THE DEVELOPMENT OF LEGISLATION TO MEET THE NEEDS OF INDIVIDUALS WITH INTELLECTUAL DISABILITY WHO, BECAUSE OF THEIR DISABILITY, ARE CONSIDERED TO PRESENT A SERIOUS RISK TO OTHERS

A Discussion Paper
THE DEVELOPMENT OF LEGISLATION TO MEET THE NEEDS OF INDIVIDUALS WITH INTELLECTUAL DISABILITY WHO, BECAUSE OF THEIR DISABILITY, ARE CONSIDERED TO PRESENT A SERIOUS RISK TO OTHERS

A Discussion Paper

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For some time there has been considerable discussion about the most appropriate ways in which to manage a small, but difficult group of people. That group consists of individuals who have an intellectual disability and whose behaviour presents a risk to others. Some individuals in this group may, from time to time, commit offences.

This group of individuals, like all New Zealanders, has particular needs and rights, which must be balanced with the right of the community to live without unnecessary fear for their own safety. While for the most part, people with intellectual disability can live satisfactorily in the community, often with some degree of support, those individuals who do present a risk to others continue to present significant difficulties for their caregivers. If their behaviour leads to charges being laid, there are few options within the criminal justice system for appropriate care.

Legislation to cover people with mental illness, quite properly does not include people with intellectual disability. These issues indicate that there is a clear need for a legislative framework to be developed to manage the care of people with intellectual disability whose behaviour places others at risk. Such a framework needs to be progressed without delay.

As part of the process of developing such a legislative framework, the Ministry of Health has commissioned this discussion paper. I regard this paper as a useful step in the process of defining more closely and the issues that need to be addressed. It will assist us greatly if you have an interest in this issue to define your position so that Government can take the next policy and legislative steps required.

Submissions close on 15 February 1996. This is an important issue which must be progressed.

Jenny Shipley
Minister of Health
EXECUTIVE SUMMARY

1. Introduction

The Ministry of Health, through its Disability Support Services and Mental Health Services sections, is currently undertaking a project to look at the most appropriate way to address the issues raised with the care of people who, because of their intellectual disability, present a serious risk to others. The project aims to identify key issues that will need to be addressed in any legislation that may be developed, examine external legislative models that might serve as a basis for the development of New Zealand legislation and identify New Zealand legislation that might need amendment in relation to possible 'compulsory care' legislation.

2. Outline of Key Issues

In relative terms the numbers of intellectually disabled persons who are at risk of serious anti-social behaviour is small. However, the issues of legislative and service development for this group are complex and require careful consideration in the light of other competing claims for resources. Issues that need to be addressed include questions of human rights and the over-representation of intellectually disabled persons in the criminal justice system.

3. Conceiving a New Legal Model

Any new legislation in this area should aim to target those persons most at risk of offending, namely persons with mild to moderate intellectual disability and should avoid any unnecessary linking with a medical model of care and treatment. It should also recognise that the distinctive needs of intellectually disabled offenders as a class may require quite specific legislative and service provision, perhaps more analogous to a welfare guardian than a responsible clinician model of care.

4. Defining Intellectual Disability

A fundamental omission in present legislation is the lack of a working definition of intellectual disability. A carefully conceived legislative definition which reflects current professional understanding of the nature of intellectual disability is essential if legal due process and equitable resource allocation are to be achieved for this group. Thought may also need to be given to the desirability of constructing a range of statutory definitions applicable to the provision of different services and legal procedures.

5. Offending by Persons with an Intellectual Disability

Offending by intellectually disabled persons is directly related to levels of community care and support and the availability of specialist services. International figures on offending are ambiguous, with significant variations in the point prevalence of offences committed by this group. However, the evidence suggests that intellectually disabled persons commit neither more nor less acts of violence than the
population at large. Nevertheless, they are often over-represented in the criminal justice system. It is suggested that this is because people with intellectual disability, while no more aggressive than non-disabled people, may have less control of their impulses, less grasp of the significance of their actions and are, therefore, more likely to come to the attention of the justice and welfare systems. Once in the system their disability, their often difficult social circumstances and the lack of effective advocacy make them especially vulnerable to official intervention and consequent institutionalisation.

6. **Sex Offences**

   Sexual naivety, poor impulse control and lack of social awareness are significant factors in sexual offending by intellectually disabled persons, although adverse psychosocial background together with personality disorder may signal an offender as being more at risk of serious and persistent offending. This may be a significantly small group of intellectually disabled offenders.

7. **Arson**

   Arson is commonly associated with a small group of intellectually disabled offenders. Often it is explicable in terms of relationship conflict, environmental disadvantage, vengeance, child-like fascination, boredom and inadequate service provision. With proper identification of those at risk of such offending, management strategies are generally able to assist the would-be arsonist to develop alternative social skills that minimise future risk. This is principally an issue of service development.

8. **Police Practice**

   International experience suggests that the most critical time for an intellectually disabled offender is the first contact he or she has with the police. Their experience at this time may affect their overall experience of the criminal justice system. The relative merits of prosecution and diversion need to be carefully investigated, while ensuring that offenders receive adequate access to psychiatric and other professional assistance. Inadequate training of police in the identification of intellectual disability may mean that some offenders are too readily and unnecessarily criminalised. This has led some professionals to suggest the need for more effective procedures for clinical assessment of suspects prior to interview and the use of independent third persons in conducting interviews. This is an area where there is a need for legislative intervention to ensure that intellectually disabled offenders are fairly treated at the point of arrest and charging.

9. **Bail**

   Intellectually disabled offenders are often disadvantaged in relation to bail applications. They may be vulnerable to refusal of bail because of the absence of appropriate facilities to accommodate them during a remand and the lack of suitable advocacy both at the police station and during subsequent court appearances. This is an area where there is a need for both legislation and service development.
10. **Fitness to Plead**

Intellectually disabled offenders have been disadvantaged in relation to issues of fitness to plead since the coming into force of the *Mental Health (Compulsory Assessment and Treatment) Act* 1992. Existing procedures for determining 'under disability' in the *Criminal Justice Act* 1985 do not fit well with the statutory definition of 'mentally disordered' in the 1992 Act. In particular the legislation fails to make it clear that being under disability is a consequence of defective understanding of legal processes and has no necessary link to mental disorder or dangerousness. Furthermore existing statutory criteria for assessing fitness to plead are narrowly formulated and in relation to intellectually disabled offenders, may not address some relevant considerations. This could be dealt with by broadening the criteria to include conclusions drawn from psychological testing and providing properly formulated tests for screening for disability. This is a matter for legislative change.

11. **Presumption of Disability**

There is a danger that some intellectually disabled offenders may be needlessly subjected to disability hearings in circumstances where a finding of disability is inevitable. For this reason it is suggested that in cases where an offender falls below a pre-determined IQ level or other assessment threshold he or she be found to be presumptively under disability, obviating the need for a formal disability hearing. Although any such presumption would be rebuttable upon proof of evidence consistent with fitness, the procedure would allow for the early diversion of appropriate cases from costly, stressful and time-consuming fitness hearings.

12. **Representation**

At present there is inadequate training for lawyers representing intellectually disabled offenders. Specific training is needed to assist counsel in developing appropriate communication and interview techniques. Supplementary advocacy roles including the appointment of a *guardian ad litem*, patient advocates and 'friends at court' need to be further investigated to ensure the maintenance of a consistent and comprehensive system of advocacy for this group. Ultimately, however, a specialist state-funded advocacy service for intellectually disabled persons may be seen as a necessary feature of stand-alone legislation for these people. This may suggest a need for both legislation and service development.

13. **Criminal Responsibility**

Because intellectually disabled persons may lack the necessary *mens rea* (mental element) required for a particular offence because of their limited appreciation of the relevant facts, it is suggested that the procedure for determining fitness to plead should be supplemented by a new procedure to be called a 'trial of the facts' to determine either whether the offender committed the physical act constituting the offence or had the mental capacity for the *mens rea* of the offence. This would go some way towards ensuring that an offender was not deprived of his liberty through
14. **Assessment and Treatment**

It is generally agreed that the training of mental health professionals is inadequate as regards the assessment and treatment of intellectually disabled persons. Training and service development should reflect a proper understanding of the factors which influence behavioural changes in this group and should focus on the development of community based programmes supported by a legislative presumption favouring community treatment. This is desirable as a matter of principle and is consistent with various international formulations of rights affecting disabled persons. This is essentially a matter of professional skills training with implications for service development.

15. **Resources and Service Provision**

Offending by intellectually disabled persons is often associated with inadequate service provision, in particular community resources. This is partly a consequence of failure to adequately distinguish intellectually disabled persons from the mentally ill in the provision of services and to make adequate concessions to the needs of intellectually disabled persons who present challenging behaviours. This may suggest a need for specialised services for intellectually disabled offenders, perhaps based on available overseas models. This would have implications for both legislation and service development.

16. **Ethical Considerations**

There are a wide range of ethical issues that need to be considered in relation to legislation for intellectually disabled offenders. Ethical problems arise in relation to questions of competency and consent, appurtenant to the disability itself and on account of the special vulnerability that the status of intellectual disability creates. Of particular importance in this context is the principle of the least restrictive alternative which has important implications for preventive detention and other custodial options for intellectually disabled offenders.

17. **Normalisation**

Normalisation, an ethical principle favouring the right of every citizen to enjoy 'citizen's rights,' has an important, but limited, application to intellectually disabled offenders. There is a danger that the application of the principle of normalisation to intellectually disabled offenders overlooks the social, economic and health disadvantages that this group experiences, and fails to appreciate that recognising a person's worth does not necessarily require dispensing identical treatment to a disabled citizen as would be given to a non-disabled citizen. It is a principle that should be applied with great circumspection to intellectually disabled offenders.
18. **Public Safety**

The issue of public safety may be seen as axiomatic to any discussion of intellectually disabled offenders. However, while dangerousness is an important consideration in formulating any new legislative response to the problems presented by this group, it needs to be evaluated in relation to known characteristics of intellectually disabled offenders as a whole. It should not be assumed that because an intellectually disabled person has committed an offence that he or she is *per se* dangerous and should be incarcerated. Dangerousness is itself an elusive concept. Its predictors are notoriously unreliable. Ultimately with this group, community protection may best be achieved by developing strategies for care and treatment which encourage the offender to become an acceptable member of the community rather than through custodial measures. This is a matter that may need both legislation and service development.

19. **Sentencing and Disposition**

Because of the broad range of issues that the sentencing of intellectually disabled offenders gives rise to, it has been suggested that legislative provision be made for a formal multidisciplinary dispositional conference to recommend to the court the most appropriate form of disposition or sentence in such cases. This may also prove to be a useful context in which to debate the appropriateness of imprisonment as a sentencing option for intellectually disabled offenders. If such persons are not to be inappropriately imprisoned there is a need for a broader range of dispositional options. This may require officially designating imprisonment as a sentence of last resort in such cases or alternatively making it presumptively unavailable as a sentence unless no other sentence or disposition is capable of protecting the public.

Consideration should also be given to new community-based sentences like psychiatric probation orders and guardianship orders which are used effectively in other jurisdictions. Some investigation of the way in which hospital orders may be applicable to intellectually disabled offenders is also required, including consideration of the possibility of adopting the Hospital Order Without Conviction, currently available in the UK.

Ultimately, the effectiveness of penal policies applied to intellectually disabled offenders will depend on the availability and effectiveness of formal post-release programmes which target their specific needs and acknowledge their special vulnerability. These are areas that will require both legislation and service provision.

20. **Human Rights**

The human rights of intellectually disabled offenders may be negatively affected by a variety of factors, including lack of access to appropriate services. Yet the clear obligation recognised by the *Declaration of the Rights of Disabled Persons* and supported, by implication, by the *Human Rights Act* 1993 is to ensure that the special needs of intellectually disabled persons are taken into consideration at all stages of economic and social planning. Any legislation aimed specifically at
intellectually disabled offenders should include a code of rights to be considered by officials when administering the provisions of such legislation.

21. **Overseas Legislative Models**
   
   **Canada**
   
   At present Canadian Federal legislation appears to make no specific provision for intellectually disabled offenders as a class. However, recent amendments to the Canadian *Criminal Code* provide for new dispositional options, applicable to the intellectually disabled. Procedures governing fitness to plead have also been altered adding a requirement for proof every two years that there is still sufficient evidence to put an accused person on trial.

22. **Australia**

   There is no uniform law governing the disposition of intellectually disabled offenders in Australia. Unlike Canada, the law is determined on a state by state basis.

23. **New South Wales**

   In New South Wales the *Mental Health (Criminal Procedure) Act* 1990 provides for a "trial on the facts" in relation to persons found unfit to be tried, similar to the English model. However, legislation in that jurisdiction does not make any specific provision for intellectually disabled persons who offend.

24. **Victoria**

   Victoria is the only Australian state to make special legislative provision for intellectually disabled offenders. Although the *Intellectually Disabled Persons Services Act* 1986 is, as its name suggests, principally concerned with the provision of services to intellectually disabled person generally, the Act makes special provision for offenders in the establishment of special programmes and services, including the concept of a 'justice plan', and by authorising co-operation between government departments. Criticism of the legislation tends to focus on details in statutory provisions rather than the principles upon which the legislation is based.

25. **Queensland**

   Queensland has an *Intellectually Handicapped Citizens Act* 1985 which aims to assist intellectually disabled persons generally to exercise their rights and responsibilities in society. The Act makes useful provision for different types of advocacy structures for intellectually disabled persons but makes no particular provision for intellectually disabled offenders.

26. **Western Australia**

   Western Australia makes broad legislative provision for intellectually disabled persons but at present has no legislation geared specifically for offenders.
27. *Australian Capital Territory*

Legislation in the Australian Capital Territory which impacts negatively upon intellectually disabled offenders is the *ACT Mental Health (Treatment and Care) Act* 1994. The Act effectively allows for the preventive detention of an intellectually disabled person thought to be dangerous. However, it has been severely criticised on account of its definition of 'mental dysfunction' which fails to adequately differentiate intellectual disability and mental disorder.

28. *United Kingdom*

In the United Kingdom all forms of mental ill-health or disability are embraced under the generic definition of 'mental disorder'. Intellectual disability is separately provided for in definitions of 'mental impairment' and 'severe mental impairment' which provide the standards for different types of assessment and service provision. However, English legislation does not make specific provision for intellectually disabled offenders, who are dealt with in the main under mental health legislation. Generally, service provision for intellectually disabled offenders in the UK is inadequate. An important development, however, has been the Government's recently declared policy of diverting mentally disordered persons (including intellectually disabled people) from the criminal justice system where prosecution is not required in the public interest.

29. *New Zealand Legislation Affected*

The present interpretative approach to the *Mental Health (Compulsory Assessment and Treatment) Act* 1992, whereby intellectually disabled offenders are accommodated within the definition of 'mental disorder' for the purposes of fitness to plead, is unsatisfactory. The present interpretative problems would be resolved by 'stand alone' legislation for this group accompanied by a strengthening of the exclusionary provisions in s4(e) which would exclude intellectually disabled persons from the *Mental Health Act* for all purposes.

30. *Protection of Personal and Property Rights Act 1988*

This legislation should not be used for dealing with intellectually disabled offenders on account of the potential for confusion between the remedial purposes of the legislation and the penal elements that would be implicit in any provisions that authorised the secure containment of intellectually disabled offenders.

31. *Criminal Justice Act 1995*

This statute would require substantial amendment whether or not it was decided to adopt the proposal for 'stand alone' legislation. Amendments would be required to most of the provisions of Part VII in order either to make new provision for intellectually disabled offenders as a separate class or to reflect changes consequent upon new 'stand alone' legislation.
32. *New Zealand Bill of Rights Act 1990*

Although no specific amendment to the Bill of Rights is called for, rights supplementary to those contained in the Bill of Rights addressing the specific process needs of intellectually disabled offenders ought to be included in legislation, possibly the *Human Rights Act 1993*.

33. *Health and Disability Services Act 1993*

The Act should be amended to provide a clear statement of principles governing the provision of services to consumers and the objectives for the development and implementation of programmes and services for people with disabilities, with specific reference to the service needs of intellectually disabled persons.

34. *Legislative Options for New Zealand*

This Report rejects both the options of piecemeal legislative amendment and compulsory care legislation for intellectually disabled offenders. The former option is rejected because the legislative changes necessary would lack coherence and would lack the symbolism inherent in a separate statute. Intellectually disabled offenders could be worse off under such a regime.

The option of compulsory care is rejected by a majority of professionals involved in the care of intellectually disabled offenders and is justified neither in terms of the interests of intellectually disabled offenders themselves nor in the interests of society as a whole.

35. *'Stand-alone' Legislation*

The Report favours separate legislation for dealing with intellectually disabled offenders. The needs of this group of persons are not met by mental health legislation, yet there is clearly a need for legislation providing the same degree of protection as is currently available for the mentally ill. Such legislation would allow the needs of intellectually disabled offenders to be met in a co-ordinated and logical manner and would be capable of reflecting the now entrenched conceptual separation between intellectually disabled and mentally disordered persons. 'Stand alone' legislation would facilitate the articulation of clear and consistent guidelines for the management and disposition of offenders at all stages of the criminal justice process and would provide a model for the legislative management of this group as yet untried in any other commonwealth country.
PART I - INTRODUCTION

1.1 Appointment and terms of reference

On 9 May 1995 I received a letter from Ms Catherine Coates, Analyst, Mental Health Services, Ministry of Health Wellington, inviting me to assist with progressing a project looking at the most appropriate way to address the issues raised with the care of people who, because of their intellectual disability, present a serious risk to others. The draft terms of reference invited me to:

1. Prepare a discussion paper, including:
   a) an outline of the key issues that need to be addressed in the development of legislation to meet the needs of individuals with intellectual disability, who because of their disability, are considered to present a serious risk to others;
   b) examination of legislative models that exist in other countries that could usefully serve as a basis for development of legislation in New Zealand;
   c) identification of legislation in New Zealand that needs to be considered and/or amended in light of possible 'compulsory care' legislation.

2. To make recommendations on the scope and nature of legislation to meet the needs of the individuals identified above.

3. To report in writing to the Manager, Mental Health Services and the Manager, Disability Support Services on the matters listed above, no later than the end of August 1995.

The terms of reference were subsequently incorporated into a contract for services between the Crown and me which required me to complete a draft report by 30 July 1995 and to present a final written report to the Manager, Mental Health Services and the Manager, Disability Support Services by 30 August 1995.

For the purposes of this discussion I recognise the threefold classification of intellectually disabled persons suggested by the New Zealand Law Commission.¹ They include some intellectually disabled persons who are non-offenders but pose a risk of harm, alleged offenders found to be 'under disability' and convicted offenders. The discussion will, however, be principally concerned with the second and third categories.

The issues involving dangerous intellectually disabled persons are complex and closely inter-related. This paper proceeds on the basis of two fundamental propositions.
• First, that issues of apprehension, identification and fitness to plead are inseparable from questions of sentencing and disposition in identifying appropriate legislative strategies for dealing with intellectually disabled persons who present a risk to others.

• Secondly, that it is necessary to abandon any preconception that a carceral approach to the social management of this group of people is presumptively necessary if the goal of public protection is to be achieved.

The analysis which follows will aim to explore these propositions in relation to a discussion of the key issues.

Because of the time constraints within which the research has been undertaken, it has not been possible to undertake an exhaustive survey of relevant legislative models in other jurisdictions. The survey in Part III is, therefore, limited to consideration of legislation in Canada, the Australian states and the United Kingdom although I have attempted to incorporate accounts of other legislative models where they have arisen in considering the literature.

I am indebted to many people who have generously given their time to assemble material for me to consider and to others with whom I have been able to consult and obtain many valuable insights. In particular I would mention Professors Bruce Archibald and Archie Kaiser of the University of Dalhousie, Dr Bill Glaser Consultant Psychiatrist of Melbourne, Ms Leanne Craze, Senior Researcher, Melbourne, Adina Halpern, Trinity Hall, Cambridge, Dr John Reed CB, Department of Health, London, Drs Sandy Simpson and David Chaplow, Forensic Psychiatrists, Auckland and Ms Carole Weaver, my research assistant. I have interpreted all the information I have received in the course of the research as accurately as possible. However, I must bear the responsibility for any inaccuracies that may appear.

The approach I have adopted in presenting my report is to deal sequentially with the individual items as they appear in the terms of reference.

PART II - OUTLINE OF KEY ISSUES

2.1 Introductory overview

In developing a legislative response to intellectually disabled persons who, because of their disability, represent a serious risk to others it is important that the problem be seen in its true perspective. In reality the numbers of people who at any one time may be considered 'at risk' of serious anti-social behaviour is likely to be very small in relative terms. The question must then be asked whether such a small group justifies the not insignificant expenditure involved in promulgating legislation if there are alternative means available of dealing with the problems presented.

However, the mere fact that the potential catchment group is numerically small does not necessarily preclude the possibility of legislation if it is the case that there is presently neither a service nor a legislative model which is workable for the safe containment of intellectually disabled offenders. If such legislation is considered desirable it should be developed after due consideration of relevant philosophical issues and service demands and in the light of current clinical practice. Because of the complexity of these issues it is suggested that they should be considered slowly and in detail and in a manner which recognises the distinctive resource claims presented by the mentally ill, the behaviourally disordered and the intellectually disabled. I would suggest that it is neither possible nor desirable to consider the claims of this group in isolation from the needs of other disabled groups when issues of scarce resources are at stake.

The issues raised by this investigation also involve important philosophical and human rights questions which need to be carefully considered. Amongst these are the question of whether psychiatric medicine should ever be used for purposes of preventive detention and why it is that people with an intellectual disability are over-represented within the criminal justice system, both as offenders and as victims.

If, as has been suggested, the implementation of Care in the Community policies is likely to lead to an increase in offending by intellectually disabled people as they are exposed to greater temptations and opportunities for offending, then it is clear that any proposed legislation will need to anticipate this fact and make appropriate provision for resources and services that are capable of responding to the challenges presented by this group of persons. One commentator has warned of the danger of looking to short term legislative solutions which may provide an avenue for the immediate disposition of intellectually disabled offenders but will not deliver the services such people need.

Any new legislation should aim to target those who are the most needy, namely those persons with mild to moderate intellectual disability who occasionally light fires and engage in socially inappropriate behaviours, but who cannot, at present, be helped unless they first commit an offence. To the extent that such legislation targets offenders it should be conceived as linked to criminal justice rather than mental health legislation. A deliberate dissociation from a mental health model will obviate the notion that psychiatrists are social control agents and will avoid the
danger of compromising the essential character of our mental health legislation which in its philosophy is concerned with assessment and treatment rather than detention. At the same time, however, any legislative response to issues of current concern should reject any temptation to return to the concept of a 'humane prison' which may allow for the long term incarceration of a group of people who displease society at large. This would represent a significant step backwards and would serve to reinforce the double stigma possessed by intellectually disabled offenders. They embody society's worst fears and prejudices: they appear not only to lack the understanding and intelligence which define the basic qualities of human kind but are also represented as a grave threat to the ordered running of civilised society.

2.2 Conceiving a new legal model

Writers have from time to time warned of the danger of looking to the law as an agent of change. The danger, it is suggested, is that the law will become too interventionist, too all-pervading, so that it stultifies rather than stimulates. While it now seems clear that intellectual disability requires legal recognition to reflect its clear separation from mental illness or disorder, the question arises whether seeking recognition of intellectual disability within a legal framework may simply serve to attract inappropriate legal intervention. An important question, therefore, in identifying legal issues in relation to intellectual disability is to ask whether the law will necessarily provide the appropriate solution or whether the subject matter of the change can be achieved otherwise than by the law.

In Australia concern has been expressed that government reform strategies identify too narrowly with medical treatment of severe mental illness and are not effectively addressed to the broad range of mixed Commonwealth and state responsibilities in the areas of disability support, accommodation, community education, research and equitable service provision across areas of special need. Recent New Zealand experience in relation to intellectually disabled persons found to be under disability in terms of section 108 of the Criminal Justice Act 1985, demonstrates that in the absence of a specific commitment to intellectually disabled offenders as a class there is a real danger of such persons 'falling between the cracks' and their needs not being adequately addressed either by the mental health or the criminal justice system.

Whether all intellectually disabled persons who have come within the ambit of the criminal law ought, as a matter of principle, to be dealt with by therapeutic, rather than penal, treatment is a matter of some debate. What may be agreed, however, is that if all such persons are to be fairly dealt with there must be in place a broad range dispositional and sentencing measures that are capable of meeting both the personal needs of the individual offender while at the same time addressing public safety concerns. These new measures will also need to be capable of addressing the widespread anxiety about violence in the community and the concern surrounding the security of the dangerously mentally ill or intellectually disabled. Often, it seems, community apprehension associates violence with all forms of mental disorder, including intellectual disability. To the extent that what is feared above all is unpredictability: the propensity to behave violently for no apparent reason, any new formal initiatives to contain intellectually disabled persons who present a risk of harm to others will need to be able to defuse the fear of injury or assault in the
I share the view that, generally speaking, if society wishes the detention of
dangerous people, it should only use the mental health system where the person has
a demonstrable clinical need which requires treatment. Beyond that, the detention
of people who offend is primarily the responsibility of the criminal justice system.14
However, because intellectually disabled persons who offend do not fit neatly into
either a therapeutic or a penal model of disposition, it may be necessary to construct
a new model of care which emphasises the inappropriateness of punishment per se
while maximising the opportunities for habilitation and social reintegration.

It has been suggested that for intellectually disabled persons, a welfare guardian type
model is more appropriate than a responsible clinician which applies to those who
are mentally ill.15 What is required for such persons is someone who can make
decisions on behalf of the 'patient' on the basis of their best interests rather than a
person who can recommend and prescribe treatment on the basis of scientific
knowledge.

This distinction is important in light of the concern expressed by a number of
individuals and organisations who made submissions to the Select Committee
considering the Mental Health (Compulsory Assessment and Treatment)
Amendment Bill to the effect that the express terms of that legislation created a clear
inference that it was the will of Parliament to use medical procedures to control
behaviour.16 The concern is that while intellectual disability is closely linked to a
therapeutic model there will always be a danger of medicalising inappropriate
behaviours rather than responding with the very particular specialist resources that
this group requires. The Royal Australian and New Zealand College of
Psychiatrists, in its submission, noted that the problems associated with the use of
psychiatry as a means of social control are evidenced by the large number of official
inquiries at psychiatric hospitals in New Zealand since 1970, a situation due, it is
suggested, to placing the interests of the State and of the psychiatric establishment
before the interests of patients. The New Zealand Medical Council has also warned
of the dangers of medicine being used as an agent of the state to control social
behaviour, noting that psychiatry in the former USSR came under intense scrutiny
because of the impression it was being used to 'treat' those whose 'disorder' was
politically different views.17

The clear consensus amongst professionals working with intellectually disabled
persons is that intellectual disability is not an affliction that is treatable in the normal
sense. There is no known treatment that will significantly enhance the intellect of
someone with an intellectual disability. Any proposed legislation should, therefore,
avoid giving the appearance that intellectually disabled persons who offend are
somehow 'treatable', when the reality is that the problems they present are often
complex and require a carefully conceived multi-disciplinary approach.
2.3 Defining intellectual disability

At present intellectual disability is not defined in New Zealand legislation. It was defined as part of the definition of mental disorder in the Mental Health Act 1969, but that definition was not carried over to the 1992 Act. Although the exclusion of a definition of intellectual disability was motivated by a laudable desire to clearly separate the concepts of mental disorder and intellectual disability it is anomalous that mental disorder is defined while intellectual disability is not.

However, for intellectual disability to achieve proper recognition it is necessary for the law to describe it in words in a clear and consistent definition containing specific criteria which is capable of application in a variety of legislative contexts. In particular, any such definition should reflect current community attitudes and government policy which would imply in general terms that intellectual disability is a cognitive impairment which reduces a person's adaptive capacity but is not a treatable disorder or disease.

However ultimately it is defined, it is important that the law accurately describes the condition of intellectual disability. Unless the law properly recognises and accurately reflects contemporary understanding of intellectual disability it will be difficult to apply statutes appropriately to the disability.

While complete agreement on the content of a legal definition will be difficult to achieve, it is useful as a starting point to reflect on a widely accepted non-statutory definition. The American Association on Mental Retardation defines intellectual disability in the following terms:

"Mental retardation refers to substantial limitations in present functioning. It is characterised by significantly sub-average intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self care, home living, social skills, community use, self-direction, health and safety, functional academic, leisure and work. Mental retardation manifests before age 18."

Although it is acknowledged that there are many forms and degrees of intellectual disability, the majority of people with an intellectual disability have only a mild disability and are generally capable of limiting the restrictions posed by their disability. While many mildly intellectually disabled persons are able to function as well as most non-disabled persons in the community when adequate services and specialised education are available, where such services are withdrawn or are otherwise unavailable, antisocial behaviour may for some become a means of signalling their stress and need for assistance.

Insofar as any proposed legislation aims to target intellectually disabled offenders who pose a serious risk to others, any definition encompassed by such legislation should identify the fact that it is principally concerned with mildly intellectually disabled persons whose offending behaviour may be remediable with appropriate professional input. Furthermore, any definition of intellectual disability for the purposes of this inquiry ought to recognise that intellectually disabled offenders are
generally not dangerous *in themselves*, but rather that the process of maturation may result in an inability to contain or control sexual or aggressive drives, as a consequence of a combination of impaired intellectual abilities and the failure of normal socialising and developmental mechanisms to provide the necessary skills to deal with such drives. It is important that the definition should not target all intellectually disabled persons as potential offenders but only that limited group whose behaviour gives reasonable cause for concern.

In the absence of a statutory regime for intellectually disabled offenders who commit serious crimes there is a danger, as John Dawson notes, that a very small group of such people will end up imprisoned, either because psychiatric dispositions are now foreclosed, or because downstream problems will arise if they are relied upon. Dawson suggests that a primary question for consideration is whether imprisonment of some intellectually disabled people is inhumane or likely to reduce offending and whether other alternatives for their control would be any more humane or effective in preventing crime.

While I agree with this analysis, I believe, for reasons adverted to later in this paper, that any relevant definition should presumptively favour the non-carceral disposition of intellectually disabled offenders wherever that is possible on the basis that institutional detention is inimical to their best interests as people needing official help and is ultimately contrary to the public interest.

There would appear to be some agreement that it may be counter-productive to attempt to find one definition to cover a variety of contexts and that no single definition will necessarily be helpful for the operation of services and criminal procedures in relation to people with an intellectual disability. Very careful consideration needs to be given to the form of words used in any proposed statutory definition if it is to achieve the social purpose for which it is designed. Use in a definition of phrases like 'serious intellectual disability' or a requirement (as occurs in the definition of 'intellectual disability' in the *Crimes Act 1900 (NSW)*) that a person requires 'social habilitation' may defeat the purpose of the legislation either by setting the standard for inclusion in the definition too high or by establishing a higher level of disability than that experienced by most people with an intellectual disability. On the other hand a generic expression like 'developmental disability' may commend itself in a statutory definition because it may be taken to refer to a wider group than 'intellectually disabled' and is capable of including persons with intellectual handicap, severe epilepsy, brain damage acquired in childhood and those with other neurological disorders needing similar provision.

It should, therefore, be possible to craft a definition of intellectual disability which uniquely targets those persons to whom any proposed legislation is directed by identifying specific features which characterise the impairment and its consequential effects. Such elements might include:

a) is attributable to an intellectual or developmental impairment.

b) is in the range of 'borderline' or 'mild' intellectual disability.
c) is manifested before the person attains the age of 18 or is the result of severe cerebral trauma experienced either before or after age 18.

d) results in inability to contain or control sexual or aggressive drives or to indulge in serious property offences as a consequence of impaired intellectual abilities and the failure of normal developmental mechanisms.

e) reflects the person's need for special interdisciplinary care, treatment or other services of lifelong or extended duration and individually planned.

Because people with an intellectual disability tend to require approaches more directed toward modification of behaviour along with support and structured environments on a long term basis, any statutory definition should reflect this reality. Because of the structure of present New Zealand legislation an 'operational' definition that could be administered by the Ministry for the purposes of providing a qualifying definition for services would not suffice in the present context. What is lacking is a clear statutory definition of intellectual disability that can provide a basis for targeting intellectually disabled offenders for special intervention that is distinct from what is currently offered by either mental health services or the criminal justice system.

In particular any legislative initiative needs to recognise that it is people with borderline, mild and occasionally moderate intellectual impairment who tend to offend, rather than those with severe intellectual impairment; and that such offending is not generally associated with the intellectual impairment as such but rather the secondary handicaps that arise from it, including such things as educational deficits and the consequences of physical, sexual and institutional abuse.

Precedents do exist for isolating the type or degree of disability necessary to bring a person within the ambit of controlling legislation. In the UK, for example, a mildly 'mentally impaired' person cannot be detained compulsorily in hospital under the Mental Health Act 1983 unless medical treatment is likely to benefit them. The restriction does not apply, however, to those with more severe grades of impairment. In the Australian state of Victoria, where eligibility for Government services is determined, in part, by intelligence testing, an intellectually disabled offender may be able to receive special services if the Court is able to obtain a declaration of eligibility and a 'justice plan' under the provisions of the State's Sentencing Act. On this basis the way in which a definition is formulated may have practical implications in the criminal justice system.

2 Dr A I F Simpson, Submission to the Social Services Select Committee considering the Mental Health (Compulsory Assessment and Treatment) Amendment Bill, 5 May 1994, 3.

6 Submission of the Directors of Mental Health of the Northern Region to the Social Services Committee considering the Mental Health (Compulsory Assessment and Treatment) Amendment Bill, 2.

7 Submission of Waitemata Health to the Social Services Select Committee considering the Mental Health (Compulsory Assessment and Treatment) Amendment Bill, 4.


10 Ibid.

11 Ibid.


13 The apparently deliberate attempt by the legislature to exclude persons with an intellectual disability only from the purview of the compulsory assessment and treatment provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992 produced the now well attested anomaly that a person with only an intellectual disability, being not mentally disordered, could not be made the subject of a finding of disability, despite clear evidence of a functional inability to participate in court proceedings. That the courts have managed to deal with these problem cases in a manner which favours the interests of defendants in receiving a fair trial, is a credit to the ingenuity and concern for procedural fairness of our Judges, but does not reflect well on the present drafting of our mental health and disabilities legislation.

14 Dr A I F Simpson, Submission to the Social Services Select Committee on the Mental Health (Compulsory Assessment and Treatment) Amendment Bill, 5 May 1994, 4.

15 Ibid, 7.

16 See submission of Wellington Regional Forensic Psychiatry Service, May 1994, 2.

17 Submission to the Select Committee on the Mental Health (Compulsory Assessment and Treatment) Amendment Bill 1994.

18 Hon R D Nicholson, supra, note 9 at 274.


20 Supreme Court of Western Australia, Persons with an Intellectual Disability: Issues for Consideration of the Courts, 1 June 1993, p3 cited in Hon Justice R D Nicholson, infra, note 21, at 82.

21 Dr A I F Simpson, supra, note 14, 2.

22 Dawson, supra, note 5, at 4.


24 See discussion on the meaning of 'developmental disability' in NSW Law Reform Commission Report, supra, par. 2.7, p 11.

25 Dr S du Fresne, Submission to the Social Services Select Committee on the Mental Health (Compulsory Assessment and Treatment) Amendment Bill.

26 Dr W Glaser, supra, note 8.
PART III - OFFENDING BY PERSONS WITH AN INTELLECTUAL DISABILITY

3.1 Introduction

In the UK the police and other criminal justice agencies are being placed under increasing pressure due to the inadequacies of community care for the mentally ill. There, growing numbers of mentally disordered and intellectually disabled offenders are finding their way into the criminal justice system due to inadequate levels of care and support in the community. While in New Zealand at the present time there is no clear evidence of an increase in offending by intellectually disabled people consequential upon inadequate levels of community care and support, anecdotal evidence suggests that some intellectually disabled persons have been marginalised as a result of changes in official policy and are at risk of criminal offending.

In relative terms the incidence of offending by intellectually disabled persons is small. In one Danish study involving a survey of 22,000 intellectually disabled persons known to the Danish services on a census day in 1973, only 290 were found to be subject to a penal court decision - a point prevalence of little over 1%. A more recent (1990) Danish study revealed a point prevalence of less than 0.5%.

However, figures are ambiguous and sometimes conflicting. Whereas a recently completed UK study (1991) of a stratified sample of sentenced prisoners found a prevalence of 0.9%, a 1988 study of the prevalence of intellectual disability in the New South Wales prison population suggested a prevalence rate of 12-13%, suggesting that such people are over-represented within the criminal justice system.

Whatever the actual incidence of offending may be there is the commonly expressed fear, already adverted to, that with the implementation of community-based care policies, intellectually disabled persons will be increasingly exposed to the risk of offending and stigmatisation within the criminal justice system. However, it may not necessarily be the case that offending by intellectually disabled people is simply a product of deinstitutionalisation. Some professionals who work with intellectually disabled people believe that, generally, 'challenging' behaviours in mentally handicapped people decrease as they move out of institutions. The real difficulty, it would seem, is that offending is more often linked to the actual 'handicap' experienced by intellectually disabled offenders, in the sense of the 'social and emotional consequences of an impairment of performance intelligence' rather than the effects of the loss of institutional living as such. Psychosocial deprivation, low socioeconomic class, a family history of criminality, cerebral abnormality, minor physical imperfections, and a history of behaviour disorder as a child, all involved in delinquency and adult crime generally, are often found in mentally disordered offender populations. One writer suggests that as offenders, people with an intellectual disability are more likely to be arrested, refused bail, convicted, sentenced to imprisonment, receive a longer term of imprisonment and serve a greater percentage of their sentence before being released on parole.
In order to be able to respond appropriately to the challenges presented by intellectually disabled persons who offend it is necessary to identify the types of offences that they are most commonly associated with. This knowledge may assist us in planning appropriate intervention strategies and more accurately assessing management and treatment needs.

There would appear to be some agreement among professionals that although intellectually disabled people are not usually dangerous, some, as they grow into adulthood, are unable to contain sexual or aggressive drives in an appropriately socialised fashion. Twelve studies on patterns of offending in intellectually handicapped males conducted between 1948 and 1990 revealed that property offences were the most common, while sex offences and arson were overrepresented. Local clinical experience suggests that offenders are more commonly the mild to moderately intellectually disabled who are usually reasonably socially adaptive and mobile and react to disappointments in an infantile (eg rage) or socially inappropriate (eg fire lighting) manner. It has been suggested that for many who have major intellectual disability and offend, it is often the case that such individuals have been offered no support, no supervision, no meaningful occupation and social activity, and no opportunity to acquire the skills that would prevent them from offending. Their social isolation and lack of active engagement could, the authors suggest, be remedied in many cases without the need for compulsory care or ongoing detention.

Many studies have emphasised a significant link between unstable upbringing and the presence of behaviour disturbance including sexual misconduct, arson and other offences. The risk of being charged with a criminal offence increases exponentially where there is an association between behaviour disorder, institutional care before five years of age, low socioeconomic status and a history of retardation in one or both parents. The most important predictor of subsequent criminal activity is behaviour disorder.

3.2 Sex offences

Sex offending by intellectually disabled offenders needs to be understood in relation to the particular psycho-social factors which typify the backgrounds of this class of persons. The relevant factors are the same as those in the backgrounds of non-handicapped sex offenders. In many cases the families are characterised by gross marital disharmony, parental separation, violence, neglect and poor control. Many offenders have themselves suffered sexual abuse as children and have a history of school adjustment and relationship problems, behaviour problems, psychiatric illness and other delinquent behaviour.

Sexual naivety, inability to understand normal sexual relationships and the significance of behaviour, lack of attainable appropriate sexual relationships, lack of relationship skills, difficulties in mixing with the opposite sex, poor impulse control and susceptibility to the influence of others, have all been cited as prominent features in sex offending by intellectually disabled people. Many will never have had any sexual experience involving another individual prior to their first sexual incident.
Not all intellectually disabled sex offenders are necessarily intractably dangerous. An important differentiation has been suggested between those intellectually disabled sex offenders who commit sex offences only, and a smaller group whose sex offending is part of a wider tapestry of offending behaviour and social problems. Studies suggest that the sex-offence-only group displayed less psychosocial pathology and their sex offending is explainable in terms of normal sex drive coupled with lack of normal outlets compounded by the factors mentioned above, including sexual naivety, poor impulse control, social ineptness and a lack of social awareness. The commentator suggests that more enlightened approaches to the sexuality of intellectually disabled people, coupled with treatment measures aimed at sex education and counselling, relationship skills and improving self-image and self-confidence, should significantly reduce the incidence of this type of offending in the future.

Offenders who commit both sex and other offences are likely to be more damaged persons with marked adverse psychosocial factors in their backgrounds and tend to be sociopathic individuals. It is this group who are likely to become persistent offenders and commit serious offences and are likely to require highly specialised assessment and treatment services.

3.3 Arson

There are many possible explanations for the reported association between arson and intellectual disability. On one view fire-raising may be related to the combination of thrill and a child-like fascination with fire, allied to a simple lack of awareness and insight into the appalling consequences of arson. However, a 1971 study of 57 intellectually disabled female arsonists admitted to three Special Hospitals in the UK, revealed that in 39% of cases the arson had occurred in a setting of direct conflict with authority and in 69% the fire was in the immediate living area of the patient. Broken homes and seriously disturbed family relationships are typical of those who commit arson generally, including people who are intellectually disabled. While the most commonly cited motives for arson amongst the mentally disordered are vengeance and pleasure, it has been suggested that fire-setting might be used as a communicative vehicle by those with poor verbalising skills and may be the explanation in many cases of arson by intellectually disabled individuals.

Other commentators have suggested that arson may be a form of displaced aggression in passive inadequate individuals who are incapable of interacting at an emotional level with others. Conflict or other stress is commonly associated with episodes of arson committed by intellectually disabled people. Because with intellectually disabled people arson is typically associated with personal and environmental disadvantage and ineffective social interaction, it is suggested that management strategies should focus upon helping the arsonist to develop alternative and successful methods of interaction skills and training in appropriate assertiveness.

It is important to note that with intellectually disabled offenders reconviction for serious offences is uncommon following appropriate official intervention. However,
the frequency of recidivism increases significantly in those with a past history of behaviour disorder. Recidivism for violent and sexual offences may be predominantly limited to this group.52

Commentators have noted the importance of follow-up for all intellectually disabled offenders, particularly sex offenders. A number of studies have found that a shorter duration of institutional care is associated with a greater likelihood of reconviction and rehospitalisation and imprisonment.53 Sex offenders are prone to relapse in times of high stress or in situations of obvious temptation and need to learn to identify, prevent and escape from high-risk situations.54 The evidence suggests a positive correlation between good outcome and stable residential placement, regular daytime occupation and regular supervision and support.55 Such support may include the establishment of a 'support network' of friends, family members and other caregivers who have some awareness of the offender's problems.56

3.4 Police practice

It has been observed that one of the most critical points of contact between a person with an intellectual disability and the criminal justice system is when contact first occurs with the police.57 Problems at this level are likely to affect the whole criminal justice process and may be difficult to overcome.58 Often mentally disordered and intellectually disabled offenders who are screened at court will have spent damaging amounts of time in police custody.59 Yet while some of those with intellectual disability who pose a substantial risk of harm are dealt with under the criminal justice system by prosecution, trial, conviction and sentence, others who come to official notice for alleged criminal activity may not be prosecuted.60 In the UK a number of recent initiatives are aimed at providing psychological and psychiatric assessment at police stations as soon as possible after the point of arrest, thereby saving both time and money and in appropriate cases, diverting mentally disordered and intellectually disabled offenders to receive health care or other appropriate interventions at the earliest possible stage.61

A new type of comprehensive diversion scheme developed in Birmingham, England, involved a trained Community Psychiatric Nurse (CPN) screening suspects for potential mental health problems at the police station and making appropriate care arrangements when the person's mental status warranted it. During its first six months of operation, of all detainees assessed by the CPN only one proceeded as far as a court appearance. The success of the scheme has been such that it has been extended to other police districts.62 Other similar schemes may use a 'project team', including a Community Psychiatric Nurse, an Approved Social Worker and a Probation Officer to undertake similar assessments in the police cells.63

The value of such schemes is that they give the police instant access to psychiatric and other professional assistance, eliminate unnecessary and possible damaging custodial detention, and provide detainees with the proper care and treatment that they require and are entitled to. If such a scheme were to be considered with a view to possible application in a New Zealand context, I would suggest that it would be desirable to include in any such assessment team a person qualified to make
psychological assessments in order to accurately assess the presence of intellectual disability.

At present in New Zealand the guidelines for prosecutorial decisions in such cases lack a clear rationale and it is likely that the decision concerning whether or not to prosecute an intellectually disabled person suspected of having committed a crime may be perceived by some as something of a lottery. At present the general discretion to prosecute is guided by two major considerations, namely:

- evidential sufficiency
- the Public Interest.

Where an offence has been committed by a mentally disordered person (which must be taken to include intellectually disabled persons - Police General Instructions do not appear to distinguish between the two groups) a prosecution is normally automatic. The police consider that issues of the mental capacity of a suspect are not within their proper province or sphere of competence and prefer to leave such matters to the courts to determine.

It has been observed in relation to Australian experience in this area that there is a wide variation in charging and prosecutorial practices. There, some police regions adopt a very compassionate and caring attitude towards the offender while others tend to stick rigidly to the rules. In New Zealand the present practice would appear to be to uniformly prosecute in all cases involving serious offences and let the courts determine issues of fitness to plead and criminal responsibility that may arise.

Because there is always a danger that a person with an intellectual disability may attract the attention of the police as a result of his or her disability, in circumstances in which a person without disability might quickly be released or otherwise avoid prosecution, there is a real risk of intellectually disabled persons being too readily criminalised. Often police interviews do not act as an effective screening procedure, most police officers being ill-equipped by training to recognise the indicia of intellectual disability. It is because police officers and police surgeons in UK receive no specific formal training in the field of mental illness and disability that the Royal Commission on Criminal Justice has urged that the police should have access to psychiatric assistance whenever required. In reality many people with an intellectual disability may enter the criminal justice system without their disability being detected. This has the potential of producing serious injustice, particularly where unskilled persons fail to assess the presence of relevant mental disorder or disability and assume an offender is competent to undergo questioning and to participate in a trial. These difficulties would seem to point to the desirability of establishing a uniform prosecutorial policy throughout the whole country.

Dr William Glaser, a Melbourne consultant psychiatrist with extensive experience in dealing with intellectually disabled offenders, has suggested that from a clinical point of view there are two special issues relating to police procedures that need to be addressed.
1. Clinical assessment of a suspect's fitness to be interviewed.

Often this assessment is performed by the police forensic physician or the police themselves seek information from treating practitioners. While, according to Dr Glaser, this arrangement works reasonably well in practice, there may be cases where a suspect is not known to service providers or the police doctor does not have the appropriate level of expertise to be able to perform an adequate assessment. Dr Glaser advocates the establishment of a panel of appropriate experts who could be called upon at short notice in such cases.

I would add that the problems are likely to be compounded where the police examining physician has limited experience in assessing mental disorder but has no experience in understanding the distinctive presentation of intellectually disabled persons.

2. Use of independent third persons when conducting police interviews of suspects with intellectual or other disability.

There would seem to be a growing consensus in a number of jurisdictions that whenever a person with an intellectual disability is interviewed by police with a view to obtaining a statement from the person, that the suspect ought to be accompanied by a support person to assist with communication and to provide independent confirmation that the interview is fairly conducted. Such a requirement is specifically provided for in the New South Wales Police Commissioner's Instructions and in a protocol published by the Nova Scotia Public Prosecution Service.

In the state of Victoria the use of such persons is now routine. There the system appears to work very successfully. However, it seems that sometimes independent third persons do not intervene appropriately during the course of an interview, even where it is clear that the suspect is having difficulty in understanding police questioning.

Alternatively, there are cases where, according to Dr Glaser, the independent third person, usually lacking qualifications as a health professional, has been asked inappropriately by the police to make judgments as to the person's fitness to be interviewed.

It is important that the role, purpose and powers of an independent third person should be clearly defined. A suggested minimum requirement is that all interviews between the police and a suspect who may have an intellectual disability be recorded, preferably on video tape. In addition, at the end of the interview the independent third person should be permitted to make some brief recorded comments as to their own impressions of the suspect and any concerns about the conduct of the interview itself.

More effective procedures for the initial identification of persons with an intellectual disability would be instrumental in minimising the prospect of such persons being inappropriately processed through the criminal justice system and the 'downstream'
problems associated with criminal justice dispositions. One writer has observed that because mentally disordered people (intellectually disabled are also included) sometimes behave in a way which attracts attention, they become suspects. Once they are suspects, their demeanour may lead investigating officers to believe that they are being evasive or telling lies. Furthermore they may be vulnerable in that they make false admissions, whether because they have the type of personality that is anxious to please persons in authority or because they are compulsive confessors. In any event, intellectually disabled people are often denied appropriate rights when interrogated or arrested by the police and their exposure to subsequent criminal justice interventions is invariably dependent upon the exercise by the police of their wide discretionary powers. Dr Glaser notes that these may well be exercised in circumstances which are unfavourable to the disabled offender, for example where an offender is arrested late at night by an inexperienced officer and the offender has poor verbal skills and limited access to legal counsel or community supports.

A further difficulty that compounds the vulnerability of intellectually disabled offenders is the fact that many suspects may not understand the police caution or the language in which it is framed. Phrases like 'evidence', 'obliged', 'statement' may not be comprehended by some offenders, yet the law does not require an arresting police officer to explain such terms to an offender. However, the absence of such a simple safeguard may increase the likelihood of a major injustice occurring as in the Confait case in the UK. There have been many cases where confessions made by mentally disordered and intellectually disabled offenders have been found to be unreliable. Glaser notes the case of Simm (Victoria, unreported, 1994) where the alleged offender, a man with an intellectual disability and autism, was remanded in custody for several months on rape charges before it was realised that his language deficits seriously compromised the validity of his 'confession'. It was likely that he did not understand the questions put to him, despite the presence of an independent third person at the interview.

In the UK there is a requirement in Code of Practice C of the Police and Criminal Evidence Act 1984 for the presence of an independent 'appropriate adult' to ensure the rights of suspects who are 'mentally handicapped' or 'mentally disordered.' The purpose of the appropriate adult is to advise the person being questioned, and to observe whether or not the interview is being conducted fairly; and to facilitate communication with the person being interviewed. Commentators note the importance of both police and appropriate adults to fully appreciate the nature of the appropriate adult's role and function and the need for ongoing police training in this area.

In a recent discussion paper the New South Wales Law Reform Commission has considered options for diversion that would offer an alternative to arrest. Included are admission centres, admission to hospital, programmes for juvenile offenders, contract-based diversion and community justice centres. While there are no equivalent options in New Zealand at the present time, the prospect of diversion offers an effective policy for dealing with minor offending by the intellectually disabled and may reduce pressure on the ability of the criminal justice system to cope with this offender group generally.
3.5 Bail

The discretion which a court has to grant bail involves a careful balancing of the liberty interests of a defendant, the protection of the public and the efficient administration of criminal justice. Recent amendments to the discretion to grant bail in New Zealand have given greater weight to the protection of the public. In the case of intellectually disabled persons suspected of committing offences bail may be denied for a variety of reasons.

Many offenders with an intellectual disability are remanded in custody because there is basically nowhere else to put them. Yet such offenders are totally unsuited to cope with the environment of a prison and often experience considerable abuse, deprivation and harassment, even in specialist units.

An important question is whether the law relating to bail should provide for particular consideration to be given to the presence of intellectual disability when weighing the appropriateness of bail and the accused's acceptance of conditions applicable to it.

The New South Wales Law Reform Commission has recommended that a Code of Practice should include provisions to ensure the presence of a support person to assist with the bail procedure and to confer on police a positive duty to take into account an accused's intellectual disability when assessing the likelihood of the accused understanding the requirement to comply with bail conditions, the importance of the accused's residential and employment status in that assessment, and the relative burden upon the accused of any conditions imposed.

An issue which arises is whether legislation ought to reflect a presumption in favour of bail in the case of intellectually disabled offenders, rebuttable upon convincing proof of the existence of certain qualifying factors. A possible model for such an approach might be the Bail Act 1982 (WA) which, while making no specific reference to persons with an intellectual disability, establishes a qualified right of bail in the case of a child. The factors to be considered in any decision concerning bail include the likelihood of the accused appearing in court in accordance with a bail undertaking, whether the safety, welfare or property of any person is likely to be endangered and whether the person needs to be held in custody for his or her own protection. Other personal characteristics like the accused's character, previous convictions, home environment, background, place of residence, and financial position must also be considered. Conditions, including home detention and medical examination, may also be imposed. This model could be adapted to provide for a special regime of bail applicable to intellectually disabled offenders.

Another suggested approach would be to write into the legislation that remand into a prison environment should be considered only as a last resort. Allied to this is the suggestion that the provision of 'bail hostels' with appropriate staffing, supervision, and suitable day programmes is a much needed alternative. In Melbourne some 'respite' community residential units are used for this purpose, although this results in the undesirable mixing of offenders and non-offenders. There is no formal
provision for bail accommodation for intellectually disabled offenders in New Zealand at the present time.

Clearly the question of bail is one that needs to be addressed in any comprehensive assessment of legislation in this area. The special difficulties faced by intellectually disabled offenders need to be given careful consideration, in particular the disadvantages associated with lack of accommodation and community ties, lack of stable employment, and ability to understand complicated bail conditions.

3.6 Fitness to plead

Because of the peculiarities in the way in which relevant legislation has been drafted, intellectually disabled offenders in New Zealand are relatively more severely disadvantaged in relation to issues of fitness to plead than offenders in other jurisdictions. The particular problems associated with New Zealand law and practice have been thoroughly considered by the New Zealand Law Commission and do not need to be rehearsed in detail in this context. However, some consideration of the essential issues is necessary.

In considering the particular challenges presented by intellectually disabled persons 'under disability' it is important that the underlying purpose of fitness to plead determinations is clearly understood. Disability hearings pursuant to the provisions of Part VII of the *Criminal Justice Act 1985* are not concerned with issues of criminal responsibility but exclusively with procedural fairness. In this context judges are not concerned with attributions of culpability or dangerousness but simply whether the offender before them is in a fit mental state to be tried.

The earliest apparent judicial statement of what constitutes disability as a matter of law in New Zealand is in the judgment of Denniston J *R v Carlyle*, where his Honour said:

"You must be satisfied that the prisoner is capable of understanding his defence, of understanding the effect of a plea of guilty or not guilty, of cross-examining witnesses, and of exercising his right of challenge."

The judgment nowhere makes any reference to the cause of any relevant incapacity, although the terms of s7 of the *Lunatics Act 1882*, which defined the procedure for disposing of a person 'upon arraignment, found to be lunatic' make it clear that the generic expression 'found to be lunatic' included those whom we would today classify as intellectually disabled. It has been argued elsewhere that the common law uniformly regarded mentally disordered and intellectually disabled offenders as indistinguishable for the purposes of fitness to plead and no differentiation was made between them in the matter of disposition.

The current difficulties in New Zealand law arising out of the apparent incongruence between the definition of 'mental disorder' in the *Mental Health (Compulsory Assessment and Treatment) Act 1992* and the 'under disability' definition in s108 of the *Criminal Justice Act 1985*, are, in my view, the result of infelicitous legislative drafting. I agree with the analysis of Judge McElrea in *Police v XYZ* where his
Honour says that it is clear that when the 1992 Act was introduced, the need to amend s108 of the Criminal Justice Act 1985 dealing with disability hearings was simply overlooked. I do not believe it was ever the Legislature's intention to exclude intellectually disabled offenders from the procedures designed to determine fitness to plead. To do so intentionally would have been to produce substantial unfairness and would have undermined the very purpose of the fitness doctrine.

One useful aspect of the Mental Health (Compulsory Assessment and Treatment) Amendment Bill was the proposed revision of the criteria in s108 Criminal Justice Act 1985 governing 'under disability'. The amendment purported to extend the range of mental conditions from which a defendant may suffer to qualify for a 'disability' hearing to include some persons with intellectual disabilities. I agree with the proposed amendment to section 108 and the inclusion within the Bill of the new definition of 'mentally impaired'. The change, were it to become law, would effectively overcome the problems the present law creates for offenders with only an intellectual disability who are, practically speaking, under disability but who, under existing law, do not fit comfortably within the definition of 'mentally disordered'. The amendment would not, however, relieve the current inadequacies of the legislation as regards appropriate dispositional alternatives for intellectually disabled offenders found to be under disability.

Clearly the legal test for disability need not necessarily be linked to mental disorder as a pre-requisite. The thrust of the common law on fitness to plead was that any disorder, whether mental or functional, which had the effect of preventing an accused from understanding and therefore, meaningfully participating in the trial process, was a relevant justification for adjourning the trial and/or diverting the accused from further criminal proceedings.

For the purposes of capacity to participate in a trial no significant consequences should turn on whether an accused is mentally disordered as opposed to being intellectually disabled. Either condition should be a sufficient trigger for a possible fitness hearing where any other statutory indicia of incapacity to plead etc, are present.

This is the approach taken in legislation on fitness to plead in other jurisdictions. For example, in the Criminal Code of Western Australia a fitness hearing may be triggered if, when an accused person is called upon to plead to an indictment, it appears to be uncertain, for any reason, whether he is capable of understanding the proceedings, in order to be able to make a proper defence. It has been noted that because the section applies where 'for any reason' uncertainty arises in relation to the understanding of an accused, it is capable of being activated by the presence of intellectual disability.

The New Zealand Law Commission has also noted that the linking of s108 to the 1992 definition of mental disorder is inadequate not only for intellectually handicapped people, but also for others who are unfit to stand trial for reasons which are not related to the 1992 definition, for example brain damage acquired in childhood.
The Law Commission recommends that s108 be amended in order ensure that the focus of a disability hearing is the defendant's ability to communicate and understand. It is the Law Commission's view that the cause of the defendant's incapacity should not be relevant, whether it be psychosis, infirmity, intellectual disability, or brain damage acquired in childhood. I would endorse this recommendation.

3.7 Screening for disability

One of the difficulties with current legislation is that it fails to provide any useful guidance to clinicians as to how legal criteria for determining unfitness are to be interpreted and applied. The criteria in present New Zealand legislation are narrowly formulated and are practical in nature and relate exclusively to what a defendant is able to say and do rather than defining conclusions that might be drawn from psychological testing. Yet in considering intellectually disabled offenders putatively 'under disability', early indications of adaptive skills and performance intelligence may be more useful indicators of fitness to plead than ability to verbalise an understanding about the nature of pleading or the proceedings in which he/she is a participant. At present there are no recognised psychological tests for screening for disability that are commonly used by clinicians in New Zealand.

In reality the group with intellectual deficit who present major difficulties to the public are largely in the IQ range 55-70. People with more profound intellectual disabilities below an IQ of 55 are usually in various types of supported care and lack the degree of personal freedom which might otherwise result in their ability to offend. Most of those with an IQ of below 60 are unfit to plead and some in the IQ range 60-70 may also be unfit, depending on other variables.

3.8 Presumption of disability

In the light of these facts a possible approach to the issue of disability screening in relation to intellectually disabled offenders only would be to create a statutory presumption that where an offender has been assessed in a preliminary assessment as having an IQ of less than, say, 55 (or subject to some other recognised standard based on adaptive ability or performance intelligence fails to meet a requisite threshold) or otherwise falls within the 'mild' to 'moderate' level of disability he or she is unfit to plead or be tried. The presumption could be rebutted by any party adducing some evidence consistent with fitness, in which event the issue of disability would fall to be determined in the ordinary way. However, in any case where the offender meets the presumptive threshold of disability and neither party to the proceedings wishes to dispute the presumption, the person would automatically be found to be under disability, thus obviating the need for a lengthy, stressful and costly disability hearing.

In making this suggestion I am mindful of the significant civil liberties issues that may be involved. Some may well contend that the idea of a presumption of disability is contrary at some level to the presumption of innocence and constitutional guarantees of a right of fair trial. Others might note the apparent contradiction of the statutory presumption of sanity in s23 Crimes Act 1961, and the
proposal of a presumption of disability. However, disability is a procedural issue and is unconcerned with the question of criminal responsibility. The proposed procedure aims to streamline the process of establishing unfitness only in respect of that narrow band of cases where the practical likelihood of being 'under disability' is little short of overwhelming and where there is scant prospect of the matter ever proceeding to trail. The proposed procedure may, nevertheless, serve the interests of a small group of mild to moderately disabled offenders who are not screened out at an earlier stage of the proceedings but in respect of whom there is substantial agreement amongst professionals, including the person's legal advisers, that their actual disability would substantially impair their capacity to participate meaningfully in a trial. In such cases 'disability' would be conceded and the only issue for the courts would be the vexed question of disposition. My experience as counsel in the case of Police v M\textsuperscript{100} confirms in my own mind the need for a simple procedure that avoids the need to formally determine disability in cases where it seems manifestly clear that a finding of disability will ultimately be made.

The advantages of such a procedure need to be considered in light of the fact that overseas studies have shown that there is considerable under-identification of people with intellectual disability as being unfit to stand trial.\textsuperscript{101} This suggests that the issue is often not raised in situations where it could be. If, in future, better informed counsel and other professionals become more adept at identifying possible disability and pursuing it as a legal issue, a procedure that is able to eliminate the need for formal disability hearings in appropriate cases may be welcomed by all those concerned in such proceedings.

However, it should be emphasised that any 'presumption of disability' would only apply to offenders with an intellectual disability alone and would not be relevant to mentally disordered offenders or offenders with a dual diagnosis of mental disorder and intellectual disability. My view is that there are too many variables associated with mental disorder for disability to ever be presumptively present. But because intellectual disability is, for the most part, a fixed developmental disorder, the character of which does not normally change during a person's lifetime, it is legitimate to assume that disability will be present in most cases where the person is below a particular threshold of adaptive ability or performance intelligence. There are not the range of potential variables that may be present with mental disorder and which may affect the person's functional capacity to participate in a trial.

3.9 Representation

Counsel have a vital role to play in assisting intellectually disabled persons within the criminal justice system. Their role is important from the time the offender is first arrested until disposition and may involve ongoing assistance depending on the nature and circumstances of any ultimate disposition.

In the UK lawyers play an increasingly important role at the police station and have a central role to play in ensuring that the safeguards for mentally disordered and intellectually disabled clients are correctly and adequately implemented.\textsuperscript{102} Commentators have warned of the need for vulnerable people to have access to a solicitor who is properly equipped to deal with the problems associated with
advising and representing mentally disordered and intellectually disabled clients, if major miscarriages that occur when such people are coerced into making confessions are to be avoided. In England the Law Society has, as from February 1995, introduced a mandatory scheme requiring all legal executives and clerks attending suspects at the police station on behalf of solicitors to undergo a specific training course which must be completed before the representatives can attend the police station to give advice. It is hoped to extend the scheme to all trainee solicitors and duty solicitors by 1 February 1997. There is no similar compulsory training scheme for lawyers operating in New Zealand at the present time although there would appear to be no reason in principle why a training scheme could not be implemented by the local District Law Societies in conjunction with the Legal Services Board.

In New Zealand lawyers have traditionally not been given specific instruction about intellectual disability, although some may have acquired anecdotal knowledge through litigation and professional involvement with organisations dealing with intellectually disabled persons like IHC. Some university courses also provide some basic tuition on the distinction between intellectual disability and mental disorder but there is, as yet, no formal training for lawyers in these matters. Such tuition should encompass such areas as the ability of a person to testify in court, relevant principles of evidence and interviewing techniques.

A similar problem has been noted in New South Wales. There it is suggested that few lawyers will have received instruction in the special needs of clients with intellectual or other disabilities, either during their training or subsequently. The authors suggest that it is crucial that lawyers identify their client's intellectual disability and understand the difficulties that people with an intellectual disability may face. This will involve the use of appropriate communication and questioning techniques if counsel are to be able to perform such fundamental tasks as taking instructions or to be able to evaluate whether the client has the capacity to give instructions.

In a number of different contexts the suggestion has been made for the establishment of a procedure to appoint a guardian ad litem to defend an action or other proceeding on behalf of the person with a disability. Such an appointment would ensure that the interests of intellectually disabled offenders are adequately represented, particularly at disability hearings, and would provide counsel with valuable assistance in taking instructions and discerning the wishes of intellectually disabled clients.

Some consideration might also be given in the context of New Zealand law and practice of preparing guidelines to address issues of criminal law and people with an intellectual disability for the benefit of court staff and judges. This has been done in Western Australia under the guidance of a Federal Court Judge.

In New South Wales the Legal Aid Commission has a specialised Mental Health Advocacy Service to provide assistance in mental health matters which extends to forensic patients. Although the Commission does not have a specialist policy unit for people with an intellectual disability, it does provide training in this area for its
solicitors and encourages all legal practitioners to develop their professional skills to enable them to communicate and effectively represent people with an intellectual disability. It is possible in New Zealand that this legal educative function could be performed by the Legal Services Board pursuant to its mandate 'To sponsor, monitor, and evaluate pilot schemes for providing legal services to the public' and 'To provide advice on the provision, to the public, of legal information and law-related education.'

In Auckland Citizen Advocacy Auckland Inc is an organisation that has amongst its aims to provide a competent person, who is unpaid and independent, to represent the interests of a person with an intellectual disability 'as if those interests were the advocate's own.' The work done by this organisation in advocating for the interests of intellectually disabled persons is extremely valuable. However, as a voluntary organisation dependent on unpaid volunteers, it can hardly be expected to shoulder the substantial advocacy demands which this group of persons may from time to time present and needs to be supported in its efforts by a carefully conceived, state funded, advocacy service which is directed to the specific and distinctive needs of intellectually disabled persons. Such an independent advocacy service would be essential if the Government were to accept the recommendation for 'stand alone' legislation for this group. Provision for such a specialist service could be achieved by an appropriate amendment to the Legal Services Act, which already allows for state funded legal representation for persons appearing in proceedings under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

While the suggestion for 'friends at court' or 'volunteer friends' to assist intellectually disabled people in dealing with the criminal justice system is valuable, it does not of itself provide a complete solution to the advocacy needs of intellectually disabled persons. In the state of Victoria the intellectually disabled constitute the largest group (35 per cent) of clients requiring advocacy from the Office of the Public Advocate in Victoria. In the absence of available figures in New Zealand we may assume that the need for representation for this group is similar in New Zealand. However, one suspects that intellectually disabled offenders are currently inadequately represented by legal counsel in New Zealand, and for this reason, amongst others, are probably over-represented in our criminal justice figures.

3.10 Criminal responsibility

The issue of criminal responsibility is concerned with the question of in what circumstances a person should be held criminally accountable for his or her actions. Criminal responsibility is not automatically excluded by virtue of the presence of mental disorder or disability in a person. In each case it is a question of the nature of the abnormality and the degree to which it is present that will determine issues of responsibility.

Criminal responsibility involves issues distinct from procedural questions concerning arrest and fitness to plead and is principally concerned with an offender's mental culpability at the time of the commission of an alleged offence. The fact of intellectual disability will often be relevant in deciding whether a person had the required mens rea (mental state required to be proved as part of the offence
alleged), although persons in the moderate to severe range of intellectual disability will seldom be subject to judicial determinations of responsibility because they will lack the mental capacity to understand or appreciate the legal character of the conduct they are charged with. Such persons will often be in sheltered or secure environments which severely limit their freedom to become involved in antisocial activity.

The main group for whom issues of responsibility will be relevant are persons with 'borderline' or 'mild' intellectual disabilities.

While all criminal defences would be theoretically available to an offender with an intellectual disability, intellectual disability is more likely to be relevant to those defences which involve abnormal mental states including insanity, automatism, mistake, provocation and lack of mens rea. The point of critical importance, as regards intellectually disabled persons, is that in many instances they may not be criminally responsible in legal terms because for various reasons they may lack the mens rea for a crime, but lack the ability to articulate their concerns in order to adequately present a defence to a charge. For example, the crime of arson,\textsuperscript{111} which is an offence commonly committed by some intellectually disabled offenders, contains a number of sophisticated mens rea elements which it may be difficult for many intellectually disabled offenders to meet because of their limited intellectual capacity. One alternative definition of the offence requires proof that the offender wilfully set fire to 'any property...if he knows or ought to know that danger to life is likely to ensue.'\textsuperscript{112} In such a case the prosecution would be required to prove that the offender both wilfully set fire to property while at the same time knowing that danger to life was likely.

In many cases the question of whether the accused was able to meet the threshold requirement for wilfulness or knowledge will never be tested because the accused will either have been found under disability or, perhaps ill-advisedly, have entered a guilty plea to the charge because the existence of intellectual disability was not identified by his/her counsel.

For these reasons I recommend that consideration be given to instituting a new procedure, to apply to intellectually disabled offenders, for a court which has determined that a person is unfit to plead to conduct a 'trial of the facts' to determine whether the accused committed the physical act involved in the offence, where this may be in issue, or to determine whether he or she had the mental capacity to fulfil the mens rea requirements of the offence charged. This procedure, for which models exist in other jurisdictions, is similar to that discussed by the Law Commission.\textsuperscript{113} It would need to be considered in light of my recommendation for a presumption of disability. I would see the presumption as having particular relevance in cases where there is no serious dispute as to the commission of the physical ingredients of the offence and where there is prima facie evidence of deliberate behaviour on the part of the offender but where it would be pointless subjecting him or her to either a disability hearing or a trial.

My concern is that an offender should not be deprived of his or her liberty through a finding of disability where there exists a reasonable chance of acquittal. In such
cases the question of responsibility should be capable of being tested so as to avoid findings of disability wherever possible.

The issue of insanity may arise where an intellectually disabled offender is charged with a serious offence, where the disability amounts to 'natural imbecility' of a degree which renders the person incapable of knowing what he is doing or that the act is morally wrong. The phrase 'natural imbecility' includes both congenital defects and disorders which develop later in life. However, because insanity is generally only pleaded in respect of the gravest offences, typically homicide, it is seldom founded on intellectual disability as a relevant qualifying condition.
60 Ibid.
61 Ibid.
62 Ibid.
63 Ibid.
65 Ibid, 11.
66 Dr William Glaser, Consultant Psychiatrist, Melbourne. Personal correspondence with the author.
67 Wardell, supra note 64, at 12. It is suggested that given the unsuitability of alternatives to prosecution in New Zealand, the weight of police policy favours prosecution in all but the rarest of cases.
69 The dangers associated with incompetent assessments which fail to identify mental disorder are discussed in Laing, supra, 373.
70 Ibid.
73 Ibid.
75 Glaser, supra, note 8.
76 Ibid.
77 See discussion in Fennell, supra, note 74, at 57 - 58.
78 Glaser, supra, note 8. Dr Glaser helpfully lists a number of matters that careful attention needs to be paid to in dealing with an intellectually disabled suspect in a police setting. They include: the offender's language, ability to define terms used by police in questioning, his/her understanding of 'caution', interventions by third persons during the interview, ability to respond to difficult or confusing questions, offender's history of institutional living and characteristic behaviour with authority figures and emotional state at the time of the interview.
82 Dr William Glaser. Personal correspondence with the author.
84 Bail Act 1982 (WA) schedule, Part C, cl 2.
85 Ibid., Schedule 1, Part C, cls 1(a) and (b).
86 Ibid., Schedule 1, Part D, cl 2.
87 Dr William Glaser. Personal correspondence with the author.
88 Ibid.
90 (1889) 7 NZLR 281.
93 Western Australian Criminal Code, s 631.
94 The Hon Mr Justice R D Nicholson, supra, note 2, at 88.
95 Law Commission Report No 30, supra, para 147.
It is suggested that most offenders with an intellectual disability have a 'borderline' or 'mild' degree of disability and are likely to be able to meet statutory criteria for fitness, or to be capable of undergoing appropriate training. See Glaser, supra. The proposal would, therefore, only target offenders who were demonstrably disabled and in respect of whom the relevant functional incapacities would be largely self-evident.
PART IV - PROVISION OF CARE

4.1 Assessment and treatment

In order to be able to adequately assess and treat intellectually disabled persons it is necessary that professionals dealing with them understand the nature of the disability and how it impacts upon the lives of its sufferers. There would appear to be a consensus view that the training of mental health professionals in this regard is inadequate. Critical issues that should be addressed in training include the nature of behavioural changes that occur in people with intellectual disability when they are confused, anxious, grieving or depressed, or when their coping mechanisms are no longer effective in managing their world and sources of stress. The danger is that ignorance amongst professionals may lead to intellectually disabled persons being judged superficially and too readily criminalised.

Treatment for intellectually disabled persons should aim to assist maturation, facilitate the development of adequate levels of control, instil a sense of personal worth and personal responsibility, establish acceptable social mores and improve social, occupational and educational skills. Day suggests that a properly formulated treatment programme with explicitly stated goals is essential. Personnel involved in care should work together to an agreed strategy and meet regularly to monitor progress and review plans. The main elements of treatment include socialisation programmes, practical skills training, further education, counselling/supportive psychotherapy and in some cases specific behavioural programmes and sex suppressant or anti-aggressive medication.

In Day's opinion the majority of intellectually disabled offenders can be managed in the community, supported by appropriate social services. Detention may be indicated when the offence committed is serious, when the patient is considered dangerous, or where the general needs of an individual for training, control and care cannot be met in a community setting. However, treatment in the community should be seen as the norm and any new legislation in this area should enact a statutory presumption in favour of community treatment, rebuttable only upon proof that the person cannot be treated adequately in the community. Such an approach is also consistent with the principle of the least restrictive environment which is now mandated in international standards for the treatment of intellectually disabled and mentally disordered persons.

The necessity for intellectually disabled offenders to be treated in a context separate from mentally disordered patients is generally acknowledged. The dangers of mixing persons who are seriously mentally ill and those who present dangerousness due to intellectual handicap or personality disorder have been noted. It is suggested that because these two groups require different types of care and treatment, mixing them prevents each group accessing appropriate treatment and produces more abnormal behaviour. It is therefore necessary for services to work actively to prevent such mixing occurring.
The UN Declaration of the Rights of Disabled Persons states that living conditions in an institution should be as normal as possible and that clients should have services to help develop their skills and capabilities and to re-integrate them into the community. Such a requirement would be manifestly impossible to achieve in circumstances where persons with completely different treatment needs are being cared for in the same therapeutic environment. I would therefore recommend that any legislation to provide for intellectually disabled offenders should contain a statement of principle that intellectually disabled persons should always be treated in an environment which is conducive to their specific needs and aspirations. This would imply that 'mixing' will be presumptively inappropriate unless the circumstances make it unavoidable.

Any new legislation in this area should provide for culturally appropriate and humane assessment, management, treatment and rehabilitation of offenders. It should also be conscious of the fine line that exists between the rights of patients to treatment for disorders that may impair their competence to decide for themselves about treatment, and their right to self-determination. The Declaration of the Rights of Mentally Retarded Persons\textsuperscript{124} contains a specific commitment to the realisation of the goal of equality of opportunity in asserting that:

\begin{quote}
"the mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings."
\end{quote}

It has been suggested that although the declaration does not have any legal force under international law or domestic law, it remains a highly persuasive document.\textsuperscript{126} In any event the general principle affirmed in this statement should provide the basis for the philosophy undergirding any relevant legislation in this area.

A valuable statement of 'Key Principles in the Treatment Relationship' is set out in the Gallen Report 1983.\textsuperscript{127} Although these are formulated principally in relation to the treatment of mental disorder, they contain valuable insights into the nature of treatment relationships many of which are transferable to dealings with intellectually disabled persons. They are reproduced in Appendix A.

4.2 Resources and service provision

In the UK it is generally recognised that mentally disordered people, including those who are intellectually disabled, are increasingly coming into contact with the criminal justice system, invariably as a result of lack of care, support and treatment in the community.\textsuperscript{128} In other jurisdictions 'gaping holes' exist in mental health delivery systems, including a great shortage of psychiatric staff.\textsuperscript{129} The inability of the Californian prison system to deliver an adequate system of mental health care to many thousands of prisoners within the jurisdiction of the California Department of Corrections, led one judge to conclude that the system subjects mentally ill prisoners to cruel and unusual punishment under the Eighth Amendment to the American Constitution.\textsuperscript{129} Whether or not provision for new options for the detention and treatment of intellectually disabled offenders should be made in the law in New Zealand, as in California, will be as much a question of resources as whether any reform is desirable.
A significant amount of criticism of the new Mental Health Act has been directed at the burden of procedural matters and time consuming tasks which the Act has generated at a time of shrinking resources. In particular concern has been expressed that psychiatrists' time is being used up in various legal contexts rather than in the actual treatment of patients, producing distortions in service delivery. This concern needs to be addressed in planning for service provision associated with any new legislation for intellectually disabled offenders. Where possible administrative structures and procedures should be established which impinge as little as possible upon the time available to clinicians to be involved in the treatment and management of patients. This may involve critically reviewing current procedures and documentation in order to streamline procedures and to achieve economies of time. Lessons learnt in relation to mental health procedures may then be applied in formulating legislative procedures governing the treatment and management of intellectually disabled offenders. Such rationalisation may be viewed as a priority given the fact that intellectually disabled people who present challenging behaviour within community settings stretch the resources of organisations like IHIC beyond their capacity to cope and because of their challenging behaviours are often inadequately catered for. In many places they have become the victims of declining levels of clinical input and have often found themselves in wards, with varying levels of security, in large hospitals because IHIC is not interested or is unable to care for them. Such services have tended to be less and less well resourced and are regarded as grossly inadequate for this patient group.

These realities seem to point strongly towards the need for specialised provision within general disability services because of the major differences between intellectually disabled offenders and other mentally disordered offenders and their specialised treatment, rehabilitation and aftercare needs. Day notes that in Holland five specialised regional services for mentally handicapped offenders have been planned and in the USA specialised units and management programmes have been developed in many states. In the UK two recent Department of Health and Home Office Reviews have concluded that a comprehensive range of specialised facilities is required, from community services for the majority to high security provision for the most dangerous offenders, together with specialised rehabilitation and aftercare services for hospitalised offenders and some long-term facilities for those requiring continuing care with minimal security. In New Zealand it has been recommended that regional health authorities should be required to ensure that comprehensive integrated systems of care for the intellectually and organically brain impaired persons contain provision for the long term supervised care and assertive follow-up of individuals who pose a risk to others. I would support this recommendation.

Some of the broader issues of service provision for intellectually disabled offenders have already been considered in John Dawson's Report to the Ministry of Health's Working Group on Secure Provision for Intellectually Handicapped Offenders. I would endorse Mr Dawson's analysis of the questions that need to be addressed. One of the important issues is determining how large is the group for whom provision needs to be made. The size of the group will to some extent determine the nature, extent and location of services that may be needed and should be the subject of a careful demographic survey. I would agree with Dawson that legislative change
alone will not provide the necessary services but that questions as to whether new services are needed, where they are to be provided and how they will be funded need to be carefully thought through before any new legislation is put in place. It would be quite pointless to establish a new regime of compulsory care in the absence of available appropriate services and funding. Indeed, it is the view of one organisation that the problems which the community experienced during 1994 with dangerous mentally disordered and intellectually disabled persons being discharged into the community were due to a lack of funding for appropriate services.

In considering the possibility of establishing new services for intellectually disabled offenders, some thought needs also to be given to a qualifying definition(s) for services. The New South Wales Law Commission has noted that different definitions may be necessary depending on the type of service which is indicated. Such definitions need not be statutory. Different government departments may use their own operational qualifying definitions for services. This may be a necessary consideration if a range of services to meet the differing needs of intellectually disabled offenders is to be provided.

A problem with the provision of new services for intellectually disabled offenders is the danger that unless special funding and service provision is made, such services will be funded by reducing the funding currently available for mental health services. I would reject such an approach. If intellectually disabled persons who offend are to be adequately catered for in any new legislative initiative, it must be properly funded. Mental health professionals are rightly suspicious of new legislative initiatives which fail to address resource and fiscal implications of proposed changes. I would note, for example, the concern expressed following the tabling of the Mental Health Amendment Bill, that already under-resourced services would be under considerable strain given that the extra resources that were required for the administration of the Mental Health (Compulsory Assessment and Treatment) Act 1992 were not forthcoming. The legitimate concern is that further demands on services, produced by new legislation will, unless properly funded, lead to a reduction in the standards of care for other patients within mental health services.

4.3 Ethical considerations

The question of whether to make separate legislative provision for intellectually disabled offenders gives rise to a diverse range of ethical questions. These include the ethics of preventive detention as applied to intellectually disabled offenders, questions of competency, autonomy, confidentiality, informed consent, paternalism, the use of medication to control behaviour, review and the ethics of normalisation. However, while specific ethical issues may have a particular bearing on intellectually disabled offenders, they are equally affected by the full range of ethical issues that affect other members of the community, including such things as privacy concerns, right to treatment, and the right to self-determination.

The debate concerning the preventive detention of dangerous intellectually disabled offenders raises the ethical problem of balancing human rights against the rights of the community. An issue for clarification will be whether, if it is considered necessary to detain a person in a secure setting on account of their dangerous
behaviour, such detention is being mandated because the person is an offender or because it is the most appropriate way to manage their psycho/social needs. The latter emphasis may ensure management and care and limit unnecessary abrogation of basic human rights, whereas the former may imply the right to impose punitive measures and the limitation of fundamental freedoms. The ethical principle of the least restrictive alternative asserts that no person should be admitted to a treatment facility unless that facility is the least restrictive setting necessary, and that no greater restriction of liberty should be imposed than is necessary. This will mean that treatment and management should be aimed towards a person's return to society and should occur in those settings which allow the individual to live as normally as possible.

This raises a fundamental question that needs careful consideration, namely, whether imprisonment is ever justified for intellectually disabled persons who offend or whether, if it is ever justified, it should occur in specialist units geared towards the particular needs of intellectually disabled persons. The overriding issue is whether other alternatives to imprisonment would be more humane or effective in preventing crime. These issues will be discussed in more detail in the following sections.

In her submission to the Parliamentary Select Committee on the Mental Health Amendment Bill, Dr Stephanie du Fresne criticised the concept of a compulsory care order as being 'grossly unethical'. Dr du Fresne's concern was that the type of order contemplated would involve preventive detention, either in hospital or in a secure place in another service of people without mental disorder, under the 'care' of responsible clinicians. It was further suggested that the results of the involuntary detention of such people, which in the context contemplated people with personality disorders rather than intellectually disabled offenders, was not only the failure to make real changes in their condition, but more importantly the frequent and spectacular failure to sustain apparent improvement when transferred to conditions of less security. The temptation, it is suggested, is then to maintain what is effectively preventive detention disguised as 'care' to avoid serious re-offending when such an apparently improved patient is released. This would seem to be a legitimate concern and highlights the need for constructing legislative models for detention which clearly reflect the purpose for which they are conceived, are appropriate for the particular mischief addressed, and prescribe outcomes which are realisable within the regime contemplated.

The issue of competency goes to the heart of intellectual disability. However, the fact of intellectual disability per se does not imply that the person is incompetent 'globally'. I would suggest that any coercive intervention in the lives of intellectually disabled offenders should aim to maximise the opportunities of such people to make choices within the contexts in which they are placed. It has been noted that the coerciveness of an individual's setting may be a determinative factor in the legal adequacy of choices he or she may make, the degree of restrictiveness often affecting the quality of their decision-making. It should also be remembered that while intellectual disability is not 'curable' or 'changeable' in the ordinary sense of those terms, nevertheless, significant changes may occur over the life span of a person with intellectual disability. Adaptive skills and service needs may change with the changing circumstances of an individual's life. The result may be that
although the intellectual impairment is the same as it was in an earlier period, a person may cease to fall within a definition of intellectual disability for particular purposes because the impact on daily functioning is reduced.\textsuperscript{146}

Consent issues are also fundamental to consideration of intellectual disability. Glaser suggests that intellectually disabled offenders are more likely than most to be forced into complying with ethically contentious treatments, such as sterilising drugs or aversive conditioning techniques.\textsuperscript{147} It is suggested that they suffer twin disadvantages in this situation. Because of their disability they are unable to develop a proper understanding of the effects and side-effects of treatments used. This means that their capacity to consent will be in doubt. Secondly, because of the nature of the criminal justice system, the voluntariness of their consent must also be in question.\textsuperscript{148} Dr Glaser suggests that in such cases an application should be made for the appointment of an independent guardian and a second clinical opinion regarding the appropriateness of any proposed contentious treatment is usually desirable.\textsuperscript{149}

An on-going implication of the impairment of autonomy that is associated with intellectual disability is the professional tendency to act paternalistically by taking over patient decision-making in order to avoid what might be perceived as undesirable consequences of poorly judged decisions. While paternalism may have been a typical professional approach to the management of intellectually disabled persons formerly, the justification for it as a normative approach may now be seriously questioned in light of the principle of normalisation and the general desirability of maximising autonomy. One alternative to paternalism, that may need to be explored in the present context, would be to deal with the actual impairments to autonomy and work to improve a patient's capacity to participate in the decision-making process. While intellectually disabled persons clearly need to be protected against the results of decisions made when they clearly lack the relevant decision-making capacity, the desirability of maximising their freedom and autonomy may mean that in some circumstances the actual encouragement to take justifiable risks.\textsuperscript{150}

4.4 Normalisation

Normalisation is currently one of the most controversial issues affecting intellectually disabled offenders and the response of the law to them. However, it has already been incorporated into legislation for intellectually disabled persons as the standard against which services for intellectually disabled persons should be judged.\textsuperscript{151} The concept of normalisation had its origins in Scandinavia after the second world war and arose from a social philosophy that every Swedish person has 'citizen's rights' and that it is the task of social organisation to help everyone, however disabled, to enjoy citizen's rights.\textsuperscript{152} As a social theory normalisation suggests that intellectually disabled persons are at risk of devaluation and strategies to enable them to assume socially valued roles in society have to be developed.

However, while the philosophical position that intellectually disabled people are normal people with a learning deficit is laudable for the majority of intellectually disabled persons, the theory has been criticised to the extent that it has resulted in an
inappropriate service provision for those who present violent or sexually assaultive behaviour. The argument is sometimes advanced from principles of normalisation that intellectually disabled persons should be treated within the penal system like any other offender. However, it has been argued that this is a fundamental misunderstanding of the principle of normalisation and 'recognition of an individual's worth does not logically require that society has to accord a retarded citizen identical treatment to that accorded to a non-retarded citizen.' Many studies are available to demonstrate that intellectually disabled offenders are unable to adjust to prison regimes, are uniformly victimised by other prisoners and are much more likely to display aggressive behaviour.

The New South Wales Law Commission, while using normalisation as a guiding principle throughout its Issues Paper, nevertheless cautions of the need to recognise the particular vulnerability of people with an intellectual disability and the need, in some cases, for protective measures. The particular inutility of sentencing such persons to terms of imprisonment, subject to normalisation principles, lies in the fact that many such offenders may have no recollection of the offence or understanding of the consequences of their actions in committing the crime. The punishment may, therefore, be of little effect. Nevertheless, normalisation principles are applied to prisoners with intellectual disability. In Western Australia such prisoners are managed within the prison mainstream except in particular cases where placement in a general purpose protection unit is necessary because of the prisoner's behaviour or assessed level of risk. It is argued that in this way normalisation principles are applied to the management of such persons in the prison environment in a manner which reflects the application of the principle of normalisation to intellectually disabled people in the general community.

A significant criticism of normalisation, insofar as it gives intellectually disabled people a greater 'opportunity' to be dealt with by the criminal justice system when they offend, is that it ignores the very real social, economic and health disadvantages which are already experienced by the intellectually disabled offender. It also reinforces stigma and prejudice and may emphasise the priorities of professional caregivers who want 'trouble-free' clients. Glaser suggests that disabled offenders present a litmus test for the ideology of normalisation, which ultimately becomes a 'mockery' for offenders who cannot understand their rights during a police investigation or who are forced to endure the 'normality' of harassment and abuse in prison.

4.5 Public safety

The issue of public safety is axiomatic to any discussion of intellectually disabled offenders. At the present time the prediction of dangerousness lacks a scientific basis and is generally unreliable. There are no studies relating specifically to the dangerousness of the intellectually disabled. However, it is suggested that assessment of dangerousness should be based on the nature of the offence, environmental factors and personality features, and the likelihood of successful treatment. Poor self-control, low frustration tolerance, emotional coldness and gross indifference to the fate and feelings of the victim together with stress factors in
the environment and a relative lack of support and supervision seem to be particularly important in the intellectually disabled.\textsuperscript{162}

Because the concept of dangerousness is itself inherently vague it is not clear what conduct does or ought to constitute dangerous behaviour. In order to establish appropriate dangerousness criteria in the context of legislation for intellectually disabled offenders who offend, I would suggest that the following questions need to be considered:

- What types of anticipated harms warrant involuntary detention?
- Is property damage or emotional injury sufficient?
- What must be the likelihood of harm occurring?
- What kinds of harm justify what periods and types of confinement?
- If a person is adjudged to be dangerous, for what period and as a result of what factors does such a state persist?\textsuperscript{163}

Statistical studies concerning the prediction of future dangerous behaviour among mental patients indicate a high rate of error, usually in the direction of over-prediction.\textsuperscript{164} One study concluded that mental health professionals were over cautious in their prediction and that prolonged incarceration was not required for the majority of such offender patients.\textsuperscript{165} Although the majority of studies on dangerousness relate to mentally ill or mentally disordered offenders, the general findings concerning risk prediction may be equally applicable to intellectually disabled offenders.

A factor which should be borne in mind when considering the dangerousness of intellectually disabled offenders is the risk that by focusing on supposedly dangerous individuals, governments may be seen as attempting to bolster 'a rather fraying conscience collective' (sic), the product of the economic and social crises and changes of these times.\textsuperscript{166} Pratt notes\textsuperscript{167} that the result is that those labelled as dangerous come to be useful scapegoats for society's ills and help to unify other citizens around the concern their conduct evokes.\textsuperscript{168} The history of events leading to the introduction of the \textit{Mental Health (Compulsory Assessment and Treatment) Amendment Bill} in 1994 amply demonstrates this risk. It is not without significance that intellectually disabled offenders were one of the principal targets of political and media over-reaction on that occasion.

Ultimately, whether someone is dangerous is not an objectively identifiable fact, but a matter of conjecture.\textsuperscript{169} The importance of recognising that there is no necessary correlation between intellectual disability and dangerousness has been noted.\textsuperscript{170} The issue of dangerousness, as relevant to determining the \textit{type} of detention that might be necessary in the case of an intellectually disabled person who offends, needs to be balanced against other relevant concerns, including such things as psychosocial deprivation, low socio-economic class and behavioural disorder. It would be easy to stigmatise intellectually disabled persons who offend as 'dangerous' and to create new dispositions appropriate to such a status, while ignoring those factors which are significantly causative of maladaptive behaviour. To do so would be to perpetuate the cycle of marginalisation that has typified the management of such people in the past, yet without any significant increment to the community in terms of habilitation.
and encouragement of productive citizenship. I would endorse the view of the
Gallen Committee of Inquiry\textsuperscript{111} that in the long term the community is best protected
by a concern for the individual patient which results in him or her becoming an
acceptable member of that community. Prisons have no place in the rehabilitation
(or the habilitation) of intellectually disabled offenders and are unable to provide any
guarantee of their safety in the community once they are released.\textsuperscript{112}

4.6 Sentencing and disposition

There would seem to be a growing perception in some quarters of the need for an
increased range of options in the sentencing and disposition of intellectually disabled
offenders. One Australian author has commented on the lack of facilities in major
prisons to cope humanely with mentally disordered detainees or prisoners.\textsuperscript{173}
However, the problem may be more pervasive than simply the inadequacy of
custodial arrangements in prisons. Intellectual disability is a relevant factor in
sentencing generally and may be conceived as either a mitigation or aggravation of
penalty, depending on the nature and circumstances of the offence, the degree of
disability present and the likelihood of the offender gaining insight from punishment.

Where an intellectually disabled offender has been convicted of a crime and
sentenced to a term of imprisonment, the issue then arises as to whether he or she
should be placed in the mainstream of the prison or within a specialised or
protection unit, if such a unit exists. There may therefore be a conflict between the
principle of normalisation and the need to provide special services and/or protect
people with an intellectual disability.\textsuperscript{174} The issue becomes one of segregation or
integration. A suggestion, which derives from submissions of the IHC to the Select
Committee on the Mental Health Amendment Bill,\textsuperscript{175} is for all matters of sentencing
and disposition involving intellectually disabled offenders to be considered in the
first instance at a dispositional conference which might involve a range of
professionals including specialist advocates, welfare guardians, forensic
psychologists and others to recommend to the Court the most appropriate form of
disposition or sentence. A formal dispositional conference, mandated by legislation,
would enable the full range of relevant issues to be addressed and would provide the
sentencing judge with valuable information in deciding upon the most appropriate
outcome in a case.

The dispositional conference could also be used following a finding of disability or
legal insanity to assist the court in deciding on the most suitable disposition and
could be instrumental in eliminating the uncertainties and wasteful delays that
characterise dispositional decisions in this area at the present time. Where
disposition involves some form of detention the question of responsibility for
ongoing management and behaviour change programmes should be clarified at the
outset, to avoid the risk of individuals being incarcerated without formal
acknowledgement of their ongoing disability needs.\textsuperscript{176}

The notion of 'determin[ing] solutions rather than sentences' is more apposite to
intellectually disabled offenders and reflects the widely held perception, perhaps
contrary to the principle of normalisation, that people with intellectual disabilities
should not experience the same consequences for their action as other people.\textsuperscript{177} In
some jurisdictions non-custodial sentences for intellectually disabled offenders are seen as the presumptive norm unless particular aggravating factors are present.\textsuperscript{178}

An area of considerable debate concerns the appropriateness of imprisonment as a sentencing option for intellectually disabled offenders. However, in some jurisdictions, changes in the philosophy of care, the growth of community mental health services, and changing clinical perceptions of the treatment needs of intellectually disabled persons has actually increased the likelihood of intellectually disabled offenders being imprisoned.\textsuperscript{179} Often the placing of such persons in prison is not the product of a principled decision by the sentencer, in the sense that imprisonment is viewed as an appropriate sentence, but rather an inevitable outcome driven by the lack of suitable alternative dispositions. In the UK this trend has been caused by a decline in the use of hospital orders and a substantial decrease in the use of residential psychiatric probation orders.\textsuperscript{180} In New Zealand the Court of Appeal has commented on the 'deplorable absence of any suitable custodial institutions for the care of intellectually handicapped and socially deviant offenders', implying that this deficit was influential in its decision to sentence the offender to a substantial term of imprisonment.\textsuperscript{181}

The incidence of physical and mental abuse of intellectually disabled offenders in a prison context is well known and attested. They are often abused and exploited by other inmates, are more likely to have problems with discipline, are less likely to obtain parole and are likely to regress in the harsh and unstimulating environment of a prison.\textsuperscript{182} Anecdotal accounts of some intellectually disabled inmates being 'happy' in special protection units surrounded with their toys and other amusements, hardly exemplify the norm. The reality is that prisons are rigorous environments for the most well-adjusted inmates, but are significantly more so for those who are socially, emotionally and intellectually ill-equipped to cope with the demands of prison life.

I would support the idea of imprisonment being officially designated a sentence of last resort in the case on an intellectually disabled offender on the basis that it offers nothing by way of rehabilitation to such persons and may often produce a significant deterioration in an offender's mental health and adaptive skills. I would go further and suggest that because imprisonment as a sanction is manifestly unsuitable to this group of people that it should be subject to a statutory rule that it should not be an available sentence unless the court is satisfied, after hearing appropriate evidence, that no other penalty is capable of protecting the public and meeting the needs of the offender. This would mean that imprisonment is not proscribed as a penalty but that the burden would be on the prosecution to justify its use in a particular case. However, in any case where imprisonment is found to be appropriate, the sentence should be required to be served in an environment that is conducive to the special needs of the offender. This would require the designation of special wings in prisons for provision of persons with special needs or alternatively the creation of specialised units for prisoners with an intellectual disability as occurs in New South Wales.\textsuperscript{183}

With proper oversight the majority of intellectually disabled offenders who are both criminally responsible and fit to plead may be dealt with through community-based sentences, in particular community care and supervision.\textsuperscript{184} Although a court
imposing a sentence of probation may impose such special conditions 'as it thinks fit
to reduce the likelihood of further offending,' neither this power nor the power to
require an offender to 'undertake [a] specified course of education or training
designed to improve work skills or social skills or both' confers the power to
require the person to receive in- or outpatient treatment. In UK psychiatric
probation orders, with such a requirement, are tailor-made for offenders who are
mildly disordered. A similar penalty could, with appropriate modifications, be a
valuable additional disposition for courts dealing with intellectually disabled
offenders in New Zealand. The sentence of community care (now community
programme) has similar potential to be tailored towards the specific needs of
intellectually disabled offenders.

Other types of non-custodial penalties currently available in New Zealand, like
community service orders, periodic detention and fines, may be of limited use with
intellectually disabled offenders because they may not understand what is required of
them and in the case of fines or other monetary penalties like reparation, may lack
the financial resources and skills to comply with them. Some consideration could be
given to the possibility of 'home based detention' as has been suggested by the West
Australian Authority for Intellectually Handicapped Persons. However, such a
proposal would need to be considered in light of the general efficacy of this type of
penal management which is currently being investigated by the Department of
Justice.

In some jurisdictions guardianship orders are used as a means of ensuring that a
person who may endanger others receives supervision. In New South Wales under
the Disability Services and Guardianship Act 1987 potential dangerousness alone
will not justify the granting of an order over an individual. The person must also
meet the criteria for guardianship orders provided for in the legislation. The Act
applies only to persons with certain disabilities (including an intellectual disability)
who is, by virtue of the disability,

"restricted in one or more major life activities to such an extent that he or she
requires supervision or social habilitation."

The use of guardianship orders could provide a valuable means of personalised
supervision for intellectually disabled persons considered dangerous. However, to
be effective in the present context such orders ought to be linked to appropriate
enforcement measures that gives the 'guardian' the statutory power to force
compliance. Any legislation should also make provision for review by the courts
where guardianship orders are ignored or otherwise prove ineffective in controlling
the behaviour of the subject person. I would agree with the Human Rights
Commission that such guardianship orders are conceptually distinct from 'welfare
guardianship orders' under the Protection of Personal and Property Rights Act
1988. I would advise against the emerging practice of using such orders under that
Act as a means of controlling the antisocial and criminal behaviour of intellectually
disabled offenders. The danger is that using remedial legislation in this way may
create the wrong signals by implying that it has a penal purpose and could lead to
the criminalisation of persons who are not able to manage fully their own affairs. It
is my view that any new form of guardianship order for intellectually disabled
offenders should be contained in alternative legislation that globally addresses the
issues pertinent to this group.

The issue of disposition is axiomatic to the management of persons with an
intellectual disability. There would appear to be a growing consensus among
professional commentators in New Zealand that the present range of dispositional
options for intellectually disabled offenders is inadequate and is in need of urgent
review. The problems associated with intellectually disabled offenders found to be
under disability, who fall uneasily somewhere between the Mentally Disordered
Persons provisions of the Criminal Justice Act 1985 and the Special Patient
provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992,
are now well known. However, the issue is not simply the need to create
dispositional alternatives that are geared to the special needs of intellectually
disabled offenders. The broader question for debate is the appropriateness of
dealing with this group within the existing structures of the criminal justice and
mental health systems at all.

Although complete separation from both systems may be considered inappropriate
or impractical for a wide variety of reasons, the fact remains that intellectually
disabled offenders in New Zealand are currently inadequately provided for by either
system. They are over-represented in penal institutions, yet are often
inappropriately placed in secure psychiatric facilities which invariably lack the
resources and appropriate professional skills to be able to respond effectively to
their presenting behaviours. The problem is not, it seems to me, one simply of
professional hegemony and unwillingness to expand the boundaries of professional
skill to accommodate an 'awkward' client group. It is a more fundamental problem
of the lack of a philosophy of care and treatment for intellectually disabled offenders
as a class and the complete absence of an infrastructure within existing penal,
disability or mental health services which acknowledges the uniqueness of
intellectual disability and is able to make provision for its special requirements. This
fundamental issue of policy must, in my view, be addressed before piecemeal
amendments are made to existing legislation to provide for additional disposition
options.

Once a philosophy of care and treatment for intellectually disabled offenders has
been clearly articulated and given appropriate legislative recognition, new
dispositional options may then be considered. As part of any such review I would
suggest that consideration be given to the following matters:

(a) The establishment of the new disposition of a Hospital Order Without
Conviction. These are provided for in UK legislation196 and allow courts to
deal compassionately, effectively and protectively with a mentally disordered
or intellectually disabled person, who may not have had the necessary
criminal intention for the offence, may not be able to conduct a defence in
the normal way, should not be burdened in the future with a criminal
conviction and who needs the care and treatment provided under a hospital
order.197 The advantage of this procedure, appropriately modified for New
Zealand needs, would be that it would provide a valuable means of diverting
some offenders from the criminal justice system into therapeutic care and
treatment, where they are unlikely to meet legislative criteria for fitness to plead and are plainly needing compassionate care rather than punishment. It would provide a benevolent alternative to criminalisation in appropriate cases.

(b) The reconstitution of hospital orders currently provided for by s118 Criminal Justice Act 1985 to enable them to be used to deal with intellectually disabled offenders convicted of an offence, who may not presently be eligible for consideration because of the limitation that the offender be 'mentally disordered.' Furthermore, an order under s118 would normally be inappropriate for an offender with an intellectual disability only, because of the statutory requirement that the person be 'detained in a hospital as a patient', which may be inimical to the therapeutic needs of the person. However, with appropriate modifications hospital orders could provide a useful means of ensuring that an intellectually disabled offender obtains the type of official help that he or she needs, while avoiding the harsh and counter-productive consequences of a prison sentence.

(c) The establishment of a formal system of post-release care for those intellectually disabled offenders who do serve terms of imprisonment. In other jurisdictions it has been suggested that the over-representation of people with an intellectual disability in the prison system may be due to recidivism in part caused by the lack of post-custodial services available. The suggestibility of intellectually disabled offenders and their inability to comprehend adequately the significance of official instructions, may make them especially susceptible to exploitation and involvement in criminal activity. For this reason post-release programmes aimed at assisting former inmates in developing life skills and socially appropriate behaviours may be seen as essential in rehabilitating such persons and in reducing the incidence of recidivism.

4.7 Human rights

There are many factors which may impact negatively on the human rights of intellectually disabled offenders. These include matters like the failure to provide inmates with immediate hospitalisation in cases of urgent need, inadequate access to mental health and disability services, inappropriate use of medication by unqualified professionals, improper use of seclusion, and the unavailability of clinical staff. While the 'substance of healing should not be sacrificed to the form of safeguarding abstract liberties' there is nevertheless a danger that we may overlook the fact that intellectually disabled persons have rights regardless of their sometime offender status and the fact that they may be compromised in their ability to prosecute their rights. It has been noted that since the international law of human rights explicitly recognises rights which apply to 'everyone' or to 'all individuals without discrimination' the rights recognised in the various international instruments apply equally to all individuals, irrespective of mental illness or criminal offending.

The Human Rights Act 1993 has extended the jurisdiction of the Human Rights Commission to deal with complaints of unlawful discrimination on the grounds,
amongst other things, of intellectual disability. A way in which intellectually disabled offenders might be discriminated against could be in the failure of government to take their special needs into consideration at all stages of economic and social planning, contrary to Article 8 of the Declaration of the Rights of Disabled Persons. Although New Zealand is not a signatory to the Declaration of the Rights of Disabled Persons, the jurisdiction of the Human Rights Commission may nevertheless extend to it by virtue of the fact that the relevant provisions of the Human Rights Act refer to 'international instruments on human rights generally.'

Furthermore, clinical practice seems increasingly to be moving towards greater willingness to acknowledge the rights of individuals, which must also include intellectually disabled offenders. This awareness of patient rights has led one professional body to suggest that every citizen has the right to be subject to fair and reasonable treatment when mentally ill, including the non-use of hospitals as pseudo-prisons. This suggested right clearly has important implications for intellectually disabled offenders.

Arguably, intellectually disabled offenders, more than most, need to be aware of their rights and how they can be safeguarded. Where such persons are competent to understand the concept of 'rights', awareness is important in order to enable them to pursue their own interests within the levels of their ability to do so and in order for them to be able to pursue concerns with their legal representatives and other public officials acting in an advocacy role, such as District Inspectors or Official Visitors.

Establishing an environment which confers basic dignity and human rights not only affirms the personhood of those whose rights have been compromised, but may in some cases be effective in providing a 'cure' for certain inappropriate behaviours. This approach is consistent with the now well attested fact that offending by intellectually disabled persons is more attributable to socioeconomic deprivation and behavioural difficulties consequent upon a disturbed family or institutional background than it is to the nature of the disorder itself.

Any legislation which may ultimately be drafted for intellectually disabled offenders should include a code of rights defining the basic rights which must be borne in mind by officials when administering the provisions of such legislation. Such a statement of rights could be linked in to existing formulations of rights for intellectually disabled persons, such as the United Nations Declaration of Rights of Mentally Retarded Persons and would include such things as the right to be treated with humanity and dignity, whether or not in detention, to live in as normal conditions as possible, to be free from exploitation, abuse and degrading treatment, to receive information about rights and to appropriate standards of care and treatment.

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116 *Keeping You Informed*, supra, 5.
118 Ibid.
119 Ibid.
120 *Cp Mental Health (Compulsory Assessment and Treatment) Act 1992*, s 28 (2).
121 See eg UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, Principle 9.1.

122 See submission of Director of Area Mental Health Services for Wellington, Porirua, Hutt and Wairarapa to Social Services Committee considering the Mental Health (Compulsory Assessment and Treatment) Bill 1994, May 1994, 2.

123 Ibid.

124 UN Declaration of the Rights of Mentally Retarded Persons UN General Assembly 26th Session, Resolution 2856,XXVI.

125 Ibid, cl. 1.


130 Ibid, 112.

131 Dr A I F Simpson, supra, 2. Some professionals estimate that the present demands of the 1992 Mental Health Act may take about 20% of the psychiatrist work force from patient care. See submission of the Directors of Mental Health of the Northern Region to the Social Services Committee considering the Mental Health (Compulsory Assessment and Treatment) Amendment Bill.

132 Dr A I F Simpson, Submission on Legislative Issues and the Difficult Problem of Control of Dangerous Behaviour, 2.

133 K Day, supra, 134.

134 Ibid.


137 October 1993.

138 Ibid, 6.

139 Submission of Services for People with an Intellectual Disability Limited to the Social Services Select Committee considering the Mental Health (Compulsory Assessment and Treatment) Bill.

140 Supra, par. 2.9.

141 Director of Area Mental Health Services for Wellington, Porirua, Hutt and Wairarapa, supra, note 120.

142 Dawson, supra, 5.

143 Supra.

144 Ibid.


146 Ibid, 1788.

147 Supra.

148 Ibid.

149 Ibid.


152 Dr K Ericson of the Mental Retardation Project Centre for Handicap Research, Sweden. Cited in Dr S du Fresne, Plea for a Measure of Normality, supra. According to Ericson's scheme normalisation has two principal themes - citizenhood and 'pupilhood' which roughly corresponds with the 'developmental model'. Depending of which particular model is emphasised either citizen's rights or the need for special training programmes may be downplayed.

153 Dr A I F Simpson, supra.

155 Op cit, supra, par. 1.10.
156 Ibid, par. 6.4.
157 Ibid, par. 6.11.
158 Glaser, supra, par. 1.5.
159 Ibid, par. 5.4.

160 D Tidmarsh (1982) *Implications from Research Studies*. In J R Hamilton and H Freeman,
*Dangerousness: Psychiatric Assessment and Management*. Royal College of Psychiatrists special
Aspects and Management*, in R Bluglass & P Bowden,Principles of Forensic Psychiatry, London,
1990, 408.

161 G Tennant, *Dangerousness*, (1971) 6 British Journal of Hospital Medicine, 269 - 274. Cited in
Bluglass, supra, 408.

162 Ibid.
163 I am indebted to a former student, David O'Connor for his formulation of these questions in a draft

164 H Prins, *Dangerousness: A Review*. In Bluglass and Bowden, supra, 499.

165 See J Cocozza and H Steadman, *The Failure of Psychiatric Predictions of Dangerousness: Clear
and Convincing Evidence* (1976) 29 Rutgers L R 1084 at 1087.

Criminal. 3, 8.

167 Ibid, 8.
168 Ibid.

170 Ibid.

171 Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters, Jan.
1983, par. 11.11.5.

172 Glaser, supra, par. 3.6.4.
173 G Campbell, *Mental Disorder and Criminal Law in Australia and New Zealand*, (Butterworths,
1988), 195.

174 New South Wales Law Commission, Issues Paper, supra, par. 6.5

175 6 May 1994.

176 Mental Health Foundation Submission to the Social Services Select Committee on the *Mental Health
(Compulsory Assessment and Treatment)* Amendment Bill.

177 Glaser, supra, par. 3.6.

178 See F J Laski, *Sentencing the Offender with Mental Retardation: Honouring the Imperative for
Intermediate Punishments and Probation*, in R W Conley , R. Luckasson,and G N Bouthilet (eds),


180 Ibid.

181 *R v Arama* Unrep. CA 191/93, 20/9/93, Casey J.
182 Glaser, supra, par.3.6.
183 See Law Commission Issues Paper, supra, par.6.7.
184 See *Criminal Justice Act* 1985,ss 46 & 53.
185 *Criminal Justice Act* 1985, s 50 (1) (a).
186 Ibid, s 50 (1) (a).

187 N Walker, *Fourteen Years on*, in K Herbst and J Gunn (eds) The Mentally Disordered Offender,
Butterworth - Heinemann (1991), 10. For a discussion of psychiatric probation orders in UK see B

188 See discussion in the New South Law Commission Issues Paper, supra, par. 6.15.

189 Submission to the Social Services Committee on the *Mental Health (Compulsory Assessment and
Treatment)* Amendment Bill, May 1994, 10.

190 See Mental Health Act 1983 (UK), s 37(3). See also A Samuels, *Current Topic - Hospital Orders

191 Ibid.


194 Submission of the Human Rights Commission to the Social Services Committee on the *Mental Health (Compulsory Assessment and Treatment) Amendment Bill*, May 1994, 1.

195 See Human Rights Act 1993, s 21 (1) (h).

196 Submission to the Social Services Select Committee on the *Mental Health (Compulsory Assessment and Treatment) Amendment Bill* from the New Zealand Branch of the Royal Australian and New Zealand College of Psychiatrists, 4.

197 See Glaser, supra, par. 4.2.2.
PART V - OVERSEAS LEGISLATIVE MODELS

5.1 Introduction

In this section I propose to examine legislation in Canada, Australia and the United Kingdom which might provide a model for New Zealand. The purpose of this review will be to provide an overview of the essential features of the legislation and to highlight those aspects which are directly applicable to the current New Zealand concerns.

5.2 Canada

In Canada criminal law is regulated by Federal legislation while mental health law is determined by Provincial legislation. Intellectually disabled offenders are dealt with under the provisions of the Canadian Criminal Code, which defines criminal responsibility and contains procedural directions for assessment, fitness to plead, disposition and review. In Canada there are no separate legislative provisions to deal with intellectually disabled offenders as distinct from other mentally disordered offenders. The Criminal Code provisions dealing with mentally disordered offenders were substantially revised and came into effect on 4 February, 1992. The general purpose of these reforms was to introduce more due process to the treatment of mentally disordered persons throughout the entire criminal process.

An important aspect of the 1992 amendments related to the disposition of the mentally disordered. In Canada, an intellectually disabled offender may be found unfit to stand trial, or if not unfit, may be found to be not criminally responsible due to mental disorder. Upon a finding of unfitness, or not criminally responsible due to mental disorder, three possible dispositions are available:

1. absolute discharge (not available as a disposition in the case of unfitness verdicts),
2. conditional discharge
3. confinement in a psychiatric facility.

The Canadian legislation mandates that the Court (and subsequently the Psychiatric Review Board) adopt the least restrictive alternative which is consistent with the accused's needs and public safety.

In the case of verdicts of unfitness, the Crown must establish every two years (where the accused remains unfit) that there is still sufficient evidence to put the accused on trial. This is a commendable requirement that enables the issue of change of status to be considered at an earlier time than might otherwise be the case. There is no similar provision in current New Zealand law although the provision should be investigated as part of any general reform of the rules governing 'under disability' in relation to intellectually disabled offenders.

At the present time Canadian legislation does not appear to recognise any relevant distinction between intellectually disabled and mentally disordered offenders for the
purposes of disposition within the criminal justice system, so may be of limited relevance for the purposes of this review.

5.3 Australia

In the Australian states both criminal and mental health legislation are within the jurisdiction of the individual states. There is no uniform law governing the disposition of intellectually disabled offenders as exists in Canada. In this section I will deal with the states of New South Wales, Victoria, Queensland, Western Australia and the Australian Capital Territory, each of which has legislation which is relevant to this inquiry. I will consider each state separately.

New South Wales

The relevant legislation is the Crimes Act 1900 and the Mental Health Act 1990. The Mental Health Act 1990 is complemented by the NSW Guardianship Act 1987, the NSW Mental Health (Criminal Procedure) Act 1990 and the Disability Services Act 1993 No.3.

The Mental Health (Criminal Procedure) Act 1990 contains provisions allowing persons involved in criminal proceedings to be found unfit to be tried and ordered to be detained in a hospital or other place. It also provides for the detention in strict custody or in a hospital of those found not guilty by reason of mental illness. Although the Act does not make any special provision for intellectually disabled offenders, it does provide for a procedure which is analogous to the 'trial of the facts' in the Criminal Procedure (Insanity and Fitness to Plead) Act 1991 (UK). This procedure increases the opportunity of being acquitted for defendants who cannot be proved to have committed the actus reus of an offence, yet who may have been found to be unfit to plead.

The Guardianship Act 1987 is general remedial legislation applicable to persons with certain disabilities (including intellectual disability) where the disability has led to restriction in one or more major life activities, to the extent that the person requires supervision or social habilitation. The legislation is analogous to the Protection of Personal and Property Rights Act 1988 (NZ) but does not make any particular provision for intellectually disabled persons who offend.

The Disability Services Act 1993 does not exclusively target intellectually disabled persons but is designed to ensure the provision of services necessary to enable persons with disabilities generally to achieve their maximum potential as members of the community.

Victoria

The Victorian *Mental Health Act* contains provisions for hospital orders and for restricted community treatment orders for persons charged with or convicted of criminal offences. It is complemented by the *Disability Services Act* 1991 which, typically of legislation of this kind, aims to ensure that persons with disabilities receive the services necessary to enable them to achieve their maximum potential as members of the community. It is not limited in its application to intellectually disabled persons.

The *Intellectually Disabled Persons Services Act* establishes 'stand-alone' legislation aimed principally at the reform of the law relating to services for intellectually disabled persons. The Act is premised on the principle that intellectually disabled persons have the same right as other members of the community to services which support a reasonable quality of life. The Act also affirms the view that intellectually disabled persons are entitled to exercise maximum control over every aspect of their lives and that their needs are best met when the conditions of their everyday life are the same as, or as close as possible to norms and patterns which are valued in the general community.

The legislation seeks to achieve these broad ends by providing for residential and other services and the protection of the rights of intellectually disabled persons. It establishes an Intellectual Disability Review Panel, the principal purpose of which is to review the cases of 'security' residents and to provide a forum for review for any person aggrieved by a decision that is able to be reviewed. The Act also establishes a system of community visitors to oversee the provision of services in any residential institution or programme.

The Act distinguishes intellectual disability from mental illness. It requires Community Services Victoria to produce a 3-year State Plan, updated annually for the development of services, and to review whether the needs of persons with intellectual disability are being met. In 1989 a State Plan was developed which allocated large resources to relocating clients from institutions to community settings. This included providing home support for 375 clients, establishing community residential units (group houses for up to six people), establishing adult day training centres to provide employment, education and support services and setting up behaviour intervention and support teams.

The Act also authorises co-operation between government departments. The Office of Corrections and Community Services Victoria have jointly provided new services for intellectually disabled offenders, including the establishment of a Secure Services Unit at a local Training Centre for 5 offenders considered to be at risk in prison. The Act also allows an Intellectual Disability Services caseworker to attach a 'justice plan' as a special condition to a variety of community orders when a person with intellectual disability is sentenced. It is suggested that the justice plan may lessen the likelihood of the client committing further offences.

What is significant about this legislation is that it acknowledges that intellectually disabled persons do have special needs which justify a singular and distinctive legislative response. It strikes a desirable balance between, on the one hand, the paternalistic desire to protect intellectually disabled persons from exploitation by
others or self-defeating activity and decision-making by the intellectually disabled themselves and, on the other hand, the desirability of maximising individual autonomy to the greatest degree possible. It also has the advantage of being a broadly comprehensive statute which both protects rights and provides services and is able to provide coherence in the delivery of services within a carefully articulated philosophy of care and protection.

It has been observed that the preamble to the Victorian statute is 'positively heroic' with fourteen principles of service delivery, which clearly establish the principles of normalisation as the standard against which services for intellectually disabled persons should be judged. The same commentator criticises the Victorian legislation as being weighted in a way that emphasises the developmental needs of intellectually disabled people, rather than their rights and obligations as citizens.

"There is a curious quality to legislation which implies that every single mentally handicapped person in the state of Victoria has a 'service plan' by law. No-one just gets on with their life." The Act is further criticised in that regardless of statements about advocacy in the preamble, the legislation does not make it mandatory for an appropriate adult to be present when intellectually disabled people are interviewed by the police, either as witnesses, complainants or suspects, and while the Court can divert people for special justice plans, the Court does not have to adapt its own procedures to make them accessible to people with intellectual disability.

These would seem to be justifiable criticisms and should be borne in mind when developing any corresponding New Zealand legislation. However, they reinforce the opinion expressed earlier in this paper that issues of apprehension, identification and fitness to plead are inseparable from questions of sentencing and disposition in formulating a legislative response to intellectually disabled persons who present a risk to others. Issues of procedure and service provision should be dealt with in as comprehensive a way as possible to ensure that at no stage of the formal process are intellectually disabled persons disadvantaged by the absence of procedures or services necessary for the full enjoyment of their rights or the fulfilment of their legal obligations. The legislation, while not perfect, nevertheless does provide a valuable model that should be carefully considered in planning for 'stand alone' legislation for intellectually disabled offenders in New Zealand.

In August 1992 the Social Development Committee of the Victorian Parliament produced its Fourth and Final Report in the Inquiry into Mental Disturbance and Community Safety. The Report considered, amongst other things, the question of community safety and intellectual disability. The Committee found that in a survey of 8009 registered clients of Disability Services clients 136 (1.7%) had been convicted of a criminal offence and that only about one-third of the 136 offences involved any threat to community safety. The Committee concluded that the prevalence of people with intellectual disability who pose a risk to community safety is small and services can generally cope with them. It was estimated at that time that in the whole of the State of Victoria there were approximately 10-15 people with an intellectual disability currently outside the criminal justice system who could
be considered to pose a serious threat to the community, although it was conceded that it would not be possible to determine with any degree of certainty who those people were.208

The Committee did not support the introduction of preventive detention for people with intellectual disability principally because of uncertainty about whether there was a need for a large number of locked unit placements. It was the Committee's view that the development of appropriate services and programmes would minimise the need for locked units and address high risk behaviours. The Committee considered that preventive detention would not protect the community, but would draw attention and resources away from programmes which could assist intellectually disabled offenders to live satisfactorily in the community.209

Queensland

The relevant legislation is the Mental Health Services Act 1974-1991, the Disability Services Act 1992, and the Intellectually Handicapped Citizens Act 1985. The Mental Health Services Act 1974 contains no definition of mental illness but extends its coverage to drug dependence and intellectual handicap as if each of those conditions were a mental illness. The Disability Services Act 1992 is similar in its content and purpose to both the New South Wales and Victorian statutes but makes no separate provision for intellectually disabled persons. However, Part 4 contains a valuable list of Objectives for the Development and Implementation of Programs and Services for People with Disabilities. These should be carefully studied with a view to their possible modification and adoption in New Zealand legislation for intellectually disabled offenders. Part 4 is attached as Appendix B.

The Intellectually Handicapped Persons Citizens Act 1985 is described as an Act 'to assist intellectually handicapped citizens in the least restrictive way to exercise their rights and carry out their responsibilities in society..." The Act provides in Part II for the establishment of the Intellectually Handicapped Citizens Council of Queensland, the principal function of which is to facilitate applications by intellectually handicapped citizens for special intervention as provided for in the Act. The Act also contains provision for special advocacy services for intellectually disabled persons, including the appointment of a 'Legal Friend' to advise an intellectually disabled person on the person's legal rights, legal procedures and specialised services available for the assistance of 'approved citizens.' The Act also provides for the establishment of a Volunteer Friends Programme to provide friendly personal support to approved intellectually disabled persons. However, this legislation makes no particular provision for intellectually disabled offenders.212

Western Australia

Western Australia makes provision for intellectually disabled offenders in a range of statutes. They include the Mental Health Act 1962 (WA), the Guardianship and Administration Act 1990 (WA), the Authority for Intellectually Handicapped Persons Act 1985 and the Disability Services Act 1993 (WA) and the Criminal Code (WA). These statutes all define intellectual disability for different purposes. There is, however, currently no legislation in Western Australia which specifically
targets intellectually disabled persons who offend, or which provides a comprehensive range of procedures for dealing with such persons within the criminal justice system.

**Australian Capital Territory**

An Australian statute which enables the preventive detention of an intellectually disabled person who is thought to be dangerous is the *ACT Mental Health (Treatment and Care) Act 1994*. The Act separately defines 'mental dysfunction' and 'psychiatric illness'. Intellectually disabled offenders would come within the definition of 'mental dysfunction' which means 'a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation, or emotion.' The Act establishes procedures for determining the review of fitness to plead and establishes criteria for determining whether a person should be released based on whether the person 'would be, or would be likely to be, a danger to the community.'

This legislation has been criticised as being a 'badly conceived and constructed piece of legislation' in that it includes everyone with a 'mental dysfunction' together under the one Act. Separate provision for those with 'psychiatric illness' were inserted only after much criticism of the legislation. However, these provisions have also been criticised as meaningless as a person who was not viewed as having a psychiatric illness could be detained as 'mentally dysfunctional person'. The Act is said to have impeded appropriate service development in both the mental health field and the intellectual disability sector.

Also relevant to this inquiry is the *Crimes (Amendment) Act 1994 (ACT)*. The Act amends the *Crimes Act 1900* and inserts a new Part XIA dealing with Unfitness to Plead, Mental Illness and Mental Dysfunction. Only 'mental dysfunction' is separately defined and bears the same meaning as in the *Mental Health (Treatment and Care) Act 1994*. Of particular interest is the provision in the Act for a Special Hearing in relation to accused persons charged with indictable offences in respect of whom the issue of fitness to plead has been raised. The Act provides for a special hearing to be conducted the purpose of which is to ensure that, despite the unfitness of the accused to plead in accordance with ordinary criminal procedures for a period of 12 months, the accused should be acquitted unless it can be proved beyond reasonable doubt that, on the evidence available, the accused committed the acts which constitute the offence. The Act distinguishes between serious and non-serious offences and provides for a verdict of not guilty to be entered if the jury at a special hearing are not satisfied beyond reasonable doubt that the accused committed the acts which constitute the offence charged.

5.4 **Overview of Australian Legislation**

Generally in Australia, there are no specific provisions for the civil commitment or preventive detention of intellectually disabled adults who are thought to be dangerous but who have not been proven to have committed a criminal offence. In some cases they may be placed in an institutional setting either via mental health provisions or under some form of guardianship.
The general trend in Australia in recent years has been to separate the mentally ill from intellectually disabled and to use guardianship provisions for detention when an intellectually disabled person's safety is at risk, but not so much when the safety of others is an issue. It has been suggested that this is a philosophical issue and while the use of guardianship orders in this way is acceptable at a pragmatic level, it would have been of assistance if dangerousness to others was a ground for guardianship and hence for short-term civil commitment.

5.5 United Kingdom

In the United Kingdom 'mental disorder' is a general term covering all forms of mental ill-health or disability. It is defined by the Mental Health Act 1983 for the purposes of the statutory provisions for the care and treatment of mentally disordered persons and the management of their property and affairs and related matters. 'Mental disorder' is defined as mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind. Several provisions relating to the care and treatment of patients are limited to persons suffering from mental illness, severe mental impairment, mental impairment, or psychopathic disorder, while some are limited to those suffering from mental illness or severe mental impairment. The terms 'mental illness' and 'arrested or incomplete development of mind' are not further defined in the statute, although statutory definitions are provided for two forms of arrested or incomplete development of mind, namely, 'severe mental impairment' and 'mental impairment'. The difference between 'severe mental impairment' and 'mental impairment' is not otherwise defined in the Act, but it is commonly assumed that the boundary between them corresponds to that between mild learning disability (IQ between 50 and 70) and moderate learning disability (IQ between 35 and 49). However, there is some evidence that the distinction between the two categories has not been applied consistently in clinical practice, with 'severe mental impairment' being used in some cases to designate patients with a severe learning disability, and in others to designate patients with a mild or moderate learning disability who have severe behaviour disorders. It has been observed that this lack of consistency may have important implications for individual patients, because the 1983 Mental Health Act imposes more conditions for the detention of a patient with a 'mental impairment' than for the detention of a patient with a 'severe mental impairment'.

For longer term admission for treatment, as opposed to admission for assessment, a person must have one of the specific forms of mental disorder: 'mental illness,' 'severe mental impairment,' 'psychopathic disorder,' or 'mental impairment'. Admission for treatment, hospital orders and transfers during sentence all distinguish between the major disorders of mental illness and mental impairment, which justify admission even if hospital treatment is unlikely to do the patient any good, and the minor disorders of psychopathic disorder and mental impairment, which only justify admission if treatment is likely to make the patient better, or at least prevent his or her getting worse. In the UK legislation 'mental impairment' and 'severe mental impairment' replaced the terms 'subnormality,' and 'severe subnormality,' used in the 1959 Act and introduced a reference to 'abnormally aggressive or seriously irresponsible conduct.' One purpose of this was to draw a clearer distinction
between mental handicap and the psychiatric disorders for which the care and treatment provisions were thought appropriate.\textsuperscript{223}

A further object of the changed definition in the UK legislation was to exclude from the Act those intellectually disabled people who did not also exhibit psychopathic behaviour and to emphasise that there must be impairment of social functioning as well as intelligence.\textsuperscript{224}

The ongoing inclusion of intellectual disability within mental health legislation in UK is historical and is related to the desire of the Percy Commission\textsuperscript{225} to sweep away the strict legal separation between the care for 'lunatics' (generally those suffering from mental illness) and 'defectives' (the intellectually disabled).\textsuperscript{226}

In the UK intellectually disabled offenders are dealt with in the main under mental health legislation, but there is a lack of specialised facilities both in the community and in hospitals, and only comparatively recently have specialised treatment programmes and units begun to be developed.\textsuperscript{227} Dangerous intellectually disabled offenders are provided for within the special hospitals. However, recent years have seen a tightening of the criteria for admission to the special hospitals and two independent reports both recommended the establishment of regional secure units for those offenders who required a greater degree of security than could be provided within local mental hospitals, but less security than that available in special hospitals. The secure units have, regrettably, made little or no provision for the intellectually disabled, which has led to an emerging view that separate regional secure units should be provided for the intellectually disabled.\textsuperscript{228}

A suggested model for services for intellectually disabled offenders aimed at preventing further offending focuses on the need to assist the person to develop a sense of social responsibility and self-control; increasing social, occupational, and self-care skills; increasing the person's understanding of the cause of their previous offences; and providing alternative and socially acceptable sources of personal status and reward. It is suggested that for many people with an intellectual disability, these aims can be achieved by means of a 'treatment package' comprising:

- Habilitation
- Education
- Occupation
- Counselling
- Specific interventions
- Health screening\textsuperscript{229}

It has been noted that the implementation of such a 'package' of services requires that such services should be provided by a multi-disciplinary team of staff skilled in the diagnosis, treatment, and care of people with intellectual disability; and that the expertise of the team should be accessible to community intellectual disability teams, and that there should be good working liaison with schools, police and probation services to identify the onset of offending, and to implement preventive measures.\textsuperscript{230} Significantly the authors recommend that there should be a suitable range of residential, occupational and recreational services to enable people to be treated in
the least restrictive environment commensurate with the need to protect the public from further offences, including services for persons needing long-term treatment and care, as well as those requiring short-term assessment.231

On the question of whether intellectually disabled offenders should be dealt with in the mental health system or the criminal justice system, the UK Government’s policy is set out in Home Office Circular No. 66/90, since modified by Circular No 12/95. It is the Government’s express policy to divert people from the criminal justice system and guidance has gone to the police, courts and prisons to that effect. Pursuant to Circular 66/90 courts are encouraged to use the existing provisions of the Mental Health Act, wherever practicable, to enable appropriate mentally disordered persons to be taken into the health system rather than the penal system. Circular 66/90 is appended to this report as Appendix C.

198 Criminal Code, s 672.54.
199 Criminal Code, s 672.33.
200 Mental Health Act 1986, s 15A.
201 Intellectually Disabled Persons Services Act 1986, s 5 (d).
202 Social Development Committee, Parliament of Victoria, Inquiry into Mental Disturbance and Community Safety, Fourth and Final Report, August 1992, par. 1.3.2.
203 Ibid. par. 1.3.2.3.
204 Dr S du Fresne, Plea for a Measure of Normality, Forensic Conference, Waitangi, Bay of Islands, 1993.
205 Ibid.
206 Ibid.
207 See Fourth and Final Report, chapter 5.
208 Ibid, p 123.
209 Ibid, 145.
212 Intellectually Handicapped Citizens Act 1985, s 35.
213 Mental Health (Treatinent and Care) Act 1994 (ACT) s 72 (3).
214 Ms L W Craze, Senior Research Officer, Australian Institute of Criminology, Canberra. Personal correspondence with the writer.
215 Ibid.
216 Crimes (Amendment) Act 1994 (ACT), s 428J (6) (c).
217 Crimes (Amendment) Act 1994 (ACT), s 428K.
218 Ms L W Craze, Senior Research Officer, personal correspondence with the author.
219 Ibid.
220 Mental Health Act 1983 (UK) s 1 (2).
221 Services for People with a Mental Impairment - A Strategy Review Completed for the West Midlands Regional Health Authority, Centre for Research and Information into Mental Disability, University of Birmingham,1992, par. 2.2.
222 Ibid.
226 Hoggett, supra, 54.
229 Services for People with a Mental Impairment, supra, note 221, par.3.1.
230 Ibid, par. 3.2.
231 Ibid.
PART VI - NEW ZEALAND LEGISLATION AFFECTED

6.1 Introduction

In this section I intend to examine New Zealand legislation that is likely to be affected by any proposal to establish separate legislation for intellectually disabled offenders. The discussion will involve consideration of the ways in which such legislation may be affected but will not include a detailed description of possible amendments. That task will be more appropriately undertaken by the Ministry in conjunction with Parliamentary Counsel at some future time. I wish only to suggest the broad parameters of possible legislative change.

6.2 Mental Health (Compulsory Assessment and Treatment) Act 1992

At present the Mental Health (Compulsory Assessment and Treatment) Act 1992 purports to exclude persons with only "intellectual handicap" from the assessment and treatment procedures of Parts I and II of the Act by an express exclusionary provision in s4(e). This provision has been effective in ensuring that intellectually disabled persons generally are not unnecessarily hospitalised but has been interpreted by the Courts in such a way as to enable intellectually disabled persons to be found 'mentally disordered' for the purposes of eligibility for disability hearings.232

This feature of the present legislation is, in my view, unsatisfactory in that it enables a Court artificially to declare an intellectually disabled offender to be 'mentally disordered' in circumstances where the Act itself does not contemplate compulsory detention of a person where the sole underlying problem is intellectual disability.233

It is generally acknowledged that this interpretative approach was necessary in order to avoid substantial injustice to intellectually disabled offenders who would otherwise have been forced to undergo a criminal trial in circumstances where there may have been substantial doubt about their functional capacity to participate in the proceedings. However, assuming that it is agreed that intellectually disabled offenders will be better catered for in omnibus stand-alone legislation that will include specific procedures for identifying 'under disability' and conducting disability hearings, I would recommend that the exclusionary provisions in s4(e) be strengthened to make it clear that in no circumstances are the procedures in Parts I and II to be invoked where intellectual disability is the sole underlying problem. This would signal to the courts that the Act is concerned exclusively with persons who suffer from mental disorder and that those with intellectual disability alone must be dealt with subject to some other statutory regime. In order to reflect current usage, the reference to "intellectual handicap" in s4(e) should be deleted and the expression "intellectual disability" substituted.

It is my view that no further amendment to the Act should be necessary, as regards intellectually disabled offenders, once it is established that intellectually disabled persons are conclusively excluded from the scope of the legislation, since subsequent procedures outlined in the Act may be interpreted as though they have
exclusive reference to persons with mental disorder. This does not create a problem for persons suffering from a 'dual diagnosis' of intellectual disability and mental disorder since it should always be possible and desirable to bring such persons under compulsion to ensure that they are treated for extant mental illness where they meet the statutory criteria for mental disorder in that regard.

6.3 **Protection of Personal and Property Rights Act 1988**

The *Protection of Personal and Property Rights Act* 1988 makes provision for orders appointing a welfare guardian for a person and for the appointment of a person as next friend or guardian ad litem for the person for the purpose of any proceedings in the District Court. These orders could be used for the care of some intellectually disabled persons. However, it is doubtful whether the present provisions defining the powers and duties of welfare guardians would extend to allowing welfare guardians to consent to secure care on behalf of such people. In any event, such a power would seem to be fundamentally inconsistent with the principle of the least restrictive intervention which has been said to be a cardinal objective in the scheme of the Act.

A similar concern was noted in a submission to the Parliamentary Select Committee on the *Mental Health (Compulsory Assessment and Treatment) Amendment Bill*. It was observed that while the Act does allow guardians to be appointed through the courts who can direct individuals to live in a particular residence and receive certain treatment, the proposal was contentious because of the Act's focus on the least restrictive alternative. The submission also noted that lack of capacity, an endemic requirement for intervention under the legislation, was not an issue with a number of the individuals who were the focus of attention at the time of the *Mental Health Amendment Bill's introduction*.

A view expressed earlier in this paper is that it may be inappropriate to consider using this legislation for dealing with intellectually disabled offenders because of its essential character as remedial legislation and the danger of criminalising people who come under the Act if it were to be used as a vehicle for such dispositions. For this reason I would oppose the idea of amending the *Protection of Personal and Property Rights Act* to make it a vehicle for dealing with the containment, care and training of intellectually disabled people who present a dangerous risk to the public for particularly damaging and destructive behaviour. Nevertheless, a welfare guardian type of model as opposed to a responsible clinician model may well be more appropriate for intellectually disabled offenders and is a matter that should be carefully considered in drafting appropriate legislation.

6.4 **Criminal Justice Act 1985**

To accommodate the changes contemplated by this reference, the *Criminal Justice Act* 1985 would require substantial amendment, although the nature and extent of the changes necessary would vary according to whether stand alone legislation was being considered or simply amendments to existing legislation. If the former course were to be chosen, the majority of the amendments would be of a consequential nature, linking existing procedures to the new statutory provisions.
intellectually disabled offenders. For example while the procedures specified in s111
governing disability hearings would remain substantially unaltered, the section itself
would need to be amended to indicate that the provisions have no application to an
offender with an intellectual disability who would be dealt with under the
appropriate provisions in the *Intellectually Disabled Offenders Protection Act*, or
by whatever name the new legislation would be addressed. Similarly, a new
definition of intellectual disability would need to be drafted for inclusion in the Act
in order to determine the threshold at which an intellectually disabled offender
would be diverted to new procedures specified under protective legislation.

In the event that there is a decision against enacting special protective legislation for
intellectually disabled offenders, a number of amendments would become necessary.
A new threshold definition of intellectual disability would be needed in order to
trigger entitlement to a disability hearing. In addition, the statutory definition of
'under disability' in s108 would need amendment to include specific reference to
intellectual disability as an alternative basis for assessing inability to plead, etc. But
given existing criticisms regarding the adequacy of existing statutory criteria for
assessing disability in an intellectually disabled offender, consideration may need to
be given to expanding the criteria to include reference to performance intelligence
and adaptive skills and a focus on understanding rather than factual knowledge in
assessing general ability to plead and communication with counsel.

A consequential amendment would also be necessary to s112(2) to clarify the fact
that intellectual disability is also a relevant evidential consideration in determining an
appeal against a disability finding.

In the absence of stand alone protective legislation, s115(2) would also need
amendment to provide for new disposition options specifically geared to
intellectually disabled offenders. In particular, I would recommend the additional
option of a new type of guardianship order which would authorise the holder of the
power to consent to the placement of the subject person in an appropriate secure
facility as part of a broader regime of guardianship. This model would be quite
distinct from that contemplated by welfare guardianship orders under the *Protection
of Personal and Property Rights Act 1988*.

Another option would be placement directly into a new form of secure unit or other
secure residential facility appropriately equipped for the particular challenges
presented by dangerous intellectually disabled offenders. Both of these new
dispositions could be added to the existing options specified in s115(2).

In the case of intellectually disabled offenders in particular, there might be merit in
considering the Canadian approach of requiring, in the case of a finding of unfitness,
that the Crown establish every two years (where the accused remains unfit) that
there is still sufficient evidence to put the accused on trial. In amending s116 the
section could specify that in the event that insufficient evidence remains, the Court
could either discharge the offender directly or, where the issue of public safety is
still a substantial concern, adopt one of the new dispositions suggested above.
Section 116 would also require significant amendment to the provisions regarding review, in the event that intellectual disability is conclusively excluded from the Mental Health (Compulsory Assessment and Treatment) Act 1992. In those circumstances the provisions governing clinical and Tribunal review would need to be modified as having reference to intellectually disabled offenders and placed in a legislative context distinct from the Mental Health Act. The new legislation would then need to be incorporated into the Criminal Justice Act 1985 with reference to intellectually disabled offenders under disability.

Similarly section 117 would need amendment to accommodate a new procedure for review pertaining to intellectually disabled offenders acquitted on account of insanity.

If it were considered appropriate to make a form of hospital order accessible to intellectually disabled offenders, either s118 would need to be amended to accommodate intellectual disability as an additional triggering condition or a new section (118A) added to make separate provision for a new type of detention order geared to the specific needs of intellectually disabled offenders. Because of the very distinctive management and care issues that accompany intellectual disability and the fact that a different regime of treatment other than detention in a hospital would be required, I believe it would be extremely difficult to simply amend s118. My preference would be for a new section authorising a new form of detention order.

Because intellectual disability is conceptually distinct from mental disorder and does not necessarily involve observable symptoms that may be amenable to assessment and treatment, existing statutory rules governing the power of the Court to require psychiatric reports in respect of offenders suspected of being under disability or legally insane may be inadequate and/or inappropriate as regards intellectually disabled offenders. At the very least section 121 should be amended to specifically authorise the Court to seek a psychological assessment where intellectual disability as opposed to mental disorder is suspected. In addition, the terms of s121(2)(b)(i) and (ii) would need amendment to provide first for psychological assessment as well as psychiatric examination and for an alternative context for inpatient examination where a penal remand is inappropriate. A hospital remand is clearly inappropriate for the psychological assessment of an intellectually disabled suspect.

6.5 Human Rights Act 1993

With the enactment of the Human Rights Act 1993, the jurisdiction of the Human Rights Commission has been extended to deal with complaints of unlawful discrimination on the grounds of psychiatric illness, intellectual disability and psychological abnormality. While the Act does not require specific amendment for the purposes of this reference, some consideration could be given to the possibility of designating specific oversight for the human rights of intellectually disabled persons. This could involve defining in the Act human rights principles with respect to persons with intellectual disability and giving a Commissioner statutory authority to oversee the human rights of intellectually disabled persons, in particular those who are particularly vulnerable to exploitation because of their social circumstances. (eg, on account of imprisonment or other institutional detention).
6.6 New Zealand Bill of Rights Act 1990

For various constitutional reasons any amendment to the Bill of Rights is likely to be difficult to achieve and will seldom be necessary. However, while the Bill does prescribe clear rules governing the rights of persons arrested or detained and charged and minimum standards of criminal procedure, it may be doubted whether these statements of rights adequately provide for intellectually disabled persons charged with offences. In particular, the rights under s23(1)(a) to be 'informed' at the time of arrest or detention of the reason for it and under s23(1)(b) to 'consult and instruct a lawyer without delay', does not necessarily imply that the suspect must understand the information given. Yet in the case of an intellectually disabled suspect, an adequate understanding is axiomatic to the exercise of the right.

For these reasons I would suggest that the rights enshrined in the Bill of Rights should be supplemented by an additional statutory formulation of rights which are applicable to intellectually disabled offenders. These could be included in stand alone legislation for intellectually disabled offenders or could be incorporated into the Human Rights Act in a new Part dealing with the rights of intellectually disabled persons.

6.7 Health and Disability Services Act 1993

This statute is principally concerned with the reform of public funding and the provision of health and disability services in New Zealand. As such its concerns in the area of service provision are general. It does not purport to address the service needs of any particular group within the community. Its orientation is towards the obligations of service providers and purchasers and the issues of accountability that arise. It does not address the needs of people with disability as consumers.

To this extent it may be argued that the Act is deficient and that if it is to deliver 'the best care or support for those in need of services; and the greatest independence for people with disabilities that is reasonably achievable within the amount of funding provided', it will need to clearly identify the principles that ought to govern the provision of services in relation to the consumers of them and the objectives for the development and implementation of programmes and services for people with disabilities. A possible model is the Queensland Disability Services Act 1992. This approach may be desirable generally in relation to all consumers of health and disability services and with specific reference to intellectually disabled persons. Such principles and objectives could be readily imported into stand alone legislation for intellectually disabled offenders, as is done in the Victorian Intellectually Disabled Persons' Services Act 1986. By contrast, the Queensland Intellectually Handicapped Citizens Act 1985 currently contains no such statement of principles and objects.
6.8 **Judicature Act 1908**

By virtue of s17, the High Court is given supervisory jurisdiction and control over the persons and estates of 'idiots, mentally disordered persons, and persons of unsound mind...'. Although this provision has no direct impact upon intellectually disabled offenders as a class, the reference to 'idiots' is anomalous and should be substituted with the phrase 'intellectually disabled persons' to reflect current usage.

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233 See *Re T* (Unreported, Mental Health Review Tribunal, Northern Region No 191, 28 July 1993). The tribunal said: "The Act does not contemplate that a person be compulsorily detained for any appreciable period as a 'patient' for the purpose of controlling that person's behaviours and improving their adaptive functioning but not otherwise treating them where the sole underlying problem is intellectual retardation."

234 **Protection of Personal and Property Rights Act 1988**, s 10 (i) & (k).


238 Submission of Auckland Healthcare Services Limited and Services for People with an Intellectual Disability Limited to the Social Services Select Committee, 3 May 1994.

239 **Health and Disability Services Act 1993**, Long Title.
PART VII - LEGISLATIVE OPTIONS FOR NEW ZEALAND

7.1 Introduction

The approach taken so far in this report has been to identify particular areas in which present procedures and legislation have failed to adequately address the needs of intellectually disabled offenders and to suggest the lines along which reform might occur. A critical question concerns the type of statutory machinery through which these changes can best be effected. It seems to me that three approaches are possible:

1. Piecemeal legislative amendment.
2. Compulsory Care legislation.

I will consider each option in turn.

7.2 Piecemeal legislative amendment

This option has the advantage that it would, presumably, be less costly to establish. The affected legislation, in particular the Criminal Justice Act 1985 and the Mental Health (Compulsory Assessment and Treatment) Act 1992, could be amended as part of the normal legislative programme without the need for referral to a select committee. I imagine it would be the quickest means of getting any new legislation passed. The disadvantages, however, would lie in the lack of cohesion between the various amendments and the lack of an overall philosophy of care and treatment of intellectually disabled offenders. Furthermore, law change of this type would not signal sufficiently strongly to the various officials and organisations involved in its administration the distinctive claims of intellectually disabled persons and their fundamental differentiation from the mentally disordered. At the end of the day intellectually disabled offenders may be worse off under such a legislative regime.

In order to effect the range of legislative changes that would be necessary to adequately secure the interests of intellectually disabled offenders as a class and to secure the goal of public protection, amending legislation of this type could be extremely complex. I can envisage major difficulties of drafting in attempting to incorporate changes favouring intellectually disabled offenders into existing legislation and corresponding difficulties of interpretation. For these reasons I do not favour this approach.

7.3 Compulsory care legislation

Given the overwhelming professional reaction against the philosophy of compulsory care reflected in submissions to the Social Services Committee on the Mental Health (Compulsory Assessment and Treatment) Amendment Bill, I would not recommend this as a viable option for intellectually disabled offenders. Quite apart
from the principled objections that may be raised to preventive detention being applied to persons with a disability, the therapeutic implications of compulsory care are inapposite to the concept of intellectual disability. Intellectually disabled offenders do not require the same types of treatment interventions needed by people suffering from mental illness but rather the development of skills and behaviours appropriate to living in the community. These could not be achieved in a regime of compulsory care.

Furthermore, the present philosophy for the management of intellectually disabled persons who present challenging behaviours clearly favours a community-based approach and acknowledges that risk to public safety may occur in virtually any context including the criminal justice system. It has been suggested that of the relatively small group of intellectually disabled offenders who constitute a risk to public safety, their 'dangerousness' is mainly a function of the inadequate services being offered to them. There is some agreement that even that small number of people who can be extremely aggressive can, with positive, skilled behaviour management strategies, be dealt with without the need for confinement. On this basis a legislative regime of compulsory care would not be justified in relation to the problem presented by this group and would be contrary to the best interests of intellectually disabled offenders as a class and society as a whole.

7.4 Stand-alone legislation

A significant feature of the submissions to the Parliamentary Select Committee on the Mental Health (Compulsory Assessment and Treatment) Amendment Bill was the large number of individuals and organisations which favoured separate legislation for dealing with intellectually disabled offenders. Although few of the submissions attempted to define the scope or structure of such legislation, there was a degree of unanimity that an alternative system for the legal control of anti-social intellectually disabled offenders was warranted.

The underlying rationale for this approach appears to be the view that whereas there is a need to provide legislation for this group of people, it is not necessary for their needs to be met by mental health legislation. Most intellectually disabled people do not have mental illness as such but rather a behavioural disorder arising from their disability which brings them into conflict with the law. One organisation considered there was a need for stand alone legislation for this group, providing the same degree of protection as the Mental Health Act 1992 does for those who are mentally ill. Such legislation is considered necessary for ensuring better care and responsiveness to those individuals who are under disability and offend and for the protection of the public; and because inadequate provision was made for that group in the process of change to the 1992 Mental Health Act. The expressed need is for legislation capable of protecting the rights of such persons and ensuring their safe and appropriate care when it is justified. Such care requires quite different settings than the care of the mentally ill.

SPID, now Spectrum Trust, considers that ultimately Government may have to consider stand alone legislation to cover the total areas of disability, a view shared by many parents of persons with intellectual disability. Realistically, however, SPID
recognises that such legislation will take time to enact and considers that appropriate services, and amendments to existing legislation should be considered first.

One concern expressed in advocating separate legislation to address the needs of individuals with intellectual impairment was the need to emphasise their right to humane handling if they offend. This identifies one of the principal areas of concern under the present law and is a matter that could be comprehensively addressed in separate legislation.

Separate legislation could also address the widely expressed concern that it is not appropriate for intellectually disabled offenders to be detained as special patients in hospitals designed for the care and treatment of the mentally disordered. One commentator has made the valuable suggestion, mindful that public safety issues demand accountability for the safe care of such persons, that because such people suffer from a disability, it may be that the most senior officer of disability services within the Ministry of Health should play a role with intellectually disabled special patients similar to the role of the Director of Mental Health with mentally disordered special patients.

The concept of stand alone legislation is also endorsed by the New Zealand Branch of the Royal Australian and New Zealand College of Psychiatrists. That body acknowledges the serious deficiency in current legislation relating to the appropriate disposition of intellectually disabled offenders and expresses the view that stand alone legislation would allow the needs of the intellectually disabled to be met in a coordinated and logical manner, rather than piecemeal through other legislation as at present.

The concerns of psychiatrists who may be required to care for intellectually disabled offenders are well expressed by one clinician who cited 'universal agreement' that intellectual disability should not be reintroduced into the Mental Health Act, but that a separate Act is indicated for the small number of disabled who warrant attention on the grounds that they are a danger to others or themselves. Dr Miller notes that the whole drift of thinking in the 1980's was towards separation of the intellectually disabled from the mentally ill and warns that if there were requests for psychiatrists to detain significant numbers of people with intellectual disability, psychiatric resources would be overwhelmed. Yet as forensic patients they would be disadvantaged by not being treated with their peers, in the absence of any forensic intellectually disabled services.

On the basis of this survey it is my strong opinion that the time has come for New Zealand to give serious consideration to the creation of separate legislation for the management of intellectually disabled people who offend. I believe this is now necessary because of the irreversible conceptual separation that has occurred between intellectual disability and mental disorder. It is no longer practicable or clinically or socially desirable to continue to attempt to deal with both groups under generic mental health legislation. Already service provision does, in many respects, acknowledge the important distinction that exists between these two groups of people. However, the distinction is not yet adequately reflected in most relevant
legislation and the absence of a formal distinction and a properly articulated philosophy of care and treatment for intellectually disabled offenders has produced some well-attested anomalies and, arguably, injustices.

The real value of such legislation is that it would be capable of addressing the needs of intellectually disabled offenders *globally*. Within the parameters of a single statute it should be possible to prescribe procedures applicable to all the separate stages of dealing with offenders within the criminal justice system and beyond. This would have the advantage of eliminating uncertainty in the official response to intellectual disability when it is identified, and would facilitate the articulation of clear and consistent guidelines in the management and disposition of offenders at different stages of the criminal justice process, touching such matters as arrest, police interviews, bail, procedures at trial (including fitness to plead), sentencing, disposition and aftercare.

I am unaware of any legislation in the Commonwealth which attempts to specifically provide in this global way for intellectually disabled offenders. The question of its actual scope is a matter that would need to be given careful consideration. At the present time I would envisage a statutory code which would be exclusively concerned with the management of intellectually disabled offenders in the manner suggested above. However, there would seem to be no reason in principle why the legislation could not be expanded as a general statute for defining the rights and obligations of intellectually disabled persons generally, but containing designated parts defining procedures for dealing with offenders. Possible models that could be drawn upon in considering the structure of such legislation include the Queensland *Intellectually Handicapped Citizens Act 1985* and *Disability Services Act 1992* and the Victorian *Intellectually Disabled Person’s Services Act 1986*.

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241 See submission of Auckland Healthcare Services and Services for People with an Intellectual Disability, supra, 8.
242 Submission of the Directors of Mental Health of the Northern Region to the Social Services Committee on the *Mental Health (Compulsory Assessment and Treatment) Amendment Bill*.
243 Citizen Advocacy Auckland (Inc.) Submission to the Social Services Select Committee on the *Mental Health (Compulsory Assessment and Treatment) Amendment Bill*. This approach is endorsed by the Mental Health Foundation. See Mental Health News, Autumn 1994, p.9.
244 Submission of Waitemata Health to the Social Services Committee on the *Mental Health (Compulsory Assessment and Treatment) Amendment Bill*.
245 Dr S du Fresne, submission to the Social Services Select Committee on the *Mental Health (Compulsory Assessment and Treatment) Amendment Bill*.
246 Submission to the Social Services Select Committee on the *Mental Health (Compulsory Assessment and Treatment) Amendment Bill*, 5.
247 P Miller, Consultant Psychiatrist. Correspondence to the Director of Mental Health, 30 March 1994.
248 Ibid.
PART VIII - RECOMMENDATIONS

Part II - Outline of Key Issues

2.1 Introductory overview

It is recommended that research be authorised into the current service needs of mentally ill, behaviourally disordered and intellectually disabled persons with a view to determining priorities in service provision and the appropriate means of meeting these needs.

2.2 Conceiving a new legal model

It is recommended that empirical research be conducted into the actual incidence of intellectual disability amongst offender populations in New Zealand and the types of offences most commonly committed by offenders with an intellectual disability in order to determine the size of the problem and to identify areas where special services may need to be deployed.

There is an urgent need to define a clear conceptual approach and a new model for the care, management and disposition of intellectually disabled persons who offend. This should acknowledge the dangers of medicalising intellectual disability and should be the product of a careful inter-disciplinary analysis of all the relevant issues.

2.3 Defining intellectual disability

A carefully conceived definition of intellectual disability should be drafted into relevant legislation in order to clearly distinguish intellectual disability from mental disorder and to provide a sound legislative basis for differentiating intellectual disability from other forms of disability for the purposes of protection and service provision.

Relevant legislation ought to contain a statutory direction that intellectually disabled persons shall not be imprisoned unless the court is satisfied because of special circumstances relating to the offence or the offender any other sentence would be either inadequate or inappropriate.

Part III - Offending by Persons with an Intellectual Disability

3.1 Introduction

Any legislative approach to sexual offending by intellectually disabled persons should recognise the distinction between the two types of intellectually disabled sex offenders, and should make service provision that is appropriate to the needs of each group.
Empirical research should be conducted into the psycho-social reasons for arson
committed by intellectually disabled persons in order to identify those most at risk of
this type of offending and to assist in the development of appropriate strategies for
crime prevention and social skills training of offenders and potential offenders.

Formal policy is needed for the development of follow-up strategies for intellectually
disabled offenders convicted of serious crime in order to minimise the risk of
reoffending.

3.4 Police practice

Consideration should be given to a system that would allow clinical and other
appropriate intervention at the point of first contact by intellectually disabled
offenders with the police in order make early identification of intellectual disability
and, where appropriate, to facilitate the diversion of intellectually disabled offenders
from the criminal justice system.

Formal steps should be taken to ensure that whenever an intellectually disabled
person is interviewed by police an independent third person is present to assist the
suspect in the interview and clarify matters that are capable of serious
misinterpretation by the suspect.

3.5 Bail

Consideration should be given to the issue of bail for intellectually disabled
offenders, in particular statutory provision for a support person to assist with the
bail procedure and the creation of a statutory rebuttable presumption in favour of
bail in the case of intellectually disabled offenders. Paras 2.6.3 and 2.6.4.

3.6 Fitness to plead

The Criminal Justice Act 1985 should be amended to include a new definition of
'mentally impaired' in order to facilitate access by intellectually disabled persons and
persons suffering from brain damage to statutory procedures governing fitness to
plead.

Because many offenders with an IQ below 70 may be unfit to plead consideration
should be given to creating a statutory presumption of disability, rebuttable upon the
production of some evidence consistent with fitness. The purpose of the
presumption would be to create a simple procedure to avoid the need for a disability
hearing in the case of an offender who was manifestly incapable of meeting the
statutory criteria for 'under disability.'

3.9 Representation

The role of lawyers assisting intellectually disabled persons within the criminal
justice system needs to be clarified. In particular consideration needs to be given to
whether lawyers in New Zealand are currently adequately equipped by their training
to represent intellectually disabled offenders in their initial encounters with police and in their conduct of criminal litigation.

Consideration should be given to the establishment of a specialised legal advocacy service for intellectually disabled persons, including offenders, that would provide training and professional education for counsel wishing to develop specialist skills in this area. Other advocacy models, including the appointment of *guardians ad litem*, and 'friends at court' could be investigated in establishing a broadly based advocacy service for intellectually disabled persons.

3.10 *Criminal responsibility*

Consideration should be given to establishing a new procedure of a 'trial of the facts' to determine the criminal culpability of an intellectually disabled offender where responsibility for either the *mens rea* or *actus reus* may be in doubt.

**Part IV - Provision of Care**

4.1 *Assessment and treatment*

The training of clinical staff should include a greater emphasis on assessment and treatment and understanding the needs of intellectually disabled persons in order to minimise the risk of unnecessary criminalisation of this group.

In developing a philosophy for the care and treatment of intellectually disabled offenders, treatment in the community should be seen as the norm. Accordingly, I would recommend the enactment in appropriate legislation of a statutory direction mandating community treatment, except to the extent that a person cannot be adequately treated in the community.

4.2 *Resources and service provision*

Any legislation to provide for intellectually disabled offenders should contain a statement of principle that intellectually disabled persons should always be treated in an environment conducive to their specific needs and aspirations.

Any comprehensive integrated systems of care that may be established for intellectually and organically brain impaired persons should contain provision for the long-term supervised care and follow-up of individuals who pose a risk to others.

Any new legislative initiative for dealing with intellectually disabled offenders should be separately funded and should not depend on funding cuts to existing services if standards of care for other patients within mental health services are not to be detrimentally affected.

4.3 *Ethical considerations*

New legislative models for detention of offenders should clearly reflect the purpose for which they are conceived, should be appropriate for the particular mischief
addressed, and should prescribe outcomes which are realisable within the regime contemplated.

4.4 Normalisation

Careful consideration should be given to the relevance of the principle of normalisation as applied to intellectually disabled offenders. The principle should not be applied in such a way as to ignore the real social, economic and health disadvantages already experienced by this group.

4.6 Sentencing and disposition

The idea of providing in legislation for a dispositional conference to assist a court in determining the issues relevant in sentencing an intellectually disabled offender should be examined.

Wherever imprisonment is an indicated sentence for an intellectually disabled offender, the sentence should be served in a special prison wing designated for such offenders or otherwise in a 'special unit' for prisoners with an intellectual disability.

Consideration should be given to legislation establishing 'psychiatric probation orders' after the UK model in order to increase the range of dispositional options currently available.

The use of Guardianship orders should be investigated as a possible means of maintaining official oversight over intellectually disabled offenders, subject to the qualification that such orders should be viewed as being conceptually distinct from welfare guardian orders under the Protection of Personal and Property Rights Act 1988.

Urgent consideration should be given to articulating a philosophy of care and treatment for intellectually disabled offenders with a view to the creation of a new legislative infrastructure for their management and service provision.

As part of any legislative reform involving intellectually disabled offenders, consideration should be given to the establishment of hospital orders without conviction as a protective order for intellectually disabled offenders who do not warrant processing through the criminal justice system.

Consideration should be given to amending the existing provisions for hospital orders pursuant to s118 of the Criminal Justice Act 1985 to provide for intellectually disabled offenders.

Post release programmes should be implemented both to ensure the on-going management and care of intellectually disabled offenders and to reduce recidivism.
4.7 Human rights

Any legislation for intellectually disabled offenders should include a code of rights to guide public officials in the proper administration of the legislation. Para. 2.16.6.

Part V - Overseas Legislative Models

5.2 Canada

The 'under disability' rules should be amended to provide for a review every two years of whether there is sufficient evidence to put an offender under disability on trial, with a view to a change of status taking place where such insufficiency is established. Para. 3.2.3.

5.3.2 Victoria

Careful consideration should be given to the provisions of the *Intellectually Disabled Persons Services Act 1986 (Vic)* as a possible model for the establishment of 'stand alone' legislation for intellectually disabled offenders in New Zealand. Para. 3.3.3.3.

5.3.3 Queensland

The list of *Objectives for the Development and Implementation of Programmes and Services for People with Disabilities* in Part 4 of the *Queensland Disability Services Act 1992* should be studied with a view to possible incorporation into local legislation for intellectually disabled offenders. Para. 3.3.4.1.

The provision for special advocacy services in the *Queensland Intellectually Handicapped Persons Citizens Act 1985* should be studied with a view to the possible incorporation of similar services in relevant New Zealand legislation. Para. 3.3.4.2.

5.5 United Kingdom

In formulating services for intellectually disabled offenders consideration should be given to the 'treatment package' model comprising habilitation, education, occupation, counselling, specific interventions and health screening. Para. 3.4.5.

Part VI - New Zealand Legislation Affected

6.2 Mental Health (Compulsory Assessment and Treatment) Act 1995

Assuming that intellectually disabled offenders would be better catered for in stand-alone legislation, the exclusionary provision in s4(e) of the *Mental Health (Compulsory Assessment and Treatment) Act 1992* should be strengthened to make it clear that in no circumstances are the procedures in Parts I and II to be invoked where intellectual disability is the sole underlying problem.
6.3 Protection of Personal and Property Rights Act 1988

The Protection of Personal and Property Rights Act 1988 should not be used as a vehicle for the disposition of intellectually disabled offenders because its character as remedial legislation is inconsistent with the penal purposes implicit in any proposed power to detain intellectually disabled offenders. Para. 4.3.3.

6.4 Criminal Justice Act 1985

Consideration should be given to the creation of a new form of hospital order geared to the specific needs of intellectually disabled offenders. Para. 4.4.7.

6.5 Human Rights Act 1993

In order to maximise the standing of intellectually disabled offenders as persons with rights, consideration should be given to designating specific responsibilities for the oversight of their rights to the Human Rights Commission. Para. 4.5.1.

6.6 New Zealand Bill of Rights Act 1990

In order to ensure that the procedural rights of intellectually disabled offenders are adequately protected, the relevant rights in the New Zealand Bill of Rights Act 1990 should be supplemented with an additional statement of rights applicable to intellectually disabled offenders. Para. 4.6.2.

6.7 Health and Disability Services Act 1993

The Health and Disability Services Act 1993 should be amended to clearly identify the principles that ought to govern the provision of services in relation to the consumers of them and the objectives for the development and implementation of programmes and services for people with disabilities. Para. 4.7.2.

6.8 Judicature Act 1908

Section 17 of the Judicature Act 1908 should be amended to delete reference to 'idiots' and substitute a reference to 'intellectually disabled persons'. Para. 4.8.1.

Part VII - Legislative Options for New Zealand

7.2 Piecemeal legislative amendment

Piecemeal amendment of existing legislation to provide for intellectually disabled offenders is not recommended because of the complexity of the issues to be addressed and the need for coherence in the amendments contemplated. Para. 5.2.1.

7.3 Compulsory care legislation
The concept of compulsory care legislation has been met with strong professional condemnation and ought not be further pursued as a model for the containment and care of intellectually disabled offenders. Paras. 5.3.1 - 5.3.2.

7.4 ‘Stand-alone’ legislation

Because of the overwhelming support for the idea of ‘stand alone’ legislation expressed in submissions to the Social Services Select Committee on the *Mental Health (Compulsory Assessment and Treatment) Amendment Bill*, it is recommended that this approach be investigated as a possible alternative legislative system for the control of intellectually disabled offenders. Para. 5.4.1.
General Comment

The whole of Section 10 has concentrated on certain aspects of psychiatric care at Oakley Hospital and has also considered allegations made about various practices at that hospital. We think in concluding this Section we cannot do better than quote the key principles in the treatment relationship, set out by Dr Louis E. Kopolow, who was previously referred to at 10.8.11, which are as follows:

"Key Principles in the Treatment Relationship:

1. The patient's humanity must be respected and protected if treatment is to be possible.

2. All mental health treatment carries with it some risks that must be weighed against potential benefits. Mental health professionals should recognize the limits of prevailing knowledge.

3. A therapist should not underestimate a patient's resources to support a strategy with which he is allied or sabotage one he opposes. (Compliance problems are a consequence of failing to recognize this principle).

4. Mental illness is not forever unless the therapist perceives it that way. Expectations influence outcome, so it is crucial that therapists be comfortable with and confident of their skills and as optimistic as possible.

5. It is better to do nothing than to provide inappropriate or inadequate care.

6. Stigmatization may be as great a handicap to the patient as the illness. Therapists should not underestimate its impact on the chances of recovery.

7. A therapist should never impose his or her own value system or bias on the patient.

8. Coercive treatment distorts the therapist's role as caregiver and may be as harmful to the therapist as the patient. A more collaborative, less paternalistic approach is needed for effective treatment.

9. Independence and improved self-esteem are the foundation blocks on which to build the patient's lasting recovery. The therapist must support these goals in all aspects of treatment.

10. Primum non nocere - first, do no harm, is the guiding principle behind all treatment.

While these principles will not guarantee that a patient's rights will be protected; they can provide a framework for bringing about needed changes in professional attitudes and behaviour that can make the mental health system more protective of patients' rights and responsive to their concerns."
PART 3—PRINCIPLE THAT PEOPLE WITH DISABILITIES HAVE THE SAME HUMAN RIGHTS AS OTHERS

Principle that people with disabilities have the same human rights as others

9.(1) People with disabilities have the same basic human rights as other members of society and should be empowered to exercise their rights.

(2) People with disabilities have the right to—

(a) respect for their human worth and dignity as individuals; and

(b) realise their individual capacities for physical, social, emotional and intellectual development; and

(c) services that support their attaining a reasonable quality of life in a way that supports their family unit and their full participation in society; and

(d) participate actively in the decisions that affect their lives, including the development of disability policies, programs and services; and

(e) any necessary support, and access to information, to enable them to participate in decisions that affect their lives; and

(f) receive services in a way that results in the minimum restriction of their rights and opportunities; and

(g) pursue any grievance in relation to services without fear of the services being discontinued or recrimination from service providers; and

(h) adequate support to enable pursuit of grievances in relation to services.

(3) This section applies regardless of the age of the person with the disability or the origin, nature, type or degree of the disability.

(4) Services, and the information necessary to support a right, should be provided in a way that is appropriate taking into account the disability and the person's cultural background.

PART 4—OBJECTIVES FOR THE DEVELOPMENT AND IMPLEMENTATION OF PROGRAMS AND SERVICES FOR PEOPLE WITH DISABILITIES

Objectives in Part to be promoted by service developers and service providers

10. This Part sets out the objectives to be promoted by service developers and service providers in the development and implementation of programs and services for people with disabilities.

Focus on the development of the individual

11. Programs and services should be designed and implemented so that their focus is on developing the individual and on enhancing the individual's opportunity to establish a quality life.

Focus on a lifestyle the same as other people and appropriate for age

12. Programs and services should be designed and implemented to ensure that the conditions of everyday life of people with disabilities are—

(a) the same as, or as close as possible to, the conditions of everyday life valued by the general community; and

(b) appropriate to their chronological age.

Coordination of, and integration of, services with general services

13.(1) Services should be designed and implemented as part of local coordinated service systems and integrated with services generally available to members of the community, wherever possible.

(2) Units of the public sector should develop, plan and deliver disability programs and services in a coordinated way.
Services to be tailored to meet individual needs and goals

14. Services should be tailored to meet the individual needs and goals of people with disabilities.

People with disabilities experiencing additional disadvantages

15. Programs and services should be designed and implemented to meet the needs of people with disabilities who may experience additional disadvantages—
   (a) because they are Aborigines or Torres Strait Islanders; or
   (b) because of their sex, ethnic origin or location.

Promotion of competency, positive image and self-esteem

16. Programs and services should be designed and implemented to—
   (a) promote recognition of the competence of people with disabilities; and
   (b) promote a positive image of people with disabilities; and
   (c) enhance the self-esteem of people with disabilities.

Inclusion in community

17. Programs and services should be designed and implemented to promote the inclusion of people with disabilities in the life of the local community.

No single organisation to exercise control over life of person with disability

18. Programs and services should be designed and implemented to ensure that no single organisation that is a service provider exercises control over all or most aspects of the life of a person with a disability.

Certain service providers to make information available

19.(1) Organisations that are service providers should make available information that allows the quality of their services to be judged.

   (2) The information should be available to the people using the services, their advocates, any person who provides financial assistance for the services and the community generally.

Access to advocacy support

20. Services should be designed and implemented to ensure that people with disabilities have access to any necessary independent advocacy support so that they can participate adequately in decision-making about the services they receive.

Raising and resolving grievances

21. Programs and services should be designed and implemented to ensure that appropriate ways exist for people with disabilities and their advocates to raise grievances about services and have them resolved.

Participation in planning etc. of services

22.(1) Services should be designed and implemented to provide people with disabilities with, and encourage them to make use of, ways to participate continually in the planning and operation of services that they receive.

   (2) Programs and services provided to people with disabilities should provide opportunities for consultation in relation to the development of major policy and program changes.

Respect for privacy and confidentiality

23. Programs and services should be designed and implemented to respect the rights of people with disabilities to privacy and confidentiality.
Consideration etc. for others involved with people with disabilities

24. Programs and services should be designed and implemented to—
(a) consider the implications for the families, carers and advocates of people with disabilities; and
(b) recognise the demands on the families of people with disabilities; and
(c) take into account the implications for, and demands on, the families of people with disabilities.

PART 5—GRANT OF FINANCIAL ASSISTANCE

Persons eligible to apply for funding

25. The following persons are eligible to apply for a grant of financial assistance—
(a) people with disabilities;
(b) service providers;
(c) service developers.

Ministerial approval of grants of financial assistance

26. The Minister may approve grants of financial assistance only if the Minister is satisfied that—
(a) the principles set out in Part 3 will be promoted by the grant; and
(b) the programs and services funded by the grant will promote the objectives set out in Part 4.

Agreement about conditions to which financial assistance is subject

27.(1) A person is not to be paid money under a grant unless the person has agreed, in writing, with the conditions on which the grant is made.
(2) The agreement may deal with a matter that is dealt with under Part 6.

(3) If the grantee is an unincorporated body, a member or members of the organisation (specified by the Minister) must agree, in writing, with the conditions on which the grant is made.
(4) If the grantee is a service provider, the agreement must set out—
(a) the objectives of the service provider; and
(b) the outcomes to be achieved by the people receiving the services; and
(c) the rights of the people receiving the services.

Minister’s powers not limited by agreement etc.

28.(1) The Minister’s powers under this Part are not limited by—
(a) the inclusion of a matter in an agreement under section 27; or
(b) a power of the chief executive of the department under Part 6.
(2) The Minister may review, amend or repeal any decision under Part 6 of the chief executive of the department.

PART 6—POWERS OF CHIEF EXECUTIVE IF SUSPICION THAT CONDITION NOT COMPLIED WITH

Powers of chief executive if suspicion that a condition not complied with

29. If the chief executive of the department suspects on reasonable grounds that a condition of a grant of financial assistance under Part 5—
(a) is not being complied with; or
(b) has not been complied with;
the chief executive may exercise 1 or more of the powers under this Part.
Dear Sir/Madam

Home Office Circular No 66/90

PROVISION FOR MENTALLY DISORDERED OFFENDERS

The purpose of this circular is to draw the attention of the courts and those services responsible for dealing with mentally disordered persons who commit, or are suspected of committing, criminal offences to

(a) the legal powers which exist; and

(b) the desirability of ensuring effective co-operation between agencies to ensure that the best use is made of resources and that mentally disordered persons are not prosecuted where this is not required by the public interest.

BACKGROUND

2. It is government policy that, wherever possible, mentally disordered persons should receive care and treatment from the health and social services. Where there is sufficient evidence, in accordance with the principles of the Code for Crown Prosecutors, to show that a mentally disordered person has committed an offence, careful consideration should be given to whether prosecution is required by the public interest. It is desirable that alternatives to prosecution, such as cautioning by the police, and/or admission to hospital, if the person’s mental condition requires hospital treatment, or support in the community, should be considered first before deciding that prosecution is necessary. The government recognises that this policy can be effective only if the courts and criminal justice agencies have access to health and social services. This requires consultation and co-operation, and this circular aims to provide guidance on the establishment of a satisfactory working relationship between courts, criminal justice agencies and health and social services.

3. Provisions for mentally disordered offenders in the prison system in England and Wales were studied by an interdepartmental working group of Home Office and DHSS officials which reported in 1987. It recommended that the courts should be encouraged to use the existing provisions of the Mental Health Act, wherever practicable, to enable appropriate mentally disordered persons to be taken into the health system rather than the penal system, and that information should be made available to the courts about the provision of places in special hospitals, regional secure units and local hospitals.
4. The first point of contact between the criminal justice system and a mentally disordered person is often the police, who may be called to intervene in incidents involving a mentally disordered person. There are a range of powers which are available to the police, and it is important that they establish close working relationships with local health, probation, and social services to assist them in exercising their powers:

(i) section 136 of the Mental Health Act 1983 provides a constable with a power to remove to a place of safety a person found in a place to which the public have access and who appears to be suffering from mental disorder within the meaning of the Act and in immediate need of care or control if the constable thinks it is necessary to do so in the interests of that person or for the protection of others. The person may be detained for a maximum of 72 hours. The power in this section may be used in relation to persons who have not committed an offence, and to those who have (or are suspected of having) committed an offence, but where it is not considered necessary in the public interest to arrest that person for the offence. Agreement should be reached with local hospitals and local social services departments so that persons detained under section 136 are assessed by a psychiatrist and interviewed by an Approved Social Worker as soon as possible for the purpose of making any necessary arrangements for the person’s treatment or care. It is desirable that, wherever possible, the place of safety in which the person might be detained should be a hospital and not a police station. Guidance on the use of section 136 is contained in Chapter 10 of the Department of Health Code of Practice on the implementation of the Mental Health Act 1983 (a copy is attached at Annex A);

(ii) Section 135 of the 1983 Act empowers a justice of the peace—on information on oath laid by an Approved Social Worker—to issue a warrant authorising any constable to enter specified premises to remove to a place of safety—which should normally be a hospital—a person believed to be suffering from mental disorder who has been, or is being, ill-treated, neglected or not kept under proper control, or who is living alone and unable to care for himself. The warrant will authorise the person’s detention in a place of safety for a maximum of 72 hours. The initiative in seeking a warrant will normally rest with an Approved Social Worker. The warrant may apply to any premises within the justice’s jurisdiction, including private property to which the police powers under section 136 do not extend;

(iii) where it is suspected that a mentally disordered person may have committed an offence, consideration should be given—in consultation with the Crown Prosecution Service, where appropriate—to whether any formal action by the police is necessary, particularly where it appears that prosecution is not required in the public interest in view of the nature of the offence. If the suspect is able to meet the requirements for a caution to be administered, he might be cautioned. If the criteria for a caution are not met, the police should consider whether any action need be taken against the suspect. In some cases the public interest might be met by diverting mentally disordered persons from the criminal justice system and finding alternatives to prosecution, such as admission to hospital under sections 2 or 3 or to guardianship under section 7 of the 1983 Act or informal support in the community by social services departments. The development of effective liaison with health and social services authorities will play an essential role in developing satisfactory arrangements to respond constructively in such cases;

(iv) the questioning of mentally disordered persons suspected of committing offences is subject to the Code of Practice for the Detention, Treatment and Questioning of Persons by Police Officers issued under section 66 of the Police and Criminal Evidence Act 1984. (Annex E of the Code summarises the provisions relating to mentally ill and mentally handicapped persons). Paragraph 9.2 requires the custody officer immediately to call a police surgeon if a person brought to a police station or already detained there appears to be suffering from a mental disorder. In urgent cases the person must be sent to hospital. These requirements apply even if the person makes no request for medical attention. In the case of mentally disordered persons, chief officers of police may find it helpful to arrange with their local health authorities for psychiatrists to fill the role of police surgeon. Chief officers will be aware that even with the protection afforded by the Police and Criminal Evidence Act 1984, some mentally
disordered suspects may make confessions which are untrue, and therefore it is always advisable to seek other evidence which may support or reject the suspect’s story.

(v) where it is decided that the public interest requires the prosecution of a mentally disordered person for an offence it should be borne in mind that he has the same right as other suspects to bail after charge. If his mental state or other factors, such as homelessness, give rise to difficulties in releasing him on bail, arrangements should be made with the health, probation, and social services to ensure that appropriate support can be provided, such as admission to hospital, where his mental condition warrants it, or to a hostel, if the managers agree. Police bail cannot, of course, be subject to conditions of residence or medical treatment. but satisfactory arrangements to provide for these on a voluntary basis may enable the police to release the suspect on bail rather than to detain him pending his appearance before the magistrates’ court;

(vi) after a mentally disordered person has been charged, wherever possible arrangements should be made with the health, probation, and social services for his assessment with a view to ensuring that he receives any medical treatment that may be necessary, and that the Crown Prosecution Service and court can be advised of any particular bail conditions or, after conviction, disposal that may be appropriate to his circumstances. At Annex B to this circular is a note outlining court psychiatric assessment arrangements which have been established at certain central London and at Peterborough magistrates’ courts to secure expert medical advice when required. Chief officers of police may wish to explore with their local chief probation officers and health authorities the possibility of setting up similar arrangements to ensure that suspects who are thought to be mentally disordered and in need of medical assessment should be seen by a psychiatrist as soon as possible.

5. A small minority of cases involving mentally disordered persons result in findings by the Crown Court of unfitness to plead under the provisions of the Criminal Procedure (Insanity) Act 1964. Details of the consequences of such a finding are set out in paragraph 13 below. It is important to note, however, that although the accused is admitted to hospital as if subject to a hospital order and a restriction order without limit of time, a finding of unfitness to plead is not a disposal by the court. The intention of the Act is that the accused should return to court to stand trial, wherever possible, if his condition improves sufficiently to enable him to do so. It is, therefore, essential that where a person is found unfit to plead, all the relevant evidence should be preserved either until the accused is remitted for trial, or until formal notification is received from the Crown Prosecution Service or Home Office that a trial will not be held.

CROWN PROSECUTION SERVICE

6. Where proceedings are instituted against a person by the police, the papers will be referred to the Crown Prosecution Service which will review the sufficiency of the evidence and consider carefully whether or not the public interest requires a prosecution in accordance with the Code for Crown Prosecutors. Any information provided by the police with the papers regarding that person’s mental condition, or discussions held with other agencies to consider the advisability of diverting him from court, will be taken into account. It will be important to distinguish between those forms of mental disorder which are made worse by the institution of criminal proceedings and those forms of mental disorder which come about by reason of the institution of criminal proceedings. Where the Service is satisfied that the probable effect upon a person’s mental health outweighs the interests of justice in the particular case, it will consider discontinuing the proceedings. Where the form of mental disorder is present without there being any indication that proceedings will have an adverse effect, the Crown Prosecutor will take account of the public interest in attempting to ensure that the offence will not be repeated as well as having regard to the welfare of the person in question.

MAGISTRATES’ COURTS

7. Mentally disordered persons have the same rights as other persons, including a right to bail. A mentally disordered person should never be remanded to prison simply to receive medical treatment or assessment. It is desirable for the court to receive professional advice at an early stage as possible on facilities which may be available to assist it with mentally disordered persons. Annex B to this circular describes court psychiatric assessment arrangements at certain central London and at Peterborough magistrates’ courts. These enable the courts to receive speedy medical advice and to ensure that, where appropriate, arrangements can be made quickly to admit a mentally disordered person to hospital, for example as a condition of bail, or, with the agreement of the hospital managers, under section 35 of the Mental Health Act 1983 following conviction.
Where neither of these courses is applicable but the accused person nevertheless requires admission to hospital for assessment or treatment, the health and social services can be asked to consider using their civil powers of admission under sections 2 or 3 of the Act.

8. In considering cases involving mentally disordered persons magistrates may wish to bear in mind the possible courses of action which may be open to them. These include:

(i) where the Crown Prosecution Service decides to proceed with a case, the court will be required to consider the question of bail in the normal way. In cases where medical treatment is considered desirable this may be achieved as a condition of bail, such as requiring residence at a hospital of attendance at an outpatient clinic, although the bailed person cannot be compelled to comply with treatment under these circumstances. Magistrates will wish also to bear in mind the desirability of arranging for a medical report on the accused's condition to be prepared on bail. Their attention is drawn to Annex C of this circular, which describes the multi-agency assessment scheme operating in Hertfordshire;

(ii) in cases where an accused person has been convicted of an offence punishable with imprisonment, or has been charged with such an offence and the court is satisfied he did the act or made the omission charged, and it is considered necessary to remand him in custody rather than on bail, the attention of magistrates is drawn to the power of the court under section 35 of the 1983 Act to remand to hospital provided it is satisfied in accordance with section 35(4) that arrangements have been made for the admission of the accused within a period of seven days. This power should be used wherever possible to obtain a medical report on an accused person's condition, providing the court has written or oral evidence from a doctor who is approved under section 12(2) of the Act as having special experience in the diagnosis and treatment of mental disorder. That there is reason to suspect that the accused is suffering from mental illness, psychopathic disorder, mental impairment or severe mental impairment and the court is of the opinion that it would be impracticable for a report on the accused's mental condition to be made if he were remanded on bail. Normally the local psychiatric hospital or unit in a general hospital will be able to provide adequate arrangements for the assessment of mentally disordered persons, but in addition most regional health authorities are able to provide secure hospital accommodation in cases where this is necessary, and placces may be sought in a special hospital in respect of persons who are thought to require treatment in conditions of special security because of their violent, dangerous, or criminal propensities. At Annex D is a note of health service hospital facilities. Magistrates' courts are requested to consider with their Regional Health Authority the establishment of working arrangements to ensure that appropriate hospital facilities can be made available speedily when necessary;

(iii) where a person suffering from mental illness or severe mental impairment is charged with an offence punishable on conviction with imprisonment (other than where the sentence is fixed by law), a magistrates' court has power under section 37(3) of the 1983 Act to make a hospital order without convicting him provided the court is satisfied that the accused did the act or made the omission charged, and that on the evidence of two registered medical practitioners, one of whom is approved under section 12(2) of the Act, the accused is suffering from mental disorder of a nature or degree which makes it appropriate for him to be detained in hospital for treatment. In the case of psychopathic disorder or mental impairment the court must also be satisfied, on the same evidence, that such treatment is likely to alleviate or stabilise the condition. Before making an order the court must be satisfied under section 37(4) that arrangements have been made for the offender's admission to hospital within 28 days of an order being made. The requirements for determining whether the offence should be tried summarily or on indictment need not necessarily be complied with, nor is a trial necessary, before exercising this power. However, its exercise will usually require the consent of those acting for the defendant if he is under a disability so that he cannot be tried (see R v Lincolnshire (Kesteven) Justices, ex p. O'Connor [1983] 1 AER 901):

(iv) where a mentally disordered person is convicted of an offence the court will wish to consider whether a non-penal disposal may be appropriately imposed. These include:

(a) a hospital order under section 37 of the 1983 Act in cases where the accused person is convicted of an offence punishable with imprisonment (other than where the sentence is fixed by law), if the court is satisfied on evidence from two
registered medical practitioners, one of whom is approved under section 12(2) of the Act, that the offender is suffering from mental disorder of a nature or degree which makes it appropriate for him to be detained in hospital for treatment, and that in the case of psychopathic disorder or mental impairment the treatment is likely to alleviate or stabilise the condition. The court must also be satisfied that, in accordance with section 37(4), arrangements have been made for the offender’s admission to hospital within twenty eight days;

(b) an interim hospital order under section 38 of the 1983 Act. To assist the court and hospital in determining whether it is appropriate to make a hospital order in respect of an offender, the courts may make an interim hospital order so that the offender’s response in hospital can be evaluated without any irrevocable commitment on either side to this method of dealing with the offender if it should prove unsuitable.

Before making an interim hospital order the court must be satisfied on evidence from two doctors, one of whom is approved under section 12(2) of the Act, that the offender is suffering from mental disorder such as makes it reasonable to suppose that a hospital order might be appropriate. It must also be satisfied in accordance with section 38(4) that arrangements have been made for the offender’s admission to hospital within 28 days;

(c) a guardianship order under section 37 of the 1983 Act in cases where the offender is convicted of an offence punishable with imprisonment (other than where the sentence is fixed by law), placing the offender under the guardianship of the local, social services authority or a person approved by it, provided he has reached the age of 16 and the court is satisfied on evidence from two registered medical practitioners, one of whom is approved under section 12(2) of the Act, that the mental disorder is of a nature or degree which warrants reception into guardianship. By virtue of section 37(6) a guardianship order is not to be made unless the court is satisfied that the authority or person in question is willing to receive the offender.

The purpose of guardianship is primarily to ensure that the offender receives care and protection rather than medical treatment, although the guardian does have powers to require the offender to attend for medical treatment. The effect of a guardianship order is to give the guardian power to require the offender to live at a specific place (this may be used to discourage the offender from sleeping rough or living with people who may exploit or mistreat him, or ensure that he resides at a particular hostel), to attend specific places at specified times for medical treatment, occupation, education, or training, and to require access to the offender to be given at the place where the offender is living to any doctor, approved social worker, or other person specified by the guardian. This power could be used, for example, to ensure the offender did not neglect himself;

(d) a probation order with a condition of psychiatric treatment under section 30 of the Powers of Criminal Courts Act 1973. This is a normal probation order which has been adapted to meet the needs of an offender who does not need to be detained in a hospital, but who is suffering from a mental condition which can be treated and needs treatment. A probation order may not be made unless the Court is satisfied that arrangements have been made for the treatment which the court intends to specify in the Order, including arrangements for the offender’s reception where he is to be required to submit to treatment as an in-patient. The court may make a probation order in the normal way, with the consent of the offender; and if it is satisfied on the evidence of a doctor approved as having special experience in the diagnosis or treatment of mental disorder that the offender needs treatment for his mental condition but does not need to be detained in hospital, the court may include in the probation order a requirement that he undergoes medical treatment with a view to the improvement of his mental condition. A condition of residence at a hospital can be attached to the probation order, if appropriate, even where formal detention under the Mental Health Act is not indicated. The court may also wish to call for a social inquiry report to assist it in reaching a decision in such cases. The offender may be required to undertake treatment for the whole of the period of the probation
order, or for part of it. If he fails to comply with the requirements of the probation order, the offender is in breach of probation and may be dealt with in the same way as any other offender who is in breach of probation;

(e) discharge, either absolute or conditional, so that arrangements may be made on an informal basis for the offender to receive any necessary medical treatment or social work support. Under such a disposal, however, treatment may not be administered compulsorily, unless the offender is subsequently detained under the civil powers of the 1983 Act.

9. It is open to any magistrates' court which is minded to make a hospital or interim hospital order in respect of any person to ask the Regional Health Authority under the provisions of section 39 of the 1983 Act for information about hospitals which can accommodate that person (see paragraph 15 below).

CROWN COURT

10. In considering cases involving mentally disordered persons the Crown Court may wish to bear in mind its powers to obtain a medical report by:

(i) remanding on bail with a condition of attendance at, or residence in, a hospital for the purpose of medical assessment;

(ii) remanding to hospital under the provisions of section 35 of the 1983 Act an accused person suffering from mental illness, psychopathic disorder, mental impairment or severe mental impairment who is awaiting trial for an offence punishable with imprisonment, or who has been arraigned but not yet sentenced or otherwise dealt with.

This power may be exercised where the court is satisfied on the evidence of a doctor, who is approved under section 12(2) of the Act that there is reason to suspect the accused is suffering from mental disorder, and the court is of the opinion that it would be impracticable for a medical report to be made if he were remanded on bail. The court must also be satisfied in accordance with section 37(4) that the accused will be admitted to hospital within 7 days. (This power may not be exercised in respect of a person convicted before the court if the sentence for the offence of which he has been convicted is fixed by law.)

11. The Crown Court has power under section 36 of the 1983 Act to remand an accused person (other than a person charged with an offence the sentence for which is fixed by law) to hospital for treatment. The court must be satisfied on the evidence of two registered medical practitioners, one of whom must be approved under section 12(2) of the Act, that the accused is suffering from mental illness or severe mental impairment of a nature or degree which makes it appropriate for him to be detained in hospital for medical treatment. The court must also be satisfied, in accordance with section 36(3), that the accused will be admitted to hospital within 7 days. The court may find this power helpful when considering cases of mentally disordered persons who may be unfit to plead but whose mental condition might improve as a result of medical treatment.

12. Cases may arise where an accused person, who has been remanded in prison custody, is transferred by the Home Secretary to hospital for urgent treatment under the provisions of section 48 of the 1983 Act. If it appears to the Crown Court in such a case that it is impracticable or inappropriate to bring that person before the court, the court may, in accordance with section 51(5), make a hospital order (with or without a restriction order) in his absence and, in the case of a person awaiting trial, without convicting him. Before doing so the court must be satisfied on the written or oral evidence of at least two registered medical practitioners, one of whom is approved under section 12(2) of the Act, that the accused is suffering from mental illness or severe mental impairment which makes it appropriate for him to be detained in hospital for treatment, and that it is proper to make such an order.

13. In cases where the accused is found to be unfit to plead under the provisions of section 4 of the Criminal Procedure (Insanity) Act 1964, the court is required by section 5 of the Act to make an order that the accused be admitted to such hospital as may be specified by the Secretary of State. This may be a special hospital, a regional secure unit or a local hospital, depending on the gravity of the alleged offence and the apparent risk to the public. The accused is treated as though subject to a hospital order and a restriction order without limit of time made under the provisions of sections 37 and 41 of the Mental Health Act 1983. In view of the nature of this disposal, courts are asked to bear in mind their power under section 4(2) of the 1964 Act to postpone consideration of the defendant's fitness to plead until anytime up to the opening of the case for the defence. This provides an opportunity to test the prosecution case and may reduce the likelihood of an innocent
15 December 1995

Dear Reader

Please find enclosed a copy of *The development of legislation to meet the needs of individuals with intellectual disability who, because of their disability, are considered to present a serious risk to others*. This discussion paper has been prepared as a discussion document for the Ministry of Health by Warren Brookbanks.

This discussion paper looks at the development of legislation to meet the needs of individuals with an intellectual disability who, because of their disability, are considered to present a serious risk to others. It also presents options of the most appropriate ways of managing people who offend because of intellectual disability, and whose disability significantly impairs their ability to appreciate the gravity of their offending.

You are invited to comment on this discussion paper. Your response will assist the Ministry of Health in determining the most appropriate ways to address the issues outlined in the report, as well as bringing to our attention any other issues that may also need to be addressed.

**Please send your submissions, by 15 February 1996 to:**

Catherine Coates  
Mental Health Services  
Ministry of Health  
PO Box 5013  
Wellington

Should you require additional copies of the paper, please contact Toni Simpson at the Ministry of Health on (04) 496-2318.

We look forward to hearing from you.

Yours sincerely

Joy Cooper  
Manager, Mental Health Services

Carol D'Audrey  
Manager, Disability Support Services
person being detained. This may be particularly important in the case of persons who appear to be suffering from severe mental impairment. Their condition is unlikely to change after receiving medical treatment and consequently they may never be able to benefit from a normal trial. Where a person is found unfit to plead the Home Secretary will arrange for his case to be reviewed at six monthly intervals during the first two years of his detention in hospital to consider his fitness to stand trial, and he would normally expect to remit that person for trial should he receive medical advice that he is fit to plead. If, at the end of two years, the Home Secretary is advised that he remains unfit to plead he will review the continuing need for the restriction order under section 42(1) of the 1983 Act and will terminate it if he concludes it is unnecessary for the protection of the public from serious harm.

14. If a mentally disordered person is convicted of an offence the court will wish to consider the suitability of non-penal disposals. These include:

(i) a hospital order in cases where a person is convicted of an offence (other than one for which the sentence is fixed by law) punishable with imprisonment, if the court is satisfied, in accordance with the provisions of section 37(2) of the 1983 Act, on the evidence of two registered medical practitioners, one of whom is approved under section 12(2) of the Act, that the offender is suffering from mental disorder of a nature or degree which makes it appropriate for him to be detained in hospital for treatment, and that, in the case of psychopathic disorder or mental impairment, the treatment is likely to alleviate or stabilise the condition. The court must also be satisfied that, in accordance with the provisions of section 37(a), arrangements have been made for the offender's admission to hospital within twenty eight days. In addition to the special hospitals (Ashworth (formerly Moss Side and Park Lane Hospitals), Broadmoor and Rampton), which provide treatment in conditions of special security for persons with violent, dangerous, or criminal propensities, most regional health authorities provide a range of hospital facilities for the treatment of mentally disordered offenders, including secure units. At Annex D is a note of health service hospital facilities;

(ii) an interim hospital order (see paragraph 8.iv.(b) above);

(iii) a restriction order. In any case where it makes a hospital order under section 37 of the 1983 Act, the court may also make a restriction order under section 41 where it appears necessary for the protection of the public from serious harm. The decision on whether to make the order rests with the court and does not depend upon the agreement of the hospital or the doctor in whose care the patient will be placed. although at least one of the doctors whose evidence is taken into account in making a hospital order must have given oral evidence in court. In reaching its decision the court must take into account the nature of the offence, the antecedents of the offender. and the risk of his committing further offences if set at large. (The law governing the making of restriction orders was clarified by the Court of Appeal in R v Birch [1989] CLR June 296.) A restriction order may be either for a specified period or without limit of time, and may be terminated at any time by the Home Secretary under section 42(1). The effect of a restriction order is that the patient may not be discharged (except by a Mental Health Review Tribunal), granted leave of absence, or transferred to another hospital without the consent of the Home Secretary. Restricted patients are generally discharged from hospital subject to conditions of residence and supervision by a doctor and a social worker or probation officer, remaining liable to recall to hospital by the Home Secretary for a period after their discharge. Where circumstances warrant it, however, such patients can be absolutely discharged from hospital instead of having to complete a period of supervised living in the community;

(iv) a guardianship order (see paragraph 8.iv.(c) above);

(v) a probation order (see paragraph 8.iv.(d) above);

(vi) discharge. Where the court is satisfied that, following conviction, the public interest requires no formal sentence or other disposal it is open to the court to discharge the offender, either absolutely or conditionally, particularly if it believes that satisfactory arrangements for the care and treatment of the offender can be made on an informal basis.

In considering these options, the court may find it useful to involve the Crown Court liaison probation officer in approaching the health authorities or social services departments or in making appropriate arrangements for the preparation of a social inquiry report.
15. To assist the courts in deciding whether to make a hospital or interim hospital order, section 39 of the 1983 Act places a duty on Regional Health Authorities to respond to requests from courts for information about hospitals which could provide accommodation for people in respect of whom the courts are considering making hospital orders. This obliges Regional Health Authorities to inform the court as to the facilities they provide for detained patients, including those who may require treatment in appropriate conditions of security; and it will also enable the Regional Health Authority to advise in cases where there is some room for doubt as to the patient's normal place of residence or other factor determining the appropriate hospital within whose catchment area he falls. The intention is to provide a court with all possible assistance short of removing the obligation in section 37(4) of the 1983 Act to be satisfied that the necessary arrangements have been made before making a hospital order, in cases where the necessary criteria for a hospital order are satisfied and it is minded to make one, but no hospital place has been made available. Regional Health Authorities have been encouraged to make standing arrangements for meeting such requests for information from courts, and it is intended that these arrangements will reduce the number of cases in which a hospital order appears suitable but the court is frustrated in the search for a place. In cases where it is desired to make use of this provision, the clerk of the court should contact the Regional Medical Officer or solicitor for the Regional Health Authority covering the area from which the offender appears to come. (There is no longer any scope for disputes between Regional Health Authorities as to responsibility for dealing with the enquiry, as any Authority approached by the court is under a statutory duty to provide information about hospitals "in its region or elsewhere" at which arrangements could be made for the person to be admitted. If the Authority first contacted believes it to be more appropriate for another Authority to respond, it will only be able to pass on responsibility if the second Authority agrees.)

16. Where a court is satisfied that at the time of committing the act with which he is charged the accused was labouring under such a defect of reason from disease of the mind as not to know the nature and quality of the act he was doing or, if he did know it, that he did not know he was doing what was wrong, it shall return the special verdict of not guilty by reason of insanity. In accordance with the provisions of section 5(1) of the Criminal Procedure (Insanity) Act 1964 the court is required to make an order that the accused be admitted to such hospital as may be specified by the Home Secretary (the level of security being determined by the seriousness of the offence and the apparent risk of further offending), where he will be detained as though subject to a hospital order and restriction order without limit of time made under sections 37 and 41 of the Mental Health Act 1983.

**Provision Service**

17. The probation service should act as part of a network of agencies (social services, health services, voluntary organisations) providing accommodation, care and treatment in the community for mentally disordered offenders. Information about facilities for accommodation, treatment, education, supervision etc should be pooled, and there should be a shared list of contact points with telephone numbers for each agency. (In some areas it may be sensible for the probation service to take the lead in co-ordinating this network, but elsewhere the lead might be taken by a voluntary organisation or by the social services with their responsibility for care in the community.) The special role of the probation service is:

- to provide information to the courts for bail and sentencing decisions;
- to provide information to the Crown Prosecution Service in connection with bail information schemes;
- to provide bail and probation hostels and other accommodation projects for offenders and persons on bail;
- to provide for the throughcare and supervision of offenders released from prison on licence and parole.

Chief Probation Officers are asked to establish liaison arrangements with other agencies to ensure that the probation service can carry out these tasks effectively. At Annex E is a note outlining seminars and training courses organised by the West Yorkshire and the Greater Manchester Probation Services and by the Northern Regional Committee for Probation Staff Development which chief officers might find helpful as examples of good practice in encouraging co-operation with other agencies and with the courts.

18. When a mentally disordered person is arrested and charged, the probation service should play its part in diverting him or her from custodial remand. They can do this in several ways. If there is a bail information scheme, the probation officer will visit the accused in police custody to interview him and obtain information which, if verified, can be passed on the Crown Prosecution Service to inform the bail decision. Mentally disordered persons may be particularly at risk of
being remanded in custody, because their circumstances and way of life may be unstable. Good liaison between the bail information scheme, the police, the health service and social services will therefore be particularly important. If in-patient treatment is not warranted, the probation officer may be able to identify suitable accommodation in a bail hostel or lodging scheme organised by the probation service, or by the social services. Intervention at this stage can prevent unnecessary remands to prison establishments.

19. If there is no bail information scheme the first contact may not occur until the accused's first court appearance. The court will have the range of options described in paragraph 8(i) and (ii) above. In particular, mentally disordered persons may be remanded to hospital by the courts under the provisions of section 35 and 36 of the Mental Health Act 1983. In other cases it is open to the courts to remand the accused on bail with a condition of residence in a hospital or of attendance at a hospital. Persons whose condition is not such as to require in-patient treatment may be considered for placement in a bail hostel where this is desirable to avoid a remand in custody. Or they may be remanded on bail with other conditions (e.g., living at a specified address). The court duty probation officer can help the court by advising on ways of avoiding a custodial remand making use of resources and treatment available in the community. This will succeed only if the probation service has good liaison with, and support from, other agencies, especially the health service and the local authority social services, whose responsibilities are described at Annex F.

20. When mentally disordered persons are convicted of offences, the court will wish to consider the possibility of a community disposal. In cases where detention in hospital for treatment under the provisions of section 37 of the 1983 Act is not considered necessary, but the offender's mental condition is still treatable, a probation order with a condition of psychiatric treatment may be given. If the offender's condition is not treatable, a probation order may be made without a condition of treatment, but with other conditions or arrangements which make for effective supervision. These may include residence at a probation hostel or other community care arrangements made by the social services or a voluntary organisation. It is important that the court should have a social inquiry report available to it in addition to medical advice. The SIR should set out the full range of sentencing options which may be suitable, and give details of the type of supervision and accommodation which could and would be provided in the community. There should be liaison between probation officer, author of the medical report and the offender's lawyer about an appropriate recommendation to the court.

21. It is important that all accused persons who are likely to be suitable candidates for probation orders are identified at as early a stage as possible and that arrangements are made quickly for their medical assessment. Chief Probation Officers are asked to review their procedures, in consultation with police, the courts, social services and health authorities, to ensure that they identify candidates for community disposals at an early stage in the prosecution process and assist in achieving a swift disposal of the case by the courts. (At Annex C is a brief description of a multi-agency assessment scheme in operation in Hertfordshire).

22. The effectiveness of probation orders with a condition of treatment depends on close co-operation, understanding and communication between the probation service and local psychiatric services, and is aided by the presence at local level of psychiatric staff with an interest in forensic psychiatry. It would be helpful for each probation area to draw up its own code of practice for probation officers undertaking supervision of a mentally disordered offender, defining lines of responsibility and accountability (e.g., clarifying boundaries between the responsible medical officer and the probation officer, especially where both are carrying statutory responsibilities).

PRISON MEDICAL SERVICE

23. Consolidated guidance will be issued shortly to the prison medical service in a circular instruction from the Director of the Prison Medical Service. This reminds medical officers when examining remand prisoners on reception into prison to be alert for signs of mental disorder. Any prisoner who is suffering from mental illness or severe mental impairment of a nature or degree which makes it appropriate for him to be detained in hospital for medical treatment and is in urgent need of hospital treatment, should be recommended for transfer to hospital in accordance with the provisions of section 48 of the Mental Health Act 1983. Medical officers are encouraged to discuss with C3 Division any case where there is doubt about what initiative to take or where there is any difficulty in securing a hospital place. Medical officers should also seek to identify those remand prisoners who might benefit from medical treatment after conviction, for example
by means of a hospital order, psychiatric probation order, or guardianship order. In such cases they should offer advice to the court and, where appropriate, should seek the assistance of the probation service, for example in arranging for a psychiatric probation or a guardianship order to be made by the court.

24. In the case of sentenced prisoners, medical officers are reminded of the need to arrange the transfer to hospital under section 47 of the Mental Health Act 1983 as soon as possible during the course of their sentences of those prisoners suffering from mental illness, psychopathic disorder, mental impairment, or severe mental impairment of a nature or degree which makes it appropriate for them to be detained in hospital for treatment. Medical officers should ask a consultant psychiatrist from the catchment area hospital or regional secure unit, or special hospital covering the prisoner’s home to visit as soon as possible to assess the prisoner and to arrange his admission to their hospital, taking account of the level of security which is required. Recommendations for transfer from two registered medical practitioners, at least one of whom is approved for the purposes of section 12 of the Mental Health Act 1983 as having special experience in the diagnosis or treatment of mental disorder, should then be put forward to C3 Division. Medical officers are encouraged to discuss any cases where there is doubt, or where difficulty is experienced in finding a hospital place, with C3 Division.

CONCLUSION

25. It is the government’s policy to divert mentally disordered persons from the criminal justice system in cases where the public interest does not require their prosecution. Where prosecution is necessary it is important to find suitable non-penal disposals wherever appropriate and the police, courts, and probation service are asked to work together with their local health and social services to make effective use of the provisions of the Mental Health Act 1983 and of the services which exist to help the mentally disordered. They are also asked to ensure that all their officers are aware of this circular, and to consider any training which is necessary to equip them in their contracts with mentally disordered persons.

26. In summary:

(i) Chief Officers of Police are asked to ensure that, taking account of the public interest, consideration is always given to alternatives to prosecuting mentally disordered offenders, including taking no further action where appropriate, and that effective arrangements are established with local health and social services authorities to ensure their speedy involvement when mentally disordered persons are taken into police custody;

(ii) Courts are asked to ensure that alternatives to custody are considered for all mentally disordered persons, including bail before sentence, and that persons who are in need of medical treatment are not sent to prison. The attention of court clerks is drawn, in particular, to the desirability of establishing arrangements in co-operation with the probation service and the local health and social services authorities, for speedy access to professional advice for the court to assist it in its decision making;

(iii) Chief Probation Officers are asked to ensure that effective arrangements are established to provide courts with information and advice to enable them to make use of alternatives to imprisonment in dealing with mentally disordered offenders. Attention is drawn to the need to co-operate with local health and social services authorities to provide professional advice to courts and to facilitate a wider use of treatment and non-custodial disposals, including remands on bail before sentence and psychiatric probation orders and guardianship orders, where appropriate, after conviction; and

(iv) Prison medical officers are asked to ensure that action is taken to arrange transfer to hospital under the provisions of section 48 of the Mental Health Act 1983 in respect of any mentally ill or severely mentally impaired person remanded in custody who appears to require urgent treatment in hospital, and to consider advising the courts of the suitability of any other mentally disordered person on remand for treatment as part of a non-custodial disposal, such as a psychiatric probation order or guardianship order, after conviction. Prison medical officers are asked to ensure that action is taken to arrange the transfer to hospital under the provisions of section 47 of the Mental Health Act 1983 of any sentenced prisoner who appears to require treatment in hospital for mental disorder.
27. Enquiries about this circular should be addressed to Robert Wallich, C3 Division, Home Office, 50 Queen Anne’s Gate, London S.W.1 (telephone 071-273-3118).

Yours faithfully

Robert Baxter
C3 Division

The annexes to this circular, are omitted. They are reproduced at Annex B of the report of the community advisory group.