the present drafting of section 23, do not assist in resolving any of its difficulties, and may replace them with new difficulties.

There are divided views about the merits of adding a volitional component to the defence, but the weight of opinion seems to be marginally opposed.

Section 23: conclusion

The overwhelming response we received was that, broadly speaking, the defence is workable, in spite of its flaws. In practice, it seems that everyone can accommodate the limitations of the defence, and on the whole would prefer to do so, in the light of any immediately obvious and viable alternatives.

We were somewhat influenced in this view by other jurisdictions’ experience. The *M’Naghten* rules, unchanged in England since 1843, are said to have weathered constant criticism. Despite the fact they have been under “sustained attack ever since their inception”, in both English and American jurisprudence, they “still hold sway”. Moreover, America offers a useful case study of many of the possible reform options, because so many of them were attempted in the various jurisdictions as part of the wave of reform in the years following the trial of President Reagan’s would-be assassin John Hinckley, with very little effect on outcomes. One explanation offered for this is that, regardless of what the rules may say, in the end, the question jurors will put to themselves when they retire is simply: ‘Is this man mad or not?’

Therefore, although problems with the insanity defence are not insignificant, we have not recommended its reform.

Procedural issues

We also considered three procedural issues: none of which are provided for in section 23 of the Crimes Act 1961 itself, but which have a bearing on the operation of the insanity defence.

The burden and standard of proof

There has been some criticism of the fact that the burden is on the accused to prove insanity, on the balance of probabilities, under section 23. Insanity is the only generally applicable criminal defence where such an approach is applied. The counter-argument of course is that insanity is unlike other defences, because it does not result in an outright acquittal. A successful claim will generally expose the defendant to an order for indefinite detention as a special patient. If the defendant were required merely to discharge his or her evidential burden, then requiring the prosecution to negate the defence beyond reasonable doubt, a number of defendants would end up being detained in a psychiatric facility when their condition probably did not warrant it. This points to the need to adopt a “balance of probabilities” standard of proof, and if that is accepted, it inevitably requires a reversal of the burden as well. Evidence at least as to the first limb of the defence (disease of the mind) is generally available primarily to the defence; if the burden were on the prosecution to negate that, even on the balance of probabilities, it is likely to be rarely discharged, resulting in indefinite detention in cases that do not warrant it.

The verdict

Concerns have been expressed from time to time about the nature of the insanity verdict: ‘acquittal on account of insanity’. There may be some confusion about the proposed alternative, and there are in fact two options: ‘guilty but mentally ill’ as a substitute for ‘acquittal on account of insanity’; or ‘guilty but mentally ill’ in addition to the insanity verdict. When used overseas, primarily in the United States, the ‘guilty but mentally ill’ verdict is an additional option to the three existing verdicts of acquittal, conviction, or acquitted on account of insanity. It is, in other words, a mitigated form of conviction. The reasons for establishing such a verdict are already provided for in other parts of New Zealand law, making it superfluous. The second option is a substitute verdict of ‘guilty but mentally ill’ – an acquittal, by a different name. This is more likely to address the problems perceived, about the way juries allegedly approach the insanity defence, and we think it is more likely to be what the proponents of this verdict have in mind when they talk about it. However, we are not, ourselves, convinced there is any real evidence of jury disinclination to acquit on grounds of insanity.

Prosecuting insanity

There are limits on the ability of the Crown to put the insanity defence in issue. In *R v Green* (1993) 9 CRNZ 523 (CA), the Court held that the Crown is not permitted to adduce evidence of insanity, with or without leave, unless the defendant has raised insanity as a defence. There is provision for a judge to ask a jury to consider the matter under section 20(4) of the Criminal Procedure (Mentally Impaired Persons) Act 2003, in a case where it appears from the evidence that insanity may have been a possibility. However, it is likely to be only in occasional circumstances that section 20(4) would apply, because without Crown evidence, it will be largely fortuitous as to whether there is the necessary evidence available for the judge to invoke it. There may be – and has been, in some cases, including *Green* – substantial evidence about, and convergence of expert opinion on, the defendant’s insanity. This creates a situation that

is arguably not consistent with the prosecutorial function – to see that justice is done, and present the case to the jury in its true light. And it raises a policy question as to whether this is consistent with the public protection rationale of the insanity defence, in cases where the defendant puts his or her capacity for criminal intent in issue and is acquitted.

We recommend a new statutory provision in the Criminal Procedure (Mentally Impaired Persons) Act 2003, for the Crown, by leave of the judge, to adduce evidence of insanity, in cases where the defence has put his or her mental capacity for criminal intent in issue, without raising the insanity defence.

PART 2 –
REMOVING
MINISTERIAL
RESPONSIBILITY
FOR MENTAL
HEALTH AND
INTELLECTUAL
DISABILITY
DECISION-
MAKING

Under section 24 of the Criminal Procedure (Mentally Impaired Persons) Act 2003, a person found not guilty by reason of insanity must be detained in a hospital as a special patient or special care recipient, if the court is satisfied that the making of such an order is necessary in the interests of the public or any affected person. That person is then subject to Ministerial decision-making, which is widely regarded as much more problematic than the defence itself.

The same issue also affects two other groups: the unfit to stand trial, and restricted patients.

Ministerial decision-making

At present, Ministers (either the Minister of Health, the Attorney-General, or the Minister of Health with the concurrence of the Attorney-General, depending on the type of case) have responsibility for three types of decisions affecting persons acquitted on account of insanity:

- discharge under section 33(3)(b)(ii) of the Criminal Procedure (Mentally Impaired Persons) Act 2003;
- reclassification under sections 31 or 33(3)(b)(i) of the Criminal Procedure (Mentally Impaired Persons) Act 2003; and
- long leave under section 50(1) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 or section 66 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

There are real problems with this, including perceived lack of independence, and risk of politicised decision-making. In the view of ourselves and others, it requires prompt and significant reform.

A new Tribunal

We recommend removing Ministers from the process, and establishing a new Tribunal (which we have given a working title of the ‘Special Patients’ Review Tribunal’), to take over the Ministerial functions. The Minister of Health would no longer be involved at all. The Attorney-General’s involvement under section 31 (for persons unfit to stand trial) would be more limited, with some new proposed safeguards to protect the Attorney-General’s interest.

The Attorney-General's role

The Attorney-General's involvement in section 31(2) cases, when the person is found to be no longer unfit, seems appropriate. If or when an alleged offender becomes fit to stand trial, it is right for the Attorney-General to be involved, on behalf of the state, in determining whether the person should be brought before a court, or absolved from criminal responsibility.

But under sections 31(3) and 31(4), the position is different.

We have recommended that decision making under section 31(3) – that is, the reclassification of persons not yet fit to stand trial – should be a matter for the new Tribunal. In the light of this, we also propose two other changes, to protect the Attorney-General's interest in that type of case. First, section 32 should be amended, so that it would remain open to the Crown to reactivate criminal charges if a patient whose “special” status has been altered under section 31(3) subsequently becomes fit to stand trial. Secondly, for persons whose status has changed under section 31(3), and who may then be subsequently released into the community at some future time, statutory mechanisms for reviewing their fitness to stand trial will be necessary.

In section 31(4) cases, it is not at all clear why the Attorney-General needs to be involved. There is no element of discretion in this decision. We recommend that the function of the Attorney-General should be replaced by senior officials at the Ministry of Health.

Establishing the new Tribunal

An independent Tribunal or Board is the most commonly observed model in the overseas jurisdictions surveyed and, in our view, is the preferred model for the present purposes, for all three classes of patient: special and restricted patients, and special care recipients.

We considered expanding upon the existing Mental Health Review Tribunals' framework, but in the end concluded that the new Tribunal should be established as a separate, built-for-purpose body, with characteristics that include:

- The Tribunal should be established under the Criminal Procedure (Mentally Impaired Persons) Act 2003. Given that the relevant decision-making powers are already in that Act, it makes some sense to locate the decision-maker in the same place on the statute book. But no less importantly, it would reaffirm the idea that this is a new body especially established to deal with all three categories of patient, including intellectually disabled special care recipients.
- A pool of potential members should be appointed, with a range of appropriate expertise, including psychiatric and legal experience, but not dominated by it. The Tribunal should have the ability to adjust its expertise as necessary by co-opting members to deal with individual cases (eg, special care recipient cases).
- It should be chaired by a current or former judge.
- Its function would be reclassification, discharge and long leave decision-making, for special patients, restricted patients, and special care recipients. There should also be provision for it to review clinical decisions for those patients.

- The Tribunal's jurisdiction should cease on reclassification from special or restricted patient to patient, and special care recipient to care recipient.

The effect of our recommendations would be that the existing Mental Health Review Tribunal would deal with all 'ordinary' patients. The new Tribunal would deal with all patients and care recipients with 'special' or restricted status, for so long as they have that status.

Changes to long leave

We recommend two changes to the provisions for long leave: abolishing the distinction between persons unfit to stand trial, who are currently not permitted long leave, and persons acquitted on account of insanity; and making long leave a matter for the new Tribunal, not the Minister.

Recommendations

- CHAPTER 6 R1 We recommend no change to the insanity defence, in section 23 of the Crimes Act 1961.
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- CHAPTER 7 R2 We recommend a new statutory provision for the Crown, by leave of the judge, to adduce evidence of insanity, in cases where the defence has put his or her mental capacity for criminal intent in issue without raising the insanity defence.
-
- CHAPTER 10 R3 Ministerial responsibility for decision-making under section 33 of the Criminal Procedure (Mentally Impaired Persons) Act 2003 (persons acquitted on account of insanity) should be removed.
- R4 We recommend no change to the prescribed maximum period in unfitness to stand trial cases.
- R5 Ministerial responsibility for decision-making under section 31 of the Criminal Procedure (Mentally Impaired Persons) Act 2003 (persons unfit to stand trial) should also be removed. There is no ground for distinguishing section 31 cases from section 33 cases, as regards the role of the Minister of Health. A non-Ministerial decision-maker is needed to deal with cases under both sections, subject to further recommendations below about the role of the Attorney-General.
- R6 The Attorney-General has a legitimate interest in matters decided under section 31(2).
- R7 Decisions under section 31(3) should be based upon a solely clinical assessment by the new (non-Ministerial) decision-maker, without the involvement of the Attorney-General.
- R8 To facilitate this, whilst still recognising the Attorney-General's interest in proceedings, section 32 should be amended, to provide that when a special patient or special care recipient's status is altered under section 31(3), proceedings are not stayed until the maximum detention period has expired.
- R9 In section 31(4) cases, in which there is no element of discretion, the function of the Attorney-General should be replaced by either the Director of Mental Health (for special patients), or the Director-General of Health (for special care recipients).
- R10 Statutory mechanisms for reviewing the fitness to stand trial of persons whose status has changed under section 31(3) will be necessary, to protect the Attorney-General's interest. For patients and care recipients still under compulsory status, we recommend that this be addressed in the course of the normal ongoing reviews, with a new statutory requirement for the Attorney-General to be notified if the person becomes fit to stand trial.

- R11 For those who have been released from compulsory status prior to the expiry of what would otherwise have been the maximum detention period, there should be a statutory requirement that they submit themselves periodically for assessment of their fitness to stand trial.
- R12 The decision-making processes for restricted patients, currently provided for in section 78 of the Mental Health (Compulsory Assessment and Treatment) Act 2003, should be aligned with our other proposals.
- R13 Neither the Attorney-General nor the Minister of Health should be involved in decision-making under section 78.

CHAPTER 11

- R14 Reclassification and discharge recommendations should continue to be clinically initiated, but decisions should be based upon broader public interests, taken into account by an independent decision-maker.
- R15 Restricted patients' release should no longer be at the discretion of the Director of Mental Health.
- R16 A Tribunal is the appropriate body for decision-making, upon clinical referral, for special patients, special care recipients, and restricted patients.

CHAPTER 12

- R17 The Special Patients' Review Tribunal should be established under the Criminal Procedure (Mentally Impaired Persons) Act 2003.
- R18 Its function would be reclassification, discharge and long leave decision-making, for special patients, restricted patients, and special care recipients.
- R19 A pool of 10 to 12 Tribunal members should be appointed, with a range of appropriate expertise. Members would require skills, knowledge or experience in one or more of the following areas: psychiatry; law (a barrister or solicitor); other senior forensic mental health; forensic consumer advice or service use; Māori issues; risk assessment and management; the reintegration of the mentally ill or intellectually impaired into society.
- R20 The Tribunal should also have the ability to adjust its expertise as necessary, by way of a power to co-opt, modelled on section 103 of the Mental Health (Compulsory Assessment and Treatment) Act.
- R21 The compilation of panels should be administratively managed, with a requirement for a quorum of three members (including the chair), and provision for a larger panel of up to five members, depending on the nature of the case. The chairperson, or his or her nominated deputy, should sit in every case.
- R22 The extended Tribunal should be chaired by a current or former judge.
- R23 Appointments of Tribunal members should be made by the Governor-General in Council.

R24 Members should be appointed for a term of up to three years, with provision for renewal.

R25 The new Tribunal should be supported by the Ministry of Health. Health's present practice, for other Tribunals, of outsourcing responsibility for this administrative function should continue and be applied to the new Tribunal.

CHAPTER 13

R26 Section 31 of the Criminal Procedure (Mentally Impaired Persons) Act 2003 presently provides only for reclassification. We recommend its amendment, to permit immediate discharge.

R27 The Tribunal's jurisdiction should cease on reclassification.

R28 There should be no difference in the grounds for a change of status, regardless of whether a case is governed by section 31(3) or section 33 of the Criminal Procedure (Mentally Impaired Persons) Act 2003.

R29 The same grounds should also be extended to section 78 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

R30 The current section 33 ground, or something closely derived from it, should be retained, and applied to the other two sections.

R31 Redrafted decision-making grounds should also provide that the safety of the public or any person or class of person is the paramount consideration, and that interference with the patient's freedom and personal autonomy should be kept to the minimum that is consistent with this objective.

CHAPTER 14

R32 The status of special patients, special care recipients, and restricted patients should be clinically reviewed 6-monthly. No change to this aspect of the legislation is required. However, in cases referred by the clinician to the Tribunal, there should be a discretion for the Tribunal to order the next review at an earlier specified time, if the patient has not been reclassified or discharged.

R33 Cases should only be referred by a clinician or specialist assessor to the Tribunal for further consideration when there is a recommendation for leave, reclassification, or discharge. However, we recommend that the Tribunal may also review other clinical decisions or specialist assessments, on application, taking over this current function of the Mental Health Review Tribunal.

R34 There should not be any provision for external applications for review.

R35 There should be no change to victims' role in release processes.

R36 The Director of Mental Health (Ministry of Health) should receive a copy of all certificates of clinical review pertaining to special patients and restricted patients. The Director-General of Health should receive a copy of all specialist assessor's certificates pertaining to special care recipients (which would, in practice, be passed on to the Director, Intellectual Disability (Compulsory Care and Rehabilitation), who has delegated authority).

R37 The Director of Mental Health and the Director-General of Health (or his or her delegate) should be given an explicit right of hearing before the Tribunal.

R38 There should be a right of appeal from Tribunal decisions, to the High Court, by either party to the proceeding.

CHAPTER 15

R39 There should be no change to the current administration of short term leave, by the Ministry of Health.

R40 The long leave availability distinction between persons acquitted on grounds of insanity, and persons unfit to stand trial, should be abolished. Those who are unfit to stand trial should be permitted long leave.

R41 The granting of long leave should be a matter for the new Tribunal, on application, rather than the Minister.

R42 Revocation of long leave should be a matter for the relevant directorate of the Ministry of Health in the first instance, with a subsequent review by the Tribunal.

Part 1

THE INSANITY
DEFENCE:
SECTION 23 OF
THE CRIMES
ACT 1961



LAW COMMISSION
TE Kaitiaki Matua o Te Ture

Chapter 1

Background

SUMMARY

This chapter sets the insanity defence in the context of other mental health legislation, briefly discusses its history, and sketches an outline of its key elements.

- 1.1 Section 23 of the Crimes Act 1961, which defines the insanity defence, provides (in relevant part):

23 Insanity

- (1) Every one shall be presumed to be sane at the time of doing or omitting any act until the contrary is proved.
- (2) 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.

...

LEGISLATIVE CONTEXT: MENTAL HEALTH LEGISLATION

- 1.2 Section 23 is only one small part of a much wider network of mental health legislation, including:

- The **Criminal Procedure (Mentally Impaired Persons) Act 2003**, which sets out procedures for finding persons unfit to stand trial; for the detention, reclassification, and discharge of persons found unfit to stand trial or insane; and for the detention of convicted defendants in hospitals or secure facilities under the Mental Health (Compulsory Assessment and Treatment) Act 1992 or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. In essence, this legislation recognises that mental disorder is a continuum. Many defendants who are disordered, to a greater or lesser extent, will not be acquitted on account of insanity. The Act recognises that even convicted and sentenced offenders may require some mental health treatment; or indeed, that a mental health disposition may be an appropriate substitute for a prison sentence in some cases.

- The **Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003**, which provides for the compulsory care of persons with an intellectual disability, defined as permanent impairment that results in significantly sub-average general intelligence, and at least two significant deficits of adaptive functioning, measured by recognised clinical tests.¹
 - The **Mental Health (Compulsory Assessment and Treatment) Act 1992**, which provides for compulsory psychiatric assessment and treatment of the mentally disordered, defined as meaning 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 poses a serious danger to the health or safety of that person or of others; or seriously diminishes the capacity of that person to take care of himself or herself.²
- 1.3 The insanity defence assesses a defendant's mental state at time of his or her alleged offending. Other dispositions are available, that address mentally disordered states at other points in the criminal process:
- Unfitness to stand trial may be declared in the light of the defendant's mental state at the time of trial, subject to prior enquiry as to whether, on the balance of probabilities, the court is satisfied that the person was responsible for the act or omission that constitutes the alleged offence.
 - Disposition options under the Criminal Procedure (Mentally Impaired Persons) Act 2003, together with the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, address mental state at the time of sentence.
- 1.4 When insanity is in issue, there will not always be a trial. Under section 20 of the Criminal Procedure (Mentally Impaired Persons) Act 2003, an agreed verdict of insanity may be reached, where the defendant indicates that he or she intends to raise the defence, the prosecution agrees that insanity would be the only reasonable verdict, and the judge is satisfied on the basis of expert evidence that the terms of the section 23 definition have been met.

HISTORICAL CONTEXT: THE HISTORY OF THE INSANITY DEFENCE

- 1.5 The insanity defence codified in section 23 of the Crimes Act 1961 is based on the 19th century common law *M'Naghten* rules, but it has an older history than that. Paul Appelbaum outlines the pre-*M'Naghten* evolution in England of the insanity defence, referring to Aristotle, and noting that "The moral intuition that a person's mental state might preclude punishment for a crime dates to antiquity".³

1 Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 7.

2 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 2.

3 Paul S Appelbaum *Almost A Revolution: Mental Health Law and the Limits of Change* (Oxford University Press, New York, 2004) at 165–167.

- 1.6 The 13th century English jurist Bracton considered that “a crime is not committed unless the will to harm be present”, and that children, adults of limited intelligence, and the mentally ill who do not understand the wrongfulness of their acts should be exculpated, even if they *prima facie* intended them.
- 1.7 The English courts’ first common law attempt at determining what constitutes insanity was the so-called “wild beast test”. This required the defendant to demonstrate that he did “not know what he was doing, no more than an infant, than a brute or wild beast”; that, in short, he (or she) was literally raving mad. This, as Appelbaum puts it, had the effect of excluding “the placidly insane, along with the mentally retarded”. A new and less rigorous test therefore developed, that was more in tune with the thinking of Bracton: whether the defendant lacked the ability to distinguish between good and evil.
- 1.8 This latter test significantly increased the incidence of insanity acquittals (which, at that stage, were outright acquittals). The Criminal Lunatics Act 1800 thus provided for indefinite confinement of persons found not guilty by reason of insanity “at the King’s pleasure”, in the interests of community safety.
- 1.9 In 1843, Daniel M’Naghten shot dead an advisor to the Prime Minister Sir Robert Peel. M’Naghten suffered from delusions and was mistaken both in his victim (whom he took for the Prime Minister), and in the belief that he was being personally persecuted by the government. However, he did know that shooting somebody was wrong and, therefore, did not meet the requirements of the dominant test at the time (the good and evil test). He was nonetheless acquitted, on the basis that delusional ideas could not justly be thought to produce a guilty mind.
- 1.10 Peel took the issue to Parliament, and the House of Lords convened a panel of judges to clarify the scope of the insanity defence. This produced what subsequently came to be known as the *M’Naghten* rules:⁴

At the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.

- 1.11 Section 23 closely follows this language.

THE ELEMENTS
AND OPERATION
OF THE
INSANITY
DEFENCE

- 1.12 The first limb of section 23 provides that no person shall be convicted of an offence by reason of an act done or omitted while suffering “natural imbecility or disease of the mind” (provided the other elements of the defence are also satisfied).
- 1.13 “Natural imbecility” might, in more modern language, be described as “intellectual disability”. In practice, this aspect of the defence is rarely relied upon, because those with severe intellectual disability, which by definition is a permanent state (unlike mental disorder, which may be somewhat more transient and treatable), are more often found to be unfit to stand trial. This means that criminal proceedings against them are suspended, very likely indefinitely, so that occasion for them to rely upon the insanity defence does not arise.

⁴ (1843) 8 ER 718 at 722.

1.14 “Disease of the mind” is “mental disorder”, in modern parlance. There is a statutory definition of mental disorder in the Mental Health (Compulsory Assessment and Treatment) Act 1992, that governs civil committal and some other dispositions. However, under section 23, “disease of the mind” is defined by two case law tests:

- The **recurring danger test**, which was defined by Lord Denning in *Bratty v Attorney-General for Northern Ireland* as follows:⁵

any mental disorder that manifests itself in violence and is prone to recur is a disease of the mind. At any rate it is the sort of disease for which a person should be detained in hospital rather than be given an unqualified acquittal.

- The **internal/external factor test**, which distinguishes between malfunctioning of the mind arising from external factors, which is not a “disease of the mind”, and malfunctioning due to internal factors, which is. The test was described in *R v Rabey* as follows:⁶

In general, the distinction to be drawn is between a malfunctioning of the mind arising from some cause that is primarily internal to the accused, having its source in his psychological or emotional make-up, or in some organic pathology, as opposed to a malfunctioning of the mind which is the transient effect, produced by some specific external factor such as, for example, concussion.

1.15 Under the second limb of the defence, by reason of natural imbecility or disease of the mind, the defendant must be rendered incapable of:

- understanding the nature and quality of the act or omission (in other words, understanding what he or she is doing, for example,⁷ believing that he or she is struggling with a demon, rather than killing a person); or
- knowing that the act or omission was morally wrong, in accordance with commonly accepted standards of right and wrong.

1.16 A defendant who wishes to rely upon the insanity defence bears the burden of proving the elements of the defence, to the civil standard of the balance of probabilities (thereby displacing the section 23(1) presumption of sanity). However, the prosecution must prove beyond reasonable doubt that the criminal act was done or omitted by the defendant, in circumstances that (if he or she was sane) would have compelled the conclusion that it was intentional.⁸

THE RATIONALES OF THE INSANITY DEFENCE

1.17 The insanity defence has two rationales.

1.18 First, some defendants who meet the legal definition of insanity would otherwise be entitled to an outright acquittal on normal criminal law principles. That is because they are “incapable of understanding the nature and quality of the act or omission” and therefore lack criminal intent. However, they may pose an ongoing risk of reoffending because of their mental disorder or disability. The public interest therefore requires that they be detained notwithstanding legal innocence, for the purpose of protecting the public. Section 23(2)(a) achieves this.

⁵ *Bratty v Attorney-General for Northern Ireland* [1963] AC 386 (HL).

⁶ *R v Rabey* (1977) 37 CCC (2d) 461; (1980) 15 CR (3d) 225.

⁷ Law Reform Commission of Victoria *Mental Malfunction and Criminal Responsibility* (Report 34, 1990) at 18.

⁸ *R v Cottle* [1958] NZLR 999.

- 1.19 Secondly, those who commit an offence while under the influence of mental disorder are arguably not blameworthy, even though all elements of the offence can be proved against them. Section 23(2)(b) addresses this category of defendant. Defendants who are “incapable of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right or wrong” would be convicted but for the insanity defence, because views about the morality of conduct are irrelevant for criminal law purposes. The defence secures them an acquittal (although they are then detained, for public safety purposes).

Chapter 2

The nature and size of the problem

SUMMARY

This chapter reviews problems with section 23, such as its confused rationales, its outdated terminology, its dissonance with modern psychiatric understanding, and possible human rights non-compliance. It concludes that while section 23 has some very significant problems, these need to be weighed against the viability of the reform options, to be discussed in subsequent chapters.

CONFUSED RATIONALES

- 2.1 The rationales of the insanity defence were described in the previous chapter. It serves dual purposes: it seeks to partly protect some defendants, particularly those who rely upon section 23(2)(b), by shielding them from a criminal conviction; and to protect the community, by ensuring that the defendant who would otherwise be entitled under normal principles of criminal liability to an acquittal (ie, section 23(2)(a) defendants) can be detained.
- 2.2 These twin rationales are evident not only in section 23, but in both of the case law tests for “disease of the mind”, which similarly mix up the defendant-focused question of criminal responsibility with a second and different question: who needs to be detained for the protection of the public (because of the likelihood that their disorder, which in turn produces criminal behaviour, will recur)? This is explicit in the recurring danger test. It is also implicit in the internal/external factor test: an internal factor is regarded as a disease of the mind because it is likely to be enduring, and therefore to pose an ongoing risk, whereas an external factor that affects a person’s mental functioning is more likely to be transient.

- 2.3 However, arguably, neither rationale is particularly well met. First, the defence is not very effective in shielding mentally disordered offenders from the consequences that flow from conviction:⁹

those ... who are found not guilty by reason of insanity are not in any sense acquitted, for they are not free of the stigma of guilt, nor are they physically freed ... [therefore] they have been doubly stigmatized as both mad and criminal ...

- 2.4 Secondly, as will be discussed in a later chapter,¹⁰ the public protection rationale has some limitations too, given the inability of the Crown to put insanity in issue, or judges to invite a jury to reach a verdict on the issue if it has not otherwise fortuitously been made available on the evidence. In other words, the availability of the public protection in any given case may well depend on choices made by the defence as to whether insanity is explicitly relied upon as a defence or put in issue.

- 2.5 Furthermore, although the original philosophical rationale for the defence was one of beneficence, it has evolved into something that leans rather more in the direction of community protection, albeit imperfectly. McSherry critiques this focus on dispositional concerns over ‘simple’ criminal responsibility, arguing that they should be two quite separate questions:¹¹

This concern about disposition is really the crux of the problem. The courts have allowed factors relevant to the question of what to do with an acquitted person who may be dangerous in the future to impinge upon the question of whether or not certain persons should be considered criminally responsible for their actions.

Traditionally, those considered responsible for criminal acts have been considered blameworthy and therefore liable to be punished. Williams points out, however, that “there are those (young children, and the very severely mentally ill or retarded) whom we think it would be useless or wrong to treat in this way”.

The defence of insanity is therefore concerned with assessing who should or should not be excused from criminal responsibility. The disposition of those found not guilty on the ground of insanity is a separate matter entirely. The detention of certain acquitted people in mental hospitals is the result of a social policy which is designed to protect the public from possible future harm.

There are therefore two separate questions which need to be asked when it appears that an accused suffers from some form of impaired consciousness at the time of committing a criminal act. The first is: how should the courts determine whether this person should be excused from criminal responsibility? The second is: if the person was not responsible because of some form of mental illness, should that person be detained because of possible danger to the public?

- 2.6 By contrast, at present, section 23 tries to do both.

9 Professor Norval Morris and Professor Richard Bonnie “Should the Insanity Defense be Abolished?” (Cleveland–Marshall College of Law, 11 April 1985).

10 See further ch 7.

11 Bernadette McSherry “Defining What is a ‘Disease of the Mind’: The Untenability of Current Legal Interpretations” (1993–1994) 1 JLM 76 at 89–90, referring to Glanville Williams *Textbook of Criminal Law* (2nd ed) (Stevens & Son, London, 1983) at 640.

TERMINOLOGY 2.7 The defence features somewhat archaic and inappropriate terminology: “insanity”, “natural imbecility”, “disease of the mind”. We described in chapter 1 their modern day equivalents: mental impairment, intellectual disability, and mental disorder.

2.8 The inappropriateness of references to insanity and natural imbecility require little further explanation: self-evidently, they are somewhat offensive and inaccurate terms. For example, some, perhaps many, who are able to rely on the defence may not be what the average person would understand by “insane”, in the sense of being globally incompetent; the nature of their cognitive dysfunction may be rather more specific. And the expression “disease of the mind” is inapt too. Many psychiatric and psychological disorders are not “diseases” as that term is medically understood; and “mind”, unlike the brain, is not susceptible to disease as such (as opposed to disorder).¹²

PROBLEMS IN THE INTERFACE BETWEEN LAW AND PSYCHIATRY 2.9 There is a further, and more fundamental, problem of incompatibility between the section 23 language and case law on the one hand, and psychiatric concepts and practices on the other. The section 23 language and case law are incongruent with criteria for psychiatrically assessing mental impairment.

2.10 We were advised that, in deciding whether any given state is a “disease of the mind”, most psychiatrists consider whether it:

- is a recognised mental disorder;
- is severe and enduring;
- is known to have effects (including temporary effects) on the cognitive functioning and/or volition of the individual;
- is likely to cause significant morbidity or risk to the sufferer or others; and
- requires ongoing psychiatric treatment.

2.11 These criteria have a rather different focus from those used by the courts, described in chapter 1, to determine whether there is a disease of the mind.

2.12 Psychiatric diagnostic criteria are also difficult to reconcile with the legal purpose of the insanity defence. The former have been developed for their own particular purpose (categorising behaviour by a common set of symptoms for treatment and/or study). They are ill-suited to the different legal purpose of assigning criminal responsibility, or absolving a person from it. Furthermore, as noted above, given that most who successfully raise insanity will be made special patients, and detained for some years, the forensic psychiatrist will be inclined to want or need to justify this by reference to a long-term need for treatment and rehabilitation (as opposed to simply a need for community protection).¹³

12 Dr Rees Tapsell “Forensic Psychiatry and the Law: A Judicial Update” (Wellington, Monday 7 November 2005). See also McSherry, above n 11 at 80: “the term ‘mental disorder’ is more commonly used as the generic term for mental pathology ‘because of the somatic or organic implication in the use of the term disease’” (quoting from J D Chaplin *Dictionary of Psychology* (Dell Publishing Co, New York, 1985) at 277).

13 Tapsell, above n 12.

- 2.13 In practice, forensic psychiatrists giving expert evidence before a court need to assist the court and jurors in understanding how the clinical description of the particular mental disorder might transpose to the legal test. This puts a heavy burden on them to make the current defence workable; it also confers significant power and responsibility upon them. However, they are not permitted to assert that the legal test has been satisfied, or that the particular defendant should or should not be held criminally responsible. This would be impermissible expert evidence as to the ultimate issue.

HUMAN RIGHTS COMPLIANCE

- 2.14 A case that the *M’Naghten* rules, and therefore section 23, may be in breach of international human rights obligations has been argued repeatedly.¹⁴ In *Winterwerp v The Netherlands*,¹⁵ three pre-requisites were identified for compliance with the European Convention on Human Rights:¹⁶
- there must be correspondence between expert medical opinion and the definition of the mental state required to satisfy the defence;
 - the court’s determination of mental impairment must be based on objective medical expertise; and
 - the court must have discretion to determine whether or not the mental state is “of a kind or degree warranting compulsory confinement”.
- 2.15 New Zealand is not subject to the European Convention. But article 9(1) of the International Covenant on Civil and Political Rights, to which we are a party, establishes a similar requirement.

Correspondence between expert medical opinion and the definition

- 2.16 We have already discussed, above, the dissonance between the statutory and case law legal tests for insanity, and psychiatric approaches.¹⁷ If anything poses a problem for New Zealand, in terms of the *Winterwerp* criteria, it is this. In practice, the scope of the legal tests is such that “innocuous categories of defendants, who are unlikely to be considered medically insane, and who present little or no threat to society” will be from time to time at risk of meeting the legal

14 See further Ronald Mackay “The Insanity Defence – Recent Developments in Jersey and Guernsey” *The Jersey Law Review* (June 2003); P J Sutherland and C A Gearty “Insanity and the European Court of Human Rights” [1992] *Crim LR* 418; Samuel Hopper and Bernadette McSherry “The Insanity Defence and International Human Rights Obligations” (2001) 8(2) *Psychiatry, Psychology and Law* 161; Andrew Ashworth *Principles of Criminal Law* (1999) at 216. See also *Attorney-General v Prior* Royal Court of Jersey, Samedi Division, 2001/35, 9 February 2001, in which the bailiff declined to apply the *M’Naghten* rules, on the ground they were inconsistent with international human rights requirements. Note, however, that on a subsequent appeal, the Jersey Court of Appeal (202 JLR 11 at 21) commented adversely on the bailiff’s ruling, although no reasons were given: “However for our part, we consider that at some more appropriate time the correctness of that ruling may have to be revisited ... in our opinion, the argument that the McNaghten Rules are incompatible with the European Convention on Human Rights does not seem to us to be correctly based”.

15 (1979) 2 EHRR 387.

16 Ashworth, above n 14.

17 See further paras 2.10–2.12.

definition of insanity.¹⁸ So, for example, diabetic hyperglycaemia,¹⁹ sleepwalking,²⁰ and arteriosclerosis,²¹ have all been held to be “diseases of the mind” in English and Canadian cases, putting the insanity defence in issue.

Requirement for the court’s determination to be based on objective medical expertise

- 2.17 Expert forensic psychiatric evidence is required about, but not determinative of, the issue of legal insanity. Whether any given mental disorder satisfies the precondition of a “disease of the mind” is a question of law for the judge to decide; and application of the defence on the facts is a matter for the fact finder (judge or jury). Expert psychiatric or psychological evidence is, therefore, not conclusive, although it would be highly unusual for it not to carry significant weight. We think it is, therefore, accurate to say that the court’s determination is indeed “based on” objective medical expertise, in terms of the *Winterwerp* criteria.

Discretion to order confinement

- 2.18 Under sections 23 to 25 of the Criminal Procedure (Mentally Impaired Persons) Act 2003, New Zealand courts have complete flexibility of disposal of persons acquitted on account of insanity. Under section 24, before ordering detention as a special patient or special care recipient, the court must consider all the circumstances of the case and expert evidence as to whether detention is necessary, and be satisfied that an order is necessary in the interests of the public, or any person or class of person (including, presumably, the acquitted person) who may be affected by it. If the court is not so satisfied, it must consider other disposition options set out in section 25, including immediate release of the acquitted person.
- 2.19 As Mackay has said,²² “If the defence gave rise to a verdict which was followed by a separate and independent disposal hearing under which the judge had unfettered discretion,” that might be acceptable in terms of the *Winterwerp* criteria. This is precisely the New Zealand position.

18 Sutherland and Gearty, above n 14.

19 *R v Hennessy* [1989] 2 All ER 9 (CA). The accused had been a diabetic for some years, and required two insulin injections daily. He was also suffering from stress, due to family and employment circumstances, and therefore had been neglecting diet and his insulin. He became hyperglycaemic (excess blood sugar, with symptoms of aggression and lack of recall similar to excess alcohol). The trial judge ruled that diabetes, a disease, was the cause of his dissociative state, so the proper defence was insanity, whereupon the accused changed his plea to guilty. His appeal was dismissed and the trial judge’s ruling upheld, holding that hyperglycaemia is an inherent defect, therefore an “internal factor” and a disease of the mind.

20 *R v Burgess* [1991] 2 All ER 769. The appellant and his female friend fell asleep after watching a horror video. The friend woke up when she felt a blow on the head, to find the appellant standing over her, about to hit her again with the video recorder. He had feelings for her that were not reciprocated, which made it a stressful time for him; this had induced sleepwalking. The court held that external factors such as stress are only triggers of a condition, the primary source of which is internal to the accused. Sleep is a normal condition (as opposed to a disease), but sleepwalking is not; it was a disease of the mind.

21 *R v Kemp* [1957] 1 QB 399. The accused hit his wife with a hammer, under the influence of arteriosclerosis, which was impeding oxygen supply to his brain. Devlin J held that the law is concerned not with the brain, but the mind; and with the effects of the disease on mental condition, not its cause. Therefore, arteriosclerosis was a disease of the mind.

22 Mackay, above n 14 at para 14.

PROBLEMS
APPLYING THE
DEFENCE IN
HARD AND
ANOMALOUS
CASES

- 2.20 Section 23, and the case law that supports it, is not always easy to apply. There can be problems in determining (usually a long time after the event) what the defendant was capable of knowing or understanding at the time; and problems determining causation, for example whether cases of drug-induced psychoses (particularly in the methamphetamine context) should be regarded as an internal or external factor.²³
- 2.21 In this respect, section 23 is no different from many other areas of law. Hard cases are, from time to time, inevitable. However, the internal/external factor test, in particular, has resulted in anomalous and irreconcilable cases that illustrate the high degree of malleability of the criteria for the defence, and have the potential to bring the law into some disrepute.
- 2.22 We noted above the case of *Hennessy*,²⁴ in which diabetic hyperglycaemia was held to be a disease of the mind. But by contrast, in *R v Quick*,²⁵ a diabetic male nurse was prosecuted for assaulting a patient. At the time of the assault, he was hypoglycaemic. He had administered his routine insulin injection, but subsequently ate little food and drank alcohol. He pleaded guilty when a trial judge held that he had put the insanity defence in issue. But on appeal, it was held that a malfunctioning of the mind that is transitory and attributable to external causes cannot be said to be due to disease. Insulin was what caused his condition of blood sugar deficiency, and this was, therefore, an external factor, not a disease of the mind:²⁶
- What this means is that if the diabetic is fortunate enough to have taken insulin, then he may escape a ruling that his condition was a disease of the mind while his diabetic counterpart who fails to take his insulin and does not stick to a proper diet faces the prospect of being found legally insane.
- 2.23 We also commented on *Burgess*,²⁷ in which sleepwalking was held to be a disorder primarily internal to the accused and, therefore, a disease of the mind. But in *R v Parks*,²⁸ the opposite result was reached. The respondent had driven by night to the home of his partner's parents, and attacked them, killing his mother-in-law with a knife. He was sleepwalking throughout. However, the disorder that causes sleepwalking, according to the court in *Parks*, is not what causes the cessation of conscious faculties upon which the respondent relied: that cause is sleep, a normal state. Since the disorder was not the cause of the impairment, the impairment could not be attributable to disease of the mind.

23 Tapsell, above n 12. In particular, on the subject of methamphetamine, Tapsell says: "Methamphetamine, known variously as 'P', 'Meth', 'Pure', is a potent stimulant which has strong addictive potential and when used in high quantities, over time, can cause psychosis (a loss of contact with reality, persecutory delusions and hallucinations) not unlike an acute episode of paranoid schizophrenia. The combination of the stimulation (and resultant loss of behavioural inhibitions) and the development of persecutory delusions and command auditory hallucinations, when acting on an already moderately anti-social personality, is a 'time bomb' waiting to go off. Methamphetamine can cause these symptoms alone as a result of a state of intoxication, it can exacerbate an underlying mental disorder (eg schizophrenia) and precipitate an acute relapse of that disorder or it can cause a longer term, intermediate state which lasts beyond the period that it takes for the body to clear it but resolves without the need for longer term treatment."

24 Above n 19.

25 [1973] 3 All ER 347.

26 R D Mackay *Mental Condition Defences in the Criminal Law* (Clarendon Press, Oxford, 1995) at 42.

27 Above n 20.

28 (1990) 78 CR (3d) 1.

2.24 In summary, therefore, as authors Hopper and McSherry have put it, the internal/external distinction has led to the absurd classification of hyperglycaemia as a disease of the mind, and hypoglycaemia as not; and somnambulism being viewed as a disease of the mind in England and not a disease of the mind in Canada.²⁹ There may well be plenty of scope to argue that exclusion of these cases from the scope of the defence was the right result; but the anomalous outcomes in virtually identical cases are somewhat difficult to defend.

2.25 There have also been difficulties, or odd chains of reasoning, in occasional New Zealand cases. For example, in *Burnskey v Police*, the medical evidence was that the offender's mind "functioned defectively", and that when exacerbated by alcohol consumption, this caused offending behaviour. This was held not to be a disease of the mind, not because the behaviour was caused by an external factor (alcohol), but because the brain defect was produced by an injury "externally" caused at birth. Apart from anything else, it illustrates the malleability of the case law tests. Otherwise, however, there is nothing really to indicate that the defence has posed major problems in practice in New Zealand.

CONCLUSION

2.26 Section 23 is therefore troubled in principle, and has occasionally produced odd or anomalous results in practice. Furthermore, the fact that the insanity defence is not very often relied upon is not in itself a reason for failing to formulate morally and legally sound criteria for it.

2.27 However, the overall size of the problem needs to be assessed against the availability of viable options for reform, which we consider in the following chapters.

²⁹ Hopper and McSherry, above n 14.

Chapter 3

Abolition of the insanity defence

SUMMARY

Some academics and law reformers have argued that the insanity defence is so conceptually flawed, it should be abolished entirely, relying instead simply upon general principles of the criminal law, and mental health legislation, to achieve the desired objectives. A few jurisdictions have attempted this. However, most people we consulted did not support it, and if nothing else, we think that it is too counter-intuitive an approach to prove successful in practice.

- 3.1 The first option for reform of the insanity defence is its total abolition. A key advocate for abolition has been Norval Morris,³⁰ but he is not alone; others have endorsed or “flirted most thoughtfully” with the idea,³¹ including three American states,³² and the Law Reform Commissioner of Tasmania.³³

THE ABOLITION ARGUMENT

- 3.2 Morris, and others, argue that the criminal law should be concerned with intent, not moral responsibility like the insanity defence. The law does not take account of other morally-based claims of absolution: the religious zealot, for example, who terrorises an abortion clinic, or the animal rights activist who breaks and enters a research facility. Furthermore, the insanity defence fails in any attempt it might be making to capture the criminal offenders who are the least morally culpable (because they are the most psychologically disturbed); plenty of convicted prisoners may be at least as seriously disturbed as persons acquitted

30 See, for example, Morris, above n 9; Norval Morris “Psychiatry and the Dangerous Criminal” (1968) 41 Southern California Law Review 514; Norval Morris *Madness and the Criminal Law* (University of Chicago Press, Chicago, 1982).

31 For a list of the other like minded jurists, and a synopsis of their arguments, see Morris “Psychiatry and the Dangerous Criminal” above n 30 at 517 and the Appendix to that paper. See also Mackay, above n 26 at 125–130, noting that the American Medical Association fully endorsed Morris’ approach in their report on the insanity defence made after the verdict in the case of John Hinckley. Hinckley was acquitted on grounds of insanity, of attempting to assassinate then US president Ronald Reagan, because, to rebut the defence, the prosecution needed to prove that he was sane beyond a reasonable doubt. The AMA concluded that the focus of the inquiry needed to be shifted back on to his criminal intent.

32 Montana, Idaho and Utah.

33 Law Reform Commissioner of Tasmania *Insanity, Intoxication and Automatism* (Report 61, 1989). The recommendation was not implemented.

on account of insanity. The insanity defence assumes that the psychotic, who manifests a disorder in the quite particular ways the insanity defence requires, is more morally innocent in his or her inability to make choices than the person pressed towards criminality by a deprived and scarred background, whose capacity for choice and ‘normal’ moral reasoning may be no less impaired. Therefore, so the argument goes, the insanity defence is badly founded in principle, and unfair in application, and mental illness would be better treated as a matter for consideration at sentencing, along with other mitigating factors.

ABOLITION CONSEQUENCES

- 3.3 If the insanity defence was abolished, defendants who lack mens rea would be acquitted. There would be other methods of dealing with them, in the interests of public safety. They might instead be civilly committed, under the Mental Health (Compulsory Assessment and Treatment) Act 1992 or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. Under the Mental Health (Compulsory Assessment and Treatment) Act 1992, there is also provision for a patient to be declared a restricted patient, following which they have essentially the same security status as a special patient acquitted on account of insanity.
- 3.4 Defendants who do have criminal intent would be convicted. However, imprisonment or other penal sanction would not be inevitable: the Criminal Procedure (Mentally Impaired Persons) Act 2003 is sufficiently flexible to allow disposition to a mental health facility in lieu of a penal sanction, or transfer to such a facility after a prison sentence has been imposed.
- 3.5 Arguably, this approach would achieve similar social policy objectives to the insanity defence, with less confusion of objectives.³⁴ By utilising civil commitment processes for the acquitted, and the already available range of mental health dispositions for the convicted, it would treat criminal and mental health law as complementary parts of an integrated system, unlike the present amalgam that is section 23. Having relied upon generally applicable criminal law principles to determine criminal responsibility (or not), mental health dispositions would moderate those outcomes, in the interests of both justice and public safety.

OUR RESPONSE

- 3.6 Attractive though the abolition argument may seem, it overstates its case. It is not, in fact, true to say, as the abolitionists do, that the insanity defence is ill-founded because criminal liability in general turns on the presence or absence of criminal intent. The criminal law, and society more generally, across all like-minded jurisdictions, does recognise other circumstances in which factual guilt, and criminal actions with intent, are justified or excused, resulting in acquittal, because the offender was placed in a position in which he or she did not have a “real” choice. Self defence, and duress or necessity, are examples.

³⁴ See further ch 1, and McSherry, above n 11, who argues that criminal responsibility should be one question, and disposition (including the option of detention) a subsequent and entirely separate question. However, it is not necessary to abolish the defence to address McSherry’s problem; all she is proposing is that the question of what defines madness, for the purpose of criminal non-responsibility, needs to be separated from the subsequent question of who is so mad, and therefore dangerous, that they need to be detained.

- 3.7 But the more fundamental counter-argument to the abolitionists' proposal is that it would diverge too far from community norms, and thus undermine confidence in the law. The brief historical review outlined above demonstrates that it has been recognised for a very long time, dating back over half a dozen centuries, that certain groups should be exculpated, and yet are properly detained. The close alignment of section 23 with this history is somewhat compelling.
- 3.8 There is some evidence and experience to back up these suppositions. Appelbaum describes how, in the years after abolition in Montana, defendants were instead found unfit to stand trial, ultimately having their charges dismissed, in the same numbers (and with the same demographics) as would have been previously found not guilty by reason of insanity. The only difference was that they were hospitalised and treated before trial (and often without trial) rather than afterwards. Therefore, the legal and mental health systems simply found another means to accomplish the same end – an end that was perceived to be the right result.³⁵ Abolition did not really 'work', as such; instead, it was worked around.
- 3.9 The Law Reform Commission of Victoria,³⁶ having considered arguments similar to those we have outlined, concluded that the insanity defence should be retained, and reformed, rather than abolished. We agree that abolition is not a viable proposal, and similar views have been expressed by those with whom we consulted. Some thought that abolition had some intellectual attraction, but the idea of putting it into practice was not supported by most.

35 Appelbaum, above n 3 at 173–175 and 181–183, citing Steadman et al *Before and After Hinckley: Evaluating Insanity Defense Reform* (Guildford Press, New York, 1993). See also Mackay, above n 26 at 129.

36 Law Reform Commission of Victoria *Mental Malfunction and Criminal Responsibility* (Report 34, 1990).

Chapter 4

The qualifying mental conditions

SUMMARY

Section 23, at present, is drafted in quite archaic terms, particularly in the terms it uses to describe the qualifying mental conditions for an insanity defence: “natural imbecility” and “disease of the mind”. “Disease of the mind”, in particular, is an open-ended, flexible concept, further defined in case law. Perhaps inevitably, it is open to a degree of interpretation on a case by case basis, and has produced some anomalous outcomes.

However, there are no options for revising the qualifying mental conditions that offer any likelihood of more certainty or better outcomes than the defence presently achieves. Furthermore, changes to the defence’s scope were not supported, by either those whom we consulted, or the much more extensive exercise undertaken by the Crimes Consultative Committee on the Crimes Bill 1989.

There are some arguments in favour of attempting a largely cosmetic redrafting exercise, as overseas jurisdictions have done, particularly a number of Australian jurisdictions. In Australia, the preferred language appears to be “mental impairment”, and that would also sit well with New Zealand’s statutory scheme. Most Australian definitions also refer, non-exhaustively, to intellectual disability and mental illness (instead of “natural imbecility” and “disease of the mind”).

However, while this seems to have been a popular and, apparently, workable approach in Australia, in New Zealand there would be some tricky aspects to it, given that the same language is already used in New Zealand elsewhere on the statute book, for civil commitment purposes. The experience of the Crimes Consultative Committee is discussed. In our view, it illustrates how minor clarifications and stylistic changes would inevitably evolve into a large redrafting exercise, with all its attendant risks.

- 4.1 The insanity defence has two parts. First, it describes the qualifying mental conditions for the defence: “natural imbecility” and “disease of the mind”. Secondly, it requires those mental conditions to have produced particular kinds of impairment consequences.
- 4.2 This chapter considers the first part: the qualifying mental conditions. The second ‘impairment consequences’ part is dealt with in chapter 5.

REVISE THE QUALIFYING MENTAL CONDITIONS

- 4.3 The “disease of the mind” element of section 23, in particular, has been broadly interpreted by the courts. It embraces a wide range of mental disorders, and indeed in some cases physical disorders (such as some forms of diabetes, and arteriosclerosis). Its scope is governed only by case law, in particular the “internal/external factor” and “recurring danger” tests discussed earlier.³⁷ The courts have used these to assess on a case by case basis when it might be proper for a defendant to be detained in a hospital, rather than acquitted and released, because of his or her mental condition. Beyond those legal tests, the outcomes in individual cases are likely to be based on expert psychiatric evidence.
- 4.4 The statute, therefore, does not do a good job of making plain the scope of the defence. The defence can of course be made to work, precisely because it is so open-textured. However, this kind of open-ended, flexible, case-based approach inevitably carries the risk of anomalous results: for example, attributing one consequence of diabetes (hyperglycaemia) to an “internal” cause and calling it insanity, while excluding another consequence (hypoglycaemia) as having an “external” cause; or the different views that have been taken in England and in Canada on whether somnambulism (sleepwalking) is a disease of the mind. The anomalies doubtless stem partly from some natural aversion to the idea of stigmatising such people with an ‘acquittal *on grounds of insanity*’, and exposing them to the risk of indefinite detention. The courts have, therefore, worked hard to distinguish some cases from other quite similar ones. However, the fact that the case law leaves open the possibility of including conditions such as sleep-walking or diabetes may also tend to suggest that its scope is simply too wide.
- 4.5 We therefore considered whether the defence ought to be redrafted, to better define its scope or to include or exclude certain kinds of conditions.

Draft a whole new statutory test?

- 4.6 One option is to start afresh with the defence, and reformulate a whole new statutory test.
- 4.7 It may well be that the “recurring danger” and “internal/external factor” tests, which presently attempt to manage the scope of “disease of the mind”, are too broad. However, while the cases that they inadvertently capture are notorious, their incidence is rare. Moreover, it is not at all clear what form of words might be employed to successfully exclude such cases (for example, those arising from organic physical causes, that would not be regarded by either the ordinary person or indeed a psychiatrist as ‘insanity’, or cases where the impairment is very short term or episodic) without also inadvertently excluding other cases that the defence ought to cover.

³⁷ See further chapter 1.

- 4.8 Whatever the scope of the new statutory provision, its function would be to attempt the filtering exercise currently managed through the tests developed in case law. We think that it would in the end produce similar, and perhaps new, anomalies; and that its novelty would cause more uncertainty than presently arises from the well-understood (if imperfect) case law.
- 4.9 We are also presenting this report in a context where there is simply no appetite for an overhaul of the scope of the defence. The circumstances in which the defence is used in New Zealand are, with rare exceptions, widely viewed as appropriate, and there is a real concern that a revamp of the defence might expand its use beyond its legitimate scope. We share that view, and have therefore concluded that a fresh start is unwarranted.

Adopt the existing civil definitions for criminal purposes?

- 4.10 A second option is to use the definitions of “intellectual disability” and “mental disorder” developed for civil purposes. This could have the effect of simplifying some aspects of the operation of the defence, and offer a solution to the problem of how to rewrite and define its qualifying mental conditions, given that there are working definitions on the statute book.
- 4.11 The meaning of “intellectual disability” is set out in section 7 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. “Mental disorder” is defined in section 2 of the Mental Health (Compulsory Assessment and Treatment) Act 1992. However, after considering these definitions, we do not consider them appropriate, for criminal defence purposes. There would be quite a number of problems with using them in this context.
- 4.12 The definitions were drafted for a different purpose. They determine the class of case in which compulsory civil commitment may be appropriate, which is a relatively high threshold. However, in the different context of an insanity defence, less impaired people arguably should be and currently would be entitled to the benefit of the defence, if they have met its other requirements.
- 4.13 The civil definition of “mental disorder”, for example, applies to a person who poses a serious danger to the health or safety of the person or others; it would deny a shoplifter, for example, the benefit of the insanity defence. It may be that a shoplifter, in practice, would never seek to rely on the defence; nonetheless, excluding them would, we think, be contrary to principle and a large change from the present scope of the law. There is a similar issue with the “intellectual disability” definition, and its requirements for a person to demonstrate quite particular levels of deficit in skills such as self-care, home living, social skills, and so on.
- 4.14 Furthermore, all of these would be additional elements for the defence to have to prove, and the Crown to rebut, over and above the defence’s current requirements. It would add to the complexity of criminal trials, and they are elements that simply do not make sense. They are, essentially, performing the same role for the civil definitions (albeit with a different objective) that the second limb of the insanity defence already performs. The definitions are also exhaustive and would, therefore,

lack the flexibility that is a current feature of the defence. Coupled with what would be quite a radical change in scope, were they to be adopted, we do not consider this a good idea, nor is it likely to be supported.

- 4.15 While it may be possible to extract and adapt parts of the civil definitions for criminal defence purposes, they (in particular, the “intellectual disability” definition, but also, to a lesser extent, the “mental disorder” one) would need to be so substantially altered, that it would require them to be redrafted, which is not an option we support.³⁸

Exclude some kinds of disorders explicitly, from an otherwise open-ended defence?

- 4.16 A third option is to leave the definition of the qualifying mental condition open-ended, but explicitly exclude some kinds of disorders or diseases.
- 4.17 For example, the insanity defence is not explicit about whether psychopathic or personality disorders may ever amount to disease of the mind. Nothing on the face of section 23 (or its case law setting out the tests for “disease of the mind”) offers clear authority on this point; and arguably the law should do so.
- 4.18 Indeed, the current position is somewhat confusing. The received wisdom has been that psychopathic and personality disorders do not and should not come within the scope of the defence. The Crimes Consultative Committee reporting on the Crimes Bill 1989 proposed to exclude them, saying: “we consider that it should be put beyond doubt that psychopathic personalities who are simply indifferent to notions of morality cannot avail themselves of a defence of mental disability”.³⁹
- 4.19 However, in *R v McMillan*,⁴⁰ the Court of Appeal held that there will be a defence of insanity even if the accused person knows that his or her act is morally wrong in the eyes of the community as long as it is not morally wrong in the eyes of the accused. On its face, this seems a broad enough statement to potentially open the door of the defence to such disorders. Even though it has not happened in practice, this might nonetheless be a key category of disorder the legislature would want to explicitly exclude from the scope of section 23.
- 4.20 On the other hand, in the 40 years since *McMillan* was decided, this has not emerged as a significant problem with the operation of the defence. In practice, we doubt there is significant confusion. Although it is not discussed in their report, we suspect that the Crimes Consultative Committee may have thought that it needed to address this issue because its proposed codification of *McMillan* would otherwise have given rise to doubt about whether the legislature had wanted psychopathic and personality disorders included.

38 See further the discussion above, at paras 4.6–4.9, and below at paras 4.30–4.32, addressing the disadvantages of this.

39 Crimes Consultative Committee *Crimes Bill 1989: Report of the Crimes Consultative Committee* (Wellington, 1991).

40 [1966] NZLR 616 (CA).

4.21 Similarly, we are not convinced that there are other specific conditions that can readily be singled out for exclusion. That might create injustices and it would inevitably arbitrarily distinguish the excluded conditions from a range of other conditions involving similar degrees of mental impairment.

4.22 In summary, given that we are not otherwise of a mind to recommend changes to section 23, we think that there is insufficient evidence of any real practical problem to justify recommending this option.

CLARIFY AND UPDATE THE LANGUAGE

4.23 If the scope of the qualifying mental conditions is not to be revised, an alternative option may be simply to clarify and update their language. We considered two approaches to doing this. One approach (recommended by the Crimes Consultative Committee, in 1991) was quite comprehensive, including definitions of the new language. The other approach (undertaken by most Australian jurisdictions) has been more limited, simply inserting appropriate modern new words, and leaving it up to the courts to interpret and apply them.

The Crimes Consultative Committee draft

4.24 The Crimes Consultative Committee 1991, reporting on the Crimes Bill 1989, proposed a revised defence that, at its heart, would have been similar to section 23, but with a new title, some more modern language, and definitions of the key terms “mental disability” and “serious mental disorder” (the Committee’s new term for “disease of the mind”).

4.25 The Committee’s proposed provision was as follows:⁴¹

28 Mental disability

- (1) A person shall be presumed to be sane at the time of doing or omitting any act until the contrary is proved.
- (2) A person is not criminally responsible for any act done or omitted to be done when suffering from a mental disability that renders the person 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 according to the commonly accepted standards of right and wrong; or
 - (c) Of regarding the act or omission as morally wrong although he or she knew that it was morally wrong according to the commonly accepted standards of right and wrong.

41 Crimes Consultative Committee, above n 39 at 94–95. The definition follows reasonably closely an earlier Law Commission for England and Wales’ proposal: Law Commission *A Criminal Code for England and Wales* (Law Com No 177). Clause 34 would have defined “severe mental illness” as a mental illness which has one or more of the following characteristics: (a) lasting impairment of intellectual functions shown by failure of memory, orientation, comprehension and learning capacity; (b) lasting alteration of mood of such degree as to give rise to delusional appraisal of the defendant’s situation, his past or his future, or that of others, or lack of any appraisal; (c) delusional beliefs, persecutory, jealous or grandiose; (d) abnormal perceptions associated with delusional misinterpretation of events; (e) thinking so disordered as to prevent reasonable appraisal of the defendant’s situation or reasonable communication with others. It defines “severe mental handicap” as a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning. At p 18 the Crimes Consultative Committee acknowledges the origins of its draft: “The draft draws extensively from clause 34 of the English Law Commission’s draft code, which in turn owes a great deal to the work of the Committee on Mentally Abnormal Offenders (the Butler Committee) which reported to the Secretary of State in 1975 (Cmnd 6244).”

(3) In this section—

“Mental disability means—

- (a) A state of arrested or incomplete development of mental functioning involving serious impairment of intelligence; or
- (b) A serious mental disorder; or
- (c) An organic disorder of, or injury to, the brain resulting in continuing, temporary or recurrent impairment of mental functioning of a serious nature,—
but does not include a psychopathic disorder or a personality disorder.

“Serious mental disorder” means a serious mental disorder or a serious mental illness, of a continuing or recurring nature, and includes such a disorder or illness having one or more of the following characteristics—

- (a) Substantial impairment of mental functioning shown by—
 - (i) Failing memory or comprehension or impairment of orientation; or
 - (ii) Disorder of language or thought;
- (b) Serious disorders of mood or perception.

4.26 In making these recommendations, the Committee rejected the original Crimes Bill 1989 draft, which in clause 28(2) provided that:

A person is not criminally responsible for any act done or omitted to be done when suffering from a mental defect or mental disorder that renders the person incapable—

- (a) of knowing what he or she is doing or omitting to do; or
- (b) of attributing to the act or omission the character that the community would commonly attribute to the act or omission.

4.27 The Committee noted that many submitters had been critical of this. It regarded it as too radical, and concluded that notwithstanding a desire to substitute “language which has a more contemporary flavour ... there are ... sound reasons for proceeding with care”.

4.28 The Committee was, therefore, explicitly not attempting to alter the defence’s scope. Despite its recommendation for a very different looking defence, its object was purely terminological change. It noted that “There is, understandably, a strong desire among lawyers to keep the defence of insanity within well-recognised boundaries” and “The public has a legitimate interest in being reassured that any reformulation of section 23 will not throw open the defence to a wide range of persons with mental abnormalities”.

4.29 However, by virtue of a non-exhaustive definition of serious mental disorder, it left room for some reinterpretation of the scope of the defence. It proposed a draft that replaced the outdated terms with a single term “mental disability”, and included definitions of both “mental disability” and its key component “serious mental disorder”, on the basis that: “Clearly the term needs to be defined in order to allay concerns that the bill widens the scope of the insanity defence”. Its aims were “to mark out the boundaries of the clause in terms which are understood and applied in contemporary psychiatry” and to find “an acceptable way of updating the present law without departing in any material way from the insanity test described in section 23(2) of the Crimes Act”.⁴²

42 Crimes Consultative Committee, above n 39 at 17–19.

- 4.30 However, a drafting exercise intended to do no more than clarify and codify would inevitably evolve into a legislative exercise of some substance, and carry contingent risks. In particular, there is a risk that this intervention would be perceived as affecting the defence's scope, giving rise to uncertainty and litigation – ironically, precisely one of the risks that the Crimes Consultative Committee expressly said it wanted to avoid. We doubt that a brand new definition could in fact avoid this risk.
- 4.31 There is also a substantial irony that, in rejecting the Crimes Bill 1989 draft as too radical and risky, the Crimes Consultative Committee then went on to recommend a draft that, on its face, presents something a great deal more far-reaching. Really, the only difference between the two approaches is that the Crimes Bill 1989 drafters changed some of the current section 23 language without explaining on the face of the statute what was intended, whereas the Crimes Consultative Committee draft expanded into definitions of key terms. Neither of them wanted to see any change to the defence's scope.
- 4.32 But to us, it illustrates our key concern: that small innocuous changes and clarifications will inevitably and swiftly lead to bigger riskier ones. It is not possible to “clarify” the defence, let alone attempt to tinker with its scope, without in the end undertaking a quite fundamental revision exercise.

The Australian approach

- 4.33 Almost all Australian jurisdictions have revised their insanity defences, to bring them up to date, by modernising the statutory language. However, in undertaking this exercise, they have not done anything, overtly, to try to prescribe or alter the scope of their defences: old language has been simply replaced with new words, with some very broad non-exhaustive guidance about some of the kinds of concepts that are included.
- 4.34 In South Australia, Victoria and the Australian Capital Territory the defence has been renamed a defence of “mental impairment”. In New South Wales it has been renamed a “special verdict by reason of mental illness”. The Western Australian Law Reform Commission proposed the term “abnormality of mind”. The Western Australian defence in section 27 of the Criminal Code Act Compilation Act 1913 is still titled “insanity”, but refers in the body of the defence to “mental impairment”, which is itself further defined in the same way as the South Australian, Victorian and Australian Capital Territory defences.
- 4.35 In almost all of those jurisdictions, the new language is then supported by brief, non-exhaustive definitions. Western Australia, South Australia, the Australian Capital Territory,⁴³ and the Commonwealth Criminal Code all include “intellectual disability” and “mental illness” in their definitions of “mental impairment”. Beyond that, they vary in the extent to which they mention other

43 We also note that the Australian Capital Territory for a time had a definition rather more prescriptive than most Australian approaches. However, they have since stepped back into line with the other Australian jurisdictions, defining mental impairment as including some concepts, non-exhaustively. Section 428N of the Crimes Act 1900 (ACT) formerly referred to “mental dysfunction”, which was in turn defined in section 428B as “a disturbance or defect, to a substantially disabling degree, or perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion”.

kinds of damage or impairment or dysfunction (eg senility, brain damage, personality disorder), and they are non-exhaustive definitions. In Victoria, there is no definition at all.

- 4.36 This is, therefore, one possible approach upon which New Zealand might model itself. In other words, the language of section 23 could simply be updated, with modern-day equivalents, whilst counting on the other ‘*M’Naghten*’ parts to the defence (as discussed in chapter 5) to continue to govern its scope. In practice, the scope of the defence is largely governed by its second part, so that arguably, even if there was some uncertainty attached to the new language, at least any “floodgates” type risk arising from the use of a broad concept such as “mental impairment” would be mitigated.
- 4.37 This would, we think, be widely supported, with the proviso that it could be achieved without changing the defence’s scope. Among those we consulted, there was agreement that the current legislative language – “insanity”, “natural imbecility” and “disease of the mind” – used to describe these mental conditions is outdated, inappropriate, and inconsistent with expert usage.

New language: “mental impairment”, “intellectual disability”, “mental disorder”

- 4.38 The two types of insanity referred to in the present defence are “natural imbecility” (ie, intellectual disability) and “disease of the mind” (ie, mental disorder).
- 4.39 The Criminal Procedure (Mentally Impaired Persons) Act 2003 uses “mental impairment” as an umbrella term that may encompass either the mentally disordered or the intellectually disabled, or indeed other causes of incapacity.⁴⁴
- 4.40 “Mental impairment” is also the language most commonly employed for this purpose in Australia, in the jurisdictions noted above that have reformed their defences. Furthermore, as noted above, most of the Australian definitions expand on the definition of mental impairment by reference to “intellectual disability” and “mental illness”.
- 4.41 The Criminal Procedure (Mentally Impaired Persons) Act 2003 deals, among other matters, with persons acquitted on account of insanity (it includes procedures for delivering an agreed insanity verdict, and disposition procedures following an insanity verdict), and persons who are unfit to stand trial. It provides that mental impairment is a necessary, but not sufficient, precondition for a finding of unfitness to stand trial. Persons who are unfit to stand trial may well be subsequently tried and acquitted on account of insanity, but the two are quite separate legal concepts.
- 4.42 This gives rise to some questions about whether it might be confusing to rename the insanity defence a defence of “mental impairment”. But we think that there would be little likelihood of confusion, and overall, it would seem to be the most suitable term, if the language was to be updated.

44 “Mental impairment” is not defined in the Act, but compare unfitness to stand trial, where mental impairment is a precondition for an unfitness finding, and the unfitness may stem from either mental disorder or intellectual disability, or any other cause.

- 4.43 In Victoria, “mental impairment” is simply used, without further elaboration. However, we think that it would be necessary and desirable to put beyond any doubt the intention that the defence should still apply to both of its current beneficiaries: the intellectually disabled, as well as the mentally disordered.
- 4.44 However, there are already statutory definitions of “intellectual disability” and “mental disorder” in New Zealand, developed for civil commitment (as opposed to criminal defence) purposes. We discussed these terms above, and concluded that it would not be appropriate to adopt them, for the purposes of the insanity defence.
- 4.45 If that language was, therefore, to be brought into the defence as part of a redrafting exercise, it would also be necessary to clarify the relationship between the criminal defence, and existing definitions of those terms under the respective Acts for civil commitment purposes.⁴⁵ Otherwise, the courts might turn to the civil definitions for guidance in determining the defence’s scope, in the absence of any legislative clarification that this is not what was intended.
- 4.46 It is unlikely to be feasible to provide, for the sake of purported clarification, that the civil definitions do not apply, without giving some sort of indication of what different definition is intended for criminal purposes.
- 4.47 An attempt might be made to find or construct other substitutes – such as “intellectual defect”, “mental illness”, or “mental disability” – but the scope of brand new terminology would be neither intuitive, nor transparent.
- 4.48 Again, therefore, an attempted small semantic change could soon lead to larger change, with its attendant risk and complexity.
- 4.49 These difficulties need to be considered in the light of the fact that the terminology used to describe the qualifying mental conditions is, arguably, of relatively little significance. It is old-fashioned, and does not express psychiatric concepts of mental illness, but in practice it generally works, for two reasons: because psychiatrists, judges and lawyers work around that conceptual incoherence and apply it in a common sense way; and because the other components of the defence restrict its scope.
- 4.50 Some have used this same logic to argue that the risks of reform are therefore quite low, and that the exercise might as well be undertaken. But we think that this cuts both ways: if the language matters little, then the rationale for reforming it really boils down to no more than a desire to make the defence ‘look and feel’ more modern, without adding anything of substance or changing anything. That is not a good enough reason to undertake what could inadvertently evolve into quite a wide-ranging exercise.
- 4.51 Whilst some refreshment of the drafting would probably be seen as desirable, and widely supported, and has been embraced in Australia, there is no real evidence of major problems with the operation of the New Zealand defence or the results it produces in practice. On balance, therefore, we do not recommend any change to the status quo.

45 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 2; Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 7.

Chapter 5

The link between mental impairment and offending

SUMMARY

The insanity defence has two parts: the mental pre-conditions for reliance upon the defence, discussed in chapter 4, and their cognitive effects, which are the subject of this chapter. The chapter reviews some possible problems with the present approach, specifically, what is meant by “incapacity”; the focus on moral wrongfulness; and the absence of any volitional element, so that people whose cognitive deficit impacts on their self-control are excluded.

The second part of the chapter considers approaches that might be taken to reform, giving examples to illustrate each type of approach. They range from treating mental impairment as a status defence; leaving it up to the jury to assess on a case by case basis; reform of the incapacity language; and inclusion of a volitional element. Overall, however, we do not consider any of the approaches better alternatives to the status quo.

- 5.1 In addition to a qualifying mental condition, discussed in the previous chapter, the defence currently requires, as a product of that impairment, quite particular types of cognitive consequences.
- 5.2 The second limb of the defence, as currently drafted, refers to a defendant: “labouring under natural imbecility or disease of the mind to such an extent as to render him incapable of understanding the nature and quality of the act or omission, or of knowing that the act or omission was morally wrong...”.

Cognitive incapacity

- 5.3 First, the current defence requires that the mental impairment must have rendered the defendant *incapable* of understanding the nature and quality of the act or omission, or of knowing that it was morally wrong, rather than a simple factual determination of whether the offender in fact *did* have such understanding or knowledge at the relevant time. Thus, offenders who do not understand or know, but are thought to have had the capacity to do so if they had turned their minds to it, will not be able to rely upon the defence.
- 5.4 This aspect of the defence has been used from time to time to exclude anti-social personality disorders from its scope: those with such disorders are argued to have the capacity to know that what they are doing is morally wrong having regard to commonly accepted standards, even if they do not reach that view in a particular case. It has also occasionally been used by the courts to remove the defence from other supposedly ‘undeserving’ cases. For example, in *R v Clarke*,⁴⁶ a depressed shoplifter, who argued that at the time of her offending she was confused and absent-minded as a result of her depression, was not able to rely upon a defence of insanity. The depression was a disease of the mind, but the court held that:
- the picture painted by the evidence was wholly consistent with this being a woman who retained her ordinary powers of reason, but who was momentarily absent-minded or confused and acted as she did by failing to concentrate properly on what she was doing and by failing adequately to use her mental powers.
- 5.5 But the distinction between incapacity and actual lack of understanding or knowledge is more likely to be glossed over or ignored in practice. It is a difficult distinction to draw. It follows from the language of the drafting that the reference to incapacity must have been intended to import something different from actual knowledge or understanding. But in practice, if a mentally impaired person genuinely did lack understanding or knowledge by reason of the disorder, it may be difficult for a fact finder to find any proper basis for concluding that the person could or should have performed better.

Focus on moral wrongfulness?

- 5.6 Secondly, the emphasis placed on knowledge of moral wrongfulness as a criterion for the defence in section 23(2)(b) seems odd. In all other respects the criminal law focuses on whether or not the act was contrary to law; the moral beliefs of individuals are irrelevant. A person who is brought up to believe that there is nothing morally wrong with smoking cannabis or engaging in unlawful protests, for example, does not have the benefit of an acquittal. But in the insanity context, in *R v MacMillan*,⁴⁷ the Court of Appeal held that even if defendants know that

⁴⁶ [1972] 1 All ER 219.

⁴⁷ [1966] NZLR 616 (CA).

other people would regard the act as morally wrong (in other words, have some sense of commonly accepted moral standards), they may still rely upon the defence if they themselves perceive that it is morally right.

- 5.7 Why should a person whose moral beliefs result from his or her mental impairment be treated differently? One possible explanation lies in the discussion above about incapacity. The defence is, arguably (though this is more explicit in Australia than New Zealand, where the drafting language is different), founded on a premise of incapacity to reason properly, to the extent of fundamental irrationality. That may help to explain why there is a certain amount of latitude about the insane person's understanding of morality, by contrast to the 'normal' person's: it follows from the incapacity concept that normal standards simply cannot be applied.
- 5.8 However, if incapacity is the essence of the defence, it is still not clear why incapacity to reason *morally* is necessarily the right test for determining when it is not proper to hold the person responsible.

No volitional element

- 5.9 Thirdly, the present defence in New Zealand is confined to cognitive impairments. Mental impairment that affects self control is not within its scope, although many jurisdictions, particularly America, have extended the scope of the defence in this way.
- 5.10 There is an argument to be made that, although volitional disorder is relatively rare, that is not a reason to exclude it from the scope of the defence. The first limb of the insanity test (incapacity to understand the nature and quality of the act) is also quite rare: people are hardly ever so deluded that they do not know what they are doing. The issue in most insanity cases relates to ability to reason morally.

REFORM OPTIONS

- 5.11 We have reviewed five approaches that might be taken to reform. These are set out briefly below. (Each example was chosen to illustrate a certain type of approach, and therefore inform discussion of the approach, rather than being necessarily an option to be picked up and imported to New Zealand law verbatim.)
- 5.12 The five approaches are: treating mental impairment as a status defence; providing a general causation test; leaving it up to the jury to assess on a case by case basis; reform of the incapacity language; and inclusion of a volitional element. Overall, however, we do not consider any of the approaches to be improvements on the status quo.

Mental impairment as a status defence

- 5.13 The previous chapter considered the nature of the qualifying mental state, and what language might be used to describe it. Mental impairment was suggested as a possibility, and the likelihood that it would need to be defined was discussed.

- 5.14 One possibility is that the defence would stop there, so that no further effects of the mental state on capacity, knowledge, moral reasoning, and so on, are considered. For example, the UK Butler Committee’s *Report of the Committee on Mentally Abnormal Offenders* proposed this test for an insanity defence:⁴⁸

at the time of the act or omission charged the defendant was suffering from severe mental illness or severe subnormality.

- 5.15 This, and similar sorts of tests, conceptualise insanity as a “status defence”: in other words, the condition absolves the defendant of responsibility for all of his or her actions, regardless of any other factors. It proceeds on the basis that:⁴⁹

the insane, like the very young, are not sufficiently rational to be fairly blamed or punished. If this is so, then lawyers should give up their attempts to define legal insanity in a way that collapses it into some traditional excuse. Crazy people are not responsible because they are crazy, not because they always lack intentions, are ignorant, or are compelled.

- 5.16 However, in our view, such an approach could not be justified. Its premise is that those with a qualifying mental impairment are “globally incompetent”, regardless of the actual nature and degree of incapacity experienced.

- 5.17 In reality, any incidence of even severe mental illness will vary in its effects; it may affect individual defendants differently, and affect capacity differently in different types of circumstances. In other words, there may well be otherwise culpable acts that are not within the sphere of influence of the illness. If a person has committed a crime uninfluenced by his or her illness, it would be wrong in principle that the person should escape conviction.⁵⁰

- 5.18 When the Law Commission for England and Wales subsequently reviewed the Butler recommendations, it described them as “generally admirable”. It proposed to implement the proposal, as follows:⁵¹

A mental disorder verdict shall be returned if the defendant is proved to have committed an offence but it is proved on the balance of probabilities (whether by the prosecution or by the defendant) that he was at the time suffering from severe mental illness or severe mental handicap [both defined].

- 5.19 However, it also recommended a significant modification. The defence would not apply if the court or jury was satisfied beyond reasonable doubt that the offence was not attributable to the severe mental illness or severe mental handicap. The modification was explained by reference to, essentially, the same arguments we have set out above.

48 Cmnd 6244 (1975).

49 Michael S Moore *Law and Psychiatry: Rethinking the Relationship* (Cambridge: Cambridge University Press, 1984) at 223.

50 See also R D MacKay “The Changing Nature of Mental Condition Defences in English Criminal Law: of ECHR and more” (Scottish Law Commission Seminar on the Reform of the Law of Insanity and Diminished Responsibility in Criminal Proceedings, 25–26 April 2002).

51 Law Commission *A Criminal Code for England and Wales*, above n 41.

- 5.20 The Law Commission for England and Wales' proposed modification is a partial response to our concerns. However, rebutting causation beyond reasonable doubt would be difficult to do, and therefore this kind of approach would still be expected in practice to substantially broaden the scope of the defence. We think that even with this kind of proviso, it would fundamentally shift the defence on its axis, something we doubt would be supported. Furthermore, it imports all of the issues discussed in chapter 4, that would arise from attempts to define the key terms. We do not recommend this approach.

General causation test

- 5.21 Another possible approach is a requirement for the unlawful act or omission to have been caused by the mental state, but in a much more general sense than section 23 presently requires. For example, in *Durham v US* American courts experimented for a time with the following case law test:⁵²

an accused is not criminally responsible if his unlawful act was the product of a mental disease or defect.

- 5.22 The *Durham* approach was founded on a test that had been developed in New Hampshire a century earlier.⁵³ The advantage is that it does not try to constrain the scope of insanity by arbitrary rules about how the mental disease or defect must manifest itself before it can meet the legal test. It also allows experts to testify in their own terms, rather than translating psychiatric concepts into the legal language used by a defence. It may, therefore, seem to have some superficial attraction, as a way of addressing the dissonance between psychiatric concepts and the insanity defence (which has collateral problems, for human rights compliance):⁵⁴

Durham was decided explicitly to facilitate psychiatrists in placing their knowledge before the court, which they felt they could not do under the *M'Naghten* test. The influential Group for the Advancement of Psychiatry had earlier written a preliminary version of its report on criminal insanity, cited and relied upon in the *Durham* opinion. This report complained about "a barrier of communication which leaves the psychiatrist talking about 'mental illness' and the lawyer talking about 'right and wrong'". The test proposed by the committee, and in essence adopted in *Durham*, allowed psychiatrists to testify directly to the presence or absence of mental disease because the test was framed in terms of mental disease itself.

- 5.23 However, Moore describes how problems had arisen with this logic, in New Hampshire almost a century earlier. Psychiatrists recognised that the concept of mental illness they used in classifying their patients for treatment purposes was too broad to have been intended to govern the scope of the insanity test for legal purposes. Therefore, they had to take upon themselves what should have been a legal and policy task: to give a separate, legal definition of mental illness as a legally excusing condition.

52 214 F 2d 847 (1954). The proviso to the Law Commission for England and Wales' revised Butler proposal, discussed above at paras 5.19–5.20, is also an example of this, with a reverse onus to the criminal standard: it would have put the onus on the prosecution to establish beyond reasonable doubt that the offence was not attributable to mental illness or handicap.

53 *State of New Hampshire v Pike* 49 NH 399 (1869).

54 Moore, above n 49 at 227–230.

- 5.24 The corollary of this, and a further disadvantage, is that it allowed psychiatrists to unilaterally alter the scope of the defence:⁵⁵

Shortly after the *Durham* decision, the staff at St Elizabeth's Hospital, which was composed of those psychiatrists most often called to testify in District of Columbia criminal cases, made a policy decision that sociopathic or psychopathic personality disturbances would not be regarded as mental illnesses within the meaning of the *Durham* rule. Psychiatrists from St Elizabeth's Hospital thereafter so testified in District of Columbia cases. Three years later, however, at a weekend meeting, the staff changed the policy, and decided that henceforth, psychopathic or sociopathic personality disturbances would be considered mental diseases for legal purposes. The Court of Appeals for the District of Columbia deferred to this psychiatric judgment, granting a new trial in one case involving a sociopathic individual because, having been tried before the change in classification by the psychiatrists, he was deprived of "new medical evidence ... on an issue vital to his defense" (namely, whether he was mentally ill). As Warren Burger, then a circuit judge who participated in that decision, later noted, "We tacitly conceded to St Elizabeth's Hospital the power to alter drastically the scope of a rule of law by a weekend change of nomenclature". ...

- 5.25 Eight years after *Durham* had been decided, the court recognised the issues, and attempted a legal definition of the "mental disease or defect" referred to in the *Durham* rule, defining it as a defect that "substantially affects mental or emotional processes" and "substantially impairs behaviour control". In 1972, the Court of Appeals for the District of Columbia abandoned the *Durham* rule entirely and adopted the American Law Institute's definition of legal insanity.⁵⁶
- 5.26 Section 23 is arguably somewhat arbitrary, and its language has become archaic. The flexibility of the *Durham* approach would respond to both of those imperatives. However, in principle, for the reasons demonstrated in New Hampshire, we do not consider it proper or desirable to give psychiatrists quite so much discretion, over what is in the end a question of law. We do not recommend this approach.

Open-ended community standards test

- 5.27 The third option, rather than throwing the defence open to psychiatrists, is to confer that discretion on the jury. The argument in favour of such an approach is that it builds on findings discussed later, in chapter 6, about how, in practice, jurors approach their task. Evidence suggests that whatever the wording of a statutory insanity defence, jurors are inclined to approach it from a non-technical moral standpoint, in deciding who should be criminally responsible. It would, arguably, be a more honest expression of the position, and the proper approach, to acknowledge that society, in the form of the jury, simply assesses case by case whether the defendant in question should be held criminally accountable for his or her actions.

55 Moore, above n 49 at 227–230.

56 Moore, above n 49 at 227–230.

- 5.28 There are several examples where such an approach has been recommended or attempted, including the Royal Court of Jersey case of *Attorney-General v Prior*:⁵⁷

at the time of the commission of the offence [the accused's] unsoundness of mind affected his criminal behaviour to such a substantial degree that the jury consider that he ought not to be found criminally responsible.

- 5.29 However, it is not an approach that we favour. We think that it would be a recipe for inconsistency, thus not serving the interests of justice, and would be an abdication of the legislative responsibility to at least try to define with sufficient precision the boundaries of the criminal law.

Different cognitive tests

- 5.30 Broadly speaking, almost all statutory insanity defences in use in like-minded jurisdictions feature any combination of three limbs: one about knowledge or understanding of the nature and quality of the conduct; another about knowledge of the (moral) wrongfulness of the conduct; and (sometimes) a third about ability to control conduct. The volition aspect does not presently feature in the New Zealand defence, and is discussed further below. The other two limbs are based on the *M'Naghten* rules.

- 5.31 The most common variant on the current New Zealand version of the *M'Naghten* rules relates to the concept of 'incapacity'.

- 5.32 For example, the Victoria Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (and other Australian legislation, such as the Commonwealth Criminal Code Act 1995) offers an insanity defence if, at the time of engaging in conduct constituting the offence, the person **could not reason with a moderate degree of sense and composure** about whether the conduct, as perceived by reasonable people, was wrong.

- 5.33 Although the drafting is unlike that in New Zealand ("incapable ... of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong"), it is doubtful whether it would make a material difference in practice. In *R v Porter*, the High Court of Australia stated that a person could be said to lack knowledge whether his or her act was wrong:⁵⁸

if through the disease or defect or disorder of the mind he could not think rationally of the reasons which to ordinary people make that act right or wrong. If through the disordered condition of the mind he could not reason about the matter with a moderate degree of sense and composure it may be said *that he could not know* that what he was doing was wrong.

57 *Attorney-General v Prior* above n 14 at para 30, adopting a definition suggested by Professor R D Mackay. Also referred to in the judgment (at para 10) is a similar recommendation from the 1953 Royal Commission on Capital Punishment (UK) (Cmd 8932, para 333): the jury should be left to determine "whether at the time of the act the accused was suffering from disease of the mind (or mental deficiency) to such a degree that he ought not to be held responsible". See further Appelbaum, above n 3: the Mental Health Law Project (US), an advocacy group that had been at the forefront of the movement for patients' rights in the 1970s, proposed that the criteria for establishing legal insanity should be left to the collective conscience of the jury, by providing that "A defendant is not responsible if at the time of his unlawful conduct his mental or emotional processes or behaviour controls were impaired to such an extent that he cannot justly be held responsible for his act".

58 (1936) 55 CLR 182 (HCA).

- 5.34 This seems akin to our own incapacity test. It offers no real advance on the present position.
- 5.35 Another drafting formulation is the concept of ‘appreciation’, which appears in a number of Australian statutes, the Criminal Code of Canada and the Scottish Law Commission’s proposed defence: “the person was at the time of the conduct unable by reason of mental disorder to **appreciate the nature or wrongfulness of the conduct**”. Similarly, section 4.01 of the American Law Institute Model Penal Code provides that:
- A person is not responsible for criminal conduct if at the time of such conduct as the result of mental disease or defect he lacks **substantial capacity either to appreciate the criminality of his conduct** or to conform his conduct to the requirements of law.
- 5.36 Appreciation has been said to convey ability to reason in a rational way, a broader concept than simple knowledge or capacity for knowledge. Appelbaum sums up the effect of the ALI Model Penal Code:⁵⁹
- One difference between the ALI standard and traditional tests is that, under the ALI standard, defendants must only manifest a lack of “substantial capacity” with regard to their relevant functions, rather than the complete absence of capacity implied in earlier formulations. Moreover, the phrase “appreciate the criminality of his conduct” was construed to permit inquiry into a broader range of mental functions, including perceptual distortion, errors in reasoning, and affective impairments, than were comprehended under the older focus on “knowing” right from wrong.
- 5.37 However, on its face, drafting a reference to appreciation would do nothing to clarify the present New Zealand language of incapacity. Both require some non-statutory unpacking, to understand what they might mean, and if the concept is indeed as broad as “errors in reasoning” and “affective impairments”, it is not at all clear how the defence would then be applied in practice. All of us some of the time, and some of us most of the time, are guilty of reasoning errors and mood swings. It must refer to a more fundamental form of irrationality: thought patterns which are alien to normal people. But the fact is that illogical and irrational thought patterns, and the mental states that accompany them, are on a continuum. ‘Appreciation’ does no better job than the present defence of clarifying where on the continuum the line between sanity and insanity ought to be drawn.
- 5.38 Overall, therefore, we do not think that either of these approaches would offer much advance on the status quo.

⁵⁹ Appelbaum, above n 3, at 168, referring to the Model Penal Code (1955), s 4.01.

A volitional test

- 5.39 The present defence is confined to the cognitive elements of decision making; it does not address volition.
- 5.40 A number of overseas jurisdictions, particularly in the United States and Australia, have now added a volitional limb to the defence:
- South Australia makes the defence available where defendants are “**unable to control their conduct**”; the Commonwealth Criminal Code is similar.
 - The Western Australia Criminal Code says: “such a state of mental impairment as to deprive him of ... **capacity to control his actions**”.
 - This is similar to New South Wales’ Crimes Act 1900: “the person’s capacity to ... **control himself or herself**, was substantially impaired”.
 - Tasmania Criminal Code Act 1924 also has a volitional element, differently worded: “a person is not criminally responsible for an act done or an omission ... made under an impulse which, by reason of mental disease, he was **in substance deprived of any power to resist**”.
 - The American Law Institute (ALI) provides: “A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity to ... **conform his conduct to the requirements of the law.**”
- 5.41 The “irresistible impulse” or volitional prong has been one of the most criticised aspects of the defence in America. It had been a popular addition to the *M’Naghten* rules in American states, but after the notorious case in which John Hinckley attempted assassination of President Reagan, and was acquitted on grounds of insanity, there was pressure, state-wide, to review and narrow the scope of their defences. In many states, the volitional limb was a casualty of that revision process.
- 5.42 McKay suggests that rejection of the volitional test in the US was essentially a policy decision, based primarily on a perceived need to narrow the scope of the insanity defence, rather than on the alleged difficulties of robust psychiatric assessment. He also notes research to the effect that the cognitive prong is not scientifically superior, and that psychiatrists are no less confident making volitional than cognitive assessments. Others, however, prefer the American Psychiatric Association’s comment that “the line between an irresistible impulse and an impulse not resisted is probably no sharper than that between twilight and dusk”.⁶⁰
- 5.43 We encountered some mixed views as to whether a volitional test ought to be included in the New Zealand defence but, on balance, it was opposed. We do not consider the arguments for introducing it sufficiently strong to outweigh reservations about whether it can be robustly applied in practice. We do not recommend it.

60 Appelbaum, above n 3 at 176. See also Mackay, above n 26 at 114–117 for a summary of the objections.

Chapter 6

Section 23: conclusion

SUMMARY

As earlier discussed in chapter 2, although problems with the insanity defence are not insignificant, having weighed them in the light of available reform options, we doubt that they are of sufficient magnitude to warrant embarking on the uncertain exercise of law reform. This chapter explains why. It places some weight on the American experience, which suggests that, however the insanity defence might be reformed, outcomes would remain largely unaltered, perhaps because regardless of the statutory language, jurors are inclined to approach it as a matter of moral judgement.

INSANITY: PROBLEMATIC, BUT BROADLY FUNCTIONAL

- 6.1 In New Zealand, the insanity defence is run between 30 and 40 times each year, and is successful about 10 times.⁶¹ These are tiny proportions of total criminal cases. Persons acquitted on account of insanity are likely to be detained for some years in a mental health facility, for periods that have some correlation with the time that they would have served if found guilty of the offence.⁶² In other words, the ‘acquittal’ has very serious consequences.
- 6.2 The importance of first ascertaining that there is a problem, before attempting to fix it, has been shown by the American experience. As discussed in earlier chapters, Appelbaum has described how, after the acquittal of John Hinckley (who had attempted assassination of President Reagan), there was a public backlash against, and fundamental misconceptions about, the operation of the insanity defence in America. There was a widely held notion that defendants were persuading lawyers and judges and psychiatrists and jurors to ‘let them off’ on insanity. We are not aware of any equivalent perceptions in New Zealand.

61 Tapsell, above n 12.

62 Skipworth et al “Insanity Acquittee Outcomes in New Zealand” (2006) 40 Australian and New Zealand Journal of Psychiatry 1003–1009.

- 6.3 Appelbaum reminds us that in reality, as the New Zealand figures above suggest, only a tiny proportion of defendants attempt to plead the insanity defence, fewer are successful with it, and there is no evidence that the use of the defence lacks integrity (in the sense of being based on deceit):⁶³

The data ... are consistent with a system that is generally doing what it is supposed to be doing: identifying a small proportion of defendants undeserving of punishment because their behaviour was affected by serious mental impairment. Reforms aimed merely at improving the current system would seem to have little scope within which to achieve their goals.

- 6.4 These conclusions are also applicable to New Zealand. There is no evidence that defendants are raising insanity as a defence in inappropriate circumstances. Nor is there any evidence that they are being denied the defence when it ought to be available to them.
- 6.5 Thus the overwhelming response from those we consulted about the defence was that, broadly speaking, it is workable, in spite of its flaws, so that “justice is done in individual cases, regardless of how inadequate the linguistic form of the rules may appear to be”.⁶⁴ We have received consistent feedback that in practice everyone can accommodate the limitations of the defence, and on the whole would prefer to do so, in the light of any immediately obvious and viable alternatives.

RISKS OF
CHANGE,
AND LACK OF
CONSENSUS
ABOUT HOW
TO CHANGE

- 6.6 We have focused in this report quite heavily on the United States’ experience. It offers a useful case study of many of the possible reform options, because so many of them were attempted as part of the wave of reform in the years following the Hinckley trial, including abolition of the insanity defence, narrowing of the legal standards for insanity, a shift of the burden of proof to the defendant, restrictions on expert testimony, changes in the post-trial disposition of insanity acquittees, and institution of an entirely new verdict of “guilty but mentally ill”.⁶⁵
- 6.7 The overall impression we have formed from our review of these reforms, and our own analysis of the issues, is that it is very doubtful that any reform options offer much of an advance on the present position. Indeed, some have been outright failures in achieving their objectives. Other authors agree:⁶⁶

The *M’Naghten* rules, unchanged in England since 1843, have so far weathered constant criticism. Despite the fact they have been under sustained attack ever since their inception, in both English and American jurisprudence, they still hold sway. In America, this is so notwithstanding much experimentation with alternatives ... Over a longish history of law reform discussion and no action in England, most English criminal lawyers have accepted that there was a desperate need for flexibility of disposal after a successful insanity plea ... However, at this point, consensus ends. Inevitably the proper scope of any new insanity defence has been much debated ...

63 Appelbaum, above n 3 at 189–190. See also Slobogin, above n 72, and Michael L Perlin *The Hidden Prejudice: Mental Disability on Trial* (American Psychological Association, Washington DC, 2000) at ch 10.

64 W J Brookbanks “Insanity Defence Reform in Australia and New Zealand” (Scottish Law Commission Seminar on the Reform of the Law of Insanity and Diminished Responsibility in Criminal Proceedings, 25–26 April 2002).

65 Appelbaum, above n 3 at 173.

66 Mackay, above n 26 at 131–132.

6.8 We think that, on the whole, this raises real questions about whether there is the necessary groundswell of support for reform, and whether we can promise a better product, with sufficient certainty that it outweighs the risks of change. On the whole, we, and those we consulted, concluded that it would be better to live with the familiar problems of section 23, than to gamble on a new version of the defence with different (but perhaps no fewer) problems.

A DEGREE OF FUTILITY

6.9 It is also arguable that there may be some futility in attempting to reform the defence, because it is fundamentally a moral question, that juries approach intuitively, regardless of the precise wording of the statutory defence. Looking to the United States again, Appelbaum concludes that “all the fuss over insanity defense reform” had very little effect on outcomes, perhaps because:⁶⁷

Perceptions of which cases should be exempted from punishment are relatively resistant to alteration by rules of law, suggesting that they are embedded in individual moral codes. Many would-be reformers of the insanity defense – especially those who would abolish it altogether – have missed this point. The insanity defense is less an imposition on commonly held notions of morality than an expression of them.

6.10 Fellow author Michael Moore agrees:⁶⁸

The only question appropriate to juries is thus one appealing to their moral paradigm of mental illness: Is the accused so irrational as to be nonresponsible? ... One rather suspects that juries have long applied this criterion, irrespective of the wording of the insanity test. As other observers have also noted: “However much you charge a jury as to the M’Naghten Rules or any other test, the question they would put to themselves when they retire is – ‘Is this man mad or not?’.”

6.11 Overall, therefore, it is our opinion that there should not be any change recommended to the insanity defence in section 23 of the Crimes Act 1961.

RECOMMENDATION

R1 We recommend no change to the insanity defence in section 23 of the Crimes Act 1961.

⁶⁷ Appelbaum, above n 3 at 191–194.

⁶⁸ Moore, above n 49 at 245. See also Brookbanks, above n 64: “Lord Justice General Cooper made the observation in submissions to the Royal Commission on Capital Punishment, that however much the jury were charged as to the M’Naghten Rules or any other test, the question they would put to themselves when they retired was ‘Is the man mad or is he not?’.” See further the discussion of this approach as one possible reform option, in chapter 5.

Chapter 7

Procedural issues

SUMMARY

We considered three procedural issues, none of which are provided for in section 23 of the Crimes Act itself, but which have a bearing on the operation of the insanity defence: the burden and standard of proof; the nature of the verdict; and whether the Crown should be permitted to put the insanity defence in issue, in cases where there is evidence of mental impairment, but the defence has not done so.

While concerns have been expressed from time to time about the first two of these issues, on further reflection, we concluded that neither of them present evidence of a sufficiently large problem, or sufficiently strong reform arguments, to warrant embarking on this exercise.

However, we recommend a new statutory provision for the Crown, by leave of the judge, to adduce evidence of insanity in cases where the defence has put his or her mental capacity for criminal intent in issue without raising the insanity defence. This may in turn help to support the exercise of the existing judicial power under section 20(4) of the Criminal Procedure (Mentally Impaired Persons) Act 2003.

BURDEN AND STANDARD OF PROOF

- 7.1 There has been some criticism of the fact that the burden is on the accused to prove insanity on the balance of probabilities under section 23.
- 7.2 Insanity is the only generally applicable criminal defence where the burden of proof is reversed. For all other defences, the accused carries only an evidential burden; the legal burden is on the prosecution throughout to establish the elements of the offence, and disprove any defence, beyond reasonable doubt. There is, it is argued, no reason to treat insanity differently from any other defence upon which the accused might rely.⁶⁹

⁶⁹ See also *Hansen v R* [2005] NZSC 74, in which the Supreme Court considered the compatibility of a reverse onus provision (in that case, section 6(6) of the Misuse of Drugs Act 1975, under which there is a legal onus on the accused on the balance of probabilities to displace the presumption of drug possession for supply) with the New Zealand Bill of Rights Act 1990, concluding that it breached the New Zealand Bill of Rights Act 1990.

- 7.3 However, insanity is not like other defences, because it does not result in an outright acquittal. A successful claim will generally expose the defendant to an order for indefinite detention as a special patient, while an unsuccessful claim will generally result in conviction and imprisonment. The dividing line between those two outcomes should be determined by reference to the disposition that is most probably appropriate to the circumstances of the case. That would not occur if the prosecution were to negate the defence beyond reasonable doubt; a number of defendants would end up being detained in a psychiatric facility when their condition probably did not warrant it.
- 7.4 This points to the need to adopt a “balance of probabilities” standard of proof. If that is accepted, it inevitably requires a reversal of the burden as well. While it would be possible to require the prosecution to negate the defence on the balance of probabilities, that would not make much sense in this context. Evidence at least as to the first limb of the defence (disease of the mind) is generally available primarily to the defence. Thus, if the burden were to rest on the prosecution, even on the balance of probabilities, the defence might need to do little more than to discharge his or her evidential burden and put the matter in issue; that could create sufficient uncertainty to lead to an insanity verdict in the absence of persuasive evidence to the contrary.
- 7.5 Some have also argued that the imposition on the defence of the burden to prove insanity may have, or be perceived to have, the practical unintended side-effect of relieving the prosecution of the burden of proving beyond a reasonable doubt a vital element of the offence – the mental element. If the evidence in support of a claim that the act was not deliberate or intentional suggests mental impairment, the effect of the insanity defence reverse onus is that the accused must prove this, if he or she wishes to rely upon it, and this becomes the focus of the trial.
- 7.6 But at least in theory, according to the court in *R v Cottle*, the judge or jury should only consider insanity “if it were already convinced that the Crown has proved to its complete satisfaction that the act has been committed by the prisoner and – if he was sane – in circumstances which compel the conclusion that the act was deliberate and intentional”.⁷⁰ If the Crown is unable to prove the required intent beyond reasonable doubt, the defendant is entitled to an outright acquittal. Furthermore, the fact of insanity having been put in issue may well, in some cases, help to negate the Crown case as to intent, even where the defendant is unable to prove insanity on the balance of probabilities.

70 [1958] NZLR 999.

- 7.7 Some suggestion was also made that, with a much broader range of dispositions now available under the legislation, the risk of indeterminate detention following an insanity acquittal is considerably reduced; and there is, therefore, a correspondingly less powerful case for requiring a defendant to prove the conditions for legal insanity. However, we find this unconvincing: a broader range of dispositions is indeed available, but the jeopardy no less large. A person acquitted on account of insanity will be indefinitely detained in most cases.
- 7.8 Furthermore, even if this argument was correct, it fails to take into account the wider community interest. In other words, in the light of the more flexible and perhaps more lenient disposition options, the community has even more of a right than previously to expect that a defendant wishing to ‘escape’ normal criminal justice should bear the burden of proof of establishing good grounds for this.
- 7.9 Ultimately, though, the largest objection to a proposal to alter the burden of proof is a pragmatic one, about the difficulty of proving the sanity of any person beyond reasonable doubt.
- 7.10 Appelbaum recounts how, in America, at the time John Hinckley was put on trial, in about half of the states the prosecution bore the burden of establishing mental capacity beyond reasonable doubt, the defendant having discharged an evidential burden; in the remainder of states, as in New Zealand currently, the burden was on the defendant on the balance of probabilities. In the Hinckley trial, the prosecution was unable to discharge its burden, and Hinckley was found not guilty on account of insanity. This plunged the United States collectively into a re-examination of the defence, and caused President Reagan to observe:⁷¹

If you start thinking about even a lot of your friends, you have to say, “Gee, if I had to prove they were sane, I would have a hard job”.

- 7.11 Most states in America with insanity defences now reflect the New Zealand position, placing the burden of proof on the defendant, usually on the balance of probabilities. While it may well be that some, perhaps a great deal, of the backlash around the Hinckley trial was not well-founded, there would nonetheless seem to be a degree of consensus in the United States, based on experience, that the present New Zealand approach is the preferable option. We are reluctant to meddle with this, in the absence of any stronger case for reform than seems to us to be available at the present time.

**THE VERDICT:
GUILTY BUT
MENTALLY ILL?**

- 7.12 Concerns have been expressed from time to time about the nature of the insanity verdict: ‘acquittal on account of insanity’. It is said that victims need to have their loss validated and somebody held accountable, especially where the offender is not manifestly insane; and furthermore, that jurors may find it difficult to even partly ‘acquit’ a person manifestly responsible for doing or causing the criminal act, even though they lacked the necessary state of mind, or had a criminal state of mind, but did not know that what they were doing was morally wrong.

⁷¹ Appelbaum, above n 3 at 168–172; Mackay, above n 26 at 117–118.

- 7.13 There seems to be some slight degree of confusion, about what exactly what would happen, if provision was introduced for an alternative ‘guilty but mentally ill’ verdict. There are in fact two options: ‘guilty but mentally ill’ as a substitute for ‘acquittal on account of insanity’; or ‘guilty but mentally ill’ in addition to the insanity verdict.

Guilty but mentally ill as an additional verdict

- 7.14 When used overseas, primarily in the United States, the ‘guilty but mentally ill’ verdict is an additional option to the three existing verdicts of acquittal, conviction, or acquittal on account of insanity. It is not a substitute for an insanity acquittal, but a mitigated form of conviction, that applies when the jury is satisfied of mental illness, but not insanity.
- 7.15 This approach had a couple of key rationales when used in the States. It conferred more robust detention powers where it was feared, or actually transpired, that insanity acquittals were producing unduly prompt release when there was still a high risk of recidivism, by ensuring that the person could at least be ‘sentenced’ to a specified period and detained for that period. It was also supposed to ensure that the criminally responsible offender, who has some degree of mental disorder and therefore requires treatment, could get it.
- 7.16 As an additional verdict of that kind, it is unnecessary in New Zealand. The existing legislative scheme already addresses the two rationales identified. In most insanity cases, confinement is indefinite, and usually lengthy, and for other mentally disordered offenders, the mix of imprisonment and mental health treatment sought is provided for by the Criminal Procedure (Mentally Impaired Persons) Act 2003.

Guilty but mentally ill as a substitute verdict

- 7.17 The second option is a substitute verdict of ‘guilty but mentally ill’. This is more likely to address the problems perceived above, about the way juries approach the insanity defence, and we think it is more likely to be what the proponents of this verdict have in mind when they talk about it, albeit calling it by the name of another verdict that operates quite differently in the States.
- 7.18 However, there are still a number of misapprehensions.
- 7.19 First of all, substituting a verdict of ‘acquittal on account of insanity’ with ‘guilty but mentally ill’ would fail to discriminate in a different way: it would deem those currently acquitted on account of insanity who lack the requisite state of mind guilty, instead of deeming those who possess the requisite state of mind (but lack knowledge of moral wrongfulness) not guilty. It would be no more precise, in that sense, just a different approach.

- 7.20 As to whether juries do, in fact, struggle to acquit the insane, the American experience has something relevant to offer here also. The first state to establish such a verdict was Michigan, in 1975. As discussed above, the verdict was not a substitute for acquittal on the grounds of insanity, but an additional option – a halfway house, as it were, between conviction and acquittal, for defendants who were guilty, mentally ill, but not legally insane. But it therefore shows what happens, when juries are permitted to choose whether to find mentally ill persons guilty, or acquit them.
- 7.21 Empirical research showed that what the verdict solely achieved was a displacement in disposition from the ‘guilty’ to the ‘guilty but mentally ill’ population. It made no difference to insanity acquittals. Juries continued to acquit the insane, rather than utilising the new verdict. This suggests either that, in fact, juries were relatively comfortable with the acquittal concept; or that they correctly recognised that the two verdicts catered for quite different sets of circumstances, and one could not be substituted for the other, whatever might be the difficulties with the insanity verdict.
- 7.22 Furthermore, although the verdict purported to be for jury trials, in application, over 80 percent of the verdicts were a product of plea bargains or bench trials.⁷²
- 7.23 We do not recommend this option.

PROSECUTING INSANITY

- 7.24 There are limits on the ability of the Crown to put the insanity defence in issue. In *R v Green*,⁷³ the Court held that the Crown is not permitted to adduce evidence of insanity, with or without judicial leave, unless the defendant has raised insanity as a defence.
- 7.25 Under section 20(4) of the Criminal Procedure (Mentally Impaired Persons) Act 2003, the judge may do so:
- in a case where it appears from the evidence that the defendant may have been insane at the time of the commission of the offence, the Judge may ask the jury to find whether the defendant was insane within the meaning of section 23 of the Crimes Act 1961, even though the defendant has not given evidence as to his or her insanity or put the question of his or her sanity in issue.
- 7.26 However, section 20(4) is likely to only occasionally apply, because without evidence from the accused as to his or her insanity, and in the absence of any such evidence from the Crown, it is unlikely that the judge will have a sufficient evidential basis to invite such a verdict.
- 7.27 The onus is therefore very much on defence choices and the presentation of their case. Evidence in possession of the Crown can be placed at the disposal of the defence, which may choose to use it or not, as they see fit.

72 Appelbaum, above n 3 at 179–180; Mackay, above n 26 at 118–121. See also Christopher Slobogin “The Guilty But Mentally Ill Verdict: An Idea Whose Time Should Not Have Come” (1985) 53 *Geo Wash L Rev* 494. Nor did it facilitate the provision of mental health treatment to mentally ill prisoners, or mitigate their punishment, the rationales discussed above at para 7.15: they were no more likely to receive treatment than prisoners with a simple guilty verdict, and if anything, were punished more harshly.

73 (1993) 9 CRNZ 523 (CA).

- 7.28 Such circumstances will arise only very rarely because, in most cases, the Crown either would not have evidence of insanity, or, if it did have access to such evidence, it may be privileged. However, in cases such as *Green* where the evidence was, apparently, available, this may be regarded as making something of a mockery of the criminal justice system. Even where there was substantial evidence about, and convergence of expert opinion on, the defendant's insanity, it was said to be entirely a matter for the defence to decide what to do with it. It creates a situation that is arguably not consistent with prosecutorial functions: to present the case to the jury in its true light; and to see that justice is done, by not convicting a person who was insane at the time of the alleged offence.
- 7.29 It also raises a policy question as to whether this is consistent with the public protection rationale of the insanity defence. That is because, if a defendant argues a lack of mens rea on the basis of mental impairment (but not insanity), he or she would be entitled to an unqualified acquittal and immediate release, rather than ongoing detention (the likely outcome of a successful insanity defence).
- 7.30 Civil commitment options, including provision for 'restricted patient' designation under the Mental Health (Compulsory Assessment and Treatment) Act 1992, are one possible response to this risk.
- 7.31 However, the question nonetheless arises, whether the Crown should have the power to put insanity in issue, and if so, in what circumstances.
- 7.32 In *Green*, the Court of Appeal reviewed the history of consideration and policy argument around this issue, in like-minded jurisdictions, by appellate courts and law reformers, including the Supreme Court of Canada's decision in *R v Swain*.⁷⁴ The weight of opinion was heavily against giving such a common law power to the Crown.
- 7.33 There were a number of reasons, many of which boiled down to concern about giving the Crown an inappropriate strategic advantage, that overall would be contrary to the interests of justice, by prejudicing the legitimate interests of the defence: for example, undermining the ability of the defence to properly put its case, by indirectly attacking the defendant's credibility, through evidence of mental incapacity; or achieving indefinite detention, under the auspices of an acquittal. The Canadian Supreme Court in *Swain*, in particular, was concerned about the importance of "individual autonomy within an adversarial system" – in other words, not undermining a defendant's right to determine his or her own destiny, that is given expression by deciding which defences will be invoked, and more generally how to run his or criminal case.
- 7.34 This is arguably especially true of the insanity defence, which is deeply stigmatising, and where defendants ought to be entitled to choose the benefit of a finite sentence, rather than indefinite detention. The Supreme Court held that such a power was incompatible with fundamental rights in the Canadian Charter.

74 (1991) 63 CCC (3d) 481 (SCC).

- 7.35 Not all of the objections reviewed in *Green* hold a lot of weight in our view, and some of them might be countered by other aspects of a package of reforms. Nonetheless, only Victoria, under section 21 of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997, has adopted an approach which gives the prosecution the same discretion as the defence to put insanity in issue, on its own initiative – the discretion ruled unconstitutional in *Swain*, and denied in New Zealand in *Green*.⁷⁵
- 7.36 However, *Swain* upheld a more limited power for the Crown, addressing the situation where a defendant puts his or her mental capacity for criminal intent into question, short of raising the defence of insanity:
- However, this is not to say that if an accused chooses to raise evidence which tends to put his or her mental capacity for criminal intent into question but falls short of raising the defence of insanity ... the Crown will be unable to raise its own evidence of insanity. In circumstances where the accused's own evidence tends to put his or her mental capacity for criminal intent into question, the Crown will be entitled to put forward its own evidence of insanity and the trial judge will be entitled to charge the jury [with considering the Canadian equivalent of the insanity defence] ... The Crown's ability to raise evidence of insanity in these circumstances is necessary because, otherwise, the jury could well be left with an incomplete picture of the accused's mental capacity. If an accused were able to raise some evidence of mental incapacity (short of an insanity defence) and, at the same time, able to preclude the Crown from raising any evidence of insanity that it may have in its possession, the possibility would arise that the accused could be acquitted by a jury which was deprived of the "full story" surrounding the accused's mental incapacity. Such a result is clearly undesirable.
- 7.37 There would seem to be at least a reasonable possibility that if such a defence strategy was pursued, there would be some evidential basis on which the judge might apply section 20(4).

75 The UK Law Commission also recommended it, without a great deal (or any) discussion: *A Criminal Code for England and Wales*, above n 41. In Canada, in *R v Swain* above n 74, the Supreme Court developed a whole new common law rule, that would allow the issue to be raised unilaterally by the Crown at the conclusion of the trial: "after a verdict of guilty had been reached, but prior to a conviction being entered. If the trier of fact then subsequently found that the accused was insane at the time of the offence, the verdict of not guilty by reason of insanity would be entered ... This new common law rule would give an accused the option of waiting until the Crown has discharged its full burden of proof to raise the issue of insanity". In other words, this offers insanity as an alternative to conviction, in the interests of justice and for the benefit of the defendant; the rationale is quite different, to the problem of public protection, which only arises in the context of a potential acquittal, and was dealt with by the Court by the separate, more limited power we recommend in para 7.39 below. According to the Supreme Court, "such a rule [ie, its proposed new two-stage trial rule] would safeguard an accused's right to control his or her defence". However, it would achieve this only temporarily, since at the second trial stage, it would be open to the Crown to raise the insanity defence against the accused's wishes. The Court envisaged that an accused might also, if he had chosen not to do so earlier, raise the issue of insanity after the trier of fact had concluded that he or she was guilty of the offence charged, but before a verdict of guilty was entered – thus conferring an effective right of second trial, the strategy of the first having failed. We do not find this a convincing option.

- 7.38 However, that would not facilitate the placing of the full picture before the jury, by way of evidence also adduced by the Crown. In *Green*, it was held that there was no permissible basis on which the Crown might adduce evidence, with or without leave. Arguably, since *Green* predated section 20(4), there might be some grounds for reconsidering it, with a view to making that section more workable. However, if that approach was supported, it would be preferable for it to be dealt with and put beyond doubt, as a legislative matter.
- 7.39 We therefore recommend a new statutory provision in the Criminal Procedure (Mentally Impaired Persons) Act 2003, that would enable the Crown, by leave of the judge, to adduce evidence of insanity, in cases where the defence has put his or her mental capacity for criminal intent in issue without raising the insanity defence. Such evidence would facilitate the exercise of the existing judicial power under section 20(4) of the Criminal Procedure (Mentally Impaired Persons) Act 2003. It would partially overrule the Court of Appeal's decision in *R v Green*.

RECOMMENDATION

- R2 We recommend a new statutory provision for the Crown, by leave of the judge, to adduce evidence of insanity, in cases where the defence has put his or her mental capacity for criminal intent in issue without raising the insanity defence.



Part 2

REMOVING
MINISTERIAL
RESPONSIBILITY
FOR MENTAL
HEALTH AND
INTELLECTUAL
DISABILITY
DECISION-MAKING



LAW COMMISSION
TE Kaitiaki Matua o Te Ture

Chapter 8

Introduction

- 8.1 The first Part of the report reviewed the insanity defence, in section 23 of the Crimes Act 1961. We do not recommend its reform, although we do recommend an amendment to the Criminal Procedure (Mentally Impaired Persons) Act 2003 to give the prosecution a limited right to adduce evidence of insanity.
- 8.2 The consequence of a “not guilty by reason of insanity” verdict is that the person – albeit acquitted – becomes a special patient or special care recipient and in most cases will be detained indefinitely, in a psychiatric institution, subject to Ministerial decision-making.
- 8.3 It is this latter aspect of the defence (ie, its consequences, when successful), that is widely regarded as much more problematic than the defence itself. In the view of ourselves, and others, this requires significant reform. The same issue also affects two other groups: the unfit to stand trial, and restricted patients.
- 8.4 Under the Criminal Procedure (Mentally Impaired Persons) Act 2003, and related legislation (the Mental Health (Compulsory Assessment and Treatment) Act 1992, and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003), for those three groups (special patients, special care recipients, and restricted patients) the Minister of Health and, sometimes, the Attorney-General, are involved in three types of decision-making: change of status, discharge, and long leave.
- 8.5 Under section 33 (persons acquitted on account of insanity) of the Criminal Procedure (Mentally Impaired Persons) Act 2003, authority rests with the Minister of Health. Under section 31 (persons unfit to stand trial), the Attorney-General and the Minister of Health have joint responsibility. Under section 78 (restricted patients) of the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Minister of Health also has a role, in consultation with the Attorney-General, in determining whether restricted patient status is no longer required.
- 8.6 We think that there are real problems with this, that have been allowed to persist for too long. In this second Part, we therefore set out our proposed reforms.

- 8.7 We recommend removing Ministers from the process, and establishing a Special Patients' Review Tribunal, to take over the Ministerial functions. The Minister of Health would no longer be involved at all, and the Attorney-General's involvement under section 31 (persons unfit to stand trial) would be more limited.
- 8.8 We have reviewed the release arrangements for persons acquitted and detained on account of insanity in other jurisdictions. Overall, what is proposed is consistent with the trend in most of those other jurisdictions.

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Chapter 9

Brief summary of the law

SUMMARY

This chapter summarises the law relating to reclassification, discharge, and long leave for persons acquitted on account of insanity, persons unfit to stand trial, and civilly committed restricted patients.

PERSONS ACQUITTED ON ACCOUNT OF INSANITY

- 9.1 A person found not guilty by reason of insanity must be detained in a hospital as a special patient or special care recipient, if the court is satisfied that the making of such an order is necessary in the interests of the public or any affected person: section 24 of the Criminal Procedure (Mentally Impaired Persons) Act 2003.
- 9.2 In such cases, decisions about reclassification and discharge rest with the Minister of Health. Under section 33, the order under which the accused is detained continues in force until a Ministerial direction is given that he or she is to be held as a patient or care recipient (ie, a reclassification), or discharged from compulsory status:

33 Duration of order for detention as special patient or special care recipient if person acquitted on account of insanity

- (1) This section applies to a defendant who has been acquitted on account of his or her insanity and who is detained as a special patient or a special care recipient in accordance with an order under section 24 (the defendant).
- (2) The order under which the defendant is detained continues in force until—
- (a) a direction is given under this section that the defendant is to be held as a patient or as a care recipient; or
 - (b) the defendant is discharged in accordance with a direction given under this section.

- (3) If, at any time while the order continues in force, a certificate is given under the Mental Health (Compulsory Assessment and Treatment) Act 1992 or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 to the effect that the defendant's continued detention under the order is no longer necessary to safeguard the interests specified in subsection (4), the Minister of Health must—
 - (a) consider whether, in the Minister's opinion, the defendant's continued detention is no longer necessary to safeguard those interests; and
 - (b) if, in the Minister's opinion, that detention is no longer necessary to safeguard those interests, direct—
 - (i) that the defendant be held as a patient or, as the case requires, as a care recipient; or
 - (ii) that the defendant be discharged.
 - (4) The interests referred to in subsection (3) are—
 - (a) the defendant's own interests; and
 - (b) the safety of the public or the safety of a person or class of person.
 - (5) A direction under this section—
 - (a) that the defendant be held as a patient is to be regarded as a compulsory treatment order for the purposes of the Mental Health (Compulsory Assessment and Treatment) Act 1992, and the provisions of that Act apply accordingly;
 - (b) that the defendant be held as a care recipient is to be regarded as a compulsory care order for the purposes of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, and the provisions of that Act apply accordingly.
- 9.3 Under section 50(1) of the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Minister may grant a person who has been detained as a special patient on the ground of insanity leave on such conditions as he or she thinks fit. The Director of Mental Health at the Ministry of Health may grant short term leave for a period up to seven days: section 52. The provisions are the same for special care recipients: see sections 66 and 67 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

PERSONS
UNFIT TO
STAND TRIAL

- 9.4 Persons judged unfit to stand trial may also be detained under section 24 of the Criminal Procedure (Mentally Impaired Persons) Act 2003. In the meantime, criminal proceedings against them are suspended, because they lack adequate mental capacity to properly participate in those proceedings (to provide meaningful instructions to counsel, for example).
- 9.5 However, the arrangements are different from those for persons acquitted on account of insanity.
- 9.6 This may be because the circumstances are different, too. In insanity cases, there has been a completed trial and verdict, whereas for the unfit, guilt remains undetermined.

- 9.7 There are three key differences. First, under section 30(1), the maximum duration of detention as a special patient or special care recipient for persons unfit to stand trial is 10 years from the date of the making of the order, if the person was charged with an offence that was punishable by imprisonment for life; or otherwise a period equal to half the maximum term of imprisonment to which the person would have been liable if he or she had been convicted of the offence charged. There is no equivalent maximum duration for persons detained on account of insanity.
- 9.8 Secondly, as with insanity patients, decisions about discharge or reclassification of persons unfit to stand trial are Ministerial decisions. But under section 31, the Attorney-General is either involved, alongside the Minister of Health, or responsible, depending on the circumstances. When the person is no longer unfit to stand trial, the Attorney General must direct that they should either be brought before the appropriate court, or held as a patient or care recipient. When the person is still unfit to stand trial, but a clinician considers that detention under section 24 is no longer necessary, the Minister of Health, with the concurrence of the Attorney General, decides whether the person should instead be held as a patient or care recipient:

31 Change of status from special patient to patient or special care recipient to care recipient where person unfit to stand trial

- (1) This section applies to a defendant who has been found unfit to stand trial and who is detained as a special patient or as a special care recipient in accordance with an order under section 24 (the defendant).
- (2) If, before or on the expiry of the relevant maximum period specified in section 30, a certificate is given under the Mental Health (Compulsory Assessment and Treatment) Act 1992 or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 to the effect that the defendant is no longer unfit to stand trial, the Attorney-General must either—
- (a) direct that the defendant be brought before the appropriate court; or
 - (b) direct that the defendant be held as a patient or, as the case requires, as a care recipient.
- (3) If, at any time before the expiry of the relevant maximum period specified in section 30, a certificate is given under the Mental Health (Compulsory Assessment and Treatment) Act 1992 or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 to the effect that, although the defendant is still unfit to stand trial, the continued detention of the defendant under section 24 is no longer necessary, the Minister of Health, acting with the concurrence of the Attorney-General, must—
- (a) consider whether, in the Minister's opinion, the continued detention of the defendant under that section is no longer necessary; and
 - (b) direct that the defendant be held as a patient or, as the case requires, as a care recipient if, in the Minister's opinion, that detention is no longer necessary.

- (4) The Attorney-General must direct that the defendant be held as a patient or, as the case requires, as a care recipient if—
 - (a) the defendant is still detained as a special patient or as a special care recipient when the maximum period specified in section 30 expires; and
 - (b) no direction under subsection (2) or subsection (3) has been given in respect of the defendant; and
 - (c) no certificate of the kind referred to in subsection (2) has been given in respect of the defendant.
- (5) A direction under this section—
 - (a) that the defendant be held as a patient is to be regarded as a compulsory treatment order for the purposes of the Mental Health (Compulsory Assessment and Treatment) Act 1992, and the provisions of that Act apply accordingly;
 - (b) that the defendant be held as a care recipient is to be regarded as a compulsory care order for the purposes of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, and the provisions of that Act apply accordingly.
- (6) The powers and duties conferred and imposed on the Attorney-General by this section are not capable of being exercised or performed by the Solicitor-General.

9.9 Thirdly, under section 66(3) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, no leave other than short term leave is available at all for special care recipients found unfit to stand trial. No leave may be authorised under section 66 (the provision that would otherwise govern leave), if a trial or hearing has yet to take place. Similarly, for special patients, section 50(1) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 refers only to special patients acquitted on account of insanity, omitting any reference to those found unfit to stand trial.

RESTRICTED PATIENTS

- 9.10 Under sections 54 and 55 of the Mental Health (Compulsory Assessment and Treatment) Act 1992, a person for whom an inpatient order has been made, who presents “special difficulties because of the danger he or she poses to others”, may be declared a “restricted patient”. For this class of patient, too, there is some Ministerial involvement in decision-making.
- 9.11 Following periodic clinical review, where the responsible clinician considers that the person is fit to be released from compulsory status, his or her case is referred to the Director of Mental Health, at the Ministry of Health, for release or referral to the Mental Health Review Tribunal. In practice, we were advised that the Director always refers such cases to the Tribunal.
- 9.12 If, in the clinician’s opinion, the person is not fit to be released, but restricted patient status is no longer necessary, revocation of that status is a Ministerial responsibility, in consultation with the Attorney-General, under section 78(6) of the Act. The Minister can seek advice from the Mental Health Review Tribunal, by applying for a review of the patient’s condition.

78 Clinical reviews of restricted patients

- (1) The responsible clinician shall conduct a formal review of the condition of every restricted patient—
 - (a) Not later than 3 months after the date of the order declaring the patient to be a restricted patient; and
 - (b) Thereafter at intervals of not longer than 6 months.
 - (2) The provisions of subsections (2), (4), and (8) to (12) of section 76 of this Act shall apply in respect of every review under this section as if it were a review under that section.
 - (3) At the conclusion of the review, the responsible clinician shall record his or her findings in a certificate of clinical review, stating—
 - (a) That in his or her opinion the patient is fit to be released from compulsory status; or
 - (b) That in his or her opinion the patient is not fit to be released from compulsory status but it is no longer necessary that the patient should be declared to be a restricted patient; or
 - (c) That in his or her opinion the patient is not fit to be released from compulsory status and should continue to be declared to be a restricted patient.
 - (4) The responsible clinician shall send a copy of the certificate of clinical review to—
 - (a) *Repealed*.
 - (b) The Director; and
 - (c) Each of the persons specified in section 76(7)(b) of this Act.
 - (5) In any case where the responsible clinician is of the opinion that the patient is fit to be released from compulsory status, the Director shall either—
 - (a) Direct that the patient be released from that status forthwith; or
 - (b) Apply to the Review Tribunal for a review of the patient's condition.
 - (6) In any case where the responsible clinician is of the opinion that the patient is not fit to be released from compulsory status but it is no longer necessary that the patient should be declared to be a restricted patient, the following provisions shall apply:
 - (a) The responsible clinician shall send a copy of the certificate of clinical review to the Minister of Health:
 - (b) The Minister of Health shall, after consultation with the Attorney-General, either—
 - (i) Revoke the declaration that the patient shall be a restricted patient; or
 - (ii) Apply to the Review Tribunal for a review of the patient's condition.
- 9.13 The Attorney-General's involvement under section 78(6) seems unusual. It may have been modelled on the provisions for persons unfit to stand trial. However, the two contexts are quite different.

Chapter 10

The nature of the problem

SUMMARY

The chapter reviews problems with the present decision-making processes, arising from Ministerial responsibility for decision-making. It recommends that Ministerial involvement needs to be reviewed in some cases, and abolished in others.

PERSONS ACQUITTED ON ACCOUNT OF INSANITY

- 10.1 At present, as reviewed in chapter 9, the Minister has responsibility for three types of decisions affecting persons acquitted on account of insanity:
- discharge under section 33(3)(b)(ii) of the Criminal Procedure (Mentally Impaired Persons) Act 2003;
 - reclassification under section 33(3)(b)(i) of the Criminal Procedure (Mentally Impaired Persons) Act 2003; and
 - long leave under section 50(1) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 and section 66 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.
- 10.2 We have identified three problems with this:
- politicisation of discharge, reclassification, and long leave decisions;
 - duration of detention as a special patient or special care recipient; and
 - the decision making processes, which have some procedural limitations.

Politicisation of decisions

- 10.3 Regardless of the best intentions of those involved in the process, a degree of politicisation is inevitable when Ministers are involved in decision-making. There are certain times (such as election years) and certain factors (for example, particularly nasty high profile cases) that will tend to make Ministers more risk averse.

- 10.4 Fairly clearly, it would be unprincipled and inappropriate for these decisions to have, or be seen to have, any political aspect to them. With effective treatment, a mentally impaired offender can be reclassified, and eventually discharged safely into the community, far earlier than the Minister might perhaps feel able to endorse in cases where the circumstances of the crime were serious or controversial.
- 10.5 Furthermore, there is some risk that the secondary effects of politicisation may affect patients' mental condition. We were told that increased stress on the patient – from delays, media coverage, and public backlash – can exacerbate unwellness and consequent safety concerns, unfairly and counter-productively jeopardising that person's release prospects.

Duration of 'special' status

- 10.6 Clinically speaking, there are real doubts about whether patient and community safety requires quite such prolonged detention as that generally experienced by special patients and special care recipients. Skipworth et al reviewed the outcomes of 135 persons acquitted on account of insanity, who were dealt with between 1976 and 2004. The authors found that patients who committed more serious offences were detained longer than those who committed trivial offences: severity of index offence was the only predictor of inpatient duration.⁷⁶ New Zealand is not alone in this. Similar findings in New South Wales were a key consideration in that jurisdiction's recent review of its discharge arrangements.⁷⁷
- 10.7 By implication, in practice, time served by such patients has a punitive aspect. The pattern of detention observed was not thought by the authors to be justified by the patients' clinical risk.

Decision-making processes

- 10.8 The decision-making process has some procedural limitations, relating to the fact that decisions are made on the papers. By contrast with an open tribunal hearing, victims must be told what has been decided, but may feel that they have had no opportunity for meaningful input. Furthermore, the Minister of Health is not obliged to give reasons for his or her decision; if any are given, they are brief. It is an important principle of natural justice for interested persons, including victims and, of course, the patient, to know how and why decisions are made. Finally, there is no right of appeal against the Executive decision, although presumably, it would be open to judicial review.
- 10.9 We were also told of the risk of delays between responsible clinicians' reports on the status of the patient, and a Ministerial decision on how to respond. Aside from raising civil liberties issues, this could, if it occurred habitually, have a practical disadvantage for forensic resources, arising from patients' unnecessary continued detention in high security units. There were differing views about the existence and size of any such problem.

⁷⁶ Skipworth et al "Insanity acquittee outcomes in New Zealand" (2006) 40 *Australian and New Zealand Journal of Psychiatry* 1003–1009.

⁷⁷ Hon Greg James QC "Review of the New South Wales Forensic Mental Health Legislation" (August 2007).

- 10.10 Ministerial responsibility for these decisions recognises both the high degree of public concern over the risk that these patients might present to the community, and the importance of decision-making accountability to the community. However, it needs to be considered whether the level of public concern is well founded (ie, whether the degree of concern is commensurate with the degree of risk). Recidivism statistics suggest that it is not. There may well be better ways of addressing both of the identified rationales for Ministerial responsibility, than the status quo.
- 10.11 This paper does not address the length of inpatient detention per se; however, if a different decision-making mechanism resulted in less lengthy periods of inpatient care, that may not be a bad thing.
- 10.12 In our view, Ministerial responsibility for reclassifying or discharging special patients and special care recipients acquitted on the ground of insanity, and granting them long term leave, is not appropriate given all of the problems set out above.

RECOMMENDATION

- R3 Ministerial responsibility for decision-making under section 33 of the Criminal Procedure (Mentally Impaired Persons) Act 2003 (persons acquitted on account of insanity) should be removed.

ARE THE PROBLEMS THE SAME IN THE UNFITNESS TO STAND TRIAL CONTEXT?

- 10.13 As noted above, section 24 of the Criminal Procedure (Mentally Impaired Persons) Act 2003 addresses two types of patient: persons acquitted on account of insanity, and persons unfit to stand trial. Both are treated alike under that section; they may be detained as either a special patient, or special care recipient, depending on the nature of their disorder or disability.
- 10.14 There are, therefore, close connections between the two types of disposition. As in insanity cases, the Minister of Health also has some involvement in decision-making in unfitness to stand trial cases, with the Attorney-General.
- 10.15 It therefore made sense, in our view, to extend the scope of this part of our work to unfitness to stand trial cases, although our original terms of reference were focused on insanity.

Comparison of the rationales for detention

- 10.16 Persons acquitted on account of insanity are detained post-trial because, although they are not responsible for their offending, they pose an undue risk to the safety of the community or themselves. Their trial has been completed. By contrast, persons unfit to stand trial have proceedings still pending against them, that are put on hold, subject to a future reassessment of the person's mental condition.

- 10.17 However, although guilt or innocence has yet to be determined, an unfitness to stand trial finding is not available unless the court is satisfied on the balance of probabilities that the evidence against the person is sufficient to establish that he or she caused the act or omission that is the basis for the charge – in other words, that there has been a degree of involvement. And to reach an insanity verdict, the jury must be satisfied beyond reasonable doubt that the criminal act was done or omitted by the person, although it may not be possible to establish the required mental element of the offence, given the person’s mental impairment.
- 10.18 In both categories of case, therefore, the rationale for detaining the accused, and the prima facie criminal conduct that has been proved, may be regarded as quite similar. And in both types of case, the legislation also recognises by a Ministerial decision-making power the degree of public interest attached to the ‘special’ classification of the accused.
- 10.19 Because of these similarities, in the light of our view that Ministerial involvement is not appropriate for insanity patients under section 33, Ministerial involvement in decision-making for patients found unfit to stand trial under section 31 needs reconsideration also. In our view, there is no proper basis for distinguishing section 31 cases from section 33 cases, as regards the role of the Minister of Health. A non-Ministerial decision-maker is needed to deal with cases under both sections.
- 10.20 However, we think that two of the section 31 and 33 differences are justified, although we have made some recommendations for change: the prescribed maximum period for detention as a special patient or special care recipient, for persons unfit to stand trial; and the role of the Attorney-General under section 31.

Prescribed maximum period – unfitness to stand trial

- 10.21 For persons judged unfit to stand trial, there is a prescribed maximum period for detention as a special patient or special care recipient: see section 30(1) of the Criminal Procedure (Mentally Impaired Persons) Act 2003. Under section 31(4), upon expiry of the period, a special patient is reclassified as a patient or care recipient. This in turn means that criminal proceedings against the person are stayed under section 32.
- 10.22 Bearing in mind that criminal proceedings in such cases are merely suspended, prior to expiry of the maximum period, section 30(1) reflects a policy that it is inappropriate for these people to remain indefinitely in jeopardy of prosecution. The section 30(1) maximum period is a safeguard for the defendant. By contrast, insanity patients are not subject to any statutory limit.

10.23 All section 30 really achieves is something akin to the civil Limitation Act, or statutory timeframes for laying some criminal charges. However, it is open to being misconstrued as being connected with punishment. For example, the authors of *Adams on Criminal Law* have taken this view, obliquely suggesting that it is anomalous:

Detention as a special patient or secure care recipient, unlike detention as a “patient” under a compulsory treatment order or as a “care recipient” under a compulsory care order, is a criminal justice disposition. For this reason the Act uses a parole-like formula to determine the maximum periods of detention following a finding of unfit to stand trial.

In other contexts the Act differentiates between offenders deserving punishment and those requiring therapeutic detention, where no element of punishment is implied (s 34(1)(b)). ... Dispositions following adverse finding at a special hearing “are not punitive in character but are intended to facilitate both the treatment and care of the person found to have committed the relevant acts and the protection of the community”.

Nevertheless, at least for the purposes of detention under these provisions, no such distinction is made ...

10.24 Despite the risk of this perception, we think that in such cases, a prescribed maximum period is appropriate. Nor do we think that the same period should apply to all cases: variation, or proportionality, commensurate with the seriousness of offending, is the proper approach. That is not because the disposition is connected with punishment. It is, instead, about the length of time for which it is proper in principle for a person to remain in jeopardy of a prosecution – the same sort of proportionality that can already be found in existing limitation provisions (albeit with limited examples). The status quo, that bases the maximum period of detention on the maximum penalty for the offence allegedly committed, offers the least arbitrary way of doing this.

10.25 We acknowledge that there will, therefore, continue to be a risk that detention in unfit to stand trial cases is seen as a de facto punishment. However, there is less likely to be a misunderstanding about this now, than there was under the former Criminal Justice Act 1985. Under that Act, for a time, there was a direct connection between the maximum period of detention and the parole eligibility period. Since that connection has long been broken, the misunderstanding problem is not significant. In any event, it is difficult to find a better solution than the status quo.

10.26 For completeness, we note that this does not pose any public safety risk. In cases where it is thought necessary, civil orders may be made under sections 30 (inpatient orders) and 55 (restricted patients) of the Mental Health (Compulsory Assessment and Treatment) Act 1992, or section 45 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (jurisdiction to make compulsory care order).

RECOMMENDATION

R4 We recommend no change to the prescribed maximum period in unfit to stand trial cases.

Rationale for the Attorney-General's involvement under section 31

10.27 Section 31 addresses three types of cases:

- cases in which the person subsequently becomes fit to stand trial (section 31(2));
- cases in which unfitness to stand trial persists, but the patient is clinically certified as being eligible for a change of status (section 31(3)); and
- cases in which the maximum period of detention as a special patient or special care recipient has expired without the person becoming fit to stand trial, whereupon change of status is mandatory (section 31(4)).

10.28 If a direction is given under any of the above subsections of section 31, that a person is to be held as a patient or care recipient, criminal proceedings are stayed under section 32 of the Criminal Procedure (Mentally Impaired Persons) Act, and the person may not be charged again.

10.29 The Attorney-General's involvement in section 31(2) cases, when the person is found to be no longer unfit, seems appropriate. The Attorney-General is the principal law officer, and the person has not yet been tried. In practice, people dealt with under this provision may well be responsible for very serious offending, and may, with treatment, become fit within a relatively short time frame (perhaps, within a year or two). The state has a proper ongoing interest in their criminal justice disposition if or when that happens. It is right for the Attorney-General to be involved, on behalf of the state, in determining whether the person should be brought before a court, or absolved from criminal responsibility.⁷⁸

10.30 For the section 31(3) category of cases, where the patient is clinically certified as being eligible for a change of status, despite being still unfit, the issues are more difficult. We were told that, in practice, this situation quite rarely arises. In a way, therefore, this makes legislative amendment somewhat immaterial. However, in principle, we consider that it is important to get the framework right.

10.31 Section 31(3) gives responsibility for these decisions to the Minister of Health, with the concurrence of the Attorney-General. This no doubt reflects the tension that may exist in such cases between the clinical decision, and the public interest in being able to bring the person to trial – since once the person's status changes, future trial will no longer be possible, because of section 32.

10.32 However, we think that, in principle, patients are entitled to the benefit of a decision based on their actual mental health status, initiated on clinical grounds. We think that the Attorney-General's different interest in the matter could and should be recognised in a different way. We propose to amend section 32, so that it would remain open to the Crown to reactivate criminal charges if a patient whose "special" status has been altered under section 31(3) subsequently becomes fit to stand trial, within what would otherwise have been the prescribed maximum period for detention under section 30 as a special patient.

10.33 If this was done, there would be no rationale for the Attorney-General's involvement under section 31(3), because there would be no prejudice to the possible future reactivation of proceedings.

⁷⁸ In practice, we were advised that it would not be unusual, upon trial, for such an offender to be acquitted on grounds of insanity, and returned to special patient or special care recipient status by that different route.

10.34 Section 32 does, however, remain necessary and appropriate for other types of cases, to ensure that proceedings are stayed when, under section 31(2) and 31(4), either the Attorney-General has decided not to pursue criminal charges, or the maximum period has expired.

10.35 In section 31(4) cases, it is not at all clear why the Attorney-General needs to be involved. There is no element of discretion in this decision. We recommend that the function of the Attorney-General should be replaced by either the Director of Mental Health (for special patients), or the Director-General of Health (for special care recipients). In practice, we understand that, in the latter case, the function would be delegated by the Director-General of Health to the Director, Intellectual Disability (Compulsory Care and Rehabilitation).

Section 31(3) review mechanism

10.36 For persons whose status has changed under section 31(3), and who may then been subsequently released into the community at some future time, statutory mechanisms for reviewing their fitness to stand trial will be necessary, to protect the Attorney-General's interest. Two possibilities need to be addressed: cases in which the patient or care recipient remains under compulsory status, and cases in which he or she has been released from it.

10.37 For patients or care recipients still under compulsory status, it is a matter than can be dealt with in the course of the normal ongoing reviews, already provided for under the Mental Health (Compulsory Assessment and Treatment) Act 1992, and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. All that is necessary would be a new statutory requirement for the Attorney-General to be notified, in the event that the person is considered by a clinician or specialist assessor to have become fit to stand trial.

10.38 For those who have been released from compulsory status, new provisions will be necessary, requiring them to continue to submit themselves periodically for assessments of their fitness to stand trial, during what would otherwise have been the maximum detention period. While we expect that this will affect only very small numbers of people, it is likely to be those whose offending was quite serious, carrying a long prison term (and whose maximum detention period was, therefore, also relatively long).

10.39 The New Zealand Bill of Rights Act implications of this approach would need to be assessed in due course by Crown Law. However, our own view is that it is likely to be a justified limitation on any of the rights that could potentially be engaged – such as, perhaps, the right to refuse medical treatment, or avoid arbitrary detention. It is likely to affect only those charged with the most serious offences. It is an approach that has been developed and recommended in the interests of accused persons, increasing the likelihood that they can be released from compulsory status when their clinical condition no longer warrants it, by separating out the Attorney-General's different interest in the matter.

RECOMMENDATION

R5 Ministerial responsibility for decision-making under section 31 of the Criminal Procedure (Mentally Impaired Persons) Act 2003 (persons unfit to stand trial) should also be removed. There is no ground for distinguishing section 31 cases from section 33 cases, as regards the role of the Minister of Health. A non-Ministerial decision-maker is needed to deal with cases under both sections, subject to further recommendations below about the role of the Attorney-General.

RECOMMENDATION

R6 The Attorney-General has a legitimate interest in matters decided under section 31(2).

RECOMMENDATION

R7 Decisions under section 31(3) should be based upon a solely clinical assessment by the new (non-Ministerial) decision-maker, without the involvement of the Attorney-General.

RECOMMENDATION

R8 To facilitate this, whilst still recognising the Attorney-General's interest in proceedings, section 32 should be amended to provide that when a special patient or special care recipient's status is altered under section 31(3), proceedings are not stayed until the maximum detention period has expired.

RECOMMENDATION

R9 In section 31(4) cases, in which there is no element of discretion, the function of the Attorney-General should be replaced by either the Director of Mental Health (for special patients), or the Director-General of Health (for special care recipients).

RECOMMENDATION

R10 Statutory mechanisms for reviewing the fitness to stand trial of persons whose status has changed under section 31(3) will be necessary, to protect the Attorney-General's interest. For patients and care recipients still under compulsory status, we recommend that this be addressed in the course of the normal ongoing reviews, with a new statutory requirement for the Attorney-General to be notified if the person becomes fit to stand trial.

RECOMMENDATION

R11 For those who have been released from compulsory status prior to the expiry of what would otherwise have been the maximum detention period, there should be a statutory requirement that they submit themselves periodically for assessment of their fitness to stand trial.

RESTRICTED PATIENTS

10.40 While there are very few restricted patients, we recommend that the processes for dealing with them, currently provided for in section 78 of the Mental Health (Compulsory Assessment and Treatment) Act 1992, should be aligned with our other proposals. To achieve this, some changes to section 78 are proposed.

10.41 We note that the Attorney-General is also consulted under section 78, by the Minister of Health, in determining whether restricted patient status remains necessary. However, by contrast with section 31, there is no justification in the section 78 context for the Attorney-General's involvement. We recommend no Ministerial involvement at all under section 78.

RECOMMENDATION

R12 The decision-making processes for restricted patients, currently provided for in section 78 of the Mental Health (Compulsory Assessment and Treatment) Act 2003, should be aligned with our other proposals.

RECOMMENDATION

R13 Neither the Attorney-General nor the Minister of Health should be involved in decision-making under section 78.

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Chapter 11

The new decision-maker

SUMMARY

Options are considered for what type of decision-maker should take over the present Ministerial functions: broadly speaking, should it be a clinical decision, or a decision for a court, or a Tribunal? A Tribunal decision is recommended, in all cases.

REVIEW AND DISCHARGE OF INSANITY ACQUITTEES OVERSEAS

- 11.1 Most jurisdictions give responsibility for discharging persons detained on account of insanity to a specialist Tribunal or Board. A couple still make it an executive decision, assisted by expert advice from either a Tribunal or the responsible medical officer (Western Australia, and Scotland, although this is about to change in Scotland). In several jurisdictions it is a court decision (Northern Territory, South Australia, Victoria, and Tasmania), but in Tasmania the court is assisted by a Tribunal.
- 11.2 In a fair-sized minority of the jurisdictions, there is continuity of decision-making at both ends of the process, with either the Tribunal (Canada and the Australian Capital Territory) or the court (Northern Territory, Tasmania, Victoria, and South Australia) involved in both disposition and discharge decision-making. However, in most jurisdictions, the position is the same as we propose below for New Zealand: the court makes the initial disposition upon finding an accused person insane, and a Tribunal or Board deals with discharge.

Should reclassification and discharge decisions be solely clinical decisions?

- 11.3 The responsible clinician, or the Mental Health Review Tribunal, is responsible for making decisions about leave and discharge of convicted defendants compulsorily detained as mental health patients under section 36 and 37 of the Criminal Procedure (Mentally Impaired Persons) Act 2003.⁷⁹ In contrast, Ministers (the Minister of Health, the Attorney-General, or the Minister of Health in concurrence with the Attorney-General) make leave, reclassification and discharge decisions for the three types of patient under consideration here: the acquitted insane, the unfit to stand trial, and civilly committed restricted patients.
- 11.4 At first glance, this might seem incongruous. However, the legislature has recognised that all three categories of case have a higher degree of public interest than all other ‘normal’ mental health dispositions. Grounds including public safety determine whether a person will be made a special or restricted patient, or a special care recipient. There may also be victims of criminal offending who have an interest, and for whom state involvement provides a measure of reassurance that their interests have not been forgotten.
- 11.5 It is arguably the clinician who is best placed to judge risk to community safety, based on his or her expert knowledge of the mental state of the patient and available treatment options; as such it is arguably appropriate for clinicians to take back what is currently the Ministerial decision-making function (with some provision for oversight).
- 11.6 On the other hand, however, clinical decision-making is unlikely to lend itself to any greater degree of transparency in decision-making, or any better forum for victims to feel they have been meaningfully involved, than the present Executive-administered process. Indeed, from these perspectives, a clinical process would be even less advantageous than the current arrangements.
- 11.7 While it is appropriate for there to be significant clinical input into decision-making, and significant weight attached to any such submissions, on balance our preliminary view is that it should not be solely a clinical judgement.

⁷⁹ See further sections 31 and 35 of the Mental Health (Compulsory Assessment and Treatment) Act 1992. If, in the first instance, the patient or his or her representative is unhappy with the clinician’s decision, the Mental Health Review Tribunal may undertake a review under section 79 of the Act. The Tribunal may also intervene of its own motion. However, Tribunal involvement is not necessary to all discharge decisions; some will be solely clinical.

- 11.8 For restricted patients, this would be consistent with what already happens in practice. Although the Director of Mental Health, on the face of the statute, may directly release restricted patients (whereas the Minister is involved in change of status decisions), we are told that this never happens in practice. Cases of this type arise very infrequently (there have only ever been seven patients declared “restricted”), and are always referred to the Mental Health Review Tribunal to be dealt with. Restricted patient cases are not really distinguishable from the other two classes of case from a public safety point of view. They should be dealt with in a similar way. Those patients’ release should not, therefore, any longer be at the discretion of the Director of Mental Health.

RECOMMENDATION

- R14 Reclassification and discharge recommendations should continue to be clinically initiated, but decisions need to be based on broader public interests, taken into account by an independent decision-maker.

RECOMMENDATION

- R15 Restricted patients’ release should no longer be at the discretion of the Director of Mental Health.

Should it be a court decision?

- 11.9 Generally the courts do not have a continuing role after sentencing in the detention of convicted defendants of “sound mind”. Parole decisions are made independently.
- 11.10 However, there is court involvement under section 74 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, where the Family Court is responsible for regular review of care and rehabilitation plans, and compulsory care orders, in respect of intellectually disabled care recipients. And overseas, several jurisdictions locate discharge decision-making with the courts.
- 11.11 Courts have the advantage of transparency in decision-making, an established comprehensive framework of procedural safeguards, and avenues of appeal to superior courts. If they were to continue to make disposition decisions, their ongoing involvement in reclassification and discharge would ensure continuity of approach.
- 11.12 However, that last advantage, in particular, may be more apparent than real. Because of court resourcing and scheduling issues, and the typically long lapse of time between a disposition, and discharge or reclassification, a case would inevitably be dealt with by a number of different judges. Furthermore, the other advantages identified are not necessarily court-specific; they might equally be provided for by other decision-makers. The formality of court proceedings may be seen as a disadvantage, potentially intimidating and distressing to the vulnerable people concerned. Nor will judges have specific expertise in forensic mental health, although they could, of course, be assisted by expert evidence.

11.13 We received mixed views as to whether court involvement might assist with delays. Some thought that the courts' timetabling facility might assist; others that competing court work pressures would make problems of delay much worse in this forum than one dedicated solely to dealing with patient reclassification and discharge.

11.14 On balance, however, we concluded that courts are unlikely to be the best forum to take over the current Ministerial decision-making functions.

A Family Court decision for special care recipients?

11.15 However, some with whom we consulted thought that, even if the court was not in general the right decision-making forum, it still should be the decision-maker for special care recipients, to whom the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 applies.

11.16 Special care recipients are quite different from special or restricted patients, to whom the Mental Health (Compulsory Assessment and Treatment) Act 1992 applies. They are intellectually disabled, perhaps requiring long term or life time care, whereas special and restricted patients are mentally disordered, and thus more likely to be amenable to treatment. Because of care recipients' impairment, it may be that some are never wholly discharged. In such cases, their situation is more akin to lifetime guardianship, in the sense that the court is providing long term oversight of the person's care. This is why, under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, the Family Court normally deals with them.

11.17 We therefore considered whether the Family Court, in preference to any other decision-maker, ought to take over the Ministerial function for special care recipients, because:

- Family Court processes are less adversarial than those of the criminal courts;
- any higher degree of public interest pertaining to this class of person could be addressed by the statutory provision of different considerations to guide decision-making;
- the Family Court's involvement would ensure that there is continuity of care for these patients, whatever their statutory status; and
- this is a group with which the Court deals anyway in the civil jurisdiction, unlike the Tribunal we propose below, where different personnel might have to be co-opted.

- 11.18 We encountered a number of objections to this proposal, including from the Family Court itself. The weight of opinion was strongly in favour of keeping all three classes of patient – special patients, special care recipients, and restricted patients – within the same jurisdiction. Furthermore, it was felt that the Family Court would face obstacles in trying to integrate decision-making for special care recipients within its other workload. Although the numbers of these patients are very small, and would not impose a significant burden on the Court, that would, in itself, give rise to another set of problems. Whereas a specialised decision-maker would acquire the necessary expertise, Family Court judges would have to come to terms on a case by case basis with highly complex and sometimes unfamiliar legislation, and would confront other logistical issues (eg, issues such as case management, and provision for adequate hearing time) that might cause delay.
- 11.19 We therefore abandoned this option.

Recommended option: a specialised independent Tribunal

- 11.20 An independent Tribunal or Board is the most commonly observed model in the overseas jurisdictions surveyed and, in our view, is the preferred model for the present purposes, for all three classes of patient including special care recipients.
- 11.21 On review of the New South Wales forensic mental health legislation, which has recently been implemented, the overwhelming majority of submissions supported transferring all such decision-making to a Tribunal, for reasons that included:
- The Tribunal’s membership (including both legal and medical experts) would ensure that it has specialist expertise in the areas of mental health and dangerousness, as well as the advantages of legal expertise.
 - The system would provide transparency in decision-making – no less transparency than a court, and a great deal more than either an Executive or a clinical decision.
 - Because a Tribunal is generally quicker and less formal than the courts, it could be clinically advantageous, because clinical recommendations could be acted on speedily, and the forum would be likely to lend itself better to ongoing monitoring of forensic patients’ progress. The relative informality and non-adversarial nature of proceedings would make the review process more user friendly for patients and their victims.
- 11.22 The proposed Tribunal would not be a substitute for clinical involvement. We envisage that, as currently occurs, there would be a clinical review and recommendation at regular six-monthly intervals. The Tribunal would only become involved if the patient applied to it for review following an adverse recommendation; or the clinician recommended reclassification, discharge, or long leave.

RECOMMENDATION

R16 A Tribunal is the appropriate body to make decisions, upon clinical referral, in relation to special patients, special care recipients, and restricted patients.

Chapter 12

Composition and structure of the Tribunal

SUMMARY

Having recommended in the previous chapter that a Tribunal should in future take responsibility for current Ministerial decisions, this chapter further considers what such a body ought to look like, and whether an existing body can be utilised.

It notes that the existing Mental Health Review Tribunal has some close similarities to analogous bodies overseas. However, some reforms to its structure and function would be necessary, to deal with the new categories of case that are of somewhat higher public interest than the Tribunal's present work. Furthermore, the proposed role for the Tribunal in dealing with special care recipients would require some different types of expertise. The practical net effect of our recommendations would be to establish a separate, purpose-built body.

Specifically, a new Special Patients' Review Tribunal is proposed, established under the Criminal Procedure (Mentally Impaired Persons) Act 2003, to be chaired by a current or former judge, and to sit in panels of up to five members.

MODELS OVERSEAS

- 12.1 The typical model employed overseas for Tribunal decision-making on the review and discharge of insanity patients looks rather like our existing Mental Health Review Tribunals: a membership of three, comprising members with legal and/or judicial, psychiatric and/or psychological, and sometimes other applicable expertise. The members of the Tribunal are generally selected by the Minister responsible under the particular legislation.

MENTAL HEALTH REVIEW TRIBUNALS

- 12.2 A Mental Health Review Tribunal is already established in New Zealand, under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Tribunals deal primarily with patients subject to "ordinary" compulsory treatment orders (although, under sections 78, 80 and 81 of the Act, they may from time to time be asked to review cases involving special or restricted patients).

- 12.3 Under section 101(2), every Mental Health Review Tribunal comprises three persons appointed by the Minister, of whom one is a barrister or solicitor and one a psychiatrist. The expertise of the third person is not specified: it may be either legal expertise, or psychiatric expertise, or more typically, the expertise of one of the Tribunal's lay community members. It therefore looks somewhat similar to analogous bodies overseas. Section 103 allows a Mental Health Review Tribunal, for the purposes of any particular case, to co-opt persons of appropriate ethnicity or gender, or any other person whose specialised knowledge or expertise would be of assistance in dealing with the case.
- 12.4 Under section 104(3), every Tribunal has the same powers and authority to summon witnesses and receive evidence as are conferred upon Commissions of Inquiry by the Commissions of Inquiry Act 1908.
- 12.5 Schedule 1 to the Mental Health (Compulsory Assessment and Treatment) Act 1992 sets out, non-exhaustively, procedures to be followed by the Tribunal on matters such as evidence and hearings.

A SPECIAL PATIENTS' REVIEW TRIBUNAL

- 12.6 As noted in chapter 10, the status of a patient as special patient, special care recipient, or restricted patient signifies that there is a special public interest in determining outcomes for the patient. That is currently put into effect by Ministerial involvement in reclassification and discharge decisions.
- 12.7 Utilisation of the Mental Health Review Tribunals as currently structured, without further change, would be consistent with overseas models.
- 12.8 However, in our view, something a little different is required, that acknowledges the particular public interest concerns that pertain to special patients, special care recipients, and restricted patients. This is partly an issue about perceptions: appropriate weight needs to be seen to be given to these decisions, and a specially-constructed Tribunal would facilitate this.
- 12.9 However, it is also about the nature of the required decision-making expertise. If, as we have already recommended above, the Tribunal was to deal with special care recipients, it would also be important that it is not perceived as a body dominated by expertise in mental illness, or too closely affiliated to the Mental Health (Compulsory Assessment and Treatment) Act 1992 model. This was something policy makers explicitly sought to avoid, when the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 was developed – hence the location of decision-making under that Act with the Family Court.
- 12.10 As a minimum, when determining those cases, its membership would need to include expertise in dealing specifically with special care recipients. However, we find this a sufficiently strong consideration that, overall, it would be both simpler and more robust to establish a whole new separate body. The costs of doing so are unlikely to be significantly more than attempting reform of the existing Mental Health Review Tribunals, and the result will be a great deal better.

12.11 We have therefore concluded that, rather than expanding upon the Mental Health Review Tribunals' framework, the new Tribunal should be established as a separate, built-for-purpose body, with characteristics that include:

- The Tribunal should be established under the Criminal Procedure (Mentally Impaired Persons) Act 2003, not the Mental Health (Compulsory Assessment and Treatment) Act 1992.
- A pool of potential members should be established, with a range of appropriate expertise, not dominated by the psychiatric and legal experience that is a feature of the Mental Health Review Tribunal.
- The Tribunal should have the ability to adjust its expertise as necessary by co-opting members to deal with individual cases (eg, special care recipient cases).
- It should be chaired by a current or former judge.

The legislative basis for the Tribunal

12.12 The Tribunal should be established under the Criminal Procedure (Mentally Impaired Persons) Act 2003, not the Mental Health (Compulsory Assessment and Treatment) Act 1992. Given that the relevant decision-making powers are already in the former Act, it makes some sense to locate the decision-maker in the same place on the statute book. But no less importantly, it would reaffirm the idea that this is a new body established to deal with all three categories of patient, including intellectually disabled special care recipients.

12.13 Its function would be reclassification, discharge and long leave decision-making, for special patients, restricted patients, and special care recipients.

RECOMMENDATION

R17 The Special Patients' Review Tribunal should be established under the Criminal Procedure (Mentally Impaired Persons) Act 2003.

RECOMMENDATION

R18 Its function would be reclassification, discharge and long leave decision-making, for special patients, restricted patients, and special care recipients.

Tribunal membership

12.14 A pool of 10 to 12 members should be appointed, with a range of appropriate expertise. Tribunal members would require skills, knowledge or experience in one or more of the following areas:

- psychiatry;
- law (a barrister or solicitor);
- other senior forensic mental health;
- forensic consumer advice or service use;
- Māori issues;
- risk assessment and management;
- the reintegration of the mentally ill or intellectually impaired into society.

- 12.15 The Tribunal should also be able to adjust its expertise as necessary, by co-opting members as required to deal with individual cases. In particular, use of the power to co-opt may be appropriate in special care recipient cases. Section 103 of the Mental Health (Compulsory Assessment and Treatment) Act, which relates to Mental Health Review Tribunals, offers a model for this.
- 12.16 The compilation of panels would be administratively managed, with a requirement for a quorum of three members (including the chair), and provision for a larger panel of up to five members, depending on the nature of the case. Panel composition might be determined, for example, by considerations of the level of public interest in the case, or the number of members necessary to ensure an appropriate mix of expertise. We recommend that the chairperson, or his or her nominated deputy, should sit in every case.
- 12.17 This kind of approach would have some precedent in the operation of the Parole Board: while the Board normally sits in three-member panels, an extended Board of seven members, headed by the judicial chairperson, deals with life and preventive detention cases.

RECOMMENDATION

R19 A pool of 10 to 12 Tribunal members should be appointed, with a range of appropriate expertise. Members would require skills, knowledge or experience in one or more of the following areas: psychiatry; law (a barrister or solicitor); other senior forensic mental health; forensic consumer advice or service use; Māori issues; risk assessment and management; the reintegration of the mentally ill or intellectually impaired into society.

RECOMMENDATION

R20 The Tribunal should also have the ability to adjust its expertise as necessary, by way of a power to co-opt, modelled on section 103 of the Mental Health (Compulsory Assessment and Treatment) Act.

RECOMMENDATION

R21 The compilation of panels should be administratively managed, with a requirement for a quorum of three members (including the chair), and provision for a larger panel of up to five members, depending on the nature of the case. The chairperson, or his or her nominated deputy, should sit in every case.

Judicial chair

- 12.18 We further recommend that a current or former judge should chair the new Tribunal. Judges and former judges have particular skills and experience in conducting hearings, deciding matters according to law, and giving reasons for decisions. More importantly, a judicial chair would assist in giving the gravitas to such decisions that the public may require.
- 12.19 This may be a High Court judge but, in our view, making this a mandatory requirement would be neither necessary nor desirable. There is no such requirement in the Parole Board context, which is currently very ably chaired by the former Chief District Court judge. It would be odd for this body to differ in that regard; we cannot find any justification for it.

RECOMMENDATION

R22 The new Tribunal should be chaired by a current or former judge.

APPOINTMENT OF MEMBERS

- 12.20 Under section 101(2) of the Mental Health (Compulsory Assessment and Treatment) Act 1992, appointment of the members of Mental Health Review Tribunals is presently a Ministerial function. We recommend that this should change and that, instead, appointments of Tribunal members should be made by the Governor-General in Council. They will be performing what is, essentially, a judicial function. It is therefore appropriate for their appointment process to be the same as judges'.
- 12.21 Members should be appointed for a term of up to three years, with provision for renewal.

RECOMMENDATION

R23 Appointments of Tribunal members should be made by the Governor-General in Council.

RECOMMENDATION

R24 Members should be appointed for a term of up to three years, with provision for renewal.

ADMINISTRATIVE SUPPORT FOR THE TRIBUNAL

- 12.22 We are proposing that the Tribunal should be established under the Criminal Procedure (Mentally Impaired Persons) Act 2003, which is administered in the Ministry of Justice. Nevertheless, it is the Ministry of Health that will be better situated to support the Tribunal and its related processes (for example, appointment processes).
- 12.23 Mental Health Review Tribunals are presently administered and supported by the Ministry of Health.

- 12.24 The appropriateness of extending this arrangement to the new Tribunal may perhaps be questioned, if the precise purpose of establishing such a body is to achieve a degree of distance from the Executive. However, we think that a review of administrative support arrangements is beyond the scope of our work for present purposes.
- 12.25 We were advised by the Ministry that, in practice, it outsources responsibility for this administrative function, to overcome any problem or perceived problem with conflicts of interest. We agree that as a minimum, some arrangement like that should continue.

RECOMMENDATION

R25 The new Tribunal should be supported by the Ministry of Health. Health's present practice, for other Tribunals, of outsourcing responsibility for this administrative function should continue and be applied to the new Tribunal.

TRIBUNAL
WORKLOAD

- 12.26 The Tribunal's workload would not be large. Based on Ministry of Health statistics for Ministerial decisions made over the last four years, the number of hearings would be around 50 per year, on average, to deal with all long leave, reclassification and discharge decisions for special patients, restricted patients, and special care recipients. That also includes provision for the Tribunal to deal with the very small number of cases seeking review of an adverse clinical decision. Mental Health Review Tribunal statistics in their annual report show that there were only two such applications in 2009/10, one from a special patient and one from a restricted patient, resulting in a single hearing.
- 12.27 If a Tribunal member (for example, the judicial chair) sat in all such cases, the role, including preparation time, might occupy around 20 working days per annum. For the remaining members of the Tribunal, who would not sit in all cases, the commitment would be somewhat less.
- 12.28 By comparison, in 2009/10 the 17-member Mental Health Review Tribunal heard 78 cases.

Chapter 13

Decision-making

SUMMARY

Decision-making grounds are reviewed, and some minor refinements are proposed. The chapter also considers the scope of the new Tribunal's jurisdiction: that is, what types of decisions it should have responsibility for making.

RECLASSIFICATION AND DISCHARGE

- 13.1 Sections 31 and 33 of the Criminal Procedure (Mentally Impaired Persons) Act 2003 set out different pathways for patients who have been found, respectively, unfit to stand trial or not guilty by reason of insanity.
- 13.2 Under section 31, a review of the patient's status, and reclassification as a patient or care recipient, is the only option for the Minister.
- 13.3 But under section 33, the Minister may simply direct discharge; he or she also has the option of reclassifying the person as either a patient or care recipient. Similarly, section 78 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 presently provides for either the direct release of restricted patients (upon clinical recommendation) by the Director of Mental Health (Ministry of Health), or their reclassification by the Minister.
- 13.4 We have considered whether it *should* be open to a decision-maker simply to discharge a special patient, special care recipient, or restricted patient. On the face of it, a staged approach, requiring first a reclassification, before discharge may be considered, appears more appropriate. Indeed, we understand this is generally current practice: patients are managed through the process in increments, with their capacity first tested by way of short and long leave, followed by a reclassification, and eventually discharge.
- 13.5 However, we have been advised that this is not always possible. There needs to be provision for direct discharge of special patients, because they do not always meet civil committal criteria for mental disorder as defined in the Mental Health (Compulsory Assessment and Treatment) Act 1992.⁸⁰

⁸⁰ See, for example, *Waitemata Health v Attorney-General* [2001] NZFLR 1122; (2001) 21 FRNZ 216 (CA).

- 13.6 It follows that reform of section 31 is required. If a person unfit to stand trial were classified as a special patient, and then reclassified as a compulsory patient despite not meeting the terms of the criteria for civil committal, his or her status would need to be immediately reviewed again. If the patient was not then discharged, he or she would inevitably succeed on a habeas corpus application, or a judicial hearing under section 84 of the Mental Health (Compulsory Assessment and Treatment) Act 1992. It would make much more sense simply to empower the Tribunal to reach that result directly.
- 13.7 We would naturally expect decision-makers to take a cautious approach, and directly discharge a person only in the event of no other available option, and were assured by the Ministry of Health that this would be the case. Furthermore, the patient's mental state would almost certainly have been extensively tested by way of long leave first.

RECOMMENDATION

R26 Section 31 of the Criminal Procedure (Mentally Impaired Persons) Act 2003 presently provides only for reclassification. We recommend its amendment, to permit immediate discharge.

WHEN SHOULD THE TRIBUNAL'S JURISDICTION CEASE?

- 13.8 Under the legislation as currently drafted, when special patients, special care recipients, and restricted patients are reclassified, they are deemed subject to either a compulsory treatment order under the Mental Health (Compulsory Assessment and Treatment) Act 1992, or a compulsory care order under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.
- 13.9 Under the Mental Health (Compulsory Assessment and Treatment) Act 1992, that means decision-making functions are transferred to either the clinician or, on an application for review, the Mental Health Review Tribunal. Under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, specialist assessments are overseen by the Family Court in all cases.
- 13.10 We considered the arguments in favour of ongoing involvement by the new Tribunal, following reclassification. There were three. First, in such cases, discharge may well be a more significant decision than change of status in the public mind, or at least no less significant, so that it would be odd to establish a whole new process, and then not utilise it at what is probably the point of key public concern.
- 13.11 Secondly, it might make reclassification decisions easier for the Tribunal. If the Tribunal did not relinquish oversight, its members would be able to observe patients throughout the course of their care and treatment, and gain a more informed appreciation of how patients' rehabilitation could be optimally supported. Otherwise, the risk would be that they only saw patients in a more advanced state of impairment, thus making them unduly risk-averse in their decision-making.
- 13.12 Thirdly, it would facilitate continuity of patient management.

- 13.13 However, these views were not supported. Almost everyone we consulted thought that the Tribunal’s jurisdiction should cease on reclassification. Some expressed concern about the greater resource demands that continued oversight would place on the new Tribunal. They questioned whether the costs would be justified by the benefits, given that the instance of recidivism (and therefore the level of risk) among former special patients is very low and they would, in any event, continue to be closely monitored, regardless of the decision-maker.
- 13.14 Others noted that while there might be some public interest in the discharge part of the process, there is no evidence of significant public concern arising from the present arrangements.
- 13.15 But the most significant objection people expressed was that it would be unfair or discriminatory for patients (former special and restricted patients) whose status has changed to be treated any differently from all other patients with the same status. They felt that our proposed alternative would create an uncomfortable hybrid status for these patients, that would be unnecessarily complicated, discriminatory, and burdensome on the review jurisdiction.
- 13.16 We were, therefore, persuaded that the advantages of continued oversight by the new Tribunal would be outweighed by the disadvantages.

RECOMMENDATION

R27 The Tribunal’s jurisdiction should cease on reclassification.

**DECISION-
MAKING
GROUNDS
OVERSEAS**

- 13.17 Most jurisdictions require certain factors to be considered on a review of patient status. While the factors vary, in broad terms they tend to require the decision-maker to weigh the need for public protection against the right to liberty of the accused and his or her other needs, such as the need for care or treatment. Considerations typically include factors such as the nature of the person’s mental impairment or other condition or disability; whether the person is, or would if discharged be, likely to endanger another person or other persons generally; whether the person could be adequately controlled by less intrusive measures; and other relevant matters.
- 13.18 In Tasmania, Victoria and South Australia the court is required to apply the principle that interference with the accused’s freedom and personal autonomy should be kept to the minimum consistent with the safety of the community.
- 13.19 In Ireland, England and Wales, Scotland, and Canada the safety of the public is the paramount consideration.

GROUNDS IN
 NEW ZEALAND

- 13.20 Under section 33 of the Criminal Procedure (Mentally Impaired Persons) Act 2003, the Minister of Health must consider whether, in his or her opinion, continued detention under the section 24 order is no longer necessary to safeguard *the defendant's own interests, and the safety of the public or the safety of a person or class of person*. Section 31 envisages a direction if in the Minister's opinion detention under section 24 is no longer necessary. However, presumably the reference to section 24 imports section 24(1)(c), thus requiring the decision-maker to be satisfied that the order is necessary in *the interests of the public, or any person or class of person who may be affected by the decision*.
- 13.21 The language of the respective considerations under the two sections is thus subtly different.
- 13.22 Section 78 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 is silent about the grounds for decision-making in relation to restricted patients.
- 13.23 Given the nature of the decisions that may currently be taken under section 31, the decision-making grounds are appropriate:
- When section 31(2) is engaged, the Attorney-General must direct that the person is either brought back before a court, or held as a patient or care recipient. There is no discretionary decision-making or balancing of factors under this subsection, other than (presumably) the application of the Solicitor-General's Prosecution Guidelines. If the person who is no longer unfit to be tried is not going to be brought before a court, he or she is entitled to change of status. This approach is correct in policy terms, in our view. No amendment is required.
 - Under section 31(3), when the person is still unfit to stand trial, the Minister of Health with the concurrence of the Attorney-General must determine whether "detention under section 24 is no longer necessary" – thus importing section 24(1)(c), which refers to "the interests of the public". Given that such persons have not been tried, "the interests of the public" is arguably exactly the right test, as opposed to the "safety of the public", because the former allows the possibility of bringing the person to trial in future to be taken into account. The "interests of the public" test is broad enough to encompass considerations of whether the possibility of future prosecution needs to be protected, by requiring continued detention of the person as a special patient or special care recipient, contrary to the clinical recommendation that has triggered the operation of section 31(3).
- 13.24 However, we have proposed changes to sections 31 and 32 that will protect the Attorney-General's interest in a possible prosecution, whilst removing the need for his or her involvement in section 31(3) decisions. We therefore recommend a corresponding change to the section 31 decision-making grounds: there should be no difference in the grounds for a reclassification, regardless of whether a case is governed by section 31(3) or section 33.
- 13.25 The same grounds should also be extended to section 78.

- 13.26 The section 33 grounds are consistent with the broad thrust of overseas approaches, although some jurisdictions set out relevant considerations in quite substantial detail. We are anxious to avoid change for the sake of change, if there is no evidence of a problem, and we are not convinced that elaborating on the grounds in the degree of detail seen in other jurisdictions adds a great deal to the exercise. Finding the right form of statutory words would be a matter for considerable, perhaps fruitless, debate and some risks. In our view, articulation of the grounds at the current, relatively high, level is the better approach. The section 33 language should therefore be retained, and extended to cover the other two classes of case.
- 13.27 However, there may be advantages in giving some emphasis to the importance of the safety of the community, as has been done in other jurisdictions. We therefore recommend providing both that the safety of the public is the paramount consideration, and that interference with the patient's freedom and personal autonomy should be kept to the minimum that is consistent with this objective.

RECOMMENDATION

R28 There should be no difference in the grounds for a change of status, regardless of whether a case is governed by section 31(3) or section 33 of the Criminal Procedure (Mentally Impaired Persons) Act 2003.

RECOMMENDATION

R29 The same grounds should also be extended to section 78 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

RECOMMENDATION

R30 The current section 33 ground, or something closely derived from it, should be retained, and applied to the other two sections.

RECOMMENDATION

R31 Redrafted decision-making grounds should also provide that the safety of the public or any person or class of person is the paramount consideration, and that interference with the patient's freedom and personal autonomy should be kept to the minimum that is consistent with this objective.

Chapter 14

Tribunal procedures

SUMMARY

This chapter considers procedural matters, such as how often a person under the jurisdiction of the new Tribunal should have their status reviewed; procedures around hearings; the role of victims; and appeal rights.

STATUTORILY PRESCRIBED PERIOD OF CLINICAL REVIEW

- 14.1 In other jurisdictions, the status of a compulsorily detained person in the mental health jurisdiction must typically be reviewed every six to 12 months. This is consistent with the approach already taken in New Zealand, under both the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, which both, in general, require six-monthly reviews.
- 14.2 This means that the status of special patients, special care recipients, and restricted patients is more frequently reviewed than the status of prisoners eligible for parole, which is reassessed annually in most cases. However, it may well be that in the mental health context, risk is more readily managed or altered within short timeframes by different treatment options.
- 14.3 We think that the current provisions for clinical review are largely appropriate, and propose only a minor change to them, for the new Tribunal's purposes. We recommend a presumption of clinical reviews every six months, but in cases referred to the Tribunal, there would be a discretion for the Tribunal to order the next review at an earlier specified time. We think that this flexibility would be desirable. (See also our earlier recommendation for changes to ensure the Attorney-General is informed, when a person becomes fit to stand trial: chapter 10.)

RECOMMENDATION

- R32 The status of special patients, special care recipients, and restricted patients should be clinically reviewed 6-monthly. No change to this aspect of the legislation is required. However, in cases referred by the clinician to the Tribunal, there should be a discretion for the Tribunal to order the next review at an earlier specified time, if the patient has not been reclassified or discharged.

TRIBUNAL
ROLE ON
CLINICAL
REVIEW

- 14.4 The new role proposed for the Tribunal is to replace the current Ministerial functions. Ministers are not involved in ongoing periodic review, and only act in the event of a clinical recommendation that a decision from them is required. This is in contrast to the way that the Family Court operates under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003: it reviews all specialist assessments of the care recipient as a matter of course.
- 14.5 Either approach might be taken, to the way that the new Tribunal functions. On balance, we recommend that cases should only be referred by a clinician to the Tribunal for further consideration when there is a recommendation for leave, reclassification, or discharge; in other words, the Tribunal would operate as Ministers currently do.
- 14.6 We also recommend that a review of all other clinical decisions may be sought from the Tribunal, on application. This would be analogous to the function presently performed by the Mental Health Review Tribunal, for special and restricted patients. It would replace that function, for those patients, and remove them entirely from the Mental Health Review Tribunal jurisdiction; in other words, the new Tribunal would now deal with all such cases, while the Mental Health Review Tribunal would deal solely with ‘ordinary’ patients.
- 14.7 This latter recommendation would have negligible resource implications, for both Tribunals. As discussed in chapter 12, there were only two applications of that kind in 2009/10, and one hearing.

RECOMMENDATION

R33 Cases should only be referred by a clinician or specialist assessor to the Tribunal for further consideration when there is a recommendation for leave, reclassification, or discharge. However, we recommend that the Tribunal may also review other clinical decisions or specialist assessments, on application, taking over this current function of the Mental Health Review Tribunal.

EXTERNAL
APPLICATIONS
FOR REVIEW

- 14.8 In most jurisdictions the legislation specifies interested persons who may apply for a review of the patient’s status in between statutorily prescribed review periods, with some statutory constraints on the frequency of application.
- 14.9 Broadly, the classes of people that may apply to the decision-maker for review are the person subject to the order (or a representative on that person’s behalf), another person with a proper interest in the matter (such as those with care, control or supervision of the person subject to the order), or the State (eg, embodied by the Director of Public Prosecutions, or a Minister of the Crown).

- 14.10 At present under both the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, interested persons are advised of the outcome of reviews of a patient's status, which supports the exercise of other rights.⁸¹ However, they are not, themselves, entitled to apply for a review. Under both Acts, the role of such persons is thus more limited than in most other jurisdictions, where an application may be initiated at any time, albeit sometimes with constraints (such as an ability for the Tribunal to decline consideration of the application, or limits on application frequency).
- 14.11 Given the relative frequency with which regular reviews occur anyway in New Zealand, and the new discretion that will be vested in the Tribunal to set a review period that is shorter than six months, we do not think there is a need for an additional application provision of the kind offered overseas. We do not recommend it.

RECOMMENDATION

R34 There should not be any provision for external applications for review.

HEARING
PROCEDURE

- 14.12 The Tribunal should adopt the current practice of Mental Health Review Tribunals, which might be described as somewhat itinerant in nature (for example, they sit in hospitals, and make use of tele- and video-conferencing as required).
- 14.13 The legislation should be silent, like the Parole Act 2002, on whether a consensus decision of all members is required, or a majority may suffice.
- 14.14 The Mental Health Review Tribunal procedures set out in Schedule 1 and other provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992 are adequate and proper in the context. They should be adopted. In particular, we do not consider that it would be appropriate for the Tribunal to take a more adversarial, court-like approach. There is already adequate provision to ensure that hearings and the processes around them follow due process. We think that a degree of informality does no harm, and may be advantageous.

81 Under the Mental Health (Compulsory Assessment and Treatment) Act a notified person may then seek further review from the Mental Health Review Tribunal, and appeal from an adverse Tribunal decision. Under the Intellectual Disability (Compulsory Care and Rehabilitation) Act, it seems that appeal rights are only conferred on a party to the proceeding: section 133. However, the specified persons are entitled to be heard on every hearing of an application: section 117. Under sections 76 and 77 of the Mental Health (Compulsory Assessment and Treatment) Act, the responsible clinician or the Mental Health Review Tribunal must send a copy of the certificate of clinical review to: the patient; any welfare guardian of the patient; the patient's principal caregiver; the medical practitioner who usually attended the patient immediately before the patient was required to undergo assessment and treatment; a district inspector; an official visitor. Under section 81 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act, the list is similar. On receipt of a specialist assessor's certificate on a care recipient, the co-ordinator of the care recipient must give or send a copy of the certificate to the following persons: the care recipient; any welfare guardian of the care recipient; if the care recipient is a child or young person, each parent or guardian of the child or young person; any lawyer of the care recipient; the care recipient's principal caregiver; the responsible district inspector.

VICTIMS' ROLE

- 14.15 The role of victims in the process needs to be considered. They do not presently have a formal “role” as such, other than a right to be kept informed of the progress of proceedings. By contrast, in Parole Board decision-making, victims have a right to be heard.
- 14.16 The proposed new Tribunal processes will have manifest advantages for victims, in terms of transparency. The question is whether they are entitled to, and would benefit from, greater involvement.
- 14.17 In other jurisdictions, there is wide variation in the nature of provision for victim involvement in proceedings of this kind, with no clear pattern. In a number of Australian jurisdictions, there is provision for victims' views to be heard, but with some limits on the degree of involvement. In the Northern Territory, Victoria and the Australian Capital Territory, a victim may prepare and submit a report setting out his or her views; leave to be heard in person may then be given to a person with a proper interest in the matter. In Tasmania and South Australia, a report setting out the victim's views is provided by the Crown. In Western Australia, the Board is to have regard to any victim statement received. In Queensland and New South Wales, the only victim-directed consideration seems to be discretionary provision for non-association conditions to be imposed.
- 14.18 The approach of the Northern Territory, Victoria and Australian Capital Territory is similar to Law Commission recommendations in our report *Sentencing Guidelines and Parole Reform*, about victim involvement in parole hearings.⁸²
- 14.19 This is a controversial and difficult area. We acknowledge the view that allowing victims to speak in such a forum, on their own terms, can be cathartic for them, and an important part of the restorative process. But in terms of the legislation, the primary considerations that the decision-maker should be concerned with are community safety and treatment. In many cases, perhaps the vast majority of cases, victims are unlikely to be in a position to comment on either of those matters. Allowing them free rein in their submissions may create unreasonable expectations and something of a misleading impression, because the decision-maker must then either disregard or fail to place a great deal of weight on a submission that is heartfelt on the part of the victim, but not relevant from the narrowly-focused statutory perspective. It was this that led us to the view, in our earlier report, that overall it is not in victims' best interests to provide for them to make oral submissions without any sort of discretionary filter.
- 14.20 In our view, *if* more victim involvement was wanted (and for the reasons that follow, we do not share this view), provision for written submissions, and a hearing in person by leave, would therefore strike the right balance. It would allow the Tribunal and the Court to use the written submissions as a basis for assessing whether a particular victim is more likely than another to be able to comment on the matters in issue. It would be consistent with the approach most commonly taken in Australian jurisdictions.

82 (NZLC R94, August 2006).

- 14.21 However, it would also be a considerable extension of victims' current rights in this context, albeit not as broad as the rights they have to appear before the Parole Board. Almost everyone we spoke to had concerns about whether victims should be involved at all in mental health decision-making, to any greater extent than the status quo. They noted that, unlike parole, decisions in this context are not the end point of a punitive process; and the Tribunal is dealing with people not responsible for their actions.
- 14.22 We agree and have, therefore, concluded that the status quo is appropriate.

RECOMMENDATION

R35 There should be no change to victims' role in release processes.

THE ROLE OF
THE MINISTRY
OF HEALTH
ON REVIEW

- 14.23 One purpose of the proposed reforms is to distance these processes from Ministerial involvement, thus protecting the interests of both patients and Ministers.
- 14.24 However, it is proper for the Ministry of Health to be aware of what is going on, so that it can brief Ministers if necessary, and make submissions to the Tribunal if that is considered appropriate.
- 14.25 We recommend that the Director of Mental Health (Ministry of Health) should receive a copy of all certificates of clinical review pertaining to special patients and restricted patients. The Director-General of Health should receive a copy of all specialist assessors' certificates pertaining to special care recipients (which would, in practice, be passed on to the Director, Intellectual Disability (Compulsory Care and Rehabilitation), who has delegated authority).
- 14.26 Furthermore, we recommend that these officials should expressly have a right to be heard by the Tribunal. This would give statutory effect to the decision of the full Court of Appeal, in *Waitemata Health v Attorney-General*,⁸³ that in the circumstances of that case, the Director of Mental Health had a right to be heard. The Court made it clear that the current provisions of the Act and its Schedule are not exhaustive, and there may be broader procedural rights that, in the interests of fairness, need to be given effect in the Tribunal's proceedings. However, it is not wholly clear that in a case with different facts, the Director, as a non-party, would always have the same standing. We consider that there is a valid interest in Health officials being heard, if they wish to do so, in all special patient, restricted patient, and special care recipient cases.

83 [2001] NZFLR 1122; (2001) 21 FRNZ 216 (CA).

RECOMMENDATION

R36 The Director of Mental Health (Ministry of Health) should receive a copy of all certificates of clinical review pertaining to special patients and restricted patients. The Director-General of Health should receive a copy of all specialist assessor's certificates pertaining to special care recipients (which would, in practice, be passed on to the Director, Intellectual Disability (Compulsory Care and Rehabilitation), who has delegated authority).

RECOMMENDATION

R37 The Director of Mental Health and the Director-General of Health (or his or her delegate) should be given an explicit right of hearing before the Tribunal.

APPEAL RIGHTS

- 14.27 Ministerial decisions are not currently appealable although they are subject to judicial review.
- 14.28 We recommend that there should be a right of appeal from Tribunal decisions, to the High Court, by either party to the proceeding.

RECOMMENDATION

R38 There should be a right of appeal from Tribunal decisions, to the High Court, by either party to the proceeding.

CH 1

CH 2

CH 3

CH 4

CH 5

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Chapter 15

Leave

SUMMARY

No change is recommended to the status quo regarding short term leave, which is managed by the Ministry of Health. For long leave, we recommend two changes: it should be a Tribunal function, not a Ministerial one; and it should be available to those unfit to stand trial, in the same way as persons acquitted on account of insanity.

SHORT TERM LEAVE

- 15.1 Currently either the Director of Mental Health (special and restricted patients), or the Director-General of Health (special care recipients) determines the short term leave (up to 7 days) of patients detained under section 24. We cannot see any reason for this to change; it seems appropriate for it to remain a Ministry of Health-administered clinical judgement.

RECOMMENDATION

R39 There should be no change to the current administration of short term leave, by the Ministry of Health.

LONG LEAVE

The distinction between persons acquitted on account of insanity, and persons unfit to stand trial

- 15.2 At present, as outlined in chapter 9, there is no provision at all for the long term leave of patients judged unfit to stand trial, although long leave is available for persons acquitted on account of insanity, at the discretion of the Minister.
- 15.3 One argument for this distinction is that if the patient is well enough to cope on long leave, he or she will be well enough to be brought back before the court and retried (if that is the course the Attorney-General still wishes to pursue), or discharged from special status. Conversely, if he or she is incapable of making decisions and communicating them for trial purposes, there may still be a danger to the public so that long leave is not a viable option.

- 15.4 However, we find this unconvincing. It is not always the case that persons capable of long leave are capable of being tried: such a person may well reach a point where he or she no longer poses a public danger, subject to being adequately medicated or cared for, but for any number of possible reasons is still insufficiently capable of giving proper instructions to a lawyer. The present distinction between those unfit to stand trial and others acquitted on grounds of insanity is discriminatory, and has no sound basis in principle.
- 15.5 Having concluded that it was difficult to find grounds for the present distinction, and that all should be treated the same – all entitled to long leave, or none – we considered the argument that no one for whom special patient or special care recipient status is judged necessary, including the insane as well as the unfit to stand trial, is fit to be on leave for a long period. On this approach, the proper thing to do would be to alter the patient’s status first, thus making them eligible for long leave. Purely logically, we found this reasonably compelling.
- 15.6 However, in practice, we understand that long leave is part of the rehabilitative process, and is used as a tool to test a person’s suitability for a reclassification. On that basis, we consider that it should be available to special patients unfit to stand trial in the same way as it currently is, for persons acquitted on account of insanity.

RECOMMENDATION

R40 The long leave availability distinction between persons acquitted on grounds of insanity, and persons unfit to stand trial, should be abolished. Those who are unfit to stand trial should be permitted long leave.

Long leave: role of the Tribunal

- 15.7 We recommend that long leave should be a matter for the Tribunal, on application, instead of the Minister. Treating it like short term leave, as an administrative matter for the Ministry of Health, would give rise to the potential for officials to informally override a Tribunal decision about the patient’s special status. The approach we propose is consistent with the current designation of long term leave as a Ministerial decision, for persons acquitted on account of insanity: see further section 50 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 and section 66 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

- 15.8 The current provision for Ministerial revocation of long leave will also need to be altered. We are advised that such decisions are often made with quite high urgency, and any new arrangement needs to acknowledge and make provision for this. We propose that revocation should be a matter for the relevant directorate of the Ministry of Health (the Director of Mental Health for special patients, and the Director-General of Health for special care recipients) in the first instance, with a subsequent review by the Tribunal.

RECOMMENDATION

- R41 The granting of long leave should be a matter for the new Tribunal, on application, rather than the Minister.

RECOMMENDATION

- R42 Revocation of long leave should be a matter for the relevant directorate of the Ministry of Health in the first instance, with a subsequent review by the Tribunal.

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