Methamphetamine, Psychosis and the Insanity Defence

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A dissertation submitted in partial fulfillment of the degree of Bachelor of Laws (Honours)
at the University of Otago - Te Whare Wananga o Otago.

October 2009

ACKNOWLEDGMENTS

"Praise the Lord! Give thanks to the Lord, for he is good! For his love endures forever."

To my supervisor John Dawson, for your patience, encouragement, sharp eye for detail, and willingness to read late drafts while in Italy;

to Stuart Anderson, for your generous support throughout my law degree;

to Kevin Dawkins, for fielding questions and pointing me to useful resources;

to Kate, for your precious friendship; and

to Mum and Dad, for your love.

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Chapter One: Introduction

In this paper I will consider the application of the insanity defence to offenders who were on methamphetamine ("meth") and were psychotic at the time of offending. The high prevalence of meth use and associated crime in NZ makes this a pressing issue.

Amphetamine and meth use in Oceania is the highest per capita of any region in the world, with annual prevalence rates almost twice that found in North America, and over four times that in Europe.[1] Research suggests that up to one quarter of frequent meth users suffer from psychosis in any given year.[2] Recent interviews with 137 frequent meth users in NZ found that in the last month 25% had committed a property crime, 32% had sold drugs, and 6% had committed a violent crime.[3] Numerous international studies have established a link between meth use and violent crime.[4] This relationship makes it inevitable that NZ courts will be faced with violent offenders who were intoxicated with meth, and potentially suffering from psychosis at the time of offending.

Meth-related psychosis often involves hallucinations and paranoid delusions, which may rob offenders of the ability to appreciate that their acts are morally wrong. For some offenders, psychosis may simply be linked to intoxication, ceasing when they come clean. For others, psychosis may persist beyond intoxication. This can represent exacerbation of a pre-existing mental illness, the realisation of a predisposition to illness, or apparently inexplicable bad luck. In any given case the mental state of the offender may be unclear, with uncertainty plaguing identification of the cause of psychosis, current diagnosis and future prognosis. This raises problems for the criminal law. Questions arise as to whether an offender in these circumstances should be considered responsible

1 It is estimated that 2.6% of the total Oceania population used amphetamine or methamphetamine in 2007. This can be contrasted with the annual prevalence rates in North America of 1.4% and in Europe of 0.4-0.6%: United Nations Office on Drugs and Crime "World Drug Report 2009" (2009) United Nations Office on Drugs and Crime www.unodc.org (accessed on 10 June 2009) at 145.

2 See Chapter Two [2.3].

3 C Wilkins, R Griffiths and P Sweetsur "Recent Trends in Illegal Drug Use in New Zealand, 2006-2008: Findings from the Illicit Drug Monitoring System (IDMS)" (2009) Centre for Social and Health Outcomes Research and Evaluation, Massey University www.shore.ac.nz (accessed on 10 June 2009) at 182.

4 See Shane Darke, Sharlene Kaye, Rebecca McKetin and Johan Duflou "Major physical and psychological harms of methamphetamine use" (2008) 17 Drug and Alcohol Review 253 at 258-259.

for their actions. Notions of responsibility can conflict with concerns for protection of the public. Diagnostic uncertainty heightens these difficulties. Further, disposition raises ethical dilemmas, with concerns about the appropriate use of forensic psychiatric wards and the role of psychiatrists as jailers. All of these issues come to a head in the application of the insanity defence, set out in section 23 of the Crimes Act 1961, to cases involving meth and psychosis. Specifically, the interpretation of the disease of the mind ("DOTM") element of section 23 is central to determining whether meth-intoxicated offenders can rely on the insanity defence.

This paper will provide the basis for an informed and principled application of the insanity defence to cases involving meth and psychosis. Recent scientific research will be summarised and linked to an examination of the DOTM element of the insanity defence. This will enable the most problematic cases and the nature of the difficulties posed to be clearly identified. A solution to these cases will then be proposed. This will take the form of a holistic approach to the DOTM inquiry, which will be set out, advocated, and then applied to the problematic cases. Overall, I aim to make a practical contribution to scholarship in this area, encouraging a reasoned and transparent approach to the much publicized issue of meth-related psychosis[5] in the context of criminal offending.

5 "Meth-related psychosis" is used throughout this paper, as opposed to "meth-induced psychosis". This reflects the diagnostic uncertainty often present when determining the cause of psychosis experienced in the context of meth-intoxication.

Chapter Two: Methamphetamine-Related Psychosis

A thorough understanding of meth-related psychosis is required if an informed consideration of the application of the insanity defence in problematic cases is to be undertaken. Unfortunately, just as meth-related psychosis causes problems for lawyers, so too it causes a host of problems for psychiatrists. Current research on meth-related psychosis provides an incomplete picture. Diagnosis of patients who use meth and experience psychosis has been described as a "conundrum".[6] This far from clear cut diagnostic picture has implications for the application of the insanity defence.

In this chapter I will provide a brief introduction to meth. I will then summarise a number of recent studies on meth-related psychosis, identifying what can be known with relative certainty, as well as gaps in knowledge.

2.1 An introduction to methamphetamine

Meth is a synthetic drug which functions as a central nervous system stimulant.[7] The most potent form of meth is crystal meth, which is commonly known as "ice", "glass", "pure" and "P".[8] Even in relatively low doses, meth causes feelings of euphoria, increased energy, heightened confidence, greater attentiveness, and (initially) a sense of wellbeing.[9] High doses of meth can result in impaired cognitive and motor performance, confusion, agitation, aggressiveness, paranoia, and psychosis.[10] Long term users are often dependent, and may smoke meth several times a week, or

6 Steve Mathias, Dan Lubman and Leanne Hides "Substance-Induced Psychosis: A Diagnostic Conundrum" (2008) 69 J Clin Psychiatry 358 at 358.
7 Charles Meredith, Craig Jaffe, Kathleen Ang-Lee and Andrew Saxon "Implications of Chronic Methamphetamine Use: A Literature Review" (2005) 13 Harv Rev Psychiatry 142 at 143.
8 Jane Buxton and Naomi Dove "The burden and management of crystal meth use" (2008) 178 CMAJ 1537 at 1537.
9 N Lee, L Johns, R Jenkinson, J Johnston, K Connolly, K Hall and R Cash "Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 14: Methamphetamine dependence and treatment" (2007) Turning Point Alcohol and Drug Centre Inc Fitzroy Victoria www.health.vic.gov.au (accessed on 10 June 2009) at 2; Meredith, Jaffe, Ang-Lee and Saxon, above n 7, 143; Buxton and Dove, above n 8, 1537.
10 Lee, Johns, Jenkinson, Johnston, Connolly, Hall and Cash, above n 9, 2.

engage in bingeing sessions separated by periods of abstinence.[11] They will develop increased tolerance to the drug, requiring larger and more frequent doses in order to achieve the desired effect.[12] Long term use can result in memory loss, poor concentration, extreme mood swings, anxiety disorders, depression, paranoia, psychosis, and chronic sleeping problems.[13] Withdrawal symptoms suffered by dependent users include intense cravings for the drug, vivid and unpleasant dreams, paranoia, aggressiveness, and psychomotor agitation.[14]

2.2 The nature of methamphetamine-related psychosis

Meth-related psychosis can occur where high doses are administered, and where there has been long term use.[15] This psychosis is typically marked with persecutory delusions and hallucinations, and closely resembles that suffered by paranoid schizophrenics.[16] Persecutory delusions consist of false beliefs, which centre around being attacked, harassed, persecuted or conspired against. This may result in fear, agitation and defensive behaviour. Delusional beliefs are firmly maintained, even in the face of clear evidence exposing their absurdity.[17] Hallucinations involve false sensory experiences, which seem to be caused by external stimulation when in fact there is no external cause. Hallucinations can occur in relation to any of the senses.[18] However, those most common in meth-related psychosis are auditory and visual hallucinations.[19] Auditory hallucinations involve the false perception of sound, most commonly voices.[20] Visual hallucinations involve the false perception of either formed images (e.g., people) or unformed images (e.g., flashes of light).[21]

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11 Lee, Johns, Jenkinson, Johnston, Connolly, Hall and Cash, above n 9, 4-5.
12 Buxton and Dove, above n 8, 1537.
13 Lee, Johns, Jenkinson, Johnston, Connolly, Hall and Cash, above n 9, 3.
14 Ibid, 6.
15 Ibid, 2-3.
16 Glenys Dore and Melinda Sweeting "Drug-induced psychosis associated with crystalline methamphetamine" (2006) 14 Australasian Psychiatry 86 at 86; Darke, Kaye, McKetin and Duflou, above n 4, 257.
17 American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR* (4th ed Text Revision American Psychiatric Association Washington DC 2000) at 821-822.
18 Ibid, 823-824.
19 Darke, Kaye, McKetin and Duflou, above n 4, 257.
20 American Psychiatric Association, above n 17, 823.
21 Ibid, 824.

Real life case studies illustrate the nature of meth-related psychosis in a more tangible way. Take, for example, the case of a 36-year-old male with a history of psychiatric illness and drug abuse, primarily with amphetamines. The delusions he suffered included persecutory beliefs that his enemies were entering his house at night and raping him in his sleep. In response he had installed a series of elaborate locks on his door, and slept with a gun under his bed and a knife by his side. He appeared to be suffering from auditory hallucinations, as he was often heard talking to himself. Medication was able to alleviate his delusions and hallucinations. However, while medicated he seemed permanently anhedonic. Attempts to reduce medication led to a relapse of psychosis and were therefore abandoned.[22]

Another case study featured a 44-year-old female meth user. She believed that her partner was injecting her with drugs, that she had been raped, and that there were cameras planted in her house. She suffered visual hallucinations in the form of persecutory messages written on objects around her and her own skin. These messages included threats that her children would be sexually harmed. In response to this she tried to scrape the writing off her skin with a knife. She also slept with a screwdriver and switchblade under her bed. She reported thoughts of wanting to harm her partner. Upon ceasing meth use and with ongoing medication, psychotic symptoms were successfully controlled. However, a small dose of meth would cause a relapse of psychotic symptoms.[23]

These case studies graphically illustrate the distressing nature of meth-related psychosis, and provide insight into why sufferers of psychosis may commit violent crimes.

2.3 The prevalence of methamphetamine-related psychosis

The rate of psychosis amongst meth users is alarmingly high. A recent Australian study of users who took meth at least once monthly reported that 23% had experienced clinically significant

22 Michael Flaum and Susan Schultz "When does amphetamine-induced psychosis become schizophrenia?" (1996) 153 The American Journal of Psychiatry 812.

23 Dore and Sweeting, above n 16.

hallucinations, suspiciousness or unusual thoughts in the past year. Further, 13% of participants screened positive for a psychotic disorder, featuring prominent hallucinations or delusions. This rate of psychosis was 11 times higher than among the general Australian population. Further, the prevalence of psychosis was high even amongst those participants who had no known history of schizophrenia or other psychotic disorder.[24] Another Australian study reported that around half of the meth users studied had experienced clinically significant hallucinations or feelings of persecution since using meth.[25] High rates of psychosis amongst meth users has also been reported internationally.[26]

Meth-related psychosis is normally transient, resolving within days to a month after meth use ceases. However, in a small proportion of cases psychosis will be enduring, suggesting the development of a more chronic psychotic condition.[27] Available data regarding the prevalence of chronic disorders amongst meth users is variable. One study suggested that anywhere between 1% and 15% of those who suffer stimulant-related psychosis will maintain some symptoms after a month of abstinence.[28] Another study found that 27% of psychotic meth users had symptoms lasting more than a month, despite abstinence and treatment, with 17% having symptoms lasting more than three months.[29] Other studies have reported that around 15% of psychotic patients take five years or more to recover, in the absence of ongoing meth use.[30]

These empirical results paint a complicated picture. It is certain that some meth users develop longer-term psychotic disorders. However, the prevalence of these disorders and their likely duration is far from clear. It can also be unclear whether ongoing problems represent the emergence of schizophrenia, or alternatively some form of protracted drug-induced psychosis as yet not fully

24 Rebecca McKetin, Jennifer McLaren, Dan Lubman and Leanne Hides "The prevalence of psychotic symptoms among methamphetamine users" (2006) 101 Addiction 1473 at 1473.
25 Wayne Hall, Julie Hando, Shane Darke and Joanne Ross "Psychological morbidity and route of administration among amphetamine users in Sydney, Australia" (1996) 91 Addiction 81 at 81.
26 Darke, Kaye, McKetin and Duflou, above n 4, 257.
27 Marc Schuckit "Comorbidity between substance use disorders and psychiatric conditions" (2006) 101 Addiction 76 at 79.
28 Ibid, 79.
29 See Mathias, Lubman and Hides, above n 6, 363.
30 See Flaum and Schlutz, above n 22, 815.

understood.[31] It is generally accepted that those with an underlying vulnerability to psychotic disorders, evidenced for example by a family history of schizophrenia, are more likely to develop a chronic disorder.[32] It is also clear that meth use, even in low doses, can exacerbate pre-existing psychotic disorders.[33] However, in rare cases users with no apparent predisposition to mental health problems develop long-term disorders.[34] The relationship between meth and chronic psychotic disorders is uncertain.

Studies to date do clearly establish that "sensitization" can occur in some meth users, although this does not qualify as a chronic psychotic disorder.[35] Sensitization is where a meth user, who has experienced a psychotic episode, develops an ongoing propensity to suffer spontaneous recurrences of psychosis, or "flashbacks". These can be triggered by relatively low doses of meth. They may also be triggered in abstinent individuals by mildly stressful situations, such as fear of conflict with another person or even the fear of emitting body odour.[36] One study of 116 abstinent subjects, who had previously experienced meth-related psychosis, found that around 31% experienced flashbacks during a 15 to 20 month period.[37] Flashbacks endured anywhere between 2 to 282 days, and generally involved the same delusions and hallucinations experienced by the subjects while on meth.[38] However, subjects returned to a totally normal state after flashbacks passed. Further, anti-psychotic drugs were shown to be effective in treating and preventing flashbacks.[39]

2.4 Conclusion

The prevalence of psychosis amongst meth users makes the application of the insanity

31 Flaum and Schlutz, above n 22, 814-815.
32 Darke, Kaye, McKetin and Duflou, above n 4, 257.
33 Dore and Sweeting, above n 16, 88.
34 Ibid, 88; Kunio Yui, Takeo Ishiguro, Kimihiko Goto and Shigenori Ikemoto "Precipitating factors in spontaneous recurrence of methamphetamine psychosis" (1997) 134 Pharmacology 303 at 304; Schuckit, above n 27, 79.
35 Yui, Ishiguro, Goto and Ikemoto, above n 34, 304.
36 Ibid, 303.
37 Ibid, 304.
38 Ibid, 305.
39 Ibid, 305.

defence to meth-intoxicated offenders an important issue. Meth-related psychosis may render individuals morally irresponsible for their conduct, as hallucinations and delusions prevent them from realising their conduct is wrong. However, it is unclear whether these individuals should be considered legally irresponsible. The nature of meth-related psychosis (including the potential for sensitization and development of a chronic psychotic disorder) is relevant when assessing whether meth-related psychosis can support a defence at law. In Chapter Three I will consider the different lines of defence which may be relied upon by an accused who was meth-intoxicated when offending. In Chapters Four to Six I will expand on the application of the insanity defence in cases of meth-related psychosis.

Chapter Three: Intoxication, Insanity and Automatism

Where an accused was in a severely disturbed mental state associated with meth use at the time of offending, three main lines of defence may be relevant: intoxication, insanity and automatism. An accused will be fully acquitted if found to lack *mens rea*, or to have been acting in a state of automatism. If found not guilty by reason of insanity, a qualified acquittal will ensue. The accused could then be treated in a mental health institution; however, he[40] could not be detained in prison. Alternatively, if all lines of defence are unsuccessful, he should be convicted and sentenced. On sentencing a therapeutic order could be imposed, which would allow for transfer between prison and hospital as required.

In this chapter I will provide a brief overview of the law of intoxication, insanity and automatism, the sentencing and disposition options, and the application of this law to cases of meth-related psychosis.

3.1 Intoxication

Intoxication is not a defence to a criminal charge *per se*. However, an accused may rely on intoxication to support a claim that he did not possess the mental state required by the offence with which he is charged.[41] For example, if an accused is charged with assault with intent to injure,[42] he may submit that he did not intend to injure the victim, offering evidence of intoxication to support this. Intoxication will be one consideration amongst many taken into account by the jury in determining whether the accused had the requisite intent. In New Zealand, evidence of intoxication is relevant in assessing the presence of any mental state required by an offence, including intention, knowledge, recklessness, and the requirement that conduct be voluntary.[43] Importantly, the onus of

40 I will use "he" throughout this paper when referring to an accused who was suffering from meth-related psychosis at the time of offending. This is not simply for ease of expression, but also reflects that around 75% of NZ meth users are male: Wilkins, Griffiths and Sweetsur, above n 3, 28.

41 *R v Kamipeli* [1975] 2 NZLR 610 (CA) at 616.

42 Crimes Act 1961, s 193.

43 *R v Kamipeli*, above n 41, 614. The English approach, set out in *Director of Public Prosecutions v Majewski* [1977] AC 443

proving the requisite mental state rests on the prosecution.[44] Therefore, it will suffice to escape conviction if the jury is left with a reasonable doubt about the accused's mental state at the time of offending. Reasonable doubt may exist in cases where the accused, although intoxicated, was still able to form the requisite mental state, but may not have done so. The matter of inquiry is "the fact of intent rather than the capacity for intent".[45] Therefore, although evidence the accused was totally unable to form the requisite mental state would found a strong defence case, it is not necessary to escape conviction. If the jury finds that the accused did have the requisite mental state, the fact that he would not have formed that intent if he were sober is not a defence. A drunken intent is still an intent.[46] The same approach is taken to intoxication arising from drug use.[47]

Although intoxication may be a factor leading to an accused's acquittal on one charge, this does not mean he will necessarily escape punishment. Intoxication may prevent the prosecution from proving a charge which requires a very specific mental state. Nevertheless, they may prove a lesser offence, with a simpler mental element. For example, the prosecution may not secure a murder conviction if they are unable to prove that the accused meant to cause death, or to cause bodily injury he knew was likely to cause death, being reckless as to whether death ensued.[48] However, manslaughter may be proven by evidence that the accused applied force to the victim, that he intended to apply force, and that this act caused the victim's death.[49] An intoxicated offender is unlikely to avoid a conviction entirely. It is improbable an accused will successfully cast doubt on the

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(HL) provides that for crimes of "basic intent", intoxication cannot be relied upon to cast doubt on the presence of a required mental element. In contrast, intoxication can be considered where the crime charged is one of "specific intent". The New Zealand Court of Appeal has left open the question of whether *Majewski* should be applied in New Zealand: *R v Roulston* [1976] 2 NZLR 644 (CA); *R v Grice* [1975] 1 NZLR 760 (CA). However, it seems unlikely *Majewski* will be followed. *Kamipeli* has been applied consistently since 1975, is consistent with principle, and its application has not led to an erosion of the justice system's credibility. Further, *Kamipeli* avoids the complication of the much criticised specific / basic intent distinction: See Bruce Robertson (ed) *Adams on Criminal Law* (online looseleaf ed) (accessed 3 March 2009) at [CA 23.54]; Richard Card *Card, Cross and Jones Criminal Law* (17th ed Oxford University Press Oxford 2006) at 760; David Ormerod *Smith and Hogan Criminal Law* (12th ed Oxford University Press Oxford 2008) at 309; Glanville Williams *Textbook of Criminal Law* (Stevens London 1978) at 471-476 .

44 *R v Kamipeli*, above n 41, 616.

45 Ibid, 616.

46 *Attorney-General for Northern Ireland v Gallagher* [1963] AC 349 (HL) at 380; *R v Sheehan* [1975] 1 WLR 739 (CA) at 744; *R v Kingston* [1995] 2 AC 355 (HL) at 369.

47 *R v Lipman* [1970] 1 QB 152 (CA) at 156.

48 Crimes Act 1961, s 167.

49 Crimes Act 1961, ss 160(2)(a), 171 and 196.

presence of basic mental elements (such as voluntariness); and there will generally be a charge available where proof of this will suffice.[50]

3.2 Insanity

The insanity defence is set out in section 23 of the Crimes Act 1961. It governs the narrow circumstances in which mental abnormality can render an accused criminally irresponsible. The provision reads as follows:

23 Insanity

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

(2) No person shall be convicted of an offence by reason of an act done or omitted by him when labouring under natural imbecility or disease of the mind to such an extent as to render him incapable –

(a) Of understanding the nature and quality of the act or omission; or

(b) Of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong.

The presumption of sanity in subsection (1) means that the accused bears the onus of proving insanity, on the balance of probabilities.[51] In some cases the judge may leave insanity to the jury even though the accused disavows the defence. This could occur where the accused adduces evidence of meth-related psychosis in order to negate a mental element or to plead automatism, and

50 Concern had been expressed that allowing consideration of intoxication in relation to all types of mental state, including recklessness and volition, would lead to high rates of acquittal and an erosion of the justice system's credibility. However, these concerns have proven to be unfounded: Card, above n 43, 760; Ormerod, above n 43, 309.

51 *Woolmington v Director of Public Prosecutions* [1935] AC 462 (HL); *R v Cottle* [1958] NZLR 999 (CA) at 1014, 1022 and 1031.

thereby puts their sanity in issue.[52]

For an insanity defence to succeed, it must first be established that the accused was "labouring under natural imbecility or disease of the mind" at the time of the alleged offending. Natural imbecility has been equated with subnormality, mental retardation, and intellectual disability. It covers both congenital defects, and defects developed later in life due to natural decay.[53] DOTM is a term which "defies precise definition and which can comprehend mental derangement in the widest sense".[54] It is a legal, not medical, concept. Therefore, whether any condition qualifies as a DOTM will be determined by the judge as a matter of law.[55] I will further explore this problematic element of the insanity defence in Chapters Four and Five.

If a natural imbecility or DOTM is established, it must then be shown that the accused was incapacitated at the time of offending in one of the stated ways. First, it may be shown that the accused did not understand the physical "nature and quality" of his conduct.[56] This covers circumstances where the accused was not conscious of acting (e.g., during a dissociative state following an epileptic seizure),[57] or misapprehended entirely what they were doing (e.g., they thought they were cutting bread but in fact cut a person's throat).[58] Alternatively, an insanity defence can succeed if an accused did not know his conduct was morally wrong. This covers circumstances where the accused was unable to think rationally about the moral quality of his conduct,[59] or where the accused knew people would regard his conduct as wrong, but believed himself to be above judgment on moral standards.[60] Whichever form of incapacitation is relied upon, it must be shown

52 Criminal Procedure (Mentally Impaired Persons) Act 2003, s 20(4). The judge also has the power to require a medical report to be prepared for the purpose of assisting the court to determine whether the accused was insane: Criminal Procedure (Mentally Impaired Persons) Act 2003, s 38.

53 Robertson (ed), above n 43, [CA23.04]; Warren Brookbanks and Sandy Simpson (eds) *Psychiatry and the Law* (LexisNexis Wellington 2007) at 134.

54 *R v Cottle*, above n 51, 1011.

55 Ibid, 1208; *Bratty v Attorney-General for Northern Ireland* [1963] AC 386 (HL) at 412.

56 The statutory language suggests that the accused must be "incapable" of understanding the nature and quality of his conduct. However, the focus of inquiry should not be the capacity of the accused to understand, but the existence or non-existence of this understanding. The same approach applies when considering whether the accused knew his conduct was morally wrong: *R v Macmillan* [1966] NZLR 616 (CA) at 621; *R v Dixon* [2007] NZCA 398; [2008] 2 NZLR 617 (CA) at [32].

57 *R v Sullivan* [1984] AC 156 (HL) at 173; *R v Cottle*, above n 51, 1009.

58 *Director of Public Prosecutions v Beard* [1920] AC 479 (HL) at 480.

59 *R v Porter* (1933) 55 CLR 182 (HCA) at 189-190; *R v Macmillan*, above n 56, 619.

60 *R v Macmillan*, above n 56, 620 and 622.

that this was caused by the natural imbecility or DOTM previously established.

If the jury is satisfied, on the balance of probabilities, that these requirements have been met, they should deliver a verdict of "not guilty on account of his insanity".[61]

3.3 Automatism

To secure a conviction for most offences, the prosecution must prove that the act was carried out by the accused with conscious volition.[62] In other words, they must show that the act was a willed bodily movement.[63] If the act was unwilled, unconscious, or involuntary the accused has a defence of automatism. Like the term DOTM, automatism has a legal meaning which does not align directly with any medical definition.[64] Automatism at law extends to cover acts committed while sleepwalking[65] and during an epileptic fit.[66] It also covers lesser states of dissociation caused by concussion,[67] hyperglycaemia,[68] hypoglycaemia,[69] and (controversially) a psychological blow.[70]

In the absence of evidence to the contrary, it will be inferred that an accused's conduct was volitional. Therefore, in order to raise this defence the accused must discharge an evidential onus by adducing evidence that gives his claim of automatism an air of reality.[71] Expert evidence will generally be required to achieve this.[72] Once this evidential burden is discharged, it is for the prosecution to exclude reasonable doubts pertaining to automatism.[73]

Where automatism is accepted by the jury, there are two possible outcomes: in cases of "sane-automatism" the accused will receive an outright acquittal; in cases of "insane-automatism" a

61 Criminal Procedure (Mentally Impaired Persons) Act 2003, s 20.
62 *R v Cottle*, above n 51, 1007.
63 Williams, above n 43, 148; George Fletcher *Basic Concepts of Criminal Law* (Oxford University Press New York 1998) at 44.
64 *Police v Bannin* [1991] 2 NZLR 237 (HC) at 241.
65 See *R v Parks* 15 CR (4th) 289 (SCC); *R v Burgess* [1991] 2 QB 92 (CA).
66 See *R v Sullivan*, above n 57; *Bratty v Attorney-General for Northern Ireland*, above n 55; *R v Meddings* [1966] VR 306 (SC).
67 See *Cooper v McKenna* [1960] Qd R 406 (SC).
68 See *R v Hennessy* [1989] 1 WLR 287 (CA).
69 See *R v Quick* [1973] 1 QB 910 (CA).
70 See *R v Rabey* [1980] 2 SCR 513 (SCC). In that case the accused attacked a female friend after suffering a psychological blow: finding out that she considered him "a nothing". See also *R v Yesler* [2007] 1 NZLR 240 (HC); *R v Stone* [1999] 2 SCR 290 (SCC).
71 *R v Falconer* (1990) 171 CLR 130 (HCA) at 43.
72 *R v Rabey*, above n 70, 552.
73 *R v Falconer*, above n 71, 43.

verdict of not guilty on account of insanity will be recorded. Insane-automatism will be found where the lack of conscious volition was caused by a natural imbecility or DOTM. As discussed above, the issue of insanity will be determined by the jury on the balance of probabilities.

3.4 Application to cases of methamphetamine-related psychosis

The outcome of cases involving meth-related psychosis will depend heavily upon whether the accused's condition at the time of offending is treated as a DOTM, or merely as a feature of intoxication.

If meth-related psychosis is a feature of intoxication, then its relevance is limited. Evidence of psychosis may support a defence that the requisite mental state has not been proven, or that the accused was acting in an automatic state. Evidence of delusions and/or hallucinations at the time of offending may raise a reasonable doubt as to the accused's mental state. Therefore, meth-related psychosis could lead to acquittal for offences involving complex mental elements, such as murder. Convictions are more likely to be secured for offences with relatively simple mental elements, such as manslaughter. It is unlikely that meth-related psychosis would support a plea of automatism. Generally speaking, meth-related psychosis does not involve a loss of conscious volition. However, if automatism is established, and the meth-related psychosis that has caused this is treated as a feature of intoxication, this will lead to an outright acquittal.

If meth-related psychosis is treated as a DOTM, it can form the basis of an insanity plea. For the insanity defence to succeed, the psychosis must have incapacitated the accused in a relevant way. For example, an accused suffering from hallucinations and/or delusions may not have known the nature or quality of his act, or that his conduct was morally wrong. If, in such a case, the insanity defence is made out, a qualified acquittal will follow. If it is not made out, the accused may be acquitted outright or convicted. A full acquittal may occur where evidence of the accused's meth-related psychosis leaves the jury with a reasonable doubt as to the presence of the requisite mental

state. If, however, no reasonable doubt remains the jury should convict.[74] As discussed above, in cases of meth-related psychosis convictions are still likely to be secured for offences with relatively simple mental elements.

3.5 Sentencing and Disposition

In meth cases involving psychosis there are three possible verdicts: guilty, not guilty, and not guilty on account of insanity. Following a not guilty verdict the accused is entitled to an outright acquittal. Some measure of control over the accused may be maintained through a civil compulsory treatment order. However, an acquitted person will be assessed and treated on the same basis as any other person.[75]

If the accused is found guilty, he will be sentenced in accordance with the Sentencing Act 2002 and the Criminal Procedure (Mentally Impaired Persons) Act 2002. The sentencing judge is expressly prohibited from taking into account intoxication as a mitigating factor.[76] However, diminished intellectual capacity or understanding, not caused by voluntary intoxication, must be taken into account.[77] Accordingly, mental disorder may be a mitigating or aggravating factor: it can mitigate where the offender is considered less culpable,[78] or is likely to experience a greater subjective impact from a penalty;[79] conversely, mental disorder which increases the risk of reoffending may be an aggravating factor.[80] In cases involving both intoxication and mental illness,

74 *R v Cottle,* above n 51, 1021; *R v More* [1963] SCR 522 (SCC) at 534; *R v Swain* (1991) 5 CR (4th) 253 (SCC) at 293; *R v Macdonald* (1976) 29 CCC (2d) 257 (SCC) at 260-261. See also Don Stuart *Canadian Criminal Law: A Treatise* (4th ed Carswell Scarborough Ontario 2001) at 399-403. But see Robertson (ed), above n 43, [CA23.38] where the author suggests that "evidence of insanity within the meaning of s 23 should be disregarded on the question of whether the accused should be acquitted because the required *mens rea* has not been proved." The author cited *Attorney-General's Reference (No 3 of 1998)* [1999] 3 All ER 40 (CA) in support. However, with respect, that case is authority for the proposition that where insanity is established on the evidence, the accused cannot escape a qualified acquittal by arguing they lacked *mens rea*. The case does not state that mental disorder cannot be relied upon to negate *mens rea* in cases where the insanity defence fails.

75 See Mental Health (Compulsory Assessment and Treatment) Act 1992.

76 Sentencing Act 2002, s9(3).

77 Ibid, s 9(2)(e). It is not entirely clear whether this mandatory consideration extends to cover mental illness: Brookbanks and Simpson, above n 53, 202. Nevertheless, the court is permitted to consider any other factor that it thinks fit: Sentencing Act 2002, s 9(4). Therefore, mental illness can be considered in sentencing and, in practice, is considered. For example, see *R v Edwards* [2007] NZCA 382.

78 Sentencing Act 2002, s 8(a); *R v Wright* [2001] 3 NZLR 22 (CA) at [22]; *R v Nilsson* CA 552/99 27 July 2000 at [10].

79 Sentencing Act 2002, s 8(h); *R v Wright*, above n 78, [22]; *R v Nilsson*, above n 78, [10].

80 Sentencing Act 2002, s 7(1)(g); *R v Wright*, above n 78, [22].

the sentencing judge must distinguish between factors contributing to offending, some mitigating and some non-mitigating.[81] Sentencing of mentally ill offenders has been described as "one of the most difficult tasks a Judge may be called upon to perform",[82] as conflicting purposes of rehabilitation and public protection must be balanced.

If the sentencing judge is satisfied that the offender is "mentally disordered" and requires compulsory treatment,[83] they have the option of making a therapeutic order: for example, the judge may impose a hybrid order, where a sentence of imprisonment is handed down in tandem with an order for detention as a special patient.[84] This means the offender will be committed to hospital, but can be transferred to and from prison during the duration of his sentence.[85] If the offender is still in hospital when his sentence ends, he will be deemed to be a civil patient.[86] Alternatively, the judge may refrain from passing sentence entirely, and instead direct the offender to be treated as a civil patient.[87] Civil patients are subject to compulsory treatment orders, and must be released once they are no longer disordered.[88] Even if an offender is sentenced to a normal sentence of imprisonment, an application can subsequently be made for transfer from prison to hospital.[89]

If the accused is found not guilty by reason of insanity, the judge may order detention as a special patient, treatment as a civil patient, or immediate release.[90] There is no presumption a special patient order will be made,[91] but the judge must consider whether this is necessary to protect the public.[92] If a special patient order is made, the accused will be held indefinitely. They will be subject

81 See *R v Edwards*, above n 77, [25].
82 Warren and Simpson, above n 52, 225.
83 The judge must be satisfied that the offender requires compulsory treatment, for the offender's own sake or for the safety of the public or a person or class of person. Mental disorder and the need for treatment must be established on the evidence of one or more "health assessors": Criminal Procedure (Mentally Impaired Persons) Act 2003, ss 34(2) and 34(3).
84 Criminal Procedure (Mentally Impaired Persons) Act 2003, ss 34(1)(a)(i), 34(2) and 34(3).
85 Ibid, s 48(2).
86 Ibid, s 48(3)(ba).
87 Ibid, ss 34(1)(b)(i), 34(2), 34(3) and 36.
88 Ibid, s 35.
89 Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 45-47.
90 Criminal Procedure (Mentally Impaired Persons) Act 2003, ss 24 – 26.
91 *R v Bayford* HC Palmerston North CRI 2004-254-97, 9 December 2004 at [21].
92 Criminal Procedure (Mentally Impaired Persons) Act 2003, s 24.

to clinical reviews every six months,[93] and tribunal reviews upon application.[94] However, it is for the Minister of Health to decide whether continued detention as a special patient is necessary, in the interests of the patient or public safety. If the Minister sees fit, he[95] can discharge the patient, or reclassify him as a civil patient.[96] The Minister cannot order transfer of the patient to prison.

A central point regarding sentencing and disposition is, therefore, that while a person found guilty and imprisoned can later be transferred to hospital for psychiatric treatment, a person found not guilty by reason of insanity and ordered to hospital cannot be transferred to prison. This means that those found insane are the sole responsibility of the mental health system, even if their mental condition improves quickly and no further treatment is required.

3.6 Conclusion

The outcome of a prosecution involving meth-related psychosis will turn largely on whether this psychosis is treated as a DOTM, or as a feature of intoxication. This characterization will determine the availability of the defence of insanity, and the extent to which the psychosis can be relied upon to negate *mens rea* or found a claim of automatism. It will, therefore, dictate whether an accused ought to be convicted, acquitted outright, or found insane and potentially subjected to indefinite detention in hospital. While in any given case the success of a defence will be a matter of fact, it must first be determined at law which defences are available to the accused. Here, the critical issue is likely to be whether meth-related psychosis will be treated as a DOTM.

93 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 77(1).
94 Ibid, s 80(1).
95 The current Minister of Health is the Hon Tony Ryall.
96 Criminal Procedure (Mentally Impaired Persons) Act 2003, s 33.

Chapter Four: The Current Approach to Disease of the Mind

Whether or not meth-related psychosis is a DOTM for the purposes of the insanity defence has significant implications for the disposition of offenders. Unfortunately, DOTM is an ill-defined legal term with uncertain application. In this chapter I will outline orthodox statements of what qualifies as a DOTM, and discuss two theories currently employed in borderline cases to determine whether it is present: that of recurring danger, and that of internal cause. Finally, I will discuss the shortcomings of these theories when applied in the context of intoxication.

4.1 Disease of the mind

DOTM is a legal, not medical, term.[97] It is for the judge to determine whether the alleged mental state of the accused, as described in expert evidence, could qualify as a DOTM and to direct the jury accordingly.[98] In cases where the evidence of the accused's mental state is contested, it is for the jury to determine which evidence to accept. Nevertheless, they must apply the legal meaning of DOTM, as set out for them by the judge, to their factual findings.

In attributing meaning to the term DOTM, judges in effect determine who can be considered criminally irresponsible,[99] and how the public should be safeguarded against mentally ill offenders.[100] This differs from the focus of the medical profession, who are predominantly concerned with identifying disease in order to provide treatment.[101] Accordingly, while the courts will consider medical evidence, they will not accord decisive weight to it.[102] What the law regards as a DOTM can at times be far removed from medical understanding.[103] This creates tension, with some judges expressing concern that the legal approach to DOTM is "regarded with incredulity outside of

97 *R v Cottle*, above n 51, 1028; *R v Parks*, above n 65, [6]; *R v Stone*, above n 70, [197]; *R v Falconer*, above n 71, 68.
98 *R v Cottle*, above n 51, 1028; *R v Stone*, above n 70, [197]; *Police v Bannin*, above n 64, 241; Williams, above n 43, 640.
99 *R v Porter*, above n 59, 187.
100 *R v Parks*, above n 65, [6].
101 *R v Porter*, above n 59, 187.
102 *R v Parks*, above n 65, [6]. As in any given case up to date medical opinion will be considered, the concept of DOTM is capable of evolving with increased medical knowledge.
103 *R v Burgess*, above n 65, 97.

court."[104] Further, continuing detention of insanity acquittees in mental institutions, when medical experts do not consider them to be mentally ill, may breach fundamental human rights.[105] Despite this, judges still attach considerable weight to policy considerations. This can lead to results that appear incongruous to medical professionals and lay people alike.[106]

Even though the judiciary have insisted on defining DOTM, they have failed to provide a clear statement of what it means. In 1958, the New Zealand Court of Appeal stated that an authoritative pronouncement on the matter would be desirable.[107] Such guidance is still awaited. Nevertheless, some core propositions can be gleaned from the case law. First, for a DOTM to be present, there must be some impairment of the mental faculties of reason, memory or understanding. A physical cause of impairment need not be identified for a DOTM to be found.[108] Second, not every disturbance of the mental faculties will be a DOTM.[109] Major mental illnesses, such as schizophrenia, clearly qualify.[110] In contrast, the "mere excitability of a normal man, passion, even stupidity, obtuseness, lack of self control, and impulsiveness" are not diseases of the mind.[111] Nor are passing states of impairment, caused by drunkenness, a blow to the head, or hypnotism.[112] However, a DOTM may result from alcoholic excess (e.g., delirium tremens) or from a blow.[113]

Beyond these clear cases, the judiciary have struggled to articulate when a mental impairment will be a DOTM. Attempts at general statements have been made. However, these have proven largely unhelpful. Take for example the hopelessly tautologous definition set out by the English Court of Appeal in *Quick*:[114] a DOTM is a "mental condition [that can] be fairly regarded as

104*R v Quick*, above n 69, 919.
105Brookbanks and Simpson, above n 53, 107-108. See also *Winterwerp v The Netherlands* (1979) 2 EHRR 387 (ECHR).
106*R v Sullivan*, above 57, 173 (an epileptic was found to be insane); *R v Burgess*, above n 65, 102 (a sleepwalker was found to be insane).
107*R v Cottle*, above n 51, 1022.
108*R v Kemp* [1957] 1 QB 399 (CA) at 407; *R v Cottle*, above n 51, 1011; *R v Hennessy*, above n 68, 292; *R v Sullivan*, above n 57, 172; *R v Porter*, above n 59, 189.
109*R v Cottle*, above n 51, 1011, 1026 and 1032; *R v Quick*, above n 69, 920.
110*Bratty v Attorney-General for Northern Ireland*, above n 55, 412.
111*R v Porter*, above n 59, 188.
112*R v Cottle*, above n 51, 1011 and 1032.
113Ibid, 1032; *Attorney-General for Nothern Ireland v Gallagher*, above n 46, 381; *Director of Public Prosecutions v Beard*, above n 58, 500; *R v Davis* (1881) 14 Cox CC 563 (Ass).
114*R v Quick*, above n 69.

amounting to or producing a defect of reason from disease of the mind".[115] Another pronouncement commonly referred to for guidance is Lord Devlin's statement in *Kemp*:[116] in determining whether a DOTM is present, it matters not whether the condition of the mind is curable or incurable, transitory or permanent.[117] This statement has been criticized as giving DOTM too broad an application.[118] More successful judicial attempts to demarcate the boundaries of DOTM have generally taken two forms: the recurring danger theory and the internal cause theory.[119] I will discuss each of these in turn.

4.2 The recurring danger theory

The recurring danger theory has its genesis in the judgments of Lord Devlin in *Hill v Baxter*[120] and of Lord Denning in *Bratty v Attorney-General for Northern Ireland*.[121] Lord Denning's formulation is most often cited and states that "any disorder which has manifested itself in violence and is prone to recur is a disease of the mind".[122] The rationale for this approach is that public safety requires the detention of individuals with recurring mental disorders.[123] Further, hospital detention would be inappropriate if the disorder is not recurring, as it would embarrass mental health authorities.[124] Therefore, a recurring disorder is necessary to warrant an insanity finding.

This approach has found support in the High Court of Australia,[125] but has also been widely

115*R v Quick*, above n 69, 922. Lord Justice Lawton purports to restate a test established by President Gresson of the New Zealand Court of Appeal in *R v Cottle*: above n 51, 1011. The words fixated upon by Lord Justice Lawton were originally used in relation to circumstances where an external factor acts upon a person, causing a transient mental impairment. President Gresson concluded that such a transient effect could not fairly be described as a DOTM. With respect, President Gresson did not appear to be propounding a test for general application.

116*R v Kemp*, above n 108.

117Ibid, 407; *R v Sullivan*, above n 57, 172.

118*R v Falconer*, above n 71, 54; Williams, above n 43, 684.

119The language of "theories" is not generally used by the courts. However, the two key approaches apparent in case law were described in this way by La Forest J of the Supreme Court of Canada: *R v Parks*, above n 65, [9].

120*Hill v Baxter* [1958] 1 QB 277 (CA) at 285.

121*Bratty v Attorney-General for Northern Ireland*, above n 55, 412.

122Ibid, 412.

123Ibid, 410.

124*R v Radford* (1985) 42 SASR 266 (SC) at 276; Williams, above n 43, 676.

125*R v Falconer*, above n 71, 54. However, it is noted that in *Falconer* comments about the necessity of recurrence were made in the context of a judgment which also endorsed the internal factor theory. See also the judgments of Sholl J of the Supreme Court of Victoria in which the importance of recurrence is emphasised: *R v Meddings*, above n 66; *R v Carter* [1959] VR 105 (SC).

criticised. Applied strictly, Lord Denning's statement would include offenders who arguably ought not be considered insane. For example, a person who must be anaethetised regularly when visiting the dentist, and is prone to lash out when recovering from an anaesthetic due to a bodily disorder would have a DOTM.[126] Conversely, this theory precludes offenders who are arguably morally irresponsible from relying upon the insanity defence. An offender may not have understood that what they were doing was wrong due to a severe mental disorder, but if this is unlikely to recur they will not have a qualifying DOTM.[127]

The rationale for the recurring danger theory has also come under attack. First, it is contended that the public can be protected from recurring danger through means other than an insanity disposition. In some cases, rejection of an insanity defence would lead to the conviction and imprisonment of the accused. In cases where failure of the insanity defence would lead to an outright acquittal (e.g., automatism cases), the accused may still be subjected to compulsory treatment under civil mental health procedures.[128] Therefore, the risk of recurring danger *per se* does not justify a conclusion that an insanity finding is needed to protect the public.[129] Second, it is disputed that an insanity verdict where an accused's disorder is unlikely to recur would result in inappropriate hospital detention. It is not mandatory that an insanity acquittee be detained in a mental hospital. The judge could immediately release the acquittee, or order that they be treated as a civil patient.[130] Therefore, in cases where there is no risk of recurrence, the insanity disposition regime could provide for an appropriate outcome.[131]

A final objection to this theory highlights the difficulty of predicting recurrence rates.[132] It seems improper that, despite potential inaccuracy, people are classed as sane or insane on this

126*R v Quick*, above n 69, 919.
127*R v Parks*, above n 65, [13].
128See Mental Health (Compulsory Assessment and Treatment) Act 1992.
129A Simester and G Sullivan *Criminal Law: Theory and Doctrine* (3rd ed Portland Oxford 2007) at 649.
130Criminal Procedure (Mentally Impaired Persons) Act 2003, ss 24 – 26.
131See *R v Cottle*, above n 51, 1028; *R v Quick*, above n 69, 918.
132*R v Yesler*, above n 70, [58]; *Police v Bannin*, above n 64, 248. See also Rees Tapsell “Forensic Psychiatry and the Law: A Judicial Update” (Paper presented at Institute of Judicial Studies High Court Update, Mental Health Issues, Wellington/Auckland, November 2005) at [6].

basis.[133]

One major judicial response to these difficulties has been to make recurrence a non-determinative factor in the DOTM inquiry. Chief Justice Lord Lane, in the English Court of Appeal, stated that recurrence was merely "an added reason for categorising [a] condition as a disease of the mind."[134] Therefore, a mental disorder need not recur to qualify as a DOTM. The same approach has been taken by the Supreme Court of Canada[135] and the House of Lords.[136] This non-determinative approach to recurrence aligns with the New Zealand Court of Appeal's statement that the "insanity provisions apply... to a condition of temporary insanity, whether recurrent or not."[137]

4.3 The internal cause theory

The internal cause theory was developed in response to the perceived shortcomings of focusing solely on recurring danger.[138] In *Quick*[139] Lord Justice Lawton noted that emphasising recurrence alone meant the cause of mental disorders was ignored. In some cases this would lead to absurd results. For example, the dental patient with a sensitivity to anaesthetics, described previously, would be found to have a DOTM.[140] On this basis the Lord Justice concluded that "a malfunctioning of the mind of transitory effect caused by the application to the body of some external factor such as violence, drugs, including anaesthetics, alcohol and hypnotic influences cannot fairly be said to be due to disease".[141]

133Michael Jefferson *Criminal Law* (5th ed Longman Harlow England 2001) at 349.
134*R v Burgess*, above n 65, 99.
135*R v Rabey*, above n 70, 533 and 551; *R v Parks*, above n 65, [14]; *R v Stone*, above n 70, [212]-[213].
136See *R v Sullivan*, above n 57, 172. The judgment of Lord Diplock is not entirely clear. However, the following passage suggests that he considers recurrence to be a relevant, but not decisive, factor in the DOTM inquiry: "The duration of a temporary suspension of the mental faculties of reason, memory and understanding, particularly if... it is recurrent, cannot on any rational ground be relevant to the application by the courts of the M'Naghten Rules": Ibid, 172. Lord Diplock is drawing a distinction between the duration of a mental impairment, and the likelihood that this impairment will recur. He states that the duration of a mental impairment is not relevant to whether an accused can avail himself of the insanity defence. Further, that in cases where an impairment is likely to recur, it is particularly clear that duration is irrelevant. The implication is that while recurrence might provide an additional reason for finding a DOTM, it is not necessary to such a finding.
137*R v Cottle*, above n 51, 1031.
138*R v Quick*, above n 69, 918.
139Ibid.
140Ibid, 918.
141Ibid, 922.

Lord Justice Lawton's statement was converted into an approach for positively identifying a DOTM in the context of automatism cases involving psychological blows: that is, the absence of a sufficiently severe external factor will support an inference of a DOTM in these cases.

In psychological blow cases the accused contends he was acting involuntarily at the time of offending, as a psychological blow caused him to enter a dissociative state.[142] The courts reasoned that no distinction could be made between physical and psychological blows leading to automatism. Therefore, just as physical causes (e.g., drugs or a blow to the head) are treated as factors external to the accused, psychological blows must also be treated as external to the accused. On this basis it was concluded that a transitory state of dissociation caused by a psychological blow would not be a DOTM, as it was caused "by the application of some external factor".[143]

However, a further problem arose in such cases: it is difficult to determine whether the cause of dissociation was the psychological blow, or was some infirmity internal to the accused triggered by the circumstances. In response to this difficulty, the "contextual objective"[144] approach was formulated. This involves comparing the accused's response to the psychological blow against the hypothetical response of an ordinary person placed in the accused's circumstances.[145] For these purposes, the ordinary person is assumed to be of normal temperament and self-control; so evidence of the accused's mental state (e.g., their depression) will be irrelevant.[146] If an ordinary person in these circumstances would not have entered a dissociative state, then by necessary inference something internal to the accused must have caused this state. This will be sufficient to support a finding of a DOTM, even if no internal infirmity can be identified by medical professionals.[147] In other words, if the psychological blow does not exceed "the ordinary stresses and disappointments of life which are a common lot of mankind"[148] but the accused has still entered

142For example, consider the case of a young man who allegedly entered a dissociative state after learning the object of his affection thought little of him: *R v Rabey*, above n 70.
143*R v Quick*, above n 69, 922.
144*R v Stone*, above n 70, [210].
145*R v Falconer*, above n 71, 55 and 58; *R v Rabey*, above n 70, [8]-[9].
146*R v Stone*, above n 70, [209]; *R v Falconer*, above n 71, 58.
147*R v Rabey*, above n 70, [8].
148Ibid, [9].

a dissociative state then a DOTM will be found.

The rationale for this approach is twofold: the presence of an internal weakness increases the likelihood of recurrent dissociation which the public should be protected from,[149] and an internal weakness makes treatment appropriate.[150]

The internal cause theory has gained a certain ascendancy in Canadian and English jurisprudence.[151] However, it has also been the target of severe criticism. It is argued that the theory does not serve the policy concerns by which it claims to be illuminated.[152] There may be no medical evidence of a mental disorder which is likely to recur, or which requires treatment. Nevertheless, in the absence of a sufficiently severe external factor to explain the accused's reaction a DOTM will be inferred. According to international human rights jurisprudence, detention in such circumstances may be a breach of rights.[153] Further, inferring a DOTM in this way seems problematic in light of the presumption of sanity.[154]

Strict application of the internal cause theory leads to absurd results. Take, for example, the cases of *Quick*[155] and *Hennessy*.[156] In *Quick*, the accused was in a hypogylcaemic state at the time of offending, which rendered his conduct involuntary. The hypoglycaemia arose after the accused, a diabetic, took insulin but failed to eat enough. The English Court of Appeal determined that the dissociative state was caused by an external factor, namely insulin. In contrast, in *Hennessy* the accused, another diabetic, was in a hyperglycaemic state. He had not taken insulin or food prior to the offending. The English Court of Appeal concluded that the dissociative state was caused by an internal factor, namely diabetes. The application of the internal cause theory in these cases cannot be impugned. However, strict application of the theory resulted in a distinction being drawn between two diabetic offenders which appears to be unfounded on policy grounds. This distinction has been

149*Police v Bannin*, above n 64, 242; *R v Parks*, above n 65, [9].
150*Police v Bannin*, above n 64, 242.
151*R v Parks*, above n 65, [9]. See *R v Quick*, above n 69; *R v Hennessy*, above n 68; *R v Rabey*, above n 70.
152Ormerod, above n 43, 282.
153Brookbanks and Simpson, above n 53, 107-108. See also *Winterwerp v The Netherlands*, above n 105.
154Crimes Act 1961, s 23(1); *R v Rabey*, above n 70, [91] per Dickson J dissenting.
155*R v Quick*, above n 69.
156*R v Hennessy*, above n 68.

widely criticized, and was described by Glanville Williams as "irrational".[157]

Strict application of the internal cause theory also leads to results which are inconsistent with well-established lines of authority. For example, sleepwalking has traditionally been cited as a clear instance of non-insane automatism.[158] However, judges have since acknowledged that it seems to be caused by a predisposition internal to the accused and therefore, according to this theory, by a DOTM.[159] In response to this difficulty, it has been argued that sleepwalking is caused by external factors (e.g., excessive exercise, sleep deprivation, sudden noises in the night).[160] It has even been proposed that it is caused by sleep, a natural external cause.[161] These suggestions appear artificial and demonstrate how the internal/external distinction can be manipulated. Sleepwalking is an example of a condition not well suited to analysis under the internal cause theory.[162]

A final objection is that the theory draws an unwarranted distinction between physical and psychological blows. The impact of a physical blow will be subjectively assessed. This means the courts will not compare the reaction of the accused to the blow with that of an ordinary person, nor will they infer a DOTM on the basis that the accused responded abnormally. A DOTM will only be found if there is evidence of a mental disorder which the physical blow has interacted with. For example, a person who suffers a minor blow to the head, and becomes concussed because they have a thin skull will not have a DOTM. Likewise, no DOTM will be found where a person has an abnormal metabolism such that consumption of alcohol effects them more than the ordinary person. In contrast, an objective approach is taken to psychological blows. The accused is compared with an ordinary person, and if their response differs from that of an ordinary person a DOTM is inferred. For example, a person who experiences an ordinary stress of life and dissociates because of

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157Williams, above n 43, 684. See also Jefferson, above n 133, 344.

158*R v Tolson* (1889) 23 QBD 168 (CA) at 187; *R v Cottle*, above n 51, 1026; *R v Falconer*, above n 71, 74.

159The difficulty in sleepwalking cases was put aptly by Blanchard J in *Erricson v Police* (1993) 10 CRNZ 110 (HC) at 117: "How... can automatism in the form of sleep-walking be attributed to an external cause, yet it usually is clearly non insane behaviour?" See also *R v Yesler*, above n 70, [28]; *R v Falconer*, above n 71, 75; *R v Parks*, above n 65, [10] and [12]; *R v Stone*, above n 70, [54] per Binnie J dissenting. Compare *R v Burgess*, above n 65 in which a sleepwalker was found to be insane

160*R v Parks*, above n 65, [12].

161Jefferson, above n 133, 344. The author stated the decision in *Parks* was reached on this basis. However, this interpretation of *Parks* is questionable.

162*R v Parks*, above n 65, [10] and [12]; Williams, above n 43, 675.

their relatively weak character will have a DOTM. Some judges argue that this distinction is unjustified.[163]

However, with respect, this is not entirely correct. The DOTM inquiry is not concerned with physical defects, but with the mental faculties of reason, memory and understanding.[164] It makes sense that an accused's thin skull, or rapid metabolism is not relevant to this inquiry, as this is not a feature of the mind. However, apparent emotional weakness is relevant to the DOTM inquiry, as it may legitimately reflect upon the state of the accused's mental faculties of reason and understanding. Nevertheless, an objection can be made to the drawing of a line strictly between physical and psychological external factors. Some physical factors, such as drugs, can interact with the underlying mental weakness of an individual to bring about a state of impairment. In these circumstances, the internal weakness is of a type which is relevant to the DOTM inquiry. Therefore, it is arguable an objective assessment should likewise be taken to these cases. The internal cause theory fails to provide for these nuances.

As with recurrence, the judicial response to these difficulties has been to treat the internal cause theory as one analytical tool used in the DOTM inquiry: it will not be decisive, and it will not be applied where this would undermine policy objectives.[165] A small number of judges have rejected the internal cause theory outright, arguing that you cannot find a DOTM without positive evidence of a mental disorder.[166]

4.4 Application in cases of intoxication

The recurring danger and internal factor theories have proven to be particularly deficient in cases involving intoxication. It is clear that a passing state of intoxication is not a DOTM. However,

163*R v Rabey*, above n 70, [94]-[96] per Dickson J dissenting.

164*R v Kemp*, above n 108, 407; *R v Cottle*, above n 51, 1011; *R v Hennessy*, above n 68, 292; *R v Sullivan*, above n 57, 172; *R v Porter*, above n 59, 189.

165*R v Parks*, above n 65, [11]. While few cases expressly acknowledge the downgrading of the internal cause theory to an analytical-tool, this implicitly occurs whenever the theory is not applied to determine the DOTM inquiry. The internal cause theory is not in fact utilised by the courts as an all-encompassing methodology.

166*R v Rabey*, above n 70, [91] per Dickson J dissenting; *R v Falconer*, above n 71, 75-76. See also Williams, above n 43, 675.

a distinct disorder caused by substance abuse may qualify even if it is temporary (e.g., delirium tremens).[167] Unfortunately, the distinction between temporary insanity caused by drink and drugs, and simple intoxication is difficult to make.[168] Further difficulties arise where intoxication occurs concurrently with an underlying mental disorder.[169]

4.4.1 Cases of psychosis during intoxication

Disparate outcomes have been reached in cases where psychosis occurred during substance use, but ceased once the drug was metabolised. The New Zealand Court of Appeal has held that psychosis induced by either the combined effects of alcohol and glue, or meth is simple intoxication, and cannot found an insanity plea.[170] Similarly, the Supreme Court of Victoria held cannabis-induced psychosis was not a DOTM,[171] and the English Court of Appeal refused to allow hallucinations experienced during the course of an LSD trip to qualify.[172] On the other hand, the Supreme Court of Canada held that evidence of a psychotic state caused by cannabis could found an insanity defence.[173] In none of these cases were principled reasons given.

The recurring danger theory may justify excluding the insanity defence in these and other cases. Psychosis will not recur in the absence of substance use; therefore, an insanity disposition to hospital is arguably inappropriate. However, it seems problematic that a person who did not know what they were doing should be convicted, simply because the mental impairment from which they suffered is unlikely to recur. Arguably, they should be entitled to avail themselves of the insanity

167 *R v Davis*, above n 113.
168 Card, above n 43, 762; Ormerod, above n 43, 312.
169 Ormerod, above n 43, 312.
170 *R v McAllister* (1984) 1 CRNZ 248 (CA); *R v Dixon*, above n 56.
171 *R v Martin (No 1)* (2005) 159 A Crim R 314 (VSC).
172 *R v Lipman*, above n 47.
173 *R v Fontaine* 2004 SCC 27; [2004] 1 SCR 702: In this case, the Supreme Court held that insanity should have been left to the jury, as the expert evidence suggested the accused had been suffering from a psychotic disorder brought on by marijuana use. The implication is that such a disorder could qualify as a DOTM. However, it is noted that the Supreme Court had an unusual view of jury's role, suggesting that the jury should weigh competing policy factors in order to determine the DOTM inquiry: Ibid, [86]-[88]. This may explain the willingness of the Supreme Court to leave insanity to the jury. Arguably, they had in effect extended the jury's role beyond finding facts to include determining the legal meaning of DOTM. That is, they were not recognising drug-induced psychosis as a DOTM, but were instead leaving it to the jury to decide whether such psychosis could be a DOTM.

defence and, if hospital detention would not be appropriate, they should be released. But this too causes difficulties, as they may again use drugs, triggering a dangerous psychotic episode.

Alternatively, the internal cause theory could explain exclusion of the insanity defence in these cases. As some drugs interact with the mental weakness of users, it is arguable an objective assessment of their effects should be undertaken. This approach would bar the insanity defence in cases involving drugs like LSD. An ordinary person who takes LSD will experience hallucinations. Therefore, these hallucinations are caused by an external factor, not a DOTM. However, where the drug in question does not induce psychosis in the average user (e.g., methamphetamine, cannabis) and the accused did become psychotic, an objective assessment would lead to a DOTM being inferred. It is unclear how common psychosis would have to be for it to be treated as a feature of intoxication experienced by the ordinary person, as opposed to a DOTM.

Neither the recurring danger not the internal cause theory provide a clear answer in cases of drug-induced psychosis.

4.4.2 Cases of pre-existing mental disorder and intoxication

Confusion has also arisen in cases where there is a pre-existing mental disorder paired with intoxication at the time of offending. For example, consider an accused with a well documented personality disorder who offends while intoxicated.[174] In these cases, both the internal disorder and the external substance will have combined to impair the mental faculties. Therefore, it is unclear whether the accused should be treated as insane or as a drunkard. Some cases suggest that if the presence of an underlying disorder was necessary for impairment to occur, then an insanity defence can be supported. The implication is that it does not matter whether the underlying disorder was the predominant cause.[175] Other cases suggest that if an external trigger is required for a disorder to manifest, this trigger is the relevant cause. Therefore, to found an insanity claim it must be shown

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174See *Attorney-General for Nothern Ireland v Gallagher*, above n 46.

175*Bedelph v R* [1980] Tas R 23 (CCA) at 27; *Meddings*, above n 66, 310.

that impairment would have occurred regardless of intoxication.[176] These two approaches are vastly different. The United Kingdom Law Commission has suggested a more pragmatic approach whereby the most significant cause of impairment is identified. If this is an underlying mental disorder, then an insanity defence can succeed. Conversely, if the most significant cause was consumption of a drug, the defence will fail.[177] However, applying this simple test involves a difficult factual inquiry, and one dominant cause may not be apparent. The internal/external distinction drawn by the courts breaks down in these circumstances.

The recurring danger theory also falters in cases involving pre-existing mental disorder and intoxication. If the impairment recurs independently of drug use, this does suggest the cause is a DOTM. However, where impairment only recurs in the context of intoxication, the central problem of causation remains. It must first be determined whether the necessity of an external trigger precludes an insanity plea. If not, the problem is again how the relevant cause of each episode should be determined. In effect, the problem is one of interaction.

4.5 Conclusion

Judicial control over the meaning of DOTM may be justified on policy grounds. However, the failure of the judiciary to provide the term with a clear meaning is highly problematic. Orthodox statements of the meaning of DOTM are fraught with tautologies. Attempts to provide a principled approach, in the form of the recurring danger and internal cause theories, fail to provide all-encompassing methodologies. In cases where intoxication is present these theories are particularly inadequate. Therefore, the current approach is characterised by uncertainty and considerable judicial discretion. Judges may pick a particular statement of what constitutes a DOTM, or a particular theory, without explaining why this approach has been preferred. Further, in application, judges may obscure their reasoning with tautologies, or manipulate judicially created categorisations to bring

176*R v Burns* (1974) 58 Cr App R 364, 374-375. This decision has been described by the United Kingdom Law Commission as an "abberration" that should not be followed: United Kingdom Law Commission *Intoxication and Criminal Liability* (UKLC R314 2009) at 55.

177United Kingdom Law Commission, above n 176, 55.

about the desired result. Policy rather than principle informs these decisions, although this is not expressed. This confusion and mystification is not desirable, as the presence or absence of a DOTM can mean the difference between conviction and acquittal, qualified or outright. An express and principled approach to the DOTM inquiry is required. In the next chapter I will propose such an approach.

Chapter Five: A Holistic Approach to Disease of the Mind

Judicial pronouncements to date have not provided a systematic approach to the identification of a DOTM that can be applied with certainty in marginal cases. Nevertheless, a number of factors relevant to the DOTM inquiry have been identified. The Supreme Court of Canada recently drew these factors together, proposing a holistic approach to the inquiry.[178] In this chapter I will outline an approach based on the Canadian model, and advocate its adoption in New Zealand.

5.1 A holistic approach to DOTM

The holistic approach proceeds on the basis that DOTM is a concept containing both medical and policy components.[179] The medical component consists of the evidence of medical experts given at trial.[180] However, the medical evidence is not determinative. It is still for the judge to decide whether the evidence can support a finding of DOTM at law.[181] This determination is driven by the policy component of the DOTM inquiry.

This component involves consideration of a number of interrelated factors, the chief of which is protection of the public from danger.[182] Relevant policy considerations have not been exhaustively defined by the courts.[183] However, factors additional to public protection include the need for and appropriateness of treatment,[184] and the credibility of the justice system.[185] Each of these factors is to be considered, accorded appropriate weight, and bears on the DOTM inquiry.[186] The overarching issue to be addressed when considering these policy factors is whether a morally

178*R v Stone*, above n 70. The Court was split 5-4, with the leading judgment delivered by Bastarache J.
179Ibid, [176].
180This evidence should reflect the current state of medical knowledge, thereby enabling the DOTM inquiry to be informed by up to date scientific understandings: Ibid, [176].
181See Chapter Five [5.4] for a fuller explanation of the roles of judge and jury.
182*R v Stone*, above n 70, [212] and [218]; *R v Parks*, above n 65, [9]; *R v Rabey*, above n 70, [17].
183*R v Stone*, above n 70, [218].
184*R v Stone*, above n 70, [203]; *R v Parks*, above n 65, [9]; *R v Rabey*, above n 70, [46].
185*R v Stone*, above n 70, [176]; *R v Parks*, above n 65, [16]; *R v Rabey*, above n 70, [88].
186*R v Stone*, above n 70, [218].

innocent accused[187] should be subjected to the insanity disposition regime.

In formulating the holistic approach, the Supreme Court of Canada recognised that the recurring danger and internal cause theories could provide useful guidance in some cases, although they had failed as all-encompassing methodologies. Therefore, these theories were relegated to the status of "factors" to be considered if, and only if, they shed light on broader policy considerations.[188] For example, the recurring danger factor might be relevant to assessing how public protection should be secured. However, if clear evidence of the likelihood of recurrence is unavailable it should be disregarded.

Therefore, the holistic approach is multi-factorial in nature, and involves the explicit exercise of discretion. Medical evidence is considered in light of a range of policy factors. These factors are balanced in order to reach a final determination. This is to be contrasted with previous approaches, which attempted to categorise conditions as a DOTM or otherwise on the basis of a single variable (e.g., recurrence of danger, internal cause).

I will now discuss each of the relevant factors in more detail, indicating the weight each factor should bear. I will then discuss two possible factors I would exclude from the inquiry, and explain why. Finally, I will outline the roles of judge and jury in applying the holistic approach.

5.2 Relevant factors

5.2.1 Public protection

The link between DOTM and public safety was clearly expressed by Justice Devlin in *Hill v Baxter*:[189] "if disease is present, the same thing may happen again, and therefore, since 1800, the law has provided that persons acquitted on account of this ground should be subject to restraint."[190] The importance of public protection has been emphasised in numerous cases.[191] Nevertheless, the

187Assuming that the accused successfully establishes the second requirement of the insanity defence: that they did not know the nature and quality or their act, or did not know that their conduct was wrong.

188*R v Stone*, above n 70, [206], [211] and [213].

189*Hill v Baxter*, above n 120.

190 Ibid, 285-286.

191*R v Sullivan*, above n 57, 172; *Bratty v Attorney-General for Northern Ireland*, above n 55, 410; *R v Kemp*, above n 108, 403;

weight accorded to this policy consideration is context dependent.

In cases of automatism, the potential outcomes are an outright or qualified acquittal. Therefore, an insanity verdict provides the only way for immediate control to be exercised over the accused via the criminal law. If there is concern about ongoing danger, consideration of public protection may weigh heavily in favour of finding a DOTM. However,this emphasis on public safety has been criticized on the basis that public protection can be secured using civil, not criminal procedures.[192] But this criticism can be incorporated within the multi-factorial approach: that is, whether the public could be adequately safeguarded by use of civil procedures would be one more factor to be considered. Nevertheless, in some cases an insanity finding may be the only means by which to protect the public. For example, a person with post-traumatic stress disorder who enters a violent dissociative state in response to certain environmental triggers could not be detained for prolonged periods in inpatient care under the civil mental health regime, but may represent a significant ongoing risk to the community.

In non-automatism cases the potential outcomes are a qualified acquittal, or conviction and sentencing. Both outcomes can provide for detention of the accused. Therefore, in these cases the need to protect the public may not carry as much weight. Nevertheless, it can still be relevant. In a case involving low-level offending, conviction may lead to a short period of detention only. In contrast, detention as a special patient can be indefinite, and this may be considered desirable.

5.2.2 The need for and appropriateness of treatment

The need for treatment is a "principal reason" for confinement of mentally ill offenders.[193]

R v Yesler, above n 70, [40]; *R v Cottle*, n 51, 1029 and 1033; *R v Falconer*, above n 71, 55 and 67; *R v Quick*, above n 69, 919; *R v Rabey*, above n 70, [17]; *R v Parks*, above n 65, [9].

192Simester and Sullivan, above n 129, 649. See also *R v Falconer*, above n 71, 63: Deane and Dawson JJ noted that if the current approach to automatism meant that some potentially violent offenders were released outright, this had to be accepted. Any concerns about safety would be "a matter to be dealt with by the means otherwise available for protecting the community from such persons and, if those means are thought to be inadequate, by legislative intervention."

193*R v Rabey*, above n 70, [46].

Furthermore, the appropriateness of sending an offender to a mental hospital is relevant.[194] If the offender suffers from a condition that is unlikely to recur, or is not a mental illness amenable to treatment, then it may not be appropriate to detain him in a mental hospital. Such detention would in effect make mental health practitioners jailers, placing them in a difficult and embarrassing ethical position.[195]

However, the flexibility provided in sentencing and disposition means that consideration of the need for and appropriateness of treatment may not carry decisive weight. A person acquitted on grounds of insanity need not be detained if this is inappropriate.[196] They may instead be immediately released, committed as a civil patient, or released from special patient status.[197] Conversely, a need for treatment cannot determine the matter in favour of insanity, as therapeutic orders are still available following a conviction.[198]

Nevertheless, conviction and qualified acquittal can still lead to different outcomes. A person found insane can never be held in prison. In contrast, a person convicted may be held in prison, in a mental hospital, or may be transferred between the two. This difference in disposition options will be relevant to the DOTM inquiry. For example, consider an accused who suffers from occasional psychotic episodes, but at other times is of sound mind. For such an accused, a hybrid order following conviction may be most appropriate. This would permit for transfer to hospital when psychotic episodes occur, and detention in prison when the accused is not in need of treatment. A preference for a hybrid order would militate against a finding of DOTM.

5.2.3 The recurring danger factor

This factor involves consideration of the likelihood that the alleged condition will recur. If a disorder is likely to recur, this may indicate that treatment is necessary and appropriate. Further, it

194*R v Radford*, above n 124, 276; *R v Quick*, above n 69, 918; Williams, above n 43, 466.
195*R v Radford*, above n 124, 276. See also Williams, above n 43, 676.
196*R v Quick*, above n 69, 918; *R v Rabey*, above n 70, [12]; *R v Cottle*, above n 51, 1028.
197Criminal Procedure (Mentally Impaired Persons) Act 2003, ss 24-26 and 33.
198Ibid, s 34.

may be relevant in determining what is required to secure public safety. If there is no continuing danger, however, this will not automatically preclude a finding of a DOTM.[199] In assessing the likelihood a disorder will recur, the psychiatric history of the accused, and the likely recurrence of any external trigger will be relevant.[200] The recurring danger factor may be of limited use where evidence as to future recurrence is equivocal.

5.2.4 The internal cause factor

The internal cause factor relates to whether the alleged impairment was caused by the psychological or emotional makeup of the accused, or the effects of some external factor. If the cause is internal, this may suggest a need for treatment, or a likelihood of recurrence which puts the public at risk.

In cases where it is difficult to untangle the internal and external causes of impairment, the contextual objective approach described in Chapter Four may be employed: that is, the response of the accused to the external factor will be compared with that of an ordinary person placed in the accused's circumstances in order to determine whether some abnormality internal to the accused has caused the impairment. This approach will be appropriate in cases where the external factor is likely to interact with or exacerbate an underlying mental infirmity. For example, the effect of a psychological blow may be contingent upon the mental state of the individual. Similarly, the effect of a drug which can cause psychosis may be contingent upon the presence of an underlying vulnerability to psychosis. In these cases, the contextual objective approach will provide insight into the mental state of the accused. In contrast, the effect of a blow to the head does not generally depend upon the pre-existing state of mind of the individual. Accordingly, the contextual objective approach should not be applied.

199*R v Stone*, above n 70, [212]-[213].

200Ibid, [214]. These are only considerations which may aid in assessing the likelihood the disorder will recur. To the extent that *Stone* suggests the jury is entitled to focus solely on the likely recurrence of the trigger, this cannot be correct: above n 70, [217]. One can imagine a circumstance where a trigger would recur frequently, but the mental state of the accused has stabilised such that impairment will not result. See also David Paciocco "Death by Stone-ing: The Demise of the Defence of Simple Automatism" (1999) 26 CR (5th) 273.

In cases involving a number of causes, it will be necessary to consider the relative contribution of each cause to the mental impairment ultimately suffered. In some cases, it will be clear that the dominant cause was one internal to the accused. However, in other cases it may be difficult to isolate one main cause. In these cases, the utility of the internal/external dichotomy may be limited.

5.3 Irrelevant factors

5.3.1 Credibility of the justice system

Another policy consideration highlighted by the courts is the need to maintain the credibility of the justice system.[201] Concern has been expressed that the legal meaning of DOTM should not be regarded with incredulity outside of the courts.[202] Further, in cases where sane automatism is pleaded, a specific concern is that the justice system's credibility will be "severely strained" if a violent offender receives an absolute acquittal.[203] This is linked to fears that automatism may be feigned, and that if pleas of sane automatism are too readily accepted there will be an increase in unmeritorious defences.[204] However, I contend that these concerns over credibility cannot carry much, if any, weight in the DOTM inquiry.

Considering first the concern that the legal approach to DOTM may be regarded with incredulity, Lord Diplock in *Sullivan*[205] stated that insanity is a technical legal term. Therefore, it should be applied in cases where the legal requirements of the insanity defence are met, even if this appears strange to those outside the courts. He concluded that if legal use of the label "insanity" was considered problematic, Parliament could change the label.[206] This has occurred in other jurisdictions, such as Canada, where the defence is more clearly described as the "defence of mental

201 *R v Quick*, above n 69, 919; *R v Yesler*, above n 70, [40]; *R v Stone*, above n 70, [176]; *R v Rabey*, above n 70, [88] per Dickson J dissenting; *R v Parks*, above n 65, [15].
202 *R v Quick*, above n 69, 919.
203 *R v Stone*, above n 70, [176]; *R v Parks*, above n 65, [15]; *R v Rabey*, above n 70, [88] per Dickson J dissenting .
204 *R v Stone*, above n 70, [176]; *R v Parks*, above n 65, [16]; *R v Rabey*, above n 70, [88] per Dickson J dissenting.
205 *R v Sullivan*, above n 57.
206 Ibid, 173.

disorder".[207] I agree with Lord Diplock.[208] It would be inappropriate for the Courts to defer to public opinion, as insanity cases often evoke strong emotional responses which may distract from pertinent considerations. Further, the courts must take a different approach to DOTM than the medical profession. The courts are tasked with determining issues of criminal responsibility and public protection, not with providing treatment.[209] This inevitably alters the context in which the meaning of the term is to be settled. Additionally, I contend that application of the holistic approach will reduce the number of cases in which a DOTM finding will appear incongruous to the public.[210]

Concerns that the defence of sane automatism will be misused are also unwarranted. I agree with Binnie J, dissenting in *Stone*,[211] in this regard. He argued that "the jury are as well placed as anyone in the justice system to uphold its credibility. The bottom line is, after all, that the task of weighing the credibility of such defences was confined by Parliament to the jury."[212] Therefore, a judge who withholds the defence of sane automatism from the jury because of doubt about its credibility usurps the jury's role as fact finder. Fear that the jury may fall into error cannot justify this.[213] Available evidence suggests that allowing sane automatism defences to be assessed by the jury will not result in a flood of unwarranted acquittals.[214] Nevertheless, should an increase in unmeritorious defences occur, the appropriate response would be legislative intervention, such as shifting the persuasive burden on to the accused, not extension of the term DOTM.[215]

207Criminal Code RSC 1985 c C-46, s 16.

208I do not agree with the result in *Sullivan*: above n 57. However, this is not because I think that public distaste toward application of the "insanity" label should carry decisive weight. Instead, I consider that Lord Diplock erred in applying the approach to DOTM laid down in *Kemp*: above n 108.

209*R v Porter*, above n 59, 186.

210The flexibility of the holistic approach ensures that the DOTM inquiry can be determined in accordance with policy and common sense. Absurd results arising from the strict application of categorical tests will no longer arise. Furthermore, as policy deliberation is made explicit under the holistic approach, the public will have access to judicial reasoning for characterization of a disorder in a certain way.

211*R v Stone*, above n 70.

212Ibid, [74] per Binnie J dissenting.

213Ibid, [29] and [88] per Binnie J dissenting.

214See Stuart, above n 74, 125: "Since *Parks* but prior to *Stone* sane automatism claims were rejected in *Bergamin* (1996) 3 CR (5th) 140 (Alta CA) and *McQuarrie* (1998) 127 CCC (3d) 282 (Alta CA)."

215*R v Carter*, above n 125, 112. See also *R v Falconer*, above n 71, 63. The appropriate response is legislative intervention as opposed to extending the scope of DOTM. The insanity disposition regime does not provide for the appropriate outcome in cases where the accused has adduced evidence of sane automatism, but this evidence is not considered compelling. It is unlikely that the accused in such a case would have an ongoing mental disorder warranting imposition of special patient or civil patient status. Detention in prison is the only appropriate option, and this could only be achieved by shifting the burden of proof.

5.3.2 Prior fault of the accused

An accused has prior fault when they form an intent to commit a crime prior to getting intoxicated, then become intoxicated and commit the crime. An accused may also have prior fault if they choose to take a drug knowing that this will make them dangerous and impulsive, and then become dangerous and commit a crime. Cases to date suggest that the presence of prior fault has implications for the application of the insanity defence.[216]

In *Attorney-General for Northern Ireland v Gallagher*[217] the accused was an aggressive psychopath, who was prone to explosive outbursts when intoxicated. He formed the intention to kill his wife while sober and in his right mind. He then obtained a knife for this purpose, got drunk, and carried out his plan. In rejecting an insanity defence, Lord Denning concluded that "[t]he wickedness of his mind before he got drunk is enough to condemn him, coupled with the act which he intended to do and did do."[218]

Similarly, in *Simms v Police*[219] the accused knew that substance use could trigger her underlying mental disorder, and that this could result in criminal offending. She nevertheless chose to become intoxicated, and offended. Ellis J suggested, without deciding the matter, that the accused's foresight of offending might prevent her from relying on the insanity defence.[220]

These cases suggest that the presence of prior fault can be fatal to the insanity defence. This is because, as Lord Denning put it, the "wickedness of [an accused's] mind before he got drunk is enough to condemn him". That is, in cases of voluntary intoxication, the mental state of the accused may be assessed prior to their intoxication.[221] If the accused intended at that time to do an act he knew to be wrong (i.e., he was wicked), then he cannot rely later on the insanity defence. This would

216*Attorney-General for Nothern Ireland v Gallagher*, above n 46; *R v Quick*, above n 69; *R v Bailey* [1983] EWCA Crim 2; *Simms v Police* HC Wellington AP 8-97, 27 March 1997.

217*Attorney-General for Nothern Ireland v Gallagher*, above n 46.

218Ibid, 382. The other members of the House of Lords determined the matter on an alternative basis: the accused had not shown that his disorder rendered him unable to know the nature, quality or wrongness of his acts. Nevertheless, Lord Denning's approach (sometimes described as the "Dutch courage rule") has received support. **REFS**

219*Simms v Police*, above n 216.

220Ibid, 9.

221This shift in the time of assessing the mental state of the accused is arguably justified on policy grounds.

be the case even if at the time he performed the act he did not know his act was wrong. Further, the obiter statements of Ellis J suggest that recklessness as to offending, at a prior time when the accused knew right from wrong, may be fatal to an insanity defence.

However, while prior fault may have this effect, this is not, I would suggest, because it prevents a finding that the accused had a DOTM. A qualifying mental disorder may be present, and even if this is triggered or exacerbated by voluntary intoxication, it will still be a DOTM.[222] Nevertheless, the accused may not be considered to satisfy the second stage of the insanity inquiry: that is, they will not be able to say that they did not know their act was morally wrong. It is in this manner that prior fault can preclude an insanity defence. Therefore, even though prior fault may be relevant to the application of the insanity defence as a whole, it is not a factor relevant to the DOTM inquiry.[223]

5.4 Roles of judge and jury

The DOTM inquiry involves questions of law and fact.[224] Therefore, both the judge and the jury have crucial roles to play in determining whether a DOTM is present. It is for the judge to determine whether a reasonable jury properly instructed could find a DOTM, such that insanity should be left to the jury.[225] The judge must also direct the jury as to the legal meaning of DOTM. The jury's role is to determine whether to accept the expert and other evidence offered at trial in support of an insanity defence, and to apply the law to their findings.

In *Fontaine*,[226] Fish J stated in obiter that the holistic approach set out in *Stone* should be

222*R v Davis*, above n 113. For example, consider a person with schizophrenia who does not suffer psychosis when they take their medication, and stay away from drugs and alcohol. If such a person formed an intent to commit a crime, stopped their medication, consumed drugs and then committed the crime they would be precluded from relying on the insanity defence. However, this would not be because they did not have a DOTM, as they clearly have schizophrenia. This would be because their prior intent would prevent a claim that they did not know the nature and quality of their acts, or that these acts were wrong.

223The extent to which prior fault may prevent an accused from establishing the second limb of the insanity defence is controversial. The NZ courts, if faced with the matter, might take a different approach to the English courts. The relevance of voluntary intoxication to the presence of *mens rea* is currently treated differently in these jurisdictions: see Chapter Three fn 43. A full discussion of this issue is beyond the scope of this paper.

224*R v Stone*, above n 70, [197].

225*R v Fontaine*, above n 173, [57].

226Ibid.

utilised by the jury to determine the DOTM inquiry.[227] However, this cannot be correct as this would require the jury to balance competing policy factors. The jury are fact finders, not policy analysts. In applying the holistic approach it is for the judge to weigh the policy concerns. In cases where there is competing evidence as to the accused's mental state, the judge will need to engage in a counter-factual inquiry. The judge should consider how the policy factors would be balanced if account X of the accused's mental state were accepted by the jury. He should also consider the balance struck if account Y were accepted, and so forth. Having determined this, the judge may then instruct the jury that a finding of X will lead to verdict A, whereas a finding of Y will lead to verdict B. For example, a judge may determine that the whole DOTM inquiry will turn on whether the disorder had an internal cause. Therefore, the judge using suitable language would instruct the jury to apply the contextual objective approach to determine whether the cause was internal or external. He would further instruct that finding an internal cause entails finding a DOTM, whereas finding an external cause will mean rejecting the insanity defence.

This division of labour would render impotent one of the objections to the holistic approach. This objection states that the policy component of the approach means that judicial and medical conceptions of DOTM can be significantly different. This is problematic, as it may confuse the jury.[228] However, no confusion can arise if the judge directs the jury to the relevant factual inquiries and instructs them as to the legal consequences of their factual findings. If these roles are adhered to, the conflation of medical and legal conceptions of DOTM should not occur.

5.5 Critical assessment of the holistic approach

Criticism of the holistic approach set out in *Stone* has taken two key forms: the approach makes it too difficult to establish a defence of sane automatism,[229] and the consideration of vague

227 *R v Fontaine*, above n 173, [86] – [88].

228 Paciocco, above n 200.

229 Ibid; Glen Luther and Mansfield Mela "The Top Ten Issues in Law and Psychiatry" (2006) 69 SASKLRev 401 at 421.

policy factors obfuscates the term DOTM.[230] Neither of these objections are persuasive.

The first objection to *Stone* must be assessed in light of criticisms that may be made of other aspects of the decision. The majority in *Stone* altered the evidential and persuasive burdens in cases of sane automatism, as well as formulating the holistic approach. It is the combination of these changes that restricts the availability of sane automatism. I agree that the approach taken by the majority to burdens of proof is undesirable. However, I do not agree that the holistic approach itself is problematic in cases of sane automatism.

Some critics argue that the holistic approach places numerous hurdles in the way of a sane automatism defence, and is therefore overly restrictive. They contend that in order to succeed the accused must show both that their disorder was caused by an external factor, and that it is unlikely to recur.[231] With respect, this argument misrepresents the holistic approach. The majority in *Stone* expressly acknowledged that "in any give case, a trial judge may find one, the other or both of [the internal cause and recurring danger] approaches of assistance."[232] Therefore, the judge does not have a checklist the accused must satisfy. The applicability of the internal cause and recurring danger factors is context dependent.

Other critics argue that the holistic approach illegitimately limits availability of the sane automatism defence by over-emphasising public protection.[233] However, this criticism is leveled at the weight attached to one factor considered in the approach. It is not a criticism of the holistic approach *per se*. A judge may fall into error in attaching weight to any given factor. However, this does not render the overall analytical framework useless.

The second general objection to the holistic approach, that it obfuscates the meaning of DOTM by introducing policy factors, is also ill-founded. The consideration of policy factors in the DOTM inquiry is inevitable. Previous approaches to DOTM did not exclude policy factors, but

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230Luther and Mela, above n 229, 421; Bernadette McSherry "*R v Stone* [1999] 2 SCR 290: Case Commentary" (2000) 7 Psychiatry Psychol & L 279 at 283; James Livingston and Simon Verdun-Jones "Sidebar Psychology: Discussing and Challenging the Defence of Psychological Blow Automatism" (2002) 47 Crim LQ 79 at 97.

231Luther and Mela, above n 229, 421.

232*R v Stone*, above n 70, [213].

233Paciocco, above n 200.

instead allowed for their consideration to be obscured. For example, a judge applying the internal cause theory could manipulate the internal/external dichotomy in order to bring about the result he considered to be consistent with policy. The holistic approach has the benefit of making explicit the exercise of discretion and consideration of policy inherent in the DOTM inquiry. This is desirable, as it paves the way for a body of case law addressing competing policy concerns and the balance to be struck between them. This will provide for greater clarity than the previous approaches to DOTM, which turned on tautologies and problematic distinctions.

In contrast, the holistic approach has been hailed by other commentators as a pragmatic method for determining the DOTM inquiry.[234] It has proven impossible to lay down a categorical statement of what will constitute a DOTM. A multi-factorial approach provides for the much needed flexibility in determining this inquiry,[235] while also offering an analytical framework. Further, it encourages judicial openness. This enables greater clarity, and aids public understanding of the judicial approach to DOTM. I join with the commentators who favour the holistic approach, and contend that it should be adopted in New Zealand. The approach has already been applied once, by Lang J in the New Zealand High Court.[236] Its wholesale adoption would provide much needed guidance in this "quagmire of law".[237]

The holistic approach was formulated for application in "cases involving claims of automatism."[238] Nevertheless, I contend it should be applied to all cases where the presence of a DOTM is at issue. The approach is sufficiently flexible to account for contextual variation. Similar policy considerations are raised in cases where insanity is pleaded, as in automatism cases. These policy factors will simply carry differing weight, depending upon the context.

234R Mackay and B Mitchell "Sleepwalking, Automatism and Insanity" [2006] Crim LR 901 at 905; Stanley Yeo "Clarifying Automatism" (2002) 25 Int J of Law Psychiatry 445 at 445.
235Mackay and Mitchell, above n 234, 905.
236*R v Yesler*, above n 70.
237*R v Quick*, above n 69, 922.
238*R v Stone*, above n 70, [163].

5.6 Conclusion

The holistic approach recognises that the DOTM inquiry involves both medical and policy components. The medical evidence of experts at trial is crucial. However, it is the judge who will determine whether this evidence can support a DOTM finding. In making this determination the judge should consider and weigh a number of policy considerations, including the protection of the public, and the need for and appropriateness of treatment. The recurring danger factor and internal cause factor may aid in assessing these policy concerns. The overarching issue for the judge is whether the accused should be subjected to the insanity disposition regime. If on one account of the accused's mental state this would be appropriate, then a DOTM may be found. Accordingly, the evidence of the accused's mental state should be left to the jury for determination.

The holistic approach provides a clear analytical framework for determining the DOTM inquiry in all cases where the issue is raised. In the next chapter I will consider its application to problematic cases involving meth use and psychosis.

Chapter Six: Applying the Holistic Approach to Cases of Methamphetamine-Related Psychosis

A person who offends while on meth and suffering psychosis may return to an ordinary state of mind, develop a recurrent psychotic disorder, or suffer intermittent flashbacks. These variations have implications for the application of the holistic approach, and consequently for the determination of the DOTM inquiry. In this chapter I will outline three problematic cases involving meth-intoxication and psychosis which may come before the courts. I will apply the holistic approach to each, reaching a conclusion as to whether a DOTM ought to be found. I will also highlight contingencies which may alter the application of the holistic approach, recognising that this approach is sensitive to case-by-case variations.

6.1 Three problematic cases

Where a person has suffered psychosis while intoxicated by meth, this may represent one of three different scenarios. The first scenario, and the most common, is that the user is psychotic while meth persists in their body. However, psychosis ceases upon metabolism of the drug and will not recur without drug use. Generally, a high dose of meth will be required to induce another psychotic episode. Essentially, the user is psychotic only while intoxicated.

The second scenario is that the user suffers psychosis during intoxication, which ceases when the drug clears their body. However, although the user returns to a normal mental state, psychosis can readily be triggered thereafter by low doses of meth, or by certain stressful situations. The user is psychotic while intoxicated and also prone to "flashbacks".

The final scenario is that the user is psychotic during meth use, and this psychosis continues even when the user abstains from the drug. They may be diagnosed with schizophrenia, or with some form of protracted drug-induced psychosis. The user is psychotic during intoxication and

psychosis persists.

Within each of these broad categories there are subtle variations which may bear on the DOTM inquiry. Nevertheless, applying the holistic approach to these generalised categories will help determine the proper outcome of the DOTM inquiry in cases involving meth use and psychosis.

In each case I will consider what may be required in the interests of public protection, and whether treatment is needed and appropriate. I will utilise the recurring danger and internal cause factors to aid these inquiries, where appropriate. Finally, I will make a general recommendation as to whether a DOTM should be found. My assessments will proceed on the basis that insanity is being pleaded, not insane-automatism. This is because meth will very rarely induce an automatic state.

6.2 Application to case one: psychotic only while intoxicated

In order to assess what may be required to safeguard public protection, and whether treatment is required, both the recurring danger and internal cause factors may be of use.

Applying the recurring danger factor, it will be relevant to consider both the likelihood that the trigger of psychosis (i.e., meth use) will recur, and the previous mental health history of the accused. Obviously, both will vary from case to case. However, I will assume that the accused has no prior history of psychotic disorders.[239] This will probably be typical of those falling into case one, as users with a prior history of psychosis will generally trigger a long-term disorder as per case three. I will also assume that there is a likelihood of ongoing drug use, as psychosis is more commonly experienced amongst frequent users. Bearing these assumptions in mind, it is likely psychosis will recur if the accused has access to meth. Therefore, to protect the public the accused must be prevented from using meth. This could occur by placing the accused in a secure environment, either prison or a hospital. If the accused is a drug addict, public protection in the long term could be secured by treating this addiction. Addiction treatment could be made available in prison or in

239A prior history of another mental disorder, such as depression, may be of some relevance. For example, ongoing depression may make it more likely for the accused to continue using drugs. However, mental disorders not involving psychosis will not bear directly on the likelihood of recurrence.

hospital.[240]

Applying the internal cause factor in this case is problematic, because meth is known to interact with underlying mental vulnerabilities in users to bring about mental disorder. Therefore, to identify the relevant cause of psychosis, the objective contextual approach should be utilised. It is necessary to consider whether an ordinary person using meth would suffer this psychosis, or whether psychosis has arisen because of some internal vulnerability of the accused. Around a quarter of frequent meth users will experience psychosis. While this will more commonly be experienced amongst those with a predisposition to psychosis, psychosis also occurs at a high rate in previously healthy users. As it is quite possible that a healthy person could suffer psychosis, arguably an internal cause ought not be assumed. Conversely, because the majority of meth users do not suffer psychosis, it is arguable that an ordinary person would not become psychotic and that some weakness internal to the accused should be inferred if psychosis has occurred. However, even if an internal cause is inferred, it is unlikely that this would be treated as the predominant cause of psychosis. Therefore, it can be concluded the sole, or at least the predominant cause of psychosis is external to the accused. It is unlikely psychosis will recur independently of this external factor. Public protection simply demands exclusion of the accused from drug use.

Considering the need for and appropriateness of treatment, it has already been established that the only ongoing disorder that may require treatment is drug addiction. Given this, an insanity disposition seems inappropriate. It would be heavy handed to send an accused to a hospital for the criminally insane in order to treat an addiction. The other alternative following an insanity finding would be to commit the accused as a civil patient. However, this would not permit the accused to be detained to receive treatment for addiction.[241] In contrast, during detention in prison treatment for drug addiction may be administered.[242] Therefore, any need for treatment could be most adequately

240See Department of Corrections "Annual Report: 1 July 2007-30 June 2008" (2008) Department of Corrections www.corrections.govt.nz (accessed on 19 September 2009) at 131-132 and 154-160.

241See Mental Health (Compulsory Assessment and Treatment) Act 1992.

242It is noted that a prisoner cannot be ordered to attend drug and alcohol treatment, but may attend programmes made available in prison on a voluntary basis. However, the inability to order addiction treatment is not problematic. Most treatments are only effective when the person willingly engages the treatment. Therefore, if court ordered treatment

met following conviction.

Weighing these policy factors together, a DOTM should not be found. Public protection can be secured adequately if the accused is convicted, assuming a sentence of imprisonment of more than negligible length is imposed. The need for treatment can be met via programmes delivered in prison. Should psychosis unexpectedly recur, there is the possibility of transfer into a mental health hospital. In contrast, the insanity disposition regime would be ill-suited in these circumstances. Indefinite detention as a special patient is not warranted and civil commitment would not suffice.

6.3 Application to case two: prone to "flashbacks"

This case essentially raises the same issues as case one, with a single variation: psychosis can now be triggered by low doses of meth, or by stressful situations in abstinent individuals. It can again be assumed that a person falling into this category would be a frequent user, with no prior history of psychotic disorders.

More may be required to secure public safety in this case than in case one. This is because, considering the recurring danger factor, the trigger which causes psychosis is now more likely to occur. Lower doses of meth will suffice and, in some instances, so too will relatively common social stressors. If social stressors act as a trigger, then excluding the accused from meth use will not necessarily ensure public safety. Furthermore, considering the internal cause factor, in this case it is clear that some internal vulnerability of the accused is a significant cause of psychosis. An ordinary person who took a low dose of meth, or was exposed to a common social stressor, would not enter a psychotic state. The presence of a significant internal cause reinforces the likelihood of recurrence and the need for steps to be taken to secure public protection. Therefore, some form of detention is required, whether that be in a prison or a hospital.

The internal cause of flashbacks also suggests there is a need for treatment. In fact, psychotic flashbacks can be effectively prevented or, if they have occurred, resolved using anti-psychotic

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were available it would likely be ineffective: see Williams, above n 43, 466.

medication. However, in these cases the accused will be of sound mind except when experiencing flashbacks. Therefore, in between flashbacks there is no need for hospital treatment. This suggests that a special patient order may be inappropriate, as this would lead to a person who was often in sound mind being detained in a mental hospital. Conversely, civil commitment would be unlikely to suffice in these circumstances. While the accused could be detained while psychotic, there would be limited power to detain him otherwise. Nevertheless, some form of oversight when he is not psychotic may be desirable, in order to prevent dangerous flashbacks by ensuring anti-psychotic medication is taken and meth use is curtailed. Detention in prison would enable access to addiction treatment and monitoring of medication use. If the accused became psychotic while in prison, he could be transferred to a hospital. A hybrid order may be particularly appropriate in such cases, enabling transfer to be more readily effected when necessary.

Therefore, considering the policy factors an insanity disposition is not required in these circumstances. Public safety can be most adequately secured through imprisonment. The treatment required can be secured in prison, or through transfer to and from hospital in accordance with a hybrid order. Detention as a special patient following an insanity finding would be inappropriate, and treatment as a civil patient would be inadequate. Therefore, a DOTM should not be found.

6.4 Application to case three: long-term psychotic disorder

The final case is that in which a recurring psychotic disorder has followed intoxication. Individuals falling within this category will often have a personal history of mental disorder involving psychosis, such as schizophrenia. Meth use in these cases may have exacerbated a mental disorder that was already present. Alternatively, individuals may have a family history of such mental disorders, and meth may have triggered a vulnerability. Finally, a small proportion of individuals who develop a long term mental disorder will have no personal or family history of ill-health. In these cases, meth is the only apparent cause of the ongoing disorder. Most individuals who develop

long-term disorders are frequent users.

Considering the need to secure public protection, in all of the variations of this final case there is likelihood of recurrence which poses a risk to the community. This recurrence of psychosis will occur even when the individual is abstinent, although ongoing drug use may make psychotic episodes more frequent. Therefore, securing public safety will require more than excluding an accused from meth use. In cases where there is a prior history or a family history of mental illness, the likelihood of recurrence will be more readily assessed. However, in individuals of previously good health, the future course of the disorder may be uncertain. In some documented cases, meth-induced psychosis has persisted for one or two years and then abated. Drug use may then cause it to recur. In these cases, the likelihood of ongoing drug use may be highly relevant to assessing the degree of risk posed by the accused.

Applying the internal cause factor in these cases also leads to a conclusion there is a likelihood of recurrence and a need to protect the public. While meth use is a cause of the psychosis, the persistence of psychosis beyond intoxication indicates something internal to the accused is at play. It may be inferred that this internal factor is the predominant cause of psychosis, as psychosis continues in the absence of meth use.

Therefore, in all cases of persisting psychosis detention is immediately necessary to protect the public. However, in cases where there is no personal or family history of mental illness the disorder may resolve quickly, rendering long-term treatment unnecessary. Nevertheless, there could be an ongoing risk of recurrence, particularly where the individual is likely to return to drug use. In these uncertain cases a special patient order seems inappropriate. If the individual is detained as a special patient and their disorder resolves they may be released. However, this could pose a risk to the community if their disorder later recurs in the context of drug use. A hybrid order might instead be appropriate. Under this order the offender would be sent to hospital following sentencing. However, if his disorder resolves, he could be transferred back to prison to wait out the rest of a

term of imprisonment. While in prison he could receive treatment for addiction, thereby mitigating the risk of future drug use causing a recurrence of the disorder.

Considering the need for treatment, in cases where there is a personal or family history of disorder there is likely to be an ongoing need for treatment in a mental hospital. Therefore, detention as a special patient is likely to be appropriate. The need for and appropriateness of treatment is more difficult to assess where the individual has no personal or family history of disorder. The course of their current psychotic disorder is likely to be unpredictable. While treatment in a medical hospital is immediately required, the disorder may resolve itself in a year or two. If special patient status is imposed and the disorder resolves, but the patient is not released because of concerns about recurrence, the mental health authorities merely provide secure care. This suggests that a special patient order would not be appropriate in these cases. A hybrid order would instead enable the accused to be transferred from hospital to prison when treatment in a mental hospital is no longer necessary.

Therefore, in cases where persisting psychosis has followed meth use, a DOTM finding will likely be appropriate in cases where the accused has a personal or family history of mental illness. In cases where no such history exists, uncertainty surrounding the future course of the disorder may mean a DOTM finding is inappropriate. Whether this is the case will ultimately turn upon the evidence presented at trial. If the experts can say with some certainty that the disorder is unlikely to abate in the near future, then a DOTM finding may be appropriate.

6.5 Conclusion

The holistic approach provides a pragmatic manner in which to determine the DOTM inquiry in cases involving meth use and psychosis. In cases where psychosis only occurs during intoxication, a DOTM will not be found. So too a DOTM is unlikely to be found in cases where meth use has caused an individual to develop a vulnerability, such that psychosis is triggered by low

doses of meth or by social stressors. In contrast, where an ongoing psychotic disorder has been triggered or exacerbated by meth use, a DOTM finding will be likely. However, uncertainty surrounding diagnosis in some cases of ongoing psychosis may tip the balance in favour of conviction and imposition of a hybrid order. These outcomes accord with policy objectives and with common sense. Further, the reasons for these outcomes are laid bare during application of the holistic approach. This is to be contrasted with the confusion which could arise when trying to apply the previous approaches (such as the internal cause theory) to these problematic cases.

Chapter Seven: Conclusion

The prevalence of meth use in NZ, and the relationship between it and crime mean NZ courts will continue to be faced with offenders who were meth-intoxicated at the time of offending. Furthermore, given the high rates of psychosis experienced by meth users, a significant proportion of these offenders will have been psychotic at the time of offending. The application of the insanity defence in these cases is a live issue. However, whether meth-related psychosis can qualify as a DOTM for this purpose is unclear. This uncertainty is problematic, as determination of the DOTM inquiry has significant implications for an offender's fate: it may determine the application of the law of intoxication, automatism and insanity, the verdicts entered, and the disposition or sentencing of the offender. This is why this paper has focused on the critical legal term DOTM.

The current judicial approach to DOTM is unsatisfactory. Definitions of it are often tautologous and judicial theories which try to fix its boundaries, such as the recurring danger and internal cause theories, have failed to provide an all-encompassing methodology. The current law is uncertain, and this permits judges to obscure their policy deliberations behind tautologies and the selective use of these theories. Given the significance of the DOTM inquiry, this uncertainty and mystification is undesirable.

A holistic approach to this inquiry can provide a solution to these difficulties. This approach is multi-factorial. It involves overt reference to policy and the transparent exercise of discretion. Under this approach, a judge would consider the medical evidence before the court along with a number of policy factors to determine whether an accused should be subject to an insanity disposition. Specifically, the judge would consider whether the evidence suggested that the public needed protection from the accused, or that the accused needed psychiatric treatment. In addition, the judge may gain assistance from the internal cause and recurring danger approaches. If, following that inquiry, the judge determined on policy grounds that an insanity disposition would be desirable,

then a DOTM would be found.

The usefulness of this approach is demonstrated when it is applied to problematic cases involving meth-related psychosis. Under this approach the classification of psychosis would no longer turn on single factors, such as the likelihood of recurrence or whether the predominant cause was internal to the accused. This would be a desirable change, as assessing the future course, or cause of the relevant disorder with any degree of certainty has often proved difficult. Instead, the multi-factorial nature of the holistic approach I am advocating would enable the available evidence and the relevant policy factors to be considered in the round.

Under this approach, a DOTM would generally be found where meth-intoxication had triggered or exacerbated an ongoing psychotic disorder. Conversely, a DOTM would not usually be found where psychosis was present during intoxication alone, or during a "flashback". Moreover, when the cause of a psychotic episode, or the likelihood of its recurrence were unclear, the weighting given to various policy factors in the DOTM inquiry could reflect that. The holistic approach is flexible in this fashion, thereby ensuring the appropriate determination is made, and that injustices are avoided that can follow from the application of rigid categories to all cases. Finally, the holistic approach ensures that the policy reasoning is made explicit in these difficult cases. This will enhance public understanding of the legal approach taken to meth-related psychosis, and provide greater clarity in the law.

The holistic approach could be applied to other cases where insanity is in issue, apart from those involving meth-related psychosis. The same policy factors would be relevant, even if the weight attached to them might differ. In this manner, the holistic approach could provide an all-encompassing methodology for the DOTM inquiry. It should therefore be adopted by NZ courts as the preferred approach to identification of a DOTM. It provides the necessary flexibility within clear parameters, while ensuring transparency in decision making. Further, taking a single approach to this inquiry would ensure a measure of judicial consistency, and would prevent judges from

picking and choosing between the available approaches without articulating their reasons. It would improve the currently confused and piecemeal state of the law, leaving the courts with a clear, principled, and effective approach to identifying all forms of DOTM.

Bibliography:

Primary Sources

Legislation: NZ

Crimes Act 1961.

Criminal Procedure (Mentally Impaired Persons) Act 2003.

Mental Health (Compulsory Assessment and Treatment) Act 1992.

Sentencing Act 2002.

Legislation: Canada

Criminal Code RSC 1985 c C-46.

Cases: NZ

Erricson v Police (1993) 10 CRNZ 110 (HC).

Police v Bannin [1991] 2 NZLR 237 (HC).

R v Bayford HC Palmerston North CRI 2004-254-97, 9 December 2004.

R v Cottle [1958] NZLR 999 (CA).

R v Dixon [2007] NZCA 398; [2008] 2 NZLR 617 (CA).

R v Edwards [2007] NZCA 382.

R v Grice [1975] 1 NZLR 760 (CA).

R v Kamipeli [1975] 2 NZLR 610 (CA).

R v McAllister (1984) 1 CRNZ 248 (CA).

R v Macmillan [1966] NZLR 616 (CA).

R v Nilsson CA 552/99 27 July 2000.

R v Roulston [1976] 2 NZLR 644 (CA).

R v Wright [2001] 3 NZLR 22 (CA).

R v Yesler [2007] 1 NZLR 240 (HC).

Simms v Police HC Wellington AP 8-97, 27 March 1997.

Cases: Australia

Cooper v McKenna; ex parte Cooper [1960] Qd R 406 (SC).

R *v Bedelph* [1980] Tas R 23 (CCA).

R *v Carter* [1959] VR 105 (SC).

R *v Falconer* (1990) 171 CLR 130 (HCA).

R *v Martin (No 1)* (2005) 159 A Crim R 314 (VSC).

R *v Meddings* [1966] VR 306 (SC).

R *v Porter* (1933) 55 CLR 182 (HCA).

R *v Radford* (1985) 42 SASR 266 (SC).

Cases: Canada

R *v Bergamin* (1996) 3 CR (5th) 140 (Alta CA).

R *v Fontaine* 2004 SCC 27; [2004] 1 SCR 702.

R *v Macdonald* (1976) 29 CCC (2d) 257 (SCC).

R *v McQuarrie* (1998) 127 CCC (3d) 282 (Alta CA).

R *v More* [1963] SCR 522 (SCC).

R *v Parks* 15 C.R. (4th) 289 (SCC).

R *v Rabey* [1980] 2 SCR 513 (SCC).

R *v Stone* [1999] 2 SCR 290 (SCC).

R *v Swain* (1991) 5 CR (4th) 253 (SCC).

Cases: England

Attorney-General for Northern Ireland v Gallagher [1963] AC 349 (HL).

Attorney-General's Reference (No 3 of 1998) [1999] 3 All ER 40 (CA).

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

Director of Public Prosecutions v Beard [1920] AC 479 (HL).

Director of Public Prosecutions v Majewski [1977] AC 443 (HL).

R v Bailey [1983] EWCA Crim 2.

R v Burgess [1991] 2 QB 92 (CA).

R v Hennessy [1989] 1 WLR 287 (CA).

R v Kingston [1995] 2 AC 355 (HL).

R v Lipman [1970] 1 QB 152 (CA).

R v Quick [1973] 1 QB 910 (CA).

R v Sheehan [1975] 1 WLR 739 (CA).

R v Sullivan [1984] AC 156 (HL).

R v Tolson (1889) 23 QBD 168 (CA).

Woolmington v Director of Public Prosecutions [1935] AC 462 (HL).

Cases: International

Winterwerp v The Netherlands (1979) 2 EHRR 387 (ECHR).

Law Commission Reports

United Kingdom Law Commission Intoxication and Criminal Liability (UKLC R314 2009).

Secondary Sources

Books

American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR* (4th ed Text Revision American Psychiatric Association Washington DC 2000).

Brookbanks, W. and Simpson, S. (eds) *Psychiatry and the Law* (LexisNexis Wellington 2007).

Card, R. *Card, Cross and Jones Criminal Law* (17th ed Oxford University Press Oxford 2006).

Fletcher, G. *Basic Concepts of Criminal Law* (Oxford University Press New York 1998).

Jefferson, M. *Criminal Law* (5th ed Longman Harlow England 2001).

Ormerod, D. *Smith and Hogan Criminal Law* (12th ed Oxford University Press Oxford 2008).

Simester, A. and Sullivan, G. *Criminal Law: Theory and Doctrine* (3rd ed Portland Oxford 2007).

Stuart, D. *Canadian Criminal Law: A Treatise* (4th ed Carswell Scarborough Ontario 2001).

Williams, G. *Textbook of Criminal Law* (Stevens London 1978).

Journal articles

Buxton, J. and Dove, N. "The burden and management of crystal meth use" (2008) 178 CMAJ 1537-1539.

Darke, S., Kaye, S., McKetin, R. and Duflou, J. "Major physical and psychological harms of methamphetamine use" (2008) 17 Drug and Alcohol Review 253-262.

Dore, G. and Sweeting, M. "Drug-induced psychosis associated with crystalline methamphetamine" (2006) 14 Australasian Psychiatry 86-89.

Flaum, M. and Schultz, S. "When does amphetamine-induced psychosis become schizophrenia?" (1996) 153 The American Journal of Psychiatry 812-815.

Hall, W., Hando, J., Darke, S. and Ross, J. "Psychological morbidity and route of administration among amphetamine users in Sydney, Australia" (1996) 91 Addiction 81-87.

Livingston, J. and Verdun-Jones, S. "Sidebar Psychology: Discussing and Challenging the Defence of Psychological Blow Automatism" (2002) 47 Crim LQ 79-110.

Luther, G. and Mela, M. "The Top Ten Issues in Law and Psychiatry" (2006) 69 SASKLRev 401-440.

Mackay, R. and Mitchell, B. "Sleepwalking, Automatism and Insanity" [2006] Crim LR 901-905.

McSherry, B. "*R v Stone* [1999] 2 SCR 290: Case Commentary" (2000) 7 Psychiatry Psychol. & L 279-283.

Mathias, S., Lubman, D. and Hides, L. "Substance-Induced Psychosis: A Diagnostic Conundrum" (2008) 69:3 J Clin Psychiatry 358-367.

Meredith, C., Jaffe, C., Ang-Lee, K. and Saxon, A. "Implications of Chronic Methamphetamine Use: A Literature Review" (2005) 13 Harv Rev Psychiatry 142-154.

Paciocco, D. "Death by Stone-ing: The Demise of the Defence of Simple Automatism" (1999) 26 CR (5th) 273-285.

Yeo, S. "Clarifying Automatism" (2002) 25 Int J of Law Psychiatry 445-458.

McKetin, R., McLaren, J., Lubman, D. and Hides, L. "The prevalence of psychotic symptoms

among methamphetamine users" (2006) 101 Addiction 1473-1478.

Yui, K., Ishiguro, T., Goto, K. and Ikemoto, S. "Precipitating factors in spontaneous recurrence of methamphetamine psychosis" (1997) 134 Pharmacology 303-308.

Looseleafs

Robertson, B. (ed) *Adams on Criminal Law* (online looseleaf ed) (accessed 3 March 2009).

Other

Department of Corrections "Annual Report: 1 July 2007-30 June 2008" (2008) Department of Corrections www.corrections.govt.nz (accessed on 19 September 2009).

Lee, N., Johns, L., Jenkinson, R., Johnston, J., Connolly, K., Hall, K. and Cash, R. "Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 14: Methamphetamine dependence and treatment" (2007) Turning Point Alcohol and Drug Centre Inc Fitzroy Victoria www.health.vic.gov.au (accessed on 10 June 2009).

Tapsell, R. "Forensic Psychiatry and the Law: A Judicial Update" (Paper presented at Institute of Judicial Studies High Court Update, Mental Health Issues, Wellington/Auckland, November 2005).

United Nations Office on Drugs and Crime "World Drug Report 2009" (2009) United Nations Office on Drugs and Crime www.unodc.org (accessed on 10 June 2009).

Wilkins, C., Griffiths, R. and Sweetsur, P. "Recent Trends in Illegal Drug Use in New Zealand, 2006-2008: Findings from the Illicit Drug Monitoring System (IDMS)" (2009) Centre for Social and Health Outcomes Research and Evaluation, Massey University www.shore.ac.nz (accessed on 10 June 2009).