**Week 11. Citizens and Criminal Justice. Psychiatric disorders and criminal behavior. A special topic**.

**12.1 Causation between psychiatric disorders and criminal behavior**

Students should refer to Chapter 2 of the course materials distributed in this course on the descriptions/definitions of various types of psychiatric disorders which have been linked with criminal behavior.

Students should also note the statistics set out in different studies in that chapter establishing the rates of persons with psychiatric illnesses who have committed criminal transgressions and/or or been incarcerated. Further data confirming the link between mental illness and involvement with criminal justice system are set out further below.

Some concerns exist over the accuracy of statistics concerning rates of different types of mental illness amongst prisoners. For instance, self-reporting methods and gathering of data by lay interviewers may over-estimate prevalence of mental illness in prisons. Furthermore, it may be difficult to establish the degree to which the problems caused by incarceration may lead to depression (although statistics concerning psychosis do not seem to suffer from this uncertainty).[[1]](#footnote-1) Nevertheless, a comprehensive 2012 study found, that worldwide, one in seven prisoners suffers from a psychosis or major depression.[[2]](#footnote-2)

Chang et al found that, using a sample size of 47,326 prisoners who were incarcerated between January 1 2000 and December 31 2009 in Sweden, having a psychiatric disorder was significantly linked with violent reoffending.[[3]](#footnote-3) In particular, the study found the following specific correlations.

Without substance use disorder With substance use disorder

Any psychiatric disorder 22% 35%

Schizophrenia 22% 42%

Bipolar disorder 15% 28%

Recent data published by the National Health Service in England and Wales reported that in a survey conducted in prisons, 71% of women and 47% of men stated that they had problems with their mental health.[[4]](#footnote-4)

This correlation remained significant even after taking into account other common causes of criminal behavior, such as environment, and levels of unemployment income.[[5]](#footnote-5) An obvious key point arising is the increased likelihood of violent reoffending when psychiatrically ill people have a substance abuse problem. A further important point is that there is a link between mental illness and substance abuse. This seems to occur in three main ways[[6]](#footnote-6)(and see further below at 12.3.2):

* Drug abuse can cause mental illness such as the cause and effect between marijuana abuse and psychosis
* Mental illness can result in drug abuse as a form of self-medication
* Some individuals may have a genetic predisposition to both mental illness and drug abuse (which of course can lead to a vicious circle).

In particular, there is a link between substance abuse and personality disorder.[[7]](#footnote-7)

Chang et al makes the point that psychiatric illnesses are generally treatable,[[8]](#footnote-8) which will lead into the next section of this chapter, as to the policies which should be used to treat mental illness in Hong Kong.

**12.2 Different Strategies**

Throughout much of the developed world, up until the 1970s and 1980s, seriously mentally ill people tended to be kept in psychiatric centres on something of an indefinite basis on the basis that they required medical care, which might be described as a medical model. After that time, human rights concerns ostensibly became more prominent and compulsory admission for treatment tended to be based on perceived notions of dangerousness to other persons or self.[[9]](#footnote-9) After that time many seriously mentally ill were released into the community. This affected significant numbers of people, as many mentally ill who were released included persons who found it difficult to cope without institutionalized care, as a competing reason for release was to decrease budget outlays. In order to give some idea of the scale of this change, there were reportedly 558,000 patients in state psychiatric hospitals in the USA in 1955. Between 1955 and 1994, approximately 487,000 psychiatrically ill patients were discharged from these hospitals. As a result, a disproportionate number of mentally ill people (when looking at the general numbers of such people in the general population) became involved in the criminal justice system. For example, currently an estimated 300,000 psychiatrically ill inmates are in prison in the USA, compared to the roughly 100,000 beds available for such patients in the public and private sector.[[10]](#footnote-10)

In some countries (such as in Europe), released patients fared better than others (such as the US) in not becoming incarcerated, as the quality of residential or community care that was provided upon release was higher in the former.[[11]](#footnote-11) In Australia, significantly large numbers of psychiatrically ill people ran afoul of the criminal justice system following de-institutionalization there in the 1980s, in large part because of an absence of proper funding there, alongside increases in drug addiction.[[12]](#footnote-12)

**12.3.1 Hong Kong - mental illness problems**

Hong Kong had a highly institutionalised system of dealing with mentally ill patients up until the end of the 1990s. Those patients who were not residing in large psychiatric hospitals were housed in ward or dormitory style accommodation and forced to live very regimented lifestyles in remote locations.[[13]](#footnote-13) At end of the 1990s, the number of psychiatric patient beds began to reduce in number with an emphasis placed on community care.[[14]](#footnote-14) Although the extent of this phenomenon is not as profound as in other developed western countries,[[15]](#footnote-15) issues arose as to whether sufficient resources were provided to ensure that the standard of care offered to these patients who had been discharged was adequate.[[16]](#footnote-16)

It was further recognized that the HKSAR government lacked sufficient statistics to even determine the likely amount of mentally ill persons in Hong Kong.[[17]](#footnote-17) In order to remedy this gap, a widespread survey was conducted in Hong Kong between 2010 and 2013 which included surveys of the prevalence of common mental illnesses as well as psychoses.[[18]](#footnote-18) It found that 13.3% suffered from general mental disorders such as depression and anxiety, and that more specifically, 6.9% of persons suffered from common depression. The study also found that 2.5% of respondents suffered from a psychotic disorder.[[19]](#footnote-19)

According to survey published in 2021, half of secondary school students in Hong Kong “reported high levels of stress.”[[20]](#footnote-20)

**12.3.2 – Direct Relationships between Crime and Mental Illness in Hong Kong**

Another Hong Kong survey published in 2015 found that 40.4% of patients between 15-25 who have been treated for psychosis committed relatively serious acts of violence (acts using force with the intention of injuring or hurting someone else) toward other persons during a three-year period after initial treatment. Substance abuse was a common factor amongst these persons and so this was regarded as an important area for intervention.[[21]](#footnote-21) Chi-Wang has noted the following figures concerning comorbidity (or overlap) between substance abuse and methamphetamine abuse, with 10% of methamphetamine users developing a persistent psychotic disorder. Also, sufferers of anti-social personality type disorder have a high rate of substance abuse.[[22]](#footnote-22) It is believed that ‘self-medication’ may play a part in this type of behaviour amongst psychiatrically ill people.[[23]](#footnote-23) So, to some extent, psychiatric illnesses either lead to substance abuse or are caused by it. Or the very act of withdrawing can of itself lead to depression or related disorders such as anxiety.[[24]](#footnote-24)

Few studies exist in Hong Kong as to the correlation between mental illness and incarceration. One study published in 2018 by KKW Chow and others of 245 prisoners (150 males and 95 females) on remand (in custody awaiting trial) in Hong Kong, found very high numbers of those remand prisoners had a lifetime history of mental illness. Breaking down the findings further, the study reported these percentage figures:[[25]](#footnote-25)

Male Female

Lifetime substance abuse 36.7% 43.3%

Lifetime mood disorder 21.6% 18.7%

Lifetime psychotic 5.3% 7.3%

Lifetime neurotic 3.7% 3.3%

**12.3.3 – Indirect Relationships between Crime and Mental Illness in Hong Kong**

Another vicious cycle is that psychiatric illness is associated with homelessness and unemployment which then of course exacerbates it, either as a cause or as an effect.[[26]](#footnote-26) As stated in Chapter 2 of your notes, unemployment can be a cause of crime, and like other criminogenic factors, it is more likely to be associated with crime if other of these types of factors are present.

In relation to homelessness, a Hong Kong study published in 2015 found that there was a strong correlation between homelessness (people sleeping rough) and mental illness. In particular, it came up with the following findings amongst the group studied:

* 71% had suffered from mental illness
* Around 30% had mood disorders, which includes bi-polar and depressive disorders
* 10% had psychotic disorders
* 25% had substance abuse disorders. This reported figure was not further broken down to cross-match particular disorders with this problem but the study did find that of those sampled, they had a higher rate of drug and violence-related crimes. Again, the reported figures are not broken down to cross-match particular disorders, but the following over-all figures were recorded.
* 49% had a criminal record
* 20% had committed drug-related crimes
* 22% had committed violent crimes
* 32% had committed thefts or robberies

Interestingly, the authors stated that a number of the originally selected subjects were too mentally ill to respond to the survey and had to be excluded. The authors concluded then that a number of the findings, such as the extent of mental illness in the cohort studied might be conservative.[[27]](#footnote-27)

Various high profile cases involving seriously mentally ill people and very violent incidents have indicated that there is a cause and effect between mental illness and certain types of crimes.[[28]](#footnote-28) Of course, these are rather extreme and isolated incidents, but, in conjunction with the indirect evidence in Hong Kong of this link and the overwhelming evidence of this association in other countries, it is worthwhile examining what strategies can be adopted in Hong Kong to reduce crime caused by mental illness.

**12.4 Adequacy of existing methods in Hong Kong**

Preventing and controlling crime requires a holistic approach and crime prevention strategies cannot be limited to use of the organs of the criminal justice system. Therefore, it is worth briefly examining the non-criminal justice measures which can be used for preventing the type of mental illnesses that could ultimately result in crime.

After discharge from hospitals, patients who have a history of violence are required to register under a system called Priority Follow Up to ensure that these patients remain symptom free. These discharged patients are required to attend outpatient clinics for treatment and are visited by psychiatric nurses on a regular basis (although patients are not legally obliged to participate in the latter). Despite these rules, as at 2015, Lee and Lam found that the system for mental health was somewhat piecemeal and underfunded.[[29]](#footnote-29)

Unsurprisingly, in this respect, a Hong Kong study published in 2015 found that better resourced community outreach programmes (e.g. use of more up to date and effective anti-psychotic medicines, more frequent home visitations, lower case-loads for workers) achieve greater success in reducing re-admissions for patients, including those with histories of violence and substance abuse, than ones which are not.[[30]](#footnote-30)

Hong Kong has relatively recently conducted a review of mental illness and the systems it has in place for alleviating it which have been outlined in the Mental Health Review Report (‘The Report’).[[31]](#footnote-31) The Report notes that, in relation to serious mental illness (‘SMI’), the Hospital Authority provides a mix of different treatments, through outpatient care, community psychiatric workers and in-patient care, to 39,100 patients with serious mental illness.[[32]](#footnote-32) There are also other more specific programmes for those with SMI such as the:

* Early Assessment Service for Young People with Early Psychosis (EASY) Programme identifying those who are at risk of developing psychosis.
* The Case Management Programme, which provides close and concentrated support.[[33]](#footnote-33)
* Also, the Department of Health offers parenting programmes through the Maternal and Child Health Centres. The programme used in these centres has been reputedly proved to be effective in significantly improving parenting performance, so as to lead to a reduction in children’s behavioural problems.[[34]](#footnote-34) These types of programmes are likely to be useful in preventing the development of anti-social personality disorder. Referral programmes also exist for psychological assistance for children by the Department of Health also exist to experts like psychologists and social workers.[[35]](#footnote-35) Resources are regularly being increased to identify at-risk parents and children.[[36]](#footnote-36)
* The Report noted a particular problem resulting from deinstitutionalization which was that people with serious mental illness (‘SMIs’) living in the community may not take their prescribed medication which can of course lead to a relapse of their conditions. While the Report did not acknowledge a link between mental illness and criminal behaviour, the preceding commentary in the chapter establishes a contrary view. In any event, the Report, because of human rights concerns ruled out the introduction of compulsory treatment orders which can be used in other jurisdictions like Australia and England to force SMIs to take their medication.

A more robust way of controlling SMIs exists under Section 42B of Mental Health Ordinance (Cap. 136) (‘MHO’) which covers patients in mental hospitals who have a medical history of criminal violence or a disposition to commit such violence. If the medical superintendent is satisfied that the person may be safely discharged subject to conditions, he or she may be discharged subject to certain conditions. Such conditions include:

* Residing at a specific place
* Attending out-patient treatment
* Consuming prescribed medication.

If the patient does not comply with these conditions or if it is in the person’s interest in relation to his safety or health or it is necessary for the protection of other persons then he/she may be recalled to a psychiatric hospital.

Such persons would be already residing in a mental hospital pursuant to s.31 of the MHO or s.35 MHO.[[37]](#footnote-37)

**12.5. Mental health order**

The bench, when sentencing a person convicted of a crime who is suffering from a mental disorder has the option of making a hospital order as a means of disposing of the matter.

Section 45 MHO essentially provides that:

* Where a person is convicted and the [court](http://www.hklii.org/hk/legis/en/ord/136/s2.html#court) is satisfied on the written or oral evidence of 2 [registered medical practitioners](http://www.hklii.org/hk/legis/en/ord/136/s2.html#registered_medical_practitioner) that the person is a [mentally disordered person](http://www.hklii.org/hk/legis/en/ord/136/s2.html#mentally_disordered_person)
* The [court](http://www.hklii.org/hk/legis/en/ord/136/s2.html#court) is of the opinion, having regard to all the circumstances, including:
* the nature of the offence
* the character and prior record of the person;
* the most suitable method of disposing of the case is by means of an order under this section.

the [court](http://www.hklii.org/hk/legis/en/ord/136/s2.html#court) may by a [hospital order](http://www.hklii.org/hk/legis/en/ord/136/s2.html#hospital_order) authorize the admission of the person to, and his detention in, the [Correctional Services Department Psychiatric Centre](http://www.hklii.org/hk/legis/en/ord/136/s2.html#correctional_services_department_psychiatric_centre) or a [mental hospital](http://www.hklii.org/hk/legis/en/ord/136/s2.html#mental_hospital).

In *HKSAR* v *Chiu Yu-to*,[[38]](#footnote-38) a person with schizophrenia committed an armed robbery with a knife. His actions appeared to be strongly related to his condition as he did not flee the scene of the crime. Rather he waited around until the police arrived. Pursuant to s.45(1) MHO, on appeal his sentence of imprisonment was substituted and he was ordered to spend 12 months at Siu Lam Psychiatric Centre.

It can be seen then that Hong Kong adopts a relatively conventional and traditionally based model for addressing people with SMIs who have either committed violence or are likely to do so. Namely, through a court which will punish the person who has committed the crime through the usual menu of sentencing options or by way of a hospital order for detention in a mental hospital of a person who may be dangerous to another person. There is no comprehensive ongoing monitoring of a patient by a problem-solving court as happens in some other jurisdictions. This type of model will be considered below.

**12.6. Mental Health Courts (‘MHCs’)**

**12.6.1 Nature of MHCs**

The primary purpose of MHCs is to move mentally ill offenders away from the criminal justice system and into “court-mandated, community-based treatment programs.”[[39]](#footnote-39) Ultimately, this should lead to a reduction in recidivism and an alleviation of psychiatric symptoms. These courts arose because of the high numbers of mentally ill people who were interacting with the criminal justice system. The types of illnesses covered often involve bipolar disorder, depression and schizophrenia.[[40]](#footnote-40) MHCs are one of a number of problem-solving courts that are currently employed widely in the USA.

**12.6.2 Key characteristics of MHCs in the USA**

MHCs have been described as having a number of key, defining characteristics:

1. The case load of the court is restricted to defendants who have committed a crime and have a mental illness.
2. Judges, prosecutors, defence lawyers and a mental health representative work together in a cooperative and non-adversarial manner.
3. There is a connection to a mental health system.
4. Defendants are monitored to ensure they comply with orders and non-compliance will result in sanctions.

Eligibility criteria differs between courts as to the type of offences and mentally ill offenders that courts will deal with.[[41]](#footnote-41) MHCs can operate in either pre-adjudication or post-adjudication modes, leading to either a dismissal of the charge or a reduction in the sentence respectively. In the former case, the matter is sent to a conventional court to be dealt with.[[42]](#footnote-42)

**12.6.3 Are MHCs successful in reducing recidivism?**

Most of the available reliable data demonstrates that MHCs lead to a reduction in recidivism, including three meta-analyses of MHCs in the USA conducted between 2001 and 2012.[[43]](#footnote-43) One study in North Carolina explored recidivism rates 5 years post-exit after being dealt with in an MHC. The recidivism rate was 39.6% for those who completed an MHC programme, as opposed to the general recidivism rate of around 50% of a comparable group of non-MHC participants for a similar period.[[44]](#footnote-44)

A literature review conducted by Lowder found that MHCs are more effective in reducing reoffending amongst adult offenders who have completed the program, rather than for those who have simply entered it[[45]](#footnote-45) (see further here in relation to 12.6.6). As a result, the authors suggested there is a need to research whether there would be attendant reductions in recidivism if there was greater use of status hearings and more intensive case management in MHCs.[[46]](#footnote-46)

**12.6.4 What are the reasons for the success of MHCs?**

Edgely[[47]](#footnote-47) has argued that successful MHCs have a number of distinctive features which make them more effective in reducing recidivism than conventional courts including that:

* Judges exercise a form of “therapeutic jurisprudence”[[48]](#footnote-48) through their interactions with participants which are formed at an early stage at status hearings by listening to participants and attempting to tailor a personalized programme to assist in their recovery. In addition, the judge works with the participant to try to achieve the sought-after outcomes, including the absence of recidivism. This is to be contrasted with the often remote, largely punitive, one off or alternatively hectoring dynamic that exists between defendants and judicial officers in the conventional criminal justice system.
* Judges are often respected as authority figures by participants (who often have not had a good active role model in their lives) and are motivated to try to please the judge.
* The interactive and consultative nature of MHCs gives participants a high degree of a personal sense of procedural fairness which is generally regarded as a motivating factor for compliance.
* They employ a helpful balance of a ‘carrot and stick’ approach of rewards and sanctions. Rewards take the form of praise or even movie vouchers. Sanctions could be criticism, additional reporting obligations and in cases of serious failure to comply, incarceration or expulsion from the programme.[[49]](#footnote-49)

Following on from some of Edgely’s findings, Kopelovich et al, noted that persons with SMI may be more sensitive than other groups to notions of procedural fairness.[[50]](#footnote-50) They also found that increases in participants’ sense of procedural fairness left them feeling more hopeful and empowered.[[51]](#footnote-51)

**12.6.5 Economic benefits of MHCs**

In one meta-analysis, Lee et al found that the operation of MHCs led to economic savings as well, amounting to a saving of $6.96 for every dollar invested in MHCs.[[52]](#footnote-52) It was not ultimately clear exactly how these figures were arrived at or even what particular criteria were used to determine them. It does seem that the calculations (looking at the articles forming the grounds for this conclusion) were largely based on the difference between the cost to the criminal justice system caused by recidivism, compared to the cost of mental health courts and associated treatment programs. Prima facie, it seems commonsensical that reductions in recidivism will lead to overall costs saving, even if the exact figures are difficult to quantify with absolute precision.

Aside from the ongoing expense of incarceration and a drain on publicly funded legal service, other considerations could be the effect that any unaddressed dysfunctional parenting caused by mental illness might have on the children of these parents with SMI[[53]](#footnote-53) and the time and costs of family care givers resulting from a failure to rectify problems associated with SMI.[[54]](#footnote-54)

**12.6.6 Should MHCs be introduced into Hong Kong?**

Important arguments against the adoption of mental health courts in Hong Kong are:

* The crime rate has been falling significantly in recent years. This may suggest that there is no compelling reason to take a radical tack in dealing with crime
* Although the evidence is strongly suggestive that MHCs have been a success story in other countries, it is not clear whether or not MHCs would be automatically successful in a different cultural setting as Hong Kong, as there may be certain nuances that work better in other jurisdictions and there are no qualitative studies of personnel or other evidence to suggest that it might work here. For instance, other countries such as the USA and Australia were able to see the earlier success of other problem-solving courts before the creation of MHCs and that example is not present in Hong Kong.
* Much of the data concerning MHCs is not based on the gold standard of randomized experimental designs and most subjects have been white men aged in their mid-thirties, and so the racial make-up is not representative of this population.[[55]](#footnote-55)
* The concern about whether or not MHCs should be introduced in Hong Kong is not merely limited to a consideration of whether or not they will work better for some defendants, and so if a pilot study would be automatically warranted. Evidence exists that for those who drop out of MHCs are more likely to recidivate (if incarcerated) than comparable groups, although the opposite effect was discovered for those drop outs who were not incarcerated. The exact reasons for this somewhat contradictory finding are yet to be established.[[56]](#footnote-56)
* MHCs are not completely homogenous in their operation and it is not clear which of these different models work best,[[57]](#footnote-57) let alone which might work best in Hong Kong. One study suggests that the MHC models which dismiss charges on adherence to the program are the most effective ones in reducing recidivism.[[58]](#footnote-58) Therefore, as MHCs are still in a state of relative infancy, it might be better to wait for the publication of the results of further research to determine which characteristics of MHCs work best.
* Because they are one of a range of participants, MHCs require medical health professionals involved in this system to alter their mode of dealing with patients in ways which might compromise their duty of confidentiality.[[59]](#footnote-59)
* While MHCs usefully try to connect participants with support services to reduce criminogenic triggers such as a lack of housing and unemployment, they do not have control over this type of resourcing.[[60]](#footnote-60) If MHC models use a carrot and stick approach, could this situation prove to be unfair to participants? On the other hand, a multi-pronged and holistic approach is bound to be more successful than simply employing one mechanism. In particular as seen above, treating a client’s mental illness can help reduce drug dependence.

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35. Ibid 61. [↑](#footnote-ref-35)
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37. *(1)An application may be made to a District Judge or magistrate for an order for the detention of a* [*patient*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#patient) *for observation on the grounds that the* [*patient*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#patient)*—(a)is suffering from* [*mental disorder*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#mental_disorder) *of a nature or degree which warrants his detention in a* [*mental hospital*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#mental_hospital) *for observation (or for observation followed by medical treatment) for at least a limited period; and(b)ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons. An application for an order for the detention of a* [*patient*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#patient) *for observation shall be founded on the written opinion in the* [*prescribed form*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#prescribed_form) *of a* [*registered medical practitioner*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#registered_medical_practitioner) *who has examined the* [*patient*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#patient) *within the previous 7 days, which opinion shall include—(a)a statement that in the opinion of the practitioner the conditions set out in subsection (1) are satisfied;(b)such particulars as may be prescribed of the grounds for that opinion so far as it relates to the conditions set out in subsection (1)(a); and(c)a statement of the reasons for that opinion so far as it relates to the conditions set out in subsection (1)(b). (1B)Upon receipt of an application under subsection (1) the District Judge or magistrate may make an order in the* [*prescribed form*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#prescribed_form) *authorizing the removal of the* [*patient*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#patient) *to a* [*mental hospital*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#mental_hospital) *for the purpose of detention and observation during the period not exceeding 7 days from and including the date of the order. (2) Every such order shall have the effect of authorizing the applicant and every public officer with such assistance in each case as may be necessary, to use such reasonable force as may be necessary in order to remove to a* [*mental hospital*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#mental_hospital) *the* [*patient*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#patient) *and if for any reason it is not practicable forthwith to remove him to a* [*mental hospital*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#mental_hospital) *to detain him in a place of safety for a period not exceeding 48 hours. (3)Where the* [*patient*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#patient) *has requested to see the District Judge or magistrate before such Judge or magistrate determines whether or not to make an order under subsection (1B)—(a)the District Judge or magistrate shall not make the order until he has seen the* [*patient*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#patient)*; and(b)a certificate by the* [*registered medical practitioner*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#registered_medical_practitioner) *who furnished the opinion for the purposes of subsection (1A) as to whether or not the* [*patient*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#patient) *has made such a request shall be sufficient evidence of the fact thereof. (4)A* [*medical superintendent*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#medical_superintendent) *may detain in a* [*mental hospital*](http://www.hklii.hk/eng/hk/legis/ord/136/s2.html#mental_hospital) *for observation, investigation and treatment any person who is the subject of an order under this section or under section 32.* [↑](#footnote-ref-37)
38. CACC 104/2000. [↑](#footnote-ref-38)
39. National Institute of Justice, “Adult Mental Health Courts” *Practice Profile* 1, available at https://www.crimesolutions.gov/PracticeDetails.aspx?ID=34. [↑](#footnote-ref-39)
40. Laura N Honeger, “Does the Evidence Support the Case for Mental Health Courts? A Review of the Literature” 39(5) *Law and Human Behaviour* (2015) 478. [↑](#footnote-ref-40)
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43. Ibid. [↑](#footnote-ref-43)
44. Ray Bradley, “Long-term Recidivism of Mental Health Defendants” 37(5) *International Journal of Law and Psychiatry* (September/October 2014) 448, 450-451. [↑](#footnote-ref-44)
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48. Ibid 575. [↑](#footnote-ref-48)
49. Ibid 575-578. [↑](#footnote-ref-49)
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51. Ibid 117. [↑](#footnote-ref-51)
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55. Laura N Honeger, “Does the Evidence Support the Case for Mental Health Courts? A Review of the Literature” 39(5) *Law and Human Behaviour* (2015) 478, 484-485. [↑](#footnote-ref-55)
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