A MENTAL HEALTH COURT FOR NEW ZEALAND?

LILY RYKEN

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INTRODUCTION

"When mental illness is a factor in lawlessness and that fact is ignored, the result can be an unproductive recycling of the perpetrator through the criminal justice system." [1]

The purpose of this dissertation is to explore the functions of Mental Health Courts (MHC) and discuss the way in which a New Zealand MHC (NZMHC) could and should operate within our current legal framework. MHCs are specialist criminal courts that deal with mentally ill offenders.[2] Their primary purpose is to divert mentally ill offenders from the criminal justice system to mental health services. The premise upon which MHCs operate is that offending committed by mentally ill persons generally stems from an inability to control or manage their mental health symptoms, rather than any form of deliberate criminality.[3] To address this cause of offending, MHCs largely prioritise treatment over punishment. Treatment takes place through diversion to mental health services. Diversion may occur either before or after a defendant is found guilty; that is, at the time that charges are laid or during the trial but before the defendant is found guilty or pleads guilty (pre-trial defendants), or at the sentencing and disposition hearing (guilty defendants). Pre-trial defendants might escape conviction following the successful completion of a treatment programme. Guilty defendants may receive a conviction and have their progress in treatment taken into account as a mitigating factor at sentencing, or avoid a conviction and be discharged. By addressing the cause of offending among mentally ill offenders, MHCs aim to reduce the high number of offenders with mental illness and decrease their rate of recidivism.

MHCs can be found in a number of jurisdictions, including North America, Canada, England and Australia. [4] The primary factor that precipitated the establishment of MHCs in these countries can be found in NZ, namely, a high rate of mental illness among offenders when compared to the community. A 2016 report by the New Zealand Department of Corrections

[1] Judith Kaye NYS Office of Mental Health Release (25 November 2002) as cited in Matthew D'Emic "The Promise of Mental Health Courts: Brooklyn Criminal Justice System Experiments with Treatment as an Alternative to Prison" (2007) 22 Crim Just 25 at 28.

[2] Warrren Brookbanks "Making the case for a Mental Health Court in New Zealand" (paper presented at the 3rd International Conference on Therapeutic Jurisprudence, Perth, June 2006).

[3] Richard Schneider, Hy Bloom and Mark Heerema *Mental Health Courts: Decriminalising the Mentally Ill* (Irwin Law, Toronto, 2007) at 5.

[4] Janet Peters and Fran Sivestri "Examples of mental health and drug courts in IIMHL countries" (2014) International Initiative for Mental Health Leadership <www.iimhl.com>.

(DOC) recorded that 91% of prisoners suffer from a lifetime diagnosis of "any mental disorder," with 62% having received such a diagnosis within the past 12 months.[5] In contrast, statistics for the community recorded only 40% of people as suffering from a lifetime diagnosis of "any mental disorder," with 21% having received such a diagnosis within the past 12 months.[6] Although there has been no official study among community based offenders, in 1999 the DOC requested a sample of probation officers to identify the number of people on parole or serving a community based sentence who were suspected of suffering from, or previously having suffered from, a mental illness.[7] The reported level of perceived mental illness was 10% (900 nationally) of community-based offenders, with approximately one-third of those (360) requiring hospitalisation.[8] The later findings of the 2016 report led the Government to allocate an extra $14 million to enable Corrections to purchase mental health services over the next two years (2017 and 2018).[9] The option of establishing a MHC in NZ was not canvassed and, to date, the NZ Parliament has not received any advice on the matter.[10]

The main problem with the way in which our criminal justice system deals with mentally ill offenders is that it does not adequately provide for their diversion to mental health services. As a result, the majority of mentally ill offenders prosecuted through the courts do not receive treatment for their mental health issues. There are three main reasons behind this. First, the ability of the Court to utilise s34(1) of the Criminal Procedure (Mentally Impaired Persons) Act 2011 (CP (MIP) Act), to order that a "mentally disordered"[11] defendant be transferred to a hospital or secure facility with a background sentence of imprisonment, is dependent upon the availability of secure forensic beds. The same can be said regarding the ability of Corrections staff to have suspected "mentally disordered" prisoners assessed and transferred to hospital under ss45 and 46 the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA). However, the demand for forensic beds is high and their availability seriously

[5] Devon Indig, Craig Gear and Kay Wilhelm *Comorbid substance use disorders and mental health disorders among New Zealand prisoners* (2016) at 9.
[6] At 9.
[7] Brookbanks, above n 2, at 8.
[8] At 8.
[9] Judith Collins "$14m to help offenders with mental health issues" (2016) The official website of the New Zealand Government <www.beehive.govt.nz>.
[10] Question from David Clendon to Amy Adams (Minister of Justice) regarding what advice, if any, hasa the Minister received about the possibility of establishing a 'mental health court'? (9 December 2015).
[11] Mental Health (Compulsory Assessment and Treatment Act) 1992, s2(1)(b).

lacking.[12] Secondly, for offenders who are not "mentally disordered" within the meaning of the MHA but nonetheless suffer from a mental disability, the only sentencing options available that provide for treatment are community supervision and intensive supervision. In practice however, these sentences are very rarely handed down. In 2013, only 4% of convicted offenders were sentenced to supervision with 1.8% being sentenced to intensive supervision.[13] This was in contrast to imprisonment, received by 9.6% of offenders.[14] Thirdly, for mentally ill offenders sentenced to imprisonment who do not meet the threshold of "mental disorder," the only option is to avail themselves of mental health services in prison. Regrettably however, the availability and quality of prison mental health services is poor. In 2012 the Ombudsmen recorded that "there are deficiencies regarding the care of mentally unwell prisoners [and] the current situation […] is unsatisfactory."[15] The report also stated that "[s]adly, prisons seem to be viewed as the best place for "care" in the sense of mere physical containment."[16]

The inability of our criminal justice system to provide adequate diversion to mental health services means that a large majority of mentally ill offenders may be "recycled" through the criminal courts. That is, they are convicted and sentenced in ways that do not address their mental health issues. Failure to address this underlying cause of offending may then result in a high rate of recidivism.

So, how can a MHC assist? Unlike traditional criminal courts, MHCs "attempt a rehabilitative response to what would otherwise have been criminally sanctioned behaviour."[17] They intervene at discrete points in the criminal justice process with the aim of diverting mentally disordered accused to mental health services. MHCs attempt to address the underlying cause of offending among mentally ill offenders, thereby reducing their rate of recidivism and increasing community safety. Despite the fact that every MHC is different and represents a specialised response to perceived local needs, certain generalisations can be made. First, all MHCs attempt to "reduce or eliminate the time spent by mentally disordered accused in

[12] Beverly Wakem and David McGee *Investigation of the Department of Corrections in relation to the Provision, Access and Availability of Prison Health Services* (Presented to the House of Representatives 2012) at 153.
[13] Geoffrey Hall *Hall's Sentencing* (online looseleaf ed, LexisNexis) at [SA1.4.1].
[14] At [SA1.4.1].
[15] Wakem and McGee, above n 11, at 93.
[16] At 93.
[17] Schneider, Bloom and Heerema, above n 3, at 3.

jail."[18] Secondly, participation in MHC is generally reserved for "individuals with mental disorders who are charged with minor to moderately serious offences."[19] Thirdly, participation in treatment takes place on an allegedly 'voluntary' basis, with the defendant able to opt-out of the programme at any time and proceed through the regular Court. Fourthly, MHCs follow an entirely different process to traditional criminal courts with the possibility of different outcomes for the accused. For example, criminal proceedings are generally adjourned or stayed by the MHC to enable therapeutic options to be tried. During a defendant's treatment, clinicians' reports are sent back to the MHC and regular review hearings are conducted to assess a defendant's progress, deal with any breaches and make any changes to treatment. Furthermore, successful completion of a treatment programme may result in the defendant avoiding conviction, even if they have first been found guilty or pled guilty.

To "appreciate mental health courts we must understand the principles of therapeutic jurisprudence [TJ]."[20] TJ provides the theoretical foundation for MHCs. It "advocates using the criminal justice system in a manner that addresses the underlying factors that may lead an individual to come into contact with the law in order to obtain a better societal response to proscribed behaviours."[21] The emphasis that TJ places upon providing treatment as opposed to punishment for mentally ill offenders stems from the belief that "the criminal behaviour of mentally impaired persons is a health issue rather than a criminal law matter."[22] Often, offending by mentally ill persons represents an inability to control or manage their mental health symptoms rather than any form of deliberate criminality.[23] Traditional sentences aimed at "hold[ing] the offender accountable for harm done to the victim and community"[24] and "promot[ing] in the offender a sense of responsibility for, and acknowledgement, of that harm"[25] may therefore be inappropriate and ineffective.

[18] At 85.
[19] At 6.
[20] At 3.
[21] Richard Schneider, Anne Crocker and Marichelle Leclair "Mental Health Courts and Diversion Programs" in Jennifer Chandler and Bertram Loeb (eds) *Law and Mind: Mental Health Law and Policy in Canada* (LexisNexis Canada, Toronto, 2016) 303 at 309.
[22] Brookbanks, above n 2, at 7.
[23] Schneider, Bloom and Heerema, above n 3, at 5.
[24] Sentencing Act 2002, s7(1)(a).
[25] Sentencing Act, s7(1)(b).

The fact that TJ advocates argue against the appropriateness and applicability of traditional goals of the criminal justice system in the context of mentally ill offenders has prompted claims that "TJ is fundamentally at odds with traditional values of the criminal justice system."[26] It is submitted that such statements are inaccurate. First, MHCs only seek to carve out a small exception for *seriously* mentally ill offenders who have committed low level offences. It is only in this context that the need for treatment of the defendant is seen to outweigh concerns of punishment and responsibility. In contrast, serious offences dictate that punishment must be delivered and the defendant must assume responsibility, *even if* they are seriously mentally ill.[27] Similarly, offenders who are not mentally afflicted, or who suffer from only a minor form of mental illness, must accept responsibility for their actions and receive punishment in the normal way.[28] By carving out only a small exception it is clear that, on the whole, TJ considers traditional goals of the criminal justice system to be valid and important, and does not seek to undermine them. Moreover, a therapeutic approach to mentally ill offenders actually promotes some traditional goals of the criminal justice system, such as rehabilitation and reintegration of the offender.[29] The need to protect the community is also enhanced by reducing the rate of recidivism through treatment. TJ does not seek to override traditional goals of the criminal justice system, but "attempts to work within the confines of these goals to *also* produce a beneficial impact on the accused."[30]

The first chapter of this dissertation will discuss the operation of MHCs in Florida and Victoria. It will also consider the operation of NZ's closest parallel to a MHC, the Alcohol and Other Drug Treatment Court (AODTC). The second chapter will begin with a discussion of the process of assessment that could be followed to identify whether a defendant meets the mental criteria. The importance of establishing a community liaison service will also be canvassed before moving to consider what the actual qualifying criteria of a NZMHC should be. Chapter Three considers the potential legal foundations for the process of a NZMHC. It looks closely at how a NZMHC could operate in respect of both pre-trial and guilty defendants in light of

[26] E. Lea Johnston "Theorizing Mental Health Courts" (2012) 89 Washington L Rev 519 at 520.
[27] Unless the defendant is "insane" under s23 of the Crimes Act 1961, which provides a defence.
[28] Unless the defendant is granted a discharge without conviction under s106 of the Sentencing Act 2002 or given an opportunity to participate in the Police Adult Diversion Scheme (PADS). Successful participation in PADS results in a dismissal of the charges under s148(1) of the Criminal Procedure Act 2011.
[29] Sentencing Act, s7(1)(h).
[30] Schneider, Bloom and Heerema, above n 3, at 44.

our current law. For example, could a stay of proceedings or an adjournment be used to enable therapeutic options to be tried? Would a NZMHC be able to use the power to dismiss charges in circumstances where a mentally ill offender has completed a treatment programme? Chapter Four considers the availability and adequacy of the range of sentencing and disposition options that a NZMHC would have. By the conclusion, I hope to have identified the main functions of a MHC and determined whether a NZMHC could operate within our current law.

INTERNATIONAL MENTAL HEALTH COURTS AND NEW ZEALAND'S ALCOHOL AND OTHER DRUG TREATMENT COURT (AODTC)

This chapter discusses the operation of MHCs in Florida, United States of America (USA) and Victoria, Australia. It also considers the operation of the NZ's AODTC, which is the closest parallel that NZ has to a MHC. The purpose of this chapter is to get a feel for the different ways in which MHCs may operate and discern some of the legal issues that a NZMHC might face. The operation of these courts is also used to reflect upon and substantiate the claims made in the Introduction that TJ is not entirely at odds with, nor does it attempt to override, traditional goals of the criminal justice system.

FLORIDA

The Broward County (Fort Lauderdale) Mental Health Court (BMHC) was the first MHC in the world to be established, in 1997. It provides diversion into treatment for both pre-trial and guilty defendants. Participants may have their charges resolved in one of three ways:

1. Dismissal of charges.
2. Withheld adjudication.[31]
3. Conviction entered with credit being given for time spent in treatment.

Qualifying mental condition

To participate in the BMHC defendants must suffer from a "mental illness" under §394.455(28) of the Florida Mental Health Act.[32] A defendant meets this definition if they have an Axis I mental illness,[33] an organic brain injury or head trauma, or are developmentally

[31] Following a defendant's contested hearing or entry of a guilty plea, it is then up to the Court or jury to determine whether the defendant is actually guilty. Instead of finding in favour of a determination of guilt, the Court or jury may withhold the adjudication and discharge the defendant. A withheld adjudication does not appear on a defendant's criminal record, but it remains part of the Court's record. See further George Tragos and Peter Sartes "Withhold of Adjudication: What Everyone Needs to Know" (2008) 82 The Florida Bar Journal 48 at 48.

[32] Criminal Procedure and Corrections, Fla Stat, title 47, §948.08(8)(a)(1), §948.08(8)(a)(1) and §948.16(3).

[33] "Axis I is primary mental health diagnosis that is usually first diagnosed in childhood, including schizophrenia, mood or anxiety disorders, certain impulse control disorders, and major depression." See further American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Washington, 1994).

disabled.[34] Entry into the BMHC is therefore reserved for offenders who suffer from a serious psychiatric or psychological condition.

Assessment:

Assessment of in-custody offenders to determine if they suffer from a qualifying "mental illness" takes place within 24 hours of arrest. [35] An initial screening is conducted by advanced doctoral students assigned to the Public Defender's office.[36] Defendants who are suspected of suffering from a qualifying "mental illness" are siphoned off to the mental health section of the prison, pending a full assessment by a psychiatrist. [37] Defendants who are confirmed as suffering from a "mental illness" have this fact recorded and presented at their probable cause/bond hearing. Provided that the defendant meets the other qualifying criteria, they are referred to the BMHC.

The speed with which candidates are identified and diverted out of prison into treatment reflects the TJ underpinnings of the BMHC. An important assumption of TJ is that confinement of mentally disordered offenders in prison is inappropriate and undesirable. The quality of mental health services in prison is poor and, as a result, mentally disordered offenders do not typically receive treatment. Failure to receive treatment means that their cause of offending remains unaddressed, thus increasing the likelihood of their reoffending upon release. This is not in society's best interests. It also heightens the negative experience of imprisonment for this group of offenders. As Shneider notes, prison "has typically produced anti-therapeutic results" for mentally disordered offenders.[38]

Qualifying offence:

[34] John Goldkamp and Cheryl Irons-Guynn *Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernadino, and Anchorage* (Bureau of Justice Assistance, Washington, 2000) at 10.
[35] Ginger Wren "Mental Health Courts: Serving justice and promoting recovery" (2010) 19 Annals Health L Rev 577 at 584.
[36] Goldkamp and Irons-Guynn), above n 34, at 11.
[37] At 11.
[38] Schneider, Bloom and Heerema, above n 3, at 44.

The BMHC provides diversion into treatment for both pre-trial and guilty defendants. What constitutes a "qualifying offence" depends upon the type of diversion.

Pre-trial diversion:

To be eligible for pre-trial diversion a defendant must be facing charges for a misdemeanour[39] or non-violent felony.[40] A charge of aggravated assault requires the victim and state attorney to consent to the defendant's participation in the BMHC.[41] Non-violent felony defendants must not have previously been convicted of a felony to participate in pre-trial diversion.[42] In contrast, misdemeanour defendants may participate regardless of their criminal history.[43] To facilitate participation in treatment, the state holds the charges in abeyance and the defendant waives their right to a speedy trial.[44] There is no maximum period for which a pre-trial treatment programme may run,[45] although in practice a maximum of one year is generally adhered to.[46] During this period, the defendant is subject to regular review hearings to monitor their progress and assess any breaches. In light of fact that "[m]ost mentally disordered individuals have periods of faltering"[47] with progress in treatment usually involving "two steps forward [and] one step back,"[48] the BMHC exercises leniency regarding non-compliance. A breach of the terms of treatment will generally result in a change in treatment or additional support and encouragement.[49] For defendants who persistently breach their terms of treatment, the BMHC reserves the power to transfer them back to the traditional court.[50] Successful completion of a treatment programme, however, results in a mandatory dismissal of the charges.[51]

Diversion of guilty defendants:

[39] Criminal Procedure and Corrections (FL), §948.16(3). "Misdemeanour" means any offence that carries a maximum penalty of up to one year imprisonment. See Crimes, Fla Stat, title 46 §775.08(2).
[40] Criminal Procedure and Corrections (FL), §948.08(8)(a)3.a. "Felony" means any offence punishable by death or imprisonment. See Crimes, Fla Stat, title 46 §775.08(1).
[41] Criminal Procedure and Corrections (FL), §948.08(8)(a)d.
[42] Criminal Procedure and Corrections (FL), §948.08(8)(a)2.
[43] Criminal Procedure and Corrections (FL), §948.16(3).
[44] Goldkamp and Irons-Guyyn, above n 34, at 15.
[45] Criminal Procedure and Corrections (FL), §948.16(3).
[46] Goldkamp and Irons-Guyyn, above n 34, at 15.
[47] Schneider, Bloom and Heerema, above n 3, at 90.
[48] At 90.
[49] Goldkamp and Irons-Guyyn, above n34, at XIX.
[50] Criminal Procedure and Corrections (FL), §948.08(3).
[51] Criminal Procedure and Corrections (FL), §948.16(4).

The diversion of guilty defendants under the BMHC is only available for non-violent felony offenders.[52] It is not available for misdemeanour offenders. This is because guilty defendants will have their charges resolved through a conviction or withheld adjudication.[53] The consequences of these two outcomes are considered to be a disproportionate response for minor offences committed by mentally ill persons. A withheld adjudication does not appear on a defendant's criminal record, however it constitutes a prior "conviction" for the purpose of any subsequent offence and may be taken into account as an aggravating factor.[54] Furthermore, it may prejudice a defendant's ability to find employment, as many employers require potential employees to disclose whether they have received a withheld adjudication.[55]

A second difference regarding the diversion of guilty defendants, is that it is open to defendants with a criminal history of felonies. The proviso to this is that the judge retains a discretion to permit or refuse entry into the BMHC, depending upon the circumstances of the case.[56] This acts as a check on public safety to ensure that dangerous offenders are not released into the community for treatment.

To facilitate treatment, guilty defendants are placed under probation or released into community control.[57] There is no maximum time that a treatment programme may run, although a period of one year is typically adhered to. Persistent failure to comply may result in the defendant being transferred back to the original court.[58] Successful completion of treatment, however, will result in the judge either convicting the defendant and sentencing them in the normal way with credit being given for time served in treatment, or withholding the adjudication.[59]

The different qualifying offence criteria for each type of diversion reflects a balancing between the need for mentally ill offenders to receive treatment and the need to ensure punishment, responsibility and community safety. The kind of offences that each type of

[52] Criminal Procedure and Corrections, §948.01(8)(a).
[53] Criminal Procedure and Corrections, §948.01(2).
[54] George Tragos and Peter Stares "Withhold of Adjudication: What Everyone Needs to Know" (2008) 82 The Florida Bar Journal 48 at 48.
[55] At 48.
[56] Mental Health, Fla Stat, title 29, §394.47892(4)(a).
[57] Criminal Procedure and Corrections (FL), §948.01(8)(a).
[58] Criminal Procedure and Corrections (FL), §948.06 2.
[59] Criminal Procedure and Corrections (FL), §948.01(2).

diversion accepts supports the claim in the Introduction, that TJ "attempts to work within the confines of traditional goals of the criminal justice system] to *also* produce a beneficial impact on the accused."[60] Thus, violent felony offenders are excluded from participation in the BMHC, regardless of the severity of their mental illness. In this context, the seriousness of the offence dictates that concerns of punishment, responsibility and community safety outweigh the desire to treat the accused. In contrast, all mentally ill misdemeanour offenders are automatically eligible for pre-trial diversion and will have their charges dismissed. Here the seriousness of the offence is low and therefore, concerns of punishment, responsibility and community safety do *not* outweigh the desire to treat the accused.

Voluntariness:

Participation in the BMHC is allegedly voluntary and a defendant must be "fully advised of the purpose of the mental health court program," and "agree to enter [it]."[61]

The issue of "voluntary" participation in MHCs is controversial for two reasons. First, there are concerns about a defendant's mental capacity and ability to understand the nature and implications of entering the MHC. In terms of the BMHC, defendants must be fit to stand trial, but beyond this there is no guidance regarding the mental capacity that a defendant must possess to be able to effectively "agree" to enter the programme.[62] A mentally ill defendant may be fit to stand trial but nonetheless be unable to "really understand the choices being presented and the consequences of those choices."[63] Secondly, there are concerns about whether the decision to enter MHC is actually voluntary or coerced. Participation in MHC means that the defendant does not have to spend time in prison and may even escape conviction. How is the decision to participate "voluntary" if the defendant is "lured into the program with the prospect of a more lenient disposition?"[64] To combat these two concerns, proponents of MHCs argue that a defendant should receive the advice of counsel before

[60] Schneider, Bloom and Heerema, above n 3, at 44.
[61] Criminal Procedure and Corrections (FL), §948.01(8)(b).
[62] Saul Spigel "Broward County (Florida) Mental Health Court" (2001) Connecticut General Assembly <www.cga.ct.gov>.
[63] Goldkamp and Irons-Guyyn, above n 34, at XI.
[64] Schneider, Bloom and Heerema, above n 2, at 89.

making the decision to enter the programme.[65] However, this is not a mandatory requirement under the BMHC.

Guilty Plea:

A defendant who is able to participate in pre-trial diversion does not have to plead guilty. However, diversion for more serious offending requires a guilty plea. Nonetheless, the majority of guilty defendants who participate in the BMHC do not receive a conviction. Instead, they receive a withheld adjudication.[66] This reflects the BMHC's strong commitment to preventing the "criminalisation and stigmatization of [mentally ill] accused that the system was supposed to be avoiding."[67]

VICTORIA, AUSTRALIA:

The Assessment and Referral Court (ARC) is Victoria's MHC. It is established under the Magistrates' Court Amendment (Assessment and Referral Court List) Act 2010 (VIC) ("ARC Act"). It only provides diversion in respect of pre-trial defendants. Upon successful completion of a treatment programme, the defendant may either be convicted or discharged.

Qualifying mental condition:

The requisite mental condition for participation in the ARC has three limbs:

1. An accused must suffer from a mental illness, an intellectual disability, an acquired brain injury, an autism spectrum disorder or a neurological impairment, including, but not limited to, dementia.[68]

[65] At 89.
[66] Goldkamp and Irons-Guyyn, above n 34, at 15.
[67] Schneider, Bloom and Heerema, above n 3, at 96.
[68] Magistrates Court Amendment (Assessment and Referral Court List) Act 2010 (Vic), s4T(2)(1).

2. The presence of at least one of these mental conditions must "substantially reduce" the capacity of the accused in at least one of the following areas: self-care, self-management, social interaction and/or communication.[69]
3. The condition of the accused must be such that they would "derive benefit from receiving coordinated services in accordance with an individual support plan."[70] T

Entry into the ARC is therefore reserved for defendants who suffer from a serious mental condition.

Assessment:

Identification of defendants who might be eligible to participate in the ARC relies upon referrals by the police, prosecutors, legal representatives, community service organisations, significant others of the accused or the accused.[71] Once a referral is made, an initial assessment is conducted by a member of the Court Integrated Services Program (CISP). Before the next sitting day of the ARC, a full assessment by a clinical advisor is undertaken. If the defendant meets the relevant mental criteria, this is presented at the next available sitting of the ARC. The final decision whether to admit the accused into the ARC rests with the ARC Magistrate.[72]

The process and speed by which potential offenders are identified for participation in the ARC is slower and less intense than the BMHC. A systematic scheme to identify potentially eligible offenders is lacking. As a result, some mentally ill defendants might never be identified or only be identified at a later stage. Some might even be prosecuted entirely through the traditional criminal court. As previously noted, the longer a mentally ill defendant spends in the criminal justice system without receiving treatment, the more detriment both they and society suffer.

Qualifying offence:

[69] Magistrates Court Amendment (Assessment and Referral Court List) Act, s4T(3).
[70] Magistrates Court Amendment (Assessment and Referral Court List) Act, s4T(4).
[71] "Assessment and Referral Court List (ARC)" (11 August 2015) Magistrates' Court of Victoria < www.magistratescourt.vic.gov.au>.
[72] Janet Peters and Fran Sivestri, above n 4, at 11.

Participation in the ARC is reserved for low-level offenders. Violent and sexual offences are excluded.[73] ARC defendants their trial adjourned for a maximum of twelve months whilst therapeutic options are tried.[74] As with the BMHC, the fact that the ARC only accepts low-level offences supports the claim that TJ is not entirely at odds with traditional goals of the criminal justice system, nor does not seek to override these goals.

Voluntariness:

Entry into the ARC requires the "consent" of the accused.[75] The term "consent" is not defined in the ARC Act, nor is there a requirement that the defendant first receive the advice of counsel. Concerns regarding the ability of a seriously mentally ill defendant to "consent" to participate in the ARC, and the questionable "voluntariness" of any such decision, are equally applicable in Victoria as in Florida.

Guilty plea:

Entry into the ARC requires the defendant *not* to enter any plea. Diversion into treatment under the ARC therefore takes place in the *absence* of a plea. Unsuccessful participation in treatment results in termination from the programme and transfer back to the original court.[76] Successful completion results in the ARC subsequently hearing and determining the criminal proceeding.[77] This is an unusual feature of the ARC and is not common to most MHCs. Generally, MHCs do not entertain the charges and an accused must participate in treatment either in the absence of a plea or following the entering of a guilty plea. Once the ARC has conducted a criminal proceeding, the charges may be disposed of in one of two ways:

1. The defendant may be found guilty and convicted and sentenced in the usual way with credit being given for participation in a treatment program.[78]

[73] Magistrates Court Amendment (Assessment and Referral Court List) Act, s4S(3).
[74] Magistrates Court Amendment (Assessment and Referral Court List) Act, s4V(4).
[75] Magistrates Court Amendment (Assessment and Referral Court List) Act, s4S(3)(c).
[76] Magistrates Court Amendment (Assessment and Referral Court List) Act, s4U(2)(c).
[77] Magistrates Court Amendment (Assessment and Referral Court List) Act, s4Y(1).
[78] Magistrates Court Amendment (Assessment and Referral Court List) Act, s4Y(5).

2. The defendant may be discharged without their guilt being determined.[79] No conviction is entered under this option.

How the ARC decides to resolve a defendant's charges depends upon a weighing of the accused's need for treatment against traditional goals of the criminal justice system. More serious charges are likely to result in a conviction with credit being given for time served in treatment, as the goals of punishment and responsibility are heightened. In contrast, minor charges are more likely to result in a discharge of the defendant.

NZ's AODTC:

The AODTC is NZ's first drug court. It does not operate with specific statutory backing. The primary legislative vehicles for its operation are the Criminal Procedure Act 2011 (CPA) and Bail Act 2000 (BA). Only guilty defendants may participate in the programme and successful rehabilitation inevitably results in a conviction with credit being given for time served in treatment.

Qualifying substance abuse criteria:

To participate in the AODTC defendants must suffer from a moderate-severe substance-related dependency, which can be seen to have driven their offending.[80] They must also be assessed as at a high risk of reoffending and pose a high risk to themselves, their family and the community.[81] The appearance of a serious mental health condition in addition to drug dependency disqualifies a defendant from participation.[82] This is because the treatment of substance abuse and mental illness are seen to be too dissimilar for one court to deal with.[83] However, problems of substance abuse generally go hand-in-hand with mental illness. As a 2016 DOC report recorded, 42% of prisoners suffer from a life-time dual-diagnosis of

[79] Magistrates Court Amendment (Assessment and Referral Court List) Act, s4Y(1).
[80] Ministry of Justice *Alcohol and Other Drug Treatment Court Handbook* (13 October 2014) Ministry of Justice <www.justice.govt.nz/courts/criminal/therapeutic-courts> at 27.
[81] At 27.
[82] At 27.
[83] As Judge Tremewan states, "We [the AODTC] cannot be all things to all people." See further Lawnews "Alcohol and Other Drug Treatment Court marks two years of a new approach" (2014) Auckland District Law Society <www.adls.org.nz>.

substance abuse and mental illness.[84] Thus, it is likely that a large number of offenders who suffer from a substance abuse addiction are excluded from participating in the AODTC because of the appearance of a mental illness as. Given the high rate of comorbidity between the two issues, it is submitted that, whilst a NZMHC should be aimed at offenders that suffer primarily from mental illness, the appearance of a substance abuse problem should not be a disqualifying criteria. A NZMHC should be able to address substance abuse in the development of a treatment plan.

Assessment:

At the defendant's first appearance, suitability for participation in the AODTC is raised by the defendant, their counsel, the prosecution or the judge. The judge then determines whether the defendant meets the other qualifying criteria.[85] If so, the proceedings are adjourned for three weeks and the defendant is granted bail to undergo an assessment.[86] If the defendant meets the substance abuse criteria, they are transferred to the AODTC for a determination hearing. This takes place within 50 days of the defendant's first appearance.[87] It is then up to the AODTC Judge to make the final decision whether to offer the defendant a place in the AODCT.[88]

Qualifying offence:

To participate in the AODT a defendant must be charged with an offence that carries a maximum period of imprisonment of up to three years. Serious violent and sexual offences are excluded.[89] To facilitate treatment, a defendant is placed on conditional bail under s30(4)(c) of the BA for a period of between 12-18 months (or longer if warranted).[90] During this time the defendant appears at the AODTC at regular intervals to assess their progress and address any breaches. Persistent non-compliance results in termination from the programme

[84] Wakem and McGee, above n 12, at 39.
[85] Ministry of Justice, above n 80, at 13.
[86] At 13.
[87] At 13.
[88] At 14.
[89] At 28.
[90] At 15.

and transfer back to the District Court (DC).[91] Defendants who successfully complete a treatment programme will be convicted and sentenced in the normal way, with credit being given for time served in treatment.[92]

Voluntariness:

Entry into the AODTC is voluntary and must take place with the "informed consent" of the defendant. The defendant must read and sign a "participant agreement," which describes the operation of the AODTC programme and what is expected of the defendant, including treatment participation, regular and random drug testing, incentives and sanctions, and the need to attend regular review hearings.[93] Defendants must be represented by and receive the advice of counsel before giving their informed consent.[94]

Conclusion:

This material identifies the range of issues for the legal system presented by Mental Health (or other Alternative Treatment) Courts. These include: the requisite mental condition that a defendant must suffer from, the range of offences that a MHC operates in respect of, the ability for a MHC to provide diversion for both pre-trial and guilty defendants, and the consequences of successful or unsuccessful participation in MHC. Where a MHC decides to draw the line regarding one qualifying criteria depends in turn upon where it decides to draw the line on another. The next chapter will consider how these issues might play out for a NZMHC.

[91] At 20.
[92] At 21.
[93] At 14.
[94] At 8.

ASSESSMENT AND QUALIFYING CRITERIA FOR A NEW ZEALAND MENTAL HEALTH COURT

This chapter considers the way in which a NZMHC could operate. First, it considers the necessary pre-cursors to get a NZMHC off the ground, namely, the assessment and identification of potential NZMHC candidates, and the need to establish a community liaison service to facilitate treatment. It then considers what the eligibility criteria for participation in NZMHC should be.

Assessment:

The timely assessment of offenders to determine their eligibility for NZMHC is vital in terms of decreasing the amount of time that mentally ill defendants spend in prison. The BMHC provides the most expeditious model for assessment with candidates being assessed and transferred to the BMHC within 24 hours of arrest. If NZ were to adopt a similar process, an initial informal assessment of in-custody offenders would need to take place. A nursing service attached to the prison could provide this service and screen in-custody offenders to identify those that potentially meet the mental criteria for a NZMHC. A second, formal assessment could then take place by a registered psychiatrist, preferably within 24 hours. Defendants confirmed as meeting the requisite mental criteria could then be transferred to NZMHC that same day or the following day. In order for such an approach to work, a NZMHC would have to sit for a specified period each day. In addition, at least in large centres, there would need to be a dedicated psychiatrist available. This process is the ideal model upon which an assessment and referral to NZMHC could operate, however, it is recognised that NZ might not have adequate resources to support this process. Thus, an alternative procedure akin to that used by the AODTC could be adopted for a NZMHC. However, a slight change in our law would be required. A proposed procedure for assessment and transfer to NZMHC could then be as follows:

1. A mentally ill defendant has their first appearance in the District Court (DC) with their eligibility for participation in NZMHC able to be raised by any party to the proceeding

or a health professional who has been involved in the defendant's assessment or treatment.

2. The judge then checks if the defendant meets the other qualifying criteria, such as commission of a qualifying offence.
3. If a defendant meets all other qualifying criteria, proceedings are adjourned for a maximum of 14 days[95] and the judge makes an order for a health assessor to prepare an assessment report on the defendant under s38(1) of the CP(MIP) Act. This section stipulates certain circumstances in which the court can make such an order. These circumstances do not cover the situation where a NZMHC requires an assessment to determine eligibility. [96] An additional paragraph would therefore need to be added to this section for this purpose.
4. The defendant is granted bail with the condition that they undergo an assessment. Assessment could take place at a community treatment provider.[97] However, if the defendant's mental illness renders them incapable of obtaining an assessment within the community without supervision, an assessment could take place in prison, at a hospital or at a secure facility. A slight change to s38(3)(a) of the CP(MIP) Act would be required to affect this. Presently, s38(3)(a) prohibits the court from ordering an assessment to take place within a prison, hospital or secure facility if the defendant is "bailable as of right." A defendant is "bailable as of right" if they are charged with an offence that is not punishable by a term of imprisonment or which carries a maximum term of imprisonment of three years.[98] Given that MHCs are generally aimed at low-mid level offences, it is likely that s38(3)(a) would frustrate the ability of the DC to order a health assessor to carry out an assessment on a defendant at a prison, hospital or a secure facility. Thus, where the purpose of an assessment conducted these settings is to determine a defendant's eligibility for participation in NZMHC, an exclusion regarding the operation of s38(3)(a) would have to be added.

[95] Under ss38(3)(b) and (c) of the Criminal Procedure (Mentally Impaired Persons) Act 2003, a defendant may only be detained in prison or a hospital for a maximum of 14 days for the purpose of receiving an assessment.
[96] Under ss38(1)(a) – (d) of the CP(MIP) Act, the Court may make an order for assessment to determine: whether the defendant is unfit to stand trial; whether the defendant is insane; the type and length of sentence that might be imposed on the defendant and the nature of a requirement that the court may pose in the defendant as part of, or as a condition of, heir sentence or order.
[97] Bail Act 2000, s32.
[98] Bail Act, ss7(1) and (2).

5. The defendant undergoes an assessment and returns to the DC at the end of the adjournment period. If they meet the requisite mental criteria the case is transferred to the NZMHC.

This procedure is lengthier than that of the BMHC model, however it puts less of a strain on resources. The fact that a defendant's mental condition is able to be raised by a health professional who has been involved in the defendant's assessment or treatment is important. This is because defence counsel might be faced with a seriously mentally ill client who could benefit from NZMHC, not only in terms of receiving treatment, but also the possibility of having their charges dismissed. Nonetheless, such a client might vehemently insist that they do not have a mental illness. In these circumstances, defence counsel might feel bound by their client's instructions not to raise the issue with the judge. It is unlikely that the prosecution will raise the issue, as the outcome of NZMHC is likely to be more lenient than proceeding through the criminal court. Therefore, it is possible that a judge might never be made aware of a defendant's mental condition. Unlike a defence lawyer, however, mental health professionals do not owe a duty to follow the instructions of the defendant. They would therefore feel less conflicted about raising the issue in the face of objection by the defendant. If a prison nurse or medical professional who has dealt with the defendant in the past is able to raise a defendant's mental condition with the judge, this issue is less likely to by-pass the Court. Apart from the need for minor changes in the CP (MIP) Act, the process outlined could be implemented relatively easily.

Community liaison service:

For MHC to divert mentally ill offenders away from the criminal justice system into mental health treatment, it is necessary to identify "treatment and related services in the community and [develop] an effective working relationship between [them and] the courts."[99] Thus, the AODTC relies upon the services of community treatment providers that have been contracted by the Ministry of Health.[100] A similar regime would need to be established for a NZMHC. The NZ Government has already gone some way towards this by granting the DOC $14 million to

[99] Goldkamp and Irons-Guyyn, above n 34, at XIV.
[100] Ministry of Justice, above n 80, at 10.

enable them to purchase mental health services for offenders in prison and the community.[101] If there is an insufficient number of mental health treatment providers, more will need to be established. For "[w]ithout the requisite facilities, a mental health court would be futile."[102]

The fact that the effective operation of a MHC requires strong links with community treatment providers generally has the flow-on effect of improving the quality of the civil mental health system in general. The increased demand on treatment providers that MHCs generate often results in an increase in funding for these institutions, which in turn improves the quality of their services.[103] The "close attention and supervision" that MHCs show to these service providers may also strengthen their effectiveness.[104] This is likely to result in fewer mentally ill people 'slipping through the cracks' of the civil mental healthcare system and back into the criminal justice system. The less mentally ill people that end up in the criminal justice system, the fewer participants a MHC has. Thus, a successful MHC "would ideally put [itself] out of business."[105]

Qualifying mental condition:

Where a NZMHC draws the line of what constitutes a qualifying mental condition depends upon where it draws the line regarding other qualifying criteria. As we saw in Chapter 1, MHCs are engaged in a balancing process between advancing the traditional goals of the criminal justice system, such as punishment and responsibility, against the need for a mentally ill offender to receive treatment. A MHC that is directed at low-level offending is therefore more likely to have a flexible definition of what constitutes a qualifying mental condition. Low level offences are less serious and therefore concerns of punishment, responsibility and community safety are low. Such a MHC can therefore accept a larger and broader range of mentally ill defendants. In contrast, MHCs that cover serious offences are more likely to have a stringent definition of what constitutes a qualifying mental condition. For example, the San Bernadino MHC accepts violent felonies that carry a maximum penalty of up to six years

[101] Judith Collins, above n 9.
[102] Sarah Ryan and Darius Whelan "Diversion of Offenders with Mental Disorders: Mental Health Courts" (2012) 1 JCLR 1 at 18.
[103] Goldkamp and Irons-Guyyn, above n 34, at XVI.
[104] At XVI.
[105] At XVI.

imprisonment.[106] In turn, the qualifying mental condition is a "serious mental illness… [that has been] previously diagnosed and [is] persistent."[107] Mentally ill offenders who have not been officially diagnosed are therefore excluded, as are those who do not have a history of mental illness. The serious of the offence means that concerns of punishment, responsibility and community safety rank high. Thus, only a minute number of seriously mentally ill defendants may escape traditional forms of punishment and responsibility to receive treatment.

It is submitted that the requisite mental condition for a NZMHC should mirror that of the BMHC. That is, it should only accept offenders who suffer from an Axis I mental illness, have an organic brain injury or head trauma, or are developmentally disabled. These three mental conditions have the same effect, namely the ability to negatively affect a person's reasoning and take away some level of free-choice. The only reason that the ARC is not open to intellectually disabled defendants is because there is a separate diversion scheme in place for them.[108] Under the proposed definition, the mere appearance of at least one of the three mental conditions would be sufficient. It would not be necessary to establish that the accused was also affected in a particular way, such as being unable to look after themselves or posing a danger to themselves or others. This second criteria forms part of the definition of "mental disorder" under the MHA. [109] Such a stringent definition would not need to be applied in the context of a NZMHC because, unlike the procedure for delivering treatment under the MHA, delivery of treatment via a NZMHC would take place on a voluntary basis, not involving civil commitment. Furthermore, the three mental conditions listed are relatively serious and set the bar high enough to ensure that traditional goals of punishment and responsibility remain relevant and applicable to the large majority of offenders. It also addresses those said to have only a personality disorder, for which effective treatment is unlikely to be available.

Qualifying offence:

[106] At 49.
[107] At 49.
[108] Peters and Sivestri, above n 4.
[109] Mental Health (Compulsory Assessment and Treatment) Act, s2.

Shneider writes: "Typically, participation in a [MHC] is reserved for individuals with mental disorders who are charged with minor to moderately serious offences."[110] However, this approach is not mandatory. The San Bernadino MHC accepts violent offenders who are facing a maximum penalty of up to six years imprisonment. Similarly, the King County MHC "considers the treatment of dangerous and violent individuals" to be "part of its mission."[111] Like the differences between MHCs regarding the qualifying mental state criteria, where each MHC decides to draw the line in terms of qualifying offences also depends upon the operation of other aspects of the process. Thus, the San Bernadino and King County MHCs accept serious offences, but they also require participants to plead guilty and be convicted at the end of the process.[112] This trade-off is seen as necessary because serious offences, including those committed by mentally ill persons, dictate that a level of responsibility must be assumed.

For reasons discussed below, it is submitted that a NZMHC should not require a guilty plea and should permit diversion to mental health care in respect of both pre-trial and guilty defendants. A guilty defendant may or may not receive a conviction. In light of these factors, a NZMHC should follow the general pattern of MHCs and only accept individuals who have committed low-moderate offences. The upper limit of offences for a NZMHC should be the same as that for the AODTC, namely offences punishable by a term of imprisonment of up to three years.[113] Violent and sexual offences should be excluded. This ensures consistency of approach between the two courts. It also finely balances the traditional goals of the criminal justice system with the need for mentally ill defendants to receive treatment.

Guilty plea:

Internationally, MHCs are divided on the requirement of a guilty plea. There are two main arguments in favour of a guilty plea. First, it forces a mentally ill offender to assume responsibility for their crime. This is seen as important in terms of the offender and also the victim. As Schneider notes, in circumstances where a defendant is escaping imprisonment and entering into treatment, a guilty plea has "psychological benefits for the victim, affected

[110] Schneider, Bloom and Heerema, above n 3, at 6.
[111] Goldkamp and Irons-Guyyn, above n 34, at 23.
[112] At 23.
[113] Ministry of Justice, above n 80, at 27.

families, others involved and the community."[114] Furthermore, it arguably increases the likelihood of compliance with treatment.[115] Despite these two benefits, it is submitted that concerns surrounding the requirement of a guilty plea outweigh any positive effects. Requiring a guilty plea takes away the chance for a defendant to defend their charges. Where a "so-called 'normal' accused would have the opportunity to litigate and avoid a conviction, it does not seem right that [a] mentally disordered accused should have to plead guilty in order to access mental health services."[116] There are also serious concerns regarding the voluntariness of a guilty plea in circumstances where "liberty is dangled in front of the accused."[117] A mentally ill defendant might plead guilty to charges that they did not commit rather than defend their innocence, simply because there is an increased likelihood that if they participate in MHC and successfully complete a treatment programme, no conviction will result. The requirement that a mentally ill defendant should not be able to enter MHC without first receiving the advice of a lawyer would only go a little way towards ensuring the voluntariness of any guilty plea. A sound explanation of the process of MHC by a lawyer might increase a mentally ill defendant's understanding of the process, but it does not change the fact that they are still left to face a choice between defending their charges and potentially facing imprisonment, or not defending their charges and avoiding imprisonment. For these two reasons, it is submitted that a NZMHC should not require a guilty plea.[118]

If a NZMHC does not require a guilty plea, this does not mean that all instances of diversion to NZMHC will take place on a pre-trial basis. With regards to minor offences, diversion may take place in the absence of a plea, however, for more serious offences, a finding of guilt, should be required. Defendants of more serious charges should have the option of either defending their charges in the DC and then being transferred to NZMHC if found guilty or pleading guilty and being transferred straight away. This position preserves the position that a guilty plea is not required for entry into NZMHC, whilst protecting the voluntariness of any guilty plea so entered.

[114] Schneider, Bloom and Heerema, above n 3, at 87.
[115] At 87.
[116] At 87.
[117] At 89.
[118] At 92.

Diversion:

The primary purpose of a MHC is to divert mentally ill offenders away from the criminal justice system into mental health treatment. For a NZMHC to truly fulfil this purpose, it should offer diversion into treatment at three main stages in a criminal proceeding: before a plea is entered, after the defendant has been found guilty or pled guilty in the DC and at the sentencing stage following conviction. Such an approach is in keeping with the recommendation made by the World Health Organisation that legislation should allow for diversion from the criminal justice system to the mental health system at all stages."[119] Under a NZMHC, minor charges should not require any plea and diversion should take place on a pre-trial basis. If a low-level offender wants to defend their charges, they may do this in the DC and then be transferred to NZMHC, however they will participate in diversion as a "guilty defendant." For more serious offences, diversion should require the determination of guilt either through a defended hearing in the DC or a guilty plea. If a defendant is convicted, sentencing should provide options for ongoing treatment.

Voluntariness:

Entry into NZMHC should be voluntary. This approach is consistent with the right of a person to refuse to undergo medical treatment.[120] In terms of determining what constitutes "voluntary" admission into NZMHC, it is submitted that the threshold should be set relatively low. For example, the defendant "must not object" or "must assent" to the decision to transfer their case to NZMHC. Obviously the defendant must be fit to stand trial, but, beyond this, they should not be expected to "have an ability to fully understand and make reasonable decisions."[121] Such a threshold is too high and likely to result in a large number of mentally ill defendants not qualifying for NZMHC. A low level of assent is also appropriate given the benefits that a defendant may obtain through participation in NZMHC, namely the possibility of avoiding conviction and prison. A relatively low level of assent at the time when a defendant is given the option to participate in NZMHC still preserves the defendant's right to

[119] Melvin Freeman and Soumitral Pathare *WHO Resource Book on Mental Health, Human Rights and Legislation* (World Health Organisation, China, 2005) at 75.
[120] New Zealand Bill of Rights Act 1990, s11.
[121] Goldkamp and Irons-Guyyn, above n 34, at XI.

refuse to undergo any specific medical treatment. That right remains extant until the moment that a medical health professional administers the treatment.[122]

It is submitted that participation in NZMHC on this basis is still "voluntary" and not coerced. The term "coercion" generally conjures up thoughts of some kind of "external, improper pressure brought to bear on a decision: 'the action of persuading or controlling a voluntary agent to do something by force or threats.'"[123] The option of participating in NZMHC presents a genuine alternative offer that would not otherwise exist.[124] It is not a threat, nor does it seek to remove a right that the defendant would have had.[125] The fact that a defendant does not like prison does not make their decision to participate in NZMHC coerced. Life is full of decisions that require us to choose between an unappealing option and a less unappealing option. For example, in employment contracts an employee is given a certain amount of annual leave per year as required by law. However, some employment contracts offer employees an additional week of annual leave in exchange for a 2% reduction in their salary. Assume that an employee really dislikes their job. Their decision to take an extra week annual leave in return for sacrificing 2% of their salary is not "coerced," simply because it is a slightly more attractive option with drawbacks of its own. Similarly, a mentally ill defendant who dislikes prison is not "coerced" into entering MHC. Furthermore, "[i]f there is concern that the promise of liberty contaminates the purity of voluntariness in entering [MHC], the same concern should be levelled at the regular courts during the process of plea negotiations"[126] and, in NZ, at the Police Adult Diversion Scheme. As with these other practices, the concern of voluntariness can be addressed by ensuring that the defendant receives the advice of counsel before assenting to participate in NZMHC. This should be a necessary requirement of entry into NZMHC.

Conclusion

[122] Kate Kensington "Treatment of Offenders within the Community: The issue of consent" (LLB (Hons) Dissertation, University of Otago, 2015) at 15.
[123] At 12.
[124] At 14.
[125] There is some debate that "coercive offers" have the same effect as threats. See further Kate Kensington "Treatment of Offenders within the Community: The issue of consent" (LLB (Hons) Dissertation, University of Otago, 2015).
[126] Schneider, Bloom and Heerema, above n 3, at 95.

A NZMHC should apply to a range of serious mental conditions. In return, it should only be available for low level offences. Diversion should take place in respect of both pre-trial and guilty defendants, and the advice of counsel should be a necessary requirement before any decision to participate in NZMHC is made. In terms of a defendant's level of assent, however, the threshold should be set relatively low. This ensures that participation in NZMHC is available for mentally ill defendants who may not have sufficient capacity and understanding to give their full and informed consent.

THE LEGAL PROCESS FOR A NEW ZEALAND MENTAL HEALTH COURT

This chapter considers the process by which a NZMHC could operate given our current law. First, it discusses the legal powers a NZMHC judge might rely on to pause proceedings and enable therapeutic options to be tried. Secondly, considers the legal mechanism of bail and how this might enable the defendant to participate in treatment. Thirdly, it explores the various means by which pre-trial defendants might have their charges resolved to avoid conviction. Lastly, it debates how some guilty defendants might also have their charges resolved to avoid conviction. Chapter Four then discusses the outcomes for guilty defendants whose receive a conviction.

Pausing proceedings to enable therapeutic options to be tried

There are three powers that could be used to pause proceedings and enable therapeutic options to be tried: the power of the court to grant an adjournment[127], the power of the Attorney General (AG) to direct a stay of proceedings,[128] and the power of the Court itself to stay the criminal proceedings.[129] The most appropriate power for a NZMHC would be the power of adjournment. This is the power used by the AODTC to enable defendants to participate in treatment.[130] The AODTC relies on s25 of the SA, which empowers the court to adjourn proceedings in respect of defendants who have been found guilty or pled guilty, to enable them to participate in a rehabilitation program. A NZMHC could similarly rely upon this section for the diversion of guilty defendants into treatment. Alternatively, and in respect of both pre-trial and guilty defendants, it could use the general power to adjourn under s167 of the CPA. This power is "wide and flexible," and may be used "for an infinite variety of reasons."[131] Aside from the proviso that an adjournment may not be granted for an "unprincipled"[132] reason, there is little restriction on when a court may use that general

[127] Criminal Procedure Act 2011, s167.
[128] Criminal Procedure Act, s176.
[129] Judges of the DC have an inherent power to stay a proceeding. See *Department of Social Welfare v Stewart* [1990] 1 NZLR 697.
[130] Ministry of Justice, above n 80, at 15.
[131] *Richelieu Investments Ltd v McCullagh* HC Auckland CIV-2003-404-4751, 30 April 2004 at [24].
[132] At [24].

power. Given this wide ambit, a NZMHC could legitimately use the power to adjourn under s167 of the CPA to enable a defendant to participate in treatment.

In contrast to the general power of adjournment, the power of the AG to direct a stay and the power of the Court itself to stay criminal proceedings are heavily regulated by the Prosecution Guidelines (PG) and case law. The A-G may only direct a stay in three circumstances:

1. Where a jury has been unable to agree after two trials.[133]
2. Where the Solicitor-General (S-G) considers that the prosecution was commenced incorrectly, or a change in circumstances renders the original decision to prosecute oppressive or otherwise unjust.[134]
3. To clear outstanding or stale charges, or otherwise to conclude unresolved charges.[135]

Similarly, a court may only issue a stay of criminal proceedings where there is state misconduct that will prejudice the fairness of a defendant's trial or undermine public confidence in the integrity of the judicial process if a trial was permitted to proceed.[136] For a NZMHC to use either one of these powers, there would need to be a change to both the PG and common law. This change would be at odds with the traditionally conservative approach to both these powers. At present, a stay by the A-G is "sparingly exercised"[137] and a stay by the courts is viewed as "an extreme remedy which will only be given in the clearest of cases."[138]

In addition, the power of the A-G to direct a stay and the power of the court to grant a stay of criminal proceedings would prohibit a NZMHC from being able to transfer a defendant who opted out of the program or continuously breached the terms of their treatment back to the original court. A stay directed by the A-G "forbids the taking of any further step in relation to the trial"[139] and a stay of criminal proceedings by the court generally halts proceedings permanently.[140] Moreover, a direction for a stay by the A-G would place the final decision

[133] Crown Law *Solicitor-General's Prosecution Guidelines* (1 July 2013) Crown Law <www.crownlaw.govt.nz/assets/Uploads/Prosecution-Guidelines/prosecution-guidelines-2013.pdf> at 23.
[134] At 23.
[135] At 23.
[136] *Wilson v R* [2015] NZSC 189, [2016] 2 NZLR 705 at [40].
[137] Crown Law, above n 134, at 23.
[138] *Wilson v R,* above n 134, at [60].
[139] *D v R* HC New Plymouth T3/96, 24 September 1997 at 5.
[140] Anna Leask "Victims denied their day in court" (2014) New Zealand Herald <www.nzherald.co.nz>.

regarding entry into NZMHC within the hands of the prosecution. It is also debatable whether the power of the A-G to direct a stay is reviewable or not.[141] Some MHCs require prosecutorial consent, however a large number do not. Prosecutorial consent protects the interests of the victim and the community. However, there is the potential for great uncertainty as to when the prosecution will and will not grant consent. The prosecution might also be influenced by the Government's "tough on crime" policy and permit only very few mentally ill offenders participate in MHC. This would frustrate the ability of a NZMHC to operate.

Bail and participation in treatment:

A mentally ill defendant could participate in treatment under a NZMHC via the BA. This is the mechanism used by the AODTC.[142] Under s168(1)(b) of the CPA, the Court may grant a defendant bail following an adjournment. Under s30 of the BA, the Court may impose various conditions upon a defendant's bail, including any condition considered "reasonably necessary" to ensure that the defendant does not commit an offence whilst on bail.[143] Where offending committed by mentally ill persons generally stems from an inability to control or manage their mental health symptoms, participation in a mental health treatment program would be considered "reasonably necessary" to prevent their reoffending whilst on bail.

The length of any treatment program and consequently the length of bail granted to a defendant must comply with a defendant's "right to be tried without undue delay."[144] There are three main purposes behind this right. First, it ensures that a defendant is afforded a fair trial.[145] Secondly, it avoids a miscarriage of justice by ensuring that a witness' memory remains fresh and they are able to recall events clearly at trial.[146] Thirdly, it protects the liberty interests of the accused.[147] Importantly, it also serves to ensure that a defendant is not kept in uncertainty about their future. As the HC has noted, uncertainty about a defendant's future

[141] Simon France (ed) *Adams on Criminal Law - Procedure* (online looseleaf ed, Thomson Reuters) at [CPA176.03].
[142] Ministry of Justice, above n 80, at 15.
[143] Bail Act, s30(4)(c).
[144] New Zealand Bill of Rights Act, s25(b).
[145] Sylvia Bell (ed) *Human Rights Law* (online looseleaf ed, Thomson Reuters) at [BOR25.02].
[146] At [BOR25.02].
[147] At [BOR25.02].

caused by an undue delay in their trial can cause significant anxiety and stress.[148] The first two purposes are particularly relevant to pre-trial defendants of NZMHC. These defendants might choose to opt out of the treatment program or be disqualified on the basis of continuous breaches. Consequently, they would be transferred back to the original court to have their case tried in the traditional way. In order not to prejudice the fairness of their trial, it is important that a treatment programme is not too long. It is also important to ensure that *all* participants in NZMHC have their charges concluded within a reasonable timeframe so as to provide them with certainty regarding their future.

So, what constitutes an "undue delay?" A number of factors are relevant including:

1. The length of the delay;
2. Waiver of time periods;
3. The reasons for the delay, including:
    a. Inherent time requirements of the case;
    b. Actions of the accused;
    c. Actions of the Crown;
    d. Limits on institutional resources; and
    e. Other reasons for the delay; and
4. Prejudice to the accused.[149]

A defendant may only waive their right not to be subject to an undue delay if they have a "full understanding of the situation and an appreciation of what the implications of the waiver are."[150] This raises concerns in the context of a NZMHC. It is unlikely that a seriously mentally ill defendant will be able to fully comprehend their right to be tried without undue delay and the implications of waiving this right. A NZMHC will therefore be unable to rely on a waiver by the defendant and must ensure that the length of any treatment program does not impinge upon the right not to be tried without undue delay. An appropriate length of time for a treatment programme would be a maximum of one year. This reflects the general length of

[148] "The Courts have accepted the pressures and personal consequences arising from an extended delay on the person subject to such a delay, can of themselves amount to prejudice for the purposes of an abuse of process application, even where they are not seen as directly impinging upon the ability of the person concerned to defend him or herself" *Hughes v Police* [1995] 3 NZLR 443 (HC) at [14].
[149] *Williams v R* [2009] 2 NZLR 750, (2009) 8 HRNZ 761 (SC) at [11].
[150] Sylvia Bell, [BOR25.02].

time that a treatment programme runs under the AODTC[151] and mirrors the length of time that a defendant would normally wait before commencing their trial in the DC.

Resolution of charges for pre-trial defendants:

In Chapter Two it was argued that a NZMHC should not require a finding of guilt or a guilty plea to facilitate pre-trial diversion into treatment. If a NZMHC operated on this basis, all pre-trial participants who successfully completed a treatment program would escape conviction. The judge would not have a discretion to convict defendants in this circumstance, however this is not a concern in light of the very low level of offending. There are three means by which a NZMHC might resolve the charges of pre-trial defendants to avoid a conviction: dismissal of the charges by the Court, withdrawal of the charges by the prosecution, or the staying of criminal proceedings by the Court. It is submitted that dismissal of the charges is the most appropriate option.

The withdrawal of charges is inappropriate because, like a direction by the A-G to stay proceedings, it places an important power solely within the hands of the prosecution. What if the prosecution decides not to withdraw the charges? The defendant would have to be transferred back to the original court. This result does not promote the primary purpose of MHCs, which is to divert mentally ill defendants away from the criminal justice system into treatment. Furthermore, given that the power of the prosecution to withdraw charges is not elaborated upon in s146(1) or the PG, it would be difficult to predict and advise a defendant on whether they would have their charges withdrawn. This is not in keeping with the desire to provide a defendant with certainty regarding their future. Due to the fact that the withdrawal of charges does not bar the possibility of future proceedings in the same matter,[152] it also does not fully 'resolve' the charges.

The power of the Court to stay criminal proceedings is also not the best mechanism for a NZMHC to use in order to resolve the charges of pre-trial defendants. This power has been

[151] Ministry of Justice, above n 80, at 15.
[152] Criminal Procedure Act, s146(2).

traditionally exercised conservatively. A change to the common law would be required to enable the Court to stay criminal proceedings in a variety of cases.

In contrast, there is nothing to prohibit a NZMHC from using the power to dismiss charges in relation to pre-trial defendants who successfully complete a treatment programme. In fact, under s148(1) of the CPA, a NZMHC would most likely be *required* to dismiss the charges of these defendants. Section 148(1) of the CPA requires the prosecution to notify the court if the defendant has completed a "programme of diversion." The Court must then dismiss the charges.[153] A dismissal is deemed an acquittal[154] and therefore provides full and final resolution of the charges. The phrase "programme of diversion" is not defined and on a literal reading could encompass pre-trial defendants who have completed a treatment programme as part of NZMHC. At present, it is used by the prosecution for defendants who participate in the Police Adult Diversion Scheme (PADS).[155] However, there is no reason to read the section as limited solely to police diversion. The predecessor to s148(1) of the CPA only applied to diversion programmes offered by the police, however, s148(1) is not as limited and is "available in respect of any diversion programme offered in respect of a public prosecution."[156] The neighbouring section of s147(1) of the CPA also favours a wide interpretation of s148(1). Section 147(1) of the CPA contains the Court's general power to dismiss charges. It simply reads that, "the court may dismiss a charge at any time before or during a trial, but before the defendant is found guilty or not guilty, or enters a plea of guilty." Although s147(4) provides three examples when the court may dismiss charges, this section is expressed as being non-exhaustive and not limiting the operation of s147(1). Thus, it is likely that the term "programme of diversion" in s148(1) will be found to encompass a treatment programme under NZMHC.

If I am wrong and s148(1) is found to apply solely to programmes of police diversion, a NZMHC could nonetheless use the general power to dismiss the charges under s147(1). As previously noted, this section is widely expressed and on a literal reading could apply to pre-trial defendants of NZMHC. Section 147(4) includes examples of when the Court may dismiss

[153] Criminal Procedure Act, s148(2).
[154] Criminal Procedure Act, s147(6).
[155] "About the Adult Diversion Scheme" New Zealand Police <www.police.govt.nz>.
[156] Simon France, above n 141, at [CPA148.01].

charged, however these are non-exhaustive and do not limit the operation of the general power in s147(1).

Resolution of charges for guilty defendants (without-conviction):

The determination of guilt and conviction of a defendant are two distinct processes. A defendant is first found guilty by the Court. Then it decides whether to enter a conviction. Thus, guilty defendants who successfully complete a treatment programme under NZMHC could have their charges resolved in one of two ways. First, a conviction might result with the defendant being sentenced in the normal way. This will be discussed in the Chapter Four. Secondly, the defendant might escape conviction via:

1. The granting of a DWOC under s106(1) of the SA;
2. The permanent staying of criminal proceedings by the court; or

It is submitted that, from the three options listed, the power of the Court to grant a DWOC is the best means of resolving the charges of guilty defendants to prevent a conviction.

A DWOC is deemed an acquittal,[157] whereas a permanent stay of criminal proceedings by the Court is not. Although a permanent stay cannot be lifted and proceedings resumed, the fact that the defendant's charges are left 'lingering,' does not provide full and final resolution in the same way as a DWOC. Section 107 of the SA states that the Court may only grant a DWOC where it is satisfied that, "the direct and indirect consequences of a conviction are out of all proportion to the gravity of the offence." This requires the Court to determine: the seriousness of the offending, the consequences of a conviction, whether such consequences are out of all proportion to the gravity of the offence and whether, in light of these three factors, it should exercise its discretion to grant a DWOC.[158] In applying the disproportionality test, the principles and purposes of sentencing, as well as any aggravating and mitigating factors are relevant.[159] It is submitted that the s107 test could be met by some guilty defendants of NZMHC who have successfully completed a treatment programme. Entry into

[157] Sentencing Act, s106(2).
[158] *R v Blythe* [2011] NZCA 190, [2011] 2 NZLR 620 at [14].
[159] Simon France (ed) *Adams on Criminal Law – Sentencing* (online looseleaf ed, Thomson Reuters) at [SA107.01].

NZMHC will be reserved for low-moderately serious offences and exclude violent, and sexual offences. Therefore, the seriousness of the offending will be low. As a result, concerns for the protection of the community will also be minimal.[160] Furthermore, the principles and purposes of sentencing that require defendants to assume responsibility for their actions and be held accountable for any harm caused[161] are not entirely applicable to mentally ill defendants. This is because their offending is more likely to stem from an inability to control or manage their mental health symptoms, rather any form of deliberate criminality.[162] Relatedly, the "diminished intellectual capacity or understanding" of mentally ill offenders is a mitigating factor,[163] as is the fact that the defendant has spent time on bail under an Electronic Monitoring (EM) condition.[164] By extension of the latter, participation in a treatment programme during bail could also constitute a mitigating factor. In light of the overall "minimal culpability and substantial mitigation" of offending committed by mentally ill defendants under NZMHC, it is likely that the consequences of conviction will be found to outweigh the gravity of the offence.

A change to our law would be required to enable a NZMHC to grant a DWOC to some guilty defendants. At present, the ability of the court to grant a DWOC is used only "sparingly."[165] Furthermore, its use is often reserved for first time offenders who have pled guilty. As Anderson J noted in *Amarasekera v Police* HC Hamiton AP116/90, 17 December 1990, "it would be extraordinary […] for a judicial concession to human fallibility to be accorded in a case where fault has not been accepted by the offender." A large number of mentally ill offenders are likely to be low-level recidivists who have been stuck in the 'revolving door' cycle described in the Introduction. A change regarding the ability of the Court to grant a DWOC to first time offenders would therefore be required. Furthermore, not all guilty defendants would have entered NZMHC via a guilty plea. Some may have defended their charges in the DC first. A change to the Court's use of the power for defendants who have pled guilty would therefore also be required.

[160] Sentencing Act, s7(1)(g).
[161] Sentencing Act, ss7(1)(a) and (b).
[162] Schneider, Bloom and Heerema above n 3, at 5.
[163] Sentencing Act, s9(2)(e).
[164] Sentencing Act, s9(2)(h).
[165] *Halligan v Police* [1995] NZLR 1185 (SC) at 1188.

Conclusion:

A NZMHC could use the general power of adjournment and the granting of bail to enable therapeutic options to be tried. Pre-trial defendants who successfully complete their treatment programme could have their charges dismissed under s148(1) or s147 of the CPA. No change in our law would be required to effect this. Guilty defendants whom a NZMHC judge decides not to convict could be acquitted under a DWOC. A change in our law would be required to effect this, as a DWOC is currently only reserved for first time offenders who plead guilty.

DISPOSITION OPTIONS FOR GUILTY DEFENDANTS AT SENTENCING

This chapter discusses how guilty defendants who have completed a treatment programme and been convicted might be dealt with at sentencing by a NZMHC. Under s9(4)(a) of the SA, a NZMHC could take into account a defendant's time spent in treatment as a mitigating factor. This could result in the defendant receiving a reduced sentence. Under this approach, it is submitted that the majority of guilty defendants should receive a conviction and discharge. There are other therapeutic sentencing options, however, that a NZMHC could utilise. In particular, s34(1)(a) and (b) of the CP(MIP) Act and ss45 and 54 of the SA.

Conviction and discharge:

Under s108 of the SA, a Court may convict and discharge a defendant, unless the offence requires a minimum sentence to be imposed. Section 109 of the SA states that the Court must first be "satisfied that a conviction is [a] sufficient penalty in itself." In practice, the power is generally used to resolve minor charges committed by a defendant who has also committed serious charges. The sentence handed down for the serious charges is viewed as sufficient to meet the overall level of criminality and therefore, the defendant is convicted and discharged of the minor ones. Despite this practice, there are no established common law principles regarding the Court's power to convict and discharge. It has simply been held that the Court has a broad discretion to consider all of the relevant circumstances of the offence and offender.[166] Thus, it is certainly possible that a NZMHC could utilise this power in respect of guilty defendants who have completed a treatment programme. Such use is in keeping with current practice, due to the fact that a NZMHC will only operate in respect of low-moderate offences. Furthermore, the fact that guilty defendants will have participated in treatment for up to one year is likely to render the fact of conviction a "sufficient penalty in itself."

Under s108(2), a court may, in addition to convicting and discharging a defendant, order that the defendant pay costs, return property or pay restitution for any harm caused by their offending. The court may also make any order that is required upon conviction. This section

[166] See further *M v Police* HC Auckland AP28-90, 20 March 1990.

ensures that a NZMHC might also make provision for traditional goals of the criminal justice system, such as responsibility and the need to address concerns of the victim.

Section 34(1)(a) of the CP(MIP) Act:

Section 34(1)(a) of the CP(MIP) Act applies to defendants who are convicted of an imprisonable offence. The Court may sentence the defendant to a term of imprisonment, however, instead of ordering the defendant to be immediately transferred to prison, the Court can make an order that they be detained in a hospital or secure facility under the MHA or the IDA. The Court must first be satisfied that the defendant is either "mentally disordered" or "intellectually disabled" in the relevant sense.[167] It must also be satisfied that the defendant's "mental impairment" requires "compulsory treatment or care."[168] Such a course of action must also be held to be in the best interests of the defendant, or for the safety of the public or any other person.[169] The period that a defendant spends in hospital or a care facility counts towards their sentence.[170] If a defendant being treated under the MHA or care under the IDA ceases to be "mentally disordered" or intellectually disabled," they must be transferred back to prison to fulfil the remainder of their sentence.[171] If a defendant is still receiving treatment or care when their sentence expires, they are not automatically discharged. Instead, they remain amenable to treatment or care, although their patient status changes. Thus a defendant who is a "special patient" under the MHA, becomes a "compulsory patient"[172] and a defendant who is a "special care recipient" under the IDA becomes a "compulsory care recipient."[173] The defendant remains in treatment or care until they cease to be "mentally disordered" or "intellectually disabled" in the relevant sense, whence they are released.[174]

[167] Criminal Procedure (Mentally Impaired Persons) Act 2003, s34(3).
[168] Criminal Procedure (Mentally Impaired Persons) Act, s34(2).
[169] Criminal Procedure (Mentally Impaired Persons) Act, s34(2).
[170] Mental Health (Compulsory Assessment and Treatment) Act, s48(2); Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s69(2).
[171] Mental Health (Compulsory Assessment and Treatment) Act, s47(1); Intellectual Disability (Compulsory Care and Rehabilitation) Act, s84(1).
[172] Mental Health (Compulsory Assessment and Treatment) Act, s48(3)(ba).
[173] Intellectual Disability (Compulsory Care and Rehabilitation) Act, s69(3)(b).
[174] Mental Health (Compulsory Assessment and Treatment) Act, s35(1); Intellectual Disability (Compulsory Care and Rehabilitation) Act, s84(1).

The purpose of s34(1)(a) of the CP(MIP) Act is to provide the Court with a therapeutic option for dealing with a defendant who is mentally disordered or intellectually disabled, whilst still ensuring that the traditional goals of punishment, responsibility and protection of the community are met. Prior to the enactment of s34(1)(a) of the CP(MIP) Act, a court could only order that a "mentally disordered" defendant be treated in a hospital no background sentence of imprisonment.[175] There was no provision for intellectually disabled defendants. Mentally disordered defendants would be released upon ceasing to be "mentally disordered" in the relevant sense. Concern regarding the premature release of dangerous defendants prompted the enactment of s34(1)(a) and hence, the ability of the court to sentence a defendant to a background period of imprisonment. Thus, s34(1)(a) was intended to apply to mentally afflicted defendants who commit *serious* crimes. The use of this section by a NZMHC is therefore likely to be very rare, given the fact that eligibility to participate in NZMHC excludes serious offences.

In addition to the fact that s34(1)(a) is primarily geared towards serious offences, which NZMHC participants will not have committed, it is submitted that imprisonment should very rarely, if ever, be imposed as a sentence by a NZMHC, either on its own or in conjunction with an order under s34(1)(a) of the CP(MIP) Act. Prison has a particularly negative effect upon mentally ill defendants, given that the provision of mental health treatment in prison is poor. The cause of mentally ill defendants' offending remains unaddressed, not only exacerbating their mental health symptoms, but also increasing their likelihood of reoffending. Such a result is not in the best interests of the defendant or society. Moreover, MHCs were developed in response to the failure of the criminal justice system to meet the needs of mentally disordered accused.[176] To this end, their primary aim is to keep mentally ill defendants *out* of prison. A sentence of imprisonment by a NZMHC is entirely antithetical to this purpose.

Section 34(1)(b) of the CP(MIP) Act:

[175] Criminal Justice Act 1985, s39J.
[176] Schneider, Bloom and Hareema, above n 3, at 42.

Under s34(1)(b), the Court may, instead of passing a sentence under the SA, order that a convicted defendant be treated as a "compulsory patient" under the MHA or a "care recipient" under the IDA. An order under this section does not involve a background sentence of imprisonment and is a more appropriate disposition option for a NZMHC. It involves civil commitment of the defendant and permits treatment to take place in either a hospital, a secure facility or a community treatment provider. The defendant must be released upon ceasing to be "mentally disordered" or "intellectually disabled" in the relevant sense.[177] A defendant convicted of an imprisonable offence who is dealt with under s34(1)(b) of the CP(MIP) Act, might therefore only spend only minimal amount of time in treatment. For this reason, s34(1)(b) of the CP(MIP) Act is "reserved for less serious offending, where deterrence and protection of the public are not imperative."[178] Given that a NZMHC will apply to low-level offences, it could legitimately make use of s34(1)(b) of the CP(MIP) Act. This section could provide a useful tool for dealing with defendants who require ongoing treatment over and above the one year maximum that a treatment programme may operate.

Supervision:

Under s45(1) of the SA, the Court may impose a sentence of supervision if the defendant has committed an offence punishable by a term of imprisonment, home detention or any form of community based sentence. The Court must be satisfied that a sentence of supervision would "reduce the likelihood of further offending by the offender through the rehabilitation and reintegration of the offender."[179] Offending by mentally ill defendants generally stems from an inability to control or manage their mental health symptoms. Thus, a sentence of supervision aimed at treating a defendant's mental condition would reduce their likelihood of reoffending and qualify under s46 of the SA. The Court may impose "special conditions" on a term of supervision if the defendant presents a "high risk of re-offending" and standard conditions of supervision would not reduce that risk of re-offending alone.[180] Special

[177] Mental Health (Compulsory Assessment and Treatment) Act, s35(1); Intellectual Disability (Compulsory Care and Rehabilitation) Act, s84(1).
[178] *R v Goodlet* [2011] NZCA 357, [2011] 3 NZLR 783 at [37].
[179] Sentencing Act, s46.
[180] Sentencing Act, s50(a) and (b).

conditions include receipt of psychiatric or other counselling,[181] attendance at a rehabilitative and re-integrative programme,[182] and the taking of prescription medication.[183] A sentence of supervision must be at least 6 months long, but may not exceed one year.[184] Unlike s34(1) of the CP(MIP) Act, which requires a defendant to be either "mentally disordered" or "intellectually disabled," a sentence of supervision does not require the presence of a mental condition. Thus, it could be used by a NZMHC for defendants who are not "mental disordered" or "intellectually disabled," but nonetheless suffer from a mental condition and require ongoing treatment.

It is unlikely that a NZMHC could utilise s45 for defendants who have completed a treatment program and whose mental health is sound, but require assistance in other aspects of their lives, such as housing and employment. Offending by mentally ill persons generally stems from an inability to control or manage their mental health symptoms. Thus, a former mentally ill defendant whose mental health is currently sound, is unlikely to be considered as requiring a sentence of supervision to reduce reoffending.[185] Such a defendant is also unlikely to meet the test of posing a "high risk of reoffending" for the imposition of special conditions.[186] Nonetheless, these defendants could benefit from ongoing assistance to address their basic living needs. Such an approach consistent with the holistic style of treatment that MHCs offer. As Chandler and Loeb note, "treatment [in MHC] is not limited to medication. It can include educational training, vocational programs and training, substance use treatment, housing and access to social services, budgetary counselling, etc."[187] The ability of a NZMHC to assist defendants who are mentally sound but lacking in other, fundamental aspects of their lives ensures that they are not just 'dumped' by a NZMHC after treatment. It promotes their *full* reintegration back into society. An additional provision would need to be included under s45 of the SA to give a NZMHC the power to sentence a defendant to supervision if they require assistance in attaining basic living needs, such as housing.

[181] Sentencing Act, s51(a).
[182] Sentencing Act, s51(b).
[183] Sentencing Act, s52(2)(b).
[184] Sentencing Act, 45(2).
[185] Sentencing Act, s46.
[186] Sentencing Act, s50.
[187] Richard Schneider, Anne Crocker and Marichelle Leclair "Mental Health Courts and Diversion Programs" in Jennifer Chandler and Bertram Loeb (eds) *Law and Mind: Mental Health Law and Policy in Canada* (LexisNexis Canada, Toronto, 2016) 303 at 316.

In addition, a NZMHC might also be empowered to retrospectively quash a defendant's conviction if they successfully comply with their terms of supervision or treatment under s34(1)(b) of the CP(MIP) Act. This power is not apparent in any MHC researched for this thesis. However, such a power would provide an additional incentive for defendants to comply with the terms of supervision or treatment. It would also promote the purpose of preventing the criminalisation of mentally ill defendants, which is one of the main functions of MHCs. Conversely, it might be considered unfair to permit the retrospective quashing of a conviction for mentally ill defendants and not others. This would have to be explored before such a power was made available to a NZMHC.

Intensive supervision:

The same arguments that were made regarding a sentence of supervision can also be made for a sentence of intensive supervision under s54 of the SA. The two sections are identical, except that intensive supervision can apply for a maximum of two years, as opposed to one.[188] Intensive supervision could therefore by used by a NZMHC for defendants who require ongoing treatment for a longer period that 6-12 months.

Conclusion

The range of therapeutic disposition options for a NZMHC seems adequate. Section 34(1)(b) ensures that "mentally disordered" and "intellectually disabled" defendants continue to receive treatment if, despite having participated in a treatment programme of up to one year, they have not reached a stage of mental soundness. Similarly, the sentences of supervision and intensive supervision ensure that defendants who are not "mentally disordered" or "intellectual disabled," but nonetheless suffer from a mental condition and require ongoing treatment are able to receive such care. A NZMHC could benefit from being able to utilise a sentence of supervision or intensive supervision for defendants who are mentally sound but require assistance in other basic areas of life. This would ensure the full reintegration of

[188] Sentencing Act, s54B(2).

participants of NZMHC back into society. An additional provision would need to be included in the SA for this purpose.

CONCLUSION

Two questions were posed at the beginning of this thesis. First, how do MHCs function? Secondly, could one function within the framework of NZ law? In regards to the first question, we have seen that the primary functions of MHCs are to: divert mentally ill offenders away from the criminal justice system and into mental health treatment; reduce the time that mentally ill offenders spend in prison; and provide an alternative means of resolving the charges to reduce criminalisation. The theory of therapeutic jurisprudence (TJ) informs this approach. This theory emphasises that traditional goals of the criminal justice system, such as punishment and responsibility, are often inappropriate in the context of offenders who are "more mentally afflicted than criminally motivated."[189] However, TJ does not aim to override the traditional goals of the criminal justice system entirely. Instead it aims to promote the goals of rehabilitation and reintegration of the offender, as well as protection of the community through effective treatment and reducing the risk of reoffending. Thus, it is more apt to say that TJ "attempts to work within the confines of [traditional goals of the criminal justice system] to *also* produce a therapeutic outcome for the accused."[190]

In Chapter One, we saw how MHCs perform their functions differently from place to place. In Florida, entry into the MHC is available for offenders who suffer from a broad range of serious mental conditions, including intellectual disabilities, whereas in Victoria, intellectually disabled offenders are excluded and handled differently. Similarly, diversion into treatment in Florida takes place both pre-trial and following the determination of guilt, whereas in Victoria diversion into treatment only takes place pre-trial. Participation in NZ's AODTC is reserved for offenders facing up to three years imprisonment and requires a guilty plea. However, a guilty plea is not required by all MHCs. This survey of the workings of some specialist courts revealed the range of legal issues that would need to be addressed in the operation of a NZMHC.

Regarding the second main question of this thesis, it is submitted that a NZMHC could largely function within NZ's existing law. No separate enabling statute would be required. Some minor modifications might be required to specific statutes, such as the CPA, CP(MIP) Act and

[189] Schneider, Bloom and Heerema, above n 2, at 43.
[190] At 43.

SA, and it would be useful to issue formal guidelines, governing such matters as the entry criteria and treatment options. Aside from those minor tweaks, however, a NZMHC could operate within our current legal framework.

The entry criteria for a NZMHC should enable therapeutic outcomes for mentally ill defendants, without subverting traditional aims of the criminal justice system. Thus, the criteria would apply to a broad range of serious mental conditions, but only to low-moderate offending. This would ensure that a NZMHC would apply only in circumstances where the goals of rehabilitation and reintegration of the offender through treatment significantly outweighed concerns about the need for punishment, responsibility and community safety. A guilty plea should not be a pre-requisite for entry, though entry should be voluntary and occur after advice from counsel. Diversion should be possible both pre-trial and following adjudication of guilt.

The assessment of defendants to determine whether they meet the mental criteria for a NZMHC could take place on a similar basis to that followed in the AODTC. Thus, a defendant's eligibility could be raised at their first appearance, with an order for assessment made by the Court. This would only require two minor changes to the CP(MIP) Act. First, a provision enabling a NZMHC to order a health assessor to prepare a report for this purpose would need to be added to s38(1). Secondly, s38(3)(a) would need reform to permit a NZMHC to order that a defendant could be assessed in a hospital or secure facility even if they were "bailable as of right." .

Regarding the process that a NZMHC might follow to enable a defendant to participate in treatment, the power of adjournment under s167 of the CPA provides an appropriate means of pausing proceedings for this purpose. The defendant could then be granted bail under s168(1)(b) of the CPA, with treatment conditions being imposed under s30 of the BA. The length of any treatment programme should not exceed 12 months to protect the defendant's right to be tried without undue delay.[191] A pre-trial defendant who successfully completed their treatment programme could then have their charges dismissed under s147 of the CPA. No change to our law would be required to effect that process. However, where the defendant was found guilty, a minor change to the Court's power to grant a DWOC would be

[191] New Zealand Bill of Rights, s25(b).

required to avoid the need to impose a conviction. At present that power is reserved for first time offenders who plead guilty. However, many mentally ill offenders are low-level recidivists. They might enter the NZMHC after first having defended their charges in the DC, and then been found guilty, as opposed to having entered a guilty plea. A minor change to either s106(1) of the SA or to the common law principles governing its use would therefore be required to permit such repeat offenders to be granted a DWOC.

The majority of guilty offenders who receive a conviction would have their charges resolved through a conviction and discharge under s108 of the SA. Where the defendant's mental health was not stable, the NZMHC could ensure they continued to receive treatment via an order under s34(1)(b) of the CP(MIP) Act, or via a sentence of supervision or intensive supervision.[192] Rarely should a sentence of imprisonment be used by a NZMHC for a defendant who has successfully completed the treatment programme, either alone or in conjunction with an order for their detention in a hospital or secure facility under s34(1)(a) of the CP(MIP) Act. Imprisonment is antithetical to the purpose of a MHC.

Generally, this range of disposition options would be adequate for the NZMHC. However, it is submitted that a slight modification might be desirable to the sentences of supervision and intensive supervision. A NZMHC should be able to use these sentences for defendants whose mental health is stable and who do not present a "high risk of reoffending,"[193] but nonetheless need help in other basic aspects of their lives, such as housing and employment. An additional provision enabling a NZMHC to use the sentences in those circumstances should therefore be added.

Significant work would be required to issue guidelines that would outline the eligibility criteria, process and consequences of participation in the NZMHC. These could be similar in form to the current guidelines to the AODTC. But those guidelines could be promulgated by the Executive, or as rules of court. No new statutory authority for them would be required. Overall, the scale of the legislative changes that would therefore be needed to facilitate a NZMHC are quite minor. They could be dealt with in a single, amending Bill.

[192] Sentencing Act, ss45 and 54.
[193] Sentencing Act, s46.

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