Mental Health Foundation OF NEW ZEALAND
mauri tū, mauri ora

21 December 2020

Dear Justice Committee

Rights of Victims of Insane Offenders Bill

Tuia te rangi e tū nei
Tuia te papa e takoto nei
Tuia i te here tangata
Tihei mauri ora
He hōnore, he korōria ki te atua ki te runga rawa
He whakaaro maha ki a rātou kua haere ki te wāhi ngaro
Rau rangatira mā, ānei ngā whakaaro me ngā kōrero nā Te Tūāpapa Hauora Hinengaro

We write to express our concern about the Rights of Victims of Insane Offenders Bill. This is a joint submission from the Mental Health Foundation of New Zealand and the Like Minds Like Mine programme (see pages 6-7 for a description).

Introduction

Firstly, we acknowledge victims' rights in forensic patient decision-making can be a complex issue. We agree victims' rights are important, and on-going support for their mental wellbeing is paramount. We believe victims' rights should be proportional and balanced against the rights of all other parties.

We broadly support the main intention of the Bill; to revise the language of the verdict of 'not guilty on account of insanity' to acknowledge the person was proven to have acted grievously, even if they lacked the intent to be guilty of the action.

However, we are concerned this Bill takes an ad-hoc approach to a system that upholds the insanity defence. We urge the committee to take a whole-of-systems approach to the insanity defence process and consider how robust improvements could be made to effect fair outcomes for all parties, including for victims. We suggest the recommendations from the 2010 Law Commission's report *Mental impairment decision-making and the insanity defence* provide a useful blueprint for reform.

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Other issues we briefly raise relate to:

- stigmatising language of current legislation (and of this Bill)
- privacy concerns, and
- the need for trauma-informed, timely, and culturally appropriate support for all victims of crime.

Context

We know people who experience mental distress are less likely to be violent than the average citizen. In fact, they are more likely to be victims of violence and crime.[i] We work hard, along with others, on the Like Minds, Like Mine programme, which aims to debunk myths that people who live with severe mental distress are violent, dangerous, untrustworthy and unsafe to be around.

The current Bill may exacerbate this sort of stigma against people with severe mental distress. By only seeking to increase victim rights in relation to crimes committed by those deemed to be insane offenders it implies there is a large population of victims of perpetrators that use the insanity defence. In fact, the insanity defence is used in only a tiny proportion of criminal cases. Between 2008-2018 the defence was successfully used between 12-28 times annually, with a spike of 43 cases in 2017/18.[1]

A fairer and more transparent system

The Bill's provision (clause 6 &7) allowing victims to make written submissions to the Minister of Health about whether continued detention is necessary adds an additional layer of bias to an already unsuitable system. Currently, the Minister of Health has statutory responsibilities for decisions affecting persons found unfit to stand trial or acquitted on account of insanity relating to discharge and reclassification from a special patient to a patient (or special care recipient to a care recipient). Evidence suggests that ministers, who may have obligations and duties to constituents and who are not immune to public pressure, could be influenced to make decisions that affect an individual's healthcare that lead to the prolonged detention for special patients that is not proportionate to clinical risk.

[1] Ministry of Justice. Table 5: Number of people found not guilty by reason of insanity, by offence type, 2008/2009-2017/2018. https://www.justice.govt.nz/assets/Documents/Publications/Unfit-to-stand-and-not-guilty-by-reason-of-insanity-June2018-v2.0.xlsx

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Forensic services are there not for punitive reasons but to support a person to recover, to participate in their usual lives and to support individuals to return to the community. However, in Aotearoa New Zealand, there is long-term evidence that patterns of detention for special patients is not related to clinical risk, suggesting that special patients are receiving punitive treatment rather than healthcare as is their human right. [2]

We support the recommendation made by the Law Commission' 2010 report for a move away from Ministerial decision-making about the reclassification or discharge of a special patient or special care recipient to a model where these decisions continue to be clinically initiated but are based on broader public interests[3], taken into account by a specialist independent tribunal. It was envisioned such a change would provide manifest advantages for all parties, including victims, because it provides a clear and transparent pathway for decision-making. At the time, the Government of the day accepted this recommendation and sought to consider it as part of a mid-2012 legislative review. However Ministerial decision-making continues to be enshrined in the Criminal Procedure (Mentally Impaired Persons) Act. We urge the Justice Committee to adopt this recommendation with urgency.

In addition, the Law Commission makes recommendations on tribunal membership.[4] We would wish to strengthen this membership to include those with lived experience of severe mental illness, and those who hold mātauranga Māori (Māori knowledge) including tohunga, kaumātua or Māori mental health specialists, rather than just 'expertise on Māori issues'.

[2] Skipworth, Brinded, Chaplow & Framptom. (2006). Insanity acquittee outcomes in New Zealand, *Australian and New Zealand Journal of Psychiatry*, 1003–1009.

[3] Currently, Ministers must consider the defendant's own interests; and the safety of the public or the safety of a person or class of person. The Law Commission proposed redrafted decision-making grounds provide that the safety of the public or any person or class of person is the paramount consideration, and that interference with the patient's freedom and personal autonomy should be kept to the minimum that is consistent with this objective.

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

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Discriminatory language

The terminology of 'insanity', 'natural imbecility' and 'disease of the mind' in the Crimes Act 1961, the Criminal Procedure (Mentally Impaired Persons) Act 2003 and this Bill is outdated and stigmatising. Tāngata whaiora/people who experience mental distress and the mental health sector have long stopped using this sort of archaic, inappropriate and outdated language. While it is not our role to dictate the letter of the law, we urge the Committee to take this opportunity to consider the terminology in legislation and adopt language that is non-stigmatising and non-offensive.

Privacy concerns

The Bill's provision (clauses 9 & 13) to provide copies of a certificate of clinical review to victims could be a breach of offender privacy and expert advice should be sought. Private health information should never, as a matter of course, be disclosed without the explicit consent of individuals except as is currently allowed by law (i.e. in limited circumstances when required for the provision of healthcare).

Trauma-informed care and support

Victims of any crime should have access to the necessary support and help. This support should be trauma-informed, timely, and culturally appropriate (with access to kaupapa Māori specialist services). The Committee should consider whether the current system adequately provides the necessary level of care and support to victims of forensic patients, including responding to stress, trauma and mental distress as well as diagnoses of mental illness, and what could be done to strengthen this. We note for example, ACC does not provide cover for people who experience a 'mental injury' caused by traumatic events outside of work, and for a personal injury claim a 'mental injury' may only be covered if it stems from a covered physical injury.

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Summary

We urge the Committee to take a whole-of systems approach when considering if the current legal framework for the insanity defence is fit for purpose, fair and leads to equitable and compassionate outcomes of all parties.

Mauri tu, mauri ora,

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About the Mental Health Foundation of New Zealand

The MHF's vision is for a society where all people flourish. We take a holistic approach to mental health and wellbeing, promoting what we know makes and keeps people mentally well and flourishing, including the reduction of stigma and discrimination (particularly on the basis of mental-health status).

The MHF is committed to ensuring that Te Tiriti o Waitangi and its Articles are honoured, enacted, upheld and incorporated into our work, including through our Māori Development Strategy. We are proud that Sir Mason Durie is a Foundation patron.

The MHF takes a public health approach to our work, which includes working with communities and professionals to support safe and effective suicide prevention activities, create support and social inclusion for people experiencing distress, and develop positive mental health and wellbeing. Our positive mental health programmes include Farmstrong (for farmers and growers), All Right? (supporting psychosocial recovery in Canterbury, Kaikōura and Hurunui), Pink Shirt Day (challenging bullying by developing positive school, workplace and community environments), Open Minds (encouraging workplaces to start conversations about mental health) and Tāne Ora (working with tāne Māori and their whānau to build wellbeing skills). Our campaigns reach tens of thousands of New Zealanders each week with information to support their wellbeing and help guide them through distress and recovery.

We value the expertise of tangata whai ora/ people with lived experience of mental distress and incorporate these perspectives into all the work we do. Established in 1977, the MHF is a charitable trust, and our work is funded through donations, grants and contract income, including from government.

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About the Like Minds Like Mine Programme

Like Minds, Like Mine is a public awareness programme to increase social inclusion and end discrimination towards people with experience of mental illness or distress. We do this through public awareness campaigns, community projects and research.

The Like Minds, Like Mine programme is funded by the New Zealand Government. Te Hiringa Hauora/Health Promotion Agency is the lead operational agency for the programme, with strategic responsibility held by the Ministry of Health.

National coordination and communications for the programme is led by the Mental Health Foundation of New Zealand. The Foundation has a long involvement in the programme, providing support for the national activities for the past decade. It has also held contracts to deliver regional activities.

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[i] References

- A study of people with schizophrenia showed they were 14 times more likely to be victims of crime than perpetrators. (Brekke et al., 2001)
- People with SMI ['serious mental illness'] are six times more likely to experience victimisation through recent domestic or sexual violence than the general population. (Khalifeh et al., 2016)
- People with 'severe mental illness' are between 2.3 to 140.4 times more likely to experience victimisation than people in the general population. (Maniglio, 2009)
- Substance abuse is far more of a risk factor for violence than mental illness. Where mental illness and substance abuse co-occur, prevalence goes up. (Steadman et al., 1998)
- In order to prevent one stranger homicide, 35,000 people with schizophrenia judged to be at high risk of violence would need to be detained. (Large et al., 2011)
- The large majority of people with 'mental illness' do not engage in violence against others, and most violence is caused by factors (e.g., substance abuse) other than 'mental illness'. (McGinty et al., 2014)
- Only about 5% of violence is attributable to 'mental illness'. (Ahonen, Loeber & Brent, 2017)

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