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ARTICLE

Criminal Minds: A Therapeutic Jurisprudence Perspective on Neurodisability and the Criminal Justice System

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Neurodisability is a complex issue for the criminal justice system nationally and internationally. This article discusses the issue with a special focus on Fetal Alcohol Spectrum Disorders and Traumatic Brain Injury from a Therapeutic Jurisprudence perspective. Neurodisability in the context of the New Zealand criminal justice system is analysed in light of New Zealand's legal rules, procedures and actors. This article highlights the multitude of ways in which the current criminal justice system produces anti-therapeutic consequences for those with neurodisabilities. These include the law of unfitness to stand trial, the trial process and sentencing, and legal professionals' lack of knowledge and skill in this area. Suggestions are made for how New Zealand could improve the criminal justice system in the future, producing more therapeutic—and less anti-therapeutic—consequences for those who experience neurodisability. These include further research into neurodisability in the context of the criminal justice system, modification of existing processes within the system, formal legislation change and—most dramatically—the development of a mental health court in New Zealand with the ability to also address neurodisability.

I Introduction

The role of the brain in who we are, how we think and what we do is widely recognised but far less widely understood. This is a key focus of the field of neuroscience—in particular, what happens when the brain is damaged. The 19th century case of Phineas Gage

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provided some of the first unique insights into the consequences of a damaged brain. Phineas Gage, a railroad worker, had an iron bar blasted through the front of his head which caused extensive damage to the prefrontal cortex of his brain. Despite his outward physical and intellectual recovery, his personality had changed to such a degree that his friends were quoted as stating that the Phineas Gage who survived was "no longer Gage".[1]

Neurodevelopmental disability (neurodisability) is an umbrella term for the conditions associated with impairments of growth and development of the brain or central nervous system. It is a topic of growing concern—particularly within the criminal justice system, where significant numbers of offenders have been shown to be affected by neurodisability. This becomes a concern when offenders are continuously cycling in and out of the criminal justice system. Therapeutic Jurisprudence (TJ) provides a unique lens for examining this issue by moving past the obvious detrimental effects of neurodisability to examine the way this affects the overall wellbeing of the individual as they engage with the criminal justice system and how this could be utilised to end the cycle.

This article discusses the implications of neurodisability for the criminal justice system, engaging a TJ perspective to both critique the current criminal justice system and suggest a better way forward to more effectively address offending by these individuals. While there are many forms of neurodisability, for the purposes of this article, the focus will be on Fetal Alcohol Spectrum Disorders (FASD) and Traumatic Brain Injury (TBI). These are two areas that have received media attention in recent years in New Zealand and have serious implications for the application of justice. Also, the article will focus on the adult—and not youth—criminal justice system. Although both FASD and TBI are also prevalent in the latter, these issues are currently being addressed in the separate youth justice system.

This article does not, and cannot, purport to cover all issues relevant to the discussion of neurodisability and the criminal justice system. However, it will provide an overview of key areas of concern from which further dialogue will—hopefully—be encouraged

I begin this article by introducing the foundational concepts: Part II introduces the field of TJ; and Part III provides an overview of two specific forms of neurodisability. Turning then to address the problems with the status quo, Part IV discusses how the criminal justice system is currently antitherapeutic for people with neurodisability, and Part V considers how the criminal justice system could be made more therapeutic for people with neurodisability. Finally, Part VI provides some critiques of the TJ approach adopted in this article.

II Therapeutic Jurisprudence

TJ is "the study of the role of the law as a therapeutic agent".[2] It is a perspective that humanises the law, focusing on the emotional and psychological effects of both the law and the legal process.[3] It is informed by the behavioural sciences and literature from psychology, psychiatry, clinical behavioural sciences, criminology and social work.[4] TJ views the law as a social force that has the ability to produce behaviours and consequences which can be considered either *therapeutic* or *antitherapeutic* in nature for those involved.

1 John M Harlow "Recovery from the passage of an iron bar through the head" (paper presented to the Massachusetts Medical Society, Massachusetts, June 1868) at 277.

2 Bruce J Winick "The Jurisprudence of Therapeutic Jurisprudence" (1997) 2 Psychol Pub Poly & L 184 at 185.

3 David Wexler "Therapeutic Jurisprudence: An Overview" (2000) 17 TM Cooley L Rev 125 at 125.

4 At 129.

TJ grew out of the field of mental health law and the recognition that—at times—safeguards and processes created to alleviate the issues with mental heath can often do just the opposite.[5] It recognises that legal rules, procedures and actors constitute "social forces" that can "produce therapeutic or antitherapeutic consequences"—sometimes to a greater degree than the actual legal outcome.[6] TJ aims to optimise the psychological experience of those who engage with legal process, where possible by producing therapeutic consequences and reducing antitherapeutic ones.[7] The term "therapeutic" is deliberately defined in broad terms to include "anything that enhances the psychological or physical well-being of the individual".[8]

Is it essential to note that TJ goals are never intended to trump other goals at play within the justice system. The founders of TJ were adamant that therapeutic goals should only be achieved within the limits of justice and acknowledged that there will be times where other goals will trump therapeutic ones. TJ suggests, instead, that legal actors should attempt to apply the law therapeutically when it is possible and consistent with these other goals and values.[9] Even where a particular rule or process is required, there will often be considerable scope for applying it in a more therapeutic way.[10] Of course, the *therapeutic* and *antitherapeutic* consequences of the law are not the only ones worth examining. But TJ states that they should not be ignored. And it suggests a need for "awareness of these consequences" in decision-making and law reform in order to allow for "a more precise weighing of sometimes competing values".[11]

TJ has moved from simply being a lens for examining mental health law to a more therapeutic approach to the law as a whole, with both theoretical and practical applications.[12] It now has relevant application in, for instance, family, employment, compensation and criminal legal spheres.

In the context of the criminal justice system, TJ emphasises rehabilitation as opposed to the traditional focus on punishment and deterrence.[13] TJ looks to the wider context of offending with the goal of preventing offenders from continuously cycling through the criminal justice system; and it aims to provide these offenders with opportunities for productive growth. Research into neurodisability and its relationship with the criminal law has been growing in recent decades and TJ provides a valuable additional perspective to examine this issue and the future direction of the law in this area.

III What is Neurodisability?

Neurodisability is an umbrella term for a number of conditions associated with impairments of growth and development of the brain or central nervous system. Some common conditions that constitute neurodisability include Cerebral Palsy, Epilepsy, Down

5 At 128.
6 Winick, above n 2, at 185.
7 At 185.
8 At 192.
9 At 203.
10 At 201.
11 At 191.
12 David B Wexler "The Development of Therapeutic Jurisprudence: From Theory to Practice" (1999) 68 Rev Jur UPR 691 at 697.
13 At 697.

syndrome, Attention Deficit Hyperactivity Disorder, FASD and TBI.[14] It is also common for neurodisability conditions to co-occur, and neurodisability is associated with widely varying mental, emotional, physical and economic consequences for individuals, their families and society.

The study of neurodisability is important in the context of the criminal justice system in two main respects, both of which will be discussed later in this Part. First, the presence of neurodisability increases the likelihood of contact with the criminal justice system for the individual. Secondly, neurodisability creates a range of new challenges for the criminal justice system that must be addressed in order to effectively deal with the offender.

It is essential to understand that neurodisability is not directly causative of criminal behaviour. Not every individual with the presence of neurodisability will engage in criminal behaviour, and not every offender will have evidence of neurodisability. However, there is considerable support for the presence of neurodisability as a risk factor for criminal offending, and so this association cannot be ignored.[15]

A *Fetal Alcohol Spectrum Disorders*

FASD were in the media spotlight with the case of Teina Pora, a New Zealand man convicted of the rape and murder of Susan Burdett at the age of 17 after claiming he was present when the murder occurred. He was eventually diagnosed with FASD and a mental age of nine or ten years old at the time of his confession. In 2015, the Privy Council quashed his convictions. Pora's counsel argued that, due to his FASD, he was easily confused, had a drive to please others and, consequently, that his confession in 1993 should be seen as unreliable.[16]

(1) What is FASD?

FASD is a non-diagnostic umbrella term encompassing a number of conditions related to prenatal alcohol exposure, including Fetal Alcohol Syndrome (FAS), Partial Fetal Alcohol Syndrome (Partial FAS), Alcohol-Related Neurodevelopmental Disorder (ARND) and Alcohol Related Birth Defects (ARBD).[17] The use of different terms in the literature must be kept in mind when interpreting research findings because not all will be generalisable to the wider FASD population.[18]

14 As noted in the introduction, this article will focus specifically on Fetal Alcohol Spectrum Disorders and Traumatic Brain Injury.

15 See ss (1)(c) and (2)(c) below for evidence of the presence of neurodisability as a risk factor for criminal offending.

16 *Pora v R* [2015] UKPC 9, 1 NZLR 227 at 278.

17 The term *Fetal Alcohol Effects* (FAE) can also be found in the literature, although it is no longer used.

18 Much of the original research on the effects of prenatal alcohol exposure focused solely on FAS. While FAS lies at the most serious end of the FASD spectrum, those at the other end may still exhibit significant behavioural and cognitive deficits even if they lack attributes associated with FAS. Raja AS Mukherjee, Sheila Hollins and J Turk "Fetal alcohol spectrum disorder: an overview" (2006) 99 JR Soc Med 298 at 298.

FASD is entirely blameless, caused through no fault of the individual it affects. It is a lifelong disability that cannot be outgrown[19] and research even suggests that "some FASD related impairments may intensify over time".[20]

Most of the research on the mechanisms by which prenatal alcohol exposure alter or damage the developing brain has been done on animals. It suggests that prenatal alcohol exposure affects the placenta, resulting in placental dysfunction, decreased fetus size, endocrine changes, and impaired blood flow and nutrient transport which likely leads to the development of cognitive and behavioural abnormalities in the fetus.[21] In addition, heavy prenatal alcohol exposure appears to cause microcephaly, where the head circumference is below the mean for the age and gender of the individual, as well as structural abnormalities in various brain regions.[22]

FASD has been described as an "iceberg" with sufferers "frequently unrecognised and undiagnosed".[23] Albert Chudley and others argue that those with FASD need to be viewed as "neurologically impaired individual[s] with a brain injury".[24] The effects of FASD are typically categorised into primary disabilities (cognitive, physical or mental)[25] and secondary disabilities (which occur as a consequence of primary disabilities, mainly behavioural and psychological).[26] Yet there are no definitive biological markers for FASD,[27] making it difficult to diagnose.

Research conducted using magnetic resonance brain imaging techniques has demonstrated that FASD-related neurological deficits are sometimes uncorrelated with facial and physical abnormalities.[28] This means that individuals without the distinctive

19 Larry Burd and others "Fetal Alcohol Spectrum Disorder as a marker for increased risk of involvement with correction systems" (2010) 38 Journal of psychiatry & law 559 at 563.

20 Timothy E Moore and Melvyn Green "Fetal Alcohol Spectrum Disorder (FASD): A Need for Closer Examination by the Criminal Justice System" (2004) 19 CR 99 at 99.

21 Larry Burd and others "Ethanol and the placenta: A review" (2007) 20 J Maternal Fetal Neonatal Med 361 at 365–370.

22 Diane K Fast and Julianne Conry "Fetal Acohol Spectrum Disorders and the Criminal Justice System" (2009) 15 Dev Disabil Res Rev 250 at 252.

23 SJ O'Driscoll "Fetal Alcohol Spectrum Disorder" [2011] NZLJ 119 at 119.

24 Albert E Chudley and others "Challenges of Diagnosis in Fetal Alcohol Syndrome and Fetal Alcohol Spectrum Disorder in the Adult" (2007) 145C Am J Med Genet Part C Semin Med Genet 261 at 269.

25 See Mukherjee, Hollins and Turk, above n 18, at 299; Erica Clark and others "Secondary Disabilities Among Adults with Fetal Alcohol Spectrum Disorder in British Columbia" (2004) 2 J FAS Int e13 at e17; and Ann P Streissguth and others "Risk Factors for Adverse Life Outcomes in Fetal Alcohol Syndrome and Fetal Alcohol Effects" (2004) 25 Journal of Developmental & Behavioral Pediatrics 228 at 233. See generally Joseph L Jacobson and Sandra W Jacobson "Effects of Prenatal Alcohol Exposure on Child Development" (2002) 26 Alcohol Res Health 282. An IQ score of 70 is typically required for a diagnosis of intellectual disability or sub-average general intelligence. See the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 7.

26 AP Streissguth and K O'Malley "Neuropsychiatric implications and long term consequences of fetal alcohol spectrum disorders" (2000) 5 Sem Clin Neuropsychiatry 177; and O'Driscoll, above n 23, at 119.

27 Problems associated with FASD *may* include abnormal appearance, a small head, low body weight, short height, poor coordination, behaviour problems, low intelligence, and problems with hearing or seeing.

28 Fred L Bookstein and others "Midline Corpus Callosum is a Neuroanatomical Focus of Fetal Alcohol Damage" (2002) 269 The Anatomical Record 162 at 172. See also Fred L Bookstein and others "Corpus Callosum Shape and Neurospsychological Deficits in Adult Males with Heavy Fetal Alcohol Exposure" (2002) 15 NeuroImage 233.

physical attributes may still be severely impaired.[29] This is problematic because significant pathology will not always be apparent to the naive observer. This can result in further problems when these individuals appear superficially not to have a disability and are expected to perform at the same level as someone without a disability.

A study of individuals born between the 1970s and 1990s estimates the prevalence of FASD in the general population as between two to five per cent.[30] Prevalence in the criminal justice system, however, appears to be considerably higher, with one United States longitudinal study reporting that 60 per cent of FASD-affected individuals[31] over the age of 12 years old had a criminal history.[32] In Canada, prevalence in the youth justice population is also high, with a systematic review suggesting that young people with FASD are 19 times more likely to be incarcerated than their non-FASD counterparts.[33]

(2) FASD and the criminal justice system

While individuals with FASD appear to be at an increased risk for lifetime interaction with the criminal justice system, it is essential to note that this does not mean that they are inherently more criminal or dangerous than those without FASD.

The impairments associated with FASD—particularly impairments to executive brain functioning—increase the likelihood of interaction with the criminal justice system in a number of ways. Individuals with FASD have difficulty understanding the future consequences of their present actions and so may be unable to grasp the gravity of their actions and the likelihood of subsequent criminal outcomes. Individuals with FASD also have issues with impulsivity which may make it difficult for them to do what they are told, even when required by law.[34] The impaired social skills (and associated peer-rejection) commonly experienced by those with FASD may also increase the likelihood of these individuals "forming friendships with delinquent peers" which—coupled with their vulnerability to "victimisation, exploitation [and] peer pressure"—significantly increase the likelihood that they will engage in offending behaviour.[35] It has also been suggested that individuals with FASD operate at a lower level of moral maturity, increasing the risk of engaging in illegal behaviour.[36] In addition, for many FASD individuals, the risk of

29 See Mukherjee, Hollins and Turk, above n 18, at 301; and Moore and Green, above n 20, at 99–100.

30 Philip A May and others "Prevalence and Epidemiologic Characteristics of FASD From Various Research Methods with an Emphasis on Recent In-School Studies" (2009) 15 Dev Disabil Res Rev 176 at 179.

31 Specifically FAS-affected or FAE-affected individuals.

32 AP Streissguth and others *Understanding the Occurrence of Secondary Disabilities in Clients with Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE)* (University of Washington, Grant No. R04/CCR008515, August 1996) at 42. 60 per cent reported ever having been charged, convicted or in trouble with the authorities, while 42 per cent had been incarcerated for a crime.

33 Svetlana Popova and others "Fetal Alcohol Spectrum Disorder Prevalence Estimates in Correctional Systems: A Systematic Literature Review" (2011) 102 Can J Public Health 336 at 339.

34 Karina Royer Gagnier, Timothy E Moore and Melvyn Green "A Need for Closer Examination of FASD by the Criminal Justice System: Has the Call Been Answered?" (2011) 18 J Popul Ther Clin Pharmacol e426 at e428.

35 Samantha Parkinson and Sara McLean "Foetal Alcohol Spectrum Disorder in children: Implications for judicial administration" (2013) 22 JJA 138 at 142.

36 Gagnier, Moore and Green, above n 34, at e428.

interaction with the criminal justice system will be even greater in adulthood, when the structure and supervision previously provided by parents and schools no longer exist.[37]

FASD impairments and deficits can also increase the likelihood of further reoffending. Individuals may have cognitive deficits that prevent them from learning from their experiences.[38] They may also fail to appreciate the purpose of legal proceedings, which makes it considerably less likely that proceedings will be effective at reducing offending behaviour.

B *Traumatic Brain Injury*

In 2015, a 14-year-old boy (aged 13 at the time he committed the offence) was convicted of manslaughter for the killing of Arun Kumar. The boy had experienced a severe head injury six years previously after being hit by a car, which resulted in a reduced mental capacity. In his judgment, Lang J stated that, had it not been for the boy's brain injury, his Honour was convinced the jury would have found the boy guilty of murder.[39]

(1) What is TBI?

A TBI is a brain injury caused by an external application of force to the head, often involving a loss of consciousness.[40] While the terms TBI and *head injury* are at times used interchangeably, they are not the same thing. An individual can, and often will, experience a head injury without it constituting a TBI.

TBIs can be either open or closed.[41] An *open* TBI involves penetration of the skull by a sharp object or an explosive missile (for example, a bullet wound) while a *closed* TBI involves blunt impact to the head without penetration of the skull (for example, a fall). A closed TBI is associated with damage to the brain from two main sources: *primary* injuries involving blunt trauma and rotational forces that occur at the moment of the trauma; and *secondary* injuries which arise following the injury and include damage to the brain as a result of raised intracranial pressure, hypoxia, and neural damage.[42]

A TBI can be classified as mild, moderate or severe, largely depending on the duration of the loss of consciousness and the extent of associated memory loss. For instance, a TBI with up to 30 minutes of loss of consciousness will only be classified as mild,[43] and the average TBI will result in "7.4 days of restricted activity, of which 3 days are spent in bed".[44]

The prevalence of TBI in the general population is estimated to be between five and 24 per cent.[45] Motor vehicle crashes have been identified as the main cause of TBIs, followed by sports injuries, assaults and falls. Within the general population, children under the age

37 Moore and Green, above n 20, at 102.
38 Parkinson and McLean, above n 35, at 144.
39 "Auckland dairy owner's killer jailed for six years" *Stuff* (online ed, New Zealand, 31 July 2015).
40 The Brain Injury Association "Brain Injury" <www.brain-injury.org.nz>.
41 See Ennis Berker "Diagnosis, Physiology, Pathology and Rehabilitation of Traumatic Brain Injuries" (1996) 85 Int J Neurosci 195 at 203.
42 Robert L Schalock "Traumatic brain injury: Implications for practice" (1998) 7 Appl Prev Psychol 247 at 248.
43 PE Voss and others "EFNS guideline on mild traumatic brain injury: Report of an EFNS task force" (2002) 9 Eur J Neurol 207 at 208.
44 Schalock, above n 42, at 247.
45 Nathan Hughes and others *Nobody made the connection: The prevalence of neurodisability in young people who offend* (The Office of the Children's Commissioner, London, 2012) at 35.

of five, men aged between 15 and 30 years old, and the elderly are those most at risk of experiencing a TBI.[46]

Similar to FASD, rates of TBI are significantly higher in the offender population than in the general population. Compared to estimates of between five and 24 percent in the general population, prevalence rates in the offender population range from 50 to 80 per cent. In a meta-analysis conducted on the prevalence of TBI in the offender population—with samples from New Zealand, the United States, England and Australia—the authors found an estimated prevalence of TBI in the overall offender population of 60.25 per cent, of which 50.19 per cent involved an associated loss of consciousness for any amount of time.[47] One study aimed to establish rates of TBI for different severities in a representative sample of adult offenders, and the researchers found reports consistent with TBI given by 64.9 per cent of offenders, 16 per cent of which were considered "moderate-severe" and 48 per cent "mild".[48]

Research also suggests that Māori are more likely to report TBI than their non-Māori counterparts. A New Zealand study in the prison population found that Māori subjects had a 12 per cent higher rate of TBI than their non-Māori counterparts.[49] Evidence also suggests that the offender population may experience greater and more severe TBIs than their counterparts in the general population.[50]

Although men in the general population are at a greater risk of experiencing a TBI, rates are also high for women within the offender population. One study of TBI in South Carolina prisoners reported that, while 65 per cent of men in the sample reported a TBI, so too did 72 per cent of women.[51] The experience of TBI is also highly prevalent in the young offender population, with one study reporting rates ranging from 65 to 76 per cent in youth in custody.[52] Information surrounding the prevalence of TBI is typically taken from samples of incarcerated individuals, so it is likely that rates in the overall offender population may be even higher than current estimates suggest.

The effects of TBI can be separated into post-traumatic effects (for example, disorientation and tiredness, and difficulties with attention, alertness and memory)[53] and long-term outcomes (for example, headaches, increased aggression and personality

46 Centers for Disease Control and Prevention "Traumatic Brain Injury & Concussion" (20 September 2016) <www.cdc.gov>.

47 Eric J Shiroma, Pamela L Ferguson and E Elisabeth Pickelsimer "Prevalence of Traumatic Brain Injury in an Offender Population: A Meta-Analysis" (2010) 16 J Correct Health Care 147 at 149–152.

48 W Huw Williams and others "Traumatic brain injury in a prison population: Prevalence and risk for re-offending" (2010) 24 Brain Injury 1184 at 1186.

49 Tracey V Barnfield and Janet M Leathem "Neuropsychological outcomes of traumatic brain injury and substance abuse in a New Zealand prison population" (1998) 12 Brain Injury 951 at 959.

50 Iain Perkes and others "Traumatic brain injury rates and sequelae: A comparison of prisoners with a matched community sample in Australia" (2011) 25 Brain Injury 131 at 133–136; and Peter W Schofield and others "Traumatic brain injury among Australian prisoners: Rates, recurrence and sequelae" (2006) 20 Brain Injury 499 at 501.

51 Pamela L Ferguson and others "Prevalence of Traumatic Brain Injury Among Prisoners in South Carolina" (2012) 27 J Head Trauma Rehabil E11 at E15.

52 Hughes and others, above n 45, at 35.

53 See Schalock, above n 42, at 249.

change).[54] The literature suggests that the greatest recovery occurs within the first six to 12 months following a TBI, and any subsequent recovery after that period will often be "slow and limited".[55] It is, therefore, essential that rehabilitation commences as soon as possible after a TBI.

(2) TBI and the criminal justice system

The experience of a TBI has been consistently shown to increase the likelihood of interaction with the criminal justice system. A New Zealand-based study conducted in Canterbury found, when investigating young adults who had experienced a childhood injury, that the experience of a TBI in childhood increases the risk of later offending.[56] The authors reported that, as the severity of the TBI increases, so too does the risk of later offending.[57] In addition, research shows that adult offenders with a history of TBI are younger at first entry into custodial systems, have higher rates of repeat offending, and spend a greater period of time in prison than their counterparts without a TBI.[58] While this relationship has been recognised, at present it is still not well understood.

As a result of the executive function deficits associated with a TBI, it is likely that individuals with a TBI have difficulty mediating and controlling their behaviour.[59] In stressful or confrontational situations they may find it harder to react in a prosocial manner and utilise skills of negotiation or dialogue, instead responding with physical aggression or violence. In addition, "increased levels of fatigue, irritability or frustration", which are common experiences for those with a TBI, may "lower a person's 'flash point' for aggression".[60] These in turn could lead to involvement in behaviours that constitute assault or destruction of property. Furthermore, individuals with TBI may experience disinhibition, increasing their propensity to act impulsively and without appropriate

54 Ian J Baguley, Joanne Cooper and Kim Felmingham "Aggressive Behavior Following Traumatic Brain Injury: How Common is Common?" (2006) 21 J Head Trauma Rehabil 45 at 50–52; Thomas J Farrer and Dawson W Hedges "Prevalence of traumatic brain injury in incarcerated groups compared to the general population: A meta-analysis" (2011) 35 Progress in Neuro-Psychopharmacology and Biological Psychiatry 390 at 393; Ferguson and others, above n 51, at E15–E16; and Schofield and others, above n 50, at 501.

55 Allan D Moore and Michael Stambrook "Cognitive moderators of outcome following traumatic brain injury: a conceptual model and implications for rehabilitation" (1995) 9 Brain Injury 109 at 113.

56 Audrey McKinlay and others "Predicting Adult Offending Behavior for Individuals Who Experienced a Traumatic Brain Injury During Childhood" (2014) 29 J Head Trauma Rehabil 507 at 510.

57 At 510.

58 Williams and others, above n 48, at 1186. The average age upon entry into custodial systems for those with a TBI is 16.4 years, compared to 20.1 years for those without a TBI. Within the past 5 years, those with a TBI spent on average seven months longer in prison than those who had not suffered a TBI.

59 See José León-Carrión and Francisco Javier Chacartegui Ramos "Blows to the head during development can predispose to violent criminal behaviour: rehabilitation of consequences of head injury is a measure for crime prevention" (2003) 17 Brain Injury 207 at 213.

60 Louisa Jackson "Acquired Brain Injury and Serious Criminal Offenders: An Argument to Expand the Court's Therapeutic Jurisdiction" (LLB(Hons) Research Paper, Victoria University of Wellington, 2013) at 9.

processing of risk and consequences[61] and increasing the likelihood of involvement in criminal behaviour, such as sexual offending or dangerous driving.

C *Conclusion*

Neurodisability affects a significant proportion of the offending population worldwide. FASD and TBI are two quite different forms of neurodisability that are considerably more prevalent in the criminal justice system than the general population. Indeed, the effects of both appear to predispose these individuals to interaction with the criminal justice system by virtue of the effects and related deficits associated with each. While causation cannot be conclusively determined (largely due to retrospective study design and self-report data collection) the evidence suggests that neurodisability should not be ignored in order to cater effectively to the offending population. With this in mind, the next Part will discuss the ways in which the traditional justice system may produce antitherapeutic consequences for individuals with neurodisability.

IV How the Criminal Justice System is Antitherapeutic for those with Neurodisability

The traditional criminal justice system in New Zealand is the adversarial system. In this system lawyers advocate for their clients before an impartial judge or jury who decides an outcome based on the evidence presented by the lawyers and their ability to examine and cross-examine witnesses and relevant parties. A defendant can choose to have extremely limited involvement in the process by refusing to give evidence. They may also have almost no direct interaction with the judge. Taken as a whole, the focus of the system is on the punishment for harm done and the deterrence of future offending.

In this Part of the article I discuss the range of antitherapeutic consequences that can arise at every stage of the traditional criminal justice system process. I will address the ways in which legal rules, procedures and actors can produce antitherapeutic consequences for those with neurodisabilities in the criminal justice system. This is not intended to be an exhaustive discussion of all the potential antitherapeutic consequences that persons with neurodisability may encounter. Rather, it will discuss key examples to demonstrate the problems faced. I follow this in Part V with a range of recommendations for how the criminal justice system could become more therapeutic in practice for offenders with neurodisabilities.

While the field of research on TBI is growing, little research has been conducted on the impact TBIs have on an individual's involvement in the criminal justice system, particularly compared with the research on FASD. For this reason, I am able to present more research and examples focusing on FASD.

A *Legal rules*

The legal rules regarding unfitness to stand trial demonstrate how the criminal justice system can produce anti-therapeutic consequences for those with neurodisability problems. The Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIP Act) sets

61 See Judith Aharon-Peretz and Rachel Tomer "Traumatic Brain Injury" in Bruce L Miller and Jeffrey L Cummings (eds) *The Human Frontal Lobes: Functions and Disorders* (2nd ed, The Guilford Press, New York, 2007) 540 at 547.

out the law in New Zealand relating to unfitness to stand trial.[62] Section 4 of the CPMIP Act defines a person as unfit to stand trial if they are unable to, due to mental impairment, conduct a defence or instruct counsel to do so. This includes being unable to plead, adequately understand the nature, purpose or possible consequences of the proceedings, or communicate adequately with counsel for the purposes of conducting a defence.[63]

Mental impairment is not defined in the Act, leaving its interpretation to the discretion of the courts. It includes a *mental disorder*, which is defined under s 2 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHCAT Act), and an *intellectual disability*, which is defined under s 7 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act). However, it is not limited to either one of these definitions. It is, therefore, possible that, while an individual may not meet the criteria for *mental disorder* for a finding of insanity under s 23 of the Crimes Act 1961, they may still be found unfit to stand trial.

For there to be a finding of unfitness to stand trial, the court must receive evidence from two health assessors regarding whether the defendant is mentally impaired.[64] A health assessor can be a practising psychiatrist registered as a medical practitioner, a psychologist or a specialist assessor under the IDCCR Act.[65] If the court is satisfied on the evidence that the defendant is mentally impaired, the court must record a finding to that effect and give each party an opportunity to be heard and to present evidence on the defendant's fitness to stand trial. The court must then make a finding as to whether or not the defendant is unfit to stand trial, and record the finding.[66] The standard of proof required for such a finding is the balance of probabilities.[67]

Neurodisability will often fall within the definition of a *mental impairment* but not a *mental disorder* or *intellectual disability*. While a number of individuals with neurodisability may meet the criteria for a diagnosis of an intellectual disability, it is certainly not a definitive consequent finding. The average IQ of individuals with FASD has been reported to be around 85.9[68] and one study found that only 34 per cent of a sample of 62 individuals with FASD had an IQ below 70.[69] This was the situation in the case of *R v Lucas-Edmonds* where the defendant was found not to meet the criteria for an intellectual disability by the psychiatrist under s 7 of the IDCCR Act and, therefore, did not fit the criteria for being unfit to stand trial.[70] Similarly, while those with TBI may experience reduced mental capacity, this is not the same as a diagnosable intellectual disability. As IQ tests measure cognitive capacity rather than global cognition, IQ tests will often exclude those with traumatic and other brain injuries.[71]

In addition, while neurodisability could arguably be viewed as an "abnormal state of mind", it is unlikely that a court would find that either FASD or TBI constitutes an abnormal

62 Criminal Procedure (Mentally Impaired Persons) Act 2003 [CPMIP Act], s 4(a).
63 Section 4(b).
64 Section 14(1). Of course, the court must first be satisfied that the evidence against the defendant is sufficient to establish that they committed the offence. Section 9.
65 Section 4.
66 CPMIP Act, s 14(2).
67 Criminal Procedure (Mentally Impaired Persons) Act 2003, s 14(3).
68 Streissguth and others, above n 32, at 20; and Mukherjee, Hollins and Turk, above n 18, at 301.
69 Clark and others, above n 25, at e13 and e22.
70 *R v Lucas-Edmonds* [2009] NZCA 193, [2009] 3 NZLR 493 at [17].
71 *R v Satherley* [2007] NZCA 381, (2005) 25 FRNZ 709.

state of mind "characterised by delusions, or by disorders of mood or perception or volition or cognition" as required by s 2 of the MHCAT Act.[72]

A further problem is the fact that neurodisability is a relatively new field and so specialised practitioners are often difficult to find. Indeed, few health assessors are specialists in either FASD or TBI, and even fewer could be considered "experts" under the definition in s 4 of the Evidence Act 2006. In the case of *Platt v R* the question was raised as to whether a proposed witness was in fact an expert in relation to FAS. The Court of Appeal found that, although the doctor had "considerable academic skills in searching and critically appraising medical literature", she claimed "no specific expertise in relation to FAS" and, consequently, her status as an expert was seriously doubtful.[73]

If the court finds that the defendant is *fit to stand trial*, the proceedings must continue. Where the defendant is found *unfit to stand trial*, the court must determine the most suitable method of dealing with the defendant under ss 24 or 25 of the CPMIP Act.

A problem will arise where the individual is found to have a mental impairment under the CPMIP Act, but neither a mental disorder under the MCHAT Act nor an intellectual disability under the IDCCR Act (as will very likely be the case for those with neurodisability). In these cases, it becomes very difficult to appropriately deal with the offender. A finding of unfitness to stand trial will provide considerable benefit to an defendant with neurodisability by saving them the stress involved in participating in a trial. However, a finding of unfitness without any practical or helpful long-term outcomes will be antitherapeutic. Indeed, the stigma attached to being found *unfit* to stand trial is likely to be antitherapeutic, particularly if this finding is not accompanied by a disposition that will provide actual benefit to the individual.

An order that the defendant be treated as a patient under the MHCAT Act cannot be made unless the court is satisfied that the defendant is mentally disordered. Similarly, an order for care under the IDCCR Act cannot be made unless the court is satisfied that the defendant has an intellectual disability.[74] The alternative options for the court are: to decide not to make an order where the person is liable to be detained under a sentence of imprisonment; or to order the immediate release of the defendant. Both alternatives are extremely inappropriate for offenders with a predisposition for continued offending[75] and neither is remotely therapeutic for defendants with neurodisability. Furthermore, even if it were that these offenders could come within the definition of "mental disorder" or "intellectual disability" for the purpose of disposition, it is unlikely that either response would be able to effectively cater to the needs of these individuals. It must be kept in mind at all times that—for the most part—neurodisability is incurable. FASD is certainly incurable and, while TBI can be somewhat rehabilitated, this will often only be effective in the early period after the TBI event. When individuals with a TBI reach the criminal justice system, it is unlikely they will be in this golden time frame for successful rehabilitation.

The law surrounding unfitness to stand trial demonstrates clearly the potential antitherapeutic consequences for those with neurodisability problems. The legal rules are set out in such a way that antitherapeutic consequences are almost inevitable for these offenders. The terminology allows for their inclusion in a definition of being *unfit to stand trial*, and yet it excludes them from any possible benefits that this legal rule might otherwise provide.

72 See definition of "mental disorder".
73 *Platt v R* [2010] NZCA 43 at [41]–[44].
74 CPMIP Act, s 25(2) and (3).
75 Section 25(1)(c)–(d).

B *Legal procedures*

The legal procedures of the trial and sentencing processes provide clear examples of how the criminal justice system can produce anti-therapeutic consequences for persons with neurodisability.

(1) The trial process

Participation in a trial is a recognisably stressful experience for those without neurodisability, who are able to understand and actively participate in the process. It is presumably far worse for those who cannot understand or engage with the process occurring around them.

Individuals with neurodisability often face significant challenges when participating in a trial, especially when their neurodisability is not apparent to the court. At the most severe end of the spectrum, individuals may be entirely unable to instruct or communicate with their legal counsel.[76] In these cases, it should be clear that the individual is not participating in any meaningful way. However, even those who are able to communicate with legal counsel may still be seriously disadvantaged in the trial process.

Kaitlyn McLachlan and others conducted a study on the psycholegal abilities of young offenders with FASD in the United States.[77] The offenders' psycholegal abilities included their understanding of Miranda rights, factual knowledge of criminal procedure, appreciation of the nature and object of proceedings, and their ability to participate in a defence and communicate with legal counsel.[78] The authors found that 76 per cent of the sample showed impairment in at least one psycholegal ability, and rates of impairment were significantly higher in the offender group than in the comparison group.[79]

Individuals with neurodisability will often have language difficulties which put them at an immediate disadvantage given the fact that "language is involved in every stage of the legal process".[80] This will hinder their ability to understand the proceedings and may prevent them from actively participating if they are unable to communicate at a level expected by the court. Language deficits may also leave individuals vulnerable to coercion and misunderstanding, which may impinge on their due process rights.[81] Individuals with FASD are particularly at risk in this area because, despite often having considerable language deficits, many will appear "chatty" or display superficial verboseness.[82] This can lead to legal professionals overestimating their level of understanding and overall competence, reducing the chance that the process will be modified to help the individual better understand the proceedings.

Characteristics of neurodisability—such as increased "impulsivity, memory problems, language deficits, cognitive deficits, and executive functioning impairments"—may also increase the likelihood of an individual making false admissions or lying during the trial

76 O'Driscoll, above n 23, at 119–120.

77 Kaitlyn McLachlan and others "Evaluating the Psycholegal Abilities of Young Offenders with Fetal Alcohol Spectrum Disorder" (2014) 38 Law Hum Behav 10 at 10.

78 At 14–15.

79 At 18–19.

80 Linda Hand and others "Oral Language and Communication Factors to Consider When Supporting People with FASD Involved with the Legal System" in Monty Nelson and Marguerite Trussler (eds) *Fetal Alcohol Spectrum Disorders in Adults: Ethical and Legal Perspectives* (Springer International Publishing, Switzerland, 2016) 139 at 142.

81 Parkinson and McLean, above n 35, at 143.

82 Fast and Conry, above n 22, at 252.

process.[83] It is important then that any information or statements provided by the defendant are corroborated. However, if the court is unaware of the neurodisability, it is unlikely to depart from the standard procedures used for witnesses. Although these individuals may not be purposefully lying, they run the risk of being charged with perjury—a highly antitherapeutic consequence—if it comes to the court's attention. Alternatively, they may confess to crimes they did not commit, as in the case of Teina Pora, which resulted in 21 years in prison despite Pora never committing the crime.[84]

The trial process may also be antitherapeutic as, due to executive functioning deficits, offenders with neurodisability may be unable to connect the consequence of the trial with the specific act they are accused of committing.[85] This will be particularly so where additional offences have been committed between the time of the original offence and the trial. An individual may have no understanding of why they have to engage in the trial. This is likely to be extremely antitherapeutic.

In addition to the antitherapeutic consequences associated with involvement in a trial, an individual's legal rights may also be impinged. Language deficits may make them more suggestible or more likely to acquiesce when questioned by opposing lawyers. The individual may make false confessions on the assumption that they will be able to leave if they agree with what the opposing counsel submits.[86] They may also fail to understand the implications of a plea, the importance of waiving the right to lawyer-client privilege, misunderstand the terms *guilty* and *not guilty*, and may assume that a false confession can be retracted.

(2) Sentencing

The Sentencing Act 2002 governs the sentencing process in New Zealand.[87] Many offenders will be sentenced without evidence of their neurodisability ever being brought to the court's attention. This will be highly antitherapeutic as these offenders will be held to a standard they cannot possibly attain, and will be sentenced in a manner that does not reflect their individual needs. However, even when the court is aware of an individual's neurodisability, sentencing can still be an antitherapeutic experience.

Sentencing offenders with neurodisability is a difficult task for judges, not least because there is very limited existing case law in New Zealand to guide them. Neurodisability can be considered in the sentencing process as a mitigating or aggravating factor.[88] It may be viewed as a mitigating factor if it predisposed the individual to engage in the offending behaviour, making them less culpable or deserving of punishment. However, an offender with neurodisability may alternatively be viewed as unpredictable, thus posing a greater risk to the community. It is unclear how neurodisability will be viewed, and this may cause offenders to hide evidence of their neurodisability from the court. It might also influence the case that their lawyer submits to the court. This may lead

83 At 254; and Gagnier, Moore and Green, above n 34, at e430.

84 See Phil Taylor "Justice after 21 years in jail: Teina Pora 'set up for new life' after Privy Council quashes convictions for Susan Burdett murder" *The New Zealand Herald* (online ed, Auckland, 4 March 2015).

85 Fast and Conry, above n 22, at 256.

86 At 254.

87 For the purposes of this article it is more appropriate to discuss sentencing as a legal procedure than as a legal rule, although it could fall under either discussion.

88 Kent Roach and Andrea Bailey "The Relevance Of Fetal Alcohol Spectrum Disorder In Canadian Criminal Law From Investigation To Sentencing" (2009) 42 UBC Law Rev 1 at 5.

to offenders missing out on the opportunity to have their neurodisability taken into account as a mitigating factor for fear of a negative outcome.

Standard sentencing considerations of deterrence or rehabilitation may not have any practical relevance for offenders with neurodisability. Principles of deterrence assume that offenders are able to make connections between cause and effect, remember the connection, and then generalise that connection to future situations. For those with neurodisability, this is often not possible due to executive function deficits. It may, therefore, be pointless to send an individual with neurodisability to prison to *learn a lesson*.[89] The principle of rehabilitation may have even less practical relevance. As explained already, neurodisability often cannot be rehabilitated. Even where—in the case of certain TBIs—it can, by the time an individual has reached the criminal justice system, it will often be too late for any successful rehabilitation efforts.[90] These principles are based on levels of cognitive functioning and abilities that simply are not present in a number of offenders with neurodisability.[91]

Even when judges are aware of neurodisability, the sentencing options available to offenders may not be appropriate. In cases where incarceration is required by statute, those with neurodisability may be at a further disadvantage. In her foreword in *New Zealand's Mental Health Act in Practice*, Susan Glazebrook made a special plea for further work with those with head injuries.[92] Glazebrook noted that, while treatment is available in prison for those with mental illness, no similar treatment is available for those with head injuries. There is also no specialised unit for the treatment of brain injuries.[93] This can be further generalised to neurodisability as a whole. Due to the various deficits associated with neurodisability, treatment, such as cognitive therapy, which is typically used in corrections, will often be ineffective.[94] Such a treatment requires cognitive ability that many with neurodisability will not have. Many will likely not even understand what is required of them within the treatment[95] and this is likely to be extremely frustrating and stressful for offenders—as well as for those who are attempting to work with them. While *treatment* may not be the correct term (note again the incurability of neurodisability) there is surely a better alternative to incarcerating offenders with neurodisability.

Incarceration will be highly antitherapeutic for offenders with neurodisability. Prisons are "noisy" and "over stimulating", requiring "new coping skills" which individuals with neurodisability will struggle to develop.[96] These individuals may have difficulty adjusting to and following the rules and routines of prison; and failure to do so may result in them being viewed as *noncompliant* and *difficult* by prison staff, which could in turn result in harsher punishments.[97] Individuals with neurodisability will also often be vulnerable to victimisation by other inmates.[98]

89 Moore and Green, above n 20, at 9.
90 Although not the case for every individual, group data suggests that recovery after "the first 6 months to a year following the injury" tends to be "slow and limited". Moore and Stambrook, above n 55, at 113.
91 Fast and Conry, above n 22, at 255.
92 Susan Glazebrook "Foreword" in John Dawson and Kris Gledhill (eds) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 7 at 9.
93 *Blackwood v R* [2011] NZCA 143 at [25].
94 Chudley and others, above n 24, at 269.
95 Hand and others, above n 80, at 142.
96 Chudley and others, above n 24, at 269–270.
97 Fast and Conry, above n 22, at 256.
98 At 256.

Both the trial and sentencing processes can produce a range of antitherapeutic consequences for offenders with neurodisability, largely due to their lack of understanding and ability to participate. Trials and sentencing will consequently be confusing, distressing and may seem unfair to the individual, making it less likely that they will learn what is required from the process.

C *Roles of legal actors*

Legal actors include all professionals directly involved in the legal process, most significantly judges and lawyers. Their roles can produce serious antitherapeutic consequences for those with neurodisability, even when the actors' intentions are good. This is largely due to a lack of knowledge and awareness of neurodisability.

It is primarily the responsibility of legal counsel to place evidence of neurodisability before the court. As already discussed, there are many reasons why an individual defendant may not disclose evidence of neurodisability to their lawyer, including fear of stigma or discrimination, the desire not to have it brought up in court, or even being unaware of one's own neurodisability. Therefore, in order for the court to consider the neurodisability, the lawyer must recognise the presence of the neurodisability. This is certainly not an easy task.

A study conducted in 2008 investigated the knowledge and attitudes of criminal justice professionals in relation to FASD in the Canadian criminal justice system.[99] The researchers found that over half of all prosecutors and judges interviewed cited the mass media as their main source of knowledge around FASD.[100] Positively, a large percentage of respondents in each group (70 per cent of judges and 50 per cent of prosecutors) reported that they had modified their practice when dealing with a person they suspected had FASD. However, the authors noted that the vast majority stated that they did not know the symptoms of FASD.[101] Almost all of the judges, and approximately three quarters of the prosecutors, believed that FASD was identifiable, and approximately three quarters of both groups based their suspicions on physical appearance.[102] Only a select few had directly engaged trained professionals when responding to individuals with FASD.

As discussed earlier, neurodisability—specifically FASD, but similarly TBI—is often not obvious to the standard observer. If legal actors are relying on their own ability to identify the presence of neurodisability, they will often miss it. Even if they do suspect the presence of some form of neurodisability, there will be few who have the training and skills to appropriately identify the specific elements (for example, whether an individual has FAS rather than ARND, or a moderate rather than severe TBI). This is further assuming that they are even able to differentiate between FASD, a TBI and something altogether different, such as an intellectual disability.

Without the appropriate knowledge and skills that come from often resource-intensive training, legal actors—despite their good intentions—are unlikely to provide therapeutic outcomes for their clients. Ad hoc modification of behaviour based on often incorrect

99 Lori Vitale Cox, Donald Clairmont and Seamus Cox "Knowledge and Attitudes of Criminal Justice Professionals in Relation to Fetal Alcohol Spectrum Disorder" (2008) 15 Can J Clin Pharmacol e306.

100 At e308.

101 Furthermore, only three of the 39 respondents were aware that the term FAE was no longer used.

102 Cox, Clairmont and Cox, above n 99, at e308.

perceptions around what neurodisability is and looks like means that defendants face inconsistent and often misinformed outcomes as a result of their lawyers' actions.

D *Conclusion*

This Part has discussed the numerous ways in which antitherapeutic consequences can occur for offenders with neurodisability in the criminal justice system. Even where intentions are good, legal rules, procedures and actors can all produce antitherapeutic consequences. My discussion was based on the legal rules around unfitness to stand trial, the legal procedures of the trial and sentencing processes, and the roles of legal actors, specifically lawyers, in dealing with clients with neurodisability. However, this is not an exhaustive list of the instances where the legal system produces antitherapeutic consequences for offenders with neurodisability. Indeed, they are merely examples of a wider problem. An antitherapeutic system will struggle to have the desired effect of reducing future offending. With this in mind, I now turn to discuss positive recommendations for reducing these antitherapeutic consequences in order to make the criminal justice system more therapeutic for those with neurodisability.

V Making the Criminal Justice System More Therapeutic for those with Neurodisability

As the previous Part demonstrated, the law can produce serious antitherapeutic consequences for those with neurodisability. In this Part I provide a number of recommendations for how the criminal justice system could operate to produce more therapeutic consequences and reduce antitherapeutic consequences for those with neurodisability, both within the existing legal framework and by more dramatic changes to the law in practice in New Zealand.

TJ allows us to consider how to make the implementation of existing law more therapeutic. I recommend further research regarding neurodisability in the context of the criminal justice system. I also recommend changes to existing processes within the criminal justice system to create more therapeutic outcomes for those with neurodisability. Finally, I offer suggestions for legislative reform and recommend, specifically, the development of a mental health court in New Zealand.

A *Further research into neurodisability in the context of the criminal justice system*

The first step to creating more therapeutic consequences for those with neurodisability in the criminal justice system is further research. Further research will bring a greater understanding of the nuances of neurodisability and the effects of the criminal justice system on the wellbeing of individuals experiencing it. In turn, this increased understanding should guide the training and professional development of relevant legal professionals. It should also be able to better inform future law reform. While research on neurodisability in general is needed, one area in which research is particularly lacking is the impact of TBI on an offender's involvement in the criminal justice system. At present, this is largely guided by research on neurodisability in general and may fail to address the specific nuances of TBI.

B *Modification of existing processes within the criminal justice system*

A practical recommendation for making the criminal justice system more therapeutic for those with neurodisability is to modify existing processes within the criminal justice system. While this may seem simple in theory, it will not be so easy to implement in practice.

As discussed already, the key reason why legal actors tend to produce antitherapeutic consequences for offenders with neurodisability is that the actors lack knowledge about neurodisability. It follows that improved training and professional development for legal professionals in the criminal justice system is necessary. In the same way that we cannot expect judges to be omnipotent when making their decisions, we cannot expect legal actors to be experts on every issue related to a defendant that comes before them without specific education and training. Even with education and training, it is unlikely that they will able to diagnose to the same standard as trained medical and psychiatric professionals. However, they should not be expected to. Training should not only focus on what neurodisability is and how best to address it in the criminal justice system, but also on how to access support and trained professionals where needed.

Training could cover matters as simple as how to better communicate with offenders with neurodisability in the trial context. The United Kingdom Department of Health Handbook provides practical advice for professionals communicating with individuals with learning disabilities.[103] For instance, the Handbook advises professionals to speak slowly and use plain language, ensure the individual understands things before moving on, prepare the individual for each stage of the communication (for example, by saying "David, I will now ask you some simple questions") and be aware that repeating a question may suggest to the person that they have given the wrong answer.[104] Practical advice such as this could go a long way to producing more therapeutic outcomes for offenders with neurodisability problems without the need for more dramatic changes, such as removing the cross-examination process. This would also, hopefully, promote consistency in how offenders with neurodisability are dealt with in the criminal justice system.

In addition, modifying existing processes and practices, such as parole conditions, would decrease the likelihood of antitherapeutic consequences. For instance, it would be beneficial to recognise that offenders with neurodisability problems may have more difficulty complying with orders, and tailor parole conditions accordingly. This could be as straightforward as ensuring that probation orders are written in simple, concrete language.[105] Such an approach may also decrease recidivism, which could prevent further interaction with the law—certainly a better outcome for an individual's wellbeing.[106]

C *Legislative reform*

A possible legislative amendment is to include neurodisability, such as FASD and TBI, in the current definition of "mental disorder" within the MHCAT Act or "intellectual disability" within the IDCCR Act. These reforms could produce therapeutic consequences by

103 Department of Health (Offender Health and Valuing People) *Positive Practice, Positive Outcomes: A Handbook for Professionals in the Criminal Justice System working with Offenders with Learning Disabilities* (2nd ed, Department of Health, London, 2011) <www.dh.gov.uk>.

104 At 32.

105 Fast and Conry, above n 22, at 256.

106 Chudley and others, above n 24, at 270.

providing the court with disposition options not currently available to them for defendants with neurodisability who are found unfit to stand trial.

However, as discussed earlier, neurodisability is, for the most part, incurable. Therefore, neither disposition option—to be treated as a patient under the MHCAT Act, or an order for care under the IDCCR Act[107]—is likely be able to effectively deal with persons with neurodisability. It is unlikely then that these offenders would be able to eventually regain their freedom. These disposition options would also be antitherapeutic because, while they would be considered unfit to stand trial, the offenders could still feel punished as if they had proceeded to trial. In fact, in many cases, their *sentence* (if we consider it holistically) may have been far less had they been to trial.

Inclusion of neurodisability in current legal definitions would demonstrate an acknowledgement of the detrimental effect of neurodisability for individuals in the criminal justice system. This could produce therapeutic consequences for individuals. However, unless this is followed with appropriate disposition options, antitherapeutic consequences are far more likely to result.

D *Developing a mental health court*

The most dramatic recommendation that I will discuss is the development of a mental health court in New Zealand that could deal with offenders with neurodisabilities. This could, for instance, be modeled on the Victoria Assessment and Referral Court List (ARCL). Mental health courts are a form of *problem-solving court* that deal with offenders who have committed crimes and have serious mental illnesses. I will briefly discuss the problem-solving court movement with specific reference to mental health courts, before turning to a case study of the ARCL.

Problem-solving courts came about as a response to growing dissatisfaction with the traditional criminal justice system and a belief that the courts were doing little to address the underlying problems of those appearing in court. Procedures were being followed and the legal rights of litigants protected. However, this appeared not to be "making a dent" in the overall problem.[108] While it is often thought that TJ provides the theoretical foundation for the problem-solving court movement, the two movements actually developed independently of each other.[109] However, problem-solving courts do tend to apply TJ principles in their practice.

Problem-solving courts are designed to solve specific problems. They are concerned with legal outcomes and help to resolve offenders' underlying problems—for example substance abuse or domestic violence—which are often intertwined with offending behaviour.[110] They aim to empower offenders to "take charge of their own conduct",[111]

107 CPMIP Act 2003, s 25(1)(a)–(b).

108 Judith S Kaye "Making the Case for Hands-On Courts" *Newsweek* (online ed, New York, 11 October 1999) as cited in Greg Berman and John Feinblatt "Problem-Solving Courts: A Brief Primer" (2001) 23 Law & Policy 125 at 129.

109 See generally Susan Daicoff "The Role of Therapeutic Jurisprudence within the Comprehensive Law Movement" in Dennis P Stolle, David B Wexler and Bruce J Winick (eds) *Practicing Therapeutic Jurisprudence: Law As a Helping Profession* (Carolina Academic Press, Durham NC, 2000) 465.

110 Michael King "What Can Mainstream Courts Learn from Problem-Solving Courts?" (2007) 32 Alt LJ 91 at 91.

111 Richard L Wiener and others "A testable theory of problem solving courts: Avoiding past empirical and legal failures" (2010) 33 Intl J L & Psychiatry 417 at 422.

with the ultimate goal of reducing recidivism and combating the "revolving door" of offenders through the criminal justice system.[112]

Problem solving courts aim to "seize upon a moment when people are open to changing dysfunctional behaviour—the crisis of coming to court—to give them the opportunity to change".[113] They modify the traditional roles of lawyers and judges, who become actors working as part of a team with other relevant professionals, such as probation officers and social workers. Problem-solving courts have been utilised in New Zealand and internationally to help resolve problems including drug and alcohol use, domestic violence and mental health issues.

Mental health courts are modelled on the drug courts—the first of the problem-solving courts—and were introduced as a response to the overrepresentation of offenders with mental illness in the criminal justice system.[114] First introduced in North America in the 1980s,[115] mental health courts are now present in more than 30 states of America and most cities in Canada; in 2010, there were more than 300 mental health courts globally, with this number continuing to rise.[116]

Mental health courts differ in a number of ways to drug courts, primarily because having a mental illness is not a crime.[117] In addition, jail is used less often as a sanction in mental health courts, and treatment plans tend to be more tailored to the specific mental illness.[118] Mental health courts combine court supervision with community-based treatment services, and divert offenders with mental illness out of the traditional court system.[119] As they aim to reduce recidivism, the courts serve to increase public safety, improve the quality of life of offenders with mental illness and increase their participation in effective treatment.[120] They also decrease court and corrections costs through the use of alternatives to incarceration.[121]

Referral to a mental health court often comes from legal counsel or the offender's family members.[122] Defendants are invited to participate in the mental health court following specialist screening and assessment, and participation is entirely voluntary. Court staff and mental health professionals work together as a team to develop treatment plans and supervise court participants.[123]

Evaluations of the mental health courts have been positive, with research showing that participation is associated with longer periods without new criminal charges, reductions in the probability of future arrests and improved overall levels of functioning for

112 At 417.
113 King, above n 110, at 91.
114 Council of State Governments *Mental Health Courts: A National Snapshot* (2005) Bureau of Justice Assistance <www.bja.gov> [*US National Snapshot*] at 1.
115 Luke Williams "Therapeutic Jurisprudence" (9 August 2010) Lawyers Weekly <www.lawyersweekly.com.au>.
116 Williams, above n 115.
117 Brenda C Desmond and Paul J Lenz "Mental Health Courts: An Effective Way for Treating Offenders with Serious Mental Illness" (2010) 34 Ment Phys Disabil Law Rep 525 at 526.
118 At 526.
119 At 526.
120 Lauren Almquist and Elizabeth Dodd *Mental Health Courts: A Guide to Research-Informed Policy and Practice* (Council of State Governments Justice Center, New York, 2009) at v.
121 Desmond and Lenz, above n 117, at 527.
122 Almquist and Dodd, above n 120, at vi.
123 *US National Snapshot*, above n 114, at 1.

participants.[124] However, individual mental health courts should continue to be evaluated, given the wide diversity that exists regarding their day-to-day operation.[125]

(1) Victoria Assessment and Referral Court List

The ARCL is a specialised court list operating as a problem-solving court, developed by the Department of Justice and the Magistrates' Court of Victoria in order to meet the needs of offenders who have a mental illness or cognitive impairment.[126] It was established by the Magistrates' Court Amendment (Assessment and Referral Court List) Act 2010[127] and is largely modelled on the Toronto Mental Health Court and Diversion Programme. Those eligible to participate in the ARCL are offenders with (or are likely to have) a mental illness, intellectual disability, acquired brain injury, autism spectrum disorder or neurological impairment, including dementia. The disorder must cause a "substantially reduced capacity in at least one of the areas of self-care, self-management, social interaction or communication".[128] Importantly, offenders who have been charged with specific excluded criminal offences that involve serious violence or sexual assaults are not eligible for the ARCL.[129]

The aims of the ARCL are:[130]

- To reduce the risk of harm to the community by addressing the underlying factors that contribute to offending behaviour
- To improve the health and wellbeing of accused persons with a mental impairment by facilitating access to appropriate treatment and other support services
- To increase public confidence in the criminal justice system by improving court processes and increasing options available to courts in responding to accused persons with a mental impairment
- To reduce the number of offenders with a mental impairment received into the prison system.

Referrals can be made by the accused, significant others, community service organisations, magistrates police, prosecutors, legal representatives and court-based support services.[131] Offenders must consent to participating. Participation typically lasts

124 Brianna Chesser and Kenneth H Smith "The Assessment and Referral Court List program in the Magistrates Court of Victoria: An Australian study of recidivism" (2016) 45 IJLCJ 141 at 146–149; Dale E McNiel and Renée L Binder "Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence" (2007) 164 Am J Psychiatry 1395 at 1401–1402; and Marlee E Moore and Virginia Aldigé Hiday "Mental Health Court Outcomes: A Comparison of Re-Arrest and Re-Arrest Severity Between Mental Health Court and Traditional Court Participants" (2006) 30 Law Hum Behav 659 at 665–669. See also Bridget M Kuehn "Mental Health Courts Show Promise" (2007) 297 Medical News & Perspectives 1641.

125 Bazelon Centre for Mental Health Law "The Role of Mental Health Courts in System Reform" <www.bazelon.org> at 5.

126 For further information about the ARCL, see Magistrates' Court of Victoria "Assessment and Referral Court List (ARC)" <www.magistratescourt.vic.gov.au> [ARC].

127 Magistrates' Court Amendment (Assessment and Referral Court List) Act 2010 (Vic).

128 ARC, above n 126.

129 Sentencing Act 1991 (Vic), cls 1, 2, 3, and sch 1.

130 ARC, above n 126.

131 ARC, above n 126.

between three and 12 months, and the offender appears regularly before the List Magistrate to discuss their progress. If the offender pleads guilty at the end of their participation, they are sentenced within the ARCL. However, if they plead not guilty, the case will be returned to the mainstream court for a contested hearing.

Mental health courts provide a creative solution to the problem of neurodisability in the criminal justice system. The Victoria ARCL is a useful model to examine because it incorporates wider mental impairment, including forms of neurodisability, as opposed to a strict definition of mental illness. Considering the current criminal justice system is failing to address neurodisability at every stage, it may be that such a dramatic shift is required.

The development of a mental health court has the potential to address the multitude of antitherapeutic consequences discussed already. A mental health court in New Zealand would provide a space in the legal system to recognise the importance of neurodisability. It could also provide an appropriate disposition option in circumstances where neurodisability is recognised. As has been discussed throughout this article, this is a major challenge for the criminal justice system at present and will continue to be in any future attempts to address the issue of neurodisability in this context. It is not enough to simply acknowledge the effect and importance of neurodisability. That is simply the first step of many. A mental health court can provide these offenders with a legal response that is neither imprisonment nor an inappropriate disposition—which, although well-meaning, can be just as, if not more, antitherapeutic than imprisonment.

Mental health courts aim to address the factors underlying offending with a specific focus on an individual's mental health and impairment issues. Responses and legal procedure are, therefore, specifically tailored to this. Offenders can be diverted out of the traditional criminal justice system where they risk being forced to participate in a system they do not and cannot possibly understand, and where their basic legal rights may be seriously at risk. A mental health court can react to the challenges that neurodisability and mental health issues pose for offenders who find themselves in the criminal justice system. It can also facilitate access to treatment and support services that an individual might otherwise struggle to access.

Many of the challenges in practice stem from a lack of knowledge and training. In the traditional criminal justice system, we do not and cannot realistically expect both the system and the actors within it to know how to address every issue an offender might bring with them to the court. In the same way that we do not expect all legal actors to be experts on drug and alcohol use, or family violence, we cannot expect them to be experts on neurodisability. Just as the offending population heterogenous, so too is the neurodisability population. However, the development of a mental health court would provide a space for knowledgeable and passionate legal actors to make neurodisability a key focus of the overall response.

At its core, the recommendation to develop a mental health court is a new approach to a problem that the New Zealand criminal justice system has so far failed to adequately address. In addition to improving the health and wellbeing outcomes of offenders, a mental health court would be better placed to address offending behaviour and ultimately prevent the cycle of offending—an outcome that benefits both the individual offender and wider society.

In Part VI, I will outline a number of critiques specific to mental health courts that must be taken into account when considering their implementation. It is arguable that an even more generalised problem-solving court may be required in the future due to the significant comorbidity of offenders with neurodisability, mental illness and drug and alcohol use. However, a discussion of this is outside the scope of the current article.

E *Conclusion*

In this Part of the article I have offered a number of recommendations to make the current criminal justice system more therapeutic for those with neurodisability. These recommendations vary in the level of difficulty of implementation and in the extent to which they challenge the structure of the present criminal justice system. However, as attractive as a TJ approach may seem, no approach is perfect. Accordingly, I turn now to offer critiques that should be kept in mind when deciding whether to implement a TJ approach within the criminal justice system.

VI Critiques of a TJ Approach

While the TJ approach provides creative solutions to the issue of neurodisability in the criminal justice system, it is not without its critics. It is important to understand the relevant critiques in order to rebut them or consider them as limitations to be minimised wherever possible. Notwithstanding the value of understanding these critiques, note that some TJ critiques are more legitimate than others.

Many critiques of TJ as an overall approach stem from a misguided understanding of what TJ truly stands for. They focus on what could happen if TJ went awry as though it is inevitable. However, this is counterproductive because it is critiquing the worst case situations that even the founders of TJ themselves could accept would be undesirable. They are certainly worth considering, but they do not need to guide all analyses of a TJ approach. One such critique contends that, so long as the defendant has altered his thoughts and behaviours, a fair hearing and an impartial judge are irrelevant.[132] Additional critiques suggest that TJ distorts the judicial process and the judge's role in it, compromising the separation of powers and threatening the judicial system as a whole.[133] Within this latter critique is the belief that "the line between the branch which interprets the laws and the one which implements them becomes completely blurred when courts become service providers intent on achieving specific outcomes".[134] According to this critique, judges are apparently free to impose their own subjective judgment, becoming official endorsers of the effectiveness of specific treatment regimes.

These types of critiques demonstrate a lack of understanding of TJ. The founders of TJ, Bruce Winick and David Wexler, make it abundantly clear that TJ values and principles are never intended to trump other normative traditional legal values.[135] While therapeutic outcomes for the individual should always be considered, they certainly do not trump traditional legal values such as fairness. While judges may have more discretion under TJ than in their traditional role, at no point does TJ provide judges with free rein to make decisions that advance specific social policies to the detriment of procedural fairness and other traditional values. Furthermore, these critiques are largely based on a narrow view of TJ, predominantly TJ in the problem-solving courts, when the aims of TJ are actually broader—to promote therapeutic outcomes across the legal system.

Additional critiques suggest that "such a broad mission of social and spiritual redemption has not been assigned to courts and judges" and that TJ is asking the courts

132 Arthur G Christean "Therapeutic Jurisprudence: Embracing a Tainted Ideal" (January 2002) Psych Rights <www.psychrights.org>.

133 Christean, above n 132.

134 Christean, above n 132.

135 Winick, above n 2, at 203.

to create solutions to problems rather than allowing society to do so through their elected representatives.[136] While the courts may not be the most desirable space to address these social problems, such a critique ignores the reality that, for many individuals, the courts are their first point of contact with a system that has any power to help. Furthermore, the courts may have the ability to implement small-scale changes that provide great benefit to individuals in a far more timely manner than if it was left solely to Parliament to implement them.

While the above critiques are relatively easy to rebut, others have more validity and must be carefully considered in any attempts to promote TJ in practice. Implementing TJ—whether by developing problem-solving courts, legislative reform or simply conducting further research and training—will be time-consuming and resource-costly.[137] Furthermore, while it is somewhat extreme to say that TJ "abandons the goal of equal justice under law",[138] it is true that, at least in the early stages of TJ implementation, not all eligible offenders will be able to receive the benefits of a TJ approach. Consequently, some offenders will be treated differently to others, which challenges fairness in the criminal justice system. However, this should not be the reason for no offenders getting the benefit of a TJ approach. It is an unfortunate inevitability that not every individual will receive the benefit of an approach right from the outset. Much like in the field of medicine, when trialling a new medication, new approaches and programmes must first be trialled with smaller groups in more controlled conditions, in order to determine their success. In the long term, however, if these approaches and programmes can be shown to be successful, they can potentially help a greater number of offenders in the future. This does not automatically outweigh concerns of unfairness, but should be weighed against those concerns when considering whether a TJ approach should be adopted.

A *Critiques specific to the mental health courts*

As the more controversial of the recommendations offered in this article, the concept of a mental health court brings with it a number of specific critiques. Research has shown the ARCL to be considerably more expensive than mainstream courts, and the time required by judges and other professionals make this approach particularly resource costly.[139] If the implementation of a mental health court can ultimately guarantee reductions in offenders cycling through the courts and decrease the need for incarceration, these costs will likely be offset. However, structured cost-benefit analyses will be required to determine whether this is so.

One could also question whether it is, in fact, therapeutic to single out people with mental impairment because this may serve to further marginalise already-marginalised individuals. While I contend that it is better for these individuals to receive treatment than to constantly cycle through the criminal justice system, not everyone agrees.[140] Moreover, a paternalistic view of what is best for an individual is antitherapeutic in itself and works against the beliefs of TJ.[141]

136 Christean, above n 132.
137 Christean, above n 132.
138 Christean, above n 132.
139 Williams, above n 115.
140 Elizabeth Richardson and Bernadette McSherry "Diversion down under — programs for offenders with mental illnesses in Australia" (2010) 33 Intl J L & Psychiatry 249 at 256.
141 Winick, above n 2, at 191–192.

Critics have suggested that mental health courts run the risk of actually deepening an offender's involvement with the criminal justice system. This is particularly so where the offences are minor. If an offender, through participation in the mental health court, enters a treatment programme that takes six months to complete, this could actually constitute a more significant involvement with the criminal justice system than had they remained in the mainstream system.

Finally, a mental health court cannot and will not fix wider societal problems surrounding resource and service shortages. While it is positive to have a system diverting people away from prison, this will only be successful if the relevant services are available for offenders as an alternative.

Despite these critiques, I argue that the mental health courts still provide a positive alternative to a traditional system that is failing to meet the needs of offenders with neurodisability. These critiques will need to be kept in mind when considering whether to establish a mental health court, and will be ongoing considerations for those involved in the court if it is established.

B *Conclusion*

In this Part of the article I have discussed a number of critiques that appear in the literature. Many of the critiques of TJ stem from misunderstandings around what TJ actually is. However, a select few critiques are valid and must be considered in any attempts to implement TJ in practice. The presence of critiques does not mean that an approach should not be taken. Rather, the critiques must be acknowledged, and those implementing therapeutic changes in the future should aim to minimise the relevant concerns wherever possible.

Ultimately, the question is whether, even given the relevant critiques, TJ is able to provide a better alternative to the traditional approach. I argue that it does.

VII Conclusion

Finding a solution to the issue of neurodisability in the context of the criminal justice system will certainly not be an easy task. Nonetheless, the issue should be explored further. Neurodisability affects a significant number of individuals within the criminal justice system, and the current system is failing to adequately address the problems that arise from their neurodisability.

In this article I have discussed the prevalence—and relevance to the criminal justice system—of two specific types of neurodisability. I have also discussed numerous ways that the current criminal justice system produces antitherapeutic consequences for individuals with FASD and TBI—and neurodisability in general.

However, I have also offered a number of recommendations for the New Zealand criminal justice system, each of which could increase the likelihood of offenders with neurodisability experiencing therapeutic rather than antitherapeutic consequences within the system. The most drastic and—I argue—beneficial of these recommendations is the development of a mental health court. I argue that this is necessary if New Zealand is serious about successfully addressing this complex issue. Increasing therapeutic consequences will provide individuals with neurodisability the opportunity to have more positive interactions with the criminal justice system. This will ideally decrease the

likelihood that they will return to the system in the future. This is beneficial for offenders and society alike.

Finally, I have discussed a number of criticisms of the TJ approach, some of which I believe to be more valid than others. These critiques demonstrate that, while TJ may be an attractive approach, it is by no means a quick or perfect fix. That being said, TJ provides a useful lens to consider the issue of neurodisability and, at the very least, provides us with a range of new options to add to the necessary dialogue about how best to address neurodisability in the criminal justice system into the future.