

**B942 Bunn, K
2009**

Orders for the disordered: The sentencing and disposition of the mentally...

KRISTEN BUNN

**ORDERS FOR THE DISORDERED:
THE SENTENCING AND DISPOSITION OF
MENTALLY DISORDERED OFFENDERS**

LLB(Hons) RESEARCH PAPER

**LAW FACULTY
VICTORIA UNIVERSITY OF WELLINGTON**

2009

Word Length: 8993

Victoria

UNIVERSITY OF WELLINGTON

*Te Whare Wānanga
o te Ūpoko o te Ika a Māui*



LIBRARY

TABLE OF CONTENTS

I	INTRODUCTION.....	2
II	THE EXISTING LEGAL FRAMEWORK	4
A	THE DOCTRINE OF MENS REA.....	5
1	Mental Disorder and Mens Rea	5
B	DEFINITIONAL INCONSISTENCIES.....	6
1	Law and Medicine.....	6
2	Mental Impairment, Mental Disorder and Intellectual Disability.....	7
C	DEFENCES.....	7
1	The Defence of Insanity	8
2	The Defence of Automatism.....	9
3	Infanticide.....	9
4	The Partial Defence of Provocation.....	11
5	The Partial Defence of Diminished Responsibility.....	12
D	THE CRIMINAL PROCEDURE (MENTALLY IMPAIRED PERSONS) ACT 2003.....	13
1	“Mental Impairment”.....	14
2	Considerations Required in Making an Order.....	15
3	Evidence of Impairment.....	16
4	Concurrent Sentences	16
5	Summary.....	19
E	RECLASSIFYING OFFENDERS.....	19
F	THE SENTENCING ACT 2002.....	20
1	Purposes of Sentencing.....	20
2	Other Principles of Sentencing.....	23
3	Mitigating Factors.....	24
G	THE NEW ZEALAND BILL OF RIGHTS ACT 1990.....	27
III	RECOMMENDATIONS.....	28
A	MENTAL DISORDER TO REMAIN A NON-COMPULSORY CONSIDERATION..	28
B	ABOLITION OF THE POWER TO ORDER CONCURRENT SENTENCES.....	29
C	REHABILITATION: POLICY AND RESOURCES.....	30
IV	CONCLUSION.....	32
V	BIBLIOGRAPHY.....	34

I INTRODUCTION

The correct approach to dealing with mental disorder in the criminal justice process poses one of the most challenging problems Parliament and the judicial system must resolve. Advances in identifying, classifying, and treating mental disorders require a system that is flexible and able to account for contemporary scientific developments. Historically, those suffering from mental disorder have been subjected to discrimination and social stigma. Mentally disordered offenders have been subjected to overt state control in their lives and “extra-constitutional detention”.¹

In the National Study of Psychiatric Morbidity in New Zealand Prisons, it was established that there was a higher rate of mental disorder among prisoners than within the community. This is particularly so for personality disorders, bipolar disorder, major depression, obsessive compulsive disorder, schizophrenia, and post-traumatic stress disorder. The study established that approximately 60 per cent of all prisoners suffered from at least one major mental disorder.² Accordingly, the sentencing and disposition of mentally disordered offenders in the criminal justice process is a large issue which, surprisingly, is scarcely reflected in New Zealand’s existing legal framework.

The manner in which mentally disordered offenders are treated in the criminal justice process requires a differential approach than that applied to offenders of “normal” fortitude. The sentencing and disposition of mentally disordered offenders is a sensitive area of law where the social protection imperative can and often does outweigh fundamental human rights.

In 2003, New Zealand implemented two pieces of legislation; the Criminal Procedure (Mentally Impaired Persons) Act (“CP(MIP)A”), and the Intellectual Disability (Compulsory Care and Rehabilitation) Act. Together, these Acts deal generally with “mentally impaired” offenders.

¹ Warren Brookbanks and Sandy Simpson *Psychiatry and the Law* (Lexis Nexis, Wellington, 2007) 4.

² A I F Simpson and others *The National Study of Psychiatric Morbidity in New Zealand Prisons* (Department of Corrections, Wellington, 1999).

However, for the most part, the current law regarding the sentencing and disposition of mentally disordered offenders is confusing and inadequate. The available defences open to all offenders are not sufficient for the adequate sentencing and disposition of mentally disordered offenders. The defence of insanity is not wide enough in ambit to deal with the majority of mentally disordered offenders. Automatism does not encompass disordered offenders with conscious volition. Infanticide will only apply to a very limited class of women.³ Provocation is rarely successful in cases where mental disorder is raised as a characteristic, and is likely to be repealed in the near future.⁴ Lastly, New Zealand has no defence of diminished responsibility, and its introduction is unlikely.⁵

Unlike in other jurisdictions such as some states in the United States of America, in New Zealand mental disorder is not a mandatory consideration that a sentencing judge must take into account.⁶ Offenders suffering from mental disorder will often fall short of fulfilling the requirements for a treatment or care order under the CP(MIP)A.⁷ For most convicted offenders, the Sentencing Act 2002 will be applied by the sentencing judge.

As a group, mentally disordered offenders often face discrimination from society. Mentally disordered offenders are often subjected to longer sentences purely because the judicial system does not know the appropriate way of dealing with them, or what rehabilitation treatment may work best. It would be equally as discriminatory for a person of "normal" fortitude to be forced into a psychiatric treatment programme as it would be to place a mentally disordered offender into a

³ Crimes Act 1961, s 178.

⁴ Hon Simon Power "The Criminal Justice System: Reform is Coming" (Victoria University, Wellington 23 July 2009).

⁵ New Zealand Law Commission *The Partial Defence of Provocation* (NZLC R98, Wellington, 2007).

⁶ Thomas Fluent and Melvin Guyer "Defendant's Illness Can Be Used By the Prosecutor as an Aggravating Factor in Capital Sentencing" (2006) 34(1) *The Journal of the American Academy of Psychiatry and the Law*, 110.

⁷ *R v Chisnall* (29 March 2006) HC WANG CRI 2005-083-806.

prison system where their mental state puts their own and others health and safety at risk.⁸

This paper posits that the most appropriate way to deal with such offenders is by way of amendment to existing sentencing law. Mental disorder is not a mandatory mitigating factor in determining a sentence length, and should remain that way. However, sentencing law should be amended so that mental disorder can be more easily considered by sentencing judges as a relevant factor in determining the type of sentence that they are to impose. Mentally disordered offenders should be receiving better and more appropriate treatment, which should be flexible as scientific rehabilitation tools are improved. Existing governmental policy and spending will need to be reassessed for these recommendations to be effective; predominant punitive and unforgiving paradigms need readjusting.

II THE EXISTING LEGAL FRAMEWORK

This paper will establish the deficiencies in the existing legal framework with regard to mentally disordered offenders. While mentally disordered offenders will often meet the requisite *mens rea* standards, they have lesser "moral fault", justifying differential sentencing and disposition treatment. The existing defences are not adequate for the appropriate disposition of mentally disordered offenders. Consequently, mentally disordered offenders are dealt with under ordinary sentencing laws. The CP(MIP)A and the Sentencing Act 2002, in their current forms, are inappropriate for the sentencing and disposition of mentally disordered offenders. Due to stringent definitions and broad judicial discretion, the CP(MIP)A is limited in ambit for dealing with the majority of mentally disordered offenders. The Sentencing Act 2002 disregards mental disorder entirely.

⁸ Brookbanks and Simpson, above n 1.

A *The Doctrine of Mens Rea*

Mens rea is Latin for the "guilty mind". It is a fundamental principle in New Zealand's criminal justice process that in order to convict a person of a criminal offence, his or her action must generally be intended.⁹ The law has used the philosophy of the "will" to distinguish between what is intended and what is unintended. The "will" is distinct from other mental activities such as wondering and imagining.¹⁰ For most offences an offender must understand the nature and consequences of their actions, and have a genuine opportunity to be able to act otherwise for criminal liability to accrue.¹¹

1 *Mental Disorder and Mens Rea*

What is and is not a mental disorder is a constantly evolving notion. The development of scientific tools and research methods requires frequent changes to the conditions and criteria that define what mental disorders are. For example, where homosexuality once was considered a mental disorder, it is not considered so now. The DSM IV defines mental disorder as any "clinically significant behavioural or psychological syndrome often associated with distress, disorder or with a significantly increased risk of suffering death, pain, disorder or important loss of freedom".¹² For the purposes of this paper, the medical definition of mental disorder, as defined by the DSM IV, will be utilised.

Often a mental disorder will detract from a person's ability to act in an entirely intentional manner, or to understand the nature and consequences of their actions. However, this is not the only way a mental disorder may affect someone. A mental disorder will not necessarily mean an offender lacks the requisite *mens rea*

⁹ R D Mackay *Mental Condition Defences in the Criminal Law* (1 ed, Oxford University Press, Oxford, 1995).

¹⁰ H A Pritchard *Acting Willing, Desiring* in White (ed) *The Philosophy of Action*, 61.

¹¹ H L A Hart *The Concept of Law* (2 ed, Clarendon Press, Oxford, 1994).

¹² American Psychiatric Association Task Force *Diagnostic and statistical manual of mental disorders: DSM-IV* (4 ed, American Psychiatric Association, Washington, 1994).

for the offence. Some of the more seriously disordered offenders will know what they are doing is wrong, but may think that they are so above the law that the law does not apply to them. For example, mentally disordered offenders suffering from psychopathy or antisocial personality disorder often exhibit grandiose behaviours, where they demonstrate a preference for their own moral code over that of society's. Another example may be where an offender knows and appreciates that their conduct is against the law but are unable to prevent it, at least in part, due to mental disorder.

The basis for imposing punitive sentences on people requires a guilty mind. Mental disorder short of insanity should, at a minimum, be considered as a factor at sentencing. *R v Tuia* recognised that mentally disordered offenders may be deemed to lack full moral responsibility. In this way, moral responsibility and guilty mind are synonymous.¹³ While many mentally disordered offenders are able to meet the requisite *mens rea* standard for criminal sanctions, their lesser moral fault requires that they should receive differential treatment within the criminal justice process at sentencing.

B *Definitional Inconsistencies*

1 Law and medicine

Disparity exists between what is defined by law as and what is defined by mental health experts as mental disorder. There is no precise legal definition of mental disorder, and any inquiry is not bound by medical evidence. Inconsistency with medical evidence is not a ground for holding a verdict unreasonable.¹⁴

At law, Judges often undertake a "disease of mind" inquiry when determining the existence of mental disorder. The disease of mind inquiry allows for a broad range of mental conditions to be taken into account, but it also has included states which would not be described as a mental disorder, such as sleepwalking and

¹³ *R v Tuia* (27 November 2002) CA 312/02, 27.

¹⁴ *R v Rotana* (1995) 12 CRNZ 650.

diabetes.¹⁵ A further philosophical disparity between law and the behavioural sciences is that the law is based on the notion of “free will” and that the behavioural sciences tend to be deterministic and based on explaining factors which determine behaviour.¹⁶ Accordingly, the law and the sciences are severely out of sync with each other. Appropriately addressing the issue of mental disorder within the criminal justice process will require the two schools of thought to be more interdependent.

2 *Mental impairment, intellectual disability and mental disorder*

Mental disorder can also be distinguished from intellectual disability. Both can fall under the generic title of “mental impairment”, as it appears in the CP(MIP)A.¹⁷ Mental disorder differs from intellectual disability, which can be defined as the early onset of “a permanent impairment of cognitive capacity” and “impairment to adaptive functioning.”¹⁸ The two distinguishable impairments also differ in the treatment required. A mentally disordered person may respond to cognitive behavioural therapies and other treatment programmes to target their particular cognitions and behavioural patterns, where an intellectually disabled offender may require care and supervision. This paper does not seek to address the issues related to the treatment of intellectually disabled offenders.

C *Defences*

The operation of defences open to all offenders in New Zealand law is deficient in appropriately dealing with mentally disordered offenders. The defence of insanity is rarely used and even more rarely successful. Automatism does not cover mentally disordered offenders with conscious volition. Infanticide applies only to a limited class of women. Provocation can act to the detriment of mentally

¹⁵ *R v Hamblyn* (1997) 15 CRNZ 58.

¹⁶ Gary Melton *Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers* (Guilford Press, New York, 2007) 8.

¹⁷ *Waitemata Health v A-G* (2001) 21 FRNZ 216.

¹⁸ Brookbanks and Simpson, above n 1, 342.

disordered offenders, and is pending repeal. New Zealand does not have a defence of diminished responsibility. These defences will be discussed in turn below.

1 The defence of insanity

The insanity defence is not wide enough in ambit to deal with all mentally disordered offenders. The insanity defence is created by section 23 of the Crimes Act 1961. A not guilty by reason of insanity verdict will result in a full acquittal. It is available to only the most insane offenders. The defence encompasses a significant range of human frailty that is taken into account when assessing culpability. It is most commonly relied on by offenders with recognised mental disorders such as schizophrenia, delusional disorder, or bipolar. Offenders suffering from less common mental disorders such as alcohol and drug withdrawal, dissociative disorders, cerebral trauma, or dementia also occasionally rely on it. Offenders with serious mental disorders such as post-traumatic stress disorder, paraphilia, personality disorders, or psychopathy rarely rely on it. Furthermore, offenders "fear" an insanity verdict and do not often plead it, thus covering a limited amount of mentally disordered offenders. There is a particularly high threshold for insanity. Insanity is only raised for the most serious offences because committal as a special patient is a risk only worth running in relation to these. It is used rarely and selectively.¹⁹

Some of the most serious mental disorders often fall short of being recognised under the defence of insanity, such as post-traumatic stress disorder ("PTSD"). PTSD is a mental disorder which results in both psychological and physical manifestations, such as emotional numbing and an increased startle response. Although PTSD is a serious mental disorder, it is rarely successful in returning a not guilty by reason of insanity verdict. This is because the test for insanity relies on a distinction between cognitive and volitional defects. Volitional defects are those where a mentally disordered offender will intend their actions, but may not be able to control their urges or tendencies. The test leaves no place for

¹⁹ Mackay, above n 9.

volitional defects, which is out of step with prevailing psychiatric thinking.²⁰ Accordingly, the insanity defence is arbitrarily selective; excluding some people who are obviously insane such as those suffering from the grandiose symptoms of psychopathy who, in their nature will understand the law, but will think that they are above it.

2 *The defence of automatism*

Automatism cannot account for the majority of mentally disordered offenders. Automatism is a common law defence preserved by section 20 of the Crimes Act 1961. It covers situations where a defendant claims that they were not in control of their actions that amounted to criminal liability. Common assertions of automatism involve actions committed by reflex, or by sleepwalking. However, automatism is arguably a denial of the *actus reus* as opposed to being a defence. Furthermore, the internal-external test can be artificial, for example resulting in different outcomes for the same disease in *Quick and Hennessy*.²¹

Like the insanity defence, automatism does not encompass mentally disordered offenders who had conscious volition, but were unable to control themselves. It also does not extend to offenders who did not believe what they were doing was wrong or against the law, such as those suffering from psychopathy or personality disorders. These are the offenders who are most in need of treatment and rehabilitation, yet the criminal justice process overlooks them.

3 *The defence of infanticide*

The defence of infanticide is created by section 178 of the Crimes Act 1961. By creating the offence of infanticide, it acts as a defence to what otherwise would be culpable homicide. The historical existence of infanticide was based on actions of females which did not conform to the "predetermined Victorian female and maternal

²⁰ Brookbanks and Simpson, above n 1.

²¹ See *R v Quick* [1973] QB 910 and *R v Hennessy* [1989] 2 All ER 9.

mother" behaviour. Nowadays, many scientists view medical evidence for the existence of infanticide as outdated and of questionable validity.²² Leading psychiatric research has been found that evidence of infanticide usually relies on temporal sequence of mental disorder following birth, as opposed to linking mental disorder directly to giving birth.²³

Data exists that suggests it is not childbirth itself that alters a mother's state of mind so that they are incapable of forming an understanding of the act of murder.²⁴ While depression after childbirth is common, it is widely thought that most cases of infanticide are more likely a result of emotional pressures or personality characteristics.²⁵ The law and the sciences are at odds;²⁶ in law such pressures and characteristics will not meet the section 178 requirements. However, mental disorder stemming from child birth is found readily due to sympathy for the mother. Studies indicate that approximately 50 per cent of women convicted of infanticide kill their children in the context of unwanted, concealed pregnancies, while the remainder are thought to be physically abusive resulting in death.²⁷

It is unclear why there is a specific defence, which differs from the general defences, dealing with only one state of mental disorder. In other jurisdictions, infanticide is subsumed by the defence of diminished responsibility. In New Zealand, it could be subsumed by insanity. The continued existence of the defence of

²² Velma Dobson and Bruce Sales "The Science of Infanticide and Mental Illness" (2000) 6(4) *Psychology, Public Policy and Law*, 1103.

²³ Ian Lambie "Mothers who kill: The crime of Infanticide" (2001) 24 *International Journal of Law and Psychiatry*, 74.

²⁴ Dobson and Sales, above n 22.

²⁵ C Rouge-Maillart, N Jousset, and B Bouju "Women who kill their children" (2005) 26(4) *The American Journal of Forensic Medicine and Pathology*, 320-326.

²⁶ Norman Finkel, John Burke and Leticia Chavez "Common Sense Judgments of Infanticide: Murder, Manslaughter, Madness, or Miscellaneous?" 6(4) (2002) *Psychology, Public Policy and Law*, 1113.

²⁷ Lambie, above n 23.

infanticide arguably only affirms an ongoing societal belief in an inherent weakness in women.²⁸

4 *The partial defence of provocation*

Section 169 of the Crimes Act 1961 creates the partial defence of provocation. It applies only to murder and it reduces a murder charge to manslaughter. In most common law jurisdictions, provocation is for those who are mentally "normal". However, the majority of these jurisdictions also have the "companion" defence of diminished responsibility. In New Zealand, provocation is rarely successful for defendant's with mental disorders, due to the requirement for ordinary self-control. In the Law Commission's report on provocation, a mental disorder was successfully raised as a characteristic relevant to provocation in only one of 81 cases.²⁹

The Law Commission has suggested repeal of the defence of provocation.³⁰ In cases such as *R v Rongonui* where provocation was successful,³¹ reference to the defendant's abnormality of mind may have been more appropriate than referring to the victim as "provoking" their own murder. The Law Commission further recommended that provocation should be weighed with other aggravating and mitigating factors as part of the sentencing process. It is more appropriate to deal with provocation and mental disorder at sentencing where it can be graded along a continuum as opposed to disorder being considered as a black and white issue as the defence stands now.³² Its repeal is also justified on the basis that it can be confusing to a layperson.

²⁸ Andrew Payne "Infanticide and child abuse" (1995) 6 *Journal of Forensic Psychiatry*, 474.

²⁹ Brookbanks and Simpson, above n 1.

³⁰ New Zealand Law Commission, above n 5.

³¹ *R v Rongonui* [2000] 2 NZLR 385.

³² New Zealand Law Commission, above n 5.

5 *The partial defence of diminished responsibility*

A defence of diminished responsibility directly takes mental characteristics into account. It is a partial defence and reduces murder to manslaughter. The defence is available to those defendants who are unable to meet the high threshold for the defence of insanity but where it would be overly harsh, because of their mental state, to hold them fully responsible for murder.

Diminished responsibility is perceived as a way of untying the hands of sentencing judges in homicide cases where mental disorder was clearly an acting factor in the offending.³³ Diminished responsibility, as it stands in other jurisdictions, has a limited application to homicide offences only. Accordingly, the introduction of a defence of diminished responsibility would not be able to solve the holistic problem of the sentencing and disposition of mentally disordered offenders in the criminal justice process. Moreover, a successful defence of diminished responsibility results only in a reduction in the sentence length, putting those who are in need of treatment and rehabilitation back into the community faster. Returning these offenders to the community quicker, without appropriate treatment and rehabilitation, fails to serve any positive goal in the criminal justice process.

At present, the defence of diminished responsibility has not been introduced into New Zealand. There are some hints of diminished responsibility within provocation where mental characteristics have been taken into account. The defence of infanticide could be viewed as a limited form of diminished responsibility. However, it is not a substantive defence in New Zealand, which has been reaffirmed in *R v Gordon*.³⁴ There have been various attempts to introduce it, such as the introduction of the unsuccessful clause 180 of the Crimes Bill 1960.

The introduction of a defence of diminished responsibility would bring New Zealand law into step with a number of other commonwealth countries, such as England and Scotland. The introduction of such a defence would allow for a wider

³³ David N Weisstub *Law and Psychiatry in the Canadian Context* (1 ed, Pergamon Press, New York, 1980), 621.

³⁴ *R v Gordon* (1993) 10 CRNZ 430.

scope of mental disorders to be considered in law that at present do not satisfy the test of insanity, and are excluded from considerations under the defence of provocation.³⁵ The idea of the introduction of diminished responsibility is popular with defending counsel and with a large portion of medical experts and expert witnesses. However, a major justification for the existence of the defence of diminished responsibility no longer exists in New Zealand, in that the mandatory life sentence has been repealed.³⁶ The Law Commission, in the Battered Defendants Report, recommended that no diminished responsibility defence should be introduced, and that mental disorder is better to be taken into account at sentencing.³⁷ This recommendation was made in 2001, and yet no specific inclusion of mental disorder as a relevant consideration was included in the Sentencing Act 2002.

Introducing a defence of diminished responsibility, while being a step in the right direction, would not be sufficient in appropriately dealing with mentally disordered offenders in the criminal justice process. In the meantime, legal professionals and the judiciary should devote sufficient time and weight to mental disorder at sentencing as a relevant consideration.

D The Criminal Procedure (Mentally Impaired Persons) Act 2003

The CP(MIP)A was intended to cover mentally impaired persons who were unfit to stand trial, and the most mentally disordered offenders, such as many of those who returned a successful defence of insanity verdict. It cannot and does not cover all mentally disordered offenders in the criminal justice process. By providing sentencing judges with the ability to order concurrent sentences of imprisonment and

³⁵ Warren Brookbanks "Diminished Responsibility: balm or bane?" in *Movements and markers in criminal policy* (Legal Research Foundation, Auckland, 1984) 82.

³⁶ New Zealand Law Commission *Some Criminal Defences with Particular Reference to Battered Defendants* (NZLC R73, Wellington, 2001).

³⁷ *Ibid.*

detainment in a mental health institute, the Act provides a mechanism which unfairly discriminates against many of the offenders that it covers.

1 "Mental impairment"

The CP(MIP)A utilises the term "mental impairment" as the threshold a judge utilise in deciding whether to sentence an offender concurrently to detention in a mental health institute and in a penal institute.³⁸ The term "mental impairment" was deliberately left wide by Parliament so that the "courts [were] free to interpret the term in line with the overall purpose of ensuring procedural fairness".³⁹ To make an order under section 34, the Court must be satisfied that compulsory care is required because of the "mental impairment". While the High Court in *R v Chisnall* held that intellectual disability can clearly be a mental impairment, it also clearly inferred that some mental disorders, such as personality disorders, will not qualify as mental impairment.⁴⁰ A personality disorder must be recognised and severe to the extent that it amounts to an "abnormal state of mind".⁴¹ The test to determine whether a given person meets the "mental impairment" threshold is whether the condition "produces pathology which may be susceptible to treatment in a clinical setting".⁴² As a threshold to reach when establishing whether or not to impose an order, susceptibility to treatment should not be the standard. While this threshold is closer aligned to the thinking of the medical profession, a mentally disordered offender should not be imprisoned solely because the sciences have not established an effective rehabilitation scheme. Accordingly, the inappropriate standard by which mental impairment is assessed will mean that many mentally disordered offenders, particularly those who are not "susceptible to treatment" in a clinical setting, will not

³⁸ Criminal Procedure (Mentally Impaired Persons) Act 2003, s 34(2).

³⁹ Justice and Law Reform Committee "Criminal Justice Amendment (No 7) Bill Explanatory Material" 2001.

⁴⁰ *R v Chisnall*, above n 7.

⁴¹ *Waitemata Health v A-G*, above n 17.

⁴² *Ibid.*

be covered by the CP(MIP)A leaving them to be sentenced under the Sentencing Act 2002.

2 *Considerations required in making an order*

Before making an order under the CP(MIP)A, the Court must be satisfied that detention in a hospital is necessary in the offender's interests or in the interests of public safety.⁴³ The Court will consider all the relevant circumstances when assessing the safety of the offender or public safety. These circumstances are not limited to the offender's own safety and the safety of the public generally; *R v Chisnall* held that the Court could assess the risk of exploitation of others in the hospital setting.⁴⁴ It was held that if an offender posed a risk to other's treatment, this would eliminate the benefit of placing them in a hospital. Finite imprisonment was justified on this basis.

The Courts have held that section 34 of the CP(MIP)A does not remove the requirements for a sentencing judge to take into account the sentencing principles and purposes under the Sentencing Act 2002.⁴⁵ The High Court in *Police v R* held that while there may be understandable compassion for mentally disordered offenders, any focused attention on rehabilitation was not the proper approach to take in determining an appropriate sentence.⁴⁶ Therefore, the safety threshold is not as easy as it first appears for a mentally disordered offender to meet. Furthermore, even if this threshold is met, a sentencing judge may still deem an order to be unnecessary or inappropriate. Accordingly, not only does the legislation need to be questioned, but also its use by sentencing judges. This provision will mean that many mentally disordered offenders will not receive treatment under the CP(MIP)A, and are left to be sentenced by the Sentencing Act 2002.

⁴³ Criminal Procedure (Mentally Impaired Persons) Act 2003, s 34(2).

⁴⁴ *R v Chisnall*, above n 7.

⁴⁵ *Police v R* (2 November 2007) HC CHCH CRI-2007-409-188.

⁴⁶ *Ibid.*

3 *Evidence of impairment*

The CP(MIP)A has no requirement for certification of mental disorder from a medical expert for an order to be made. Section 34(3) requires the Court to be satisfied that an offender is mentally disordered, on the evidence of one or more health assessors. This gives sentencing judges great discretion in exercising their powers to make an order under section 34(1). While under the Mental Health (Compulsory Care and Treatment) Act 1992 ("MH(CAT)A"), which has subsequently been repealed in part, the certificates of health assessors were not binding on the sentencing judge, they were afforded great weight as they certified that the offender had satisfied specific diagnostic criteria.⁴⁷ Without this certification, there is "no obligation on the Court to specifically address each condition nominated in subsection 2 [that the mental disorder requires compulsory care in the interests of the offenders safety or the safety of the public] even though he or she must be satisfied of those matters in a global sense."⁴⁸ The disregard sentencing judges may have of medical opinion could result in an arbitrary distinction being made between mentally disordered offenders. Those who may have received treatment under the provisions of the MH(CAT)A may not receive such care under the CP(MIP)A.

4 *Concurrent sentences*

The CP(MIP)A was designed to fill a hole in the law created by the MH(CAT)A. Under the MH(CAT)A, the Courts could either impose a sentence on an offender or order their detainment as a "patient". They could not do both. The Court could not determine the length of the offender's detainment or the type of institute they were to be held in.⁴⁹ Many offenders detained in rehabilitation

⁴⁷ *R v Redmile* [1987] 1 NZLR 157.

⁴⁸ James Bruce Robertson (ed) *Adams on Criminal Law* (5 ed, Brookers, Wellington, 2007).

⁴⁹ Mental Health (Compulsory Care and Treatment) Act 1992.

programmes required compulsory treatment for minimal periods of time and were discharged into the community swiftly.⁵⁰

Section 34(1)(a) of the CP(MIP)A was passed to ensure that the criminal courts could impose orders on such offenders which better suited their treatment needs. It sought to ensure that those offenders who needed care received it in a judicious fashion. This section enables a sentencing judge to order an offender to serve a finite term of imprisonment while also being concurrently detained as a “special patient” in a mental health hospital.⁵¹ If at any stage the offender ceases to require treatment, they are returned to prison to serve the rest of their sentence, unlike being discharged into the community as under the MH(CAT)A. In deciding whether to order a concurrent sentence,⁵² as opposed to ordering a sentence merely of treatment,⁵³ the Court will have regard to the original crime. In *R v S*, the High Court held that for the most dangerous offenders a concurrent order under section 34(1)(a) will be appropriate.⁵⁴ By implication, the Court will be likely to impose an order under section 34(1)(b) for less serious offences.

Ordering concurrent penal detention and mental health treatment attempts to marry two conceptually different aims together, namely rehabilitation and punishment. This change was introduced to mitigate the premature discharge of a disordered offender into society, who no longer required compulsory care.⁵⁵ At common law, concurrent sentences were deemed appropriate where “two offences arise out of a single set of facts (the one transaction) and the nature of the offending is similar”.⁵⁶ Unless two offences have arisen from a single set of facts, to say that a mentally disordered offender is to serve a concurrent sentence sends the message

⁵⁰ Robertson, above n 48.

⁵¹ Criminal Procedure (Mentally Impaired Persons) Act 2003, s 34(1)(a).

⁵² Criminal Procedure (Mentally Impaired Persons) Act 2003, s 34(1)(a).

⁵³ Criminal Procedure (Mentally Impaired Persons) Act 2003, s 34(1)(b).

⁵⁴ *R v S (No 2)* (1991) 7 CRNZ 576.

⁵⁵ Justice and Law Reform Committee, above n 39.

⁵⁶ Geoff Hall *Sentencing: 2007 Reforms in Context* (Lexis Nexis, Wellington, 2007) 406.

that they are more blameworthy than a non-disordered offender who, if having committed the exact same offence, would only have received a single sentence.

The Ministry of Justice argued that imposing both a penal sentence and a rehabilitative sentence recognises the separate nature of the two concepts; that with concurrent sentencing, mental disorder will be treated until the offender is well, upon which punishment will be attended to.⁵⁷ This argument may have some validity on an academic level. However, to combine these two modes sends a confused message to the community about the offender and the crime they have committed. The label of a concurrent sentence may induce perceptions that mentally disordered offenders are more blameworthy or more liable than non-disordered offenders. Running a hospital order and a term of imprisonment concurrently rejects the notion that “the hospital order as a sentencing option is a benevolent alternative to a custodial sentence”.⁵⁸ If an offender is so mentally disordered as to require treatment in a mental health institute, their ability to comprehend the purposes and principles of a sentence of imprisonment will be questionable. Accordingly, a concurrent sentence will be “inhumane to impose” as they will not have the necessary capacity for the purposes of sentencing to have effect.⁵⁹

There exists no obvious reasoning advocating solely for concurrent sentencing;⁶⁰ the problem of prematurely releasing offenders into the community could also be avoided by giving sentencing judges the power to review the question of imprisonment if and once the mental disorder remits itself. If, at that stage, the offender is deemed able to understand the purpose and implications of a penal sentence, they should serve the remainder of their sentence within a penal institute. The judge should not have the option of extending a sentence at this stage, and time spent within the mental health institute should contribute to the totality of the length of the sentence served. Consecutive sentencing is not advocated for; the single

⁵⁷ Ministry of Justice *Advice on the Sentencing Bill* (submission to the Justice and Law Reform Committee, 2001).

⁵⁸ Brookbanks and Simpson, above n 1, 217.

⁵⁹ *Ibid.*, 218.

⁶⁰ *Ibid.*, 217.

sentence runs from the time a mentally disordered offender is sentenced, regardless of the location of where they are to serve it. This allows for incapacitation of those who recover from mental disorder quickly. It does not lengthen the sentence further for those mentally disordered offenders who take longer to get well. Parliament should address the issue of what purpose of sentencing is to be accorded priority, in particular with regard to mentally disordered offenders. The ultimate question is whether the judiciary should be primarily focused on social protection and deterrence, or on rehabilitation. The judiciary does not have to be tied to either exclusively, and it is a decision for the legislature as to whether they should be accorded equal weight or whether one should take priority. An increased focus on rehabilitation will result in benevolent and humane outcomes.

5 *Summary*

In summary, while the CP(MIP)A purports to remedy the stark deficiencies that were apparent in the MH(CAT)A, it also has flaws of its own which need addressing. Together, these deficiencies leave the making of a hospital order under section 34 of the CP(MIP)A with very limited scope and applicability.

E Reclassifying Offenders

There is difficulty in reclassifying offenders once they are deemed to no longer require compulsory treatment. The decision to return a disordered offender to serve the remainder of their concurrently running sentence in prison is made by the Director of Area Mental Health Services.⁶¹ This decision can be gravely misjudged, which may see mentally disordered offenders prematurely returned to a penal institute.⁶² There are no appropriate review and safeguard mechanisms for this decision, which is problematic and can be dangerous. This was evidenced in the process regarding and the treatment of convicted offender Murray Childs. Childs suffered from “severe depression, psychosis, and had a history of self-mutilation”,

⁶¹ Mental Health (Compulsory Care and Treatment) Act 1992, s 47(1).

⁶² Ian Stewart “Lax process criticized in jail suicide” (18 May 2009) *The Press* Christchurch.

yet upon his return from a designated care unit, was placed into a general cell wing in prison where he had access to razors. The prison guards had not been notified of the extent of Childs' disorders, as the nurse who facilitated the transfer did not want the guards to think that they had a psychopath on their wing. The guards did not monitor Childs adequately and he subsequently committed suicide.⁶³

F The Sentencing Act 2002

The Sentencing Act 2002 is used for sentencing the majority of all offenders. In general, most mentally disordered offenders will not meet the requirements of the available defences or the CP(MIP)A, and will be sentenced under the Sentencing Act 2002 ("the Act"). However, the Act also has its deficiencies. The majority of the purposes of the Act are not readily applicable to mentally disordered offenders, and mental disorder is entirely disregarded from the Act.

1 Purposes of sentencing

New Zealand's main aim of its sentencing legislative framework focuses on the harm done, not why it is caused or how the circumstances may have contributed to it. It is largely concerned with the protection of the public at large. The Sentencing Act was passed in 2002 as the Labour Government's response to the Norm Withers referendum.⁶⁴ As evidenced in the parliamentary debates during the first, second and third readings of the Bill, the Act was intended to be a tough response to what was perceived as weak sentencing and parole laws.⁶⁵ This "just deserts" approach to sentencing ignores the reality of the effect mental disorder can have on the behaviour of persons.⁶⁶ Accordingly, mental disorder and rehabilitation will often be secondary to the question of protection of the public.⁶⁷ There is an

⁶³ Ibid.

⁶⁴ (14 August 2001) 594 NZPD 10911.

⁶⁵ Ibid.

⁶⁶ Brookbanks and Simpson, above n 1, 212.

⁶⁷ Ibid, 213.

“inherent contradiction” in the sentencing of mentally disordered offenders; mental disorder itself suggests a requirement for treatment, yet the Courts always ultimately focus on punishment.⁶⁸

There are also other purposes of sentencing, some of which are also reflected in practice in New Zealand’s system, others much less. The less often cited purposes are generally those which better recognise the impact mental disorder can have on an offender’s behaviour. Section 7(1) of the Act establishes the purposes of sentencing or otherwise dealing with offenders:

- (a) to hold the offender accountable for harm done to the victim and the community by the offending; or
- (b) to promote in the offender a sense of responsibility for, and acknowledgment of, that harm; or
- (c) to provide for the interests of the victim of the offence; or
- (d) to provide reparation for harm done by the offending; or
- (e) to denounce the conduct in which the offender was involved; or
- (f) to deter the offender or other persons from committing the same or a similar offence; or
- (g) to protect the community from the offender; or
- (h) to assist in the offenders rehabilitation and integration; or
- (i) a combination of 2 or more of the purposes in paragraphs (a) to (h).

The applicability of the majority of these purposes to mentally disordered offenders is problematic. Disordered offenders quite often will not understand the significance of the principle of punishment as required for the purpose of deterrence to have any effect. Because mentally disordered offenders may be deemed to lack full moral responsibility, they may not deserve to be held fully accountable for their actions, making the accountability purpose hard to apply.⁶⁹

⁶⁸ Ibid, 206.

⁶⁹ Mackay, above n 9.

The purpose of incapacitation, or social defence,⁷⁰ allows for mentally disordered offenders to be detained even if they may not be “blameworthy”, as they pose a danger to society at large. The principle of proportionality juxtaposes this purpose in regard to mentally disordered offenders. If applied, the principle of proportionality will ensure that the rights of such offenders are upheld so that they are not subjected to unduly protracted sentences and arbitrary assumptions about their future behaviours.

The purpose of incapacitation bases a sentence not on the present offence but on the likelihood of recidivism. This purpose can act detrimentally in regard to mentally disordered offenders; although not more blameworthy, they are seen as “riskier” and have a greater rate of recidivism than “normal” offenders. Too great a focus on incapacitation leaves room for mentally disordered offenders to be discriminated against; they may be subjected to longer sentences than offenders of “normal” fortitude, based solely on the existence of mental disorder.

Deterrence focuses on the individual offender and, through the imposition of exemplary sentences, seeks to deter that individual, or society at large, from offending.⁷¹ Deterrence is an inappropriate purpose to apply in relation to mentally disordered offenders as often they will not completely comprehend the significance of punishment, or may not deserve it. It is more likely that mental disorder may mean that a given sentence “will impact on [a mentally disordered] offender more heavily than it would a person in normal health”.⁷²

The purpose of restitution looks to the needs of the victim of an offence and requires the offender to put right the wrong done by their conduct and to restore the moral equilibrium.⁷³ Unlike any other purpose of sentencing, restitution ignores the characteristics of the offender, and society at large. It is argued that it makes offenders accept responsibility for their crime; that it is useful because it, like

⁷⁰ Sentencing Act 2002, s 7(g).

⁷¹ Sentencing Act 2002, s 7(f).

⁷² *R v Tsiaras* [1996] 1 VR 398.

⁷³ Sentencing Act 2002, s 7(c).

rehabilitation, is “something offenders do, rather than something they have done to them”.⁷⁴ Because restitution focuses on damage and harm done to the victim, the intention and mentality of the offender is irrelevant.

Rehabilitation is offender focused.⁷⁵ Rehabilitation aims to reduce recidivism by changing the behaviours, attitudes or skills of the offender. This is the most appropriate way of dealing with mentally disordered offenders. Without rehabilitation, the causal factor of the offender’s behaviour will not be altered. If mental disorder is not properly addressed, the risk of recidivism cannot be reduced by any significant degree. If mental disorder is left untreated, the risk a mentally disordered offender poses to society will still be present once their sentence is served. This is further compounded by the fact that total irresponsibility in law by reason of insanity will result in indefinite detention in a mental health institute. A semi-irresponsible person, such as a mentally disordered offender, will require not punishment but treatment, and will receive neither.

In the parliamentary debates during the readings of the Sentencing Bill, denunciation, deterrence, and social protection were particularly emphasised. Rarely was rehabilitation mentioned.⁷⁶ While subsection 2 states that no single purpose was intended to have greater weight than any other, the time devoted to discussing each purpose in the House would suggest otherwise.

2 *Other principles of sentencing*

Where possible, there should be a focus on protecting the rights and liberties of mentally disordered offenders in the criminal justice process. Such a focus seems discordant with the purposes of accountability and deterrence; the purpose of holding a disordered offender responsible for his or her crime cannot be met unless

⁷⁴ Ministry of Justice *Sentencing and Guidance: A Discussion Paper* (Ministry of Justice, Wellington, 1997) 79.

⁷⁵ Sentencing Act 2002, s 7(h).

⁷⁶ Hansard, above n 64.

the law has an active role in the treatment of their mental disorder.⁷⁷ Minimum criminalisation requires that the Court imposes the least restrictive outcome that is appropriate in the circumstances. For an offender of “normal” mental fortitude, a sentence of compulsory treatment and rehabilitation is unlikely to be the least restrictive outcome. The opposite may be argued for mentally disordered offenders; subjection to imprisonment in a penal institute will not be the least restrictive option available. Providing rehabilitation and treatment to these offenders will be more likely to be successful in reducing the risk of recidivism.

3 *Mitigating factors*

Section 9(2) of the Act lists mitigating factors that the Court must consider, to the extent that they are applicable, when they are sentencing an offender. They include:

- (a) the age of the offender;
- (b) whether and when the offender pleaded guilty;
- (c) the conduct of the victim;
- (d) that there was a limited involvement in the offence on the offender's part;
- (e) that the offender has, or had at the time the offence was committed, diminished intellectual capacity or understanding;
- (f) any remorse shown by the offender, or anything as described in section 10;
- (g) any evidence of the offender's previous good character.

While subsection (2)(e) requires diminished intellectual capacity to be taken into account, there is no express mention of diminished mental capacity or mental disorder. Diminished intellectual capacity is not wide enough to cover mentally disordered offenders; most of which will be functioning at a “normal” intellectual

⁷⁷ Brookbanks and Simpson, above n 1, 207.

capacity level. Subsection 4 allows the Court to take into any other factor it deems applicable, but does require not the Court to detail reasons as to why it did or did not consider the factor as relevant.

The legislature's failure to make provision for mentally disordered offenders in the list of mitigating factors in the Act reflects the punitive attitude that is taken towards sentencing mentally disordered offenders. It is likely this was intended; mental disorder was not discussed once during the parliamentary debates. The blatant exclusion of mental disorder leaves room for the trivialising of the special treatment requirements a mentally disordered offender will often need. This is particularly so because of the limited scope of the CP(MIP)A, which will see many mentally disordered offenders fall outside of it.

Furthermore, the Supreme Court of South Australia in *R v Wiskich* established the general principle that where there is mental disorder, provided there is no link between the mental condition and the commission of the offence the Court should not depart from the norm sentencing rules. Taking mental disorder into account as a mitigating factor where there is no link between the committal of the offence and the mental disorder goes against the point of having a punitive system.⁷⁸ While the Courts justify longer sentences for the most "dangerous" mentally disordered offenders in the name of public protection, there is broad consensus across most schools of thought that mentally disordered offenders should not be dealt with in the same manner as offenders of "normal" fortitude.⁷⁹ In this way, allowing mental disorder to be taken into account as a relevant factor can produce more humane results.

The greatest conflict within this Act is that between section 7(1)(g) which advocates for the protection of the public, and section 8(h) which requires that the court:

⁷⁸ *R v Wiskich* [2000] SASC 64.

⁷⁹ Brookbanks and Simpson, above n 1.

“take into account any particular circumstances of the offender that mean that a sentence or other means of dealing with the offender that would otherwise be appropriate would, in the particular instance, be disproportionately severe”.

This paper is mostly concerned with disproportionately severe sentence length. However, there could also be disproportionate severity in the offender's subjective experience of imprisonment. Imprisonment, particularly if a sentence is lengthened, may affect those with a mental disorder greater than non-disordered offenders. Subjective severity should be a compulsory consideration for sentencing judges to take into account when sentencing mentally disordered offenders. The subjective experience of treatment and rehabilitation programmes is most likely going to be less severe than that of a sentence served in prison.

The Courts have held that only upon evidence that a mentally disordered offender is not a risk to a community, should a mental disorder be taken into account as a mitigating factor and that a sentence be reduced.⁸⁰ However, the Court of Appeal in *R v Abraham* held that:

“inability to appreciate the consequences of the offender's actions and to exercise independent self-control, especially when that is combined with evidence of a continuing disorder and of drug dependency which is likely to exacerbate it and increase the risk of re-offending, may require the sentencing judge, in the interests of the public at large, to put aside thoughts of discounting the penalty which the offence would otherwise warrant.”⁸¹

Because the principles and purposes of sentencing are applied as normal to most mentally disordered offenders, there is room for sentencing judges to be greater swayed by public protection pleas and to increase sentences based purely on the

⁸⁰ *R v Abraham* (1993) 10 CRNZ 446.

⁸¹ *Ibid.*

existence of a mental disorder. Because purely lengthening a sentence does not automatically provide the offender with any mental health care, the public interest is not necessarily served. What is likely to be an underlying cause of the offending may not be addressed and risk of recidivism may not be reduced.

However, other cases have been decided contrary to the ruling in *R v Abraham*.⁸² More recently, the Court of Appeal in *R v Tuia* held that lengthening a sentence purely because of mental disorder would be unprincipled; that this would be a matter for mental health legislation, and not for criminal sentencing.⁸³ If an offender is deemed sane enough to not require treatment under the CP(MIP)A, their mental disorder should not be relevant to extending or decreasing the length of their sentence. The existence of a mental disorder should not be a reason for the early release of an offender into the community, without the appropriate treatment and rehabilitation, as would happen if mental disorder was listed as a mitigating factor. Accordingly, due to division in judicial thinking, the Act should be amended to stipulate the manner in which a sentencing judge is to treat mental disorder. There must be caution to avoid mental disorder being considered as an aggravating factor purely because mentally disordered offenders are often considered more "risky".⁸⁴

G *The New Zealand Bill of Rights Act 1990*

Section 19 of the New Zealand Bill of Rights Act 1990 requires that everyone has the right to freedom from discrimination on the grounds established in the Human Rights Act 1993. These grounds prohibit discrimination against anyone suffering from any psychological impairment or abnormality. Section 22 of the New Zealand Bill of Rights Act 1990 gives every person the right to liberty, including the right not to be arbitrarily detained. The detainment of an offender in a prison for a sentence longer than would be imposed but for the existence of mental disorder clashes with the right to liberty. The Courts tend to justify limitation on this right on

⁸² Ibid.

⁸³ *R v Tuia*, above n 13.

⁸⁴ Brookbanks and Simpson, above n 1, 205.

the basis of public protection. However, in particular, if a mentally disordered offender is sentenced to a longer finite term of imprisonment in a penal institute, as opposed to a mental health institute, they most likely are not receiving the adequate treatment that they need. If an offender is so mentally disordered as to require longer detainment in the interests of public protection, they should never be sentenced to a term of imprisonment in a penal institute, but to one in a mental hospital. Accordingly, mental disorder short of insanity should only be relevant to extending an offender's treatment if it is in a mental health institute or rehabilitative scheme. To increase a sentence of imprisonment solely due to mental disorder could be viewed as a breach of freedom of liberty and a person's right to be free from discrimination. While the paramount consideration will necessarily be on the protection of the public, sentencing laws should conform as closely as possible with fundamental rights owed to all individuals.⁸⁵

IV RECOMMENDATIONS

The current operation of the law is not satisfactory in relation to mentally disordered offenders. This paper posits that, while the existing Sentencing Act 2002 is flawed, it is the most appropriate arena for the disposition of the majority of mentally disordered offenders. It is not suggested that the only ethical treatment of all mentally disordered offenders is pure rehabilitation and therapy. However, reforms can and should be made which better account for the care and rehabilitation of mentally disordered offenders.

A Mental Disorder Should not Become a Compulsory Mitigating Factor

First, it is recommended that mental health and disorder should not be a mitigating factor in reducing the length of a sentence, particularly where there is no link between the crime and mental disorder. There is danger in excluding mental health from the list of mitigating factors; the judiciary and legal profession need to

⁸⁵ Ibid, 214.

be careful that the deliberate omission of mental disorder does not undermine the special treatment requirements a mentally disordered offender may need. Instead, amendment to the Sentencing Act 2002 should be made to ensure that mental health and disorder is relevant to the type and form of the punishment an offender receives. As science and technology advances, society learns how to better treat mentally disordered offenders. A mentally disordered offender, who fails to meet the requirements of the insanity defence, or the CP(MIP)A, should still receive treatment for their disorder, whether this is during imprisonment or in community-based facilities such as habilitation centres. They should not be held in a penal institute solely because of mental disorder. Furthermore, they should not be held in a penal institute longer than a non-disordered offender would be. In this way, while still punishing the offender for their crime, the criminal justice process may better be able to reduce the risk of recidivism by treating one of the likely causal factors in the committal of the offence itself.

B Abolition of the Power to Order Concurrent Sentences

Secondly, the ability of a sentencing judge to order concurrent sentences under the CP(MIP)A should be abolished. Concurrent sentencing sends confused messages to the community about blameworthiness, and forces the judiciary to accord equal weight to the purposes of sentencing. If an offender is so mentally disordered such that they require treatment under the CP(MIP)A, they most likely will not have the capacity to rationally comprehend the purposes of sentencing. To order a concurrent sentence of imprisonment would therefore be inhumane. For mentally disordered offenders, the legislature should make the choice between the two discordant aims of sentencing; social protection or rehabilitation. A concurrent sentence order, where an offender has not committed more than one offence, is unnecessarily discriminatory against mentally disordered offenders. The problems that arose under the MH(CAT)A can be avoided in the same way as imposing concurrent sentences as by imposing a single sentence. In the case where an offender is to receive care under the CP(MIP)A, the courts should retain the power to review the question of the sentence if and once the illness remits itself, and the offender has

the rational capacity to understand the purpose and implications of a penal sentence. The offender should not be eligible for release to the community if their specific mental disorder improves at any stage of their sentence.

C *Rehabilitation: Policy and Resources*

The limited scope of the CP(MIP)A, exacerbated by the limited application of defences to a mentally disordered offender, often leaves a sentencing judge with no option other than imposing a sentence of imprisonment in a penal institute. This is in itself problematic; it is widely accepted that the mental health services in prisons are seriously lacking and deficient.⁸⁶ The lack of treatment for mentally disordered offenders places not only the offenders at risk, but also other prisoners and also prison staff.

While the Court of Appeal in *R v Arama* dealt with an offender who was intellectually disabled, the judgment outlined that while there is the provision of some mental health facilities within prisons, they are generally reactive. They do not support long term rehabilitative goals and are generally inadequate in addressing the mental disorders which are so prevalent in the population of prisons.⁸⁷

The inadequacy of resources to deal with mental disorder within penal institutions has recently been evidenced in the suicide of prisoner Antonie Dixon. Dixon was indisputably mentally disordered; he suffered from addiction to alcohol and "P", a class A methamphetamine. Dixon refused to take medications prior to his death, and was often beaten in prison by other inmates. At trial, while he failed to satisfy the requirements of the insanity defence, prosecutors accepted that Dixon did suffer from a severe personality disorder and paranoia.⁸⁸ Although Dixon committed suicide prior to being sentenced, his suicide demonstrates the inadequacy of within-

⁸⁶ New Zealand Office of the Auditor-General *Mental health services for prisoners* (Office of the Auditor-General, Wellington, 2008).

⁸⁷ *R v Arama* (1993) 10 CRNZ 592.

⁸⁸ Elizabeth Binning "Dixon: 'They Want Me to Kill Myself'" (6 February 2009) *The New Zealand Herald* Auckland.

prison mental health facilities to care for those prisoners who have not satisfied the test of requiring treatment in their own interest or the interests of the safety of the public.⁸⁹

The Ministry of Justice has acknowledged that imprisonment is never appropriate for intellectually disabled offenders, but do not hold the same view for mentally disordered offenders. In their submissions on the Criminal Procedure (Mentally Impaired Persons) Bill, they noted the backlog of prisoners waiting for psychiatric treatment.⁹⁰ Lord Butler stated in his Report of the Committee on Mentally Abnormal Offenders that where an offender suffered from a mental disorder, they should be placed in the care and custody of the mental health institutions as opposed to being sent to prison.⁹¹ The idea that mentally disordered offenders should never be subjected to detainment in a penal institute, over 30 years later, is still a contentious issue. There is continuously strengthening evidence, that is now almost universally accepted, that as less mentally disordered offenders are treated in mental health institutes, the numbers in prison dramatically increase, and vice versa.⁹² Henry Rollin concludes his article mentally disordered offenders with "on the grounds of humanity and public safety, it is unacceptable that mental disorder in this readily accessible group of offenders should go undetected and untreated."⁹³

The resources available for treatment and rehabilitation in the criminal justice process need to be increased. While the general focus of the criminal justice process is on punishment and social protection, mentally disordered offenders will not receive the treatment that they require within penal institutes. In order to

⁸⁹ Criminal Procedure (Mentally Impaired Persons) Act 2003, s 34.

⁹⁰ Ministry of Justice *Advice on the Criminal Procedure (Mentally Impaired Persons) Bill* (submission to the Justice and Law Reform Committee, 2002).

⁹¹ Lord Butler *Report of the Committee on Mentally Abnormal Offenders* (Cmnd 6244, Home Office and Department of Health and Social Security, London, 1975).

⁹² Henry Rollin *The Mentally Ill should be in hospital, not prison* (1996) 2 *Journal of Forensic Psychology and Psychiatry*, 326.

⁹³ *Ibid*, 329.

effectively rehabilitate and reduce the risk of recidivism of mentally disordered offenders, it must be recognised that prolonged incarceration, without adequate treatment, is not of assistance. Whether through greater funding for therapeutic programmes within penal institutes, or greater funding for community-based treatments such as habilitation centres, the treatment of mental disorder should be better addressed. While the strongest focus of our post-trial criminal justice process is on “just deserts”, the commitment to addressing the root of offending will continue to be neglected. Greater dedication to establishing a comprehensive strategy to deal with the immense incidence of mental disorder within prisons is required.⁹⁴

V CONCLUSION

Mentally disordered offenders in the criminal justice process are subject to some differential treatment under the law. However, the majority of mental disorder goes untreated. Sentencing judges are not required to take mental health into account as a mitigating factor when determining an appropriate sentence. The insanity defence is narrow and harsh, and with automatism, excludes a many of the most mentally disordered offenders. In determining provocation, “mental characteristics” are rarely relied on. When they are, they are rarely successful. The defence of diminished responsibility has not been introduced in New Zealand, and it is unlikely that it will be. Accordingly, the defences available are not fully adequate in appropriately sentencing mentally disordered offenders.

Vast improvements to the mental health services within penal institutes are required; it is not adequate to discriminate against mentally disordered offenders merely because there is no miracle cure for their disorders. If the purposes of punishment cannot practically be applied to and understood by mentally disordered offenders, finite sentences of imprisonment will not be the best route for dealing

⁹⁴ Rt Hon Chief Justice Dame Sian Elias “Blameless Babes” (Annual 2009 Shirley Smith Address, Wellington, 9 July 2009).

with them. While the drive for the purposes of social protection and deterrence for criminal offences from victims and society in general is understandable as part of human nature, it denies the fact that prison sentences are often incapable of reforming most mentally disordered offenders. It is inevitable that they will eventually end up in the community again. Without treatment, the risk of recidivism will not have changed. Relationships between the mental health sector and the legal profession should be encouraged; working closer to enlighten society about the effect mental disorder may have on behaviour. There should be greater sharing of knowledge between the two professions, so that the treatment and punishment of mentally disordered offenders is not left solely in the hands of the judiciary. Meanwhile, scientists and legal professionals, and the judiciary should devote time and effort into determining and developing the most appropriate sentencing and disposition options.

VI BIBLIOGRAPHY

A Legislation

Crimes Act 1961.

Criminal Procedure (Mentally Impaired Persons) Act 2003.

Mental Health (Compulsory Care and Treatment) Act 1992.

Sentencing Act 2002.

B Bills

Crimes Bill 1960.

Criminal Procedure (Mentally Impaired Persons) Bill 2002.

Sentencing and Parole Bill 2001.

C Cases

Police v R (2 November 2007) HC CHCH CRI-2007-409-188

R v Abraham (1993) 10 CRNZ 446

R v Arama (1993) 10 CRNZ 592.

R v Chisnall (29 March 2006) HC WANG CRI 2005-083-806.

R v Gordon (1993) 10 CRNZ 430.

R v Hamblyn (1997) 15 CRNZ 58.

R v Hennessy [1989] 2 All ER 9.

R v Quick [1973] QB 910.

R v Redmile [1987] 1 NZLR 157.

R v Rongonui [2000] 2 NZLR 385.

R v Rotana (1995) 12 CRNZ 650.

R v S (No 2) (1991) 7 CRNZ 576.

R v Tsiaras [1996] 1 VR 398.

R v Tuia (27 November 2002) CA 312/02, 27.

R v Wiskich [2000] SASC 64.

Waitemata Health v A-G (2001) 21 FRNZ 216.

D Texts

Brookbanks, Warren "Diminished Responsibility: balm or bane?" in *Movements and markers in criminal policy* (Legal Research Foundation, Auckland, 1984) 82.

Brookbanks, Warren and Sandy Simpson *Psychiatry and the Law* (Lexis Nexis, Wellington, 2007) 4.

Hall, Geoff *Sentencing: 2007 Reforms in Context* (Lexis Nexus, Wellington, 2007) 406.

Hart, H L A *The Concept of Law* (2 ed, Clarendon Press, Oxford, 1994).

Mackay, R D *Mental Condition Defences in the Criminal Law* (1 ed, Oxford University Press, Oxford, 1995).

Melton, Gary *Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers* (Guilford Press, New York, 2007) 8.

Pritchard, H A *Acting Willing, Desiring in White* (ed) *The Philosophy of Action*, 61.

Robertson, James Bruce (ed) *Adams on Criminal Law* (5 ed, Brookers, Wellington, 2007).

Weisstub, David N *Law and Psychiatry in the Canadian Context* (1 ed, Pergamon Press, New York, 1980), 621.

E Journal Articles

Finkel, Norman, John Burke and Leticia Chavez "Common Sense Judgments of Infanticide: Murder, Manslaughter, Madness, or Miscellaneous?" 6(4) (2002) *Psychology, Public Policy and Law*, 1113.

Fluent, Thomas and Melvin Guyer "Defendant's Illness Can Be Used By the Prosecutor as an Aggravating Factor in Capital Sentencing" (2006) 34(1) *The Journal of the American Academy of Psychiatry and the Law*, 110.

Lambie, Ian "Mothers who kill: The crime of Infanticide" (2001) 24 *International Journal of Law and Psychiatry*, 74.

Payne, Andrew "Infanticide and child abuse" (1995) 6 *Journal of Forensic Psychiatry*, 474.

Rollin, Henry "The Mentally Ill should be in hospital, not prison" (1996) 2 *Journal of Forensic Psychology and Psychiatry*, 326.

Rouge-Maillart, C, N Jousset, and B Bouju "Women who kill their children" (2005) 26(4) *The American Journal of Forensic Medicine and Pathology*, 320-326.

F Other Secondary Sources

American Psychiatric Association Task Force *Diagnostic and statistical manual of mental disorders: DSM-IV* (4 ed, American Psychiatric Association, Washington, 1994).

Binning, Elizabeth "Dixon: 'They Want Me to Kill Myself'" (6 February 2009) *The New Zealand Herald* Auckland.

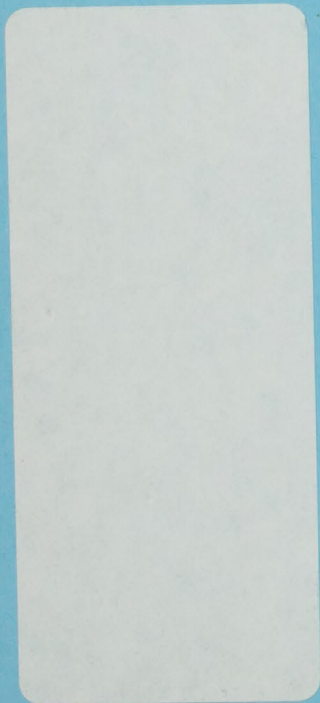
Dobson, Velma and Bruce Sales "The Science of Infanticide and Mental Illness" (2000) 6(4) *Psychology, Public Policy and Law*, 1103.

Elias, Rt Hon Chief Justice Dame Sian "Blameless Babes" (Annual 2009 Shirley Smith Address, Wellington, 9 July 2009).

Hansard (14 August 2001) 594 NZPD 10911.

A5741
VUW
A66
B942
2009

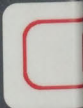
- Justice and Law Reform Committee "Criminal Justice Amendment (No 7) Bill Explanatory Material" 2001.
- Lord Butler *Report of the Committee on Mentally Abnormal Offenders* (Cmnd 6244, Home Office and Department of Health and Social Security, London, 1975).
- Ministry of Justice *Advice on the Sentencing Bill* (submission to the Justice and Law Reform Committee, 2001).
- Ministry of Justice *Sentencing and Guidance: A Discussion Paper* (Ministry of Justice, Wellington, 1997) 79.
- New Zealand Law Commission *Some Criminal Defences with Particular Reference to Battered Defendants* (NZLC R73, Wellington, 2001).
- New Zealand Law Commission *The Partial Defence of Provocation* (NZLC R98, Wellington, 2007).
- New Zealand Office of the Auditor-General *Mental health services for prisoners* (Office of the Auditor-General, Wellington, 2008).
- Power, Hon Simon "The Criminal Justice System: Reform is Coming" (Victoria University, Wellington 23 July 2009).
- Simpson, A I F and others *The National Study of Psychiatric Morbidity in New Zealand Prisons* (Department of Corrections, Wellington, 1999).
- Steward, Ian "Lax process criticized in jail suicide" (18 May 2009) *The Press* Christchurch.



VICTORIA UNIVERSITY OF WELLINGTON LIBRARY



3 7212 01600663 5



A
V
A
E
Z