NOTE: PURSUANT TO S 25 OF THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992, ANY REPORT OF THIS PROCEEDING MUST COMPLY WITH SS 11B TO 11D OF THE FAMILY COURTS ACT 1980. FOR FURTHER INFORMATION, PLEASE SEE HTTP://WWW.JUSTICE.GOVT.NZ/COURTS/FAMILY-COURT/LEGISLATION/RESTRICTIONS-ON-PUBLICATIONS.

IN THE COURT OF APPEAL OF NEW ZEALAND

CA856/2013
[2014] NZCA 280

BETWEEN	M (CA856/2013) Appellant
AND	THE QUEEN Respondent

Hearing: 11 June 2014

Court: French, Venning and Mallon JJ

Counsel: D J Allan for Appellant
D R La Hood for Respondent

Judgment: 27 June 2014 at 3.30 pm

JUDGMENT OF THE COURT

The appeal against the order under s 24(2)(a) of the Criminal Procedure (Mentally Impaired Persons) Act 2003 requiring the appellant to be detained as a special patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992 is dismissed.

REASONS OF THE COURT

(Given by French J)

Introduction

[1] In May 2013, the High Court found Ms M not guilty by reason of insanity of one charge of wounding with intent to cause grievous bodily harm.[1]

[2] Following that finding, Ronald Young J made an order under s 24(2)(a) of the Criminal Procedure (Mentally Impaired Persons) Act 2003 (the CPMIP Act) that Ms M be detained in a hospital as a special patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHCAT Act).[2]

[3] Ms M now appeals the order making her a special patient. She says such an order was not necessary and that the correct disposal was an order under s 24(1)(a) of the CPMIP Act that she be treated as a patient under the MHCAT Act, accompanied by a compulsory inpatient treatment order under s 30 of the MHCAT Act.

Background

[4] On 12 June 2012, Ms M entered a room where her partner was on the bed watching television. She was holding a large stainless steel knife. She drove it into his chest saying: "If I didn't do it, you would." She then removed the knife and her partner was able to run to a neighbour's house for help.

[5] The partner suffered life-threatening injuries. He required emergency surgery and a subsequent operation but is expected to make a full recovery.

[6] Ms M, who is in her 40s, has suffered from schizoaffective disorder since her late teens. She has a history of recurrent admissions to hospital. In April 2012 she stopped complying with her treatment programme and subsequently suffered a psychotic relapse. The attack on the partner occurred during this relapse. She believed her partner was going to have a heart attack and would die unless she stabbed him.

---

1 *R v [M]* [2013] NZHC 1283.
2 *R v [M]* [2013] NZHC 2134.

[7] When the case came before the High Court, proceedings under the CPMIP Act were initiated and reports obtained from two consultant forensic psychiatrists, Dr Brunskill and Dr Majeed. Both were of the view that at the time of the attack, Ms M was insane within the meaning of the CPMIP Act and the High Court accordingly so found.

[8] The two psychiatrists did not, however, agree on the appropriate disposal. Dr Brunskill considered Ms M should be detained in hospital as a special patient.[3] Dr Majeed, on the other hand, considered that her treatment and risk management needs could be met by less restrictive orders. In his view, the appropriate course of action was for her to remain on an indefinite compulsory inpatient treatment order under s 30 of the MHCAT Act before being transitioned onto an indefinite compulsory community treatment order under s 29 of that same Act.

[9] As noted in *M (CA819/2011) v R,* the key practical difference between an inpatient order and a special patient order is that under a special patient order, it is the Minister of Health who determines how long the order is to remain in force.[4] The Director of Mental Health is also integrally involved in decisions relating to the security and care of the patient. These include the granting of short-term community leave. Longer-term community leave will be granted by the Minister to a special patient only if two medical practitioners have certified the patient is fit to be allowed to be absent from the hospital.

[10] By way of contrast there is no corresponding framework for a person subject to an inpatient order. The order allows the clinician responsible, acting alone, to release the patient from compulsory status if the clinician considers the patient is fit to be released.

[11] In light of the disagreement between the two doctors, further reports were obtained and a hearing held before Ronald Young J in which the two were cross-examined.

---

3 This view was supported by another consultant psychiatrist, Dr Dean, in an earlier report dated 16 October 2012.

4 *M (CA819/2011) v R* [2012] NZCA 142, (2012) 28 FRNZ 773 at [11].

[12] By that time, Ms M's mental health had significantly improved.

[13] In his subsequent decision, the Judge noted that both doctors agreed that so long as Ms M's mental state is controlled, then she is unlikely to pose a significant danger to anyone. It was also common ground that there is no reason to be concerned while she remains an inpatient. The disagreement was about how to manage the risk of a relapse in the community.

[14] In Dr Brunskill's view, what mattered in assessing future risk was that Ms M has a long history of relapsing and resisting treatment. He acknowledged that her current attitude towards treatment is positive but pointed out that it is untested, especially in the community. He described the extra safeguards built into special patient status as being "the third person in the room" and considered those safeguards were important in safely managing Ms M's risk long-term.

[15] Dr Majeed, however, was confident that the degree of supervision provided by a community treatment order or an inpatient order (were Ms M on leave in the community) would be sufficient. While in the community, she would be monitored by a forensic mental health team who would be able to pick up any concerns well before she became a danger. Dr Majeed emphasised Ms M's current insight into her mental illness and her acceptance of the need for treatment, the absence of any personality disorder, the absence of any previous history of violence and the support she has in the community, including from the partner. A special patient order would mean she would be likely to lose her leave "rights" and in Dr Majeed's opinion this would impede her treatment.

[16] The Judge acknowledged the substantial progress made by Ms M but said he was unable to share Dr Majeed's confidence that it would be maintained in any release to the community, having regard to the past history. The Judge further noted in light of the extreme violence inflicted on the partner that it was reasonable to assume a high risk of violence were Ms M to relapse in the community. He accepted that some control could be exercised through community treatment orders or if she were on leave as an inpatient. However the Judge said he did not consider such

orders sufficiently recognised Ms M's vulnerability or the seriousness of the stabbing and the public's potential vulnerability to her.

[17] The Judge identified the advantages of a special patient order as being that it gave a seriousness to any relapse or vulnerability; it enabled protective action to be taken immediately as necessary; and it would give notice both to the health professionals treating Ms M and Ms M herself of the need to carefully monitor her mental health. In the view of the Judge, the urgency with which any concern would be treated would be heightened appropriately if Ms M were a special patient. He said he ventured to suggest that if she had been a special patient in 2012 when the community health team became aware she was unwell, she would have been returned to hospital for treatment.

[18] The Judge concluded by saying he was satisfied it was necessary to make an order pursuant to s 24(2)(a) of the CPMIP Act that Ms M be detained as a special patient. He said he recognised that the order would result in a short-term loss of community contact for Ms M but he expressed the hope that the Director of Mental Health and the Minister would soon authorise resumption of the community programme developed by the doctors.

Grounds of appeal

[19] The appeal was brought under s 29 of the CPMIP Act.[5]

[20] In written submissions, the primary ground of appeal was that the Judge's decision to prefer the evidence of Dr Brunskill over the evidence of Dr Majeed was unreasonable and could not be supported having regard to the evidence.

[21] The argument was formulated in those terms because of an assumption that the appeal standard contained in s 385(1) of the Crimes Act 1961 applied to appeals under s 29.

---

[5] The appeal provisions of the Criminal Procedure Act 2011 do not apply because the proceedings were commenced before those provisions came into force.

[22] However at the appeal hearing, counsel resiled from that approach. Mr Allan properly conceded that there was sufficient evidence to justify the Judge's finding. It was also accepted that when faced with conflicting expert evidence, the Judge was entitled to prefer the evidence of one expert over the other and that in determining whether it was necessary to make the order, the Judge was not limited to the medical assessments.

[23] Instead, it was argued that the decision was wrong because the Judge failed to take into account relevant factors and because his risk assessment was based on an assumption that clinicians would not act responsibly.

Analysis

[24] Section 24 of the CPMIP Act provides that the court can only make a special patient order if satisfied that "the making of the order is necessary in the interests of the public or any person or class of person who may be affected by the court's decision".

[25] It was common ground following *H (CA841/2012) v R* that the statutory requirement of necessity sets a high threshold, sitting somewhere on the spectrum between expedient or desirable on the one hand and essential on the other.[6]

[26] It was also common ground that in assessing future risk, the Judge was required to assume clinicians will act responsibly and that if he had not done so then that would be contrary to *H (CA841/2012) v R* and amount to an error of reasoning.

[27] We agree. However, we are not persuaded that the Judge did make any such error. When asked to identify any offending passages in the judgment, Mr Allan was unable to do so. It transpired that he was relying on a comment made orally by the Judge when questioning Dr Brunskill. The Judge is recorded as having said: "I know the theory but the reality is Doctor, that the experience of the Courts is that ... the level of supervision that one hopes for doesn't always occur". Mr Allan submitted that we should draw an inference from the comment that the Judge lacked

---

6 *H (CA841/2012) v R* [2013] NZCA 628 at [13].

confidence in clinicians doing their jobs and that such thinking must have influenced the outcome.

[28] In our view, such an inference is not justified. As Mr Allan acknowledged, such thinking does not form any part of the written reasons given by the Judge for his decision. The decision was primarily based on Dr Brunskill's opinion that a special patient order was necessary. That opinion did not in any way rest on concerns that future clinicians might not follow proper treatment standards.

[29] A further related argument raised by Mr Allan was that the Judge failed to refer to the definition of "mental disorder" and the definition of "fit to be released from compulsory status" in s 2 of the MHCAT Act. The combined effect of the definitions is that a person with an abnormal state of mind characterised by delusions is only fit to be released from compulsory status if he or she no longer poses a serious danger to the health and safety of others.

[30] In this case, the relapse that led to the stabbing occurred after a community mental health team had discharged Ms M from compulsory treatment in March 2012. In the view of the treatment team, she did not meet the criteria for being detained for treatment under the MHCAT Act.

[31] Mr Allan contended it was arguable that the relapse and hence the offending only occurred because the treatment team failed to apply the statutory definition correctly and that if in the future it were to be applied correctly (as the Judge was required to assume) it was unlikely Ms M would be discharged from compulsory treatment for many years. Ms M's low risk of reoffending could thus be appropriately managed on the less restrictive basis advocated by Dr Majeed. This was something, in his submission, the Judge failed to take into account.

[32] We do not accept that submission. In our view, it is too simplistic. It overlooks Ms M's long history of resistance to treatment and relapses. It also overlooks the central basis of the Judge's finding, namely that this was a case where it was necessary that any decision as to release from compulsory treatment should not be left to a single treating clinician. The oversight and input of the statutory

"third person in the room" was required. Taken to its logical conclusion, Mr Allan's argument would mean that a special patient order could never be made.

[33] The final argument advanced by Mr Allan was that the Judge failed to refer to s 25(4) of the CPMIP Act. However, s 25(4) only applies if the Judge is not satisfied a special patient order is necessary. In this case the Judge was so satisfied and therefore s 25(4) is irrelevant.

[34] We are satisfied that none of the grounds of appeal have any merit. The Judge correctly directed himself in terms of the statutory criteria and reached a decision that was clearly open to him.

[35] It was a decision we too would have reached on the evidence, for the same reasons given by the Judge as summarised above. In our view it was, as the Judge said, far too early to be able to say that Ms M's risk could adequately be managed without a special patient order. The order is necessary.

Outcome

[36] The appeal is dismissed.

Solicitors:
Crown Law Office, Wellington for Respondent