NAME OF APPLICANT SUPPRESSED.

IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY

CIV 2009-485-541

IN THE MATTER OF	the Intellectual Disability (Compulsary Care and Rehabilitation) Act 2003
BETWEEN	V M Appellant
AND	RIDCA CENTRAL (REGIONAL INTELLECTUAL DISABILITY CARE AGENCY) Respondent

Hearing: 22-23 September 2009

Counsel: A J Douglass and J McHerron for Appellant
D La Hood for Respondent
L Hansen and M Coleman for Attorney-General as intervenor

Judgment: 8 December 2009

JUDGMENT OF SIMON FRANCE J

Table of Contents

Introduction

[1] VM is presently detained under a compulsory care order. In February of this year the order was extended for one year pursuant to s 85 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 ("the Act"). This case involves a challenge to the February decision. It puts in issue what criteria are relevant to the exercise of the power contained in s 85 for the Family Court to extend the initial care order, for either a further finite period or perhaps indefinitely.

[2] The appellant's appeal has two components. First, there is an argument that the Act has been wrongly understood to provide for only two types of compulsory care order – a secure care order or a supervised care order. The appellant contends that there is a third, hitherto unrecognised, option. When the Family Court extended

the order for another year, it considered there were only two options and so the decision is flawed.

[3] Second, it is said that the Court considered the wrong factors when deciding the application for an extension. The Attorney-General's position is that the only criterion is that VM must continue to pose a risk to herself or others. The appellant submits that other factors are relevant. Particularly, though, that it is necessary to have regard to the nature of the offence that initiated the process, and what was the maximum period of detention that might have arisen from that offending. Supplementary points concern arguments about discrimination, proportionality and the United Nations Convention on the Rights of Persons with Disabilities.

Facts

[4] VM was charged with possession of a knife in a public place. That offence carries a maximum penalty of three months' imprisonment. She was found unfit to plead, this being the second time in her life such an assessment has been reached.

[5] Pursuant to s 25 of the Criminal Procedure (Mentally Impaired Persons) Act 2003, the Court ordered that VM be detained under the Act as a care recipient (with supervised care). The order was for two years, and ran from 20 December 2005. Since then she has remained in care at various residential facilities in the Wellington area.

[6] A first renewal was sought in November 2007, although not confirmed until 29 February 2008; the application had the effect of extending the existing order until determined. Judge Ellis, who had not made the initial order but had granted the first extension, granted a second renewal in February of this year. As at the time of the appeal hearing, VM had therefore been a compulsory care recipient for over three and a quarter years. The February 2009 extension followed extensive reports, and the hearing of considerable oral evidence.

[7] VM has an IQ of 58, and is regarded as posing risks of self harm, and harm to others. The primary evidence before the Court was provided by Dr Barry-Walsh.

The following passages from the judgment under appeal identify well the issues and risks VM is seen to present:

> [25] Dr Barry-Walsh summarised VAM's risk issues under three general headings. There is a particular and substantial risk arising from her proclivity for developing intense attachments with potential for both concern and harm for the object of attachment. Secondly there is a history of impulsive acts of aggression the source of which is not well understood but which has been substantially reduced by the environmental factors of her current placement. Finally VAM appears to represent a significant risk to herself through her impulsive tendency to abscond and walk long distances often with little regard for traffic or her personal safety.
>
> [26] Dr Barry-Walsh reported on previous efforts to assist and manage VAM by means of a personal order under the Protection of Personal and Property Rights Act 1988 ("PPPR") which were unsuccessful primarily because of her frequent abscondings.
>
> [27] He summarised his conclusions as follows:
>
> > Consistently people have reported that VAM is a complex individual and my own assessment would echo these opinions. It is difficult to make a decent understanding both of VAM's motivations and of her underlying mental health problems as well as other aspects of her personality functioning. In light of this and given the evidence of persisting incidents that although less in severity have continued with a concerning degree of frequency, and noting the failure of previously less coercive attempts to manage VAM in the community, it is my opinion that the only reasonable clinical option for VAM is to seek a further extension of her care order subject to the IDCCR Act.

[8] By way of background I interpolate that the reference to intense attachments illustrates the complexities of these matters. Although the offence with which VM was charged on its face appears relatively minor – possessing a knife in a public place – the context was that VM had formed an intense attachment to one of her health care providers. When VM was found with the knife, she was on that person's property at their house. It seemed VM believed that the health care provider had not been giving VM enough attention. The seriousness of the situation was undoubtedly greater than that represented by the charge.

[9] Returning to the evidence, the care manager testified VM posed on-going issues although there was improvement. His assessment was that VM could not manage on her own in an unsupported flatting situation. She would need close support:

> from caregivers who understand and have expertise in relation to her clinical and emotional issues as well as her personal and housing needs. (Judgment, paragraph [28])

[10] At the time of the hearing VM was living in a house with two others. Rostered to the house were two full time care-givers who provided supervision and assistance. One day a week the focus was on VM being self-sufficient within her flat and her care-giver testified she had been managing that for some time. VM was able to make unaccompanied trips to a nearby village, and also went on escorted trips into the community.

[11] The primary concern remained her ability to cope if she formed an attachment to a person. At that point her focus was seen as being very single minded on that attachment to the detriment of maintaining other skills and capacities.

Further evidence

[12] On the appeal further evidence was provided. I remain uncertain as to its purpose in terms of an appeal, but it was admitted by consent and I outline it.

[13] First, there is updated information on VM. She was to be moved in late September to a different facility which had an emphasis on preparing people for returning to the mainstream community. Orally I was advised that, subject to a further renewal application being made and granted, it was hoped that VM might be recommended for removal from compulsory care by next June.

[14] The main fresh evidence was a report from a consultant psychiatrist, Dr Duff. At the appellant's request Dr Duff had reviewed VM's file, and the various reports and assessments associated with it. She had not herself interviewed or assessed VM. As far as I understand, the appellant relies on Dr Duff's assessment for the proposition that there may be an issue as to whether VM also suffers from a mental illness. In evidence before the lower Court Dr Barry-Walsh was firm in his view VM did not have a mental illness. Dr Duff appears to consider there is enough for an assessment to be undertaken pursuant to the Mental Health (Compulsory Assessment and Treatment) Act 1992.

[15] Dr Duff appears critical of some of the medication VM is receiving and queries the existence of informed consent in relation to the medication. She recommends a second opinion be obtained under s 62(3)(c) of the Act. Finally, Dr Duff expressed concern over the lack of clear pathways and markers as to how VM can establish that she no longer needs care.

A preliminary point

[16] In his ruling of 27 February 2009, the Judge noted that he had been alerted to an error in the documentation surrounding the original order. Briefly, the paperwork was consistent with a person who had been found not guilty by reason of insanity. The Judge obtained the original file and reviewed all the material, which is described in his judgment. His Honour concluded that committal had wrongly occurred but the error was of no effect for reasons explained.

[17] At the outset of this hearing I inquired whether any issue was taken with this part of the judgment, and was advised none was. Accordingly, the case proceeds on the basis that VM was made subject to a compulsory care order involving supervised care for a period of two years from 20 December 2005. The order was made because VM was found unfit to stand trial, and the Court was satisfied to the appropriate standard that VM caused the act which was the formal basis of the charge. (VM was legally represented at the time and this aspect was conceded by then counsel.)

How the Intellectual Disability (Care and Rehabilitation) Act 2003 works

[18] Mr Lester Mundell is the Chief Advisor, Disability Support Services for the Ministry of Health. He filed an affidavit which provides a helpful summary of the Act and its workings.

[19] Persons suffering from intellectual disability, as defined in the Act, can come within the Act only if charged with, or convicted of, a criminal offence. Two points emerge from that proposition which need highlighting:

a) a person who is intellectually disabled but does not have a mental disorder does not fall within the mental health regime. They cannot be committed under Mental Health (Compulsory Treatment and Assessment) Act 1992;

b) a person who is intellectually disabled, but who has not been found unfit to plead or convicted of an offence, cannot come within the Intellectually Disabled (Compulsory Care and Rehabilitation) Act 2003.

[20] Put affirmatively, intellectually disabled persons can only come within a compulsory care regime if they also have a mental disorder, or if they have been charged with an offence and convicted, found unfit to plead, or found not guilty by reason of insanity.

[21] VM was found unfit to stand trial. The available options were –

a) detain her as a special care recipient. This form of compulsory care order lasts for half the maximum penalty of the charged offence. Thereafter, the person will become a care recipient for six months, subject to extension;[1]

b) make VM a care recipient subject to a compulsory care order for either secure care or supervised care. These orders can be for up to three years and thereafter can be extended;

c) make no order.

[22] Had VM been convicted of the offence, the options would have been –

a) sentence her in the normal way;

b) sentence her, and also make her a special care recipient;

---

[1] The issues in this case do not touch on special care recipients, so that category is not considered further.

c) not sentence her but make a compulsory care order, again at one of the two levels of secure or supervised care.

[23] It was noted earlier that a compulsory care order will be for either secure care or supervised care. An issue in this case is whether there is a third type of order, but assuming for the moment there are only the two, it is convenient to set out the practical characteristics of each.

[24] Secure care is provided in a hospital or a community facility. Supervised care is provided in a community facility. Mr Mundell provided an overview of what each entails (I focus particularly on the security aspects):

1. Secure care in a hospital. This will have 24 hour rostered staffing. There will be a capacity to provide a 2:1 escort when needed, and 24 hours' capacity to implement plans and account for the person's whereabouts. The facility is designed to be secure so rules attach to the design of windows, doors etc. There will be CCTV, entry and access security, and the ability for staff to observe and interact at all times. The Ministry has 21 secure hospital beds spread across Auckland and Wellington. It can also purchase more availability in the Waikato, Christchurch and Otago regions.

2. Secure care in a community facility. There is broad similarity in the staffing arrangements to that which applies to hospital care, although the night time staff are described as "awake staff". I infer this is more in the role of watching, providing security at the door etc rather than more active care. Unlike the hospital setting there is no planned seclusion option or facility. The community facility will have an enclosed courtyard whereas the hospital equivalent is described as an internal courtyard. The hospital perimeter is described as secure; the community facility has a perimeter fence to the height allowed by planning laws. Whereas a hospital obviously will have predominantly professional nursing and medical care staff, the

community facility is staffed primarily by "non professional Community Based rostered staff".

3. Supervised care in a community facility. This facility is described as having "the ability to have wake night staff". The entrances and exits are monitorable, there are outdoor spaces, it will be fenced and there may be a locked gate. It is plainly a much lower level of control and security. Care is provided by Community Based staffing.

[25] The Ministry of Health has responsibility for administering the Act. It has established Regional Care Agencies and Regional Support Accommodation Services. The Regional Care Agencies are contracted to meet the Ministry's obligations under the Act. In addition, however, they provide services to "civil" clients who have been assessed as needing such services. Obviously, from what was said earlier, these persons participate on a voluntary basis. Likewise, the Supported Accommodation Services can provide their services to civil clients, many of whom will be former care recipients.

[26] As at the time of the affidavit:

a) 124 persons were subject to compulsory care orders. 51 of those orders were for secure care;

b) 155 civil clients were receiving services;

c) 40 care recipients had had their orders extended, and 10 on more than one occasion.

Against that background I turn to the issues raised on the appeal.

Issue one – a third type of compulsory care order?

Introduction

[27] As noted, the usual understanding of the Act has been that it provides for two types of compulsory care order – secure care and supervised care. Section 85 can be used to illustrate a source of the usual understanding. It provides:

> **85 Extension of compulsory care order**
>
> (1) The Family Court may, on the application of the co-ordinator, extend the term of a care recipient's compulsory care order.
>
> (2) If the Court extends a compulsory care order for a care recipient no longer subject to the criminal justice system, *the Court must consider and determine whether the care recipient must receive supervised care or secure care*.
>
> (3) The Court may order that a care recipient no longer subject to the criminal justice system receive secure care only if it considers that supervised care would pose a serious danger to the health or safety of the care recipient or of others.

[28] The typical inference taken from this provision is that subsection (2), in requiring a Court to choose between secure and supervised care, is setting out the only two available options. The appellant's case is that this is wrong. She says s 85(1) should be read as the basic order. Section 85(2) then represents available additional orders. Thus, under this analysis there would be three available orders:

a) compulsory care order;

b) compulsory care order involving supervised care;

c) compulsory care order involving secure care.

[29] Option a), the basic care order, is said to involve all that supervised care does, other than that there is no ability to direct where the care recipient lives.

Appellant's submissions in support

[30] The appellant wants to have the same level of care and help as she currently has, and to be required to take medicine, but not be able to be told where to live and with whom. The appellant believes that care managers are able to authorise that sort of care management arrangement.[2] The basic proposition being advanced is that if care managers can do it as part of administering the Act, the Court should be able to do it right from the outset. It should be one of the care orders available to the Court when making its initial decision.

[31] The appellant's argument from that point is essentially a defensive one. The Act is analysed to show it does not prevent such an interpretation, and alternative readings are provided for those provisions which might suggest otherwise. More affirmatively, it is noted that if the Court had a non-detention option, it would be better placed to promote an intellectually disabled person's autonomy and right to liberty.

[32] Emphasis is placed on s 3(a) of the Act. Section 3 is the Purposes section, and (a) states a purpose of the Act to be:

> to provide courts with appropriate compulsory care and rehabilitation options for persons who have an intellectual disability and who are charged with, or convicted of, an offence; and

[33] An example of the "alternative reading" approach of the appellant is provided by the appellant's treatment of s 4 of the Act. That section is called an Outline, and provides an overview of the scheme of the Act. One part of s 4 provides:

> Persons subject to this Act are known as care recipients. Care recipients who are special care recipients must receive secure care, while other care recipients may be eligible for supervised care, that is care that may be given in a place other than a secure facility.

---

[2] The respondent and intervenor dispute that care managers have this power. The relevant provisions can be read either way. It is not an issue I need to resolve for the purposes of this judgment.

[34] The appellant submits that provision can be read to isolate out the fact that care recipients "may" be eligible for supervised care. It is suggested the use of "may" means they may also be eligible for a level of care less than that.

Decision on issue one

[35] At the oral hearing I indicated a lack of enthusiasm for this ground of appeal. Further reflection on the statutory provisions has only reinforced that. The concepts of secure care and supervised care can be found right throughout the Act. The role of many of the definitions and provisions is to establish the conditions and characteristics of "secure care". What is plain is that their point is to establish a contrast with the less rigorous conditions that attach to supervised care.

[36] Whenever a Court is deciding whether to make an order, or to extend an initial order, there is a provision such as s 85(3) which says:

> The Court may order that a care recipient no longer subject to the criminal justice system receive secure care only if it considers that supervised care would pose a serious danger to the health or safety of the care recipient or of others.

[37] The pattern discussed earlier is apparent. Secure care is only to be ordered if serious dangers to health and safety exist. If not? The answer is found in s 85(2):

> If the Court extends a compulsory care order for a care recipient no longer subject to the criminal justice system, *the Court must consider and determine whether the care recipient must receive supervised care or secure care*.

[38] That subsection requires the Court to choose between secure and supervised, and subsection (3) sets out the test for governing that choice. The appellant's argument is to suggest subsection (2) could be read as if it said:

> supervised care or secure care or neither.

[39] That reading is untenable. It is notable that the Act provides no guidance as to how one would choose between supervised care and whatever this third option is called. It provides no criteria because the choice does not exist.

[40] Similarly, I set out earlier the extract from s 4, and how the appellant would have it read. It is, however, a strained reading at best. The more obvious reading is special care recipients must have secure care; other care recipients may be eligible for supervised care but if not, they too will receive secure care.

[41] Elsewhere in the Act there is a description of the power to control where people live. The only options discussed in this context are secure care and supervised care. More examples of the legislative scheme could be given, but they would only make the same point.

[42] I do not accept that there is a tenable argument that a third care option exists once an order is made. I add that last qualification because it should not be forgotten that at the time of making the order the Court does have a non-detention option. It is open at that stage to make no order at all. Once the decision is made to make the person a care recipient, the only options are secure care or supervised care.

[43] This ground of appeal fails.

Issue two – criteria governing exercise of renewal power

Judgment under appeal

[44] In his judgment, Judge Ellis set out a number of concerns that are often raised by care recipients, or by the District Inspectors, or by counsel. I cannot put these better than his Honour did, so I consider it appropriate to set out a much longer than usual extract from the ruling under appeal:

> [44] In my judgment of 6 March 2008 I noted that s 85 gives no guidance as to the considerations and factors to be taken into account by the Court on an application for extension. I approached the matter therefore by considering the matters on which the Court would need to be satisfied on an originating application for the making of a Compulsory Care Order in respect of the person. I concluded that if the application then before me had been for an originating application I was satisfied that all the necessary criteria would be met for the making of an order and was thus satisfied that the existing order ought to be extended.

[45] I am not persuaded that such an approach was wrong in principle and no other principled approach has been suggested.

[46] I do however acknowledge the concerns expressed by counsel for the care recipient and by the District Inspector that, if the simple logic of my 6 March 2008 decision is followed, then it is virtually inevitable that orders for persons such as VAM may be perpetually extended. Neither counsel nor the District Inspector believed this was within the spirit or intent of the IDCCR Act.

[47] It has become apparent on this and other similar applications for extension of Compulsory Care Orders that the limitation of compulsory care for the intellectually disabled to those who have been charged with or convicted of an imprisonable offence has had unfortunate and likely unforeseen consequences.

[48] Although the review of Compulsory Care Orders (and care and rehabilitation plans) is done by the Family Court, the care recipients are *"selected"* through the gateway of their experience of the criminal justice system. Many of them, such as VAM, might have a considerable history of impulsive, aggressive, even violent behaviour which has been dealt with in the past otherwise than by bringing them before a Criminal Court.

[49] Now a person such as VAM has found herself arrested and charged with a specific criminal offence and as a result has been made subject to a process of what is effectively compulsory detention and significant restrictions of her individual liberty which are potentially of indefinite duration.

[50] In VAM's case the offence with which she was charged was under s 13A Summary Offences Act 1981 for possession of a knife without reasonable excuse in a public place. The maximum penalty on conviction for that offence is a term of imprisonment not exceeding three months or a fine not exceeding $2,000.00.

[51] Had VAM not been found unfit to stand trial then the Court would have had the sentencing, detention, treatment and/or care options available as provided by s 34 CPMIP Act. Because VAM was found "unfit to stand trial" (even though the charge was of a summary offence not carrying the right of election of trial) the disposition options open to the Court were covered by ss 24 and 25 CPMIP Act.

[52] If VAM had been considered a high risk in need of secure care then the option would have been for s 24(2)(b) that she be *"detained"* in a secure facility as a special care recipient. In that case s 30 CPMIP Act would apply to limit the period under which she could be *"detained"* under s 24 to a period equal to half the maximum term of imprisonment to which she would have been liable if she had been convicted of the offence charged.

[53] All of that seems improbable in VAM's case but it illustrates the point that the maximum period of *"detention"* which could have been imposed even had VAM been convicted on the offence for which she was charged would have been six weeks. These provisions also underline the connections between the compulsory care and criminal justice systems,

leading to an expectation on the part of care recipients of specific and finite outcomes consistent with ordinary sentencing principles.

[54] Any other offender in the community not suffering a mental impairment who had been convicted of a similar offence would, after serving their maximum sentence (subject to parole) be free to return to the community irrespective of their criminal history or risk of violence. Clearly, a person in VAM's circumstances would not have been sentenced to imprisonment at all on such a charge but would realistically have faced a 'sentence' of community work or a short term of supervision.

[55] A strong theme which arises in many if not all of these cases is that the care recipients who have come through the Court system have a clear understanding that the Compulsory Care Order is a form of punishment or consequence – a "sentence" - for their wrongdoing which is expected to be finite in duration.

[56] Repeatedly at such hearings on applications for extension of Compulsory Care Order the Court is told by or on behalf of the care recipients – as the Court was told by VAM - that they believe they have *"done their time"* and that it is unfair for their *"detention"* to be extended. That sense of unfairness must be increased when so much of the other evidence emphasises the care recipients good behaviour and positive progress.

[57] Looking at the same issue from the other side, clinicians and specialist assessors regularly tell the Court that the hearing process on applications for extension of orders is disruptive and may have a negative impact on the rehabilitation of the care recipient. The Court is told that many care recipients, knowing the term of the Compulsory Order, will accept and submit to the restrictions imposed on them and can be productively engaged in programmes and educational opportunities offered. The process of application for extension, the business of consultation with lawyers and focussing on hearing dates, can become all consuming causing confusion and distress and is almost always a distraction preventing the care recipient from engaging constructively in other activities.

[58] Coming from that point of view clinicians will often ask for the maximum period of extension available (three years) believing it to be in the best interests of the care recipient to maximise the opportunities for rehabilitation and minimise the disruption of legal processes.

[59] Not surprisingly, counsel for care recipients firmly oppose such an approach.

[45] Of VM herself, the Judge observed:

[65] VAM does therefore meet the criteria – and is always likely to meet the criteria – for the making of a Compulsory Care Order through the Family Court. Such an order could not have been made against her unless she had been charged with an offence, but since such a charge was laid (however minor) she is in 'the system".

[46] His Honour's assessment was that, although VM had improved in some areas, there was still a need for a care order. The judgment concluded:

> [77] I acknowledge again the concerns of counsel that my approach effectively lays the foundation for a permanency of compulsory care for VAM, and others in her situation. That is a justifiable concern that would appear to require a more far reaching review of the policy and underpinning principals of the legislation. As I indicated to counsel at this hearing, I would be happy to see the issues considered by the appellate court.

Appellant's submissions

[47] The appellant's submission is that it is disproportionate for VM to be still subject to a care order when she was originally charged with an offence carrying a maximum penalty of three months' imprisonment. The disproportionality argument is buttressed by a submission that it is also discriminatory since other people who pose risks are not subject to the same controls. In the context of discrimination reliance is placed on the United Nations Convention on the Rights of Persons with Disabilities.

[48] In relation to the disproportionality argument, the appellant relies on New Zealand authority which has applied this well known sentencing principle to the initial decision of whether to make an order. The appellant submits the principle is equally applicable to the decision whether to extend orders.

[49] Concerning discrimination, the comparator groups on which the appellant most focuses are intellectually disabled persons who have not offended, and those with mental disorders who come under the complementary mental health regime. The appellant's submission is that both are better treated than the intellectually disabled offender.

[50] The appellant disputes the Attorney-General's position that on-going risk is the sole determinant. It is submitted that such a position is inconsistent both with the Act's focus on care and rehabilitation, and the legislative history.

[51] In relation to legislative history, the appellant notes that at the time when there was to be a civil commitment route for intellectually disabled persons, the test

for making an order clearly focussed on dangers to the public and to self. However, the legislature moved away from that. It abandoned a civil commitment process, it changed the emphasis to care and rehabilitation, and the focus on safety was so downplayed that the word risk now hardly appears in the Act at all. Against that background it is submitted the Attorney-General's focus is unsupportable.

[52] A final feature of the submission that I need to record is the emphasis given to arbitrary detention. To a large extent the proposition that VM's detention is arbitrary is a conclusion reached from the existence of these other factors, rather than from consideration of what amounts to arbitrariness. However, other matters that are touched on as supporting the claim are the inadequate nature of the guidelines produced to assist the specialist assessors, a claim that VM may not be giving informed consent to her medication, and a claim that VM might have a mental disorder and should have been assessed under the mental health legislation.

[53] Because I do not address these in the primary discussion, I briefly record that I do not consider there is an evidential base for the informed consent claim. It is sourced in Dr Duff's affidavit but she has not spoken to VM, and nor was the matter raised before the Family Court. Concerning mental disorder, there is a consistent stream of contrary expert opinion to that of Dr Duff. That is not to say who is correct, but to observe it has been considered, and there have been assessment routes open to VM and her counsel that could have been pursued. Although not to minimise the importance of those aspects, I was also not satisfied that either claim, if established, would have made VM's detention arbitrary.

Attorney-General's submissions

[54] The Attorney-General as intervener accepted the burden of meeting the appellant's submissions in this context. As earlier noted, the Attorney-General submits the only justification for on-going detention can be risk to safety. Further, however, it is submitted that the existence of risk justifies on-going detention without reference to any other factors such as the original offending or the length of detention.

[55] The Attorney-General submits that the statutory scheme supports this emphasis on risk to safety. Reliance is placed on s 37(1) of the Act which sets out the obligations on the specialist assessor at the time the order is first being considered:

> **37 Assessment examination**
>
> (1) The specialist assessor or assessors designated under section 32(b) must conduct an assessment examination—
>
> (a) to ascertain whether the proposed care recipient has an intellectual disability and is in need of compulsory care; and
>
> (b) if that is the case, to assess the level of care that is required to manage the risk that the proposed care recipient's behaviour poses to the health and safety of the proposed care recipient or of others. (emphasis added)

[56] It is also noted that the hierarchy of options available to the Court when making an order reflects the same focus, since risk is the primary determinant of which level of care order is chosen. The same choice and criteria are reflected in the extension power, s 85.

[57] Finally, it is noted that s 11 of the Act says that any exercise of powers under the Act shall be guided by the principle that a care recipient be treated so as to protect:

> a) the health and safety of the care recipients and others;
>
> b) the rights of the care recipient.

[58] It is submitted that these two s 11 criteria are important in their focus. They can be, and are, given effect to by the State maintaining the capacity to detain the care recipient only when the care recipient presents a degree of risk that makes detention necessary. That approach is submitted to represent the best balancing of the person's rights and the community's safety. For that reason the Attorney-General submits that if the only risk is of self-harm, then autonomy means a higher threshold is appropriate before detaining.

[59] The second part of the Attorney-General's submission is that this statutory scheme is wholly consistent with human rights principles. In broad terms it is submitted that as long as the threshold remains need based on risk, any extension will not result in arbitrary detention and will be proportionate to the risk posed, which is the correct focus. It is submitted the seriousness of the original offending is irrelevant (other than that it may inform the risk assessment). It is submitted that it is not enough that it would be good for the person to be treated; that does not justify detention and it is the risk criterion that ensures compatibility with human rights norms.

[60] The Attorney-General submits any consideration of human rights principles should occur against the background of the whole legislative scheme. In this regard the Attorney-General emphasises the safeguards that are built into the system: the Act sets out care recipients' rights; there is a need for Court review after the first six months, and internal review every six months; orders can only initially be for three years; the Family Court has control of extensions; there are review and inspection functions for both district inspectors and the High Court; and persons can be released by order of the Court any time within the currency of an order. (It is noted that whilst under the mental health legislation a compulsory treatment order can be only initially for six months, as opposed to three years under the intellectual disability scheme, and is subject to only two six month extensions, the second of these extensions becomes indefinite unless cancelled.)

[61] Turning to the principles relied on by the appellant, it is submitted that protection of the public by detention of the dangerous has long been recognised as legitimate State conduct, so long as it is visited with the appropriate safeguards such as regular review. These reviews ensure that the compelling reasons for detention persist. If they do, the possibility under the Act of perpetual renewals under s 85 does not raise an issue of arbitrariness, because the scheme has in-built continual reviews and assessments of necessity.

[62] Detailed submissions are addressed to the issues of proportionality and discrimination. Concerning proportionality, it is submitted that this is a sentencing principle and is not to be applied to a decision about whether to extend a treatment

order. The purposes of each situation are wholly different – one is about punishment, the other is about treatment and care.

[63] In relation to discrimination, the Attorney-General disputes that the groups relied on by the appellant are valid comparators. Further, it is impermissible to select parts of a legislative scheme as the basis for a discrimination claim. One must compare the whole of the two schemes. It is submitted that the scheme is not discriminatory, and that the safeguards earlier identified ensure compliance with all human rights requirements.

The respondent's submissions

[64] The focus of the Regional Intellectual Disability Care Agency was on the particular case. It was appropriate to allow the Attorney-General to address what were largely criticisms of the legislation. The Agency's position is that the evidence is compelling that VM needs continuing care. I will consider this in the last section of the judgment.

Relevant factors when deciding a s 85 application

Risk

[65] In my view there is no question that any applicant for an extension must demonstrate that the care recipient continues to pose a level of risk that merits ongoing coercive powers. It has never been enough that objectively it would be good for the person to remain subject to a care order.

[66] The centrality of risk is obvious in the Act, albeit that the actual word "risk" is used very little. For example, when making the original order, the Court is required to determine the level of care. That is a decision not based on an assessment of the recipient's personal needs but on an assessment of the level of risk that they pose either to themselves or others.

[67] Likewise, s 11 is important. Whilst one should not overlook or minimise the repeated emphasis elsewhere throughout the Act on care and rehabilitation, the terms of s 11 merit repetition:

> **11 Principles governing exercise of powers under this Act**
>
> Every court or person who exercises, or proposes to exercise, a power under this Act in respect of a care recipient must be guided by the principle that the care recipient should be treated so as to protect—
>
> (a) the health and safety of the care recipient and of others; and
>
> (b) the rights of the care recipient.

[68] I do not consider it either controversial, or debateable, to say that the care recipient must be assessed as presenting a degree of risk to herself or the community that justifies continued detention. If she does not, then persuasion not coercion must be used to ensure the appropriate level of care is achieved.

Other factors are also relevant

[69] The far more contentious issue is the Attorney-General's submission that static risk is sufficient on its own for continual renewals, regardless of the length of detention that might result. For example, in the passages cited earlier, Judge Ellis observed that VM's risk assessment may well remain unchanged for as long as one can foresee. If that risk justified the order in the first place, the Attorney-General's submission is that it will continue to do so until there is change. This will be so regardless of the number of renewals and irrespective of the comparatively minor offence that led to her coming under the auspices of the Act.

[70] I have come to the view that the Attorney-General's proposition must be rejected. It is inconsistent with a scheme that also emphasises rehabilitation, and in VM's case would produce a situation that is wholly disproportionate both to the circumstances that initially allowed the State to exercise coercive powers, and to the either static or diminishing risk she currently presents. In reaching that view I have not overlooked that the form of detention in issue is at the lesser end of a detention spectrum. However, the parties rightly agreed a compulsory care order was a form of detention, and I use the expression coercive powers within that context.

[71] I now proceed to develop the reasons for these conclusions.

Discrimination

[72] I do not intend to undertake a formal analysis of the discrimination claim. The reality is that Parliament has specifically legislated for care and detention of the intellectually disabled who have criminally offended. The appellant's argument is that aspects of the legislation are discriminatory vis a vis either non criminally offending intellectually disabled people, or mentally disordered people. I very much doubt a discrimination claim is valid, but anyway make the observation that the Court cannot repeal the power to extend care orders, nor is it asked to declare the provision non-compliant with the New Zealand Bill of Rights Act 1990. However, I do consider there is merit in considering how the particular extension power fits with the risk prevention options available in other situations.

[73] A group on which the appellant focussed were intellectually disabled persons who have not offended but present similar risks. They do not fall within the Act and there is no civil commitment route. As has been identified this was a deliberate policy choice by the legislature. The point of difference between the two groups is the offending, not the disability. It is the manifestation of a safety risk by criminally offending that engages the State's right to exercise coercive powers.

[74] That said, one can still reflect on the broad divide that emerges between a VM who was found in possession of a knife and a VM who was not. One has been subject to control for 3¼ years, the other could never be. Given that the choice has been made that intellectual disability plus risk cannot alone justify coercive powers (hence no civil care order route), it seems wrong to wholly ignore the circumstances that put VM under care. It would be surprising if a relatively minor offence justified <u>indefinite</u> State control, when but for that comparatively minor offence there would be no capacity at all to force care on VM.

[75] I next consider, as a comparison, the treatment of the non-disabled criminal offender who poses an on-going risk. For myself, in terms of a formal discrimination analysis, it is this group I would have been most interested in as a

comparator. Ms Coleman, who argued this aspect for the Attorney-General, contended that discrimination law did not allow you to use one part of a scheme for comparator purposes. The comparison had to be between the whole legislative treatment of the disabled offender and the whole legislative treatment of the non-disabled offender. Whilst I accept the theory of that point of view, it can become dangerous if allowed to expand the scope of any discrimination inquiry so as to overwhelm it. I accept caution is needed, but if one can validly separate out portions of a scheme, it is difficult to see that is never legitimate to then consider if that portion is discriminatory. By valid I mean that the separated portion has to not be thereby divorced from its context within the overall scheme.

[76] Returning to non-disabled offenders who pose risks, there are two groups – those who are subject to the indefinite sentences of life imprisonment and preventive detention, and those subject to finite sentences. No-one has suggested VM's circumstances would qualify her for an indefinite sentence, so she is validly compared to the offender who has received a finite sentence and who poses an on-going risk.

[77] As a society we regularly release into the community offenders who pose a known on-going risk. We do so because there is no power to do otherwise. Leaving to one side the comparatively new and rare "extended supervision order", when persons subject to a finite sentence reach full term they must be released. Conditions can be imposed for a while but they will end. If that offender has served the whole of his or her sentence they will have done so only because they were seen as posing on-going risks. If that risk continues to exist at full term, they must nevertheless be released. There is no power to apply for an extension of the sentence; no alternative order exists that would allow them to be otherwise contained for risk-prevention reasons.

[78] This reality that we release non-disabled offenders who pose known risks, probably often much greater than VM's, is in my view a powerful indicator that Parliament cannot have intended that s 85 could be used to indefinitely control an intellectually disabled offender who has only ever been assessed as needing supervised care. Because we do not detain, and indeed cannot detain, indefinitely a

dangerous offender who is subject to a finite sentence, I do not agree that s 85 contemplates that VM, if her risk remains static, might be subject to repeated extensions.

Proportionality

[79] In the preceding section I concluded that s 85 was not designed to allow for indefinite detention of someone like VM. That means that, contrary to the Attorney-General's case, static risk of the type VM represents will not justify indefinite detention. The issue which then arises is what factors assist a Court to determine whether it is time for the detention to end. This is an assessment that will be required to be made by the Court each time there is an extension application.

[80] One suggestion advanced by the appellant is proportionality. I agree with that as a general concept, but it is important to focus on what it is that the detention must be proportionate to. I begin by considering some of the cases highlighted by counsel.

[81] The Attorney-General points to decisions of the United States Supreme Court such as *Jones* v *United States* 463 US 354 (1983). There Mr Jones had been acquitted of a misdemeanour on the grounds of insanity. The maximum penalty would have been one year. After a hearing, he was ordered to be detained as a dangerous patient. After being subject to that order for one year, he brought proceedings claiming an entitlement to release. The application was based on the fact that the maximum penalty for the original offence was one year. A majority of the Court held:

> The remaining question is whether petitioner nonetheless is entitled to his release because he has been hospitalised for a period longer than he could have been incarcerated if convicted. The Due Process Clause "requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed." *Jackson* v *Indiana*, 406 U. S. 715, 738 (1972). The purpose of commitment following an insanity acquittal, like that of civil commitment, is to treat the individual's mental illness and protect him and society from his potential dangerousness. The committed acquittee is entitled to release when he has recovered his sanity or is no longer dangerous. See *O'Connor* v *Donaldson, supra*, at 575-576, pp. 73-74 (1970). And because it is impossible to predict how long it will take for any given individual to recover – or indeed whether he ever will recover – Congress has chosen, as it has with respect to civil commitment, to leave the length of commitment indeterminate, subject to periodic review of the patient's suitability for release.
>
> In light of the congressional purposes underlying commitment of insanity acquittees, we think petitioner clearly errs in contending that an acquittee's hypothetical maximum sentence provides the constitutional limit for his commitment. A particular sentence of incarceration is chosen to reflect society's view of the proper response to commission of a particular criminal offense, based on a variety of considerations such as retribution, deterrence, and rehabilitation. See, e.g., *Gregg* v *Georgia*, 428 U. S. 153, 183-186 (1976) (opinion of Stewart, POWELL, and STEVENS, JJ.); *Kennedy* v *Mendoza-Martinez*, 372 U. S. 144, 168 (1963); *Williams* v *New York*, 337 U. S. 241, 248-249 (1949). The State may punish a person convicted of a crime even if satisfied that he is unlikely to commit further crimes.
>
> Different considerations underlie commitment of an insanity acquittee. As he was not convicted, he may not be punished. His confinement rests on his continuing innless and dangerousness. Thus, under the District of Columbia statute, no matter how serious the act committed by the acquittee, he may be released within 50 days of his acquittal if he has recovered. In contrast, one who committed a less serious act may be confined for a longer period if he remains ill and dangerous. There simply is no necessary correlation between severity of the offense and length of time necessary for recovery. The length of the acquittee's hypothetical criminal sentence therefore is irrelevant to the purposes of his commitment.

[82] Consistent with this approach, the Attorney-General submits the penalty for the original offence and indeed the original offence itself, are irrelevant. The purpose of detaining a care recipient has nothing to do with punishment; the vast majority are not subject to the criminal justice system and it is inapt to take decisions about them by reference to a "maximum penalty" fixed by reference to different criteria and set for a different purpose.

[83] There is obvious analytical merit in this proposition, but as Judge Ellis observes it is a distinction that is often lost on the persons involved.

[84] As noted the appellant's position is that the original offending and the maximum penalty are relevant. Support for this can be found in decisions of our Court of Appeal. In *R* v *Elliot* [1981] 1 NZLR 295 the Court applied a proportionality assessment to the decision whether to detain Mr Elliot as a committed patient. The Court observed that to invoke the committal option:

> … without regard to the gravity of the offending is to overlook that the subject is before the Court only because he has committed an offence. Reasonable proportionality between the offending and the severe curtailment of liberty interest in an order for detention as a committed patient must not be lost. If that proportionality is not present and involuntary commitment is thought necessary the authorities should invoke the procedures under the Mental Health Act in the normal way.

[85] Mr Elliot had been convicted of assault, involving the use of a pitchfork. Mr Elliot had previous assault convictions, one of which had led to him being made a committed patient. On that occasion he remained an inpatient for five months before his release. At the time of this second committal order, the legislation set out a test that the person's mental condition "required" that he be detained in the interests of safety. The Court emphasised the use of that word. "Requires":

> is a strong word and it is used in s 395 in an imperative sense. It is not enough that the medical practitioners consider that the treatment and rehabilitation of the offender is desirable in the public interest. It is not sufficient that they consider it desirable that he should be involuntarily committed to a mental hospital. They must consider his detention to be necessary in his own interest as for the safety of the public.

[86] More recently in *R* v *Barnes* CA 69/05, 16 June 2005, the appellant successfully challenged a decision to detain him as a special patient. The Court ruled, by consent, that the underlying reports on which the sentencing Judge had acted were insufficient to confer jurisdiction to make the order. Mr Barnes had been found guilty of reckless wounding, and not by reason of insanity of possessing an offensive weapon. The facts of the offending are not disclosed. However, the Court observed:

> [13] Further, the judgment in *Elliot* refers at p 295 to the need for reasonable proportionality between the offending and the severe curtailment of liberty inherent to an order for detention. Imposition of an order under s 24 cannot be viewed as a proportional response to charges of possession of an offensive weapon, and for that reason also, the order made on sentencing was not well founded.

[87] In *R* v *P* [2008] NZCA 469, the appellant had been found unfit to stand trial and was placed under a care recipient order for two years. He had been charged with sexual violation (x2), indecent assault and doing an indecent act. The appeal concerned the length of the order, and the Judge's refusal to stay the charges he was facing.

[88] The offending in *P* involved sexual assaults on the appellant's young son. The recommendation of the care co-ordinator was for supervised care, with various other recommendations concerning counselling, access to his children and supervision made. The nature of both the care (supervised) and the term (two years) had been recommended by the specialist assessor.

[89] The Court in *P* began its decision with observations that bear similarity to the passages cited earlier from the United States Supreme Court:

> [38] We accept Mr Mount's submission that once the appellant moved from the criminal justice system to the regime under the ID(CCR) Act, the focus changed from the Sentencing Act 2002 considerations (in particular, accountability and deterrence) to a focus on health and safety and risk management: (s 11, ID(CCR) Act).
>
> [39] A five Judge bench of this Court stated in *R* v *Bridger* [2003] 1 NZLR 636 at [42]:
>
> > The law must give full weight to the principle that criminal punishment has an essentially moral base and lesser moral fault requires recognition.
>
> [40] The same principle applies to the process of criminal trial. Samuel Butler's satire *Erewhon* supplies a thought-provoking study of the problem of disassociating the principle of individual responsibility from criminal punishment. In Butler's utopia, people are punished for misfortune and disease, while murder is an affliction for which the offender is treated. Parliament has responded to the problem explored in Butler's novel by differentiating as far as practicable between the categories of criminal offender and, as relevant to the present case, of persons under intellectual disability whose conduct has been anti-social but who lack the mens rea which is an essential element of a criminal offence.
>
> [41] The jurisdiction under s 23 of the CP(MIP) Act for the Court to order inquiries terminates once a finding of unfitness to stand trial has been made. Once a care recipient has come within the ID(CCR) Act he or she falls within a different regime reflected in oversight by the Family Court (ss 45 – 46). That is so despite the fact that where a prisoner charged or convicted of an offence is also a care recipient that does not of itself prevent the operation of criminal processes (s 36).

[90] These cases can be brought together to provide guidance on the exercise of the s 85 power. As emphasised in *Jones* and *P*, the rationale of care orders has nothing to do with punishment. They are about care, treatment, and realistically the controlling of risks. That different focus tells against any specific focussing on the actual maximum penalty of the original offence.

[91] There are several reasons why this must be so. First, the maximum penalty is dictated by totally different comparative punishment considerations. Second, if there were some sort of mathematical exercise, it would effectively have prevented any order being made in relation to VM since the maximum penalty was three months. Third, as is the case with VM, the actual charge let alone the maximum penalty may be quite misleading in terms of the circumstances and context of the offending.

[92] However, although the specific maximum penalty is not a factor, I consider the general seriousness of the original offending, and what charge the circumstances could have supported, are relevant. The points made in *Elliott* hold true. An intellectually disabled person can only be subjected to State control because they have offended. Although thereafter the purposes of detention move away from criminal justice concepts such as punishment, one should not ignore altogether that it is the offending that separated the care recipient from other intellectually disabled persons who present risks. Accordingly, I consider in a broad sense that there should be maintained proportionality or focus on what brought the care recipient within the system. The less serious the original offending, the less one would normally expect extended periods of detention.

Care and rehabilitation

[93] In an article written when the Act was a Bill, but largely in its enacted form, Professor Brookbanks observed:[3]

> Clearly, there is the danger that legislation of this type will be used for purely preventive purposes, regardless of its potential for therapeutic benefit.

---

[3] "New Zealand's Intellectual Disability (Compulsory Care) Legislation" in K. Diesfel and I. Freckelton (eds) *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Commitment* (Ashgate, Portmouth, 2003) 533.

> Such an attitude should be resisted. The "care" aspect of this Bill must be given real efficacy to ensure that those from whom the public is protected are also acknowledged as people with legitimate human aspirations to whom fundamental rights and freedoms also attach.
>
> … Nevertheless, care will need to be exercised to ensure that care recipients are not unnecessarily detained under the legislation in circumstances where meaningful "care" can no longer be provided – in order simply to achieve the preventive detention of the person.

[94] These passages help identify another factor which I consider needs attention when considering a s 85 application. It is important to focus on where the detention is going. What progress has been made and is any more likely?

[95] It is plain from the material on VM that improvements in some areas can be achieved, notwithstanding the essentially constant state of the basic disability. Coping mechanisms, avoidance techniques, living and care skills are all examples.

[96] There was no oral evidence before me so no opportunity to obtain further information. I am accordingly unsure where the balance lies in this area between any capacity to "force" the issue of progress, and the need to allow progress to occur at its own pace. It does seem to me there is a risk in the case of a person such as VM that if the law is considered to be that a static risk will inevitably justify extension, there may arise an approach that is cautious, feels no constraints of time, and which is motivated solely by what is best for the person in the long run.[4]

[97] Whilst one could fairly ask "how that can be wrong?", it has to always be remembered that persons such as VM are being subjected to a form of detention that must be for as short a period of time as is required. There is no general capacity to impose on people treatment that would undoubtedly be good for them, and this is well illustrated by the total absence of coercive power in relation to the intellectually disabled who have not offended.

[98] To summarise this aspect, for reasons already given, prospects of progress can never be enough on their own to justify continued detention. Other factors will

---

[4] One of Dr Duff's concerns was this type of issue; namely, that in her view there had not been enough focus on moving things along (my phrase), nor the setting of markers to measure progress.

also need to be considered, and sufficient risk is a prerequisite. Conversely, though, the absence of any expectation of further progress should trigger an even firmer consideration of the appropriateness of an extension. Professor Brookbank's warnings have validity and I consider care is needed. If there are no rehabilitation prospects, then on-going detention would be sourced primarily in care needs, and risk. It would be surprising if those who represent lower levels of risk, as evidenced by their recent care status, would be subject to extension when no rehabilitation improvements are expected.

Other factors

[99] The other topics raised do not need individual consideration. Matters such as the Convention may well lead to a similar outcome, or at least reinforce the underlying thinking. I am satisfied there is nothing in them that is inconsistent with my conclusions and thereby needs separate consideration.

Conclusion

[100] It is important to emphasise that the contents of this judgment are not meant to represent rules or a template. There may be considerations that have been overlooked which in the particular case may be relevant.

[101] The main conclusion I have reached is that the issues which inform a s 85 consideration will be different from, or at least wider than, the initial consideration undertaken when the order was made. Extra factors come into play when considering extensions.

[102] The underlying consideration which should inform the extension decision is that a compulsory care order is a form of detention that requires on-going, and sometimes increasing, justification. It cannot be justified solely by reference to the needs of the care recipient or what is good for them.

[103] It must be justified by the risk the person presents, usually but not exclusively to others, and that risk must be of a nature and level to justify extending the length of the detention that has already occurred. Where the material indicates no likely further gains are to be achieved, a hard consideration is required to assess if the risk justifies more detention.

[104] To summarise the various points discussed in the judgment in relation to extension applications:

a) risk to self or others is a necessary precondition to any extension. If the risk is primarily to self, it needs to be remembered there is no general capacity to control people for their own good;

b) the maximum penalty for the offence which led to the care recipient coming under the Act is not a measuring stick for how long the detention should be. However, the general seriousness or otherwise of the offence is a relevant factor in considering whether further detention can be justified;

c) the statutory test of "needed" involves considering a variety of factors including the initial offence, the length of detention to date, the assessments of likely further progress and the timeframes attached to any projected progress;

d) the detention must be for as short a time as is necessary.

Issue three – VM's case

[105] VM's extension was considered against the same criteria attaching to the initial making of the orders. Accordingly it is appropriate that this Court reconsider the material. Some caution is needed in that there has been no opportunity to discuss with the witnesses some of the other matters I have identified as relevant.

[106] There is another case specific contextual matter. The present order will have almost expired and presumably there will be a renewal application filed or about to be. That would provide a fresh opportunity for consideration against these criteria. However, it is an appeal against a detention order and there should be some scrutiny by this Court.

[107] I am of the view that the correct approach is for me to look at and determine if I am satisfied the order should not have been made. If I am, it should be quashed. In reaching that assessment I need to bear in mind I am considering some factors not put to the witnesses. If I am not satisfied, then the appeal should be allowed and it can be remitted back. That route will allow fresh consideration either of the present application, or more likely a renewed application.

Material on VM

INITIAL OFFENCE

[108] In September 2005 VM went to the house of a former support worker, who was not home. VM approached a window and pulled from her pocket a 7 cm knife. She waved it at the window, retreated to the footpath and then repeated the exercise. VM explained at the time she had gone to the window to smash it; the knife was to use on the police.

[109] The contemporaneous reports show VM had been fixated with the support worker for some time. There had been a previous assault on that person. It appeared VM was becoming increasingly frustrated at a perceived level of inattention.

[110] At the time VM was 32 years old; she had had brief periods in hospital and otherwise had regularly been in situations of community placement. At the relevant time she was in an independent supported flat.

VM's RISK

[111] 2005 was the second time that VM had been found unfit to plead. The first occasion was in 1998 and it related to an assault on her mother. The summaries of that event imply it was a culmination of physical assaults rather than a one off event.

[112] Throughout the years there have been regular assessments by experienced people; the records are a testimony to the care and thought that goes into these situations. In October 2007, near the end of the initial care order, a comprehensive summary was compiled. The then report writer put together a list of known incidents to that point:

a) in August 1995 there was an assault on her mother, smashing a window and absconding from an IHC placement. Charges were laid but dropped;

b) later in August 1995 another assault on her mother which led to charges and a finding of unfit to plead;

c) in 1999 incidents of destructive behaviour such as throwing stones (a recurring theme), assaults (undetailed) and jumping from a moving car;

d) over 2003–2004 assaults on both mother and father, and social problems such as creating an incident at a shopping mall to secure a ride home from the police;

e) throughout 2005 support staff found her behaviour aggressive, impulsive and threatening;

f) over the same period VM obsessed over a support worker, broke into her home and waited for her. This was to foreshadow …

g) in 2005 the offending that led to the current care order. It concerned a different female support worker.

[113] Over the period VM has been in care there seem to have been few incidents of actual violence but many occasions of aggressive and threatening behaviour. Staff and advisers have worked hard to avoid situations leading to obsessions with a particular person, and to teach her to manage frustrations.

[114] Dr Ian de Terte, a clinical psychologist, conducted an assessment in July 2008. Under health and safety he wrote:

> Although file information indicated that there have been a number of incidents in the last 6 months, staff reported that her behaviour had been much more settled over the last 6 months and her aggressive behaviour had reduced. However, staff believed that if Ms M was not in a service like Timata Hou her behaviour would deteriorate and she would probably reoffend violently. I have elected not to undergo a risk assessment at this time because a formal risk assessment was completed by Ms Huddleston in September 2007 and this placed Ms M at risk of reoffending violently. Mr M agreed that his daughter should remain at Timata Hou for her own safety. Ms M reported that on 15 July 2008 she became angry with staff and she utilised time out strategies to regulate this anger.

[115] What emerges there and from other assessments is an apparent conundrum. Increasingly VM's risks can be managed if she is maintained in a structured setting. Whilst that structural setting is in law a situation of detention, she has considerable freedom of movement, and goes out on her own. The concern is that the diminishing risk she thereby presents can only be maintained at that level by maintaining the detention arrangements.

[116] In December 2008 Dr Barry-Walsh reported:

> To assist in my assessment I was able to review a number of recent incident reports with regard to Ms M. A report dated 12th November 2008 related to Ms M absconding. There was a similar incident that day where she was described as swearing. This appears to have accumulated in her running off and being detained by the police as she was concerned she had glass in her foot. There is also an incident reported 13th November 2008 where Ms M has been angry and has kicked a chair in a garage as well as threatening to smash a letterbox. She required PRN medication because of concerns over safety. There are numerous other incident reports which reflect the requirements of staff who frequently intervene with Ms M. These interventions have often centered around outbursts of anger and threats of harm to property or others as well as several assaults of a minor nature upon co-clients.

[117] In evidence he said:

> Yes. Well, I think, as I've outlined in my report, really risk falls into two areas. There's a particular and concerning risk around the attachments that she's developing on various occasions, with women, that have led to the index offending and have led to behaviours that cause particular concern for the person involved. The second area of risk is more around her impulsive, or apparently impulsive actions, of running off, which she had done on several occasions just prior to my seeing her previously when she'd been under the triple PR Act and had been managed in the community, that had been a major problem, simply taking off, going back to her parents, not staying where she was. Her capacity to care for herself in those episodes, they're poorly thought out, she may go off in bare feet, she may have no clear plan for where she's going, and also there have been incidents where she's had minor, if you know, contretemps, with those around her, I think throwing a tub of margarine and a Marmite around was seen on a couple of occasions. I also think that if you look at the history with Timata Hou, they appear to have done a better job than – and maybe because of the IDCCR Act and the constraints that imposes, but they appear to have done a better job of containing Vicky in the sense that there's less efforts to run away and the efforts that occur are very well managed, she's quickly returned, so, if you look at that risk, it appears to have been modified quite well during the time in Timata Hou.

[118] In taking in those extracts, which obviously include descriptions of some comparatively minor events, I do not wish to be seen either as trivialising the risks VM presents, nor as implying that Dr Barry-Walsh or the other professionals in any way have an unrealistic approach. I have been nothing but impressed by the quality and amount of resources dedicated to VM; one need only consider that I have already cited from two extensive psychological and needs assessments done within six months by two senior experienced experts. Indeed Dr Barry-Walsh himself acknowledged or identified the issue this case is really about. In answer to a question he observed:

> Yeah, well that's the difference between the legal system and the mental health system. I'm expected to anticipate risk and make judgments accordingly, it's clearly up to the Court to make a decision about the appropriateness of the IDCCR Act. I think what I'm saying is that clinically it's worked very well. Clinically, in my assessment of Ms M, there hasn't been sufficient change to suggest that anything less than that would work, so I'm saying from a clinical perspective it makes sense to continue it.

VM's PROGRESS

[119] Dr Duff in her peer review of the file identified concerns with the absence of clear markers for progress. In her view there needed to be better articulation, both for VM but also decision-makers, of the things that VM needed to achieve in order to bring her care recipient status to an end. Dr Duff's concern was the potential for the situation to drift on.

[120] Subsequently, the respondent filed evidence that indicated VM was being moved to a different facility. The focus of the new facility was much more towards preparation for return to independent life in the community, albeit with such assistance as can be organised within community groups. From my reading of the file the concern about the latter is not the general unavailability of such support, but that those organisations are not equipped to assist the aggressive so there can be reluctance to take on cases such as VM.

Decision

[121] The respondent's position is that the case for a conclusion that VM "needs" to be a care recipient is very strong. Matters referred to are:

a) the repeated assessments of high risk of further acts of violence, especially if outside a controlled setting;

b) a repeated history of absconding;[5]

c) her proclivity for forming attachments, and a history of acts of aggression;

d) assessment that she could not manage herself in an unsupported flatting situation;

---

[5] Involving a habit of walking off in a way that raises concerns for her safety from traffic, inadequate clothing and the like.

e) the progress achieved within the framework of a care order;

f) the concerns over external agencies being willing to take VM on;

g) her family's inability to cope.

[122] These points are a fair summary of the file and the clinical assessments. The dilemma is starkly presented. It is not to disparage VM's autonomy to record my clear view that, along with the clinicians, I consider that the current arrangements are what are best for VM. Like them I have concerns, for her and others, should this situation be ended. It carries a real risk of setting back progress. If released there is a clear risk that she will act in a way that brings her to the attention of the authorities; if charged, there is the possibility, or higher, that VM will be found unfit to plead. The cycle may well be resumed and the clinicians and support workers could legitimately feel frustration.

[123] However, if the detention cannot be supported on the criteria I have earlier identified, VM is entitled to the opportunity to live where she wants. That is what has motivated her challenge. It may be unrealistic but it may be her right to try.

[124] The initial order was made in November 2005; under challenge is a 2009 decision justifying continued detention until November 2009 and realistically February 2010.

[125] The offending with which VM was initially charged involved significant risks. She was armed, illegally on property, and focussing on a person with whom she was fixated. What VM might have done with the knife is speculative; there is no record of her ever using one against a person. I do not have the detail of the assault on her mother but assume any use of a weapon would have been noted.

[126] In recent times VM has not been actually violent. She has been aggressive and threatening. No doubt the recipients of such conduct are skilled in managing the situations and so the absence of actual violence may well reflect their capacities rather than be a commentary on VM.

[127] That VM poses a risk to the safety of others, especially in an uncontrolled environment, is beyond dispute. The nature of that risk, and how, if at all, it will manifest itself cannot be known other than that she has in the past lashed out at people, and she has threatened to do more.

[128] I do not consider that these circumstances supported a second extension. At the time of the decision improvements seemed to have levelled out; within the controlled environment, VM's risks were being managed. Compared to the already relatively low scale of offending that initiated the Act's processes, VM's conduct has not deteriorated and objectively has improved. VM has been only ever classified as needing supervised care.

[129] Assessing the matter afresh, and taking account of what led VM to be within the system, the length of time she has been in it, the fact that she has through that time been maintained in supervised care, and the absence of any increase in the risk she presents, I consider that a second extension should not be authorised. Continued detention would be disproportionate. As at February 2009 there seemed little prospect of change in the immediate future (although an updated November report belies that). Given it seemed that things were unlikely to change, I am of the view that the scheme of the legislation is not to authorise on-going detention of someone presenting VM's risks, given the circumstances against which the original order was made.

[130] The appeal is allowed, and the compulsory care order is quashed. This judgment will take effect seven days from the date on which it is issued to allow time for VM to find other accommodation.

Simon France J

Solicitors:
A J Douglass, Barrister, PO Box 5494, Wellington
J McHerron, Barrister, PO Box 5494, Wellington, email: jason.mcherron@waterfront.org.nz
D La Hood, Luke Cunningham & Clere, PO Box 10357, Wellington, email: dlh@lcc.co.nz
L Hansen, Crown Law, PO Box 2858, Wellington, email: lisa.hansen@crownlaw.govt.nz
M Coleman, Crown Law, PO Box 2858, Wellington, email: martha.coleman@crownlaw.govt.nz