28 January 2022

To the Ministry of Health

Victim Support submission on the Mental Health Act

1. Introduction

Victim Support is a non-government organisation that has been offering practical and emotional support to victims of crime and trauma for more than 30 years. Last year Victim Support helped more than 40,000 victims of crime and trauma in the immediate aftermath, through the justice process, and beyond. These included victims of special patients — those not guilty by reason of insanity and those unfit to stand trial.

Victim Support routinely makes submissions on legislation based on academic evidence, victims' lived experience, and our frontline experience of supporting victims. Last year we submitted on the Rights for Victims of Insane Offenders Bill, strongly advocating for the rights of victims whose offender was dealt with in the health system to be comparable to those whose offender was dealt with in the justice system. We applaud the outcome of this bill, which aligns with overseas jurisdictions and meets our obligations under the United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power.[1]

This current submission is based on the premise that the rights victims of special patients have fought so hard to achieve must be consistent across all relevant legislation. We have provided a brief evidence-based overview of the needs of crime victims and victims of special patients. We have then focussed solely on section 8.6: *People within the justice system (special patients*) and the question of whether they should be given the right to consent to treatment if they have decision-making capacity. We have also included two further recommendations that are relevant to victims of special patients.

2. What we know about victims of crime

Victims of crime are widely considered to be a vulnerable and disempowered population, with few rights compared to offenders. By the time they reach court, victims may be suffering from posttraumatic stress disorder (PTSD), and other adverse psychological reactions; physical ill-health from stress and/or injuries; and financial losses. There is growing research that instead of finding healing in the justice system, victims face further stress, disempowerment, costs, and PTSD.[2] Victims' experience of the justice system is linked to their likelihood of reporting crime and participating in the justice system, which is critical given that past victimisation is one of the best predictors of future victimisation.[3] Therefore, the experience of victims after a crime plays a critical role in not only victims'

[1] United Nations (1999). Handbook on Justice for Victims: On the Use and Application of the Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power. United Nations Office for Drug Control and Crime Prevention. p 36.
[2] Orth, U. (2002). Secondary victimization of crime victims by criminal proceedings. *Social Justice Research, 15 (4)*, 313-325.
[3] Kilpatrick, G. and Acierno, R. (2003). Mental health needs of crime victims: Epidemiology and outcomes. *Journal of Traumatic Stress, 16 (2)*, 119-132.

emotional recovery, but also in crime prevention and societal trust and confidence in the justice system.

Victim Support's research among victims of serious crime showed that victims' most important needs are for support, to have a voice, and to receive information.[4] The main barriers to perceived justice are fear (for their safety and that justice would not be served), a sense of exclusion in the justice system, and a sense of unfairness in that offenders' needs were perceived to be more important than their own. Similar findings by the Chief Victims Advisor[5] and Hāpaitia te Oranga Tangata Safe and Effective Justice advisory group[6] have prompted a call to action by Chief Victims Advisor Dr Kim McGregor to improve the experience of all victims of crime in our justice system.

For these reasons, Victim Support has been lobbying for improved procedural justice for crime victims—that is, balancing the rights of offenders and victims so the process by which outcomes are reached in the justice and mental health systems are fair and respectful to both parties.

3. What we know about victims of special patients

The Rights for Victims of Insane Offenders Bill was prompted by acknowledgement that victims whose offender was dealt with in the health system had even fewer rights and were more marginalised than those whose offender was dealt with in the justice system. Victim Support has observed that the fear, exclusion, and unfairness that victims feel in the justice system is often amplified among victims in the mental health system.

> Victims of such crimes have identified that one of the biggest hurdles in their understanding of the process is that while the accused physically committed the crime, he/she is not held accountable in the way that other offenders are in the criminal justice system. The person who committed the crime is diverted into the forensic mental health system, not a prison. The individual you know as the offender becomes a patient, not an inmate, and is treated by nurses, social workers and psychiatrists… Victims may be angry that the patient was in such a state to commit the crime when they should have been on medication, in treatment, or under close supervision. Some people may be angry that the individual is not being punished and sent to prison.[7] (p 2)

This anger and fear is compounded by the fact many victims are family members of the special patient. Victimisation by a family member or friend "tends to be more personal and therefore more painful and generally is a continuing cause of stress and fear because such victims know that they may encounter the perpetrator in the future and moreover they may feel that they are a likely potential target."[8] Victims are often torn between caring for the patient and wanting to support their recovery, while at the same time needing to manage their own safety.[9]

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[4] Victim Support (2019). *Victims' Voices: The justice needs and experiences of New Zealand serious crime victims*. Retrieved from https://victimsupport.org.nz/sites/default/files/2020-11/VS-Victims-Voices-Research-Report-Aug-2019_WEB-PRINT.pdf

[5] Chief Victims' Advisor (2019). *Te Tangi o te Manawanui: Recommendations for Reform.* Retrieved from https://chiefvictimsadvisor.justice.govt.nz/assets/Documents/Publications/Te-Tangi-Final-PDF.pdf

[6] Hāpaitia te Oranga Tangata Safe and Effective Justice (2019). *Public Survey of Attitudes Toward the Justice System*. Retrieved from https://safeandeffectivejustice.govt.nz/assets/Research-Evidence-Files/bcc5d4f5d9/2019-survey-attitudes-justice-system.pdf

[7] Canadian Resource Centre for Victims of Crime (2012). *Experiences of victims of mentally ill offenders in Canada*. Retrieved from https://crcvc.ca/wp-content/uploads/2021/09/CRCVC_MentalIllnessReport_E.pdf

[8] Barnett, M. and Hayes, R. (2009). The Role of Victims in NSW Forensic Patient Proceedings. *University of Western Sydney Law Review,13,* 7-35. p 18. Retrieved from http://138.25.65.17/au/journals/UWSLRev/2009/2.pdf

[9] Canadian Resource Centre for Victims of Crime (2012).

We sense a deep mistrust of the mental health system among victims, both family of special patients and strangers alike. While the path through the criminal justice system is well known, victims often feel the health system is shrouded in secrecy and the path is uncertain. Some jurisdictions such as New South Wales and Queensland have dedicated support services for victims of special patients offering support, information, and advocacy as they navigate the forensic mental health process. In New Zealand, this service is offered by Victim Support.

One of the families we've recently supported is that of Glen Collins, who was stabbed to death by a man found not guilty by reason of insanity. Glen's mother, Karilyn, says the defendant "definitely had more rights than us and was treated with more dignity than us". The family lives in a state of anxiety, their sense of safety depending on knowing where he is at any given time and the state of his mental health. "It's the not knowing," says Karilyn. "We got a letter saying he's moving but we weren't allowed to know where he was going or when he was going. I'm frightened; I'm really, really frightened. I double check 100 times my windows, my doors. He could find my address. He was saying he thought Glen was Hitler. But what if he comes for me because I'm Hitler's mother? When I'm on the bus I'm scared about who's sitting behind me."

New Zealand's Victims' Code states that victims should be treated on the principle "that [their] safety and the reduction of harm [is put] first".[10] Victims such as Karilyn Collins have the right to feel safe and to be safe, and to know that legislation is in place to protect themselves and others from potential harm. The safety concerns Karilyn speaks of are widely shared by victims both in New Zealand and overseas. A recent review into New South Wales' Mental Health Act concluded that there was insufficient "consideration for the safety and interests of victims".[11] It also found that victims had "genuine and legitimate concerns" that should not be lumped under the umbrella of public safety concerns. The review concluded that "the present system must be improved in order that the voices of victims of crime are heard and that the mental health system is not indifferent to their needs."[12] We have made progress in New Zealand with The Rights for Victims of Insane Offenders Bill. If we are genuine about making a difference to victims in the mental health system, all legislation must be consistent with the international movement to enhance therapeutic benefits for victims.

4. What giving certain special patients the right to refuse treatment would mean for victims

While there is no known research on the impact on victims of allowing special patients the right to consent to treatment if they had capacity, it is abundantly clear to us that this would further exacerbate their safety fears and distrust of the health system. Patients' treatment decisions do not exist in a vacuum. They need to be understood in the context of the victim experience and that many people are victims in the first place *because* the special patient refused treatment at some point.

Indeed, the person charged with Glen Collins' murder was a mental health patient under the care of the Northland District Health Board. He had left Whangārei and been without his medication for schizophrenia for some time when he stabbed Glen to death in Upper Hutt on September 20, 2018.

[10] Ministry of Justice (2015). *Victims Code*. Retrieved from https://victimsinfo.govt.nz/assets/Victims-code/Victims-Code.pdf

[11] Mental Health Review Tribunal (2017). *A Review in Respect of Forensic Patients*. Retrieved from https://www.health.nsw.gov.au/mentalhealth/reviews/tribunal/Publications/mhrt-review-report.pdf

[12] Ibid. p7.

"I'm outraged, I just feel that as the person who did that to my son, he's still winning," says Karilyn about the possibility her son's killer may have the option of refusing treatment. "He said the medication used to make him get sick. I'm terrified at the prospect of him being released and not on meds. What if he gets out, do we wait for the next victim? I thought New Zealand was a safe place but this is just like letting a loose cannon go." Karilyn says if her son's killer were able to refuse treatment it would be an insult to Glen and to his family. "I feel that he's getting off scot-free. If that goes through it's not fair to victims. They [policy makers] need to put their feet in my shoes. It's insulting and it's outrageous."

Karilyn's fears of the patient not taking medication are echoed by several victims of special patients who have shared their stories in a Canadian resource to support victims in the forensic health system:[13]

I think my son should be monitored for the rest of his life. I feel there is always a risk for a slip…that he might lose insight and go off his medication. – Eric (p 11)

I worry that he will not take his medications once he is released from the hospital without any supervision. I feel an increasing need for counselling as the years go by. – Karen (p 9)

We hear all about "his remarkable, better than expected recovery" at his annual Review Board hearing. While he's in care, he's not a concern: it's after release that worries me… What was not made clear to me by victim services or other criminal justice staff is that the accused/patient/killer retains the ultimate decision after he is released about whether to treat his mental illness with medication or not – he cannot be forced. – Carol (p 5)

The extant research on the impact of voluntary versus involuntary treatment for psychiatric hospital patients indicates that victims and society may have reason to be concerned if special patients refused treatment. Greenberg et al.[14]interviewed 30 psychiatric inpatients who were forcibly medicated. On reflection, 60% retrospectively agreed with being involuntarily medicated, with 53% stating this increased the likelihood they would take medication voluntarily in the future. We cannot rule out that the opposite would also be true: that if the inpatients had refused treatment, they would be *less* likely to voluntarily take medication upon their release.

Further, a New Zealand study found that a small percentage of forensic patients in hospital and community settings who had capacity to consent would refuse treatment if they had the choice.[15] Of the 68% of the 109 patients who had treatment-related decision-making capacity, only 3% said they would refuse treatment. This small group consisted of three people found not guilty by reason of insanity: two for murder and one for attempted murder. The risk of relapse and future violence for this group, who were all inpatients on antipsychotic medication, was predicted to be significantly higher without treatment if they were in the community. This finding highlights that small numbers of patients may have individual high risks of treatment non-compliance, and therefore relapse and violence, once released — despite having decision-making capacity. Any victim of a special patient will tell you that one such person in the community is one too many. Allowing such patients to refuse treatment on the basis of their being a minority would be tantamount to our refusing support to victims of special patients because they are a minority.

[13] Canadian Resource Centre for Victims of Crime (2012).

[14] Greenberg, W. M., Moore-Duncan, L., & Herron, R. (1996). Patients' attitudes toward having been forcibly medicated. *Bulletin of American Academy of Psychiatry and the Law, 24*, 513–524.

[15] Skipworth, J.J., Dawson, J., and Ellis, P.M. (2012). Capacity of forensic patients to consent to treatment. *Australian & New Zealand Journal of Psychiatry, 47(5)*, 443–450.

This study also found that another 5% of patients were deemed competent decision-makers but admitted only taking their medication because it was "the only sensible option to secure release". The authors state: "it is important to realise that what appears to be competent consent may be entirely the product of concerns about a patient's liberty". This begs the question whether, once released, there would be any motivation for this group to continue treatment.

The authors concluded that "granting patients with capacity the right to refuse treatment…could lead to the clinically and ethically fraught situation of detention without treatment" (p 443) and that "uncertainty surrounds the long-term consequence of respecting these competent treatment decisions, particularly whether third parties would be exposed to unreasonable risks". (p 444).

Victim Support is of the opinion that any risk to society or victims is unreasonable, and that any uncertainty about whether refusal of treatment equates to risk of violence is unacceptable. We also note that most victims have an expectation that every effort will be made to rehabilitate an offender while in prison or in a psychiatric facility. Indeed, research shows that most victims are more interested in keeping safe and seeing the offender rehabilitated than being punitive.[16]

5. Balancing the rights of special patients with the rights of victims

The Ministry of Health's *Special Patients and Restricted Patients: Guidelines for Regional Forensic Mental Health Services* states: "When managing special patients, forensic mental health services are required to balance the rights, treatment and rehabilitative needs of the individual patient against the safety of the public **and the concerns of victims**".[17] Victim Support supports the balance of rights between victims and offenders/special patients. We acknowledge the independence between assessing a person's criminal responsibility and that person's capacity to make treatment decisions. We support mental health patients being granted consent to make treatment decisions if they have capacity in general, but not in the cases of those who are special patients found not criminally responsible for a serious crime. The distinction between special patients and other mental health patients' rights to refuse treatment is made in several other jurisdictions, including Queensland and the United Kingdom.

In Queensland, patients can only be treated under the Mental Health Act if they have a mental illness, they have no capacity, and have a risk of either imminent serious harm to self/others or serious deterioration. However, s632(2) states that treatment and care may be provided without consent and with use of reasonable force for involuntary patients found not guilty by reason of insanity or unfit to stand trial subject to a forensic order or treatment support order.[18] The Mental Health Court must consider the degree to which it is necessary to protect the safety of the community and any victim impact statement when making these orders.

In the United Kingdom, consent must be sought for mental health patients under s3 (admission for treatment) and s37 (hospital order for forensic patients), but this can be overridden by the treating clinician.[19] In these cases, the patient has the right to seek a second clinical opinion after three months of treatment if they don't wish to continue with a particular medication.

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[16] Herman, J. L. (2005). Justice From the Victim's Perspective. *Violence Against Women 11 (5)*, 571–602.

[17] Ministry of Health (2017). *Special Patients and Restricted Patients: Guidelines for Regional Forensic Mental Health Services*. Ministry of Health. p III.

[18] Queensland Mental Health Act (2016). Retrieved from https://www.legislation.qld.gov.au/view/pdf/asmade/act-2016-005

[19] Mental Health Act (2007). Retrieved from https://www.legislation.gov.uk/ukpga/1983/20/contents

The Council of Europe draws the distinction between the rights of people with a mental disorder to refuse care for their mental health and their right to refuse care for their physical health. [20] They state that involuntary treatment should be allowed for mental health patients who refuse treatment irrespective of whether they have capacity to consent or not if they suffer from a mental disorder; pose a threat to themselves or others; no appropriate, less restrictive alternative is available; and the patient's opinion has been considered.

Even George Szmukler, a strong proponent of mental health patients' right to consent to treatment if they have capacity, admits that forensic patients who have capacity but refuse treatment may have to forfeit their rights if they pose a danger to others.[21] Involuntary treatment would be permissible if there was an effective treatment available and that the period of that treatment does not exceed the prison term for the crime for which they were held not criminally responsible.

Victim Support strongly advocates for special patients who have been held not criminally responsible for serious offences to be dealt with separately in the Mental Health Act. In accordance with the examples above, we believe every effort should be made for the special patient to consent to treatment, which, will no doubt involve an investment in professional education and training to build a trustworthy two-way relationship between patient and clinician. However, we believe it is in the best interests of the patient, the victim, and society that involuntary treatment is permitted, independent of decision-making capacity, if the special patient is considered to pose a danger to others in the future if untreated while being held in a psychiatric facility, or an imminent risk if they are being treated in the community. The safety of victims and society must be paramount for the wellbeing of the patient, the victim(s), society, and for the public trust and confidence in the mental health system.

6. Other provisions we want to see for victims in the Mental Health Act

Victim impact statements to be used for Mental Health Review Tribunal (MHRT) submissions

Following on from the provision in The Rights for Victims of Insane Offenders Bill for victims of special patients to deliver a victim impact statement, we believe it makes sense for these statements to be forwarded to the MHRT. These could be updated as needed, so that victims don't have to prepare a fresh submission each time the special patient is considered for leave, release, or a change in their status. Both Queensland and New South Wales have recently included this provision in their mental health reforms following victim feedback that it would help reduce revictimisation from having to retell their story.

Right to request a non-association/non-contact order in relation to special patient's leave and release

Victims of violent offenders imprisoned for more than two years have the right to request a non-contact order when the offender is released. There is no justifiable reason why this cannot be applied to victims of special patients when they make a submission to the MHRT. This would give victims confidence that they could go about their daily lives without the fear of being contacted by the special patient. The New South Wales and Queensland mental health reviews found this was deeply important to victims and allayed many of their fears. This change is necessary to remain consistent with the criminal justice system and with the Victims' Code, which states that victims should be treated on the principle "that [their] safety and the reduction of harm [is put] first".[22]

[20] Council of Europe, Committee of Ministers (2004) *Recommendation Rec (2004)10 of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder and its explanatory memorandum, 22 September 2004*. Retrieved from https://www.coe.int/t/dg3/healthbioethic/Activities/08_Psychiatry_and_human_rights_en/Rec(2004)10%20EM%20E.pdf

[21] Szmukler, G. (2017). *Men in white coats: Treatment under coercion.* Oxford: Oxford University Press.

[22] Ministry of Justice, (2015) *Victims Code*.

7. Conclusion

Victims of special patients in the mental health system commonly experience life-long fear that the patient will refuse treatment and reoffend. It's important to note that emotional safety (feeling safe) can be just as important to victims as physical safety (being safe) and that both need to be taken seriously under the Mental Health Act. Revictimisation and fear contribute to diminished trust and confidence in the justice/health system, which may influence victims' decision to report crime and participate in the justice process.

This is an opportunity for New Zealand to get to the heart of victims' needs in the mental health system, and to develop legislation that has therapeutic benefits for victims whose legitimate concerns must be heard. We must learn from jurisdictions that have researched and accelerated victims' rights in the mental health system and take this opportunity to make the changes we know victims need. We cannot expect trust in a system if it is indifferent to the needs of victims.

Summary of recommendations

- At least in the cases of serious offences, special patients should be considered separately in the Mental Health Act. While every attempt to gain their consent for treatment should be sought, special patients who have decision-making capacity should still be subject to involuntary treatment. This is an important harm reduction measure for victims, and given this may prevent future violence, we believe this is in the long-term best interests of victims, society, and patients.
- The Mental Health Act should include provision for victim impact statements to be forwarded to the Mental Health Review Tribunal (MHRT) so victims don't have to repeat their story when they make a submission.
- Victims should have the right to request a non-association/no contact order in relation to the patient's leave and release when they make a submission to the MHRT.

Contact information

Victim Support would welcome the opportunity to discuss this further.
Please contact:
Dr Petrina Hargrave
Research, Advocacy & Victims' Lead
Petrina.hargrave@victimsupport.org.nz